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TO ERR IS HUMAN—EXCEPT WHEN ONE IS A PHYSICIAN?

A Reflection on Fallibility, Blame, and Responsibility in the Practice of Medicine

Claude Jacques Chambriard[1,2*], Sergio Augusto Lopes de Souza[3] Zartur José Barcelos Menegassi[1]

[1]Department of Orthopedics and Traumatology, School of Medicine, Federal University of Rio de Janeiro (UFRJ), Rio de Janeiro, Brazil

[2] Civil Police of the State of Rio de Janeiro (PCERJ), Rio de Janeiro, Brazil

[3]Department of Radiology, School of Medicine, Federal University of Rio de Janeiro (UFRJ), Rio de Janeiro, Brazil

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***Corresponding author:** Claude Jacques Chambriard, Department of Orthopedics and Traumatology, School of Medicine, Federal University of Rio de Janeiro (UFRJ), Rio de Janeiro, Brazil

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ABSTRACT

"To err is human" expresses a basic truth about human judgment: even competent, conscientious, and experienced people remain vulnerable to uncertainty, incomplete information, cognitive limitations, fatigue, and unforeseen outcomes. Yet when an adverse outcome occurs in medicine, the tolerance usually extended to human fallibility often narrows dramatically. This essay argues that recognizing physicians' fallibility does not diminish professional responsibility, but makes its assessment more ethically coherent. Adverse outcomes, complications, errors, negligence, and responsibility are not interchangeable concepts. Fair accountability requires reconstruction of the information and circumstances available at the time of the clinical decision, attention to systemic as well as individual contributors, and a causal link between a culpable departure from an appropriate standard of care and the harm that followed. The essay also examines hindsight bias, defensive medicine, disclosure, apology, and the need for a just culture in health care. Medicine should neither excuse preventable harm in the name of humanity nor impose an impossible duty of infallibility.

Keywords: medical error; professional responsibility; patient safety; negligence; hindsight bias; just culture; disclosure; apology

THE SEDUCTION OF INFALLIBILITY

"To err is human" is among the most familiar expressions used to understand, excuse, or forgive a failure. It does not mean that every mistake is acceptable, nor that consequences should be ignored. Its deeper meaning is that error belongs to the range of human possibilities. People perceive incompletely, decide under uncertainty, work with limited information, and are influenced by fatigue, urgency, emotion, environment, and the limits of their own knowledge. Even when acting in good faith and with appropriate preparation, a person may misinterpret a situation, choose an option that later proves unsuccessful, or fail to achieve the intended result.

That ordinary recognition of fallibility changes when the person who erred is a physician. Medicine acts upon goods of extraordinary value: life, health, bodily integrity, autonomy, and dignity. When a medical decision ends badly, what is lost may be a function, a life project, or life itself. The emotional and moral weight of such outcomes explains why physicians are held to demanding professional standards. It does not, however, justify replacing careful analysis with the automatic conclusion that harm proves error, or that error proves culpability.

A physician does not cease to be human upon receiving a medical degree. Residency, specialization, experience, and professional prestige do not confer omniscience. At the same time, humanity cannot serve as a generic excuse for poor practice. To practice medicine is to assume a heightened duty of preparation, prudence, diligence, communication, and recognition of one's limits. The ethical problem therefore lies between two equally unsatisfactory extremes: treating fallibility as permission to be careless, and treating professional responsibility as a duty to be infallible.

The modern patient-safety movement emerged in part from the recognition that preventable harm is real and that health systems have historically underestimated both its frequency and its causes.[1] The lesson should not be that physicians are less responsible than previously believed. It should be that responsibility is more complex than a simple search for the last identifiable person who touched the patient.

Adverse Outcome, Error, and Negligence Are Different Concepts

One of the most persistent difficulties in discussions of medical responsibility is conceptual collapse. An adverse outcome is often called an error; an error is then treated as negligence; negligence is then assumed to establish responsibility. These steps may feel intuitively persuasive after harm has occurred, but they are not logically equivalent.

