La culture du blâme : comment la reconnaitre, en libérer votre milieu d'apprentissage et s'en sortir intact

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Professeur de Médicine, chercheur boursier clinicien FRQS
Titulaire, chaire Lise and Jean Saine en soins intensifs

Au terme de cet atelier, les participants seront en mesure d'identifier :

- Le blâme en milieu médical et les circonstances 'à risque'
- Les éléments légaux spécifiques au milieu de la santé du Québec – qui est responsable de la gestion du blâme lorsqu'il se produit ?
- L'impact du blâme sur la qualité de soins livrés au patient et sa place en pédagogie médicale
- Les effets du blâme sur les individus : comment s'en sortir

Ce que je vous propose

- Introduction de la notion du blame
- Jeu de rôle
- Révision des données
- *pause*
- Cadre logistique et législatif (format question/réponses)
- Implications soins aux patients et enseignement
- *Pause*
- La survie

Qu’est ce qu’on veut dire quand on parle de blâme

- Shame is the most powerful, master emotion. It’s the fear that we’re not good enough. ~ Brené Brown

Le blâme

- Différencier l'erreur du blâme
- La dimension de la honte y est presque toujours associée

Encore plus de médecins ont besoin d'aide psychologique

Les problèmes d'environnement de travail sont notamment en cause

PHOTO D'ARCHIVES

Des syndicats croient que le climat négatif dans le réseau a eu un impact sur la hausse des nouvelles demandes d'aide.

HÉLOÏSE ARCHAMBAULT
Vendredi, 22 juillet 2016 06:30
MISE à JOUR Vendredi, 22 juillet 2016 06:30

Pas moins de 578 médecins ont fait une nouvelle demande à leur programme d'aide psychologique en 2015, une hausse annuelle de 12 % qui n'est pas étrangère au climat négatif dans le réseau, selon plusieurs.

«On ne peut pas dire que le climat du système de santé actuel n'a pas eu d'impact sur la consultation des médecins», réagit Christopher Lemieux, président de la Fédération des médecins résidents du Québec (FMRQ).

Près du double

Au total, 1370 docteurs ont eu recours au Programme d'aide aux médecins du Québec (PAMQ), en 2015, soit pratiquement le double par rapport à 2006 (voir tableau).

RSR Réseau en Santé Respiratoire du FRSQ

McGill

TED Ideas worth spreading

WATCH DISCOVER ATTEND PARTICIPATE

Brian Goldman:

Doctors make mistakes. Can we talk about that?

TEDxToronto 2010 · 19:28 · **Filmed** Nov 2011

31 subtitle languages

View interactive transcript

Share this idea

Facebook LinkedIn Twitter Link Email Embed

1,224,522 Total views

Waiting for pixel.rubiconproject.com...

Ask me anything

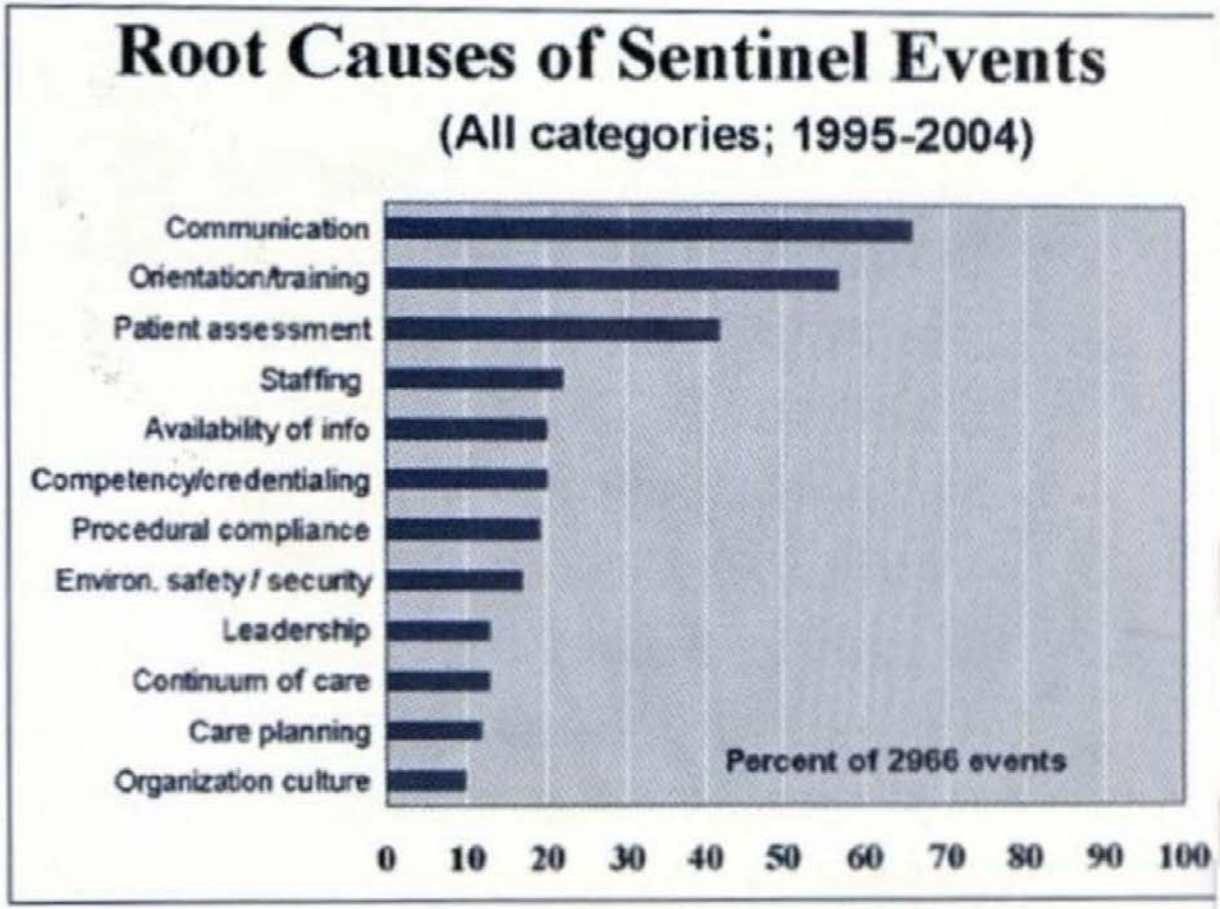
RSR Réseau en Santé Respiratoire du FRSQ

Chaire Lise et Jean Saine en soins intensifs de l'Université de Montréal à l'Hôpital Maisonneuve-Rosemont

McGill

May 2005 • Volume 25, Number 5 The C

The Joint Commission's Sentinel Event Policy: Ten Years of Improving the Quality and Safety of Health Care



The Joint Commission's Sentinel Event Policy *(continued)*

(Continued from page 4)

Table 1. Type, Number, and Percentage of Sentinel Events

Type of Sentinel Event	Number of Events	Percentage
Patient suicide	415	14.0%
Wrong-site surgery	370	12.5%
Operative/postoperative complication	365	12.3%
Medication error	326	11.0%
Delay in treatment	221	7.5%
Patient fall	144	4.9%
Patient death/injury in restraints	124	4.2%
Assault/rape/homicide	107	3.6%
Transfusion error	85	2.9%
Perinatal death/loss of function	84	2.8%
Infection-related event	57	1.9%
Patient elopement	57	1.9%
Fire	51	1.7%
Anesthesia-related event	49	1.7%
Ventilator death/injury	39	1.3%
Maternal death	38	1.3%
Medical equipment–related event	37	1.2%
Infant abduction/wrong family	21	0.7%
Utility systems–related event	18	0.6%
Other less frequent types	358	12.1%

Table 2. Settings Where Sentinel Events Occur

Setting of Sentinel Event	Number of Events	Percentage
General hospital	1,935	65.2%
Psychiatric hospital	361	12.2%
Behavioral health facility	157	5.3%
Psychiatric unit in general hospital	150	5.1%
Emergency department	124	4.2%
Long term care facility	99	3.3%
Ambulatory care	74	2.5%
Home care	57	1.9%
Clinical laboratory	6	0.2%

Table 3. Outcomes, Number, and Percentage of Sentinel Events

Sentinel Event Outcome	Number of Events	Percentage
Patient death	2,279	74%
Loss of function	312	10%
Other	492	16%
Total patients affected	**3,083**	**100%**

Table 4. Root Causes and Percentages of Sentinel Events

Root Cause of Sentinel Event	Percentage of All Sentinel Events
Communication	66%
Orientation/training	57%
Patient assessment processes	42%
Staffing levels	22%
Information availability	20%
Competency/credentialing	20%
Procedural compliance	19%
Environmental safety/security	16%
Leadership	13%
Continuum of care	13%
Care planning	12%
Organization culture	10%

Table 5. Sources for Sentinel Event Identification

Source	Number of Reports	Percentage
Self-report	1,885	63.6%
Complaints	308	10.4%
Media	263	8.9%
Identified during survey	224	7.6%
Centers for Medicare & Medicaid Services or state reports	160	5.4%

Le blâme en milieu médical et les circonstances ‘à risque’

L’environnent professionnel

Jeu de rôles

Le blâme en milieu médical et les circonstances ‘à risque’

- La culture
- Le savoir
- L’émotion
- La détresse morale
- Le conflit
- Pour que le blame et la honte en fasse partie il faut trois ingrédients:
  - l’isolement, le secret et le jugement

ORIGINAL RESEARCH

Emotional Impact of Patient Safety Incidents on Family Physicians and Their Office Staff

Maeve O'Beirne, MD, PhD, CCFP, Pam Sterling, BSc, Luz Palacios-Derflingher, PhD, Stacey Hohman, BScH, and Karen Zwicker, BScH

doi: 10.3122/jabfm.2012.02.110166

Conclusions: **All members of the health care team report experiencing emotions related to patient safety incidents in their practice. Incidents with minor or no harm still invoked emotional responses from the providers. It is important to understand the impact that patient safety incidents have on the medical clinic as a whole. (J Am Board Fam Med 2012;25:177–183.)**

Les éléments légaux spécifiques au milieu de la santé du Québec – qui est responsable de la gestion du blâme lorsqu'il se produit ?

