La comunicació al pacient dels esdeveniments adversos

Perspectiva des de l'ètica assistencial

Màrius Morlans Molina, metge

Comitè de Bioètica de Catalunya

Sessions tècniques del Consorci

Barcelona, 19 d'abril de 2018

Consorci de Salut i Social de Catalunya

Comitè Bioètica Catalunya

"I am called eccentric for saying in public that hospitals, if they wish to be sure of improvement, must find out what their results are. Must analyze their results to find their strong and weak points. Must compare their results with those of other hospitals... Such opinions will not be eccentric a few years hence."

E. A. Codman. MD. 1917. (1869 - 1940)

A STUDY IN HOSPITAL EFFICIENCY

AS DEMONSTRATED BY THE CASE REPORT OF THE FIRST TWO YEARS OF A PRIVATE HOSPITAL

BY

E. A. CODMAN, M.D.

THIS paper is intended to be a practical illustration of the detailed operation of the End Result System of Hospital Organization recommended by the Committee on Standardization of Hospitals of the Clinical Congress of Surgeons of North America.

See *Surgery, Gynecology, and Obstetrics*, January, 1914.

See also "The Product of a Hospital," *Surgery, Gynecology, and Obstetrics*, April, 1914.

Sir Cyril Chantler, Lancet 1999, 353:1178-81

"Medicine used to be **ineffective,** but **simple and safe**".

"Now is **effective,** but **complex and relatively dangerous**".

133 People to take care of the patient

The Patient

To Err is Human

Building a Safer Health System

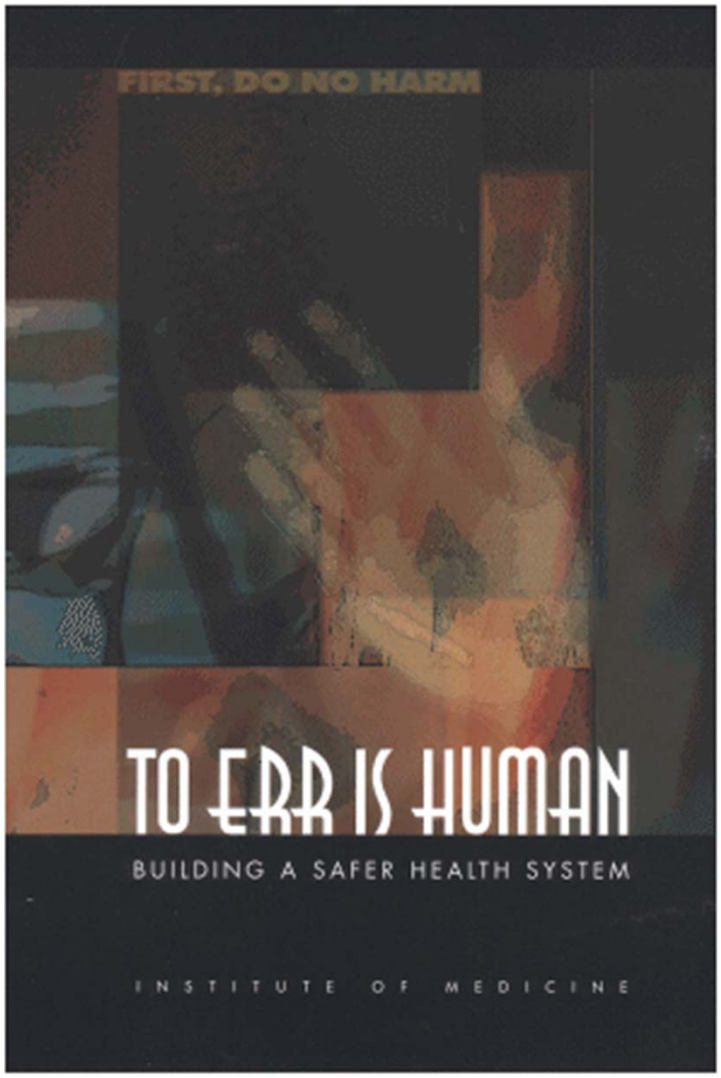
Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors

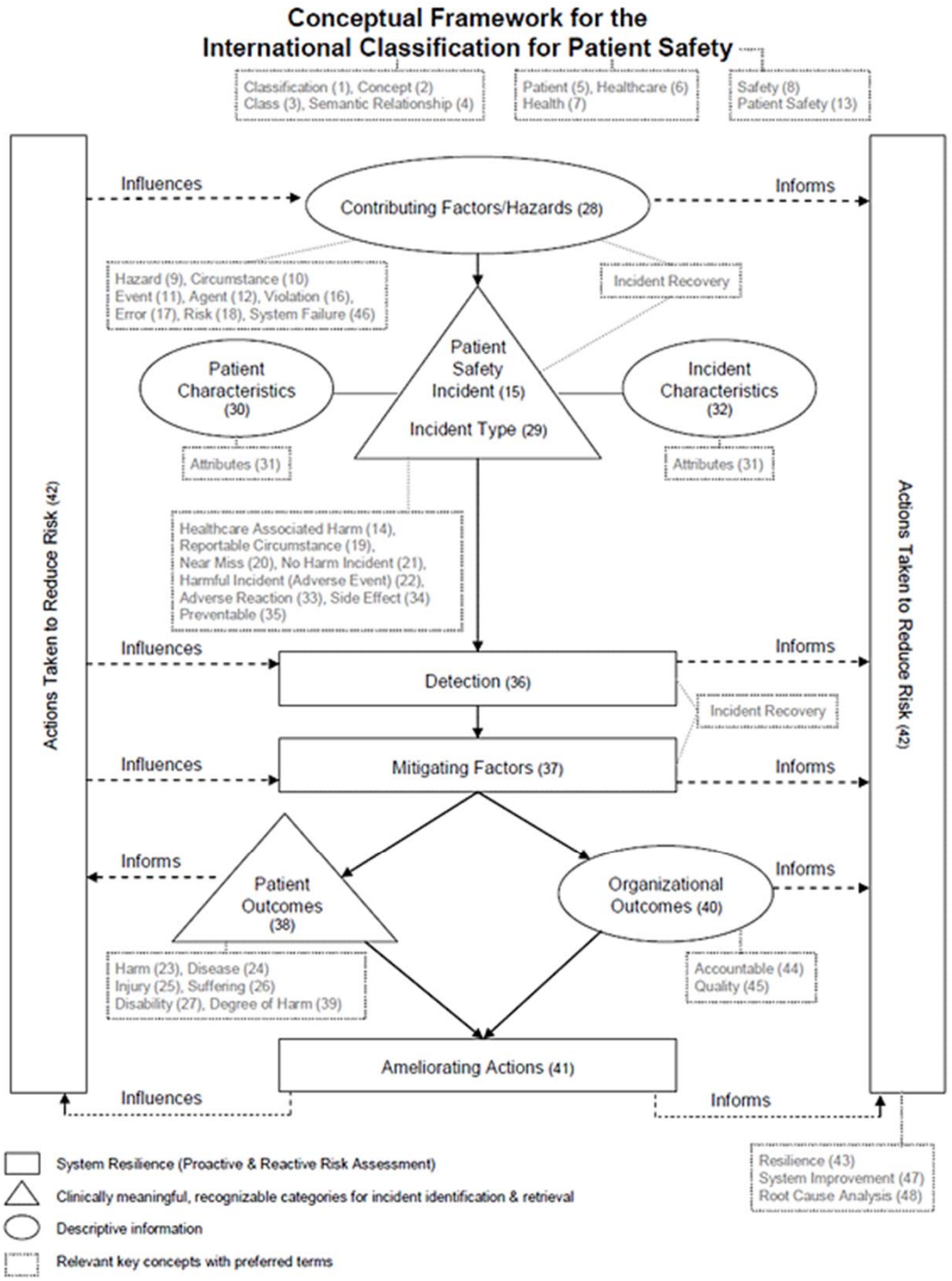
Committee on Quality of Health Care in America

INSTITUTE OF MEDICINE

NATIONAL ACADEMY PRESS
Washington, D.C.

