

# Mistakes in general practice

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What have I learnt about mistakes in general practice in seven years as Health and Disability Commissioner? In my work, I assess and investigate complaints about general practice, speak to general practitioners all over the country, and follow the debate about mistakes in general practice in medical journals and the media. I offer some reflections on mistakes in general practice, from an independent observer's vantage point.

## Mistakes happen

There is fairly good evidence that mistakes happen in general practice on a regular basis. Patients report a high rate of mistakes in their dealings with general practitioners,<sup>1</sup> and complaints to the Health and Disability Commissioner (HDC) reveal numerous examples of patients being prescribed an inappropriate medicine, or the wrong dosage of the right medicine;<sup>2</sup> not being informed when their test results are received;<sup>3</sup> doctors misdiagnosing the patient's condition through a lack of care;<sup>4</sup> undertaking an inadequate examination and failing to follow up troubling symptoms;<sup>5</sup> and communicating poorly with patients.<sup>6</sup> Although no research equivalent to the 'adverse events in New Zealand public hospitals' study<sup>7</sup> has been undertaken, there is no reason to believe that adverse events in general practice occur less frequently than the incidence rate of 12.9% reported in the Davis study. Tony Dowell's statement that '*New Zealand has a high quality system of general practice and primary care*'<sup>8</sup> may well be true, but it is an anecdotal rather than evidence-based claim.

Interestingly, although general practitioners in New Zealand are will-

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ing to admit seeing mistakes in practice, local doctors were much more likely to report the site of a reported mistake as somewhere other than the doctor's office, than were surveyed doctors from overseas countries.<sup>9</sup> Primary care researchers have speculated that this suggests '*reluctance on the part of New Zealand's doctors to acknowledge involvement in medical errors – even when willing to report them.*'<sup>10</sup>

## Language matters

Although doctors are quick to recite Alexander Pope's aphorism, '*to err is human, to forgive divine*',<sup>11</sup> in practice, use of the term 'error' to describe mistakes in general practice invariably causes hackles to rise. This is an example of the gulf in language and thinking that exists between lawyers and doctors. For lawyers, to describe harm to a patient as having been caused by an 'error' of an individual or organisation is not to ascribe blame, but simply to state that the individual or organisation failed to exercise the standard of 'reasonable skill and care' expected of a similar person or entity in similar circumstances. In contrast, most doctors view a legal finding of 'error' as signifying moral blameworthiness.

It was therefore deeply problematic that, from 1992 to 2005, the Ac-

cident Compensation Corporation accepted some claims from patients injured during medical treatment on the basis of 'medical error' (defined as '*the failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances*'<sup>12</sup>). And for some doctors it remains troublesome that they be found in breach of the Code of Patients' Rights for failure to provide services '*with reasonable care and skill.*'<sup>13</sup> A breach finding is seen as evidence of moral culpability, even though it simply represents the opinion of an independent adjudicator assessing the quality of care for a single patient by a doctor whose care for hundreds of other patients over many years may have been exemplary.

Personally, I have come to prefer using the word 'mistake' when things go wrong in medical care, and the terms 'inadequate', 'substandard' or 'inappropriate', rather than 'error', 'fault' or 'carelessness', in describing lapses in health care and communication. The former expressions focus on the gap between expected and actual practice, rather than on the motivation of the practitioner. There is a world of difference between a lawyer's statement that someone failed to exercise reasonable care, and the colloquial statement that an individual was

careless (although some instances of a lack of care will be attributable to lax practice or carelessness).

### Medical self-esteem is fragile

Medical practitioners who perceive that they have failed a patient, or whose care is subject to an adverse finding, often experience emotions of shame and guilt.<sup>14</sup> No doubt this reflects the high expectations that society, and doctors themselves, place on the medical profession. Certainly, the self-esteem of some doctors is fragile. For a profession that is committed to excellence in caring for patients, and continuous professional development, there is often a hyper-sensitivity to criticism of any aspect of practice.

Taking one's work seriously and caring deeply about the quality of one's work are worthy attributes for any professional. Over-reacting to complaints and external investigations, and resorting to 'defensive medicine' as a permanent practice, is a less admirable response. Doctors recognise it is important that patients can complain about their medical care.<sup>15</sup> They have a responsibility not to over-react to complaints – and then cite their over-reaction as self-fulfilling evidence of a harmful impact on their quality of care. Given the absence of malpractice litigation in New Zealand, and the rehabilitative approach taken by HDC in handling patients' complaints, there is something rather self-indulgent in the response of a small minority of doctors who cry: '*Woe is me! I must practise defensive medicine.*' No other industry would tolerate such a dismissive and defensive attitude to public concerns.

