The Palms Medical Centre Ltd

A Report by the

Health and Disability Commissioner

(Case 08HDC06359)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

On 18 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. On 25 March 2007, she sought advice from a doctor at The Palms Medical Centre Ltd in Palmerston North (the Medical Centre), who made a provisional diagnosis of supraspinatus bursitis[1] and prescribed anti-inflammatory medication.

Over the next months, Mrs A's shoulder pain grew progressively worse. By July 2007 the pain had spread to her left side and she was suffering from arm weakness and numbness in both hands. By August 2007, Mrs A was also suffering from persistent numbness in her shoulder, and on 28 August 2007 Dr B, a medical practitioner at the Medical Centre, referred her to a rheumatologist. An MRI scan was subsequently ordered by the rheumatologist, which revealed significant cervical stenosis with myelopathy[2] requiring surgery to prevent further neurological deterioration. After undergoing surgery, Mrs A's gait and co-ordination improved, but she continues to suffer neurological symptoms, including incontinence, and is no longer able to work.

From her initial consultation on 25 March 2007 to her consultation on 27 August 2007, Mrs A consulted doctors at the Medical Centre six times. Five of these consultations were directly related to her initial complaint of shoulder pain.

This report considers the care provided to Mrs A by the Medical Centre, in particular the adequacy of systems for ensuring continuity of care.

Complaint and investigation

On 21 April 2008, the Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided by the Medical Centre. The following issue was identified for investigation:

- *The appropriateness of care provided to Mrs A by The Palms Medical Centre Ltd from March to November 2007, particularly the adequacy of systems for ensuring continuity of care.*

An investigation was commenced on 16 September 2008.

[1] Inflammation of a bursa resulting from injury, infection or rheumatoid synovitis. It produces pain and tenderness and sometimes restricts movement at a nearby joint.
[2] Narrowing of the cervical (neck) spinal canal, which causes compression of the nerve roots.

The parties involved in this case were:

Mrs A	Consumer
The Palms Medical Centre Ltd	Provider
Radius Medical Solutions Ltd	Franchisor of the Medical Centre
Radius Health Group Ltd	Owner of Radius Medical Solutions Ltd
Dr B	Doctor at the Medical Centre
Dr C	Doctor at the Medical Centre
Dr D	Doctor at the Medical Centre
Dr E	Doctor at the Medical Centre
Dr F	Doctor at the Medical Centre
Dr G	Doctor at the Medical Centre
Ms H	Practice co-ordinator at the Medical Centre
Dr I	Rheumatologist, MidCentral DHB
Dr J	Orthopaedic surgeon, MidCentral DHB
A second medical practice	Other medical practice

Information was reviewed from:

- Mrs A
- The Medical Centre
- Dr B
- Accident Compensation Corporation.

Initial advice was obtained from HDC's clinical advisor, general practitioner Dr Stuart Tiller (see **Appendix 1**). Further expert advice was obtained from general practitioner Dr Keith Carey-Smith (see **Appendix 2**).

Information gathered during investigation

The Medical Centre

Background

The Medical Centre is a large, busy medical practice. It describes itself as an "accident and family medical centre".[3] According to its website it offers general practitioner services and accident and medical services. During the relevant period, the Medical Centre employed around 12 doctors, several of whom were locums. None of the six doctors seen by Mrs A was vocationally registered as a general practitioner. The Medical Centre provides its patients with the choice of being seen by the first doctor available on the day, or they can book an appointment with their preferred doctor. However, patients generally have to wait longer to be seen if they choose the latter option.

[3] http://www.radiusmedical.co.nz/index.php/medical-centres/lower-north-island/thepalms.

The Medical Centre is one of 19 Radius medical centres throughout New Zealand. It is technically a privately owned company (The Palms Medical Centre Ltd) operating under a franchise agreement with Radius Medical Solutions Ltd as the franchisor. Radius Medical Solutions Ltd is a subsidiary company of Radius Health Group Ltd.

Chronology of events

13 August 2002
On 13 August 2002 Mrs A became a registered patient at the Medical Centre.[4]

1 April 2005
On 1 April 2005 the Medical Centre joined the Manawatu Primary Health Organisation (PHO). Mrs A became formally enrolled with the PHO on 19 October 2006.

18 March 2007
On 18 March 2007, Mrs A experienced pain in her right shoulder while digging in her garden. She consulted an osteopath and took paracetamol, neither of which alleviated the pain.

25 March 2007
On 25 March 2007, because her shoulder pain continued, Mrs A consulted Dr C at the Medical Centre. Dr C assessed Mrs A's shoulder movements and made a provisional diagnosis of supraspinatus bursitis. Dr C prescribed anti-inflammatory medication, suggested some shoulder exercises, and advised her to return if the pain did not settle.

6 May 2007
Mrs A continued to experience shoulder pain and, on 6 May 2007, she returned to the Medical Centre and was seen by Dr D. Dr D noted that the pain had radiated to Mrs A's right hand and arm, and prescribed pain relief and anti-inflammatory drugs. Dr D requested a cervical spine X-ray,[5] but no record was made about the arrangement for following up the X-ray result. No physical examination or management plan was documented in the notes.

Dr D responded:

> "Although I did not record that I examined her, I believe I did [examine her] and found no apparent weakness. It was my view that the pain was coming more from the C spine rather than her shoulders and I therefore ordered a C spine X-ray.

[4] The Medical Centre advised that Mrs A's primary doctor left in December 2006. Following this, Mrs A saw various doctors at the Medical Centre, but by the end of August 2007 she was seeing Dr B on a regular basis.
[5] This X-ray test takes pictures of the seven neck (cervical) bones.

> I would like to acknowledge and accept that I should have done a more detailed examination and documented it … "

9 July 2007

On 9 July, Mrs A again presented to the Medical Centre 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 Dr E, who suspected Mrs A's symptoms were secondary to cervical spine spondylosis[6] and carpal tunnel syndrome.[7] Dr E gave Mrs A wrist splints to use at night and asked her to come back in one week's time.[8]

The results of the cervical spine X-ray, which was ordered by Dr D on 6 May 2007, were received by the Medical Centre on 9 July 2007. The results were normal and a note was made by Dr D that Mrs A had been informed of this.

27 July 2007

On 27 July, Mrs A attended the Medical Centre with chest pain, and was assessed by Dr F. He conducted an examination of the respiratory system and attributed the chest pain to pleurisy,[9] as Mrs A had recently suffered an influenza-like illness. There is no record of any discussion or examination in relation to Mrs A's ongoing shoulder pain.

8 August 2007

On 8 August, Mrs A consulted a doctor at a different medical practice. She complained of pins and needles in her hands. The doctor suspected carpal tunnel syndrome and blood tests were ordered. The blood test results were sent to Dr B at the Medical Centre on 9 August 2007. The results showed abnormal lymphocytosis[10] and mildly elevated CRP,[11] and the TSH[12] results suggested that Mrs A might be slightly under-replaced with thyroid hormone.[13] The results included the note "bloods review in a week"; however, it was unclear whether the second medical practice or the Medical Centre were to follow this up. Dr B did not contact Mrs A to ensure follow-up arrangements were in place.

The Medical Centre acknowledged that it was unclear whether Mrs A had been advised by the second medical practice to make a follow-up appointment with them or the Medical Centre. The Medical Centre advised that it had assumed the other medical practice would ensure follow-up arrangements were in place (and in fact they were[14]) as it understood responsibility for following up abnormal test results lay with the requesting doctor.

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[6] Degeneration of discs and vertebrae at the top of the spinal column.
[7] A painful condition caused by compression of a key nerve (median nerve) in the wrist.
[8] Mrs A next attended the Medical Centre on 27 July 2007.
[9] Inflammation of the covering of the lung and the inner surface of the chest wall often due to infection.
[10] Abnormal increase in the amount of lymphocytes caused by a variety of infections and diseases.
[11] C-reactive protein — a protein found in blood in response to inflammation.
[12] Thyroid Stimulating Hormone.
[13] This can be due to a deficiency of iodine, a problem with the functioning of the pituitary gland or hypothalamus, or a problem with the thyroid gland itself.
[14] Mrs A had made an appointment at the second medical practice for the following week.