1999




Conceptual Framework for the
International Classification for Patient Safety
Classification (1), Concept (2)
Class (3), Semantic Relationship (4)
Patient (5), Healthcare (6)
Health (7)
Safety (8)
Patient Safety (13)
Actions Taken to Reduce Risk (42)
Influences
Contributing Factors/Hazards (28)
Informs
Hazard (9), Circumstance (10)
Event (11), Agent (12), Violation (16),
Error (17), Risk (18), System Failure (46)
Incident Recovery
Patient
Characteristics
(30)
Patient
Safety
Incident (15)
Incident Type (29)
Incident
Characteristics
(32)
Attributes (31)
Attributes (31)
Healthcare Associated Harm (14),
Reportable Circumstance (19),
Near Miss (20), No Harm Incident (21),
Harmful Incident (Adverse Event) (22),
Adverse Reaction (33), Side Effect (34)
Preventable (35)
Influences
Detection (36)
Informs
Incident Recovery
Influences
Mitigating Factors (37)
Informs
Informs
Patient
Outcomes
(38)
Organizational
Outcomes (40)
Informs
Harm (23), Disease (24)
Injury (25), Suffering (26)
Disability (27), Degree of Harm (39)
Accountable (44)
Quality (45)
Ameliorating Actions (41)
Influences
Informs
Actions Taken to Reduce Risk (42)
Resilience (43)
System Improvement (47)
Root Cause Analysis (48)
System Resilience (Proactive & Reactive Risk Assessment)
Clinically meaningful, recognizable categories for incident identification & retrieval
Descriptive information
Relevant key concepts with preferred terms

Les preguntes implícites

- Cal comunicar els esdeveniments adversos?
- Perquè?
- Qui ha de comunicar?
- Com s'ha de comunicar?

Índex

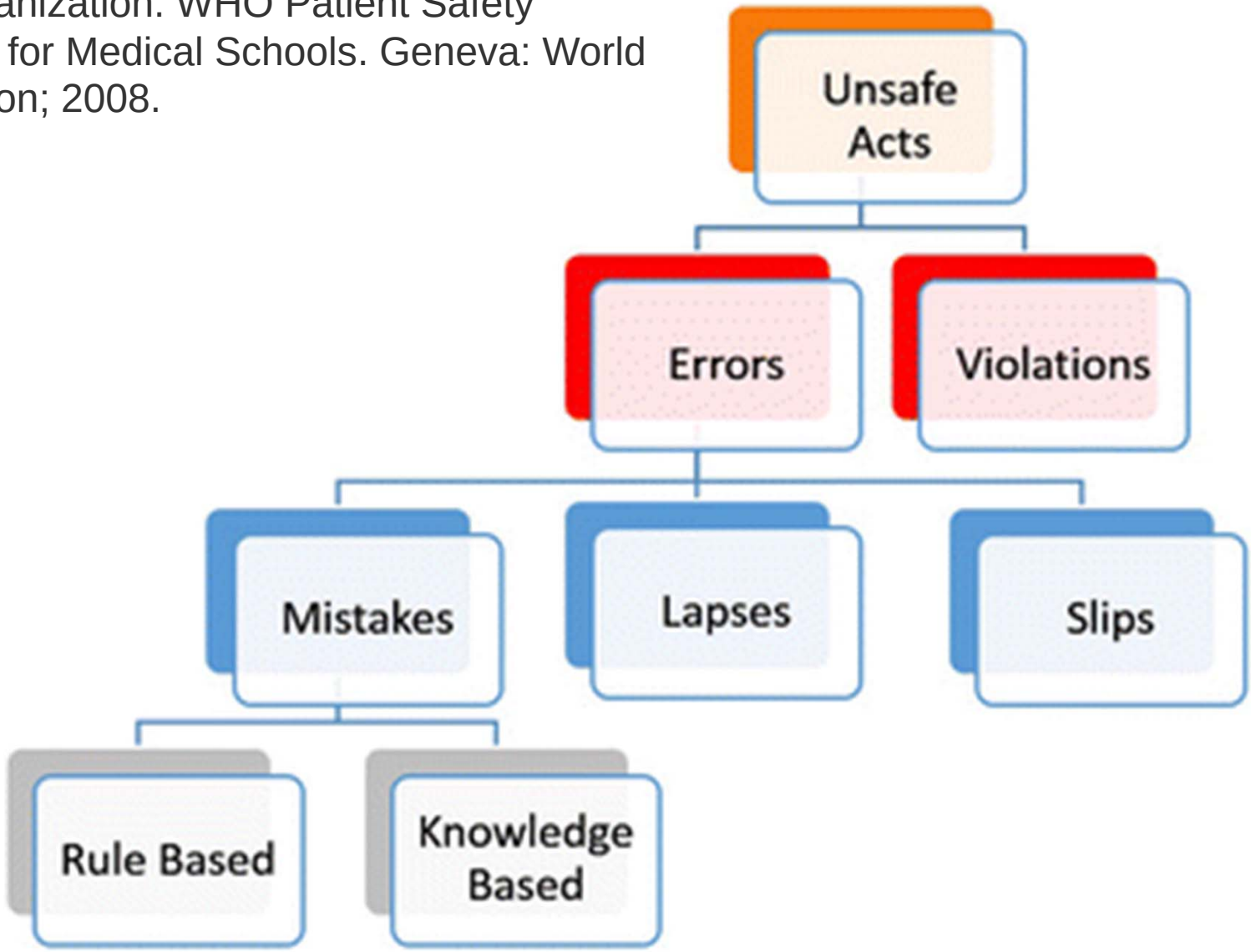
- Implicacions ètiques de les definicions possibles
- Evidència empírica de la comunicació
- Els conceptes i principis ètics rellevants
- L'opinió dels implicats
- Procediments recomanats
- Polítiques corporatives i institucionals
- Conclusions

L’ètica i el llenguatge

"Sólo a través del lenguaje podemos plantearnos el sentido del bien y del mal, porque aunque sean cuerpos los que ***actúan****, su actuación, como actuación* ***moral****, camina por el* ***discurso*** *de las palabras, fuera ya del orden de las cosas y los cuerpos.* ***La ética es precisamente lenguaje****…”*

Lledó, E. *Memoria de la ética*; Madrid, Taurus, 1994

Vorld Health Organization. WHO Patient Safety
urriculum Guide for Medical Schools. Geneva: World
ealth Organization; 2008.