‘Shame and blame’

- Comme intégral a une culture médicale décrite et définie dans les premiers papiers sur les incidents et les erreurs médicales

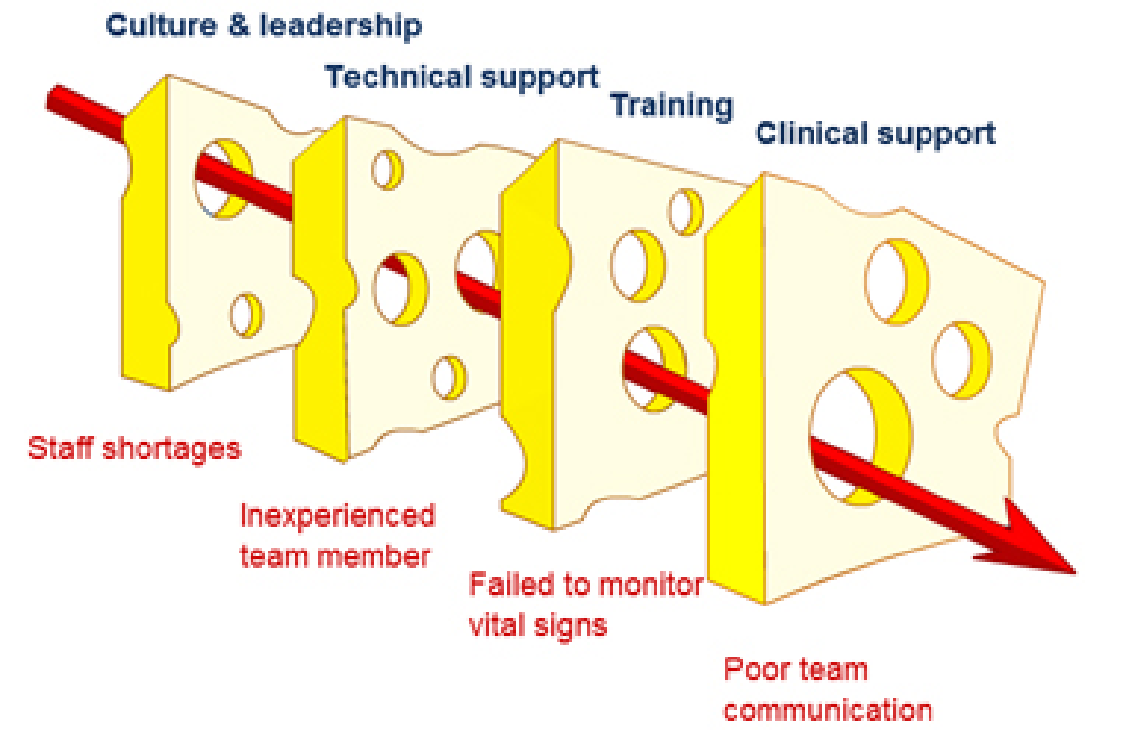
Houston, we have a problem

- Premiers documents identifiants une culture de blame et de honte comme source d'erreur en soi
- Documents législatifs appliqués au Québec
- Le quotidien

La comparaison de cultures

Health care is a decade or more behind other high-risk industries in its attention to ensuring basic safety. Aviation has focused extensively on building safe systems and has been doing so since World War II. Between 1990 and 1994, the U.S. airline fatality rate was less than one-third the rate experienced in mid century.[16] In 1998, there were no deaths in the United States in commercial aviation. In health care, preventable injuries from care have been estimated to affect between three to four percent of hospital patients.[17] Although health care may never achieve aviation's impressive record, there is clearly room for improvement.

To err is human, but errors can be prevented. Safety is a critical first step


Culture & leadership
Technical support
Training
Clinical support
Staff shortages
Inexperienced team member
Failed to monitor vital signs
Poor team communication

TO ERR IS HUMAN

Building a Safer Health System

THE NATIONAL ACADEMIES

National Academy of Sciences
National Academy of Engineering
Institute of Medicine
National Research Council

chance possible of achieving the desired outcome.

This report describes a serious concern in health care that, if discussed at all, is discussed only behind closed doors. As health care and the system that delivers it become more complex, the opportunities for errors abound. Correcting this will require a concerted effort by the professions, health care organizations, purchasers, consumers, regulators and policy makers. Traditional clinical boundaries and a culture of blame must be broken down. But most importantly, we must systematically design safety into processes of care.

Loi sur les services de santé et les services sociaux

- Fin des années 90 : publication de diverses études qui lèvent le voile sur le phénomène des événements indésirables et de leurs conséquences;
- Au Québec, un comité ministériel (Comité Francoeur) est mandaté afin d'évaluer l'ampleur de ce phénomène et de proposer des solutions;
- Les travaux permettent de conclure que la situation du Québec n'est pas différente de celle des autres pays;
- Décembre 2002 : des modifications sont apportées à la LSSSS (projet de loi no 113);
- Plusieurs organismes font la promotion de la sécurité des patients :
  - Agrément Canada, Conseil québécois d'agrément, Institut canadien pour la sécurité des patients, Institut pour l'utilisation sécuritaire des médicaments du Canada, Campagne québécoise : Ensemble, améliorons la prestation sécuritaire des soins de santé, etc.

Un premier constat s'est imposé avec force : il n'y a aucune raison de penser que la nature, la gravité et la fréquence des accidents évitables en milieu de santé au Québec sont substantiellement différentes de celles qui prévalent dans les pays qui ont déjà procédé à un examen approfondi de ce phénomène. Il en résulte que les accidents évitables constituent, au Québec comme ailleurs, une cause significative de morbidité et de mortalité, et qu'ils appellent une attention particulière, au même titre que les autres traumatismes non intentionnels qui figurent parmi les priorités en matière de santé.

Deuxième constat : le phénomène des accidents évitables, pour indéniable qu'il soit, reste largement occulté par un voile de malaise, de gêne et de fausse pudeur. Le mot accident *et davantage encore le mot* erreur *demeurent trop lourdement chargés, il y a lieu de les désamorcer ; ils véhiculent également une culture de culpabilisation, de blâme, d'échec et d'humiliation dont il faut les délester. La réduction du taux d'incidence des accidents évitables – puisque tel doit être l'objectif – ne pourra être atteinte qu'au moyen d'un profond changement de la culture de l'ensemble du réseau. Tout progrès en ce sens ne sera possible qu'à travers une culture nouvelle faite de transparence, de communication ouverte et de franche discussion. Il faut créer les conditions qui rendront possible ce changement qui ne peut être que graduel.*

Enfin, troisième constat, particulièrement troublant : les accidents évitables représentent, pour les victimes ou pour leurs proches, un fardeau dont on semble encore sous-estimer la lourdeur sur le plan humain. Les témoignages que nous avons pu recueillir à cet effet sont accablants. Les risques sont encore énormes d'être laissé dans l'ignorance, sans soutien véritable, parfois même sans réparation adéquate des traumatismes subis, aussi bien physiques que psychologiques. Les victimes et leurs proches éprouvent des sentiments de désarroi, d'impuissance, voire de colère devant une indifférence perçue comme érigée en système. À cela s'ajoutent les insuffisances d'un régime d'indemnisation fondé sur le principe de la responsabilité professionnelle et trop souvent hors de portée des victimes elles-mêmes.

Le principal obstacle à plus de transparence est la culture de culpabilisation, de blâme et de sanction. Cette culture doit être modifiée. L'expérience d'autres secteurs d'activité en fait foi : il n'y aura réduction significative du taux d'accidents en milieu de santé que si les faits sont systématiquement rapportés, et discutés ouvertement et en toute franchise.

La réalité

- culture de divulgation progressive axée sur les patients et variable d'un milieu a l'autre
- Erreurs médicamenteuses au centre des vérifications et des systèmes
- Variabilité énorme quant a la définition d'un évènement sentinelle
- Inexistence systémique de processus et de lapse de temps
- Discordance entre Agrément Canada et gestion hospitalière locale, provinciale

Implications soins aux patients et enseignement

Implications soins aux patients

Erreurs et documentation

Medication-related errors occur frequently in hospitals and although not all result in actual harm, those that do, are costly. One recent study conducted at two prestigious teaching hospitals, found that about two out of every 100 admissions experienced a preventable adverse drug event, resulting in average increased hospital costs of $4,700 per admission or about $2.8 million annually for a 700-bed teaching hospital.[10] If these findings are generalizable, the increased hospital costs alone of preventable adverse drug events affecting inpatients are about $2 billion for the nation as a whole.