The Medical Centre also explained the lack of a follow-up telephone call to Mrs A once it became apparent that she had been seen by another doctor:

> "Although we acknowledge the value of phoning our patients for this courtesy follow-up, implementing this as usual practice with a patient data base of close to 16,000 is extremely hard to do. With keeping this in mind the delays in information being provided by other primary and secondary health care providers also plays a part in phoning patients for courtesy follow-up as they sometimes see their usual General Practitioner prior to us receiving clinical feed back from the other General Practitioner."

14 August 2007
On 14 August, Mrs A consulted the second medical practice to follow up her blood test results. The consultation notes state:

> "Patient for review. Bloods indicate ?viral infection. Patient also complains of sensitive skin along the left leg and left side. Plan: repeat bloods in a month and if symptoms still present then refer to […] for conduction studies in the arms ?carpal tunnel syndrome. Follow up."

As can be seen from the notes, the second medical practice suspected carpal tunnel syndrome and were planning a follow-up in a month. A copy of the discharge summary was sent to Dr B.

17 August 2007
On 17 August, Dr B provided a repeat prescription for thyroxine after a telephone message request from Mrs A.

20 August 2007
On 20 August, Mrs A consulted Dr B. There is no record of a clinical examination, but he noted in the clinical record that "numbness in the shoulder persists". Dr B weighed her and ordered a full blood count.

In his response, Dr B provided some background information to this consultation. He advised that Mrs A had arrived at the Medical Centre requesting an urgent appointment to discuss a prescription for a weight loss drug, Duromine, and also her regular thyroid and asthma prescriptions. As the practice manager agreed the matter was urgent, she arranged for Mrs A to be seen between appointments, despite Dr B being fully booked. Mrs A was advised that this was a short appointment to discuss her prescriptions only.

Dr B explained that during the consultation he noted her recent visits to other doctors at the Medical Centre and asked her about her unresolved neck and shoulder pain. He then undertook an examination and noted "some worrying symptoms". However, as there were no "red flags" to indicate an urgent referral to hospital, he wrote a "semi-urgent" referral to an orthopaedic surgeon. Dr B also advised that he would have referred Mrs A for an MRI scan at this point, but this was not possible as she did not have any health insurance and could not afford tests privately.

Dr B explained that as he was double-booked he wrote Mrs A's notes after the consultation, as he believed that his priority was to ensure the well-being of his patient in front of him. Despite the notes, Dr B advised that he gave Mrs A his full attention during the consultation, examined her, took a full history and completed the necessary referrals and lab forms.

Dr B further advised that, in any event, details of the consultation could have been accessed by colleagues if required:

> "In my notes … it says 'referral done to orthopaedic surgeon'. If one of my colleagues was looking at this consultation he would see that a referral was done and he would go and have a look at the referral letter and what I had written to get a full picture of what happened during that consultation. I can assure you that I now always take accurate and full notes in the consultation screen."

27 & 28 August 2007

On 27 August 2007, Dr B was in receipt of the blood test results of 20 August 2007, which indicated Systemic Lupus Erythematosus,[15] a possible cause of joint pain. Dr B arranged for Mrs A to be recalled for review. Although there is no clinical record of a consultation that day, Dr B advised that he did see Mrs A later that day and ordered further blood tests. On 28 August 2007 Dr B sent a referral letter to the rheumatology clinic at Palmerston North Hospital for an urgent review.

19 September 2007

Mrs A's blood test was repeated on 17 September 2007 and she consulted Dr B on 19 September. Dr B's notes state simply "depression due to chronic illness", and antidepressants were prescribed.

Dr B provided further detail about this consultation in his response:

> "When [Mrs A] returned … she was very emotional. She was crying and upset because she had been ill for so long … I explained that all the appropriate referrals had been made. I reminded her that her appointment with the rheumatology department was coming up. I felt at this point that [Mrs A] was showing signs of depression and following discussion prescribed her … an anti-depressant … I also prescribed some pain medication for her shoulder and organised for her to be seen again in three weeks … because [the anti-depressant] takes approximately 2–4 weeks to start working. I also made the appointment to assess her condition and my treatment of her depression and to make sure that her referrals were actually progressing."

10 October 2007

Mrs A attended a rheumatology review at Palmerston North Hospital on 10 October 2007. Rheumatologist Dr I found significant neurological changes and referred Mrs A for a semi-urgent MRI of her brain and spine. Dr I wrote a letter to Dr B, advising that

[15] A chronic inflammatory disease of connective tissue, affecting the skin and various internal organs.

she "would not like to speculate on the possible diagnosis at this stage until seeing [Mrs A's] MRI".

19 October 2007
The MRI was performed on 19 October 2007 and revealed cervical stenosis[16] at the C5/6 level with cervical cord myelopathy[17] caused by a large cervical disc protrusion.

The provisional MRI results were sent to Dr I the same day and a copy delivered to Dr B's inbox at the Medical Centre. Dr B was on leave (until 24 October 2007) when the results were received and his inbox was not cleared by another doctor. Mrs A was eventually informed of the results by Dr G (a doctor at the Medical Centre) on 25 October 2007.

The Medical Centre advised that it is the responsibility of the doctor going on leave to ensure another doctor agrees to check his or her inbox results. There is a software switch which, in theory, diverts the contents of one doctor's inbox to another. However, in November 2008 the Medical Centre became aware of a "technical glitch", which meant some incoming reports or letters were not diverted to the covering doctor's inbox.

23 October 2007
On 23 October 2007, after reviewing Mrs A's MRI results, Dr I wrote a letter of referral to an orthopaedic surgeon, Dr J, requesting him to evaluate and advise "fairly [urgently]" on the surgical management of Mrs A. A copy of this letter was sent to Dr B.

25 October 2007
Mrs A telephoned the Medical Centre for the MRI results on 25 October 2007. She was told that the results could not be given over the telephone and that she would need to come in to collect them. When Mrs A attended, she was seen by yet another medical practitioner, Dr G. Dr G reviewed Mrs A's clinical history over the past seven months and noted that Mrs A was now suffering from urinary incontinence. Dr G sent a referral letter for a non-urgent private orthopaedic consultation (a copy of the referral letter from Dr I to Dr J had not been received by the Medical Centre at this stage).

The Medical Centre defended Dr G's decision to send a non-urgent (rather than urgent) referral letter:

> "A report on the 23 October 2007 from the Rheumatology unit advised that [Dr I], Rheumatologist had already initiated a referral to [Mr T] Orthopaedic Surgeon, Palmerston North Hospital. This information had not been received at [the Medical Centre] at the time of the consultation on the 25/10/2007 and therefore [Dr G] gave the [patient] the option of going private to try and speed the referral process up as the public system can be slow at times due to

[16] Narrowing of the spinal canal in the neck region.
[17] Dysfunction of the spinal cord.

> demand. As the patient had already been referred and treatment was completed on the 8/11/2007 our Doctor did not cause any undue delays in the process as referring her up to the hospital immediately would not have [sped] the process up based on the information that the hospital already had in the system regarding her medical condition."

29 October 2007
Mrs A was seen by Dr J, who discussed with her the need for surgery to prevent further deterioration. Dr J wrote to Dr I (with a copy to Dr B) informing her that Mrs A would be undergoing surgery on 8 November 2007. The letter detailed the surgery and Dr J's guarded prognosis for recovery of neurological function. This letter was received by the Medical Centre on 6 November 2007.

8 November 2007 onwards
Mrs A underwent cervical decompression surgery on 8 November 2007. On 15 November Mrs A transferred her care to another medical practice. Mrs A continues to suffer neurological symptoms, including urinary incontinence, and is no longer able to work.

The Medical Centre explained that the letter from Dr J advising of Mrs A's upcoming surgery was dated 29 October 2007 and was received by the Medical Centre on 6 November 2007. The letter was scanned into an inbox that was no longer in use on 8 November and did not get allocated to Dr B's inbox until 17 November.

