Erreurs Médicales révélation et vécu

G Capellier

Réanimation Médicale

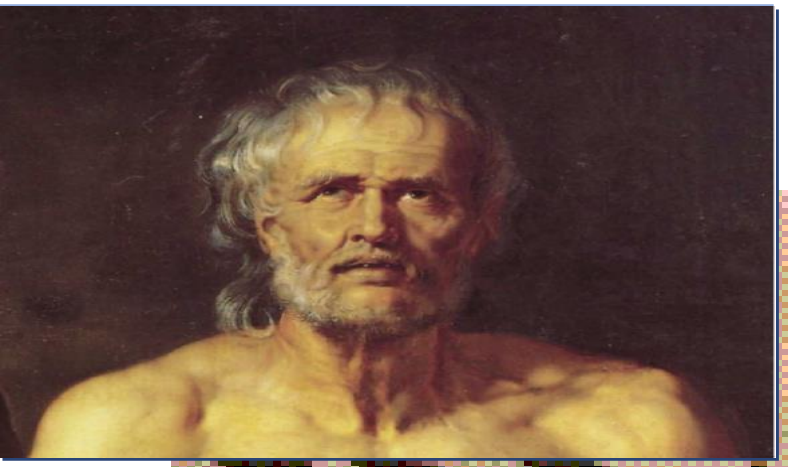
CHRU Besançon

Quelques questions

- Pensez vous que l'erreur en santé existe?
- Avez-vous vécu directement (en tant que soignant)une erreur?
- Avez-vous été présent lors de la survenue d'une erreur?
- Avez-vous été vous-même victime d'une erreur?
- Un de vos proches a-t-il été victime d'une erreur?
- Avez-vous assisté à une discussion de l'erreur avec une famille?
- Avez-vous assisté à une discussion d'une erreur en staff?
- Avez-vous connaissance d'erreurs qui ont modifié la pratique?
- Avez-vous connaissance de répercussions sur l'équipe qui était impliquée dans une situation d'erreur?
- Connaissez vous un système d'appui aux soignants en cas d'erreur?

Erreur ?

- Femme jeune
- Admission aux urgences
- Douleur tho depuis qq jours, brutale, toux
- Pas d’antécédent rapporté, qq cigarettes/jour
- Relève et transmission à la garde
- Diagnostic posé et CAT
- …



ERRARE HUMANVM
EST,
PERSEVERARE
DIABOLICVM

Annæus Seneca

Causes of death, US, 2013

Based on our estimate, medical error is the 3rd most common

AVOIDABLE MEDICAL ERRORS ARE THE THIRD LEADING CAUSE OF DEATH IN AMERICA

Center for Justice & Democracy at New York Law School
www.centerjd.org

However, we're not even counting this - medical error is not recorded on US death certificates

Data source:
http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf

Les erreurs médicales à l'hôpital, cause majeur mortalité

LE MONDE | 04.05.2016 à 00h33 • Mis à jour le 04.05.2016 à 12h09 | Par Paul Benkim
et Pascale Santi (/journaliste/pascale-santi/)

Le Monde 04-05-2016

le 17 décembre 2007 à l'hôpital Georges Pompidou de

50 000 décès en France ?

« Avec 15 millions d'hospitalisations en France en 2013, le nombre de décès liés aux erreurs médicales pourrait ainsi avoisiner les 50 000, en faisant la troisième cause de mortalité du pays après les cancers et les maladies cardio-vasculaires », indiquait Le Lien, association de défense

la troisième cause de décès aux Etats-Unis, derrière les cancers. C'est le constat auquel parviennent deux médecins ichael Daniel, tous deux du service de chirurgie de l'université (Maryland). Pour parvenir à ce classement, ils ont effectué un calcul ant aux données d'hospitalisation dans leur pays en 2013 – un peu plus de sions – le pourcentage d'événements indésirables mortels évitables dans des es, remontant parfois à la période 2000-2002. C'est ainsi qu'ils en concluent que édicales sont à l'origine de 251 000 morts par an.

Définitions

- **Erreur médicale :**

« Failure of a planned action to be completed as intended or use of a wrong plan to achieve an aim »[1]

« Echec dans la réalisation d'une action planifiée, ou utilisation d'un mauvais plan pour atteindre un but »

1) Institute of Medicine *« to err is human »*

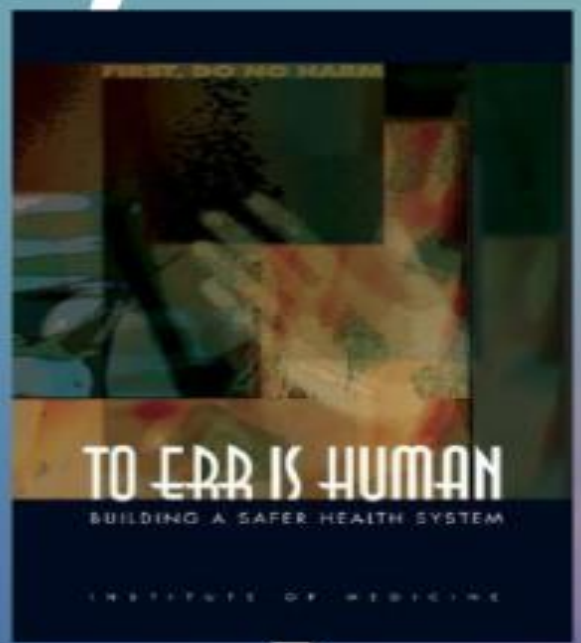
Définitions

Adverse events / évènements indésirables:

- « Injury that might have resulted from a medical intervention (or lack thereof) »

Evènements défavorables ayant un certain caractère de gravité et associés à des soins réalisés lors d'investigations, de traitements ou d'actions de prévention »

Le risque d'erreur



Omniprésence du risque d'erreur

- Urgence
- Imprévisibilité
- Sévérité des pathologies
- Technicité
- Complexité des diagnostics
- Complexité des procédures thérapeutiques
- Coordination de moyens humains

Vincent (200
Rothschild e
Colin & Wes
Valentin et a
Laurent et al
Stewart et al
Mira et al. (2

Erreurs et réanimation

- Report d'évènements indésirables graves chez 17% des malades de Réanimation

- La fréquence des erreurs graves augmente avec la complexité de la prise en charge. Les erreurs de prescription auraient plus que doublé entre 1983 et 1998

Duwe B, Crit Care Clinics 2005; 21:21-30

- **To day, most medical errors are recognized as systematic and prone to repetition**

France: 10% d'erreurs médicales graves

- 50% pour les DC inattendus
- Report France (n=322)
  - Pas de révélation 13,4%
  - Révélation mais pas de divulgation de détails 24,5%
  - Révélation mais pas de divulgation de la cause de l'erreur 44,1%
    - Pru'homme S. et al Presse méd. 2016; *Freund et al. JEM – Goulet et al, Crit Care*

A PIECE OF MY MIND

After the Medical Error

Miranda Worthen, MPhil, PhD
San Jose State University, Health Science & Recreation, San Jose State University, San Jose, California.

I grew up knowing that my father had saved my mother's life. This wasn't some romantic drama. During her first cone-down radiation treatment for invasive breast cancer, she convinced the radiologist to let my father, an internist practicing in the same hospital, watch. As the machine was lowered, he realized that the cone was aimed at a 10-year-old fibroadenoma scar instead of her cancerous tumor. My dad stopped the treatment and my mom had new tattoos drawn, only to realize that these were also incorrectly placed. They drove to the surgeon's office, where the surgeon consulted his handwritten note and drew the location of the recent tumor with permanent marker.

