Errors in practice

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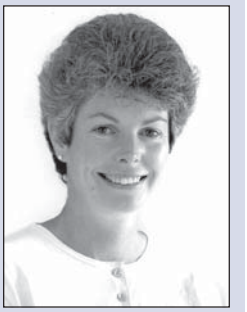

General practice is now the only vocation in which doctors deal with a patient holistically. It is our task to make sense of the stories our patients tell us, to draw out the significant strands, weave them into a pattern that will allow us to arrive at a conclusion, to plan treatment – and all this in 15 minutes or less! While deliberating, we must be mindful of resource constraints, our laboratory and pharmaceutical budgets, best practice guidelines and, more recently, any effect on our practice of strike action by health workers. Teamwork is vital so that we can provide ongoing care to those patients with chronic illnesses, as well as our usual acute care services. General practitioners seem to have taken over the task of the old general medical outpatient clinics. A special feature of this vocation is that many GPs live and work in the same area, so we meet our patients socially and grow old with them too. We spend years building up relationships of trust with our patients. However GP numbers are decreasing – in proportion to the increase in need for our services. We all feel the pressure of the expectations of both patients and funding agencies to perform.

Most doctors will admit to possessing some degree of obsessiveness. This is a useful and admirable trait in providing care for our patients. It is natural when presented with a patient's problem that doctors want to find the answer. In general practice we have to learn to manage uncertainty, often observing a patient over time until the answer emerges. With the passage of the years and experience in the job comes the realisation that there is still much that we need to learn! The potential for error is huge. This thought can be overwhelming and probably deters some doctors from becoming GPs for, to paraphrase Gerard Manley Hopkins, *'the mind has mountains, cliffs of fall'*.[1]

Sir Donald Irvine, former president of the General Medical Council in the UK was quoted recently as saying that *'if you can look the public in the eye and say everyone has a good doctor, then there is no boundary to what you can achieve.'* The definition of a good doctor, which followed this statement, was one who is technically competent, capable of good relationships with patients and colleagues and who was honest. No mention here of one who does not make mistakes. That would be utopian. Doctors are often inclined to believe that patients expect perfection – among other attributes – from them. In reality, patients are well aware of our frailties, but certainly expect honesty from us.

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Medical error certainly makes the headlines with reports such as the one from the chief medical officer in the UK, Sir Liam Donaldson, who advised recently that the risk of dying in hospitals there from medical error was 1:300.[2] Davis and colleagues found that just over two per cent of hospital admissions in New Zealand were associated with an adverse event.[3]

So what are the errors that occur in general practice here and how big a problem are they?

A review earlier this year of 100 cases in the Medical Protection Society (MPS) files in New Zealand covering the years 2001–2005 showed that GP matters amounted to 38%, which is approximately in proportion to the overall number of GPs. Of these, errors (as distinct from complaints) formed a quarter of the cases. They related mainly to either a delay in diagnosis or a failure to diagnose. Diagnoses included temporal arteritis, pancreatic and renal cancers, aortic aneurysm and postoperative infection.

It is a paradox that most negligent actions do not give rise to complaints and that most complaints do not arise from negligent actions. MPS files internationally also show that where an adverse event occurs, further action is usually only taken if there are also predisposing factors. Typical of such factors are miscommunication, no communication, inattentiveness, apathy, delay and rudeness.

When errors occur the result can be devastating, not only for the patient but also for the doctor and other health professionals involved, as well as for the doctor's family. It is in this instance that our natural obsessive traits can be harmful, in that they can make it difficult to deal constructively with the situation.

In another life, when I sat on the Medical Disciplinary Committee, it saddened me to see so many instances where it was a lack of communication that caused both patient and doctor to go through a gruelling process in an attempt to achieve satisfaction. There was no independent structure available in those days to enable both sides to meet at an earlier stage, unlike now when we can use advocacy services for mediation.

Wayne Cunninghams's study published in 2004[4] regarding the effect of complaints on doctors in New Zealand demonstrated how deeply hurt many of our colleagues felt and how this had a widespread impact on their families and other patients. Typical feelings engendered were anger, shame, guilt, and a loss of confidence in their abilities and their competence. The negative impact on many of the doctors lasted for some years and affected the way in which they related to their other patients. A few even gave up their practices.

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Doctors tend to cope in varying ways with the realisation that an error has occurred. Typically negative strategies are denial, discounting, distancing oneself from the issue and one's colleagues and family and covering it all up. Needless to say these do nothing to promote a resolution.

How can we do it better?

There is now an acceptance worldwide that we need to have systems in place to deal with errors and the emphasis is on being open. It pays dividends in terms of patient satisfaction. In the USA, since many states have adopted the policy of open disclosure, there has been a significant downward trend in malpractice claims and in the size of the claims settled. The experience in Australia and the United Kingdom has been similar. A recent study undertaken by Farzad Soleimani[5] of 229 New Zealand hospital doctors reported that they were now more open to reporting errors to their patients, with 86% saying that they thought that disclosure would reduce the likelihood of a complaint. We already use risk strategy principles to manage many of our patients' illnesses. We can adapt these in our approach to errors and complaints. These include managing risk, accepting responsibility, being flexible with changing circumstances, admitting error and taking appropriate action.