Categorization of unsafe events

International Journal of Humanities and Social Science Vol. 2 No. 22 [Special Issue – November 2012] 30-42

Defining Failure: The Language, Meaning and Ethics of Medical Error

Christiane Schubert, Gerald Winslow, Susanne Montgomery, Ahlam Jadalla,

Abstract

Despite the technical sophistication of modern medicine errors cannot be avoided. As errors are situated in the complexity and dynamicity that characterize healthcare environments they are difficult to define. A conceptual framework of medical error needs to account for the reality of medical work and the nature of error as a language-mediated social and legal construct. We identify four aspects that serve as a distinct framework: the notion of intent, the etiology of medical error and its multi-factorial flow, peer-reviewed contexts, and outcomes that may or may not result in harm to patients. The former assume moral quality and become concerns of justice. Specifically, a restorative justice approach supports the disclosure of errors to patients and addresses their physical, mental, spiritual, and social effects. The result of this contextually grounded, outcome-oriented model and accompanying definition of medical error provides practical guidance for hospital policies on dealing with medical error issues.

Característiques de l'assistència mèdica

1. ***Incertesa***. La informació sobre la eficàcia i efectivitat de les intervencions mediques és poblacional no individual. (Altres: interval de temps entre la prescripció i l'administració del fàrmac).
2. ***Complexitat creixent de les organitzacions sanitàries***. Dificultats en la comunicació entre professionals.
3. ***Confusió i fusió de conceptes i contexts***. L'error és una funció del context i no pot ser separat de les seves circumstàncies (Urgències).
4. ***Vincle entre error i culpa***. No és el mateix que s'hagi fet malament o que hagi succeït.

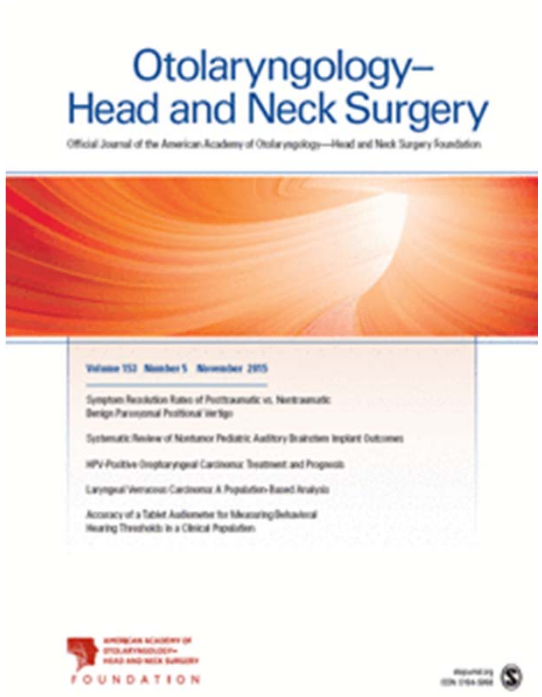
Esdeveniments adversos deguts a problemes de comunicació

Otolaryngol Head Neck Surg. 2012 Jan;146(1):129-34. doi: 10.1177/0194599811421745. Epub 2011 Sep 9.

Interdisciplinary development and implementation of communication checklist for postoperative management of pediatric airway patients.

Kim SW[1], Maturo S, Dwyer D, Monash B, Yager PH, Zanger K, Hartnick CJ.

- ✓ Equip multidisciplinar pediàtric va desenvolupar i implementar un checklist post quirúrgic i protocol electrònic simple de traspàs de pacients.
- ✓ La seva implementació va eliminar els esdeveniments adversos ***deguts a problemes de comunicació.***



Marc conceptual per a definir *Error mèdic*

1. ***Clarificar la noció d'intencionalitat o voluntarietat***. No es fa a propòsit. El càlcul benefici/risc i la no maleficència, els efectes secundaris.
2. ***Etiologia multifactorial***. Individual, complexitat tecnològica i organitzativa, cultura i estratègies institucionals, condicionants de l'entorn.
3. ***Context***. Els estàndards de bona pràctica mesurats segons les condicions de treball. Revisió per parells.
4. ***Resultats***. Impacte en l'existència saludable física, mental, espiritual i social.

Communicating With Patients About Medical Errors
A Review of the Literature

Kathleen M. Mazor, EdD; Steven R. Simon, MD; Jerry H. Gurwitz, MD

Background: Ethical and professional guidelines recommend disclosure of medical errors to patients. The objective of this study was to review the empirical literature on disclosure of medical errors with respect to (1) the decision to disclose, (2) the process of informing the patient and family, and (3) the consequences of disclosure or nondisclosure.

Methods: Wesearched 4 electronic databases (MEDLINE, CINAHL, PsycINFO, and Social Sciences Citations Index) and the reference lists of relevant articles for English language studies on disclosure of medical errors. From more than 800 titles reviewed, we identified 17 articles reporting original empirical data on disclosure of medical errors to patients and families.

Conclusions: Empirical research on disclosure of medical errors to patients and families has been limited, and studies have focused primarily on the decision stage of disclosure. Fewer have considered the disclosure process, the consequences of disclosure, or the relationship between the two. Additional research is needed to understand how disclosure decisions are made, to provide guidance to physicians on the process, and to help all involved anticipate the consequences of disclosure.

Arch Intern Med. 2004;164:1690-1697

Characteristics of Articles With Empirical Data Related to Disclosure of Medical Errors to Patients

Source	Data Collection Method	Subjects (Location)	Sample Size (Response Rate)	Definition of Error or Adverse Event	Stages of Disclosure Findings Are Applicable to
Allman,[22] 1998	Questionnaire	Physicians (United States)	39 (18%)	An act or omission for which the house officer felt responsible that had serious or potentially serious consequences for the patient, and that would have been judged wrong by knowledgeable peers.	Decision
Beckman et al,[31] 1994	Review of depositions	Plaintiffs (United States)	45 (NA)	Adverse outcome.	Process, consequences
Blendon et al,[32] 2002	Questionnaire	Members of the public and physicians (United States)	1207 (67%); 831 (62%)	"Sometimes when people are ill and receive medical care, mistakes are made that result in serious harm, such as death, disability, or additional or prolonged treatment. These are called medical errors. Some of these errors are preventable, whereas others may not be." Also specific vignettes.	Decision, process
Gallagher et al,[23] 2003	Focus group	Patients and physicians (United States)	52 (NA); 46 (NA)	Error: "failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim." Adverse event: "injury that was caused by medical management and resulted in measurable disability." Also specific vignettes.	Decision, process, consequences
Hickson et al,[33] 1992	Questionnaire	Malpractice claimants (United States)	127 (35%)	Care deviated from the community standards of care; deviations caused death or permanent injury.	Consequences
Hingorani et al,[34] 1999	Questionnaire	Patients and physicians (United Kingdom)	246 (81%); 48 (100%)	Specific vignette.	Decision
Hobgood et al,[24] 2002	Questionnaire	Patients and relatives (United States)	258 (80%)	"If something did go wrong in the administration of your health care"; "medical mistake."	Decision
Kraman and Hamm,[25] 1999	Claims records	Veterans Affairs medical center (United States)	NA	Malpractice or substantial error resulting in loss of a patient's function, earning capacity, or life.	Consequences
Lamb et al,[35] 2003	Questionnaire	Hospital risk managers (United States)	245 (51%)	"Unexpected harm that occurs as a result of treatment or care, not directly because of a patient's illness or underlying condition." Plus specific vignettes.	Decision, process

