Other journals in brief

A selection of abstracts of clinically relevant papers from other journals.
The abstracts on this page have been chosen and edited by Paul Hellyer

A response to the 'no blame' culture

Tigard DW. Taking the blame: appropriate responses to medical error. *J Med Ethics* 2019; **45**: 101–105.

Expressions of guilt, remorse and regret are beneficial to healing relationships with patients.

The medical community is moving away from a 'culture of blame' to a 'culture of safety' when confronting medical errors. Yet the concepts of personal responsibility, in particular the expression of moral emotions – guilt, regret and remorse – play an important role in the process of disclosure to patients and families. These responses therefore inform apologies to patients and show that mistakes are being given priority.

Practitioners fear blame because of concerns about being sued, reputational damage and punitive responses from management. Tigard argues, however, that removal of blame is neither necessary nor possible – nor is it desirable on the grounds that removal reduces the efficacy of apology and forgiveness.

Blame can arise from many sources, including self. Self-blame gives rise to emotions such as guilt, regret and remorse, which are frequently perceived negatively. Regret, however, can act as a motivator for behaviour change and remorse as aiding ownership of a problem. Self-blame tends to be ingrained in practitioners, even when harms are beyond their control but there is a tendency for others to blame less if self-blame is evident.

Punitive action and lawsuits may decrease if self-blame is expressed through an apology. Studies have found that complainants are motivated not by vindictiveness but by the lack of apology, a desire to prevent a recurrence of the situation and to receive an explanation. As those who are engaged in self-directed blame are motivated to behaviour change, removing blame may act against re-establishing relationships and improving practice.

Apologising entails a sense of taking responsibility and without a response based on remorse or regret, any apology could be seen as of less value and remove the possibility of forgiveness. Consequently, Tigard argues, removing the concept of blame is far from desirable – 'Self blame (is) a mechanism that stands to achieve distinct consequential goods.'

These goods include providing consolation to others and a re-establishment of trust within the practitioner-patient relationship, as well as improvements in healthcare delivery. However, a lack of apology, remorse or regret may indicate compassion fatigue on behalf of the practitioner and the care for the psychological health of staff is paramount to a safe, effective healthcare system.

The thrust of Tigard's argument is that those who are unable to express some degree of self-blame, however irrational, are less able to allow patients and families to move on from the situation than those who are willing to take blame and ownership. For these reasons the current move towards a blame-free culture should be resisted.

DOI: 10.1038/s41415-019-0104-2

Oral hygiene procedures for dementia sufferers

Jablonski RA, Kolanowski A M, Azuero A *et al*. Randomised clinical trial: Efficacy of strategies to provide oral hygiene activities to nursing home residents with dementia who resist mouth care. *Gerodontology* 2018; **35**: 365–375.

Some simple strategies are successful.

'Care resistant behaviour' (CRB) is frequently exhibited by those with dementia, making mouth care interventions difficult or impossible. This study examined the effectiveness of managing oral hygiene using threat reduction (MOUTH) intervention. MOUTH is a toolbox of strategies that includes approaching the patient at or below eye level with a calm demeanour; providing mouth care in front of a sink and a mirror; avoiding 'elder-speak' (sing-song baby talk); allowing the patient to complete a task; using appropriate gestures and simple commands; distraction; and rescuing, where a second worker replaces the first.

One hundred and one nursing home residents were randomly allocated to two groups. Subjects in the experimental group were more likely to assent to mouth care and to complete the mouthcare procedure. During the intervention weeks, time spent on mouth care increased in both groups but was significantly higher in the experimental group.

Whilst the MOUTH intervention did not eradicate CRB, it was found to be effective in managing it.

DOI:10.1038/s41415-019-0105-1

Post war child dental health was poor

Munday B A, Gelbier S. Post-1948 Oral hygiene services for children. *Dent Hist* 2019; **64**: 20–24.

Improved funding for community services is still needed.

Triggered in part by the removal of sugar from the food ration in 1953, the rate of dental decay in post-war children's teeth was very high. Despite the introduction of the NHS and free dental treatment for children in 1948, many did not attend the dentist unless forced to do so in pain.

The introduction of dental auxiliaries went some way to alleviate the problem but the lack of connection between education services and health services was not helpful.

Preventive services were initially frowned on as non-productive but the introduction of a diploma in oral health education for dental nurses and the publication of *The Scientific Basis of Oral Health Education* in the 1970s began to see a change of attitudes. Community projects emphasising the preventability of oral disease increased in the 1990s.

The authors lament, however, that despite these initiatives, dental disease is still common in children, in particular in those from socially deprived areas and suggest that the reinstatement of a properly funded community-based service is essential to turn the tide.

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