La révélation un triple enjeu -

A soi-même

- Reconnaissance de l'impact émotionnel

Role model positif
Débriefing

Dans le service

- Apprentissage
- Sortir de l'isolement
- Surmonter la charge émotionnelle collectivement

Just culture
RMM

Patient et la famille

- Obligation morale et juridique
- Qualité de la relation médecin-patient

Soutien
Guides et protocoles
Formation

Etat des lieux

- **La reconnaissance de ses propres erreurs reste difficile pour de nombreux soignants**

Sahel, 2001 ; Volpp, 2003

- **Difficulté à aborder les erreurs dans les staffs et RMM**

Wu, 2000; White, 2005

- **Les professionnels ne savent pas où chercher de soutien suite à une erreur**

Gallagher et al, 2003

Survenue d'une erreur: répercussions

- **Première victime**
- Deuxième victime
- Troisième victime

La révélation de l'erreur !

It’s time to apologise

Fiona Godlee *editor in chief, The BMJ*

EDITOR'S CHOICE

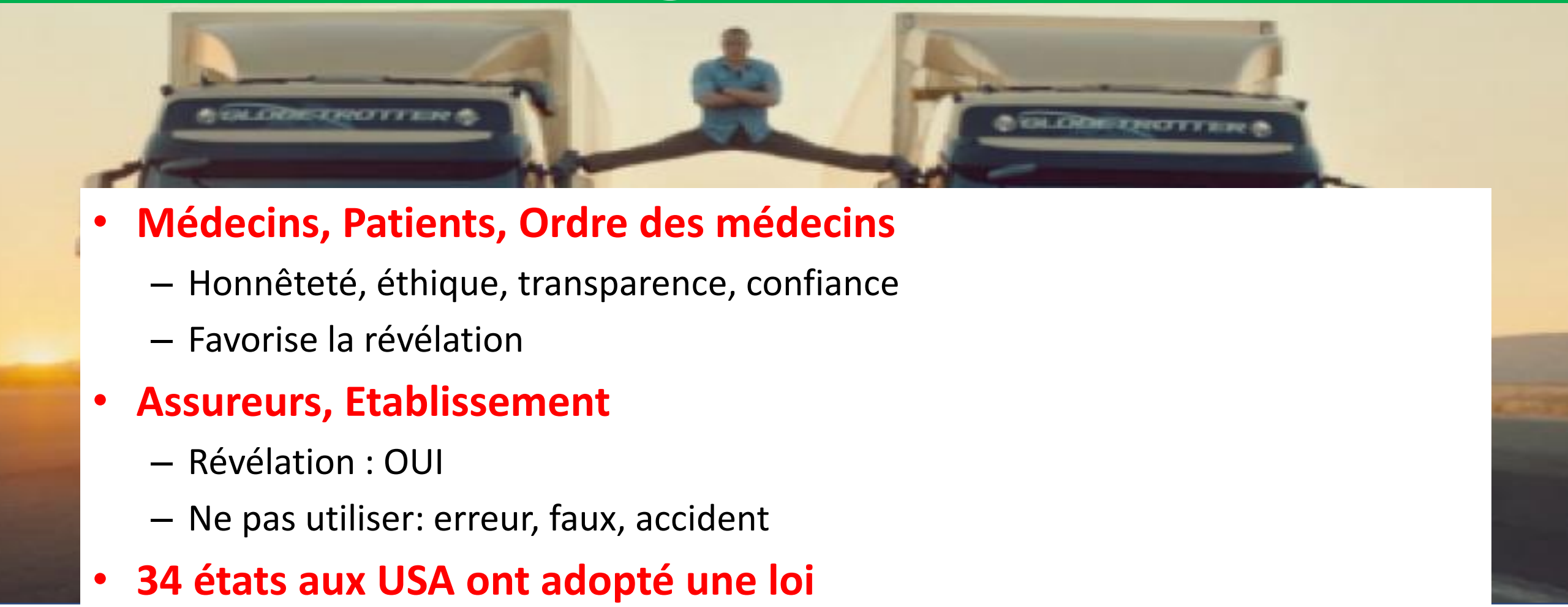
BMJ 2015;351:h4695

- Apologising when things go wrong for patients should be a simple matter.
- More comfortingly, he reminds us that apologies are not always for making a mistake but for the fact that medicine is an imperfect art.

The practice of medicine is hard enough without having to bear the yoke of perfection

David Hilfiker, NEJM, 1984 error in a rural family practice

Révélation de l'erreur: Le grand écart



- **Médecins, Patients, Ordre des médecins**
  - Honnêteté, éthique, transparence, confiance
  - Favorise la révélation
- **Assureurs, Etablissement**
  - Révélation : OUI
  - Ne pas utiliser: erreur, faux, accident
- **34 états aux USA ont adopté une loi**
  - « I'm sorry » law qui ne permet pas un plaignant d'utiliser la révélation de l'erreur comme un signe de faute

Erreurs et santé

Demande d'informations par malade-famille	Insatisfaction	
• Informations insuffisantes	• 82%	89%
• Manque de clarté	• 67%	76%
• Manque de véracité	• 63%	80%
• Conditions d'accueil	• 63%	61%
• Pas de possibilité de parler	• 44%	

Vincent C Lancet 1994; Vincent CA Quality Health Care 1993

Contentieux:

21% ont eu des explications dans les jours qui suivaient

20% ont attendu plus de 6 mois des explications

37% n'ont jamais reçus d'explication

Erreurs et santé

- **Qu'attendent la famille, les malades:**
  - >90% que les médecins discutent de l'erreur
  - 80% détails de l'erreur
  - 98% reconnaissance de l'erreur
- **Qui doit révéler l'erreur selon la famille**:

	Médecins	IDE	Etablissement
Erreur grave	95%	57%	84%
Erreur	95%	67%	78%

Pas simple de dire!: L’étudiant

- **Au cours des études médicales**
  - Diminution de la réflexion éthique
  - Perte de la capacité de critiquer
  - Diminution des capacités d’empathie
  - Diminution de leur souhait de reporter une erreur d’un collègue
  - Impossibilité d’aborder ces problèmes avec leurs enseignants (distance, peur, sanctions, moquerie)

