Raising the bar never feels fair

No doubt we are mentally preparing for long evenings glued to the TV as the Olympic events unfold in the coming month. Those with short stubby legs like mine will probably identify with my memory of backyard efforts as a child trying to clear a high jump bar. It was always too high and I never made the grade. I tried, but eventually gave up and moved to other exploits.

Later I graduated from medical school in an era when it was possible to assume that I knew all I needed for a lifelong career in medicine. There was no CME or CQI or peer review. There were very pleasant drug company sponsored dinners with colleagues, with clinical presentations to promote the sponsor's product, at which some learning was gained.

The part one examination of the RNZCGP could then be taken with credit given for proven general practice experience and without formal GP training.

More mature GP colleagues were invited to apply to be 'grandfathered' into the fledgling RNZCGP. Most of us younger ones (then) were preoccupied with establishing practices and families and allowed this invitation to pass us by. As registration criteria changed to recognise general practice as a specialist vocation, there was a flurry of activity as I and many others raced to catch up with the educational requirements of vocational general practice.

In this way many of us somewhat reluctantly entered this new world of lifelong medical education and accountability. CME, CQI and peer review brought us up to speed. Now the attention has moved to the same for our practices with systems, policies, protocols, managerial standards and cultural awareness to be judged against cornerstone standards.

The temptation is to feel that all this accountability is unreasonable, especially when one requirement is fulfilled only to be followed by another. The concept of continuous accountability may feel arduous. The bar keeps rising. But then so do my own expectations when I need to visit my GP or wonder what my non-specific chest pain might signify. If we GPs weren't such a healthy non-smoking bunch and got sicker more often we might have a better patient perspective on the need for quality standards. We need to take this perspective of continuous improvement on board, to embrace it as indicative of our professionalism and self-esteem as family physicians.

In a Commonwealth Fund study in 2004, primary care patients gave New Zealand primary providers a 74% approval rating for 'excellent' or 'very good' care. A similar percentage agreed that their doctor 'always listens carefully'. On average there is less than one complaint to the Health and Disability Commissioner daily for an estimated 50,000 daily primary care patient contacts. Although many patients choose not to complain, that low complaint figure is still a good indicator of the esteem held by patients towards primary care providers. General practice can rightly accept such affirmations as indicative of the quality of care provided by most New Zealand family practitioners. We can and should hold our heads high. High enough to see over the bar but not too high, lest we get lost in the clouds and forget our patients who need to be able to trust us.

Two recent complaints brought to the attention of HDC provide examples of the need to raise the bar in clinical practice as new treatments and interventions have become standard.

The first involved an allegation of missed clinical cues of pulmonary embolism. The patient had recently undertaken long distance travel and presented with 'bronchitis'. He died three days later of pulmonary embolism. Clinical advice provided to the Commissioner drew his attention to a recent alert from the Medical Protection Society which stated that 'it is essential that the training and knowledge of medical students and newly qualified doctors reflect modern approaches to VTE'. The advice I provided to the Commissioner added, 'As the understanding of the diagnostic and treatment possibilities in relation to VTE has progressed in recent years, **it is essential that general practitioners keep abreast of the new developments** in this area.'

The second case involved an alleged inadequate response to a presentation of chest pain in a middle-aged man. The general practitioner commenced a therapeutic trial of metoprolol with a view to review in one month. The Commissioner was advised that while it may have been considered reasonable in previous decades for a general practitioner to undertake a therapeutic trial with medication, as one way of clarifying a possible ischaemic heart disease diagnosis, such a stance is no longer appropriate. With the progress in investigation and treatment of this condition in the last decade, and the greater availability of exercise testing, angiography, and peri-infarction stenting, such a therapeutic trial with medications would no longer be considered an appropriate diagnostic process for a general practitioner. It is appropriate, however, to prescribe preventive medications such as aspirin, nitrate spray, and perhaps a beta blocker while a patient is awaiting urgent outpatient assessment or investigations.

The bar is rising. It will continue to rise. That is good for patients and for our professionalism as vocational general practitioners. Let us embrace that challenge wholeheartedly as an expression of the specialised and esteemed status we enjoy and have earned.

Dr Stuart Tiller, FRNZCGP MPHTM
Clinical Advisor

New Zealand Doctor, 30 July 2008

Postscript
Dr Tiller is leaving HDC to return to full-time practice. We will be asking the College for help in finding a suitable successor — a current vocationally registered GP, someone wise and experienced, able to work in-house at Auckland on a part-time basis. If you're interested, email hdc@hdc.org.nz.