A treatment may be correctly indicated and still fail. A technically appropriate operation may be followed by a recognized complication. A drug given in the correct dose may cause an unexpected reaction. A diagnosis may reasonably remain uncertain during an early encounter because the disease has not yet produced the findings that later make it appear obvious. Diagnostic practice itself is probabilistic and iterative, and even well-designed systems cannot eliminate every diagnostic failure.[2]

Thus, not every adverse outcome is an error; not every error causes harm; and not every harmful error is negligent. In ordinary common-law language, professional negligence generally requires more than an undesirable result: there must be a duty, a departure from the applicable standard of care, harm, and a causal relationship between the departure and the harm. Other legal traditions use somewhat different categories, but the ethical distinction is similar. Competence, recklessness, omission, uncertainty, and unavoidable complication should not be treated as synonyms merely because all may precede a bad outcome.

This distinction matters for patients as much as for clinicians. If every complication is labeled negligence, genuine negligence becomes harder to identify with precision. Conversely, if every mistake is described as an

unavoidable complication, professional accountability becomes meaningless. The ethically defensible position is neither automatic accusation nor reflexive professional solidarity. It is disciplined differentiation.

A concise way to express the distinction is this: the bad outcome is a fact; the error is a technical judgment about a decision or action; negligence is a normative judgment about whether the conduct unjustifiably fell below an appropriate standard; and responsibility is a consequence that should follow only after the relevant elements, including causation, have been established.

The Tyranny of Hindsight

Every adverse event is investigated after it has happened. That obvious fact creates a powerful distortion. The retrospective observer already knows the final diagnosis, the test that eventually became abnormal, the complication that occurred, the treatment that failed, and the outcome. The treating physician did not possess that knowledge at the time of decision.

Once the outcome is known, ambiguous signs may appear clear, uncommon diagnoses may appear foreseeable, and tests that were not ordered may appear indispensable. This is the domain of hindsight and outcome bias. Research in medicolegal judgment has long warned that knowledge of an adverse outcome can influence retrospective assessments of whether clinical conduct was reasonable.[3] The danger is not simply intellectual. It can change the moral character we assign to an earlier decision: uncertainty becomes ignorance, a difficult judgment becomes carelessness, and a statistically unlikely event becomes something the physician "should have known."

A fair assessment should therefore reconstruct the clinical moment rather than merely narrate the outcome backward. What information was actually available? What symptoms were present? Which diagnoses were reasonably probable at that stage? How urgent was the situation? Which resources were available? What did contemporary evidence and professional practice support? Could a reasonably prudent physician, facing the same information under similar conditions, have made the same choice?

This temporal discipline does not excuse failure to respond to clear warning signs. It prevents a different error: importing knowledge obtained later into an earlier decision and then condemning the clinician for not possessing it. We should judge the past with the standards and information available in the past, not with the certainty created by the future.

The Individual and the System

Contemporary health care is rarely the work of one person. Diagnosis and treatment may depend on physicians, nurses, pharmacists, laboratories, imaging services, electronic records, protocols, administrators, equipment, staffing, and communication across multiple transitions of care. Harm may emerge not from one dramatic act but from the alignment of several modest vulnerabilities.

James Reason's distinction between a person approach and a system approach remains useful. The person approach concentrates on the individual who committed the unsafe act; the system approach asks what conditions made the act more likely and what defenses failed.[4] The World Health Organization likewise treats patient safety as a property of systems, structures, processes, technologies, environments, and human behavior rather than as the product of vigilance alone.[5]

A systems approach, however, must not become a new form of evasion. Some actions are genuinely reckless. Some clinicians practice beyond their competence, ignore obvious danger, conceal information, abandon patients, or repeatedly violate safeguards. To say that systems influence behavior is not to say that individuals never deserve blame.