Pas simple de dire!: Le Médecin

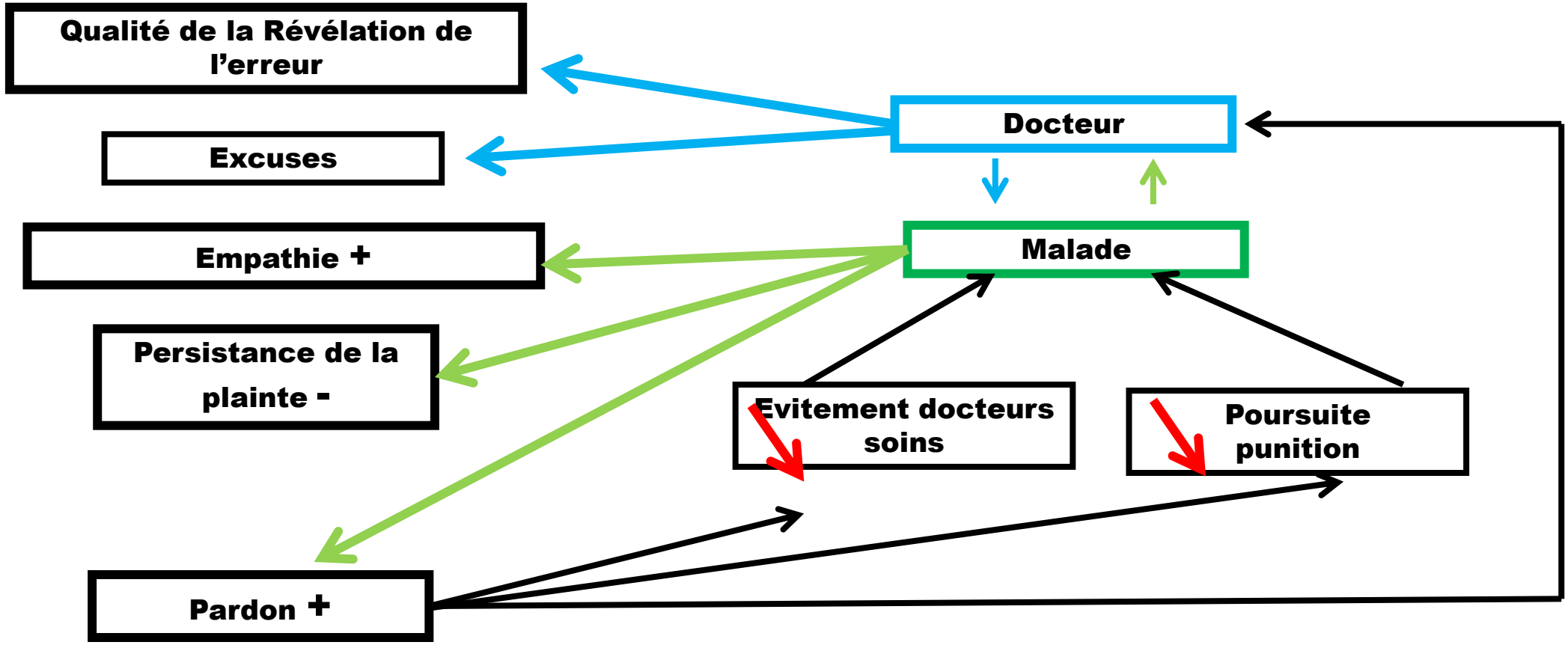
- Perfectionnisme et connaissance
- Peur d'apparaître « décalé » face à de jeunes collègues ou étudiants
- Peur d'être confronté à l'échec
- Perte de sa propre estime
- Crainte d'être catégorisé comme un « convalescent ».
- Détresse et violence du malade
- Perte de privilèges, bonus

Medical errors: Disclosure styles, interpersonal forgiveness, and outcomes

Social Science & Medicine 156 (2016) 29–38

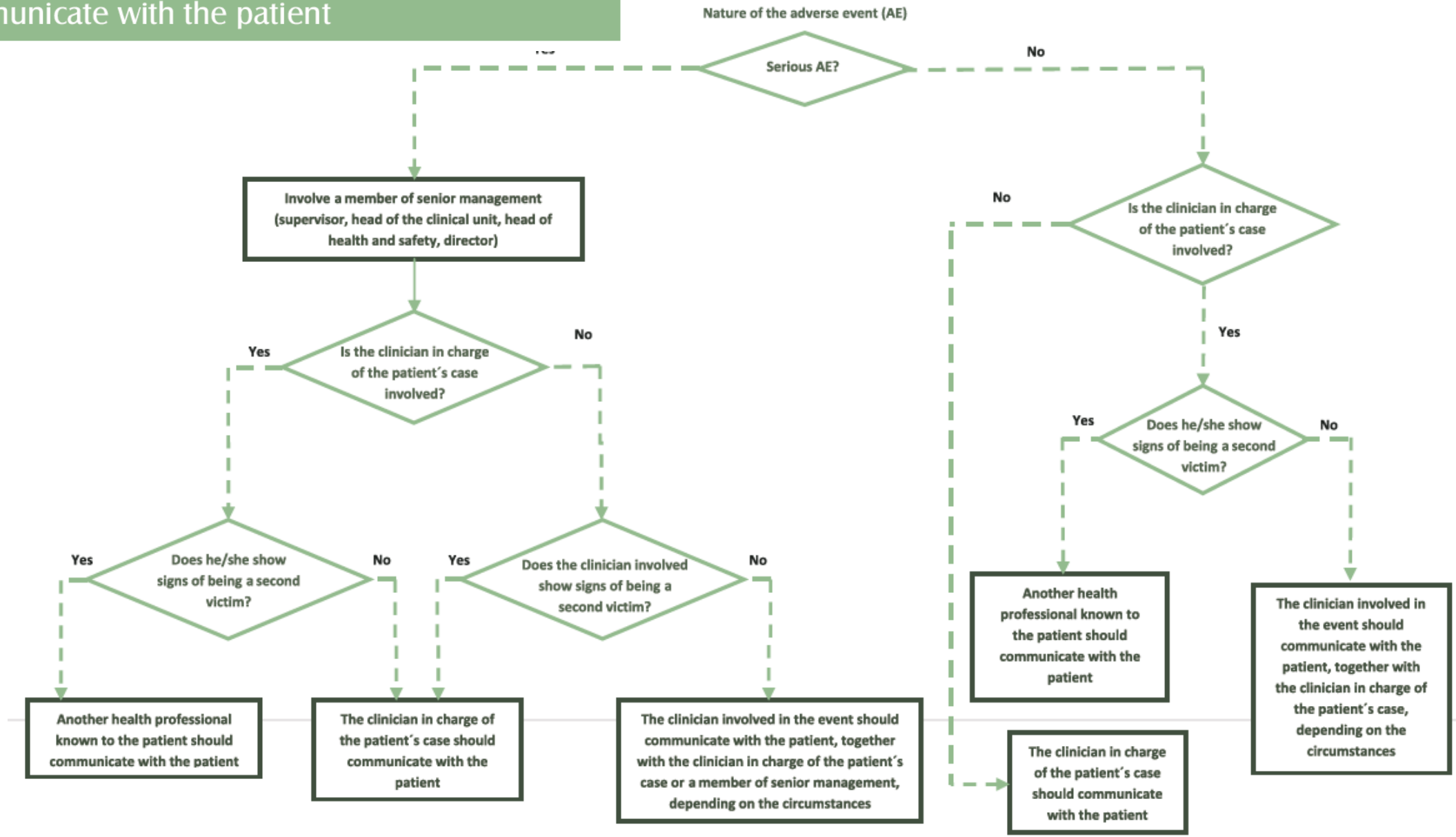
Annegret F. Hannawa [a, *], Yuki Shigemoto [b], Todd D. Little [c]

[a] Center for the Advancement of Healthcare Quality and Patient Safety, Faculty of Communication Sciences, Università della Svizzera italiana (USI Lugano), Via G. Buffi 13, 6900 Lugano, Switzerland



La bonne révélation de l'erreur:
une interaction professionnels - malade

Algorithm for deciding who should communicate with the patient



"Explicitly implicit": examining the importance of physician nonverbal involvement during error disclosures[1]

Annegret F. Hannawa

Institute of Communication and Health (ICH), Faculty of Communication Sciences, University of Lugano, Switzerland