The most extensive study of adverse events is the Harvard Medical Practice Study, a study of more than 30,000 randomly selected discharges from 51 randomly selected hospitals in New York State in 1984.[30] Adverse events, manifest by prolonged hospitalization or disability at the time of discharge or both, occurred in 3.7 percent of the hospitalizations. The proportion of adverse events attributable to errors (i.e., preventable adverse events) was 58 percent and the proportion of adverse events due to negligence was 27.6 percent. Although most of these adverse events gave rise to disability lasting less than six months, 13.6 percent resulted in death and 2.6 percent caused permanently disabling injuries. Drug complications were the most common type of adverse event (19 percent), followed by wound infections (14 percent) and technical complications (13 percent).[31,32]

ADEs also result in increased visits to physician offices and emergency departments. In an analysis of 1,000 patients drawn from a community office-based medical practice who were observed for adverse drug reactions, adverse effects were recorded in 42 (4.2 percent), of which 23 were judged to be unnecessary and potentially avoidable.[73] In an analysis of 62,216 visits to an emergency department by patients enrolled in a health maintenance organization (HMO), it was found that 1,074 (1.7 percent) were related to medication noncompliance or inappropriate prescribing.[74]

Thomas et al., in their study of admissions to hospitals in Colorado and Utah experiencing adverse events, found that about 30 percent were attributable to negligence.[77] The hospital location with the highest proportion of

BOX 2.1
Types of Errors

Diagnostic
- Error or delay in diagnosis
- Failure to employ indicated tests
- Use of outmoded tests or therapy
- Failure to act on results of monitoring or testing

Treatment
- Error in the performance of an operation, procedure, or test
- Error in administering the treatment
- Error in the dose or method of using a drug
- Avoidable delay in treatment or in responding to an abnormal test
- Inappropriate (not indicated) care

Preventive
- Failure to provide prophylactic treatment
- Inadequate monitoring or follow-up of treatment

Other
- Failure of communication
- Equipment failure
- Other system failure

SOURCE: Leape, Lucian; Lawthers, Ann G.; Brennan, Troyen A., et al. Preventing Medical Injury. *Qual Rev Bull.* 19(5):144–149, 1993.

Why Do Errors Happen?

The common initial reaction when an error occurs is to find and blame someone. However, even apparently single events or errors are due most often to the convergence of multiple contributing factors. Blaming an individual does not change these factors and the same error is likely to recur. Preventing errors and improving safety for patients require a systems approach in order to modify the conditions that contribute to errors. People working in health care are among the most educated and dedicated workforce in any industry. The problem is not bad people; the problem is that the system needs to be made safer.

CHEST Clinical Commentary

ICU CARE MODELS

Changing the Work Environment in ICUs to Achieve Patient-Focused Care*

The Time Has Come

Kathleen McCauley, RN, BC, PhD; and Richard S. Irwin, MD, FCCP

Eight Behaviors for Smarter Teams

Roger Schwarz

The **Eight Behaviors** for **Smarter Teams** are:

1. State views and ask genuine questions
2. Share all relevant information
3. Use specific examples and agree on what important words mean
4. Explain reasoning and intent
5. Focus on interests, not positions
6. Test assumptions and inferences
7. Jointly design next steps
8. Discuss undiscussable issues

The human factor: the critical importance of effective teamwork and communication in providing safe care

M Leonard, S Graham, D Bonacum

Qual Saf Health Care 2004;**13**(Suppl 1):i85–i90. doi: 10.1136/qshc.2004.010033

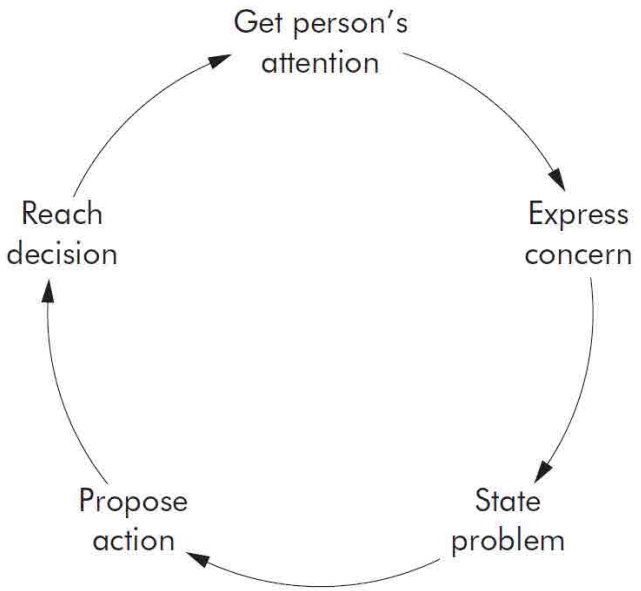


Figure 1 Assertion cycle. This is a model to guide and improve assertion in the interest of patient safety.

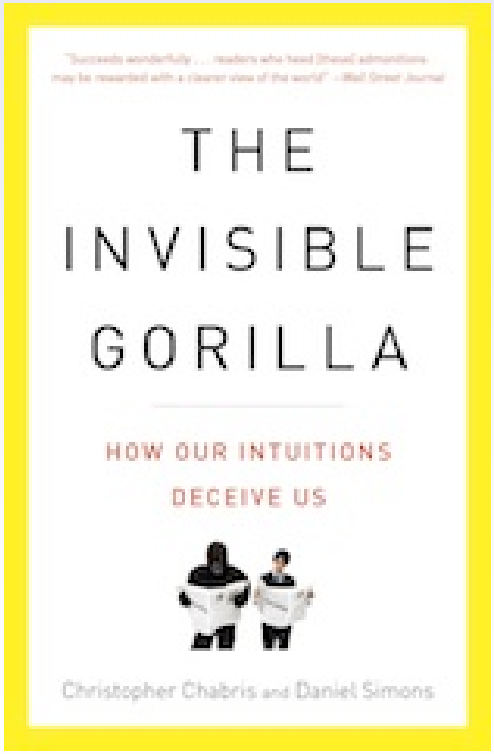
Why Blame & Shame Don't Work

Instead of accusing, blaming or shaming, consider redirecting toward a solution using some of these approaches:

- How can we do this differently?
- This is what I need from you. How can I help you achieve this?
- Instead of defending another person – just listen.
- When you do not agree with their perspective – comment on how they must feel withoutagreeing with why they feel that way. (e.g. "Everybody hates me." – It must be awful to feel that way.)
- What would you like to do about that?
- How can we do that in a way that is healthy for you?
- How can we change that to work better for you?
- What is a solution that you think would make this better for everyone?
- What would be helpful?
- I hear your frustration. I want to help you move forward to a work situation that is at the very least not negative. What would that take?
- Follow up with, and what else?...And what else?

Le tort additionnel associé au blame d'un ou plusieurs individus

- **La notion de vérité et sa polarisation**



Les biais et distorsions cognitives associés au blâme et a la honte

- **Biais de confirmation**
- **Biais de persistance de croyance (‘belief’) initial**
- **Biais d’autorité**
- **Biais de rétrospective**

uting factors. Given that the information about an accident is spread over many participants, none of whom may have complete information,[11] hindsight bias makes it easy to arrive at a simple solution or to blame an individual, but difficult to determine what really went wrong.

failure.[12] Even when equipment failure occurs, it can be exacerbated by human error.[13] However, saying that an accident is due to human error is not the same as assigning blame. Humans commit errors for a variety of

According to Cook,[7] *Safety is a characteristic of systems and not of their components. Safety is an emergent property of systems.* In order for this property to arise, health care organizations must develop a systems orientation to patient safety, rather than an orientation that finds and attaches blame to individuals. It would be hard to overestimate the underlying, critical importance of developing such a culture of safety to any efforts that are made to reduce error. The most important barrier to improving patient safety is lack of awareness of the extent to which errors occur daily in all health care settings and organizations. This lack of awareness exists because the vast majority of errors are not reported, and they are not reported because personnel fear they will be punished.

Culture et leadership

Principle 1. Provide Leadership

- Make patient safety a priority corporate objective.
- Make patient safety everyone's responsibility.
- Make clear assignments for and expectation of safety oversight.
- Provide human and financial resources for error analysis and systems redesign.
- Develop effective mechanisms for identifying and dealing with unsafe practitioners.

Wanted: Morally Courageous Leaders

Cole Edmonson, FACHE

The Power of a Moral Compass

The concept of the moral compass in healthcare is based on four guiding points: (1) integrity, (2) responsibility, (3) compassion, and (4) forgiveness. Having the ability to visualize this compass creates a sense of direction toward an inspired vision. Healthcare organizations guided by leaders with a strong moral compass operate within a framework of humility and intellectual curiosity that is grounded in doing the right thing.

Un changement de culture

Il nous est apparu que l'objectif de diminuer les accidents évitables ne pourra être atteint qu'à travers un changement radical de culture, cette constellation de mentalités, attitudes et comportements partagés par l'ensemble du personnel soignant. La culture actuelle – composée, d'une part, d'opacité, de fausse pudeur, de gêne, parfois même de négation et, d'autre part, de culpabilisation, de mesures punitives et de blâme – doit céder la place à une culture de transparence, de communication ouverte, de franche discussion, et cela dans la plus grande confiance mutuelle.