(continued)

REVIEWS

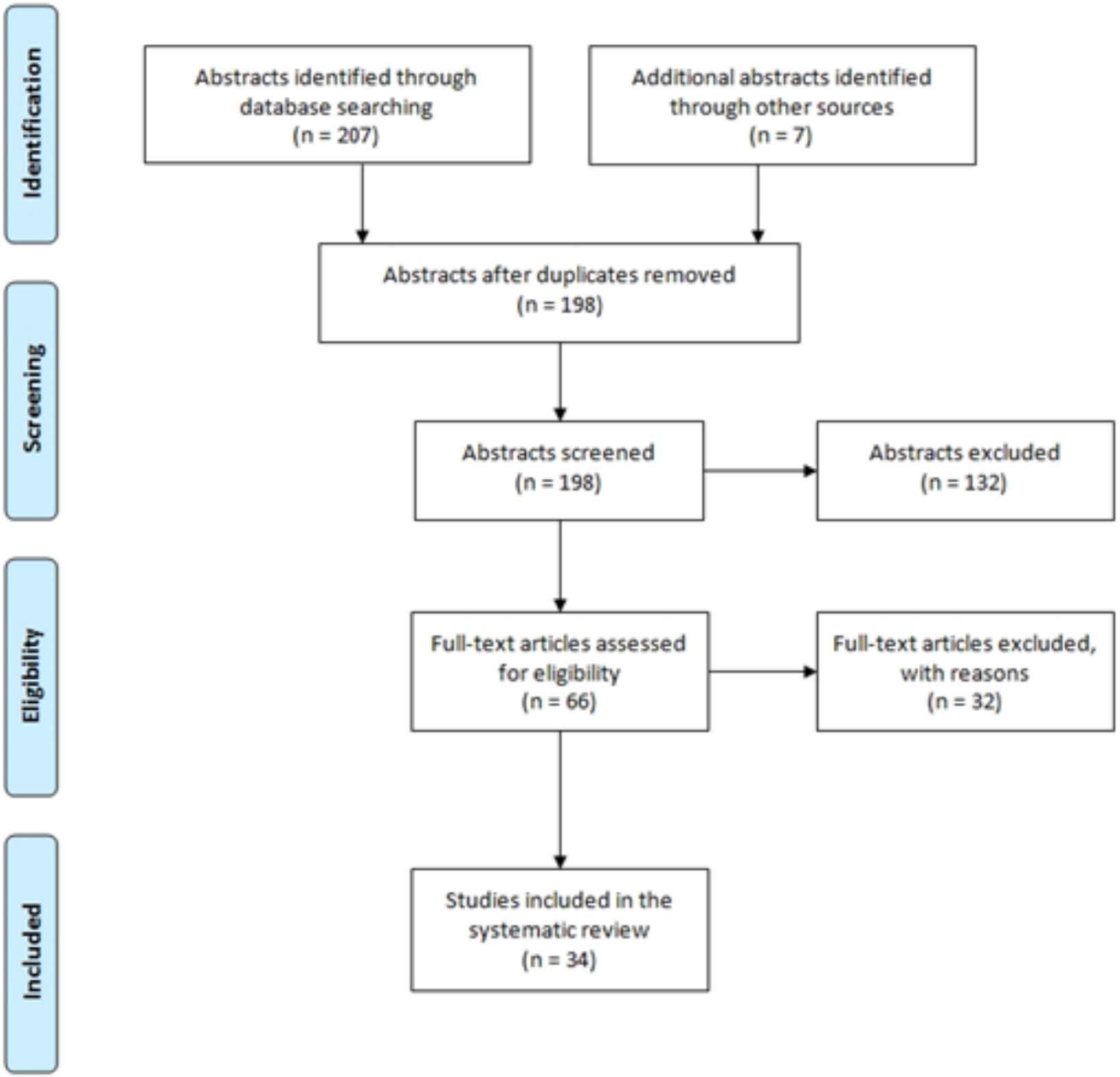
Medical errors: Moral and ethical considerations

Wilfred Bonney

School of Business and Technology, Capella University, Minneapolis, MN, USA

Abstract

Medical errors are an inevitable part of the practice of medicine and pose a significant threat to the safety of patients. Improper management of healthcare professionals, clinical workflow processes, and information systems often leads to medical errors. Disclosure of medical errors to patients and family members serves as a catalyst for litigation and thus, the establishment of appropriate moral and ethical standards cannot be ignored when implementing solutions to remedy the situation. In this paper, a systematic literature review was used to explore and evaluate the moral and ethical issues that confront the healthcare industry as a result of medical errors. The practical implications of medical errors were also discussed.


Identification
Screening
Eligibility
Included
Abstracts identified through database searching (n = 207)
Additional abstracts identified through other sources (n = 7)
Abstracts after duplicates removed (n = 198)
Abstracts screened (n = 198)
Abstracts excluded (n = 132)
Full-text articles assessed for eligibility (n = 66)
Full-text articles excluded, with reasons (n = 32)
Studies included in the systematic review (n = 34)

Conceptes morals i ètics rellevants en l'*Error mèdic*

- ***Autonomia i dret a l'autodeterminació personal***. Reconeix el dret de la persona malalta a decidir d'acord amb els seus valors i conviccions.
- ***Beneficència i no maleficència***. Fer el millor pel pacient i evitar el mal innecessari.
- ***Revelació i dret a saber***. Per poder decidir sobre com actuar per reparar l'error. Incrementa la confiança.
- ***Justícia***. Assignació equitativa de recursos. Reparació de l'error
- ***Veracitat***. Obligació de dir la veritat sobre els resultats i els riscs abans i després de la intervenció (consentiment). Base de la confiança en la relació clínica.

Medical Errors—What and When: What Do Patients Want to Know?

Cherri Hobgood, MD, Clifford R. Peck, MD, Benjamin Gilbert, JD, MPH, Kathryn Chappell, RN, MSN, Bin Zou, MPH

Abstract

Objectives: 1) To determine how and when emergency department (ED) patients and their families wish to learn o health care errors. 2) To assess the error threshold this population believes should trigger reporting to governmen agencies, state medical boards, and hospital patient safety committees. 3) To evaluate the role patients and families believe medical educators should play in this process. **Methods:** A 12-item survey was administered to a convenience sample of ED patients and families during evaluation in a tertiary care academic ED. Results were tabulated and data were reported as percentages. Statistical significance was analyzed using the chi-square test. **Results:** 258 surveys were returned (80%). A majority of respondents wished to be informed immediately of any medical error (76%) and to have full disclosure of the error's extent (88%). An overwhelming majority of respondents endorse reporting of errors to government agencies (92%), state medical boards (97%), and hospital committees (99%). Most respondents believe medical educators should focus on teaching students to be honest and compassionate (38%) or on how to tel patients about mistakes (25%). The frequency of hospital admission or physician visits per year had no impact on any response pattern (ns with x2 test). **Conclusions:** Regardless of health care utilization, a majority of respondents wan full disclosure of medical error and wish to be informed of error immediately upon its detection. Respondents suppor reporting of errors to government agencies, the state medical board, and hospital committees focused on patien safety. Teaching physicians error disclosure techniques, honesty, and compassion were endorsed as a priority fo educators who teach error management.