- Traduction de l'empathie
- Relation avec satisfaction du patient
- Impacte la compliance et adhérence
- Conditionne le contenu (ressenti) de la visite
- Impacte l'évolution du malade
- Relation avec anxiété, doses d'antalgiques
- Conditionne l'évaluation du professionnalisme
- Influence le N de procès pour erreur médicale

Lessons learned for reducing the negative impact of adverse events on patients, health professionals and healthcare organizations

JOSE JOAQUIN MIRA[1,2], SUSANA LORENZO[3], IRENE CARRILLO[2],

Checklist of actions recommended regarding care of patients who experience an adverse event

Date: _____

Centre/Hospital: _____ Unit/Service: _____

PATIENT CARE

Action	Cor Date
☐ Inform the clinician in charge of the patient's case of the incident and request their involvement	
☐ Inform the nursing supervisor of the hospital ward/unit of the incident and request their involvement	
☐ Provide the patient with the care he/she requires without delay.	
☐ When needed, offer to the patient the option of changing his/her healthcare team.	
☐ Assess whether there is an imminent risk to the patient who has experienced the AE or other patients	
☐ Act rapidly and appropriately to prevent the risk of a new AE	
☐ Ensure a direct and personal line of communication with the patient (3□month follow□up)	
☐ Designate a health professional as the contact person for the patient	
☐ Inform the patient's primary care doctor	
☐ Offer psychological support to the patient and family	

Checklist of actions recommended to prevent recurrence of the same type of adverse event

Date: _____

Centre/Hospital: _____ Unit/Service: _____

PROACTIVE APPROACH TO PREVENTING REOCCURRENCE OF AN ADVERSE EVENT

Action	Completed Date	Completed Time	Comments
☐ Collect and store evidence that may help to determine what happened			
☐ Record information on what happened as soon as possible (testimonials of involved healthcare professionals)			
☐ Make a note of the people present at the time of the incident (including healthcare students)			
☐ Construct a detailed timeline of what happened			
☐ Write a brief report of the most important information for subsequent analysis of the AE			
☐ Submit this brief report containing the key information to trigger the launch of the process of reviewing what happened and learning from the experience			

Checklist of actions recommended regarding the provision of honest information to patients and their families

Date: _____

Centre/Hospital: _____ **Unit/Service:** _____

INFORMING THE PATIENT AND/OR FAMILY MEMBERS

	Action	Completed		Comments
		Date	Time	
☐	Provide honest information to the patient, together with an apology – *this being done by a senior clinical specialist and another health professional with an established relationship with the patient*			
☐	Give the health professional involved in the incident the option of participating in the meeting to inform the patient, accompanied by another health professional (if they would like and are able to do so)			
☐	Set up an information team depending on the characteristics and magnitude of the AE			
☐	Assess whether there are intrinsic patient related factors that weigh against informing the patient directly			
☐	Decide, by consensus among a team of professionals, what information is to be given (facts and objective data)			
☐	Meet any special needs of the patient in terms of communication			
☐	Provide a suitable place to talk with the patient and/or family members without interruptions			
☐	Record the meeting for informing the patient (with patient consent)			
☐	Check whether the patient will or would like to be accompanied by a family member			
☐	Request written consent from the patient to share information with specialists in other centres or health services			
☐	Have available information about potential financial compensation			
☐	Inform the patient about the steps being taken to determine what happened and how to prevent similar events in the future			
☐	Make sure that the patient and/or family members understand the information given			
☐	Make a note in the patient's medical record of the information given in this meeting			
☐	Plan patient follow up			

Survenue d'une erreur: répercussions

- Première victime
- **Deuxième victime**
- Troisième victime

rreur

s

stics
ures

s

"Secondes victimes"

WU, BMJ (2000)

Vincent (2001) BMJ
Rothschild et al. (2005) CCM
Colin & West (2006) JAMA
Valentin et al. (2013) ICM
Laurent et al. (2014) CCM
Stewart et al. (2015) BMJ
Mira et al. (2015) BMC

Error in Intensive Care: Psychological Repercussions and Defense Mechanisms Among Health Professionals

Alexandra Laurent, PhD[1]; Laurence Aubert, MSc[1]; Khadija Chahraoui, PhD[1]; Antoine Bioy, PhD[1]; André Mariage, PhD[1]; Jean-Pierre Quenot, MD, PhD[2]; Gilles Capellier, MD, PhD[1,3]

Medical errors – not only patients' problem

Adam Stanglerski[1], Izabela Warmuz-Stanglerska[1], Marek Ruchała[1], Joanna Zdanowska[1], Maria Danuta Głowacka[1], Jerzy Sowiński[1], Piotr Ruchała[1]

- Tro
- Re
- Co

- Cu
- He

V

Stresseurs professionnels en réanimation

PS-ICU GROUP

- **Liés au patient** (déc… n, souffrance…)
- **Liés à la famille** (co… esse…)
- **Liés aux soins** (Arré…
- **Liés au contexte ins…** s responsabilités, absence de soutien,
- **Liés à l'équipe** (con… ce, rumeurs…)
- **Liés à l'organisation du service** (changement de personnel, iniquité dans la répartition de la charge en soin…)
- **Liés au condition de travail** (bruit, matériel manquant…)
- **Personnels** (événements de vie difficiles, horaires incompatibles)

Erreur médicale:
- **Risque**
- **Doute**
- **Réalité**

A court terme

- Troubles anxieux
- Remise en question
- Colère

- Culpabilité
- Honte

« Je culpabilise tu vois euh voilà quoi, t'es humain ... »

« ... Je l'ai tout de suite dit, ils ont vu que j'avais peur, donc une conscience, je pense, professionnelle... »

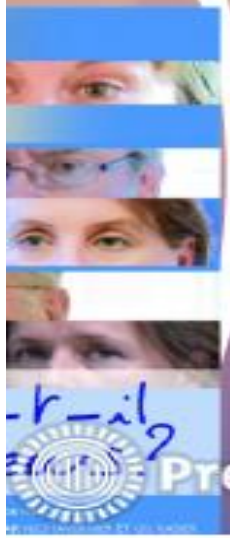
Signal d'alarme

"La peur de se voir reprocher une chose, la solitude, j'étais très très seul"

"Dire j'ai fait une erreur, c'était dire je suis inapte, il faut que je change d'orientation"

"On a honte aussi, enfin on se trouve mauvais quoi... on a mal fait son métier"

Peur du jugement de l'autre



Vécu de l'erreur

• Honte

Peur du jugement de l'autre

Vécu de l'erreur

A long terme

- **Culpabilité**

"je l'ai tué"
"il est mort à cause de moi"

- **Perte de confiance**
- **Inscription de l'événement en mémoire**

Ré

Bi

Inscription de l’erreur

« *I remember it like yesterday, but it was 25 years ago* »,

Rinaldo Bellomo (ICM, 2013)

Stratégies défensives

Confrontation à l'erreur

Verbalisation

Apprentissage

Mise a distance de l'erreur

Rejet de la responsabilité

Dédramatisation

Rationnalisation

The impact of medical errors on physician behavior: Evidence from malpractice litigation☆

Ity Shurtz*

Department of Economics, The Hebrew University, Jerusalem 91905, Israel

Journal of Health Economics 32 (2013) 331–340

Après un procès pour erreur médicale, l'incidence des césariennes augment de 4% et continue d'augmenter pour atteindre 8% après 2,5 ans.