Accident Compensation Corporation claim

Mrs A's claim to the Accident Compensation Corporation was accepted in April 2008 as treatment injury, specified as "urinary incontinence and sensory disturbance on left side of the body, left leg and left foot and residual weakness in lower limbs due to delay in diagnosis and treatment for C5/6 cervical disc protrusion and myelopathy". ACC relied on external advice from two general practitioners in accepting the claim as treatment injury.

Dr Niall Holland advised ACC:

> "Clearly significant symptoms were present when [Mrs A] was seen by [Dr I] the rheumatologist. None of the records available to me indicate that the general practitioners had tested for or detected the hyper-reflexia, clonus or leg weakness that was apparent to [Dr I]."

Dr Ian St George advised ACC:

> "Although this would be a rare presentation in general practice the diagnosis should have been suspected earlier, and appropriate referral made."

The Medical Centre's responses

General response

The Medical Centre was supplied with a copy of Mrs A's complaint, together with the initial clinical advice obtained from general practitioner Dr Stuart Tiller (see **Appendix 1**). The Medical Centre responded that the complaint, together with Dr Tiller's advice, had been reviewed at its regular peer support meeting and the Medical Centre had undertaken an "Analysis of Event" report (the report).

Analysis of Event report

In relation to the consultations on 25 March 2007 and 6 May 2007, the report concluded that "both consultations provided good clinical notes and examination, [advice] on treatment provided, medication provided …". This analysis was undertaken by the practice co-coordinator, Ms H.

In relation to the 27 July consultation, the Medical Centre stated that "a fuller examination should have been provided and consideration of referred pain from the neck … should have been explored".

The report notes that the records from 20 August "are not of the standard expected — lacking detail of consultation/examination of patient and [advice] or discussion regarding care and treatment".

The Medical Centre acknowledged that the notes of the 27 August consultation were "not of a good standard" and intended to address this issue by "copying and pasting the relevant information from the referral letter into the clinical notes in the future".

In relation to the consultation on 19 September, "clinical documentation is below that expected ... However Dr B could not provide any further clinical diagnosis until [Mrs A] had been seen by the specialist and [the specialist's] report had been received."

The Medical Centre explained its lack of contact with Mrs A around the time of her surgery on 8 November 2007 in its "Analysis of Event" report. The Medical Centre advised that it was partly due to human error (the letter was scanned into an inbox that was no longer in use), and partly due to technical problems that meant correspondence was not received in a timely fashion. The Medical Centre reported that it was addressing the "human error" factor through continuous training. In relation to the technical problems, it has informed Medtech, but has had "limited success to date". In the meantime, the Medical Centre advised that reception staff have been asked to routinely check and reallocate correspondence, and nursing staff are now required to review correspondence to ensure results and reports needing urgent medical input are viewed by the correct doctor in a timely fashion.

The Medical Centre noted, however, that even if these technical issues are rectified, pre- or postoperative contact is often impossible owing to the realities of the primary and secondary care interface:

> "While it would be ideal [to contact patients around the time of surgery] in many cases it is unrealistic to achieve, especially with patients receiving care in the public sector, due to the fact that generally the treating GP is rarely informed of the actual date for surgery. In the correspondence received for [Mrs A] prior to surgery, there was no date mentioned for surgery, and the only notification of surgery was received some time after the event — the delay also being compounded by the acknowledged technical issues outlined elsewhere in this response. The fact that [Dr B] did not phone the patient regarding surgery is not indicative of a lack of good care; he did not contact her because he was unaware she was having surgery. Contacting a patient is a nice personal touch which we encourage our staff to do if they are aware of a surgery date."

Actions taken

The Medical Centre advised that, in March 2007 (prior to these events), it had created a new role of Clinical Director to improve the quality of care at the practice. Dr C was appointed to this role and since then he has undertaken ongoing reviews and developed several new protocols including protocols for booking appointments, following up test results/reports, handling of incoming correspondence and improving patient notes. (The details of each protocol are outlined below.) The Medical Centre stated that it would be providing feedback to its staff on a regular basis on the "critical clinical indicators for quality care", with a particular emphasis on best practice for documentation of consultation notes.

The Medical Centre also advised that the following steps had been taken to improve the quality of care for patients:

(1) as of April 2007, it holds regular meetings for doctors employed at the Medical Centre to discuss concerns about patient management, documentation of patient notes, and new protocols;

(2) education sessions and relevant continuing medical education (CME) opportunities have been made available to staff;

(3) doctors are encouraged to regularly seek second opinions from other doctors; and

(4) a communication book for each team has been introduced to keep staff up-to-date with daily practice events.

Continuity of care

The Medical Centre noted that Mrs A's complaint "highlights the need for all of us to work as a team for the benefit of our patients. As such we have made improvements to our processes." The Medical Centre informed Mrs A that it had discussed the complaint at its in-house peer support meeting to ensure staff work in a more efficient patient-focused way in the future.

The Medical Centre reiterated: "The aim of the Practice has always been for the patient to see their preferred GP. However, one third of the patients presenting to [the

Medical Centre] are actually casual patients, ie most likely registered/enrolled at another practice and they present to [the Medical Centre] because their own GP is not available." The Medical Centre advised that, in circumstances where patients opt to see a different doctor from their regular doctor (such as Mrs A chose to do on a number of occasions), its patient management system allows for sharing of information and "ensures that all GPs and nurses have access to our patient's clinical notes and can therefore review all current and previous notes to assist with the ongoing management of care and diagnosis".

The Medical Centre further advised that, since these events, the front page of Medtech had been modified so that a summary of all the patient's conditions, medications, allergies, and preventative care can be viewed on one screen.

Clinical documentation

The Medical Centre accepts that the standard of clinical documentation by some of its doctors was below an acceptable standard. It stated that lack of detail in the case notes "could impair continuity of care" and, in Mrs A's case this, together with the failure by some doctors to adhere to continuity of care policies, "resulted in a lost opportunity to build a picture about [Mrs A's] presentation and therefore potentially interfered with continuity of care".

Since these events the Medical Centre has introduced an auditing system to monitor clinical documentation:

> "[Clinical documentation] will now be audited on a monthly basis until such time as standards are consistently met by all general practitioners and practice nurses at [the Medical Centre] … Initial monthly auditing will be done for a period of 6 months and reporting of results provided to staff monthly. When criteria [are] not met corrective action will be initiated and monitored with each staff member or administration area."

Cornerstone Accreditation and Accident & Medical Accreditation

The Medical Centre advised that since these events it has obtained Accident and Medical accreditation[18] and Cornerstone accreditation.[19] The Medical Centre advised that it has since changed its focus away from A&M to general practice in order to attain Cornerstone Accreditation, which involves auditing of notes and changing systems to comply with standards set by the Royal New Zealand College of General

[18] Accident and Medical accreditation demonstrates that an accident and medical clinic has met criteria in the Accident and Medical Clinic Standard. Accident and medical clinics seeking accreditation are responsible for having systems in place to monitor adherence to the Standard. In addition to internal processes, an approved external accreditation body audits Accident and Medical Clinics to verify adherence to this Standard. Accident and Medical Clinics that meet, or exceed, the agreed standards are endorsed by ACC.

[19] Cornerstone accreditation is a programme specifically designed by the Royal New Zealand College of General Practitioners to improve the quality provided by general practices in New Zealand to patients by setting standards relating to practice systems, practice and patient information management, quality improvement and professional development.

Practitioners (RNZCGP). While accreditation does not ensure ongoing compliance, the Medical Centre stated:

> "[We] consider that any accreditation process initially provides benchmarks for service standards that must be met, however it is an ongoing journey to continually work towards and maintain … Both Cornerstone Accreditation and Accident and Medical Accreditation, through contracted independent auditors, require proof that ongoing monitoring is maintained, corrective action initiated if the criterion is not met and ongoing staff education and commitment to Continuous Quality Improvement."

