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Patient Safety

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Medical safety has recently become an essential central theme of health policy. The United States has been a driving force with the publication of the report “to err is human” in 1999, placing emphasis on (1) the incredible frequency of avoidable, undesirable events (almost 5% of the aggregate of severe cases and less severe cases), (2) their seriousness (1 death per 1000 hospital admittances), (3) their crippling cost to the health system, (4) and a very new factor of recommending a systematic and organisational approach.

Other Anglo-Saxon countries became quickly involved in this step and the subject was even placed on the agenda of the last European presidencies of Luxembourg and the United Kingdom.

Is medical safety a new question?

Many people will say that the priority of medicine has always been to administer the safest, best performing treatments which are least prone to side effects.

This step is historic and necessary, but patient safety relates rather to events not anticipated by the patient and the nursing team (that does not form part of the reading of risks which can be announced to the patient). These events are linked to failures of the care system in the broad sense of the term. It is thus a question of dealing with the faults/failures of the medical system and reducing their frequency and severity.

Let us recognise that medicine, instead of investing in this field and teaching it, has rather hidden it.

Let us also recognise that the ultimate goal of patient safety is not access to rare, last chance treatment for a patient for whom there is no hope, but the security of repeated and standard acts for the mass of ordinary patients. The two objectives are even regularly in conflict because the most daring therapeutic strategies are often the least standardised and the most subject to errors of care.

Why the so recent emergence of the problem?

Benchmarking analyses teach us that the question of error only becomes central for optimised systems which appear to have reached a high level of performance. Despite this inherent

indication of quality, the dominating paradox is that such optimised systems quickly become even more prone to error:

• Society demands greater transparency of real risk; this transparency also makes the question of faults more visible, while they are paradoxically fewer than before.

• Measures of constraint (protocols, regulations) are increasing, and are paradoxically providing the law with a better tool for judging faults.

• Growing intolerance reduces the threshold of triggering crisis situations, which, in return, also increases pressure on safety. The result is an acceleration of pressure on safety.Medicine does not escape from these acknowledgements, with the aggravating impact of two structural

factors:

• The medical system is not a system at homogeneous risk. This heterogeneity must be integrated into the definition of security strategies.

• The hospital sector is divided up (there are more than 3,000 hospitals in France), and its natural independence slows down the generalisation of good practices and the transfer of good initiatives.

These paradoxes are inevitable in the life of complex systems, and have several consequences: once pressure has been put on safety, the latter will only increase, and the space for solutions will be less and less specialised and more and more systemic.

Systemic Analysis at the Action Centre

The failure of the healthcare system is almost always the failure of an entire system rather than of an isolated actor. The actor at the foot of the patient's bedside makes the final mistake, but this mistake is itself the result of a failure of social construction: teams, unsuitable buildings, insufficient training of the actor, unavailable materials, economic pressures, defective management of manpower, medical chart at risk, etc. The systemic analysis aims to reach these

major causes, and to manage protection on all levels of the system. Several factors, however, must be considered in order for the systemic approach to be successful:

• It does not clear the actor at the foot of the patient's bed of his errors. Understanding total failure does not exclude understanding local failure and bringing about improvements.

• It is radically necessary to distinguish between

•• complaint following a failure managed by justice or an internal healthcare inspection, which can lead to possible sanctions;

•• the systematic analysis of failures for a safety objective, without concept of an external complaint, which must avoid professional sanctions under penalty of the return of a decredibilised experience.

• The idea of an in-depth analysis of the causes of events is essential. To correctly address the systemic aspect, it is necessary to avoid the temptation of statistical approaches and invest in longer, less frequent analyses carried out on the major causes (see the article by Professor Vincent on page 24, the ALARM method).

• The more analysis is made in-depth at a systemic level, the more it affects aspects of social construction of the practice and management of the system, and the more it is necessary to go back to the protagonists of the action and management to lead it. This is often only feasible in the temporal vicinity and space of the event, in the department or the hospital. It is therefore necessary to distinguish between:

•• the macro surveillance of health indicators, which can be directly brought up in raw data on a national level for a centralised epidemiological analysis (system of vigilance, etc.) and the

•• systemic analysis, which necessitates a much stronger mobilisation than local actors, and a decentralised and more qualitative analysis.

In all cases, the concept of dynamics is essential. Human systems are permanently developing and it is more strategic for risk control to have a return experience in drifts of practices than in serious medical events on patients.

Conclusion: success, but a remarkable French position France has followed closely behind safety issues with success but also with a slight delay and a rather out of line philosophy that can be caricatured as follows:

• The founding idea of public Anglo- Saxon thinking departs from a rather negative report on the health system which should be improved in order for access to care to remain possible for the largest number of people at an acceptable cost and result for the user. The engine of change is external (insurers, patient associations). Patient safety agencies are the natural response to this perspective.

• The founding idea of public French thinking – but also of public demand – is to do things in such a way as to best preserve a health system considered to be effective, but threatened by societal transformations. Associations and insurances are relatively discrete, and the engine of change rests on the medical profession, which explains why errors are not put forward. The debate is not about better access to care (the offer is excessive for all), lower costs for users (it is almost guaranteed), or performance (which is considered to be good), but it is above all about the means of maintaining this 'national privilege' of good medicine in a market largely regulated by the State, and therefore whose cost is supported

by the State. The notion of error is not part of this discussion and the agencies only tackle it indirectly through the idea of added risk.

Is this different position a problem? Not for the time being: the actions do not really differ as long as they approach the methods and processes care in contact with the patient. The battles are synchronous, but differently assembled. In the long term, France should however question its singularity, above all from a European perspective, because it publishes its position and appears to adopt the standards of others without totally sharing them; it could suffer from European harmonization, which is hardly a guarantor of its specificity. If there is an increase in this specificity and its relevance, which is totally defendable, it will undoubtedly be necessary to better argue this singular position.

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