ACADEMIC EMERGENCY MEDICINE 2002; 9:1156–1161.

Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors

Thomas H. Gallagher, MD
Amy D. Waterman, PhD
Alison G. Ebers
Victoria J. Fraser, MD
Wendy Levinson, MD

Context Despite the best efforts of health care practitioners, medical errors are inevitable. Disclosure of errors to patients is desired by patients and recommended by ethicists and professional organizations, but little is known about how patients and physicians think medical errors should be discussed.

Objective To determine patients' and physicians' attitudes about error disclosure.

Design, Setting, and Participants Thirteen focus groups were organized, including 6 groups of adult patients, 4 groups of academic and community physicians, and 3 groups of both physicians and patients. A total of 52 patients and 46 physicians participated.

Main Outcome Measures Qualitative analysis of focus group transcripts to determine the attitudes of patients and physicians about medical error disclosure; whether physicians disclose the information patients desire; and patients' and physicians' emotional needs when an error occurs and whether these needs are met.

Results Both patients and physicians had unmet needs following errors. Patients wanted disclosure of all harmful errors and sought information about what happened, why the error happened, how the error's consequences will be mitigated, and how recurrences will be prevented. Physicians agreed that harmful errors should be disclosed but "choose their words carefully" when telling patients about errors. Although physicians disclosed the adverse event, they often avoided stating that an error occurred, why the error happened, or how recurrences would be prevented. Patients also desired emotional support from physicians following errors, including an apology. However, physicians worried that an apology might create legal liability. Physicians were also upset when errors happen but were unsure where to seek emotional support.

Conclusions Physicians may not be providing the information or emotional support that patients seek following harmful medical errors. Physicians should strive to meet patients' desires for an apology and for information on the nature, cause, and prevention of errors. Institutions should also address the emotional needs of practitioners who are involved in medical errors.

JAMA. 2003;289:1001-1007 www.jama.com

HEALTH CARE INSTITUTIONS nationwide are developing ambitious programs to prevent medical errors.[1,2] Yet, despite our best efforts, medical errors will inevitably occur.[3] An important component of the response to an error is deciding whether and how to tell the patient about what happened. Disclosing medical errors respects patient autonomy and truth-telling, is desired by patients, and has been endorsed by multiple ethicists and professional organizations.[4-19] In addition, hospital accreditation standards and some state laws now require that patients be informed about "unanticipated outcomes" in their care.[20-23]

The limited available data, however, suggest that full disclosure of errors to patients may be uncommon. In a 1991 study, 76% of house officers said they had not disclosed a serious error to a patient.[24] Multiple factors may inhibit physicians from disclosing errors, such as fear that informing the patient of an error could lead to a malpractice suit, damage the physician's reputation, and be awkward and uncomfortable.[15,25-31] Some institutions are developing new policies requiring or strongly encouraging disclosure of some errors to pa-

care professional had informed them of the error.[12] Failure to tell patients about medical errors could impair patient trust and satisfaction and increase the chances of a malpractice suit.[13-15,26,38-43]

Greater insight into patients' and physicians' attitudes toward error disclosure could improve the way institutions and practitioners handle these events.[32,34,35,44-48] Most prior studies have examined either patients' or physi-

the error and that patient's physician. Therefore, strategies for responding to medical errors should simultaneously consider the attitudes of physicians and patients about errors and their disclosure.[12,15,52] To better understand this

Author Affiliations: Departments of Medicine and Medical History and Ethics, University of Washington School of Medicine, Seattle (Dr Gallagher); Department of Medicine, Washington University in St Louis School of Medicine, St Louis, Mo (Drs Gallagher, Waterman, and Fraser and Ms Ebers); and the

tening in an outer circle. The patients talked with each other about medical errors and why they happen. Physicians then moved into the inner circle while patients listened in the outer circle. Physicians commented on what they had heard the patients say and then talked among themselves about the experience of making errors and discussing errors with patients. The remainder of the joint focus group took place with all participants in a common circle and focused on the optimal resolution of medical errors from both participants' perspectives.

Analyzing the Focus Groups

The focus group audiotapes were transcribed verbatim and reviewed by 3 investigators (T.H.G., A.D.W., and A.G.E.) to identify major themes. Two investigators (A.D.W. and A.G.E.) then reread each transcript, manually coding the presence of each theme as well as identifying quotations exemplifying these themes. Any differences of opinion about the meaning of specific passages in the transcripts were discussed and resolved. Only the themes that recurred in each of the relevant focus groups are presented herein.

RESULTS

Although patients' and physicians' attitudes about medical errors and their disclosure would enhance th trust in their physicians' honesty a would reassure them that they were ceiving complete information abo their overall care. However, patients lieved that "human nature" might l health care workers to hide errors fr patients. One patient said:

> And that's the first instinct . . . so thing's gone wrong. You know, hopef the first thing is to correct it or save the p son or whatever, but the second is co your hide.

Physicians agreed in principle t

Table 2. Comparison of Patient and Physician Attitudes About Medical Error Disclosure

Focus Group Themes	Patients' Attitudes	Physicians' Attitudes
Definition of error	Broad; includes deviations from standard of care, some nonpreventable adverse events, poor service quality, and deficient interpersonal skills of practitioners	Narrow; deviations from accepted standard of car only
What errors to disclose	All errors that cause harm	Errors that cause harm, exce when harm is trivial, patie cannot understand error, patient does not want to know about error
Disclose near misses?	Mixed	No
What information to disclose about error	Tell everything	Choose words carefully
How to disclose error	Truthfully and compassionately	Truthfully, objectively, professionally
Role of apology	Desirable	Concerned that apology crea a legal liability
Emotional impact of error	Upset, angry, scared	Upset that patient was harme and about how error cou impact career

derstood that medical errors were inevitable. The possibility that a medical error might happen in their care was frightening to patients.