Much of the flagellation about society's response to mistakes in medicine is self-imposed.<sup>16</sup> With the notable exception of some media outlets, and a tiny minority of aggrieved patients, the public and the official bodies that regulate medical practice are understanding of mistakes and of the complex nature of modern medicine. Polls of trusted role models in society invariably place doctors at the top of the list – well ahead of lawyers,

journalists and politicians. Instead of pointing the finger outwards, doctors who are subject to review following a mistake in their practice should seek to learn any lessons from the experience, and move on. Peers, colleges and the profession as a whole need to do a much better job of supporting doctors when a patient is harmed by a mistake in general practice, and the circumstances are subject to external scrutiny.

### Patients are forgiving

Most doctors need no reminder of the enormous store of goodwill that patients have for them. The patient who complains is the exception,<sup>17</sup> and where a complaint is made following an adverse event, the motivation is frequently to prevent the same thing happening to someone else.<sup>18</sup> When I meet general practitioners at conferences and continuous professional development meetings, discussion often turns to the prevalence of complaints, and the vexatious nature of complaints. Neither claim is supported by empirical evidence. In my experience, although doctors may find it vexing to be subject to a complaint, less than one per cent of complaints are made in bad faith.

When mistakes happen, even when significant harm results, patients are remarkably forgiving if they receive an honest and empathetic response, with an explanation of what went wrong, an acknowledgement and apology for any shortcomings, and a commitment to prevent the problem recurring. If the patient has a long-standing professional relationship with the doctor involved in the mistake, and there is an appropriate response, a complaint is very unlikely. As noted by Court, '*patients will not become complainants if they continue to value the professional relationship more than their right to complain.*'<sup>19</sup> General practice is characterised by ongoing professional relationships, and GPs who work in traditional practice settings are less likely to be subject to a complaint when a mistake occurs than their colleagues who see 'casual' pa-

tients (for example, in accident and medical clinics).

### Doctors work in imperfect systems

Because so many general practitioners work in sole practice, or on their own even if within a partnership or shared premises, the interplay of other actors and factors may be less immediately obvious than in settings such as an emergency department or hospital ward, where a procession of nurses, junior doctors, and specialists are involved in a patient's care. Thus when mistakes happen in general practice, it may be tempting to focus solely on the acts and omissions of the individual doctor.

Yet the lesson that most lapses in care are attributable to flawed systems, rather than individual failure, holds true in general practice. General practitioners rely on receptionists and practice nurses; patient histories; their own and other practices' record-keeping systems; laboratory reports; information relayed by pharmacy, general practice and specialist colleagues; and stretched public hospital systems. Opportunities for fallibility abound. In addition to the imperfect systems in which they deliver care, general practitioners are subject to the pressures of heavy patient loads, the explosion of medical knowledge, waves of health and legislative reforms, and the paperwork that bedevils modern practice.

All these factors need to be weighed in the balance in undertaking a root cause analysis of why a mistake occurred, and determining whether an individual practitioner and/or an organisation should be held accountable for failure to provide an appropriate standard of service. Application of the defence of having taken 'reasonable actions in the circumstances' – defined to include '*the consumer's clinical circumstances and the provider's resource constraints*'<sup>20</sup> – enables a fair and balanced application of the Code when investigating a complaint of unsatisfactory care in general practice.

However, blaming the system is no excuse for mistakes in general prac-

tice. It is especially troubling to see doctors who share premises and have unsatisfactory support systems hide behind the lack of a corporate or partnership entity to escape liability for the flawed system, while the individual practitioner caring for the unhappy patient seeks to assign responsibility to 'the system'.<sup>21</sup> Patients of 'X Street Medical Centre' would usually be surprised to learn that the centre is simply a grouping of independent practitioners who accept no responsibility for the standards of practice of their co-tenants. Increasingly, responsibility will need to shift to the PHO funding such practitioners, to ensure that support systems are of an appropriate standard to promote good quality care.

### Reducing the incidence of mistakes

The challenge of improving the quality of general practice care is an enduring one. While many practitioners and practices 'aim for excellence', others settle into a familiar pattern of practice which may not meet the standard of good quality care. In New Zealand, as in other developed countries, the solution to reducing the incidence

of mistakes in general practice lies somewhere in the balance of internal morality and external regulation.<sup>22</sup> Appeals to professionalism will not suffice. We need to encourage and support peer review, clinical audit, and other mechanisms of self-regulation – but recognise that despite claims that our current model of health professional regulation ensures the fitness and competence of individual doctors, in truth current oversight of practice is light-handed and reactive.

As Liam Donaldson has observed in England, '*Most doctors know of another doctor whom, on balance, they would prefer not to treat their own family. Unsatisfactory practice compromises patient safety. The medical profession has a duty to identify such practice and remedy it.*'<sup>23</sup> Inevitably, the future will bring increased pressure for verification that an individual doctor's knowledge, skills and performance 'on the job' is of an acceptable standard. And at the systems level, we are likely to see more funders requiring practices to achieve Cornerstone accreditation, and greater use of financial incentives to reward good quality care.