Dr B's response

Dr B defended the care provided by him to Mrs A. He stated that his care was of a "very high standard despite the lack of notes in the clinical consultation screen" and that his actions were clinically appropriate. He advised that he "care[s] about all his patients and deeply empathise[s] with what [Mrs A] has gone through". He "now always takes accurate and full notes in the consultation screen".

Dr D's response

Dr D advised that he has resigned from the Medical Centre. He has been working in a three-doctor general practice and has had two visits by assessors from the RNZCGP where his notes, management records and lab results have been audited. He has completed two self-audits of his consultation notes and submitted them to the RNZCGP.

Mrs A's response

Mrs A commented on the Medical Centre's response to her complaint as follows:

> "The staff turnover at The Palms must be huge as there are always new doctors in there all the time.
>
> When I first started this complaint all I wanted was for them to realise that they can't fob people off, but now with the letter that they sent me saying how they were sorry [about] what had happened to me, [Dr B] has no idea of what I have to put up with now as he never contacted me at all from the time he referred me to [Dr J]. (Out of sight out of mind.)
>
> I have gone from a fit 43 [year old] woman playing sport etc. to a 43 [year old] woman who is incontinent, numb from under my left arm down to the rest of my side, hyporeflexia in my left leg. I had to change jobs and now have no career options as I couldn't physically do the job to its full capacity.
>
> I go through stages where I am angry because of what's happened to me.
>
> It has changed my whole life for the worse, financially, emotionally and physically."

Mrs A also commented:

> "I don't want what happened to me to happen to other people.
>
> But the doctors can't treat people like this. They're too busy making money. People need to make sure that they don't get fobbed off like this, when they know something's wrong."

Opinion: Breach — The Palms Medical Centre Ltd

Introduction
Between March and October 2007, Mrs A consulted doctors at the Medical Centre eight times. Seven of the consultations related to shoulder pain, and involved her seeing five different doctors at the Medical Centre. After referrals to a rheumatologist and an orthopaedic surgeon, Mrs A was diagnosed with cervical stenosis with myelopathy on 19 October 2007.

Mrs A was suffering from a rare condition.[20] My expert advisor, Dr Carey-Smith, noted that "diagnosis in this type of situation is difficult". I acknowledge that, even if Mrs A had been diagnosed earlier, it cannot be determined that she would have undergone surgery any sooner or the outcome for her would have been any different. My concern is that the Medical Centre's systems did not ensure that Mrs A was provided with good quality, well co-ordinated care.

Like all patients, Mrs A was entitled to services provided with reasonable care and skill.[21] She was also entitled to co-operation amongst the doctors at the Medical Centre to ensure quality and continuity of services.[22] The Medical Centre provides Accident and Medical (A&M) services as well as general practice services for its patients. A&M services are generally one-off consultations and involve acute medical problems, while general practice services are intended to provide ongoing primary medical care. The Medical Centre advised that it has "faced some challenges in the past in providing the service that we want to provide in Palmerston North [as there is] a chronic shortage of GPs". The Medical Centre explained that several of the doctors who saw Mrs A were locums. None of the six doctors Mrs A saw at the Medical Centre was vocationally registered as a general practitioner.

The size and structure of the Medical Centre makes it likely that patients with ongoing problems will be seen by a number of different doctors. It is therefore vital that processes are in place to ensure that patients who are attending for general practice care (rather than A&M services) are provided with continuity of care. Mrs A was

[20] ACC expert advisor Dr Ian St George noted that "this would be a rare presentation in general practice in such a young person …".
[21] Right 4(1) of the Code of the Health and Disability Services Consumers' Rights (the Code).
[22] Right 4(5) of the Code.

registered with the Medical Centre as her primary care provider. This meant that the Medical Centre was responsible for the provision of continuity of care for Mrs A and for the management of her health problems.

The Medical Centre had a responsibility to have good systems in place to ensure patients received good quality care, and were not disadvantaged by the number of doctors involved in their care. In particular, it was responsible for having effective policies for the handling of incoming reports and results, patient follow-up, and delegation of responsibilities amongst doctors. In my view, the Medical Centre failed to provide Mrs A with good quality, well co-ordinated care and therefore breached the Code of Health and Disability Services Consumers' Rights (the Code). The detailed reasons for my opinion are set out below.

Continuity of care

Follow-up of results
Dr Carey-Smith advised that doctors at the Medical Centre did not appropriately follow up investigations ordered and incoming results.[23]

Concerning the X-ray ordered by Dr D on 6 May 2007, but not performed until 9 July 2007, Dr Carey-Smith noted:

> "It appears that two months elapsed before the X-ray was done, and ideally in this situation an 'alert' or recall should alert the doctor that no report had been received in a reasonable time."

In its response, the Medical Centre advised that "[s]ome GPs at [the Medical Centre] have not made use of [the alert] facility correctly until recently … There are some technical issues with Med[t]ech which make the follow up of patient test results more problematic." The Medical Centre acknowledged that these explain, but do not excuse, the delay in reviewing Mrs A's X-ray result.[24]

Dr Carey-Smith also criticised the lack of follow-up arrangements after Mrs A's blood test results were delivered to Dr B's inbox following her appointment at the second medical practice on 8 August. Despite the results containing a note "review in a week", no arrangements were made by Dr B to do so. Dr Carey-Smith advised:

[23] I note that this is not the first time the Medical Centre has been criticised for similar omissions. In a previous case I found the Medical Centre, and a doctor employed by it, in breach of Right 6(1)(f) of the Code for failing to notify a patient of his test results in 2002 (Case 02HDC18949). The Medical Centre has also been the subject of adverse comment by HDC on a further two occasions: for failure to follow up abnormal test results in 2003, and for poor communication with a patient after a failed vasectomy procedure in 2005.

[24] However, the Medical Centre noted that the usefulness of the alert system was limited "… where outpatient department waits can be at least [three] and up to 12 months … Such long delays mean that over time the accumulation of many outstanding items makes the task bar less useful. It is also important to note that especially with referral letters, the Practice does not receive consistent notification about appointments, so consequently the requesting GP does not know when or if the patient has received an appointment."

> "In view of the symptoms and signs reported, ideally [Dr B] should have ensured follow-up arrangements were in place, as well as arranging for review of the abnormal lymphocytosis, mildly elevated CRP, and thyroid tests … The lack of … indication of further action by [Dr B] constitutes mildly below-standard care."

Dr Carey-Smith advised that, while some responsibility lay with the second medical practice for ensuring adequate follow-up arrangements were in place, "if a patient is seen by another provider who forwards results to the usual GP, both parties should take responsibility to ensure action has been taken on abnormal results". Given that there was ambiguity as to who was following up Mrs A in a week's time, Dr B had a responsibility (as did the second medical practice) to ensure action had been taken.

In response, the Medical Centre argued that "the treating doctor has the duty of care and responsibility to follow up their own investigations". That is an oversimplification of the legal position. 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.

In relation to Mrs A's consultations with him in August, Dr B advised that he would have referred Mrs A for an MRI scan at this point but this was not possible as she did not have any health insurance and could not afford tests privately. However, Dr Carey-Smith advised that, as no examination findings were recorded in the notes and there were no "red flags" evident, he "[can] see no clinical indication for ordering [a CT/MRI scan] at the August consultations unless objective neurological deficit had been found".

Dr Carey-Smith also criticised the Medical Centre for its inadequate follow-up once Mrs A's rheumatology results were delivered to Dr B's inbox on 19 October 2007. While the primary responsibility for follow-up lay with the ordering doctor (rheumatologist Dr I), he advised that in these circumstances (where there was a serious abnormal result, and it was not known at that point that an appropriate surgical referral had been made) the Medical Centre should have ensured action was being taken. As Dr B was away, the results sat in his inbox until Mrs A contacted the Medical Centre for her results on 25 October 2007.

Although the Medical Centre had a policy in place that required doctors to delegate the responsibility to check their inbox while away, this did not happen in Mrs A's case. The Medical Centre has explained that this was due to a technical glitch with the Medtech system (discovered in November 2008). The "software switch" used to divert the contents of one doctor's inbox to another did not function correctly, meaning some (non-MedLab) incoming reports or letters were not diverted to the covering doctor's inbox. Clearly, the system in place during this period to ensure that a covering doctor received all incoming reports and results was not adequate to ensure appropriate follow-up of significant results.