Physicians shared patients' fear of medical errors. One physician described a sense of dread when he realized that he might have made a medical error:

> If something goes wrong with a patient . . . the things that come to the doctor's mind are "Was it something I prescribed? Was it an instruction I failed to give? Did I do something wrong?" You get that sinking feeling probably on a daily ba-

Els pacients volen saber

- Que ha passat i perquè ha passat
- Les conseqüències per la seva salut
- Com es corregiran aquestes conseqüències
- Com es previndran futurs errors
- Esperen la disculpa
- Que han après els professionals de l'error
- Com ho transmetran als metges en formació

Impacte emocional en els pacients

- Tristesa, ansietat, depressió
- Por a futurs errors
- Enuig per la prolongació de l'estada
- Frustració si l'error es podia prevenir
- Especial rebuig als errors dels professionals poc atents
- Els pacients pensen que la manera de revelar l'error afecta directament en la emotivitat de com el viuen: se senten millor quan hi ha una revelació honesta, compassiva i amb disculpes

Impacte emocional en els metges

- Culpabilitat, dificultat en perdonar-se un mateix
- Pèrdua de l'autoestima
- Por al litigi
- Por a la repercussió en el prestigi personal
- Necessitat de compartir-ho: parlar-ne en la sessió clínica
- Benefici de la revelació: es troben millor; la culpa i el perdó

Should We Disclose Harmful Medical Errors to Patients? If So, How? JCOM May 2005 Vol. 12, No. 5

Thomas H. Gallagher, MD, and Mary Hardy Lucas, RN, MA

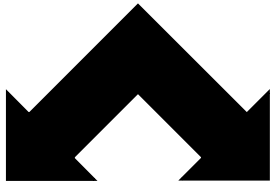
Abstract

Objective: To assess the strength of the evidence for disclosing errors to patients, focusing on patients' and physicians' attitudes toward disclosure and disclosure's effect on malpractice claims, and to present practical suggestions for disclosing medical errors. **Methods**: Review of the literature. **Results**: A gap exists between patients' preferences for disclosure and current clinical practice. Patients have consistently expressed a desire to be told about harmful medical errors, and want to know why the error happened, how recurrences will be prevented, and to receive an apology. However, current data suggests that as few as 30% of harmful errors are disclosed to patients. Physicians support the general principle of disclosure, but hesitate to share the information patients want about errors. Physicians identify fear of liability as one important barrier to error disclosure and experience significant emotional distress after a harmful medical error. Limited data suggests that some institutions have adopted policies of more open disclosure without adverse malpractice consequences. The current disclosure literature contains important but unanswered questions, such as how patients' preferences for disclosure vary along cultural and other dimensions, and whether recommended disclosure strategies improve patient trust and the likelihood of lawsuits. In the absence of definitive evidence about the outcomes of disclosure, practical suggestions for talking with patients about errors can be derived from the literature on doctor-patient communication, breaking bad news, and conflict resolution. **Conclusion**: Patients want to be told about harmful errors in their care, but at present such disclosure is uncommon. Closing gaps in the existing disclosure literature could help clinicians communicate more effectively with patients following harmful medical errors.

Efectes de la revelació en els litigis

- ***Estudis de reclamacions judicials***: Gravetat de la lesió; manca de tacte en el maneig de la informació; necessitat econòmica; 37% canvi de conducta amb comunicació i disculpa.
- ***Estudis amb historietes il·lustrades***: La gravetat de la lesió és un predictor de la possibilitat de litigi molt més fiable que com s'ha comunicat l'error.
- ***Avaluació de programes de comunicació***:
  - University of Michigan Health System
  - COPIC

Reclamació



Judicial

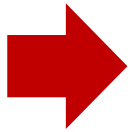
Demanda civil

Denuncia penal (possibilitat de inhabilitació professional)

Demanda patrimonial (Contenciós administratiu)

