

3. Norris, AH, Shrestha, NK, Allison, GM, *et al.* 2018 Infectious Diseases Society of America clinical practice guideline for the management of outpatient parenteral antimicrobial therapy. *Clin Infect Dis* 2019;68:e1–e35.
4. Tice, AD, Rehm, SJ, Dalovisio, JR, *et al.* Practice guidelines for outpatient parenteral antimicrobial therapy. IDSA guidelines. *Clin Infect Dis* 2004;38:1651–1672.
5. Shah, AB, Norris, AH, editors. *Handbook of Outpatient Parenteral Antimicrobial Therapy for Infectious Diseases*. Third Edition. Infectious Diseases Society of America website. [https://www.idsociety.org/globalassets/idsa/clinical-affairs/opat\\_epub\\_finalv3.pdf](https://www.idsociety.org/globalassets/idsa/clinical-affairs/opat_epub_finalv3.pdf). Published 2016. Accessed November 16, 2022.
6. Healthy People 2030. US Department of Health and Human Services website. <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>. Published 2022. Accessed November 16, 2022.
7. SAMHSA's concept of trauma and guidance for a trauma-informed approach. substance abuse and mental health services administration, HHS Publication No. (SMA) 14-4884. US Department of Health and Human Services website. [https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA\\_Trauma.pdf](https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf). Published 2014. Accessed January 13, 2023.
8. Felder KK, Jungbauer RM, Woods ML, Vaz LE. Social-risk screening changes medical decision making in a complex outpatient pediatric antibiotic therapy program. *J Pediatr Infect Dis Soc* 2022. doi: 10.1093/jpids/piac128.

## From a culture of blame to a culture of grace: A letter in reply to Papadakis

Kyle J. Gontjes MPH<sup>1</sup>  and Kristin Collier MD<sup>2</sup>

<sup>1</sup>Division of Geriatric & Palliative Medicine, Department of Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan and <sup>2</sup>Department of Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan

*To the Editor*—We read Dr Papadakis' article titled "Coronavirus disease 2019 (COVID-19): Faith healing or science? An old-time problem," with great intrigue.<sup>1</sup> Dr Papadakis commendably articulated his perception that patients and their families often, preferentially, attribute positive outcomes "to the supernatural power of God" while holding a "strong tendency to blame healthcare professionals, especially critical care physicians, for negative outcomes."<sup>1</sup> Underpinning this argument is a lament for the negativity that healthcare professionals and the institution of medicine are subjected to, both from within and without. Here, we expand upon this observation by discussing the "culture of blame" found within medicine, with a focus on its relevance to patient safety. To respond to this phenomenon, we advocate for the fostering of an inclusive "culture of grace" in our profession.

### The pervasive culture of blame

Prevalent in evidence-based medicine is a "quixotic quest for certainty."<sup>2</sup> Appeals to medical infallibility and intolerance for error fosters perfectionistic tendencies in medicine.<sup>2</sup> Perfectionism, fear of punishment, and peer social dynamics can fracture patient safety cultures.<sup>2</sup> Furthermore, amid the considerable advances of our field is a societal deification of the healthcare professional, which proliferates an unrealistic expectation that there is nothing that the institution of medicine cannot accomplish. The stigmatization of medical errors and negative outcomes contributes to a "culture of blame" within medicine, which we define as an environment that contributes to the proliferation of negative apportionment of blame onto an individual or institution. Symptomatic of this "culture of blame" are the intrinsic and extrinsic expressions of guilt, shame, and isolation that are often felt by healthcare professionals when failures are attributed to them without adequate personal, peer, and administrative support.<sup>3</sup>

Although the COVID-19 pandemic has superficially united the population, this crisis has accentuated intergroup differentiation across values, virtues, and beliefs.<sup>4</sup> Divisiveness and negativity bias promotes unhealthy apportionment of blame, which drives society further from unity and healing.<sup>4</sup> As healthcare professionals have been subjected to high levels of stress during the pandemic,<sup>5</sup> fostering an alternative, restorative culture that remedies toxic blame and promotes the inclusive service of our stakeholders and ourselves is critical.

