Prescrire International Editorial

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Medical incident analysis: effective teamwork is needed

When, despite our best efforts, things do not go as anticipated, it can be difficult to admit that a patient did not receive optimal care.

In retrospect, when reviewing the patient's file, we may discover and understand what went wrong. Such errors are best reported through a dedicated adverse event reporting programme such as Prescrire's *Preventing the Preventable* programme. In this way, each case can be analysed objectively, thus helping others to avoid repeating the same mistake.

It is more difficult to deal with all the issues raised by a medical error on one's own. It is with the help of other colleagues involved in the patient's management that preventable errors can best be identified and dealt with.

But how can we avoid assigning blame? How can we avoid repeating the same mistakes in the future?

It takes time, patience, open discussion and the participation of all those involved in the patient's management to improve the quality of care. Reporting errors requires a safe, non-judgemental environment to avoid the fear of rejection or being accused of whistle-blowing, of "rocking the boat". Colleagues must organise to optimise the collective analysis of adverse events.

Groups of nurses, physicians, pharmacists and midwives have already taken the initiative, persuaded that answers to thorny clinical issues are best obtained through multidisciplinary cooperation.

The benefits of this synergistic and reflective approach are also evident in other areas, as exemplified by physician-pharmacist "quality circles" created for the rational choice of drug therapy. All these groups share one overriding objective: to simply improve the quality of patient care.

The temptation to jump to conclusions and to assign blame must be resisted: it is difficult to put ourselves in a colleague's situation, and we may have only a partial view of the incident. For example, we may be unaware that the colleague in question failed to receive all the available information. It should also be remembered that problems are always clearer in hindsight.

We must dare to speak openly, and work together to understand medical incidents that occur in our daily practice. It is in patients' best interests to identify preventable errors, without undermining colleagues' respect for one another.