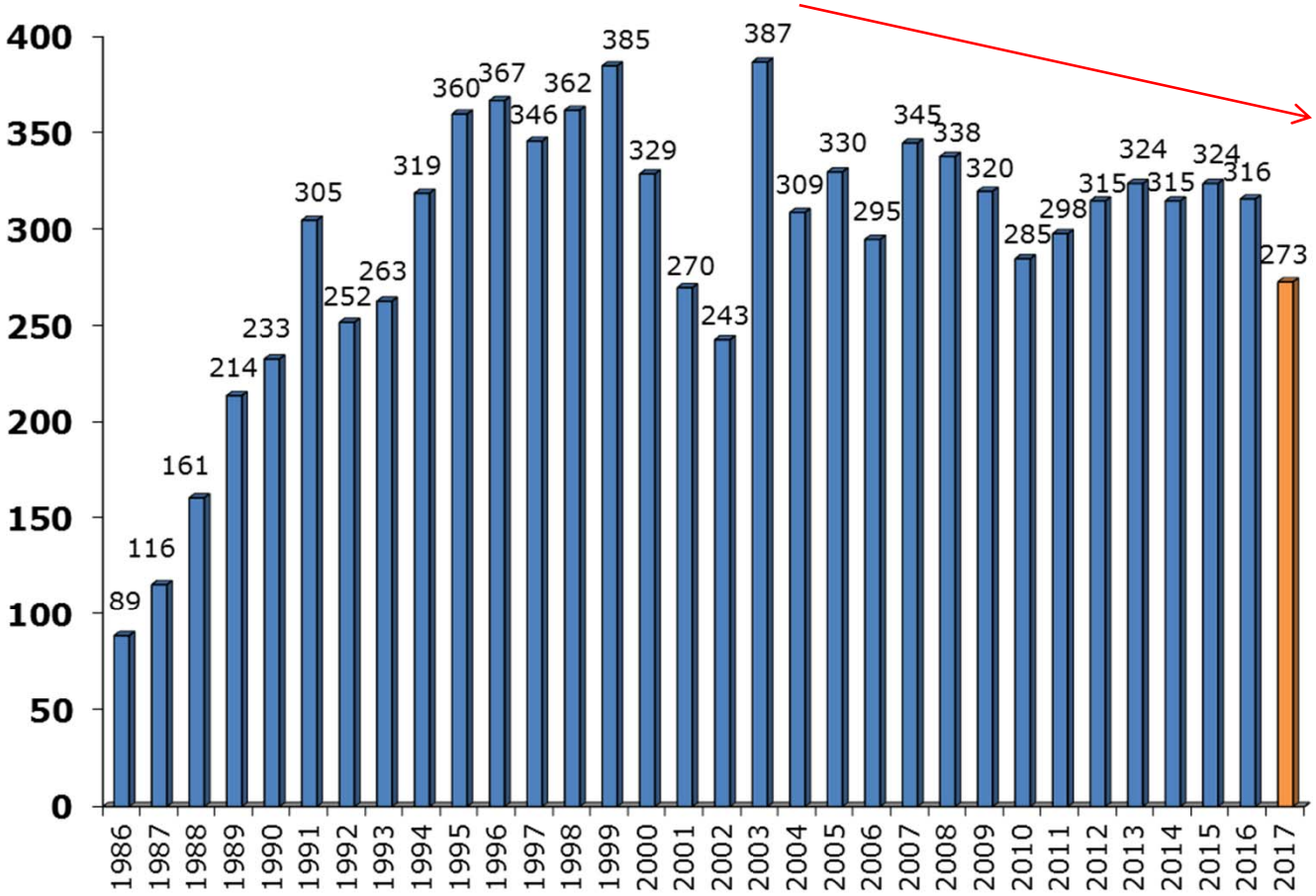
Extrajudicial

Acord econòmic



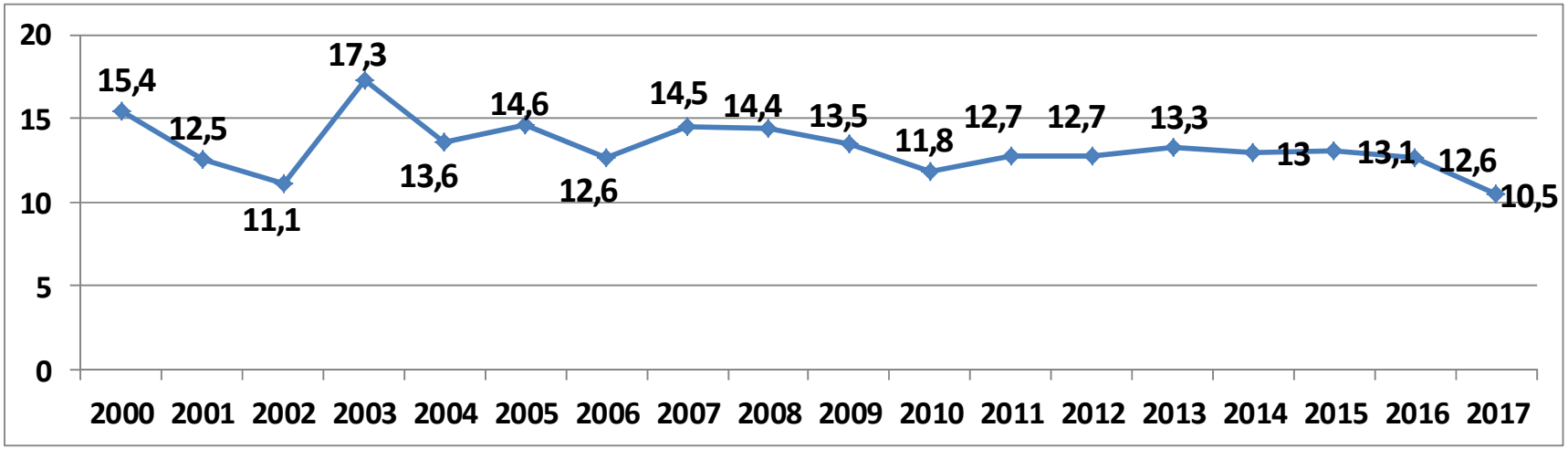
No acord

Número d'expedients: 9.388. Base dades CCMC



Font: Servei de Responsabilitat Civil COM

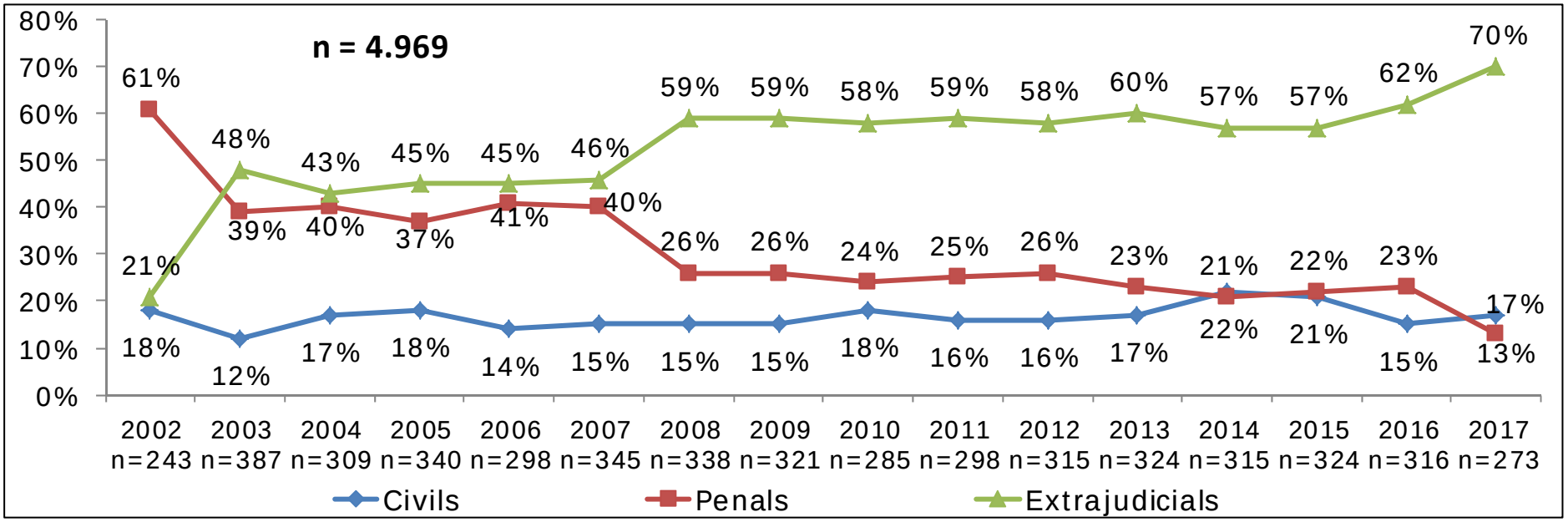
Reclamacions per 1000 assegurats/any



Font: Servei de Responsabilitat Professional del COMB

Percentatge del tipus de reclamacions per any CCMC

Font: Servei de Responsabilitat Professional del COMB



La opinió dels metges

J Patient Saf. 2015 Feb 24. [Epub ahead of print]

Transparency When Things Go Wrong: Physician Attitudes About Reporting Medical Errors to Patients, Peers, and Institutions.

Bell SK[1], White AA, Yi JC, Yi-Frazier JP, Gallagher TH.

- ✓ Comunicació de l'error a Pacients, Companys i Institucions
- ✓ Enquesta 3.038 metges d'Estats Units i Canadà
- ✓ Major predisposició a la transparència:
  - ✓ Els metges d'EEUU, dones, practica publica, joves, especialitat quirúrgica, experiència prèvia en comunicació d'errors.
  - ✓ També la creença que reduiria el risc de reclamació o que hi hauria canvis al sistema sanitari.
- ✓ La creença que disminuiria la confiança en el facultatiu es va associar a menys predisposició a la transparència.

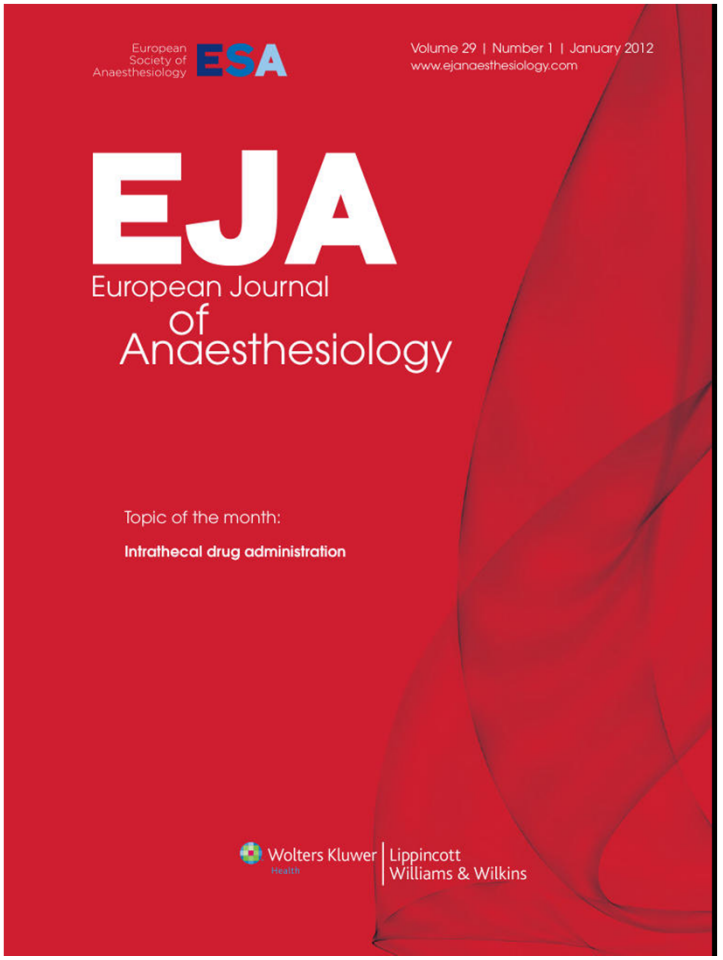
La opinió dels metges

Eur J Anaesthesiol. 2015 Jul;32(7):471-6. doi: 10.1097/EJA

Disclosing and reporting medical errors: Cross-sectional survey of Swiss anaesthesiologists.