Implications enseignement

Clinical training and education is a key mechanism for cultural change. Colleges of medicine, nursing, pharmacy, health care administration, and their related associations should build more instruction into their curriculum on patient safety and its relationship to quality improvement. One of the challenges in accomplishing this is the pressure on clinical education programs to incorporate a broadening array of topics. Many believe that initial exposure to patient safety should occur early in undergraduate and graduate training programs, as well as through continuing education. Clinical training programs also need to ensure that teaching opportunities are safe for patients. One workshop participant told of a monitoring device used to alert staff to possible problems with the patient that was turned off because it was seen as interfering with the teaching experience.

The need for more opportunities for interdisciplinary training was also identified. Most care delivered today is done by teams of people, yet training often remains focused on individual responsibilities leaving practitioners inadequately prepared to enter complex settings. Improving patient safety also requires some understanding of systems theory in order to effectively analyze the many contributing factors that influence errors. Again, the "silos" created through training and organization of care impede safety improvements. Instruction in safety improvement requires knowledge about work-

Détresse morale associée au blâme et à la honte

McGill

Student Psychological Wellbeing at McGill University:

Sample

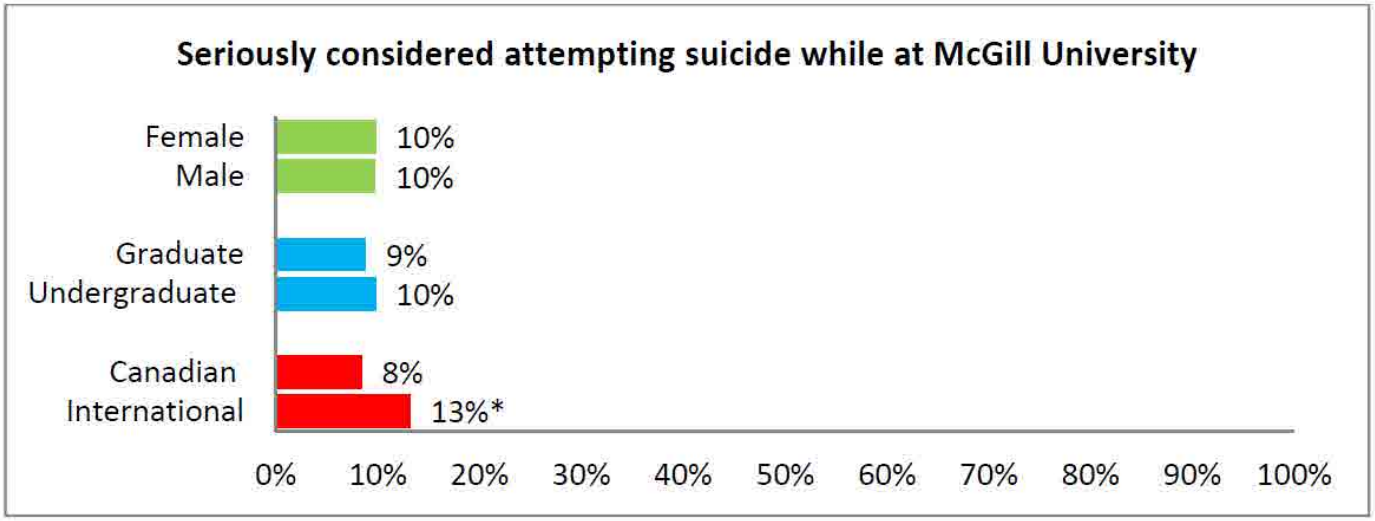
2,500 students were randomly selected to participate in the survey. The sample included 1,800 undergraduate and 700 graduate students.

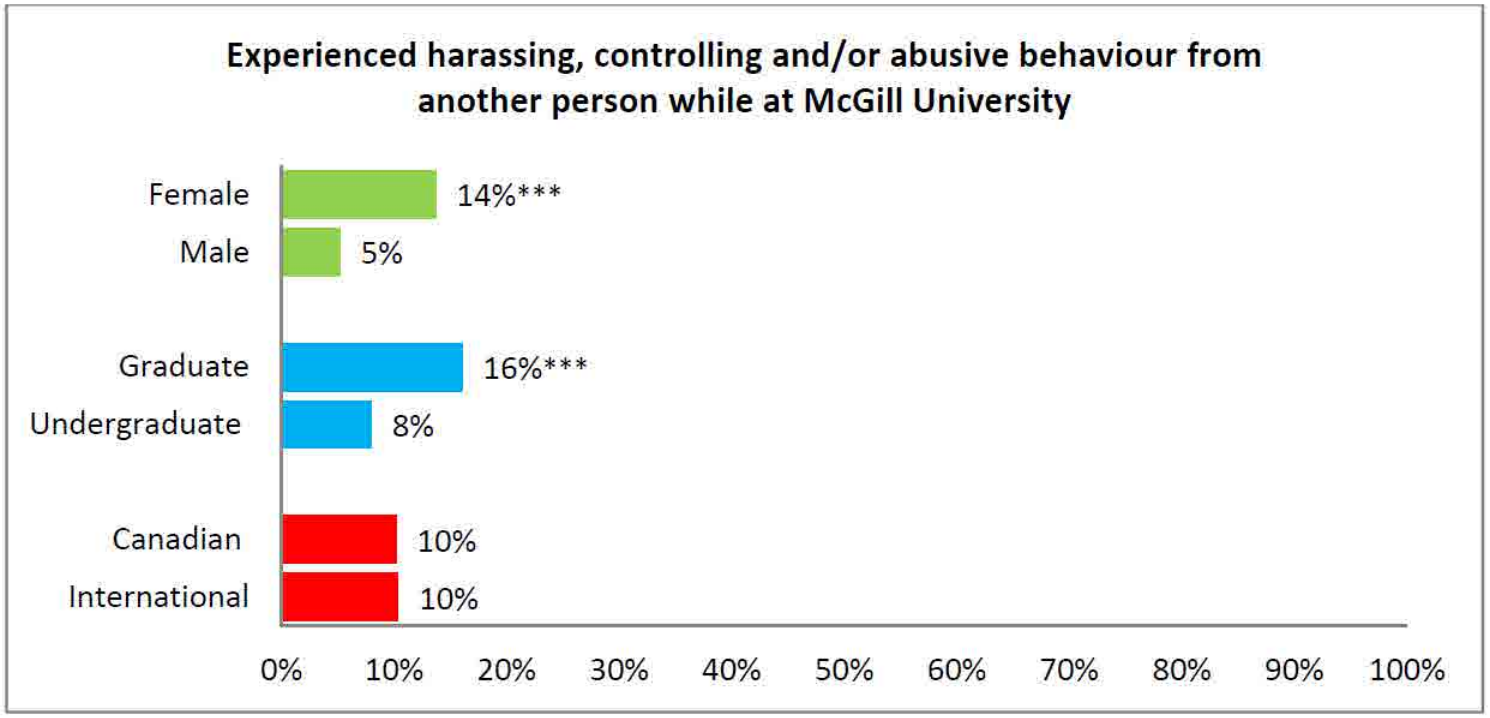
Table 3-Percentage of McGill Respondents who Accessed Resources

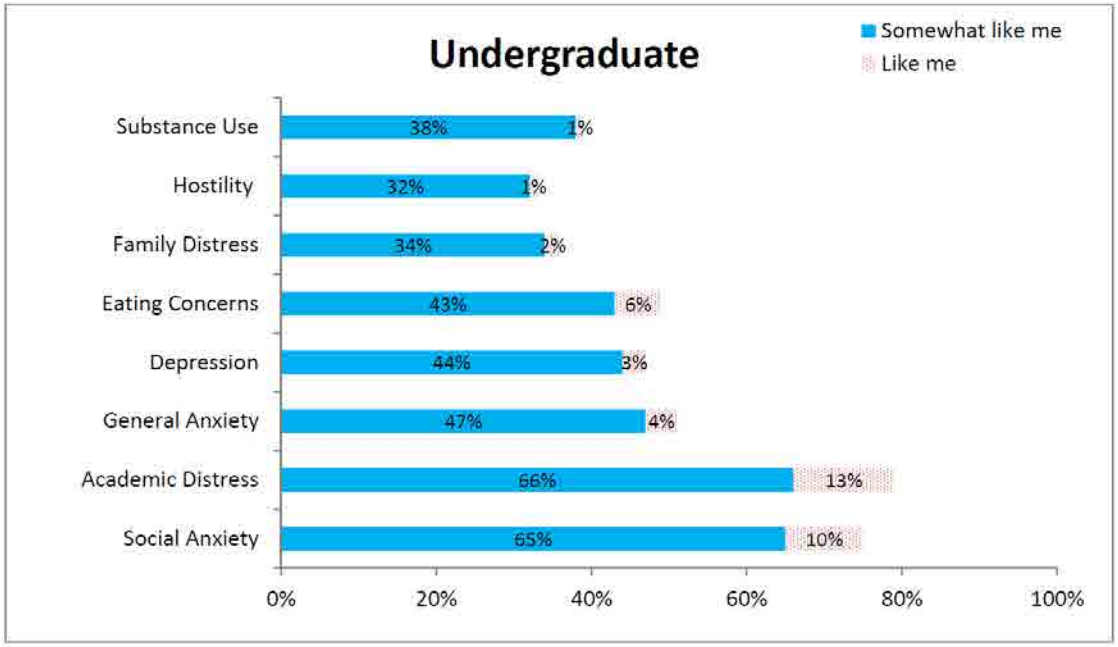
Suicidality

- Suicidality is defined as thoughts related to taking one's life and attempts to do so. Suicide is one of the leading causes of death in University students (Jed Foundation, 2013). A recent American national study of university students indicated that 6% of students seriously considered suicide and 1.3% attempted suicide (Locke, Bieschke, Castonguay & Hayes, 2012).