The inverse error is equally serious. Blaming the individual at the sharp end may create the appearance of accountability while leaving intact the understaffing, poor communication, unavailable diagnostics, unsafe workflows, dysfunctional technology, or administrative decisions that will help produce the next event. There is no genuine patient safety in a system that punishes the last participant but preserves the conditions that made failure predictable.

The goal should be a just culture: one capable of distinguishing inadvertent error from negligent behavior, negligent behavior from reckless conduct, and individual choices from failures built into the organization. Accountability is weakened, not strengthened, when morally different behaviors are treated as though they were the same.

Accountability Without Scapegoating

The physician has a responsibility different from that of a layperson because medical knowledge creates both capacity and obligation. Clinicians are expected to recognize risks that patients cannot reasonably identify, understand contraindications, interpret warning signs, communicate uncertainty, seek help when appropriate, and remain within the boundaries of their competence. Professional responsibility is therefore heightened responsibility.

But heightened responsibility is not unlimited responsibility. A physician cannot guarantee that every disease will be recognized at its earliest moment, that every operation will be complication-free, that every patient will respond to treatment, or that every biological event can be prevented. The appropriate question is not whether a better outcome can be imagined after the fact. It is whether, under the circumstances that actually existed, the clinician failed without adequate justification to do what a competent and prudent professional reasonably should have done.

This requires attention to causation. A documentation defect, communication lapse, or technical deviation may be important and deserve correction, but it should not automatically be treated as the cause of every subsequent harm. Conversely, the absence of certainty should not be used to erase a causal contribution that is well

supported by the clinical sequence. Ethical accountability depends on proportionality: responsibility should reach those who contributed to the harm, in the measure of that contribution, including individuals, teams, institutions, and sometimes multiple interacting factors.

Such proportionality protects both patients and professionals. Patients are poorly served by a ritual search for a culprit when the true causes remain uncorrected. Physicians are poorly served by a culture that treats every unfavorable outcome as proof that somebody must have been negligent. Correct accountability is different from rapidly finding somebody to blame.

Is There Still Room for the Word "Sorry"?

The moral consequences of a blame-centered culture become especially visible after harm occurs. Patients commonly want to know what happened, why it happened, what will be done to mitigate the consequences, and how recurrence will be prevented. They also value humane acknowledgment of what they have endured. Yet physicians may fear that candor, regret, or apology will be interpreted as an admission of legal fault.[6]

The word "sorry" is ethically richer than a confession of negligence. It may express sympathy for suffering, regret for an outcome, acknowledgment of a communication failure, recognition of an error, or acceptance of responsibility. These meanings should not be collapsed into one. "I am sorry this happened" and "I violated the standard of care" are not the same statement.

Avoiding all expressions of regret may protect a clinician from a feared legal interpretation, but it can also leave a patient emotionally abandoned at precisely the moment when the therapeutic relationship is most fragile. A humane response to harm should allow empathy without requiring premature legal conclusions and should allow truthful acknowledgment of error when an error has in fact occurred.

Evidence from disclosure-and-resolution programs complicates the assumption that openness necessarily increases liability. Programs that combine early disclosure, investigation, apology when appropriate, and fair resolution have been developed precisely because the traditional "deny and defend" response often fails patients, clinicians, and institutions. The University of Michigan experience and the U.S. Agency for Healthcare Research and Quality's CANDOR framework are prominent examples.[7] They do not establish that apology is a universal solution, but they demonstrate that transparency and accountability need not be enemies.

A medicine that cannot say "sorry" may become legally guarded while becoming morally impoverished. The aim should not be to make apology compulsory, but to preserve the possibility of honest, compassionate communication without treating every expression of humanity as a self-executing verdict of negligence.

Blame, Silence, and Defensive Medicine

When every adverse outcome is immediately converted into accusation, clinicians learn that uncertainty is dangerous to admit, incidents are dangerous to report, and reflective discussion is dangerous to document.