My initial advisor, Dr Tiller, was critical of Dr G's actions at the 25 October consultation. He advised that, given the serious condition that had been identified by MRI scan and the seriousness of Mrs A's symptoms (incontinence, spastic gait) Dr G should have attempted to obtain an orthopaedic appointment within the next 24–48 hours. If an appointment was not available, Dr G should have discussed the situation with the hospital orthopaedic registrar "with a view to urgent same day assessment". Dr Carey-Smith agreed that an emergency admission at this point was indicated, rather than an orthopaedic referral (not even marked urgent).

The Medical Centre argued that because Mrs A had been referred to a specialist, initial recall regarding follow-up of results should have been the responsibility of the treating specialist (who should then refer to the appropriate services for treatment).[25] As noted above, unbeknown to Dr G at the time, Dr I had already referred Mrs A to Dr J (orthopaedic surgeon) and therefore no delay was caused by Dr G's decision.

Although the primary responsibility for following up the results of tests ordered in hospital lies with the clinician who ordered the test, where the results are reported to a general practitioner, that practitioner has a residual responsibility to check whether any significant abnormality that clearly needs follow-up has been followed up. I accept Dr Carey-Smith's opinion that Dr G still owed Mrs A a duty of care in these circumstances, particularly where there had been a progression or change in the clinical situation (in this case, apparent deterioration in neurological status). Dr G failed to make an urgent referral of Mrs A to hospital or follow up with the hospital specialists to check whether the rheumatologist had already made a referral.

Contact with patient

Dr Carey-Smith also criticised the lack of pre- and postoperative communication with Mrs A by the Medical Centre. He agreed with Dr Tiller's view that "a concerned general practitioner would have contacted his patient to offer support and ensure arrangements were in place". The Medical Centre pointed to the primary and secondary care interface and stated that in many cases it is "unrealistic" to expect the Medical Centre to contact patients before surgery (particularly where patients are receiving care in the public sector, "due to the fact that generally the treating GP is rarely informed of the actual date for surgery"). The Medical Centre also pointed to the technical issues with receiving results and that Dr B did not phone the patient because he was unaware she was having surgery. In its view, contacting a patient "is a nice personal touch which we encourage our staff to do if they are aware of a surgery date".

As outlined above, the technical issues the Medical Centre experienced with forwarding patient results to covering doctors goes some way to explaining the lack of follow-up with Mrs A around the time of her surgery. However, doctors at the Medical Centre were aware of Mrs A's concerning results (including, at the end of October, the results of her MRI scan) and were informed (by late November, at the latest) about her major surgery. In these circumstances, I accept Dr Tiller and Dr

[25] The Medical Centre also does not believe that Dr G should be criticised because there was a delay in the hospital staff acting on the MRI results.

Carey-Smith's advice that some contact with the patient would be expected. In my view, this lack of contact is symptomatic of the lack of continuity of care provided by the Medical Centre to Mrs A.

Patient responsibility

Dr B accepts that he had overall responsibility for Mrs A's care for eight years, and notes that the Medical Centre strongly advised its patients to return to their regular doctor. The Medical Centre submitted 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.[26]

I have been provided with 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.

Conclusion

In my view, the quality and continuity of Mrs A's care was jeopardised by the failure of several doctors at the Medical Centre to take a holistic approach to Mrs A's care. Mrs A attended the Medical Centre for primary medical care, but on a number of occasions the doctors took an "episodic" approach to her care. As Dr Carey-Smith commented:

> "[T]he consultation approach portrayed in several of the consultations is more akin to an A&M clinic dealing with acute problems, than to a general practice responsible for ongoing clinical care."

Dr Carey-Smith commented that the Medical Centre's policies regarding continuity of care were generally adequate but that they "lack clear mention of systems for managing deputising of care and incoming reports/results". He suggested that a policy for ensuring clinical responsibility for patients with chronic problems lies with one specific clinician would be appropriate for a practice like the Medical Centre.

Dr Carey-Smith summarised his view of the standard of care Mrs A received at the Medical Centre:

> "The overall standard of care provided to [Mrs A] by The Palms over the period in question showed variable quality, ranging from thorough consultations with good documentation, to substandard care … Practice systems are satisfactory. However, continuity of care is reduced because of the

[26] The Medical Centre also pointed to other providers who it believed should also be held accountable for the role they played in Mrs A's care. In particular, the second medical practice (in relation to the two appointments Mrs A had there on 8 August 2007 and 14 August 2007) and the rheumatology specialist at Palmerston North Hospital.

> practice size and structure, the number and seemingly transitory nature of doctors employed and the lack of a specific clinician with overall responsibility for care of the patient. I consider that, for such a practice, systems for ensuring continuity for patients with chronic problems, and dealing with incoming documents, are mildly deficient. Patient care appears to be largely episodic and focussed only on the presenting problem."

Dr Tiller was similarly critical of the discontinuity of care experienced by Mrs A. He stated:

> "It is my view that integral to general practice is the provision of continuity of care through the teamwork of the doctor and the practice nurses. When the usual general practitioner is absent, it is expected that a colleague or locum would continue to provide continuity according to the current direction and management plan of the clinical computer record. Where multiple doctors provide care and a specific 'owner' doctor is not nominated, it is expected that the team of primary care doctors would provide that continuity. It appears to me that a team of doctors were providing general practice care to [Mrs A] and that no one doctor was clearly nominated as her general practitioner. It is my view that it was incumbent on that team of doctors to ensure continuity of care for [Mrs A].
>
> …
>
> Whether she obtained a regular appointment with a doctor of her choice, or obtained a 'walk in' appointment, it is my view that she was entitled to continuity of care from whichever doctor she consulted."

Documentation

Mrs A's care was jeopardised by the poor standard of documentation of her consultations on several occasions. Given the structure of the Medical Centre, it is vital that a detailed and clear record of the history, examination, assessment and management plan of each consultation is documented, in order to assist other doctors at the Medical Centre to provide continuity of care to the patient. As Dr Carey-Smith notes:

> "When multiple doctors are involved, full and accurate records become even more important. For example, if there is no record of history and/or examination, a subsequent doctor will be obliged to assume these have not been done, and forced (sometimes unnecessarily) to repeat them."

Similarly, if accurate and detailed records of consultations are not kept, care becomes fragmented and ongoing problems are not resolved. As noted by Dr Tiller:

> "Fundamental to general practice care is continuity. In this regard the clinical records are critical because they should provide an indication of the current and ongoing management plan so that any subsequent doctor can peruse the

> preceding treatment events and continue the management in a systematic and progressive manner, leading to a diagnostic and therapeutic conclusion."

In this case Dr Carey-Smith pointed out that the clinical records made by several of the doctors at the Medical Centre fell below expected standards. For instance, Dr D's clinical records of the consultation that took place on 6 May 2007 are regarded by Dr Carey-Smith as inadequate.

Of particular concern are the deficits in Dr B's clinical records for the consultation on 20 August 2007 and the lack of any record of the consultation that apparently took place on 27 August 2007 — considered to be "poor practice" by Dr Carey-Smith. Dr B argued that details of the consultation could have been accessed by colleagues if required because he had noted "referral done to orthopaedic surgeon". He suggested that, if another doctor was looking at this consultation, he or she could have a look at the referral letter to get a full picture of what happened during that consultation. However, Dr Carey-Smith notes that Dr B's referral letter "[does] not constitute a full record of the consultation" and, due to the deficiencies in Dr B's recordings, "it is impossible to confirm all the areas covered and actions taken".

Dr B's clinical records for the consultation on 19 September 2007 (when a diagnosis of "depression due to mental illness" was made despite no record of a mental health assessment) were also regarded by Dr Carey-Smith as "below standard". Dr Carey-Smith does not accept Dr B's argument that the immediate well-being of patients excuses poor records as "these can always be completed after the consultation if necessary, even if the situation is an emergency (not the case for this consultation)".