### Religion, spirituality, and science in the era of evidence-based medicine

Although we share Dr Papadakis' concern for blaming healthcare professionals for negative outcomes, we raise concern with the article's separation of science and faith. Religion and spirituality are essential healthcare partners owing to the high global prevalence of religiosity,<sup>6</sup> the contribution of religiosity to human flourishing,<sup>7,8</sup> and the increasing calls for the integration of spiritual care into medicine and public health.<sup>9</sup>

According to the Pew Research Center's 2017 report, "The Changing Global Religious Landscape," religiously affiliated people currently make up 84% of the world's population—a proportion that is projected to increase in the coming decades.<sup>6</sup> Religious beliefs, directly and indirectly, influence one's health behaviors and healthcare decision making.<sup>7,8</sup> Furthermore, participation in religious and spiritual communities instills meaning and purpose in one's life, which may provide hope, assist in coping with adversity, and promote the development of healthy behaviors.<sup>7,8</sup> Studies have demonstrated that religiosity and spirituality are associated with both positive mental and physical health outcomes.<sup>7,8</sup>

In light of the importance of religion and spirituality to human flourishing,<sup>7,8</sup> healthcare professionals have been encouraged to holistically assess the biological, psychological, social, and spiritual domains of health.<sup>9</sup> This comprehensive approach can assist in promoting the provision of excellent, patient-centric healthcare and the implementation of culturally competent interventions.<sup>9</sup> For instance, the integration of this model during discussions of medical uncertainty and negative outcomes may ameliorate the pain, blame,

**Author for correspondence:** Kyle J. Gontjes, E-mail: [kgontjes@umich.edu](mailto:kgontjes@umich.edu)

**Cite this article:** Gontjes KJ and Collier K. (2023). From a culture of blame to a culture of grace: A letter in reply to Papadakis. *Infection Control & Hospital Epidemiology*, 44: 852–853, <https://doi.org/10.1017/ice.2021.386>

and fear felt by the patient, provider, or healthcare team. In summary, although Dr Papadakis' concern for an unbalanced share of praise between the spiritual and the scientific is admirable and worth acknowledging, we encourage a more inclusive appraisal of the role of religion and spirituality in medicine and public health.

### Toward a culture of grace

In response to these observations, we propose transitioning from a "culture of blame" to a "culture of grace" in our profession. This culture is marked by an environment in which individuals and institutions are empowered to serve as inclusive agents of goodwill that seek to construct opportunities to promote human flourishing and restoration. Integral to this "culture of grace" is the practice of forgiveness. Given the nearly universal capacity to be wronged, whether individually or collectively, the opportunities for forgiveness in medicine and public health are extensive.<sup>10</sup> Forgiveness can be defined as the absence of ill will that is often accompanied by expressions of goodwill directed toward an individual, institution, or even toward oneself.<sup>10,11</sup>

As we gravitate away from the COVID-19 pandemic, failure to forgive and extend love to our neighbor may further the cycle of negativity, promote more division, and reinforce a "culture of blame" within medicine and the greater public. Individual- and group-level forgiveness interventions have been demonstrated to reduce depression, anxiety, and promote positive affect.<sup>11</sup> Interweaving forgiveness into discussions of medical error and negative outcomes amid the traditional expressions of responsibility and harm reduction may assist in ameliorating the stress and stigma associated with these outcomes. Particularly actionable for the healthcare professional, especially amid failure, is the practice of self-forgiveness. Practicing self-forgiveness can plant seeds of grace and mercy within, which, when collectively performed across an institution, can facilitate the blossoming of a redemptive, transformative environment that ameliorates medicine's "culture of blame." Therefore, we propose the fostering of a "culture of grace" in our profession, one marked by forgiveness and upbuilding, inclusive healthcare.