Institutions may become less interested in understanding failure than in controlling exposure. The result can be silence rather than safety.

One response is defensive medicine: tests, consultations, admissions, and referrals undertaken partly to reduce perceived liability rather than because they offer proportionate clinical benefit, along with avoidance of high-risk patients or procedures. In a frequently cited U.S. survey of high-liability specialties, defensive practices were reported by a striking majority of responding physicians.[8] The exact prevalence varies by setting, but the ethical concern remains: a system designed to punish error can unintentionally alter clinical choices in ways that increase cost, expose patients to unnecessary procedures, and discourage clinicians from accepting difficult cases.

Fear also has a personal cost. Clinicians involved in serious errors may experience shame, anxiety, loss of confidence, and professional isolation. The literature has described the clinician harmed by the aftermath of an error as a "second victim," a term that has generated debate but captured an important reality: the suffering of the professional does not cancel the suffering of the patient, yet it should not be ignored.[9] A mature safety culture can care for harmed patients, investigate events rigorously, and support clinicians without confusing support with exoneration.

Punishment has an indispensable place when conduct is deliberately unsafe or culpably below professional standards. But punishment is a poor substitute for analysis. If the ultimate purpose is safer care, every response to an adverse event should ask not only, "Who failed?" but also, "Why was failure possible, what made it more likely, and what must change before the next patient is exposed to the same risk?"

A Framework for Fair Medical Responsibility

A disciplined evaluation of possible medical fault should be individualized, chronological, and technically grounded. At minimum, it should answer several questions.

First, what was the clinician's concrete duty in that encounter? Responsibility should reflect the physician's role, specialty, participation in the patient's care, and the resources reasonably available. Second, what information existed at the time? The decision should be evaluated from the clinical data then known, not from discoveries made later. Third, what standard of care was reasonably applicable in that context? The relevant comparison is not with perfection, but with competent and prudent professional practice under similar circumstances.

Fourth, was there an unjustified departure from that standard? Labels such as "negligence," "recklessness," or "incompetence" should follow analysis, not replace it. Fifth, did the departure cause or materially contribute to the harm? Sixth, was the harm reasonably avoidable? The fact that another course can be imagined does not prove that the alternative would probably have prevented the outcome.

Seventh, what systemic factors influenced the event? Staffing, workload, equipment, access to tests, protocols, handoffs, electronic systems, organizational culture, and administrative constraints may be ethically and

causally relevant. Eighth, what information and participation were offered to the patient? Respect for autonomy requires meaningful communication about risks, benefits, alternatives, uncertainty, and changes in the clinical situation.

Only after this reconstruction is it possible to distinguish complication from preventable harm, uncertainty from incompetence, systemic vulnerability from individual negligence, and an excusable error from culpable conduct. The point is not to make accountability harder. It is to make accountability accurate.

CONCLUSION

"To err is human" applies to physicians because physicians remain human. Their training does not abolish uncertainty, cognitive limitation, fatigue, incomplete information, biological variability, or the possibility that a reasonable decision will end badly. Yet the same phrase cannot be invoked as a shield against the obligations created by professional knowledge.

The physician should answer for what was reasonably within professional control: the quality of evaluation, the adequacy of decisions, respect for applicable standards, communication, follow-up, recognition of limits, and prudent use of available means. When harm results from an unjustified breach of those duties, accountability is warranted. When the outcome results from unavoidable disease, unpredictable biology, a recognized complication, a limitation of knowledge, or circumstances that could not reasonably have been prevented, harm should not be transformed into presumed culpability.

Medicine needs a culture capable of holding both truths at the same time. Fallibility without responsibility can produce impunity. Responsibility without recognition of fallibility can produce injustice. Between those extremes lies the difficult work of ethical judgment: protecting patients, learning from failure, repairing systems, acknowledging genuine negligence, and refusing the comforting but dangerous fiction that safety will be achieved by demanding human beings never err.

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