The Medical Centre advised that it has a patient management system that allows all doctors and nurses to have access to all the patients' clinical notes "to assist with the ongoing management of care and diagnosis". However, such a system is of little use if the notes from the consultation lack detail or the consultation is not documented at all. It is concerning that the Medical Centre had no system for identifying when documentation by its staff was inadequate.

The Medical Centre has acknowledged that Mrs A's complaint highlighted a number of deficiencies in its systems relating to patient follow-up, handling of inwards correspondence, and documentation, but considers that its clinical management of Mrs A was appropriate. In its view, adequate assessments were carried out and appropriate steps were taken by its doctors. The Medical Centre is also concerned that its doctors should not be labelled incompetent just because of the limited documentation. It argues that, whether the history and examination at each consultation was adequate, cannot be proven "due to a lack of documentation".

Sketchy consultation notes make it difficult to confirm the facts of a case and determine whether an appropriate standard of care was provided at each consultation. The treatment recommended by the doctors may well have been adequate. However, this investigation has considered the overall appropriateness of the care provided to Mrs A by the Medical Centre, particularly the processes and policies in place to ensure patients attending the Medical Centre were provided with continuity of care.

While individual doctors' conduct has been commented on where relevant to the Medical Centre's responsibilities, no individual doctor has been investigated. I will, however, send a copy of this report to the Medical Council of New Zealand with a recommendation that it consider whether any of the doctors seen by Mrs A at the Medical Centre should undergo a competence review.

Summary

All medical centres have a responsibility to ensure that quality of care is not compromised for patients with chronic problems. Mrs A's experience is a graphic illustration of what happens when a patient attends a large franchise operation where multiple doctors provide episodic care but no single doctor takes overall responsibility. It 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.

In my view, the Medical Centre failed to provide Mrs A with an appropriate standard of care in several respects. The Medical Centre's policies were inadequate to ensure that it delivered continuity of care to a patient who required multiple consultations. For instance, the policies concerning the management of incoming reports and test results, delegation of doctors' responsibilities, and patient handover and follow-up were deficient and potentially caused delays in diagnosis and treatment. Documentation of consultations was often of a poor standard, providing little or no assistance to doctors at subsequent consultations. Communication with Mrs A was infrequent and demonstrated a relaxed attitude towards continuity of care. These are serious defects. Mrs A received fragmented, poor quality general practice care. I note again that none of the doctors she saw at the Medical Centre was vocationally registered as a general practitioner.

One has to ask, "Is this as good as it gets?" In my view, 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.[27]

I conclude that The Palms Medical Centre failed to provide Mrs A with services with reasonable care and skill, and failed to ensure continuity of care, and therefore breached Rights 4(1) and 4(5) of the Code.

Comment from Radius Health Group Ltd

Radius Health Group Ltd (the owner of the company that franchises the Medical Centre) denies any responsibility for the problems encountered by Mrs A at the Medical Centre. It submitted:

> "While Radius Health Group Limited ('Radius') provides the various policies and procedures to the [Medical Centre] (and many other centres), it does not

[27] I note that the MidCentral DHB has been singled out for praise for its development of primary health care (speech from Minister of Health, "Primary Care Implementation: Next Steps", 12 September 2008). This case suggests that more work may be needed.

manage or control the implementation of those policies and procedures. The [Medical Centre] has its own shareholders and independent board of directors. It has a practice manager, clinical director, managing director and a nurse manager, none of whom are accountable to Radius …

… The problems that arose … were all at the clinical level, but had the policies and procedures provided by Radius been adhered to, we are certain that [Mrs A] would never have had to experience the level of care that she did and may have been correctly diagnosed much earlier."

"We are of course deeply saddened to hear of [Mrs A's] experience and we are sure that a valuable lesson has been learned from this situation arising …"

Actions taken

In response to this case, the Medical Centre made a number of improvements. It has implemented a number of new policies and is monitoring compliance with new and existing policies (as outlined on pages 9–10). The Medical Centre provided a summary of the specific steps it has taken in order to improve the quality of care for its patients:

(1) Introduced a new protocol whereby each enrolled patient will have a preferred provider at the Medical Centre who is responsible for that patient's care (however, other doctors involved in the patient's care will remain responsible for any management that they institute). In the event the preferred provider is away, either the doctor in question or the Practice Manager is to arrange cover for that doctor's inbox.

(2) Requested assistance from the RNZCGP to help it identify how continuity of care could be better achieved.[28]

(3) Implemented systems to encourage closer working relationships within the medical team so the practice nurse can assist with the management of patients. For example, the nurse triages all walk-in patients, and it has regular team meetings (with a medical representative at the nurses' meetings and a nurse representative at the doctors' meetings).

(4) Implemented a new protocol for booking appointments, which takes into consideration a number of factors including the urgency of the patient's needs, whether the patient is registered at the Medical Centre or another practice, and whether the patient has a preference to be seen by a particular doctor. Once the doctors are fully booked and the walk-in queue reaches a certain point, patients are referred to Palmerston North Hospital's Emergency Department. In addition, doctors are not allowed to be double-booked unless permission is given from the individual doctor. The Medical Centre acknowledged that, at the time of these

[28] The Medical Centre advised that the RNZCGP has agreed to assist in this respect.

events, its appointment system meant that patients were not turned away, thereby creating "enormous pressure on the doctors to see patients quickly". The new appointment booking protocol should result in a significant reduction in workloads of individual doctors. Patients are also now able to make an appointment request online for more than seven days ahead.

(5) Introduced a whiteboard system for handing over patient care and to allow for more effective communication between handovers.

(6) It will ask all doctors to enquire at each consultation if the patient has any unresolved issues, and to review previous recent case note entries or inbox items to see if there are any outstanding issues. It has implemented a prompt to remind doctors to do this at each consultation.[29]

(7) Introduced a new policy in relation to patients who do not attend follow-up appointments where test results are to be discussed. In these cases the receptionists will phone the patient to remind them that the doctor wants to see them to discuss their results.

(8) Every doctor will undergo a formal appraisal with Dr C (the Medical Centre's Clinical Director) over the next 12 months, and any further training or upskilling identified in these appraisals will be implemented.

(9) An external auditor will review all clinical notes to identify any areas where additional training or upskilling is needed.

(10) Quality Health will conduct a surveillance audit of the practice.

It further advised that the Clinical Director:

> " … is involved in a constant process of assessing the clinical competence of the medical practitioners currently working at the Centre and identifying needs for additional training and upskilling … [Dr C] has the opportunity to review other GPs' case notes when he is consulted by patients and he is able to assess the quality of the notes and management plans made. There is the opportunity for staff, particularly nurses and GPs, to approach [Dr C] with any concerns they have about specific patient's care or about current practice protocols. [Dr C] also reads many current journals … and also consults other online evidence based medicine resources. This information is used … for education purposes …"

Three of the Medical Centre's doctors are seeking vocational registration as general practitioners, by enrolling in the registrar training programme to obtain RNZCGP fellowship. One has obtained RNZCGP fellowship and one had completed the equivalent training overseas.[30]

[29] Dr Carey-Smith believes that the reminders and prompts "will assist doctors to develop a more holistic consultation approach" and adds that the system "will be aided if continuity of care improves (consideration of areas other than the presenting problem is more likely if the patient is already known to the doctor)".

[30] Dr Carey-Smith and the RNZCGP recommend that all permanent doctors should have (or be working towards) vocational registration.

These are commendable steps. The steps taken by the Medical Centre to implement the recommendations and improve its systems in order to prevent similar events have been acknowledged by Dr Carey-Smith:

> "The [Medical Centre] is to be complimented for the obvious effort put in to improving practice systems as a result of this case. Clearly the complaint and the Commissioner's report have resulted in significant action to rectify identified issues, and put in place systems to reduce future error. In particular, instituting the position of Clinical Director, systems to improve continuity of care and follow-up referrals and results, and monitor ongoing quality of clinical care, are valuable improvement initiatives. The actions summarised [above] show an excellent grasp of the issues and should help reduce future errors."