- This study examined suicidal ideation and attempted suicide. Approximately 10% of McGill respondents indicated that they seriously considered attempting suicide while at University. Suicide attempts while at University ranged from 0% to 2%.




Experienced harassing, controlling and/or abusive behaviour from another person while at McGill University
Female
Male
Graduate
Undergraduate
Canadian
International
14%***
5%
16%***
8%
10%
10%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%


Undergraduate
Somewhat like me
Like me
Substance Use
Hostility
Family Distress
Eating Concerns
Depression
General Anxiety
Academic Distress
Social Anxiety
38%
1%
32%
1%
34%
2%
43%
6%
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4%
66%
13%
65%
10%
0%
20%
40%
60%
80%
100%

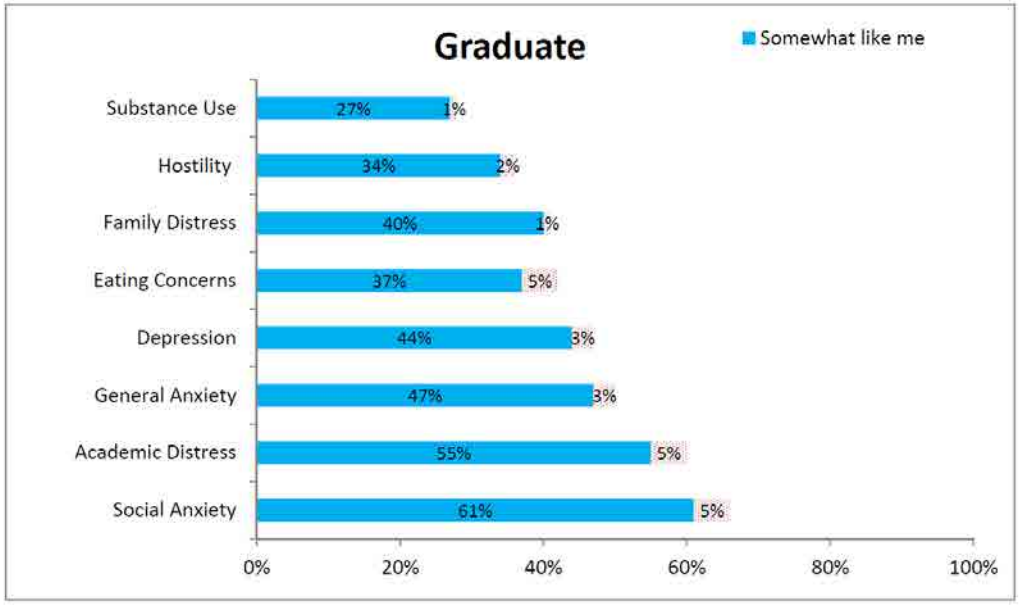
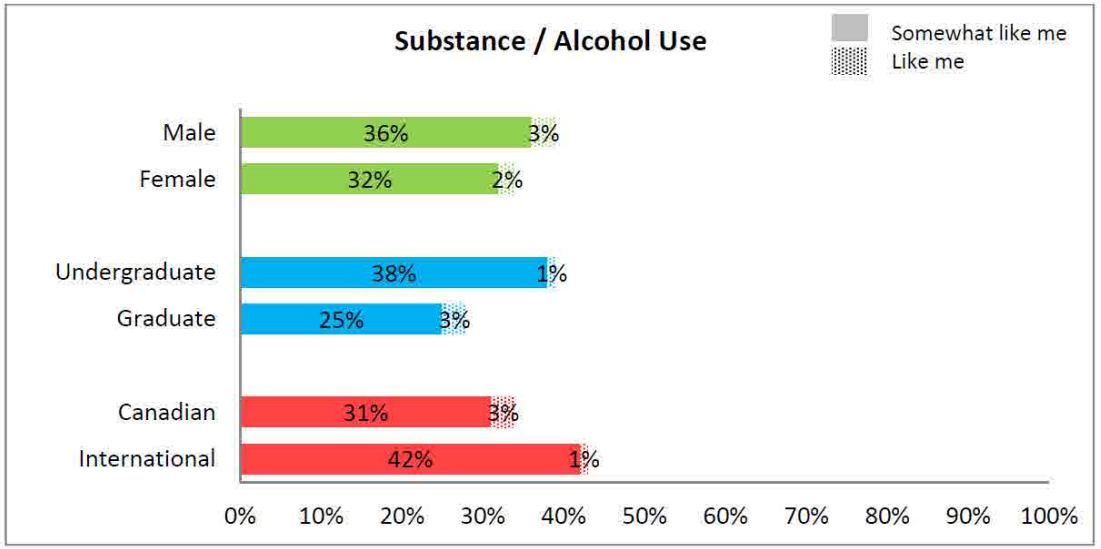
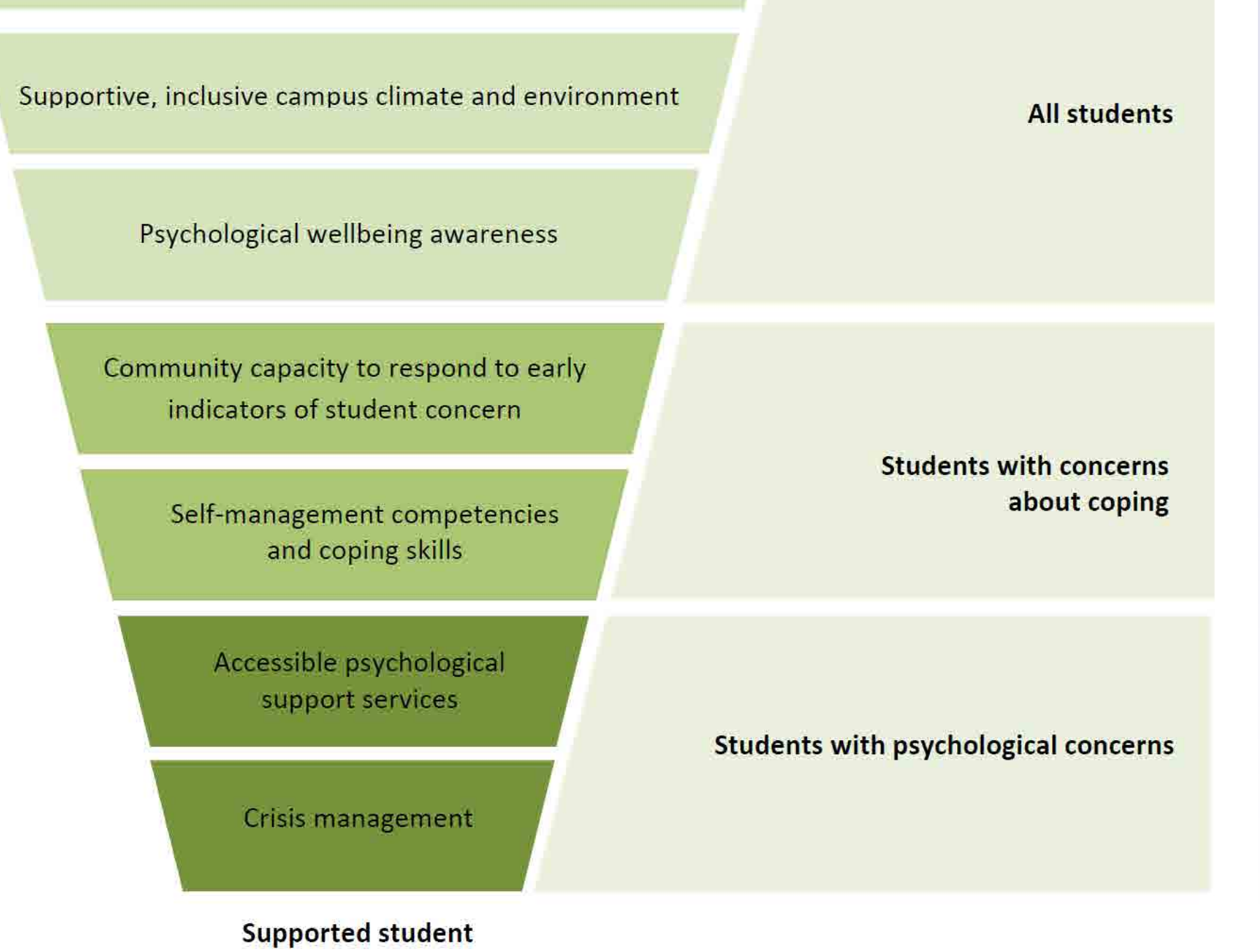