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Group practices, where GPs have easier access to advice and support from colleagues, are now the norm. Most GPs are in Peer Review Groups, meeting on a regular basis. This is especially beneficial for rural GPs who often work in relative isolation. In the PHO environment we are finding ways to work more co-operatively with our nursing colleagues and pharmacists. Computer use for clinical notes and prescriptions is widespread, so that legibility is no longer an issue. Despite this, how many of us have inadvertently printed the wrong medication, or the wrong instructions? Do our notes from a consultation allow someone following us to understand what the issues were and what management was planned?

Flexibility is needed when things are not going as planned, when the patient does not seem to be responding to treatment, when the test results do not correspond with the patient's symptoms. We have to be prepared to reconsider the original diagnosis – even start again in our investigations.

We have grown accustomed to having protocols in place for our management of chronic diseases and for pandemics. Similarly, all practices should have a complaints system in place, with notices giving information about it to patients, appointing a designated complaints manager and having a process to deal with the complaint which is fair and equitable to all concerned. The Medical Protection Society is happy to provide advice about any aspect of this. The aim is to facilitate resolution of the adverse event quickly. As part of this system, practices should have a Significant Event Register where any event which happened that did, or could have had, a serious outcome is noted, analysed and actioned appropriately. Most patients who complain about an adverse event do so in the hope that remedial action can be taken to ensure that it is not repeated.

Having gone through this process, it is somewhat easier to respond to a request for information and explanation from the Health and Disability Commissioner's office.

Should a patient wish to seek financial cover for the effects of an error, or an adverse event, then they make a claim through ACC and this system has undergone a major change since 1 July 2005. The terms 'Medical Mishap' and 'Medical Error' have been replaced with 'Treatment Injury'. There are two facets to this: the claims process and the harm process. In the claims process, the patient no longer has to prove that an error occurred in order to gain cover. Where an event is known to be either a necessary part of treatment, or an ordinary consequence, then cover will not be provided. Both the number of claims made and the number accepted for cover have increased markedly since July 2005. Claims involving GPs come 12th out of 34 health professionals listed.

With regard to the harm process, ACC also has a statutory obligation to report when it believes that there is a risk of harm to the public. Events are now being assessed as 'Sentinel' – when the result is an unanticipated death or major loss of function unrelated to the natural course of the illness or condition, or 'Serious' – when the event or pattern of events has the potential to result in death or major permanent loss of function. While ACC no longer investigates for the purpose of finding and reporting medical error, they do report such events to the Medical Council and leave further investigation to that body. When informing claimants of acceptance of cover, ACC includes advice about how to contact the Health and Disability Commissioner if the patient has any concerns about the quality of care that they received.

ACC is not obliged to inform a doctor about a harm notification that has been made concerning them to the Medical Council. MPS is now dealing with several surprised doctors who have been notified by the Medical Council that they have been involved in a Sentinel or Serious event and asking if the matter has been dealt with by way of a review – when they knew nothing about the claim in the first instance.

It is not always obvious when an error has occurred. MPS records show that there is usually a delay between the time an adverse event occurred and the time that a complaint about it is made. Only 42% of adverse incidents are reported within one year; by seven years 99% are reported. Hence the reason that MPS does not offer a no claims bonus.

A survey in the UK some years ago showed that patients who had suffered an adverse event wanted an apology or explanation first, then an inquiry into the causes, then support in coping with its effects. Very few wanted disciplinary action

What should you do if you have had an error occur?

MPS advises the principle of the three Rs – recognise, respond, resolve. The first thing is to ensure that the patient is safe. Speak with a trusted colleague – or the MPS – then involve the patient or the patient's family in responding and seeking resolution. In an address to the Annual College Conference in Wellington in 2004, Mark O'Brien of the Cognitive Institute spoke eloquently of the feeling that patients experience of being abandoned whenever something had gone wrong. This then fuels a complaint. A survey in the UK some years ago showed that patients who had suffered an adverse event wanted an apology or explanation first, then an inquiry into the causes, then support in coping with its effects. Very few wanted disciplinary action. However, doctors need to be prepared for an angry response from the patient, at least initially. Barrister Gaeline Phipps provides excellent advice in a recent article in *NZ Doctor* entitled *'Complaints need systemic responses'*.[6]

GPs need to be aware of their own needs throughout this stressful time. MPS, in association with MAS, has instituted a counselling service for members, which offers four free sessions, with the possibility of more if necessary. This service can be accessed by contacting one of the medico-legal consultants on 0800 225 5677. Most of the members who have used the service so far have not actually been the subject of a complaint.

There can be positive outcomes from a review following an error, especially when issues such as overwork and fatigue have been identified as important factors. If changes can be made that engender, or re-capture, the essence of general practice that was the reason we all entered this vocation in the first place, then the trauma of dealing with an error will not have been in vain.

Competing interests

None declared.

References

1. Gerard Manley Hopkins: Poems 1876-1889: Carrion Comfort.
2. Published in The Guardian 7 November 2006.
3. Davis P, Ley-Yee R, Briant R, et al. Compensation for medical injury in New Zealand: Does 'no-fault' increase the level of claims making and reduce social and clinical selectivity? J Health Polit Policy Law 2002; 27:833-54.
4. Cunningham W. The immediate and long-term impact on New Zealand doctors who receive patient complaints. NZ Med J. 2004; 117 (1198).
5. Soleimani F. Learning from mistakes in New Zealand hospitals: what else do we need besides 'no-fault'? NZ Med J 2006; 119 (1239).
6. Phipps G. Complaints need systemic responses. NZ Doctor 1 November 2006.