



## Letter to the Editor

### A new SFAR/APSF collaboration: Another step towards the common goal of patient safety



A new partnership has been created between the SFAR (French Society of Anaesthesia and Intensive Care Medicine), under the auspices of the CAMR (Risk Analysis and Management Committee), and the Anesthesia Patient Safety Foundation (APSF). This new link that unites us was forged by the common desire to improve the safety of patients over the course of the perioperative period. The SFAR has responded positively to the proposal of the APSF and Drs. Mark Warner (President of the APSF) and Steven Greenberg (Editor-in-Chief of the *APSF Newsletter*) to unite our efforts. Thus, a French translation of the *APSF Newsletter* will be published three times per year by the CAMR for French-speaking anaesthetists and ICU doctors. This newsletter features a range of articles pertaining to the improvement of the safety of patients during the perioperative period.

Anaesthesia professionals are undoubtedly committed to ensuring patient safety, which, in parallel, has led to an in-depth consideration of the subject since the 1970s in numerous countries. Various reports at the time reported a mortality rate directly related to the technique or anaesthetic treatment in the order of 1 to 2 for every 10,000 procedures [1].

Many fields of medicine are modelled after ultra-safe systems (such as aeronautics and the nuclear industry) for standardisation of patient treatments. This desire for normalisation and of protocolisation has led to the creation of agencies such as The Joint Commission (TJC) and the Agency for Healthcare Research and Quality (AHRQ) in the United States and, in France, the National Agency for Evaluation in Health (ANAES), followed by the National Authority for Health (HAS).

In parallel, since the seminal publication in 1978 of the Harvard medical [2], analysis of adverse events has been developed and modelled after the aviation sector in order to understand what precipitates medical accidents (or near misses).

The report *To err is human* in the United States (1999) [3], followed by the national investigation of adverse events linked with healthcare (ENEIS) in France (2004) [4], justify this process, as they have reported that the delivery of medicine to patients can result in a significant amount of avoidable errors and suboptimal care.

Thus, in the early 1980s, media coverage of anaesthesia incidents prompted societies to undertake steps to improve the quality and safety of patient care. In Boston, MA, in 1984, Drs. Ellison (Jeep) Pierce, Jeff Cooper and Richard Kitz organized the first meeting on anaesthesia patient safety and called it, “International Symposium on Preventable Anesthesia Morbidity and Mortality.” Following this symbolic meeting of over 50 international participants, Dr. Pierce, the American Society of Anesthesiology (ASA) President in 1985 called for an independent entity whose goal would be to improve anaesthesia patient safety. This

organisation was named the “Anesthesia Patient Safety Foundation (APSF)”.

In parallel, the French Society of Anaesthesia and Intensive Care Medicine created the Safety Committee in this same period. In 2000, it became the Risk Analysis and Management Committee, undertaking the same tasks as before. Since the start of these groups, the direct mortality attributable to anaesthesia has been reduced by nearly a factor of 10 (one death for every 150,000 procedures) in France as well as all other Western countries [5].

The strengths of the APSF are its independence (which allows it an organisational agility and a certain degree of freedom), its multidisciplinary composition representing a broad range of stakeholders (anaesthetist doctors, anaesthetist nurses, equipment manufacturers, pharmaceutical industry representatives, risk managers, lawyers, underwriters, and biomedical engineers) and its leadership's focus on improving perioperative patient safety through enhancing education, research, and exchanging ideas internationally. Consequently, the APSF has experienced rapid development and it has had a major influence in the world by promoting safety in anaesthesia. APSF grants provide specific funding for research focused on safety in anaesthesia. The APSF also plays a role in education through its website site and its newsletter, the world's most widely circulated anaesthesia publication and available free of charge in six languages.

Among the patient safety topics designated as priorities by the APSF are the prevention of medication errors, safeguarding the administration of opioids, the development of a safety-conscious culture, improvement of the quality of transitions of care, prevention of burnout, and the elimination of disruptive distractions. A full list of the APSF priorities can be found in the October 2018 *APSF Newsletter* (<https://www.apsf.org/article/apsf-highlights-12-perioperative-patient-safety-priorities-for-2018/>).

For its part, the CAMR is the task force of the SFAR that has been assigned the objective of analysing the potential risks for patients and promoting strategies to overcome these risks. The lines of work are based either on the considerations of the committee or on issues of concern or questions raised by physicians. Risk analysis is also based on data derived from the incident files declared to the main French insurers of medical liability.

Just like the APSF, in recent years the CAMR has worked on issues aimed at improving the quality and safety of anaesthesia and intensive care: the creation and the dissemination of cognitive aids or crisis checklists, the formulation of recommendations for clinical practice (such as the prevention of medical errors, monitoring during patient transport to the postoperative anaesthesia care unit and in the hospital, reducing distractions in the operating theatre, safeguarding of the administration of opioids, and modalities for monitoring), partnering with insurance companies to provide information based on the analysis of the

closed claims, fact sheets (e.g., transfers to the ICU, prevention of errors involving the wrong side, etc.).

Anaesthesia incidents still occur despite the decrease in their frequency. Technological progress that has taken place in anaesthesia since the 1980s has allowed for better monitoring (such as measurement of pulse oximetry, capnography, and the fraction of inspired and expired gases, etc.), the advent of new products with more suitable pharmacological properties (e.g. a short half-life), a safer patient care pathway (e.g., obligatory anaesthesia consultations and preoperative evaluation, mandatory patient monitoring in a dedicated post-intervention room, etc.) and a great number of benchmarks for clinical practice. Debriefing of declared adverse events, as well as analysis of closed claims in the United States or French insurance databases, show that human factors remain a central element in the occurrence or the exacerbation of anaesthesia incidents.

Looking forward, the approaches to be developed for further improvement and safety of anaesthesia care are continual training of staff and the development of simulation, which is still underutilised compared to in the civil aeronautics sector. Likewise, the development of a safety-conscious culture in teams is a priority objective.

The APSF and the SFAR hence have the same objectives of continued improvement of safety in anaesthesia with zero tolerance for incidents. We are proud to join forces and we need everyone to participate in this endeavour. It is with this in mind that the CAMR now proposes a French version of the newsletters that are published by the APSF on a regular basis.

#### Disclosure of interest

The authors declare that they have no competing interest.

## References

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