



Being human as a physician

I should probably start by admitting that I'm writing this in early January, even though you're reading it in March. That's the reality of print deadlines. I'm also writing while traveling to Vancouver. The Comox airport is having one of those days—forgotten boarding passes, equipment not working, a delayed barista to make my coffee. Plenty of opportunities to feel frustrated, and plenty of people I feel like blaming.

Because it's January, and because this is my first trip as president, I'm reflecting on my career. Early in my medical career, mistakes were often criticized—if not first quietly hidden—and almost always accompanied by shame. If something went wrong, someone had to be at fault. This way of thinking can become a habit. Even today, I notice an instinct to look for blame when things don't go smoothly. I work hard to counter this, usually by reminding myself of my own history of mistakes, both in and out of medicine. I am human, after all.

As physicians, we are trained to aim high. From the first days of medical school, we are taught that details matter, excellence is expected, and errors can have serious consequences. That culture of high standards has saved countless lives. But alongside that, often unintentionally, we have created something far less healthy: a culture in which mistakes are tightly bound to shame.

The truth is that mistakes in both medicine and leadership are inevitable. They happen despite good intentions, deep knowledge, and careful practice. They happen to trainees and experienced clinicians alike, in hospitals, clinics, and even the

Doctors of BC boardroom. Yet many of us experience mistakes not as opportunities to learn, but as personal failures—evidence that we are not good enough. Carrying mistakes this way takes a toll. It is one of the quieter drivers of burnout, anxiety, and loss of joy in our profession.

Shame thrives when we feel alone. When we believe we are the only ones who have made an error, we withdraw. We replay events over and over, questioning our competence and worth. We avoid talking about what happened, not because we don't care, but because we care deeply—and because we fear judgment even more. This isn't weakness. It's a predictable response in a culture that too often equates error with blame.

The cost of that culture can be high. Shame does not make us safer clinicians; it makes us more isolated ones. It discourages openness, stifles curiosity, and blocks improvement. When mistakes are hidden, systems can't learn. When honesty feels risky, the profession becomes less resilient—as do the people within it.

It's important to say this clearly: acknowledging mistakes does not mean abandoning accountability. Accountability and compassion are not opposites. We owe our patients and each other transparency, responsibility, and reflection. But accountability rooted in fear leads to defensiveness and silence. Accountability rooted in learning leads to safer care, stronger systems, and healthier clinicians.

Changing this culture starts with everyday conversations. The words we choose after an adverse event matter. Do we ask “Who made the mistake?” or do we ask

“What happened, and what can we learn?” Do we rush to judgment or do we try to understand the context and pressures involved? As Carl Jung put it, “Know all the theories, master all the techniques, but as you touch a human soul, be just another human soul.”

We also need to pay attention to how we treat each other after a mistake. The idea of the “second victim” is well recognized: clinicians involved in adverse events often experience guilt, anxiety, depression, and burnout. Leadership empathy should be routine, not remarkable. Sometimes hearing “I've been there” can make the difference between coping and struggling.

Psychological safety is not a soft concept. It is essential for both patient safety and physician wellness. Teams that feel safe to speak up identify risks earlier and adapt better. Systems that support clinicians instead of shaming them see more reporting and less harm. This isn't about lowering standards; it's about meeting them with honesty and compassion.

As I walk alongside you this year, I believe that not only is it acceptable for me to acknowledge mistakes, it is essential. Imperfection is compatible with professionalism. Our patients benefit when we are reflective and supported. And we benefit when we work in a profession that understands that excellence is not the absence of mistakes but the presence of integrity, curiosity, and caring for ourselves and each other.

My flight is being called. Now, where did I put my boarding pass? ■

—Adam Thompson, MD
Doctors of BC President