Graduate
Somewhat like me
Substance Use
Hostility
Family Distress
Eating Concerns
Depression
General Anxiety
Academic Distress
Social Anxiety
27%
1%
34%
2%
40%
1%
37%
5%
44%
3%
47%
3%
55%
5%
61%
5%
0%
20%
40%
60%
80%
100%

Table 8- Benchmark Comparisons of the Eight Subscales

	McGill (n=463)		AAU Peer Group (n=3,191)				US National Average (n=29,686)			
	Mean	*Std. Dev*	*Mean*	*Sig*	*Std. Dev*	*Effect Size*	*Mean*	*Sig*	*Std. Dev*	*Effect Size*
Depression	**1.07**	1.15	**0.88**	***	1.08	0.17	**0.85**	***	1.08	0.19
Generalized Anxiety	**1.13**	1.16	**1.03**		1.12	0.09	**1.04**		1.15	0.08
Social Anxiety	**1.57**	1.24	**1.51**		1.19	0.05	**1.51**		1.21	0.05
Academic Distress	**1.57**	1.18	**1.34**	***	1.15	0.19	**1.23**	***	1.21	0.29
Eating Concerns	**1.05**	1.17	**1.08**		1.16	-0.03	**0.99**		1.13	0.05
Family Distress	**0.83**	1.06	**0.74**		1.02	0.08	**0.81**		1.08	0.02
Hostility	**0.67**	0.86	**0.6**		0.83	0.08	**0.61**		0.85	0.07
Substance / Alcohol Use	**0.82**	1.14	**0.78**		1.07	0.04	**0.69**	***	1.07	0.11

**p<.05; ** p<.01; ***p<.001*




Supportive, inclusive campus climate and environment
Psychological wellbeing awareness
All students
Community capacity to respond to early indicators of student concern
Self-management competencies and coping skills
Students with concerns about coping
Accessible psychological support services
Crisis management
Students with psychological concerns
Supported student

- Principal's Commission on Mental Health, Queen's University (2012) recommended a four-level pyramidal approach

Evaluation & the Health Professions
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Health Care Professionals as Second Victims after Adverse Events: A Systematic Review

EDITOR'S CHOICE

The natural history of recovery for the healthcare provider "second victim" after adverse patient events

S D Scott, L E Hirschinger, K R Cox, M McCoig, J Brandt, L W Hall

Table 4 Most commonly reported physical and psychosocial symptoms

Physical symptoms	n (%)	Psychosocial symptoms	n (%)
Remorse	19 (61)		
Depression	17 (55)		
Repetitive/intrusive memories	16 (52)		
Self-doubt	16 (52)		
Return to work anxiety	15 (48)		
Second guessing career	12 (39)		
Fear of reputation damage	12 (39)		
Excessive excitability	11 (35)		
Avoidance of patient care area	10 (32)		

them. However, participants found it difficult to completely put the event behind them. This is a unique stage for recovery as it has three potential paths: dropping out, surviving or thriving. Dropping out involved changing professional role, leaving the profession or moving to a different practice location.

Qual Saf Health Care 2009;**18**:325–330. doi:10.1136/qshc.2009.032870

Table 3. Overview of the Symptoms of the Second victim ($n = 41$ Included in This Literature Review)

Psychological symptoms		Physical symptoms		Behavioral symptoms		Cognitive symptoms		Possible long-term effects	
Feelings of guilt	$n = 19$[a]	Sleeping disturbances, fatigue	$n = 2$	Insomnia	$n = 4$	Disturbance in concentration	$n = 1$	Burnout	$n = 4$
Anger	$n = 14$	Uncontrollable crying, uncontrollable shaking, increase blood pressure, exhaustion, abdominal discomfort, nausea, vomiting or diarrhoea, muscle tension, headaches, eating disorder	$n = 1$	Seeking solace in alcohol or drugs, isolation	$n = 2$			Decrease quality of life	$n = 3$
Irritation	$n = 13$							Possible PTSD, concentration difficulties	$n = 2$
Psychological distress, fear	$n = 12$							Affected memory, easy loss of nerves, anxiety	$n = 1$
Depressed mood, feelings of embarrassment, humiliation, uncomfortable	$n = 8$								
Feelings of shame, feelings of inadequacy, regret, grief, sadness, self-doubt, disappointment	$n = 7$								
Frustration, anxiety	$n = 6$								
Loss of self-confidence	$n = 4$								

(continued)

Table 3. (continued)

Psychological symptoms		Physical symptoms	Behavioral symptoms	Cognitive symptoms	Possible long-term effects
Feelings of remorse, repetitive intrusive memories, anxiety, horrified	$n = 3$				
Sadness, nervousness, anguish, self-blame	$n = 2$				
Indifference, devastation, believe actions were reasonable, depression, loss of temper, hypervigilance, disbelief, spiritual distress, panicky, confusion, vulnerability, feelings of betrayal of others, discouragement, sorrow, excessive excitability, upset, dysphonic feelings, intense feelings of agony and anguish, desperation	$n = 1$				

Note. PTSD = posttraumatic stress disorder.
[a] Symptoms were mentioned in 19 out of 41 publications.

Table 4. Overview of Coping Strategies ("Ways of Coping Scale" by Folkman and Lazarus; $n = 41$ Included in This Literature Review)

Seeking social support	$n = 15$[a]
For example, talking to someone about feelings; accepting sympathy; and understanding from someone; asking a relative or friend for advice	
Accepting responsibility	$n = 6$
For example, promising to do things differently; criticizing or lecturing oneself; apologizing or doing something to make up	
Distancing	$n = 5$
Foe example, not letting it get to them; going on as if nothing has happened; trying to forget the whole thing	
Emotional self-control	$n = 4$
For example, trying to keep feelings from interfering with other things; trying to keep feelings to themselves; keeping others from knowing how bad things are	
Escape-avoidance	$n = 3$
For example, wishing the situation would go away or be over; having fantasies of how things might turn out; trying to make themselves feel better by eating, drinking, using drugs or medications	
Planful problem solving	$n = 2$
For example, concentrating on what to do next; knowing what had to be done, doubling effort to make up; making a plan of action and following it	

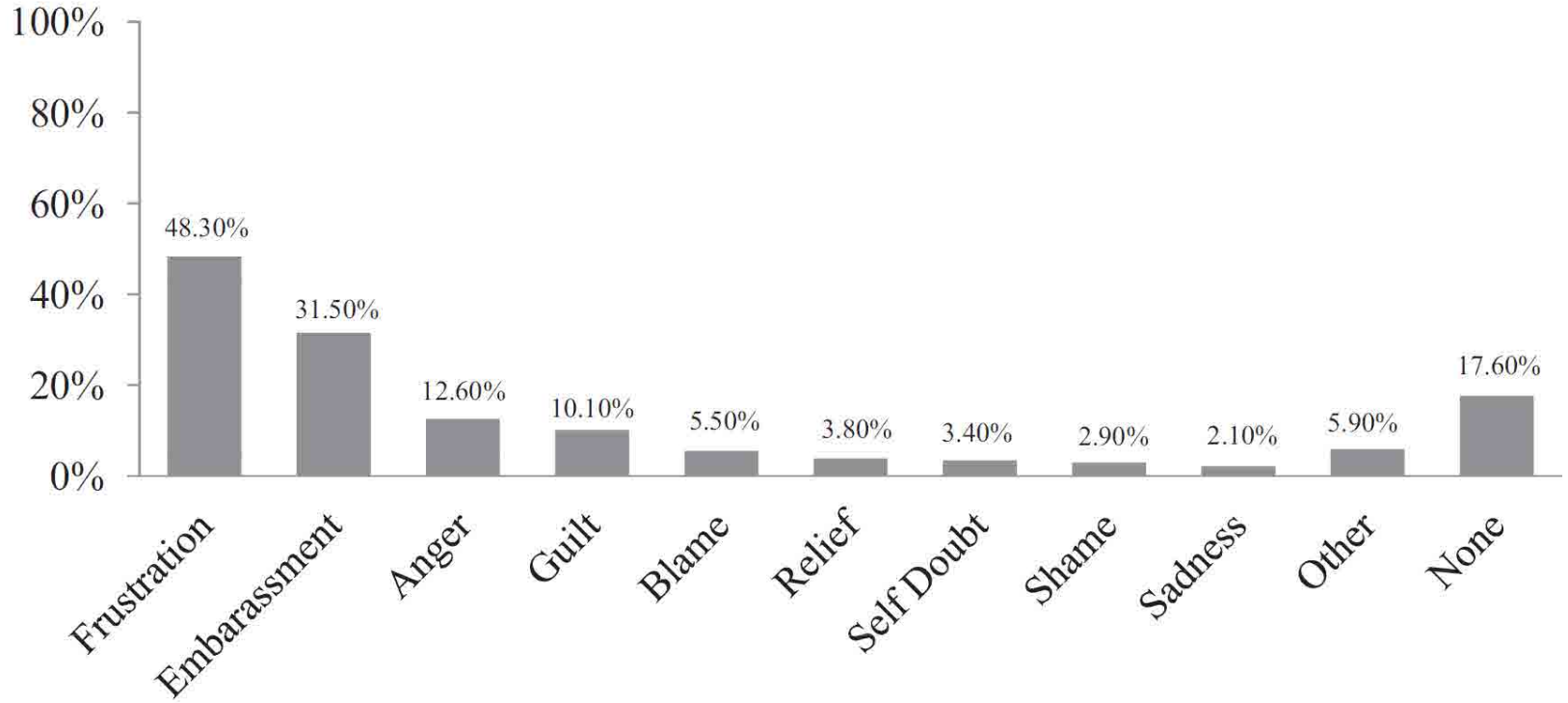
[a] Out of 41 publications, 15 mentioned this coping strategy.

