Viewing the safety imperative from the French policy perspective

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1. FRANCE HAS BEEN SLOWER THAN OTHER EUROPEAN COUNTRIES AND THE USA IN DEVELOPING A NATIONAL CONCERTED STRATEGY FOR PATIENT SAFETY

French citizens can choose their doctors and specialists (despite a soft gatekeeper mechanism installed in 2005), can access both public and private hospitals, and are free to move from one physician or institution to another, regardless of location, as often as they want. The country ranks among the best Organisation for Economic Co-operation and Development countries for many global healthcare performance markers, such as life expectancy and the rate of amenable mortality.[1] Comparisons of consumer satisfaction across Europe place France among those nations with the highest rates of satisfaction.[2]

For all of these reasons, patient safety has not been a subject of national political debates.[3] The press have highlighted and commented repeatedly on major crises where patient safety was compromised such as HIV-contaminated blood administered to haemophiliacs in the 1980s, surgical site infections in the 1990s, the heat wave in the summer 2004 and radiation overdoses in 2008. These have led to individual blames, domain-dependent technical corrections, new guidelines, new agencies and even new laws for enforcing patients' rights. Only recently has there been a political vision for a centralised governance of patient safety addressing a national transversal plan incorporating features such as a national adverse event (AE) reporting system or the need for incentives to accelerate the acquisition of a safety culture by medical actors.

2. PATIENT SAFETY RESULTS IN FRANCE ARE NOT THAT GOOD

These results on the global performance of the healthcare system and on public satisfaction should not hide the reality of the figures of patient safety in France. The 2004 National AE study indicated that the rate of AEs in hospitals was similar to that in other countries including the USA.[4] A similar study is being duplicated in 2009. Personal communications from the authors suggest that progresses are at best limited. Furthermore, there is little information available on the rate of AE in the ambulatory sector.

Except for a few examples (eg, surgical site infections, methicillin-resistant *Staphylococcus aureus*), one must admit that progress in patient safety in France during the last decade has been as deceptive as in the rest of the world. The unique difference with the USA's vision given by Leape *et al* (***see page 424***) is France's relative "slow start" in that we have not invested as much in political incentives, national initiatives and field campaigns as many Anglo-Saxons countries.

3. THE NATIONAL PICTURE IS CHANGING: FRANCE HAS JOINED INTERNATIONAL ACTIONS IN PATIENT SAFETY AND PROMOTES INNOVATIVE ACTIONS

The need for a national approach of patient safety is now recognised for at least two reasons.

First, professionals have gained greater awareness of the importance of patient safety and of its systemic ramifications throughout the healthcare system. This has changed their vision on the status of patient safety. The hospital and ambulatory sectors have been working for years under a permanent crisis management due to staff shortages, budget deficits, increasing case loads and so on. This ambiance of chronic crisis has long placed patient safety considerations far down. Now, French professionals realise that the system may well collapse, and that focus on patient safety could become an excellent entry point, both politically and professionally, to address the crisis of the system.

Second, there is evidence that the French citizens perceive their healthcare system as deteriorating in the face of ongoing reforms associated with a rise in individual financial contributions and a gradual imposition of constraints essentially to curb increasing deficits straining the solidarity principle to which the public is deeply attached.

Furthermore, Europe is becoming an inescapable reality of healthcare politics. France has considerably increased international cooperation, namely, those on patient safety, learning and trading ideas from foreign experiences. In the past 3 years, France has joined the High Fives's WHO initiative, participated in almost all ECs testings and benchmarking initiatives in the patient safety field (EC projects *MarQuis, Simpatie, DUQuE*) and taken the lead of the EUNetPas Project (European Network of Patient Safety with the *Haute Autorité de Santé* as Project leader).

The French healthcare agencies have initiated intensive transversal efforts in the past 5 years in search for a national win–win model of patient safety, multiplying self-evaluation and field testing through the accreditation programs, and taking lessons from foreign successes and failures.

Gradually has emerged a series of directions for improvement based on a mix of traditional visions and innovative proposals to break the mould of patient safety and increase cost/efficacy of efforts.[5] These address essentially three priorities:

- First, although the global picture is disappointing, there have been a number of initiatives that have proved effective in the hospital setting in foreign countries. France will adopt and promote these initiatives, such as the surgical checklist. France is also promoting several suggestions promoted by Leape *et al*: education of professionals on patient safety (courses are becoming mandatory in medical curricula) and increased transparency on errors (a new national AE reporting system is being field tested). The role of clinical governance is widely recognised and has been a major subject of the law *Hôpitaux, Patients, Santé et Territoires* adopted in July 2009.[6]

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- Second, we suffer in France as elsewhere from the lack of measurement of patient safety, and even worse, from a slow capacity of reaction to bad results when measurements are in place. Not only do these urgently need to become more outcome centred, but the information also needs, as pointed by Vincent and colleagues,[7] to be given to ''hands on'' professionals through safety dashboards applicable at the level of wards and offices, prompting wise decisions and rapid midcourse corrections.
- Third, we suggest going beyond an in-hospital vision of patient safety and adopting an approach giving priority to continuity of care. Although this idea sounds obvious for all countries, we propose three innovative strategies in choosing the modalities of such an approach:
  - We recommend adopting patient safety interventions compatible with the reality of the medical crisis that will lead on a large scale to equivalent actors and not to champions.[8] Creating champions with an outstanding safety record in their narrow technical field may actually hide a gradual deterioration in the system as a whole. A growing number of patients will have difficulty in accessing these top professionals. We suggest giving priority to safety interventions that have the potential to be massively adopted by all professionals and medical clinics in the nation while remaining compatible with present economical and staffing crisis conditions.
  - We recommend going beyond insurance-driven highly publicised AEs. Patient safety cannot remain driven by emotional and insurance-driven responses to AEs that have drawn high media attention.[9] Most national patient safety programmes have given high priority to these AEs (eg, wrong side surgery, infections, and dramatic drug errors), with immediate sanctions being imposed. However, these publicised AEs concern few people. If the same amount of effort were expended on improving safety with regard to frequent, unpublicised errors in the hospital and ambulatory sectors (errors of coordination among professionals or of strategy of care), the impact on public health might be far greater. We thus suggest giving priority to a new category of AEs—integrated AEs. These are not related to a single event but to repeatedly making poor strategic choices and to poor organisation of care, causing delays in appropriate care. The new law adopted in July 2009 (see above) reinforces this vision.
  - We recommend putting greater priority on the successful control of disease and not so much on isolated AEs. Professorial judgments of what is a human error are often counterproductive for safety and may even carry a feeling of injustice for care givers. Many AEs are only seen in the prism of a failure by the care givers themselves and not in the prism of the contextual control of disease. For example, France has a high level of consumption of psychotropic drugs for the elderly. The rate of adverse drug errors is very high. No action, including multiple recommendations published in past years, has been successful. A transversal group of specialists belonging to various colleges of caregivers and agencies has recently turned the approach upside down considering that what is important is not so much these errors but what is really feasible by a caregiver trying to satisfy the demands of the elderly patient, reducing risks, complying with all pressures including economical pressures, and remaining reasonably in control of the disease. This last strategy repositions patient safety in medicine as resulting from a comprehensive compromise in the face of contradictory pressures affecting care. After a 1-year experience of this new approach addressing global drug management for the elderly, the prescription of psychotropic drugs could decrease significantly for the first time.[10] The 2006 HAS (*Haute Autorité de Santé*) national voluntary accreditation program for doctors also seeks to influence day-to-day practice, asking for the reporting of near misses with a specific emphasis on barriers that were unrealistic and ineffective (despite being cited in recommendations).[11]

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