McLennan SR[1], Engel-Glatter S, Meyer AH, Schwappach DL, Scheidegger DH, Elger BS.

- ✓Anestesiologia (àrea pionera en Seguretat Clínica)
- ✓Enquesta 281 anestesiòlegs (5 hospitals Suïssa)
- ✓Elevada variabilitat entre centres.
- ✓Comuniquen als pacients el 100% d'errors seriosos, 77% menors y 19% "quasi errors".
- ✓Tots desitjaven rebre formació sobre la comunicació d 'errors.



Recomanacions en la comunicació d'errors

1. ***Demanar ajuda*** als companys i a la institució: política institucional
2. ***Planificar la conversa*** amb cura: que es sap i que no, lloc, assistents
3. ***Preguntar al pacient*** que sap de l'error.
4. ***Informació bàsica*** amb llenguatge planer. Compromís d'informar si l'anàlisi revela noves dades.
5. ***Disculpa sincera***. Estar preparat per la reacció emotiva.
6. ***Explicar que es fa per saber*** com va succeir i com ***es preveu evitar-ne***. Preveure comunicació futura si hi ha més informació.
7. ***Oferir suport***: consell, treball social, segona opinió, compensació econòmica

Polítiques institucionals, USA

- Joint Commission on Accreditation of Health Care Organizations.

Revisions To joint Commission Standards in Support of Patient Safety and Medical Health Care Error Reduction. July 1, 2001.

- Content of Medical Error Disclosures. Thomas H. Gallagher, MD.

AMA Journal of Ethics. POLICY FORUM, 2004, VOL.6 Nº 3

Polítiques institucionals locals

- Estrategia de Seguridad del Paciente del Sistema Nacional de Salud Período 2015-2020. **SANIDAD 2016.** MINISTERIO DE SANIDAD, SERVICIOS SOCIALES E IGUALDAD

- http://seguretatdelspacients.gencat.cat/ca/detalls/noticia/Actualitat-00302: As a critical behavior to improve quality and patient safety in health care: speaking up:

http://safetyinhealth.biomedcentral.com/articles/10.1186/s40886-016-0021-x

Ens queda molt per fer

Gac Sanit. 2015;29(5):370–374

Original breve

Algo no estamos haciendo bien cuando informamos a los/las pacientes tras un evento adverso

José Joaquín Mira[a,b,*,1] y Susana Lorenzo[c], en nombre del Grupo de Investigación en Segundas Víctimas

[a] Departamento de Psicología de la Salud, Alicante-Sant Joan, Alicante, España
[b] Universidad Miguel Hernández, Elche Alicante, España
[c] Unidad de Calidad, Hospital Universitario Fundación Alcorcón, Madrid, España

INFORMACIÓN DEL ARTÍCULO

Historia del artículo:
Recibido el 6 de febrero de 2015
Aceptado el 17 de abril de 2015
On-line el 28 de mayo de 2015

Palabras clave:
Seguridad del paciente
Gestión y organización
Eventos adversos
Pacientes

RESUMEN

Objetivo: Analizar qué hacen hospitales y atención primaria para asegurar una información franca a los/las pacientes tras un evento adverso (EA).
Método: Encuesta a 633 directivos/as y responsables de seguridad (colectivo de dirección) y 1340 profesionales de ocho comunidades autónomas. Se exploró el nivel de implantación de recomendaciones para una correcta información tras un EA.
Resultados: 112 (27,9%) directivos/as y 386 (35,9%) profesionales consideraron que en su centro se informaba correctamente tras un EA; 30 (7,4%) directivos/as afirmaron disponer en su centro de un protocolo sobre cómo informar; sólo 92 (17,4%) médicos/as y 93 (19,1%) enfermeros/as habían recibido entrenamiento para informar a un/a paciente tras un EA.
Conclusiones: Existen importantes carencias a la hora de planificar, organizar y asegurar que el/la paciente que sufre un EA reciba una disculpa e información franca de lo sucedido y de lo que puede pasar a partir de ese momento.

Código de Deontología Médica. Guía de Ética Médica. OMC, 2011

Artículo 17

1.- El médico deberá asumir las consecuencias negativas de sus actuaciones y errores, ofreciendo una explicación clara, honrada, constructiva y adecuada

2.- Las quejas de un paciente no deben afectar negativamente a la relación médico paciente ni a la calidad de la asistencia que se le preste.

Codi de Deontologia CCMC, Girona, 2016

Norma 28.- El metge ha de ser sempre sincer amb els seus pacients i especialment quan es produeixin complicacions, errors o accidents. Si el pacient pateix algun dany físic o psíquic estant sota la seva atenció, el metge procurarà amb promptitud :

- Remeiar si és possible o al menys pal·liar la situació adversa produïda.

- Explicar el mes aviat possible al pacient, als seus familiars o a ambdós, de forma completa i comprensible, què és el que ha succeït i les previsibles conseqüències a curt i llarg termini.

Raons per comunicar els esdeveniments adversos

Ètiques:

- Respecte a les persones: dret de la persona malalta a la informació
- Justícia: reparació del dany físic, psíquic i moral

Assistencials:

- Consentiment per reparar el dany físic
- Alleujament del malestar psicològic
- Recuperació emocional i professional dels implicats

Raons per comunicar els esdeveniments adversos

Institucionals:

- Restablir la confiança, bàsica en la relació clínica
- Informar als programes de prevenció i detecció
- Promoure la elaboració de guies que orientin la comunicació
- Programes de formació dels professionals en la comunicació

Qui i com s'ha de comunicar?

- La responsabilitat de comunicar és individual i institucional: recau en els professionals implicats i en els directius del centre per la responsabilitat que tenen en la detecció i prevenció, en la promoció de guies de comunicació i programes de formació en comunicació.
- Comunicació pensada i planificada, començant per escoltar la persona afectada, responent amb llenguatge planer i compassiu, amb disculpes sinceres i oferint reparació, suport i compensació econòmica.

Actituds professionals a promoure

- Comprendre que la medicina és una pràctica incerta
- Assumir que l'error és inherent a la pràctica humana
- Valorar i cuidar la comunicació entre professionals i amb les persones malaltes
- Comunicar l'error i acceptar l'avaluació per parells
- Aprendre a comunicar l'error a la persona afectada

Gracies 7234mmm@comb.cat