ORIGINAL RESEARCH

Emotional Impact of Patient Safety Incidents on Family Physicians and Their Office Staff

Maeve O'Beirne, MD, PhD, CCFP, Pam Sterling, BSc, Luz Palacios-Derflingher, PhD, Stacey Hohman, BScH, and Karen Zwicker, BScH

ure 2. Reported Emotional Responses.



Caring for Our Own: Deploying a Systemwide Second Victim Rapid Response Team

Department Editors: Michael A. DeVita, M.D., Rinaldo Bellomo, M.D., Kenneth Hillman, M.D. Readers are invited to submit inquiries regarding their own case studies on rapid response teams (also called medical emergency teams) to Steven Berman (sberman@jcrinc.com) or Michael DeVita (mdevpgh@yahoo.com).

Susan D. Scott, R.N., M.S.N.; Laura E. Hirschinger, R.N., M.S.N., A.H.N.-B.C.; Karen R. Cox, R.N., Ph.D.; Myra McCoig; Kristin Hahn-Cover, M.D.; Kerri M. Epperly, R.N., C.C.R.N.; Eileen C. Phillips, R.N.; Leslie W. Hall, M.D.

Source of Emotional Support After a Clinical Event When Offered

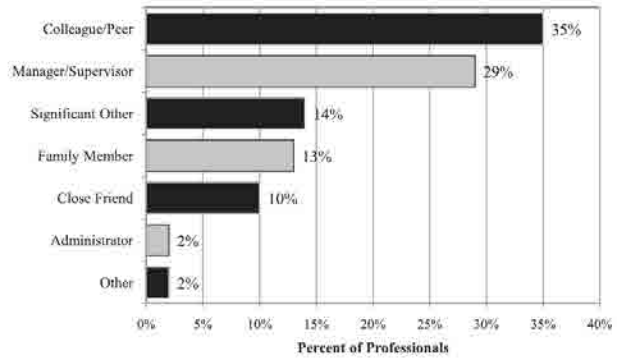


Figure 2. *When support was offered, 35% of the 898 second victims who responded reported receiving support from colleagues and peers, and 29% received support from supervisory personnel.*

Internal Versus External Support for Second Victim Assistance

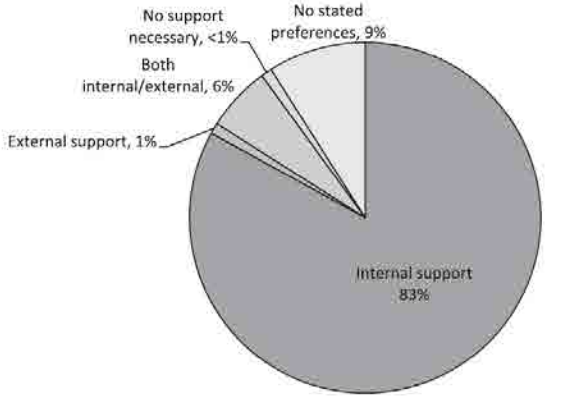
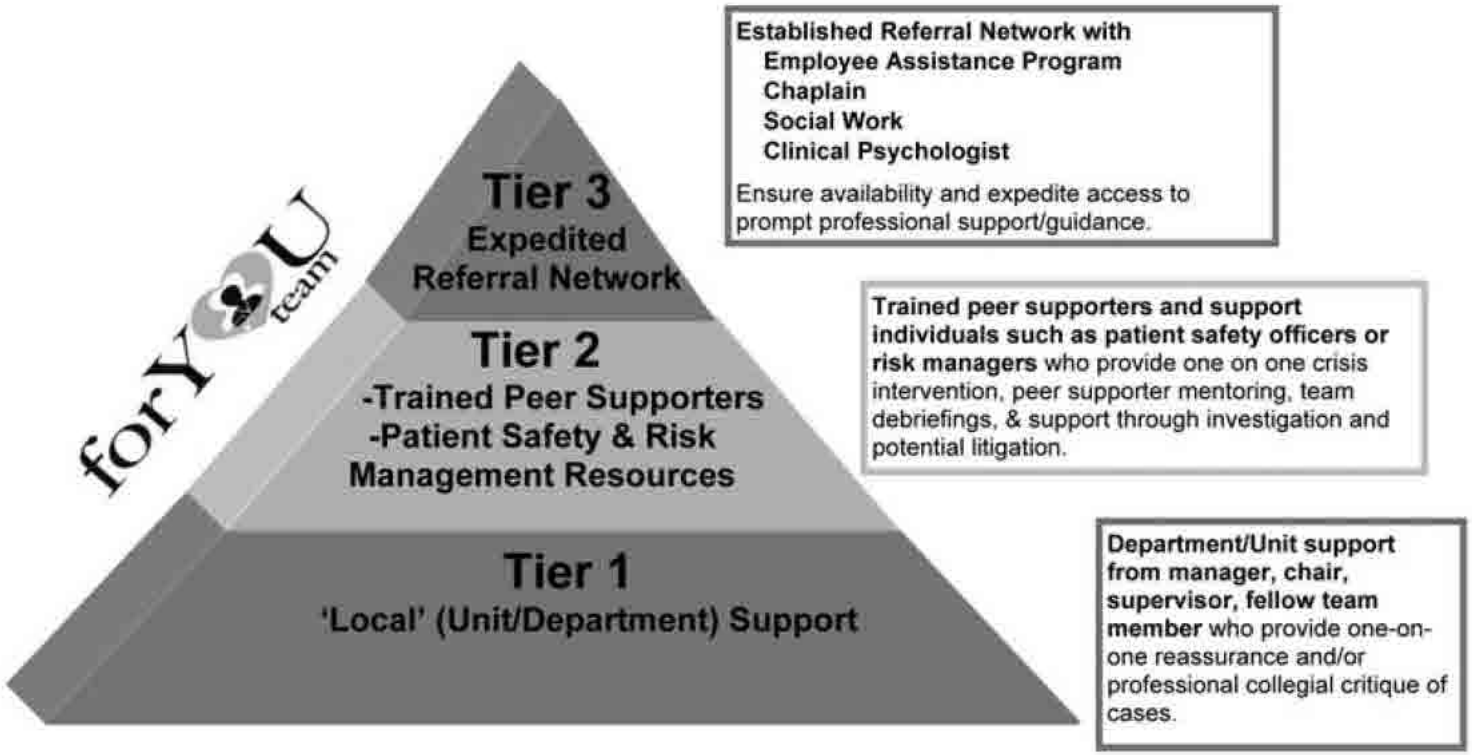


Figure 3. *Only 1% of narratives from the 354 respondents expressed a desire to involve professionals or other individuals outside the internal practice environment. Some 6% desired a complement of both internal and external support structures, and 9% described characteristics of a supportive environment but did not indicate where the services should originate (internal versus external support). Fewer than 1% (3 participants) did not believe that any support structure should ever be necessary and made comments such as "welcome to health care—get used to it."*

ber of responding health care providers and the narratives expressing personal suffering and desired institutional support. Regardless of professional group or years of experience, respondents preferred formal support that was provided by the insti-

Scott Three-Tiered Interventional Model of Second Victim Support



gure 4. *The Scott Three-Tiered Interventional Model of support consists of three tiers, with the nature of support escalating from Tier 1 through Tier 3.*

Conclusions

Health-care leaders are often in the position of reviewing perceived medical errors with negative patient outcomes with hospital staff. In most cases, negative outcomes are not caused by willful acts of harm, but instead by human error, slip, or lapse; organizational process failures; or insufficient resources. Looking back on these index cases, it is important to frame case reviews in the workplace in a way that will not result in perceived blame. Leaders can teach staff how to investigate and debrief following a negative patient outcome in a way that does not incur blame, cultivating an environment of performance improvement instead of punishment to prevent B-RD. The distress caused by blame should foster proactive reaching out to provide support to those who may be affected by a negative patient outcome.

From a blame culture to a just culture in health care

Naresh Khatri
Gordon D. Brown
Lanis L. Hicks

Background: A prevailing blame culture in health care has been suggested as a major source of an unacceptably high number of medical errors. A just culture has emerged as an imperative for improving the quality and safety of patient care. However, health care organizations are finding it hard to move from a culture of blame to a just culture.

ultures and (2) to find out ways to reform a blame culture.