Nevertheless, I endorse Dr Carey-Smith's advice that some additional measures need to be taken. Below are my recommendations to the Medical Centre.

Recommendations

Medical Centre
I recommend that the Medical Centre:

1. Advise the Medical Council and HDC by **31 August 2009** of its assessment of the clinical competence of all medical practitioners currently working at the Medical Centre, identifying any needs for additional training or upskilling.

2. Report to HDC on outcomes of discussions with RNZCGP to improve continuity of care, by **31 August 2009**.

3. Report to HDC on the results of the planned external and Quality Health audits, by **30 September 2009.**

4. Review the system for follow-up of patient test results and referrals in light of this report and advise HDC of the outcome of its review by **30 September 2009**.

RNZCGP
I recommend that the Royal New Zealand College of General Practitioners develop and implement, as part of the Cornerstone accreditation programme, a mandatory standard for records whereby any significant, unresolved problem from previous consultations is discussed with the patient, and an acknowledgement made in the notes whether the problem has been resolved or is still under active management.

Follow-up actions

- A copy of this report will be sent to the Medical Council, with a recommendation that it consider whether any of the doctors seen by Mrs A at the Palms Medical Centre should undergo a competence review.

- A copy of this report with details identifying the parties removed, except the experts who advised on this case, the name and location of the Palms Medical Centre Ltd, and the names of Radius Medical Solutions Ltd and Radius Health Group Ltd, will be sent to the Royal NZ College of General Practitioners, the Ministry of Health, the Manawatu Primary Health Organisation, Medtech Global Ltd, the Quality Improvement Committee, all district health boards, the Accident and Medical Practitioners Association, and the New Zealand College of Practice Nurses, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix 1 — Expert advice, general practitioner Dr Stuart Tiller

Initial advice

"Clinical advice.

1. It is my view that it is clear from the clinical records that [Mrs A] attended The Doctors/The Palms, Palmerston North for her general practice care. It is my view that integral to general practice is the provision of continuity of care through the teamwork of the doctor and the practice nurses. When the usual general practitioner is absent, it is expected that a colleague or locum would continue to provide continuity according to the current direction and management plan of the clinical computer record. Where multiple doctors provide care and a specific 'owner' doctor is not nominated, it is expected that the team of primary care doctors would provide that continuity. It appears to me that a team of doctors were providing general practice care to [Mrs A] and that no one doctor was clearly nominated as her general practitioner. It is my view that it was incumbent on that team of doctors to ensure continuity of care for [Mrs A].

2. The Royal New Zealand College of General Practitioners, in their publication, Aiming for excellence, have detailed standards for New Zealand general practice. Criterion D.9.1-6 details the essential standards in relation to clinical record keeping of consultations in general practice. These standards are considered best practice and important by the college. This criterion lists that consultation records should include:

- Patient reason for the encounter
- Examination findings
- Investigations
- Diagnosis and assessment
- Management plans
- Information given to patients
- Medications by indication
- Intermediate clinical outcomes
- Screening and preventive care recommended.

In this regard, it is my view that the consultation record of Dr E dated 9 July 2007, well met these expectations for essential standards of documentation. I do not consider her records of that day to be exceptional, but rather of a good standard that would meet the expectation of the RNZCGP in a random assessment of clinical records for the purposes of Cornerstone accreditation.

The good record of Dr E stands as a standard against which the other [doctors] might be viewed.

My advice upon the care provided to [Mrs A] will be based upon the above two principles.

25 March 2007. [Dr C].
It is my view that an appropriate standard of care was provided and that the management plan was reasonable.

6 May 2007. [Dr D].
I note that six weeks had elapsed from the first consultation. The shoulder pain had improved with chiropractic treatment but had relapsed. [Dr D] wrote that there was "no apparent weakness" but it is unclear whether this comment resulted from patient enquiry or from an examination. If this comment was historical then I would note that no clinical examination was documented. It was necessary to provide a clinical examination and an ongoing provisional diagnosis. These would be required to meet the standard set by the RNZCGP. It was appropriate to undertake an X-ray of the cervical spine for pain that was not settling. [Dr D] did not note what arrangement was made to follow up on the X-ray result.

9 July 2007. [Dr E].
Over two months had elapsed since the previous consultation. [Dr E] took a good and comprehensive history of the shoulder pain including social factors. She documented a thorough examination. Her management plan was clear with advice regarding follow-up. This was care of a good standard.

The same day [Dr D] noted that the cervical spine X-ray result was to hand and that [Mrs A] was aware of the results.

27 July 2007. [Dr F].
Over two more weeks had elapsed. [Dr F] was specifically consulted regarding pleuritic chest pain after a flu-like illness. He provided a focused examination of the respiratory system with negative findings. It is my view that had he been concerned to ensure continuity of care, that his perusal of the previous two consultations might have caused him to consider alternative differential diagnoses such as whether this pleuritic chest pain might be a reflection of some other condition, including referred pain from the shoulder or cervical spine.

8+9 August 2007. [Dr B].
[Dr B] would have realised that [Mrs A] had consulted another doctor, perhaps for a second opinion. The TSH blood result suggested that [Mrs A] might be slightly under-replaced with thyroid hormone. He should have made a computer alert entry for the benefit of whichever doctor was subsequently asked to prescribe thyroxine for [Mrs A]. It is my view that many 'owner' general practitioners when receiving a copy of a consultation and blood tests from another GP, would telephone their patient to establish contact, indicate interest and commitment to continuity of care, and make himself available for

comment. [Dr B] took none of these actions. It is my view that the actions of [Dr B] fell mildly below the usual standard for a doctor providing general practice level care.

17 August 2007. [Dr B].
[Dr B] was asked to provide a repeat prescription for thyroxine. Although he had seen the mildly elevated TSH result the week previously, he made no comment in this regard and prescribed thyroxine at an unmodified dosage. He did not make any entry to indicate that he would repeat the TSH in three months. It is my view that failure to attend to this 'minor' matter of care indicated a careless attitude to continuity and standards of care.

20 August 2007. [Dr B].
It is unclear how [Dr B] was aware of the fact that the 'numbness in the shoulders persists'. He, appropriately, made an orthopaedic referral.

If [Dr B] consulted with [Mrs A] on this day, then it would be my view that his documentation was seriously deficient. There was inadequate history of the progress of the illness now of five months' duration and no clinical examination was documented. It is unclear whether [Mrs A] was involved in the decision making regarding orthopaedic referral. The referral letter contained information that is not in the clinical records.

27+28 August 2007. [Dr B].
[Dr B] was now in receipt of elevated tissue auto-antibody results. He decided that a rheumatology referral was more appropriate and sent this referral, ordered repeat blood tests for one month, and requested his nurse to recall [Mrs A] for review and presumably discussion. This was appropriate care.

19 September 2007. [Dr B].
The only consultation record for this day was, 'depression due to chronic illness. Treat.' Fluoxetine was prescribed. It is my view that these notes were significantly below an acceptable standard for a doctor providing a general practice level of care for the first management of a new diagnosis of acute depressive illness. No followup or safety net advice was documented.

18+19 October 2007. Dr HBHS[31] and [Dr B].
Important diagnostic information was received that indicated the serious nature of [Mrs A's] condition. Neither doctor indicated sufficient interest to contact her to express their concern for her, to ensure that ongoing specialist

[31] The Medical Centre advised that "HBHS" was not a person but the name of an inbox that was automatically created when a new appointment calendar was created for a clinic. I have written to the software developer alerting it to the problem, and requesting it consider how it can be fixed.

care was in place and to fulfil their role as primary care general practice providers. It is my view that many, if not most, general practitioners would make the time to telephone a patient in such circumstances. The failure to do so, I would view as a moderate departure from general practice standards.