**Acknowledgments.** The authors wholeheartedly extend their gratitude to the following individuals for their thoughtful discussion of the topic and their critical review of the manuscript: Dr Payal K. Patel MD, MPH; Dr Lona Mody MD, MSc; Dr Joyce Wang PhD; Dr L. Clifford McDonald MD; Dr Ron Moolenaar MD, MPH; and Ms Angela Post MA, BCBA, LBA.

**Financial support.** No financial support was provided relevant to this article.

**Conflicts of interest.** All authors report no conflicts of interest relevant to this article.

### References

1. Papadakis M. Coronavirus disease 2019 (COVID-19): Faith healing or science? An old-time problem. *Infect Control Hosp Epidemiol* 2021. doi: 10.1017/ice.2021.198.
2. Hoffman JR, Kanzaria HK. Intolerance of error and culture of blame drive medical excess. *BMJ* 2014;349:g5702.
3. Robertson JJ, Long B. Suffering in silence: medical error and its impact on healthcare providers. *J Emerg Med* 2018;54:402–409.
4. Lam ME. United by the global COVID-19 pandemic: divided by our values and viral identities. *Human Soc Sci Commun* 2021;8:31.
5. Eftekhar Ardebili M, Naserbakht M, Bernstein C, Alazmani-Noodeh F, Hakimi H, Ranjbar H. Healthcare providers experience of working during the COVID-19 pandemic: a qualitative study. *Am J Infect Control* 2021;49:547–554.
6. The changing global religious landscape. Pew Research Center website. <https://www.pewforum.org/2017/04/05/the-changing-global-religious-landscape/> Published 2017. Accessed August 6, 2021.
7. Koenig HG. Religion, spirituality, and health: the research and clinical implications. *Int Schol Res Not* 2012;2012.
8. VanderWeele TJ. On the promotion of human flourishing. *Proc Natl Acad Sci* 2017;114:8148–8156.
9. Sulmasy DP. A biopsychosocial-spiritual model for the care of patients at the end of life. *Gerontologist* 2002;42:24–33.
10. VanderWeele TJ. Is forgiveness a public health issue? *Am J Public Health* 2018;108:189–190.
11. Akhtar S, Barlow J. Forgiveness therapy for the promotion of mental well-being: a systematic review and meta-analysis. *Trauma Violence Abuse* 2018;19:107–122.

## Quantifying healthcare-acquired coronavirus disease 2019 (COVID-19) in hospitalized patients: A closer look

Farrin A. Manian MD, MPH and Chaitanya Karlapalem MD 

Department of Medicine, Mercy Hospital-St. Louis, St. Louis, Missouri 63141

*To the Editor*—We commend Trick et al<sup>1</sup> for their timely article examining the important topic of hospital-acquired coronavirus disease 2019 (COVID-19) during the pandemic. We wish to offer a few comments, particularly related to the methodology and conclusions of their study.

**Author for correspondence:** Farrin A. Manian, E-mail: [Farrinman@gmail.com](mailto:Farrinman@gmail.com)

**Cite this article:** Manian FA and Karlapalem C. (2023). Quantifying healthcare-acquired coronavirus disease 2019 (COVID-19) in hospitalized patients: A closer look. *Infection Control & Hospital Epidemiology*, 44: 853–854. <https://doi.org/10.1017/ice.2023.26>

First, the investigators categorically excluded all patients who tested positive for severe acute respiratory coronavirus virus 2 (SARS-CoV-2) within the first 5 days of hospitalization based on observational data early during the pandemic that found a mean (as well as a median) incubation period of ~5 days for COVID-19.<sup>2,3</sup> Unfortunately, with an incubation period as short as 1–2 days<sup>4,5</sup> and as many as 17.3% of patients developing symptoms <3 days after exposure,<sup>4</sup> a screening method that considers only patients who have tested positive for SARS-CoV-2 after 5 days of hospitalization undoubtedly runs the risk of underestimating the frequency of hospital-acquired COVID-19. Accordingly, patients