Conclusions: On the basis of the review of related literature, we conclude that (a) a blame culture is more likely t occur in health care organizations that rely predominantly on hierarchical, compliance-based functional management systems; (b) a just or learning culture is more likely to occur in health organizations that elicit greater employee involvement in decision making; and (c) human resource management capabilities play an important role in moving from a blame culture to a just culture.

pause

Outils utiles

Crucial Conversation

- Une conversation entre 2 individus ou plus
  - Les enjeux sont élevés
  - Les émotions sont fortes
  - Les opinions ne concordent pas

- Le seul enjeu:
  - Le DIALOGUE

Reconnaitre le terrain

- Sa teneur (‘contenu’) et conditions
- Le manque de sécurité
- Le ou les autres se déplacent vers le silence ou la violence
- Votre réaction au stress

L’instrument de mode de Conflit Thomas-Killman

High

Assertiveness

Low

RSR
Réseau en Santé Respiratoire du FRSQ

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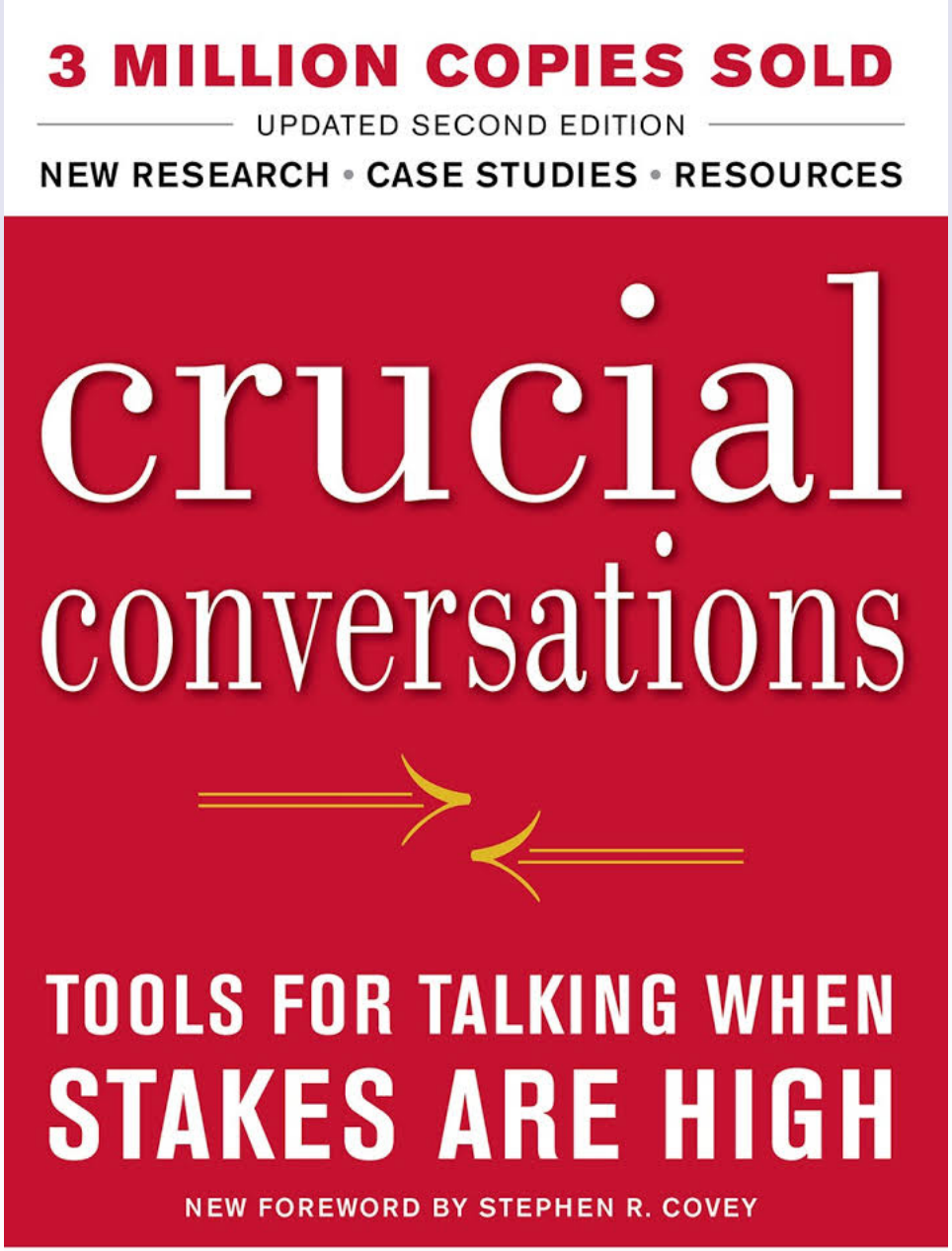

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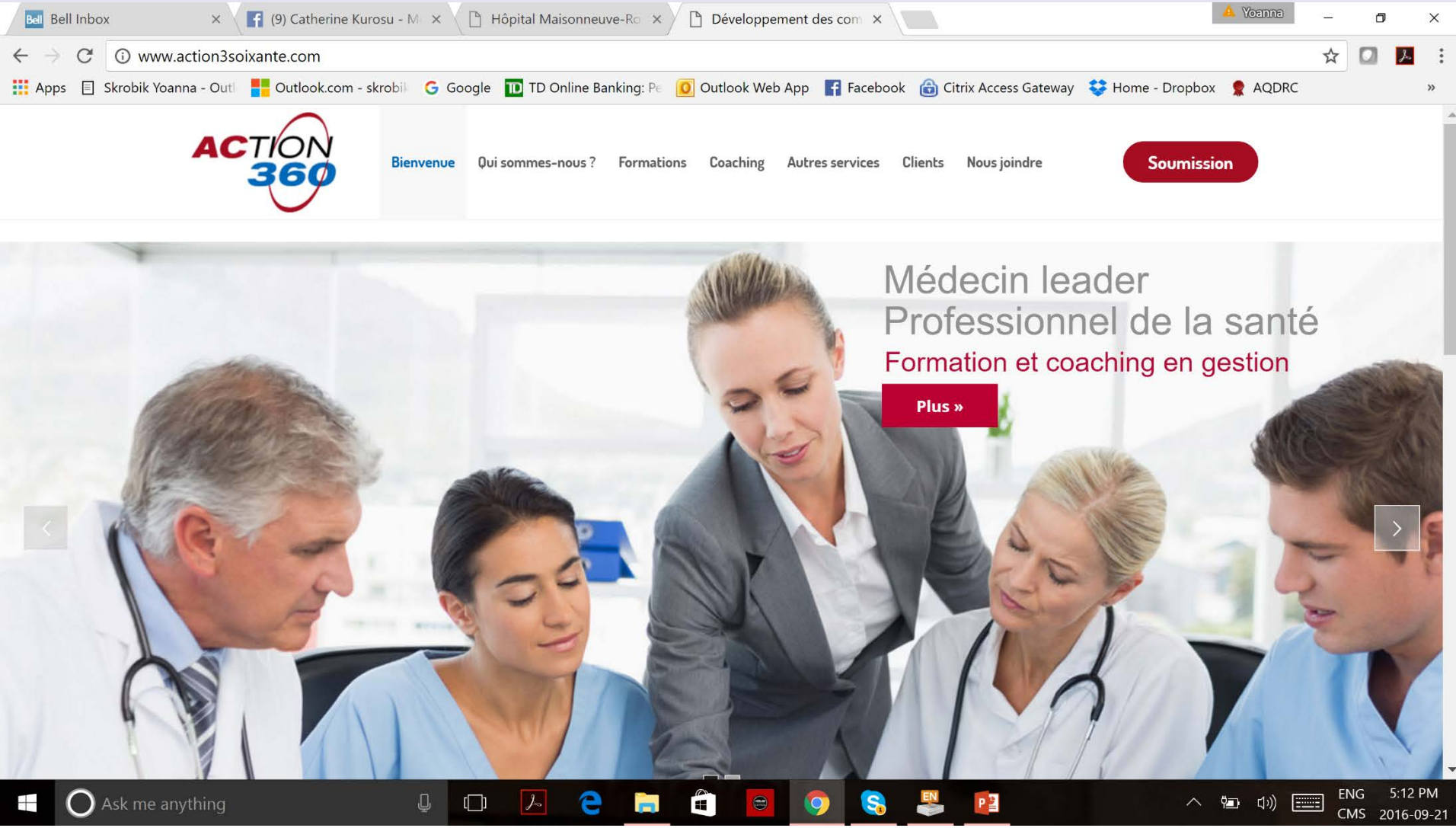
Références

- **Crucial Conversations: Tools for talking when stakes are high**
- **Crucial Confrontations: Tools for resolving broken promises, violated expectations and bad behaviour**
- **Influencer: How to change anything.**
- **Change Anything: The new science of personal success.**
- **Getting to Yes**
- **Getting Past No**
- **Difficult Conversations: How to discuss what matters most**

Éléments aidants

AHS assembled a multi-disciplinary team to develop a Principles and Supports Framework to foster psychologic
event. Dr. MacLeod invited other healthcare organizations to share their challenges and processes so that we c
continue the dialogue on helping second victims.



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CHAIRE LISE ET JEAN SAINE
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Ask me anything

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Chaire Lise et Jean Saine en soins intensifs de l'Université de Montréal à l'Hôpital Maisonneuve-Rosemont

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La narrative

- *Publications surtout de régions de guerre ou de désastre; émergence de littérature de combattants*

- *If you trade your authenticity for safety, you may experience the following: anxiety, depression, eating disorders, addiction, rage, blame, resentment, and inexplicable grief.* ~ *Brené Brown*

- Introduction de la notion du blame
- Jeu de rôle
- Révision des données
- Cadre logistique et législatif (format question/réponses)
- Implications soins aux patients et enseignement
- La survie

merci