There is no magic bullet. Technical competence and modern support systems are necessary – but not sufficient. The relationship between the individual patient and their doctor will remain at the heart of general practice. In my view, we still have a long way to go to achieve 'patient-centred care'. The quality of general practice care would be significantly enhanced if patients felt freer to ask questions about their care and enter a true therapeutic partnership with their doctor. Too often, patients feel that the consultation is rushed, and leave the doctor's rooms with unanswered questions – with the stage set for misunderstandings and mistakes. Good communication is key, and requires an environment that facilitates open and honest communication.<sup>24</sup> When it is achieved, patients and doctors are likely to find their professional relationship more rewarding, the outcomes of care improved, and the risk of preventable harm reduced.

### Competing interests

None declared.

### Endnotes

- See, for example, the 2004 Commonwealth Fund International Health Policy Survey of Primary Care in Five Countries (including New Zealand).
- See, for example, Opinions 04HDC19938 and 99HDC01986. Opinions are accessible on the Commissioner's website, [www.hdc.org.nz](http://www.hdc.org.nz).
- See Opinion 00HDC07636.
- See Opinion 01HDC04864.
- For examples of GPs disciplined in 2006 for lack of care, see Decisions Med 05/15D, Med 06/28D and Med 06/33D of the Health Practitioners Disciplinary Tribunal ([www.hpdt.org.nz](http://www.hpdt.org.nz)).
- See Opinion 02HDC04045.
- Davis P, Lay-Yee R, Briant R. Adverse events in New Zealand public hospitals I: occurrence and impact. NZMJ 2002; [www.nzma.org.nz/journal/115-1167/271/](http://www.nzma.org.nz/journal/115-1167/271/).
- Dowell A, Coster G, Maffey C. Morale in general practice: crisis and solutions. NZMJ 2002, [www.nzma.org.nz/journal/115-1158/102/](http://www.nzma.org.nz/journal/115-1158/102/).
- 36.4% of New Zealand reported 'errors' were said to have occurred in the doctor's office, compared to 69.3% of 'errors' reported by GPs from Australia, Canada, England, the Netherlands and the United States: Tilyard M, Dovey S, Hall K. Avoiding and fixing medical errors in general practice: prevention strategies reported in the Linnaeus Collaboration's Primary Care International Study of Medical Errors. NZMJ 2005. [www.nzma.org.nz/journal/118-1208/1264/](http://www.nzma.org.nz/journal/118-1208/1264/).
- Tilyard study, cited above.
- See also the influential report of the Institute of Medicine, *To Err is Human: Building a Safer Health System* (1999).
- The Injury Prevention, Rehabilitation, and Compensation Act 2001, s 33(1).
- Right 4(1) of the Code of Health and Disability Services Consumers' Rights states: 'Every consumer has the right to have services provided with reasonable care and skill.'
- Cunningham W, Wilson H. Shame, guilt and the medical practitioner. NZMJ 2003; [www.nzma.org.nz/journal/116-1183/629/](http://www.nzma.org.nz/journal/116-1183/629/).
- Cunningham W. New Zealand doctors' attitudes towards the complaints and disciplinary process. NZMJ 2004; [www.nzma.org.nz/journal/117-1198/973/](http://www.nzma.org.nz/journal/117-1198/973/). Ninety-five per cent of respondent doctors agreed that it is important that society can complain about doctors.
- The Tilyard study (see 9 above) found that '*regardless of the malpractice environment they practised in, general practitioners in all six countries tend to resort to 'don't make mistakes' as their default suggestion for preventing, averting, or remedying errors.*'
- Bismark M, Brennan T, Paterson R, Davis P, Studdert D. Relationship between complaints and quality of care in New Zealand: a descriptive analysis of complainants and non-complainants following adverse events. Qual Saf Health Care 2006; 15:17–22.
- Bismark M, Dauer E, Paterson R, Studdert D. Accountability sought by patients following adverse events from medical care: the New Zealand experience. CMAJ 2006; 175(8):889–94.
- Court D. Communication, complaints and claims. In: *Cole's Medical Practice in New Zealand*; 2006. p 151.
- Clause 3 of the Code.
- See, for example, Opinion 03HDC03134.
- Paul C. Internal and external morality of medicine: lessons from New Zealand. BMJ 2000; 320:499–503.
- Donaldson L. Good doctors, safer patients (Department of Health, London, 2006). p vi.
- Right 5(1) of the Code states: '*Every consumer has the right to effective communication in a form, language, and manner than enables the consumer to understand the information provided...*'