As good as it gets in general practice?

In 2009, we cling to an ideal of general practice care that may be realised far less often than we think. *Aiming for Excellence: RNZCGP Standard for New Zealand General Practice 2009* describes general practice as having "a unique consultation process that establishes a relationship over time, through effective communication between clinician and patient", and as "responsible for the provision of longitudinal continuity of care as determined by the needs of the patient" (page 5). This depiction of general practice fits well with traditional general practice, where continuity of care has traditionally meant that a patient visits the same doctor over time. But how is this achieved in the increasing number of medical centres where a patient sees many different doctors?

A report published on the HDC website[1] on 12 August 2009 is a graphic illustration of what happens when a patient attends a large medical centre where multiple doctors provide episodic care but no single doctor takes overall responsibility. The report is also notable for being the first time HDC has publicly named a medical centre found in breach of the Code.

Accident and Medical Centre

Mrs A attended The Palms Medical Centre — a large, busy medical practice in Palmerston North — for eight years. The Palms describes itself as an "accident and family medical centre", offering general practitioner services as well as accident and medical services. It provides patients with the choice of being seen by the first doctor available on the day, or booking an appointment with their preferred doctor. The Palms is one of 19 Radius medical centres throughout New Zealand.

At the time Mrs A attended The Palms Medical Centre, around 12 doctors were employed. Several were locums and at least half were not vocationally registered as general practitioners. Dr B was Mrs A's regular GP.

Sorry saga of Mrs A

In March 2007, Mrs A (aged 42) experienced pain in her right shoulder while digging in her garden. After consulting an osteopath and taking paracetamol she continued to experience pain in her right shoulder. A week later, she sought advice from a doctor at The Palms, who made a provisional diagnosis of supraspinatus bursitis and prescribed anti-inflammatory medication.

Mrs A continued to experience shoulder pain and, on 6 May, she returned to The Palms. She was seen by a different doctor, who noted that the pain had radiated to her right hand and arm, and prescribed pain relief and anti-inflammatory drugs. Although the doctor requested a cervical spine X-ray, the result of the X-ray (normal) was not received by the medical centre until 9 July.

On 9 July, Mrs A again presented to The Palms with ongoing right shoulder and arm pain, which had now spread to her left side. She was also experiencing numbness in both hands and some weakness in her arms. Mrs A was seen by yet another doctor, who suspected her symptoms were secondary to cervical spine spondylosis and carpal tunnel syndrome. Dr E gave Mrs A wrist splints to use at night and asked her to come back in one week's time.

On 27 July, Mrs A attended The Palms with chest pain, and was assessed by a different doctor again, who conducted an examination of the respiratory system and attributed the

chest pain to pleurisy, as she had recently suffered an influenza-like illness. There was no reference to Mrs A's ongoing shoulder pain.

On 8 August, Mrs A consulted a doctor at a different medical practice complaining of pins and needles in her hands. The doctor suspected carpal tunnel syndrome and ordered blood tests. The blood test results, sent to Dr B at The Palms the next day, showed abnormal lymphocytosis and mildly elevated CRP, and the TSH results suggested that Mrs A might be slightly under-replaced with thyroid hormone. The results included the note "bloods review in a week". Dr B did not take any action on these results.

On 14 August, Mrs A consulted the second medical practice to follow up her blood test results. Carpal tunnel syndrome was suspected, and the plan was to follow up in a month. Dr B was informed of this.

On 20 August, Mrs A consulted Dr B, who noted in the clinical record that "numbness in the shoulder persists". Dr B weighed her and ordered a full blood count.

A week later, Dr B reviewed Mrs A's blood test results, which indicated Systemic Lupus Erythematosus. Dr B arranged for Mrs A to be recalled for review. There was no record of a consultation that day, but Dr B advised that he did see her and ordered further blood tests. The next day Dr B sent a referral letter to the rheumatology clinic at Palmerston North Hospital for an urgent review.

Mrs A's blood test was repeated on 17 September and she consulted Dr B on 19 September. Dr B's notes stated simply "depression due to chronic illness", and he prescribed antidepressants.

On 10 October Mrs A was seen at the hospital by a rheumatologist, who found significant neurological changes and referred her for a semi-urgent MRI of her brain and spine. The MRI revealed cervical stenosis at the C5/6 level with cervical cord myelopathy caused by a large cervical disc protrusion. The provisional MRI results were sent to Dr B's inbox at The Palms Medical Centre, but Dr B was on leave when the results were received and his inbox was not cleared by another doctor.

On 23 October, after reviewing the MRI results, the rheumatologist referred Mrs A to an orthopaedic surgeon requesting "fairly urgent" advice on surgical management. A copy of this letter was sent to Dr B.

On 25 October Mrs A telephoned The Palms for her MRI results, and was told to come in to collect them. She was seen by yet another medical practitioner, who reviewed her clinical history and noted that she was now suffering from urinary incontinence. The new doctor sent a referral letter for a non-urgent private orthopaedic consultation.

