Failure to study FPs' medical errors a mistake

Attempts to solve medical errors are focusing too narrowly on hospital-based problems and ignoring similar issues in family doctors' offices, a Halifax emergency physician warns. Speaking during an August symposium on medical error at Dalhousie University, Dr. Sam Campbell said that because family physicians often practise independently and without access to a second opinion, their practice patterns may be based more closely on experience with isolated cases and "whim" than on current evidence.

"Errors in this context are seldom recognized and frequently become part of routine practice, [where they are] rarely reported and seldom analysed," said Campbell, an assistant professor of emergency medicine at Dalhousie. If there are adverse events, they are attributed to "bad luck," not medical error. "In many cases, patient comfort and familiarity with a certain pattern of practice slow down any quality-improvement mentality in the primary care practice, in that the physician is more under the scrutiny of patients than peers."

Campbell said the heavy workloads faced by today's FPs only make matters worse. "Office equipment may go uncalibrated for years, and the slow deterioration of both skills and equipment is often unnoticed. With limited opportunity for CME, heavy workload and increased responsibility for managing sicker patients as a result of hospital bed shortages, the primary care practice is being pushed further into the risk zone for medical error."

He said these errors can take many forms. Even though most patient contacts involve minor problems, the FP often provides the only channel for diagnosing unexpected and unsuspected disease. In this case, the continuity of care that is the hallmark of family medicine can cause error by creating predictable patterns of practice that, in turn, lead to complacency.

In an interview, Campbell said typical errors in primary care practices include polypharmacy and prescribing the wrong drug. He said many of these prescribing errors occur because of pressure from patients demanding specific drugs. He's not sure how to solve the problem, but said Australia's voluntary reporting system isn't the answer, because "voluntary reporting is only a sign of the conscientiousness of the physician." He added that few attempts have been made to quantify the error rate in family practices, but he and some colleagues from Dalhousie have applied for funding to launch a study.

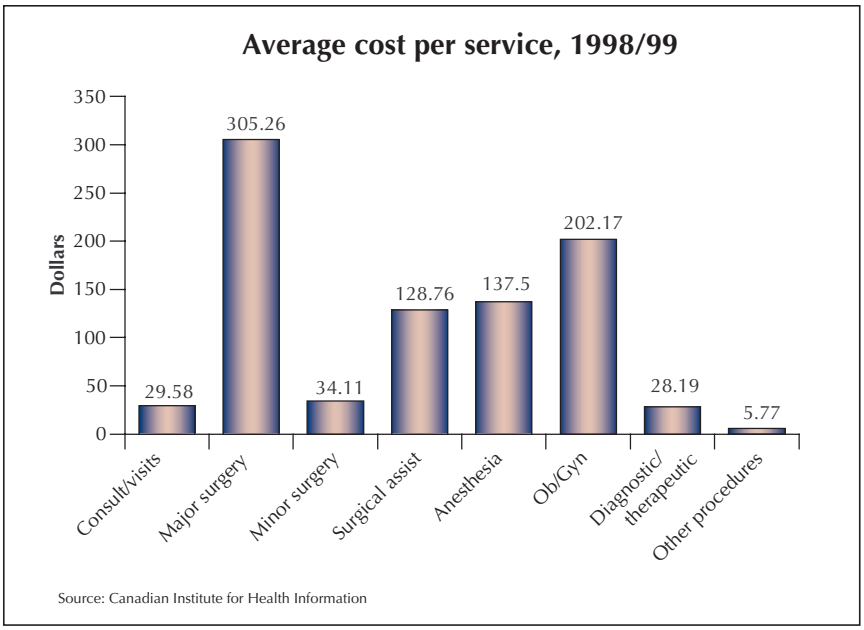
Campbell said family medicine must move immediately to prevent mistakes, but it must follow a different path than hospital-based medicine. Although crude estimates of error can be made by analysing death reviews, medicolegal claims and registries of adverse drug reactions, "these represent, in most cases, outliers, and ignore the majority of errors in primary care." — *Patrick Sullivan*, CMAJ

PULSE

Fee-for-service MDs averaged $33 per service in 1998/99

During the 1998/99 fiscal year, fee-for-service physicians earned more than $8 billion for providing over 240 million services, or an average of $33 per service. The Canadian Institute for Health Information also reports that family physicians provided most of the services (64%) and received 47% of total payments.

The number of services provided in Canada increased by less than 1% and actually decreased slightly on a per capita basis (-0.2%) between 1996/97 and 1998/99. Total payments per capita increased by 2% over the same period.



Consultations and visits accounted for 70% of all fee-for-service payments to physicians, with payments for surgical, anesthetic and other services accounting for the rest. The average cost of all visits in 1998/99 was $29.58, while the average cost for procedures was $50.38. During the 3 years from 1996/97 to 1998/99, the overall percentage increase in the cost per service for all procedures was just over 4%. There was a 7% increase in the cost per diagnostic and therapeutic procedure, compared with almost no change in the cost for obstetric/gynecologic procedures (0.2%). — *Lynda Buske*, lynda.buske@cma.ca