Available online 17 December 2012

JEL classification:
I12

rates jumped discontinuously by
errors and treatment patterns. C-
increase 2.5 years after a medica

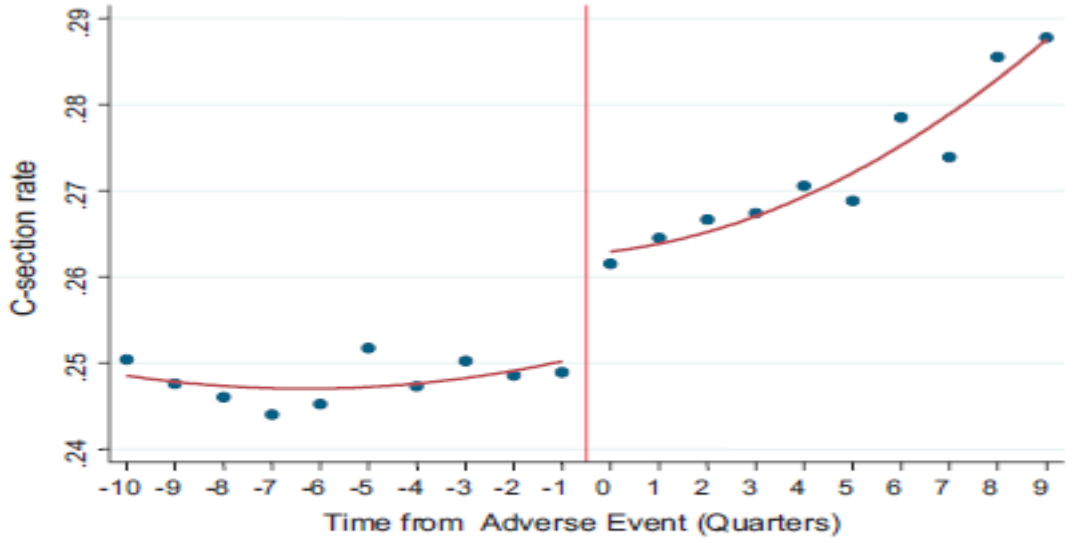


Fig. 5. Short-run effect of an adverse event. *Note*: The figure plots per-period C-section rates in the adverse event panel. The vertical line denotes the time of the adverse event.

- **Impact sur la décision du médecin**
- Excès de précaution: « Defensive medicine »
- Altération du jugement
- Prévention des risques légaux
- Accompagnement des équipes
- Impact sur les médecins d'un même établissement ?

Understanding the Barriers to Physician Error Reporting and Disclosure: A Systemic Approach to a Systemic Problem

Bianca Perez, PhD, Stephen A. Knych, MD, MBA,† Sallie J. Weaver, PhD,‡ Aaron Liberman, PhD,* Eileen M. Abel, PhD,§ Dawn Oetjen, PhD,* and Thomas T. H. Wan, PhD||*

J Patient Saf • Volume 10, Number 1, March 2014

- **Conditions à remplir pour pouvoir révéler une erreur**
  - Intra personnelle
  - Inter personnelle
  - Institutionnelle
  - Sociétale
  - Sécurité psychologique

Wisdom in Medicine: What Helps Physicians After a Medical Error?

Margaret Plews-Ogan, MD, MS, Natalie May, PhD, Justine Owens, PhD, Monika Ardelt, PhD, Jo Shapiro, MD, and Sigall K. Bell, MD

> We don't receive wisdom, we must discover it for ourselves after a journey that no one can take for us or spare us.
> —Proust[1]

Abstract

Purpose

Confronting medical error openly is critical to organizational learning, but less is known about what helps individual clinicians learn and adapt positively after making a harmful mistake. Understanding what factors help doctors gain wisdom can inform educational and peer support programs, and may facilitate the development of specific tools to assist doctors after harmful errors occur.

Method

Using "posttraumatic growth" as a model, the authors conducted semistructured interviews (2009–2011) with 61 physicians who had made a serious medical error. Interviews were recorded, professionally transcribed, and coded by two study team members (kappa 0.8) using principles of grounded theory and NVivo software. Coders also scored interviewees as wisdom exemplars or nonexemplars based on Ardelt's three-dimensional wisdom model.

Results

Of the 61 physicians interviewed, 33 (54%) were male, and on average, eight years had elapsed since the error. Wisdom exemplars were more likely to report disclosing the error to the patient/family (69%) than nonexemplars (38%); $P < .03$. Fewer than 10% of all participants reported receiving disclosure training. Investigators identified eight themes reflecting what helped physician wisdom exemplars cope positively: talking about it, disclosure and apology, forgiveness, a moral context, dealing with imperfection, learning/becoming an expert, preventing recurrences/improving teamwork, and helping others/teaching.

Conclusions

The path forged by doctors who coped well with medical error highlights specific ways to help clinicians move through this difficult experience so that they avoid devastating professional outcomes and have the best chance of not just recovery but positive growth.

Themes and Subthemes Gleaned From Participants' Responses to the Question "What Helped You in the Wake of the Error?"[a]

Acad Med. 2015 Sep 4

"What helped": Themes and subthemes	Representative quotations
Talking about it	
Talking about it/who to turn to	I think I called one of my colleagues that same afternoon and said, "Can I talk to you a minute about this?" I don't remember exactly when that was, it might have been that night or the next day, but at some point I did. That was very helpful. (319)
Acknowledging the mistake	Everybody was minimizing it, probably to protect me.... I couldn't really tell anybody, and that really got to me. Everybody tries to protect their friends and their trainees and their coworkers whenever they have a complication like that. But, I think the downside is it doesn't allow people to get the support that they need. (352)
Holding the feelings without trying to solve	She immediately understood the importance of what had happened and just held it, didn't try to resolve it or say, "Here's a way to understand it, it will go away," or put it in the right place. (337)
Emotional impact	I'm not sure how much people understood how devastating I found it. I think it's easy to cover that. I think that on some level, people need to kind of remind you that actually you shouldn't leave medicine, because I really thought about it. It's a very, very, very vulnerable time. I don't know exactly how that could be cared for but I think recognizing that, normalizing that, so the right setting would be a place where somebody would say, "You know, a lot of people have an error like this and they think about leaving medicine. Has that happened to you?" (362)
Knowing I'm not alone	I think it is important to talk to attendings, to find people who are supportive and to go at it with a sense of how could I have avoided this … part of it [what was supportive] was that he [the attending that this resident talked to] talked about three serious medical errors that he had [made], one in particular that he still thinks about on a regular basis. He is an awesome attending, highly respected for his knowledge base, his research, his interpersonal skills. For me that was useful and helpful, because he's a great doctor, and he's still thinking about this … that's part of being a doctor. (385)
Disclosure and apology	It was helpful for me to speak to the patient, and, again, I wish I had done a more appropriate disclosure to him.... I think that would have gone a long way for me. (369)
Forgiveness	Okay, the only forgiveness that I decided to give myself is partial to this day and it always will be but that's okay. I figure that I keep that other unforgiven part as the pressure to keep doing better. (318)
A moral context	I just wanted to run the other way, but in the end that is not who we are as doctors. We are here to take care of patients, even when, especially when, things don't go well. (379)
Dealing with imperfection	One of the processes of growing older, more experienced, more mature, is [that] reality replaces icons. People think of me as perfect. I happen to know it is not true. I don't need or want anyone to have that concept of me anymore. (350)
Learning/becoming an expert	You can see why I might want to do my [resident] project on it [the misdiagnosed condition] … why I consider myself a minor expert on the condition, that was part of my coping skills, was to learn about it and say, How I can I help other people? (300)
Preventing recurrences/ improving teamwork	That is certainly something else that is huge, having a team, a real team that works together. We have the opportunity to back each other up when somebody misses something and creating an environment where … we acknowledge [errors] when they happen. (318)
Helping others/ teaching about it	When it was clear that I had established a reputation as a good clinician, then I felt more comfortable sharing all my mistakes with my residents and helping them learn from those sorts of things because I think that, aside from having a mistake happen yourself, there are few things that are more powerful than hearing somebody else tell you about their mistakes. (369)