On 29 October Mrs A was seen at Palmerston North Hospital by an orthopaedic surgeon, who recommended surgery to prevent further neurological deterioration, and informed the rheumatologist and Dr B that she would be undergoing surgery on 8 November. This letter was received by The Palms on 6 November but did not get allocated to Dr B's inbox until 17 November (partly due to a glitch in the system that should divert the contents of one doctor's inbox to another).

Mrs A underwent cervical decompression surgery on 8 November. She continues to suffer neurological symptoms, including urinary incontinence, and is no longer able to work. Mrs A subsequently transferred her care to another medical practice. In April 2008, she made a complaint to HDC.

HDC decision

My investigation considered the overall appropriateness of the care provided to Mrs A by The Palms Medical Centre, particularly the processes and policies in place to ensure patients attending the centre were provided with continuity of care. Although individual doctors' conduct was commented on where relevant to the medical centre's responsibilities, no individual doctor was investigated.

Mrs A was suffering from a rare condition that was difficult to diagnose. But she saw five different doctors at The Palms about her shoulder pain. None was vocationally registered as a GP. The doctors took an "episodic" approach to her care.

In my view, the approach to consultations "appeared to portray that of an A&M clinic dealing with acute problems, rather than a general practice responsible for ongoing clinical care". The size and structure of the medical centre made it likely that patients with ongoing problems would be seen by a number of different doctors. Processes should have been in place to ensure that patients who attended for general practice care (rather than A&M services) were provided with continuity of care, and were not disadvantaged by the number of doctors involved in their care. My expert, Dr Keith Carey-Smith, observed that doctors at the medical centre did not appropriately follow up investigations ordered and incoming results on several occasions. There was also a lack of contact with Mrs A by the medical centre.

The Palms argued that, because "the treating doctor has the duty of care and responsibility to follow up their own investigations", its doctors had no duty to follow up results of tests ordered by other general practices or specialists. This is an oversimplification of the legal position. I noted:

> "The starting position is that primary responsibility for following up abnormal test results lies with the clinician who ordered the test. However, if the abnormal results are reported to the patient's general practice, the practice has a residual responsibility to check whether any significant abnormality that clearly needs follow-up has been followed up. In this way, the general practice acts as a safety net to check that any significant abnormality is being followed up."

Mrs A's care was also jeopardised by the poor standard of documentation of her consultations. Continuity is fundamental to general practice care, and clinical records are critical in providing an indication of the ongoing management plan so that any subsequent doctor can examine the preceding treatment and continue the management in a systematic way. Although The Palms had a patient management system allowing all doctors and nurses to have access to all patient clinical notes, such a system is of little use if the notes from the consultation lack detail or the consultation is not documented at all. Given the structure of the medical centre, it was vital that a detailed and clear record of the history, examination, assessment and management plan of each consultation was documented, to assist other doctors working there to provide continuity of care to patients.

The medical centre suggested that Mrs A herself should be held partly responsible for any delay in diagnosis, as she did not wait to see the same GP regularly and left long periods

before making another appointment. However, I noted that there was "no evidence that Dr B and the Medical Centre clearly explained to Mrs A what it meant to be enrolled as a patient of the practice, and why it was important for her to seek all her primary medical care there, and to see Dr B as her regular doctor within the practice. I suspect that for Mrs A, as for many patients of general practices, the nature of the patient–doctor contract was left unclear. In these circumstances the individual patient can hardly be blamed for occasionally seeing other doctors within and outside the Medical Centre."

Improvements

The Palms has taken a number of steps to improve the quality of care for patients since these events. They include a new Clinical Director role; regular meetings to discuss concerns about patient management, documentation, and new protocols; education sessions and CME opportunities for staff; a communication book for each team to keep staff up to date with daily practice events; and changes to the appointment booking system. Enrolled patients now have a preferred provider responsible for their care. Doctors enquire at each consultation if the patient has any unresolved issues, and review recent case note entries or inbox items to see if there are any outstanding issues. The Palms has recently obtained Accident and Medical accreditation and Cornerstone accreditation, and has shifted its focus from A&M to general practice.

Conclusion

The Palms is to be commended for the improvements made to its practice systems. In relation to Mrs A's care, however, I concluded that it failed to provide her with good quality, well co-ordinated care and therefore breached Rights 4(1) and 4(5) of the Code of Consumers' Rights.

This case is a reminder of the benefits for patients in having an ongoing relationship in primary care with a medical practitioner who is familiar with them and their medical history. Mrs A received fragmented, poor quality general practice care. As I noted in my report:

> "One has to ask, 'Is this as good as it gets?' If this is the face of modern primary medical care in New Zealand, it is not a pretty picture. It suggests that for all the fine rhetoric about quality of care, and the emphasis on accreditation of systems, more work is needed to translate that into good care in practice for patients."

Ron Paterson
Health and Disability Commissioner

New Zealand Doctor, 12 August 2009

[1] Opinion 08HDC06359, accessible at www.hdc.org.nz.