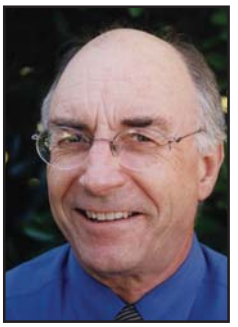
Editorial



Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.

The fact that we all make mistakes and will continue to do so is no excuse for complacency. We can do better. The fact that most errors in medical practice can be attributed to systems failures rather than personal negligence does not absolve us from criticism. We are all part of the systems in which we work and we all have a responsibility to introduce changes that will reduce mistakes to a minimum. The fact that medical malpractice litigation is uncommon in New Zealand does not reduce our accountability although it does help us to keep our costs down.

I recently reviewed the significant events (the term still seems inappropriate, as every consultation is a significant event, but we have stuck with it) in our three (FTE) GP practice. We have been documenting significant events for two months short of four years. We have reviewed 97 events. These by no means include all of the mistakes that have occurred in our practice over this time, but the list probably gives a reasonable idea of the type of mistakes that are common. Communication issues have been involved in more than a third of the events discussed. Care management problems accounted for nearly 23%, medication errors for 17% and organisation or practice management issues for 12%. Discussion of these events in practice team meetings has led to a number of changes in the way in which we practice and, we believe, has decreased the incidence of mistakes in the practice over the past four years. However, it has not eliminated them.

The number of events that we have recorded is interesting. A study documenting anonymously reported errors by 79 primary care doctors in six countries over a six-month period in 2001 recorded 508 errors or about 13 errors per doctor per year.[1] Our figures work out at about eight errors per doctor per year, so we are probably under-reporting. However, we must remind ourselves that what we are doing is not a scientific investigation; it is solely a tool for improving the quality of care that we provide.

Although we have had a no-fault compensation system in New Zealand since 1974, reducing medical malpractice litigation to a minimum, it is only since the 2005 changes covering all treatment injuries that the full impact of the no-fault system has affected patients who experience the consequences of medical mistakes. The no-fault system does not mean that patients are not compensated for adverse effects, nor does it mean that doctors can get away with making mistakes. Indeed, it has been stated that *'compared with a medical malpractice system, the New Zealand system offers more timely compensation to a greater number of injured patients and more effective processes for complaint resolution and provider accountability'*.[2] The challenge lies in improving the systems that have been introduced to improve patient safety. Amer Kaissi argues that *'health care organizations must change their assumptions, beliefs, values, and artefacts to change their culture from a culture of blame to a culture of safety and thus reduce medical errors.'* He goes on to discuss how *'reporting, analyzing, and acting on error information can result in reduced errors in health care organizations'*.[3] That is why we report and discuss mistakes that happen in our practice.

The standard of care expected of a GP in New Zealand is *'that of a reasonably competent general practitioner, exercising ordinary professional care and skill'*.[4] It behoves us, therefore, to talk with our peers, discuss cases, share incidents and innovations and to review carefully those areas of practice that appear to be crossing boundaries. For it is, by and large, our peers who set the standards against which our practice will be measured.

The contributors to the theme papers of this issue are internationally and nationally respected experts who have a special interest in what happens when things go wrong and in how we can make changes to help prevent that happening. We are grateful for their contributions.

References

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