Lessons learned for reducing the negative impact of adverse events on patients, health professionals and healthcare organizations

JOSE JOAQUIN MIRA[1,2], SUSANA LORENZO[3], IRENE CARRILLO[2],

Checklist of actions recommended regarding the provision of support to the second victim

Date: _____

Centre/Hospital: _____ Unit/Service: _____

SUPPORTING THE CLINICIAN AND THE HEALTHCARE TEAM OF WHICH HE/SHE IS A MEMBER

	Action	Date	Comments
☐	Adopt a positive attitude, recalling that AEs often have systemic causes.		
☐	Identify who may be second victims related to the AE		
☐	Speak to the potential second victim(s) – *this being done by a close colleague with a similar professional profile and skills to provide support*		
☐	Arrange for the clinical duties of the second victim to be covered by others (only if the clinician desires)		
☐	Encourage the second victim to increase/maintain their level of daily leisure activities including activities with friends and family		
☐	Help the second victim with the paperwork related to work leave (if appropriate) in coordination with the centre´s Occupational Health and Safety Service (according national rules)		
☐	Be alert to symptoms suggesting the second victim needs additional support		
☐	Assess whether the second victim needs personalized care with a professional counsellor		
☐	Assess whether the second victim needs legal advice		
☐	Inform the second victim about the professional liability coverage under the centre's policy		
☐	Inform the Occupational Health and Safety Service only if the physical or psychological health of the second victim is affected		
☐	Inform the second victim about the specific support within and outside the institution		
☐	Coordinate emotional and legal support		
☐	Monitor the second victim the days following the incident to ensure effective recovery from event		
☐	Keep the second victim informed about the patient information process and analysis of what has happened		
☐	Invite the second victim to participate in the root cause analysis of the incident if the clinician is able and it is adequate		
☐	Organize the second victim's return to clinical practice following the AE (with a progressive increase in their duties)		
☐	Plan monitoring of the second victim during the 3 months following the AE		

Review article

The Second Victim: a Review

B. Coughlan[a], D. Powell[b,*], M.F. Higgins[c,*]

[a] UCD Midwifery, School of Medicine, University College Dubli, Republic of Ireland

Table 1
Reported Experiences of Second Victim.

Common
Guilt
Anxiety
Fatigue
Frustration
Anger
Difficulty concentrating
Self- Doubt
Less Common
Reliving event/post-traumatic stress disorder (PTSD)
Avoidance of patient care
Severe anxiety about return to work
Depression
Suicidal Ideation

Table 2
Risk factors for Development of Second Victims.

Poor Outcome(s) to patient(s)
High level of personal responsibility for affected patient
Young, previously healthy patients
Multiple patient lives
Female healthcare professional
Institutions handling of error
Culture of safety and disclosure

Fig. 1. Supports reported as required and useful by Second Victims.

Personal and professional profile of candidates for the team providing first-line support to second victims

The following is a list of skills, types of knowledge and other characteristics that professionals who are going to form the team providing first-line support to second victims should possess and develop. Ideally, in each ward, unit, department, service or team, there should be a person who possesses these characteristics to offer support to second victims:

Personal qualities

- Empathy.
- Reflexive, non-impulsive personality.

Basic knowledge

- of the second victim experience (stages of recovery, needs, etc.).

Experience in the centre

Knowledge

- of the patient safety plan and associated interventions.
- of the referral process for cases in which a need for more specialised care is identified.

Skills

- to adopt a supportive attitude based on active listening and avoiding at all times a judgemental attitude.
- to adopt a respectful attitude, avoiding being judgemental.
- of verbal and nonverbal communication.
- to identify symptoms of depression, anxiety and post-traumatic stress disorder.
- to identify specific needs at personal, family and professional levels.
- to share, in a respectful way, similar personal experiences, if this may be reassuring for the second victim.

Appropriate management

- of key words and actions (what to say/do and what not to say/do).
- of physical contact in response to the emotional needs of the health professional involved.
- of silences in order that they are reassuring for the person involved.

According to methodology of Scott and her team, asking healthcare staff who they would look to for help if they became a second victim is a strategy that could be used to identify individuals in each area with the desired characteristics to offer support.

Survenue d’une erreur: répercussions

- Première victime
- Deuxième victime
- **Troisième victime**

Les enjeux pour l'équipe

- Quelle réaction possible quand un soignant est informé, a connaissance d'une erreur médicale?
  - **Difficulté d'appréhender l'erreur**
    - travail imparfait, renvoi à la difficulté de l'exercice, aux résultats controversés
  - **Fragilité de notre institution, travail, environnement**
    - « the glass house effect »
  - **Risque du lanceur d'alerte:**
    - isolement, absence de droits (rarement sans conséquence pour le déclencheur)
  - **Dilution de la responsabilité**
    - D'autres vont s'en rendre compte et vont probablement agir
  - **Perceptions du public**
    - Inaction des médecins et corporatisme
    - Responsabilité rejetée sur des facteurs externes

When a Surgical Colleague Makes an Error

Ryan M. Antiel, MD,[a,b] Thane A. Blinman, MD,[c] Rebecca M. Rentea, MD,[d] Katherine W.

PEDIATRICS Volume 137, number 3, March 2016

« An ICU needs a **safety culture** that is rooted in a committed **leadership**, the **aknowledgement** that **error** is **inevitable**, a reporting system, and continuous **learning** »

Marta L render and Larry Hirschlorn

Critical Care Clinics

Safety in Criticial Care Medicine 2005, 31 - 42

Living With Uncertainty in the Intensive Care Unit

Roman Jaeschke, MD, MSc
Derek C. Angus, MD, MPH

JAMA, June 10, 2009—Vol 301, No. 22

RMM: bénéfices attendus, observés

The surgical morbidity and mortality (M&M) conference has been referred to as the "golden hour of surgical education" (Gordon 1994)

Adv in Health Sci Educ (2013) 18:527–536
DOI 10.1007/s10459-012-9389-5

REVIEW

Undesirable features of the medical learning environment: a narrative review of the literature

Jochanan Benbassat

- **Environnement d'apprentissage médical: nécessité d'une attitude bienveillante et compréhensive**
  - Entendre la crainte de l'étudiant de faire des erreurs et de ne pas être performant (**The fear of personal inadequacy and failure**)
  - Reconnaître l'incertitude
  - Ne pas dévaloriser publiquement un étudiant (ou d'autres formes d'attaques personnelles)
  - Entendre les difficultés et la détresse psychologique, pouvoir demander de l'aide

Residents	Surgical	Non Surgical
Observed colleague treated harshly	39%	20%
Believe treated harshly if acknowledge medical errors	35%	12%
Compromise their own values when dealing with medical errors	11%	2%
Feel free to express concern about medical errors	70%	83%

iment to the transparent disclosure of errors among residents that might disproportionally affect surgical training programs. (J Am Coll Surg 2013;217:1145–1150. © 2013 by the American College of Surgeons)

