From the American Academy of Family Physicians

MEETING ON PATIENT SAFETY TAKES DIFFERENT TACK: AMBULATORY CARE

When the Institute of Medicine (IOM) concluded in its groundbreaking 1999 report, "To Err Is Human," that the know-how already existed to prevent many medical errors, it struck a chord among all health care professionals.[1] That chord resounded loud and clear for primary care physicians.

Granted, the IOM report looked mainly at hospital-based errors, but the content of the report has led to much soul-searching among those who practice ambulatory care. Many primary care physicians have come to the same conclusion, namely, that office-based practices have flaws in their systems of care that work to the detriment of patients.

First of Its Kind

Concern about medical errors gave impetus to the first National Ambulatory Primary Care Research and Education Conference on Patient Safety held September 18-19, 2003, in Chicago. The AAFP was a sponsor of the conference.

Whereas many meetings have been held on the topic of patient safety, this was the first national gathering devoted solely to safety in ambulatory primary care settings.

"We hope that the content and format of this unique meeting will lead to stimulating discussions, new alliances, collaborations and program developments lasting long after we're adjourned," said John Hickner, MD, MS, conference chair and director of the AAFP National Network for Family Practice and Primary Care Research.

With sufficient interest among participants, the event could become an annual meeting for those seeking to improve primary medical care delivery through research and education, said Hickner.

Recognizing that medical errors are a problem for all physicians in primary care, the meeting's planning committee included leaders in internal medicine and pediatric medicine in addition to leaders in family medicine.

The meeting, supported by the Agency for Healthcare Research and Quality (AHRQ), arose from discussions among members of the Primary Care Organizations Consortium and staff of the AAFP Developmental Center for Research and Evaluation in Patient Safety in Primary Care (DCERPS-PC).

Tools Are There

Sessions included presentations on error reporting and disclosure, drug-to-drug interactions and interventions, and patient safety curricula for medical schools and residency programs.

A frequent refrain at the meeting, however, was the notion that health care professionals could use existing knowledge to improve safety.

In her keynote address, Helen Burstin, MD, MPH, director of the AHRQ Center for Primary Care Research, spoke of the importance of information technology for patient safety.

"The IOM noted in its report that grocery stores have better technology than doctors," she said, expressing the hope that physicians will soon make use of such technology as bar codes and computerized records.

Key to Patient Safety: Patients

Plenary speaker Gerald Hickson, MD, associate dean for clinical affairs at Vanderbilt University, predicted that his role as a malpractice researcher would do little to win friends in medical practice. But lawsuits offer clues on how to improve the medical system, he said. His research has shown that regardless of specialty, relatively few physicians—9%—account for roughly half of complaints.

"We need patients to be our partners," he said. "Our colleagues who are disruptive don't promote that."

And even when a lawsuit is dismissed, it offers a lesson, Hickson said. "Poor communicators are sued more often."

He added, "There's been much said about the tip of the iceberg. The unsolicited patient complaint *is* the iceberg. For every one who complains, 30 will not."

His point? Physicians should not stand by silently while a colleague provides bad care. And this idea needs to be implanted early on. Medical students and residents should be trained to provide feedback to their colleagues.

What Engineers Can Teach Primary Care

Are primary care physicians just not system-oriented? Are they laboring in faulty structures but blind to the fact?

One industrial engineer who attended the conference thinks so. "Maybe it's time to bring people in from an outside perspective and look at the situation from a design point of view," said Ben-Tzion Karsh, PhD, an industrial engineer from the University of Wisconsin-Madison who specializes in health care settings.

"We talk too much about errors, not about hazards in design," he said.

What he sees in health care is an information-rich

field in which doctors must weigh data coming from many sources: written history, test results, patients and family members.

And although paper charts are fraught with hazards, electronic medical records are not an automatic solution if they are not customized to a specific practice, Karsh said.

From what enterprise could health care professionals learn?

"UPS," he said. The shipping company has engineered a business design in which the shipping of packages can be tracked with pinpoint accuracy throughout the world.

And although no one is arguing that patients are like packages, the concept presents an example of using tried-and-true technology.

Want to Learn More?

The proceedings of the National Ambulatory Primary Care Research and Education Conference on Patient Safety will be published online this winter on the AAFP DCERPS-PC Web site (http://www.aafp.org/ptsafety.xml).

Toni Lapp
AAFP News Department

Reference

1. Kohn LT, Corrigan JM, Donaldson MS, Eds. *To Err Is Human: Building a Safer Health System*. Committee on Quality of Health Care in America, Institute of Medicine. Washington, DC: National Academy Press; 1999.

From the American Board of Family Practice

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MAINTENANCE OF CERTIFICATION PROGRAM FOR FAMILY PHYSICIANS (MC-FP)

Questions from the American Board of Family Practice (ABFP) Diplomates

By the time this issue of the *Annals of Family Medicine* has been published, the ABFP will have distributed to its Diplomates an overview of the MC-FP and a Frequently Asked Questions supplement. Those Diplomates who have certified/recertified in 2003 will be the first to enter the MC-FP cycle on January 1, 2004. For more information regarding the MC-FP, please visit our Web site at http://www.abfp.org.

Since the introduction of the MC-FP, the Board has received a number of questions from family physicians in the field. Below are some of these questions with answers from James C. Puffer, MD, ABFP executive director.

From a Process B Diplomate

Q I am curious how Process B Diplomates like me will be able to meet the new MC-FP requirements. I originally certified with the ABFP in 1985 and have subsequently gone the Process B route in 1991, in 1997, and again in 2003 because I practice in an occupational medicine setting. Consequently, chart review requirements have made Process B unviable, as I am not actively managing cases, such as breast cancer or hyperthyroidism.

A We are developing unique Part IV components (eg, patient safety, systems-based practice) that will give all of our Diplomates who previously certified