

Avoiding medical errors in general practice

JONNY COXON AND JONATHAN REES

The two main types of error in general practice are diagnostic and prescribing errors. The authors consider how they might arise and suggest ways in which they may be avoided.

The spectre of medical error has always been with us, but seems to be looming ever larger over recent years. Lately, we have seen the Francis report¹ into the Mid Staffordshire scandal, and the subsequent Berwick report to distil lessons learned.² In October 2014, Jeremy Hunt made a speech quoting a report³ that outlined costs of £1–2.5 billion incurred by the NHS as a result of preventable adverse events. But as we all know, in our profession, the price of error goes way beyond the financial. Patients must surely always be the central focus of any discussion on this subject. For healthcare professionals meanwhile, there are the perils of litigation, exposure, even humiliation. Undeniable high levels of distress, as well as newly overdefensive practice, can ensue.⁴ As was recently highlighted in this publication, we can even face custodial sentences.⁵

Away from the headlines, medical errors are happening all the time. In our honest moments, we can all instantly recall our own. There is doubtless less emphasis on errors occurring in general practice, where the stakes are often not as high. But as we know, 90% of NHS patient interactions occur in our care, within an increasingly pressurised workload. Clearly, there is ample and growing opportunity for mistakes to arise. Whatever the costs that we fear, do we understand how often we are making errors, what they are, and

indeed which are more likely to result in malpractice claims? Hopefully, armed with some of that knowledge, we can learn more about how we might avoid them.

PREVALENCE OF MEDICAL ERROR

Error is probably inevitable in situations of high complexity (human illness), limited information (medical knowledge) and complex systems (modern healthcare).⁶ It is not, however, easy to define medical error or to measure its extent accurately. For various reasons, any reliance on reporting for a true picture would certainly be misplaced. As was stated in the 2014 *Review of candour*, 'primary care shows particularly low rates of reporting considering the level of activity in this sector'.⁷ This serves as an instant reminder that we should probably all be reporting and sharing more of our adverse events. Much patient safety evidence points to a link between greater incident reporting and a more effective safety culture within organisations.⁸

Before we start to take comfort from some reported low levels of adverse events, we can look elsewhere. We start to get more of an idea of how commonly we are making mistakes when we turn to retrospective studies that look specifically at the two most common types of error: diagnosing and prescribing. Diagnostic errors are in fact thought to occur at a rate of around 10–15%.¹⁰ To that, we can add

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BLOG

Do you have any tips to share on helping to avoid medical error, in or out of general practice?
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Avoiding Errors In General Practice

George Dudley Aspinall Parr



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