RMM: réponse institutionnelle

- Étude auprès de résidents et de praticiens et enseignants
- Questionnaire composé de 22 items
- Taux de réponse de 52% (83% pour MD et 33% pour Résidents)

Faculty and Resident Opinions Regarding the Role of Morbidity and Mortality Conference

Sean P. Harbison, MD, Glenn Regehr, PhD, *Philadelphia, Pennsylvania*

THE AMERICAN JOURNAL OF SURGERY® VOLUME 177 FEBRUARY 1999

Response to Open-Ended Questions, Faculty Versus Resident

Questions/Respons	Faculty Number of	Resident Number of
In my opinion, the go		
Education		
To reduce error		
Quality assurance		
To learn to manage		
To improve patient		
Not clear		
To ascribe blame		
Total responses		

M&M conference could be improved by:

	132 (25%)1	49 (25%)2
	102 (19%)2	5 (3%)7
	73 (14%)3	9 (5%)5
	67 (12%)4	56 (28%)1
	61 (11%)5	34 (17%)3
	42 (8%)6	34 (17%)3
	33 (6%)7	5 (3%)7
	28 (5%)8	7 (4%)6
	538	199

	Faculty	Resident
Education	47%	43%
Reduce errors	18%	31%
Improve patient care	7%	2%
Improve by Openness less defensiveness	12%	28%

- Bosk CL. *Forgive and Remember: Managing Medical Failure.* Chicago: University of Chicago Press; 1981.

Faire évoluer le système

- Exemple pour erreur médicamenteuse *(Prévalence très élevée)*
  - Prescriptions assistées par ordinateur
  - Stockage des médicaments similaires
  - Codes barres, Pousse-seringue intelligent…
  - Pharmaciens présents lors des visites

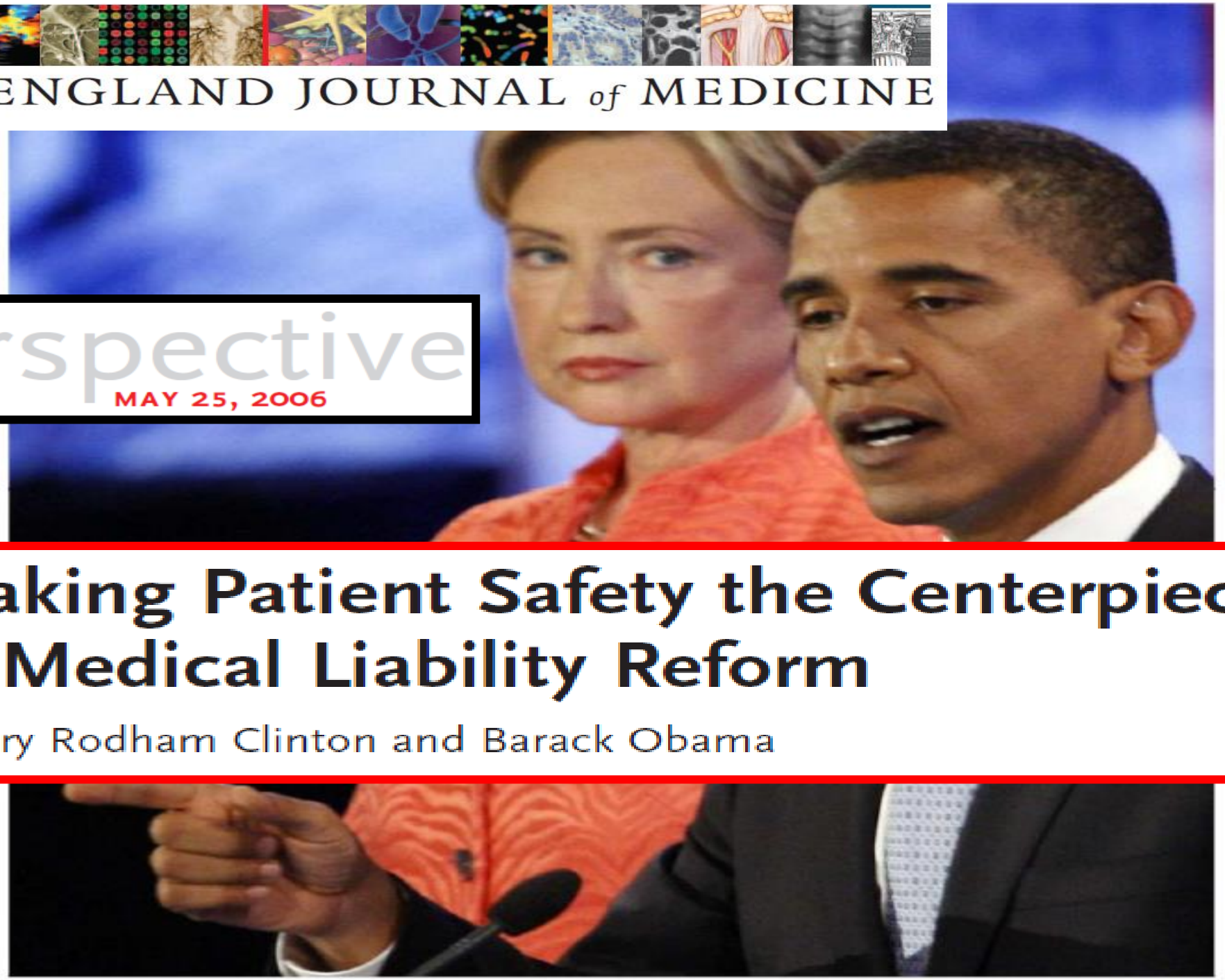
⇒ Réduction du nombre d’erreurs !

⇒ Effet réel ? Peu de preuves…

Administration : le droit à l'erreur

Simplifier la vie des Français : une des promesses d'Emmanuel Macron durant sa campagne présidentielle. Dix-huit mesures au total ont été présentées avec notamment un droit à l'erreur.

The NEW ENGLAND JOURNAL of MEDICINE



Perspective

MAY 25, 2006

Making Patient Safety the Centerpiece of Medical Liability Reform

Hillary Rodham Clinton and Barack Obama

NCCMERP
National Coordinating Council for Medication Error Reporting and Prevention

Statement Opposing the Criminalization of Errors in Healthcare

Statement

The National Coordinating Council for Medication Error Reporting and Prevention opposes the criminalization of errors in healthcare.

Background

The Council acknowledges that human error is inadvertent and unintentional.[1] Criminalizing human error is a deterrent to error reporting, learning from errors, and error prevention. As a result, unsafe systems may be perpetuated rather than improved. Criminal acts and patient harm

The Council acknowledges that human error is inadvertent and unintentional.[1] Criminalizing human error is a deterrent to error reporting, learning from errors, and error prevention. As a result, unsafe systems may be perpetuated rather than improved. Criminal acts and patient harm related to competency and/or licensure issues are not addressed in this statement as they are beyond the Council's purview.

urges healthcare organizations to use these data to improve performance of systems and individuals. Further, the Council recommends proactive use of information from internal and external sources about risk and error to improve patient safety before patient harm occurs.

The Council also recommends a culture of shared accountability for safety among leaders (for good systems design within the scope of their ability and control) and healthcare workers (for making safe behavioral choices and immediately reporting unsafe conditions.)

Criminalization does not prevent human error, nor do safety procedures prevent intentionally harmful or reckless behavior. A transparent, fair, and consistently applied process should be used to investigate health care errors and respond accordingly to the results.

NAN ALERT

The National Alert Network (NAN) publishes the alerts from the National Medication Errors Reporting Program. NAN encourages the sharing and reporting of medication errors, so that lessons learned can be used to increase the safety of the medication use system.

Dangerous Abbreviations

UPCOMING MEETINGS

There is no meeting avaiable.

Previous Meetings

J Prev Med Public Health 2017;50:68-82 • https://doi.org/10.3961/jpmph.16.105

pISSN 1975-8375 eISSN 2233-4521

Journal of Preventive Medicine & Public Health

Table 3. Obstacles to disclosure of patient safety incidents

Area	Key findings
Medical lawsuits and punishment	Despite the expected effects of disclosure of patient safety incidents on medical lawsuits and punishment, fear of medical lawsuits and punishment had a major effect on medical professionals' intentions to disclose patient safety incidents [17,30,39]
Medical professionals	Fear of a damaged professional reputation among colleagues and patients was frequently suggested as an obstacle to the disclosure of patient safety incidents [17,32,52]
Patients	Many medical professionals were afraid of undermining patient trust when they performed disclosure of patient safety incidents [17,18,29,31,32,51,52]
The situation when conducting disclosure of patient safety incidents	The complexity of the situation when disclosing patient safety incidents could make medical professionals hesitant to disclose patient safety incidents [18 29,31,58]
Patient safety culture	The absence of a patient safety culture was mentioned as a reason for a failure to disclose patient safety incidents [32,61]

Table 4. Facilitators of disclosure of patient safety incidents

Area	Key findings
Establishment of a patient safety culture	Creation of a safe environment for reporting patient safety incidents facilitated the disclosure of such incidents [61,62]
Introduction of a policy for the disclosure of patient safety incidents	A framework and guidelines for the disclosure of patient safety incidents would help medical professionals to disclose such incidents [64]
Education and training on the disclosure of patient safety incidents	Education and training on the disclosure of patient safety incidents could enhance medical professionals' ability and intention to disclose patient safety incidents [65-74].

Set of recommendations

Color reference to order actions according to aims

FOR INSTITUTIONAL CARE

FOR PATIENT CARE

TO REDUCE THE RISK OF AE IN THE FUTURE

TO SUPPORT THE PROFESSIONAL

SAFETY AND ORGANIZATIONAL POLICIES

PATIENT CARE

PROACTIVE APPROACH TO PREVENTING REOCCURRENCE OF AN AE

SUPPORTING THE CLINICIAN AND THE HEALTHCARE TEAM

ACTIVATION OF RESOURCES TO PROVIDE AN APPROPRIATE AND TIMELY RESPONSE

INFORMING PATIENTS AND/OR FAMILY MEMBERS

DETAILED ANALYSIS OF THE INCIDENT

PROTECTING THE REPUTATION OF HEALTH PROFESSIONALS AND THE ORGANIZATION

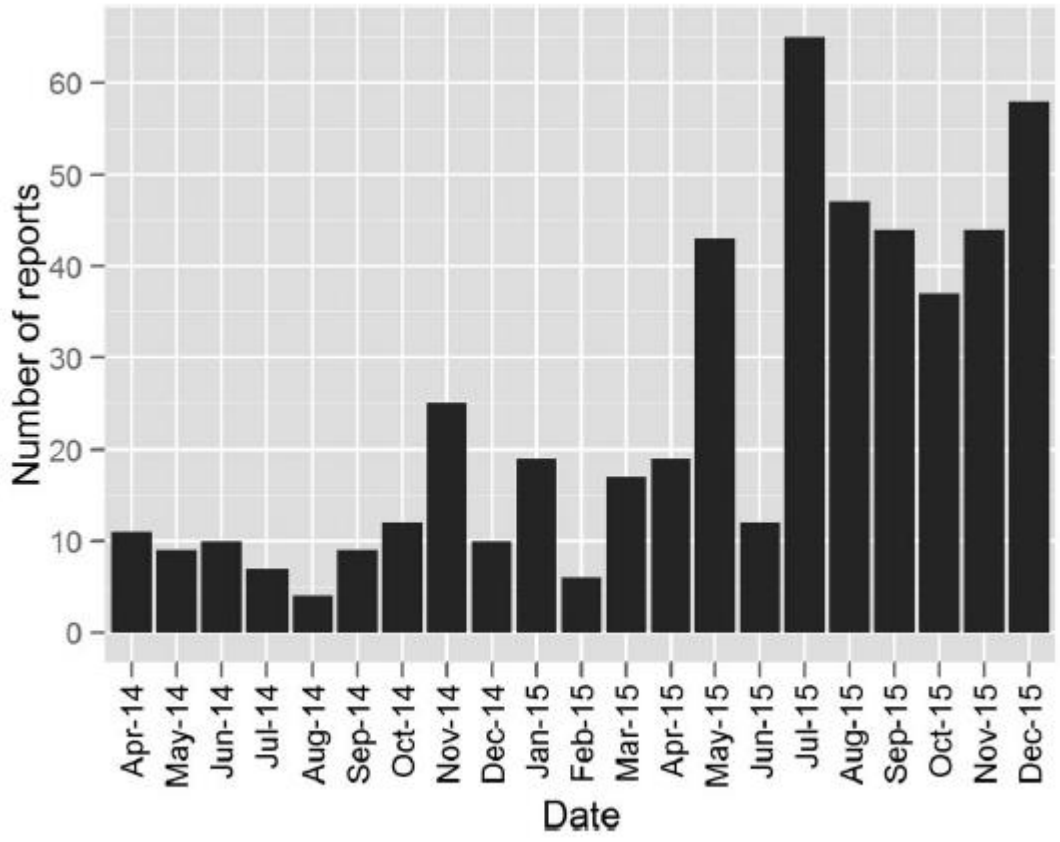
Révélation: Annonce d’un dommage lié aux soins

- Entendre la détresse des malades et des familles
- Nécessité de comprendre, de disposer d’explications
- Connaître les répercussions, disposer d’informations sur prise en charge
- Promouvoir une communication active
- Promouvoir un environnement de travail vertueux
- Mouvement vers la prévention de l’erreur, facteurs humains
- Promouvoir l’apprentissage et le développement du médecin et du soignant au décours d’une erreur médicale.

Aimez vous les gâteaux ?

Learning from excellence in healthcare: a new approach to incident reporting

Nicola Kelly,[1] Simon Blake,[1,2] Adrian Plunkett[1]



re 1 Frequency of excellence reporting.

- Psychological research has revealed that people can learn effectively both from reflecting on failure (negative reinforcement) and success (positive reinforcement).
- On ne dit pas assez quand c'est bien!

Kelly N, *et al*. *Arch Dis Child* September 2016 Vol 101 No 9

La révélation à la famille de l'erreur en réanimati… répercussions psychologiques chez les profes… santé

- Fréquence de l'erreur
- Révélation de l'erreur est insuffisante
- Contexte difficile avec de multipl…
- Impacte le soignant (quelq… …onnel)
- Retentissement dans l… …issement
- Modifie probable… …es
- Nécessite a… …ation, rôle du Non-Verbal
- Consci… …bidirectionnels de la révélation
- In… …ombre de procès et d'indemnisation

Reconnaissance du « soignant imparfait mais bon »