25 October 2007. [Dr G].
[Mrs A] phoned in for her MRI scan result but was advised that she must collect a copy of this from a nurse. When [Mrs A] attended she was seen by [Dr G]. [Dr G] reviewed the clinical history over the previous seven months. She discussed the possibility of private referral to an orthopaedic surgeon under ACC funding. [Dr G] sent a letter to a private orthopaedic clinic. It is my view that the action of [Dr G] was a serious departure from an acceptable standard for a general practitioner given the serious condition that had been identified by MRI scanning and the serious symptoms of [Mrs A], who was experiencing incontinence, had a spastic gait and could barely write her name. The appropriate general practice action was for [Dr G] to telephone and obtain an orthopaedic appointment within the next 24–48 hours. Failing the availability of this, she should have discussed the situation with the Palmerston North orthopaedic registrar on duty, with a view to urgent same day assessment and possible admission for surgery at the earliest.

7 November 2007. [Dr B].
[Dr J], the orthopaedic surgeon, had written detailing the surgery and his guarded prognosis for recovery of neurological function. It is my view that [Dr B] should have rung [Mrs A] to wish her well with the surgery which held significant risk, and to express regret that his clinic had been unable to reach an earlier diagnosis. His failure to do so was at least a mild departure from expected standards for a doctor providing general practice level care."

Further advice

"Thank you for your note requesting that I review the response from Radius Medical dated 24 June 2008.

There is also a letter of apology to [Mrs A] on file. This letter was written by [Dr B] on 22 June 2008.

Clinical comment.

[Dr B] has apologised for the delay in diagnosis of the cervical disc prolapse. He has also apologised for his failure to follow up with a telephone call when the serious diagnosis became apparent from investigations undertaken by other providers, or around the time of the corrective surgery.

[Dr B] has indicated that his practice has recently undergone the audit review required for the RNZCGP Cornerstone accreditation. He anticipates that this will result in improved systems and processes.

He has acknowledged the need 'for all of us to work as a team for the benefit of our patients'. This particular case has been discussed at a regular in-house Peer support meeting.

[Dr B] has not acknowledged my view that [Mrs A] was attending Radius the Palms, for her general practice care. He has indicated that with their large and busy patient base it is not reasonable to expect follow-up with courtesy telephone calls. It remains my view that for a general practice patient such as [Mrs A], this is an expected standard to ensure continuity of care.

It is my view that adherence to the standards established by the RNZCGP Cornerstone accreditation process should be monitored, lest the busyness of a 16,000 patient base practice result in a fall back to the deficiencies identified by this complaint."

Subsequent advice

"Thank you for the request that I review the further response dated 8 September 2008, from [Dr B] medical director of the Radius Palms medical centre.

Background.

On 5 August 2008 the Commissioner advised [Dr B] 'I am not satisfied that the gravity of this complaint has been acknowledged, and I am therefore concerned about a recurrence. I am particularly concerned about how you will ensure continuity of care for patients seeing multiple doctors at Radius Medical in light of [Mrs A's] experience. Your response will need to convince me that a formal investigation is not necessary, by explicitly identifying how further issues like those faced by [Mrs A] will be prevented.'

The crux of my earlier clinical advice was based upon the premise that [Mrs A] was presenting repeatedly with the same progressive clinical illness to Radius Palms with whom she was a registered patient. Whether she obtained a regular appointment with a doctor of her choice, or obtained a 'walk in' appointment, it is my view that she was entitled to continuity of care from whichever doctor she consulted. Fundamental to general practice care is continuity. In this regard the clinical records are critical because they should provide an indication of the current and ongoing management plan so that any subsequent doctor can peruse the preceding treatment events and continue the management in a systematic and progressive manner, leading to a diagnostic and therapeutic conclusion.

The response [of] [Dr B].

- We have completed the Cornerstone accreditation process of the RNZCGP.
- We have achieved accreditation of our accident and medical practice.

- [Dr B] has commenced the educative process which leads to the granting of the Fellowship of the RNZCGP.
- CQI monitoring of staff and systems and clinical records will be ongoing.
- We are working on different ways to utilise the services of practice nurses and other support staff to provide continuity of service.

Practice coordinator [Ms H] has undertaken an analysis of the care provided to [Mrs A] [and concluded]: 'Delays in treatment and diagnosis were hampered due to extended periods between appointments, treatment provided by other medical professionals outside the practice, presenting symptoms pointed towards a diagnosis of carpal tunnel syndrome, X-ray results being normal, reports from other GPs and results not being seen within a period of 72 hours. Results being transmitted to an in-box that was no longer in use meant that results were not seen in a timely manner — this has now been rectified'.

Clinical advice.

It is my view that none of the actions listed by [Dr B] and [Ms H] address the very clear statement of the Commissioner that 'I am particularly concerned about how you will ensure continuity of care for patients seeing multiple doctors at Radius Medical in light of [Mrs A's] experience'.

- Cornerstone accreditation ensures that systems considered necessary by the RNZCGP are in place at the given time of audit. It does not ensure ongoing compliance. I note that [Dr B] has advised that Radius Palms will continue its own internal process of ongoing audit review.
- Accreditation as an A+M practice may create internal confusion for staff regarding the requirement for provision of continuity of care to patients presenting repeatedly with an ongoing clinical illness. A+M practice is usually focused upon quality management of one acute accidental or medical event at one point in time. This style of practice significantly differs from that required by general practice. A core value of general practice care is continuity over time for chronic illness or ongoing illness requiring more than a once only intervention.
- I would expect the educative process of the Fellowship of the RNZCGP would enable [Dr B] to gain a better understanding of the nature of general practice, in distinction from A+M practice, and the requirement general practice patients have for continuity of care from a team that includes nurses, receptionists and usually one doctor. It is usual in general practice for a patient to identify with a specific doctor on most occasions. It would be usual for that doctor and/or the practice nurse to be available for intercurrent telephone or other advice and to provide support and advice during major medical events, such as those that occurred for [Mrs A] in November 2007. At the time of spinal surgery in November 2007 [Mrs A] had become incontinent of urine, was experiencing numbness down the left side of her body, weakness of her right leg and could barely write her name,

she has been left with adverse neurological sequelae. She has been unable to return to her former occupation.

- Practice nurses are integral to the team work of general practice. In the context of a clinic that incorporates both A+M and general practice care it might be helpful to have a specific nurse working with a specific doctor in order to facilitate continuity and team work.
- It is my view that [Ms H] has missed the point of the Commissioner's remarks regarding continuity of care. Her report unduly emphasises delays on the part of [Mrs A] in returning to Radius Palms for further assessment, advice, investigation and treatment. She appears to imply that [Mrs A] is responsible for the delay in diagnosis of her condition. It remains my view that had the various doctors consulted by [Mrs A] at Radius Palms provided continuity of care that her diagnosis may have been made earlier."

Appendix 2 — Expert advice, general practitioner Dr Keith Carey-Smith

"Introduction

In order to provide an opinion to the Commissioner on case number 08/06359, I have read and agree to follow the Commissioner's Guidelines.

My opinion is based on my training in general medicine/surgery and general practice, and my experience and ongoing education as a rural general practitioner in Taranaki for over 30 years. This includes care of patients with musculo-skeletal conditions. I have no experience in Accident and Medical (A&M) clinics. My qualifications are FRNZCGP, Dip Obstetrics (NZ) and DA(UK).

Purpose

To provide independent expert advice about whether The Palms Medical Centre Ltd provided an appropriate standard of care to [Mrs A].

[At this point in his report, Dr Carey-Smith sets out the background to the case, the documents sent to him, and the questions asked of him — which he repeats in his report. This detail has been omitted for the purpose of brevity.]

General comments:

The course of events is clearly documented in the records and documents provided. The background (copied above) appears to provide an accurate summary of events over the period in question. Dr Stuart Tiller's advice [Appendix 1] also well summarises the relevant consultation records, and I largely agree with his opinion. The information provided is sufficient to form an opinion, although deficiencies in clinical records limit my ability to judge clinical performance in several of the consultations.

Opinion

1. *Please comment generally on the standard of care that The Palms Medical Centre Ltd (The Palms) provided to [Mrs A].*

The overall standard of care provided to [Mrs A] by The Palms over the period in question showed variable quality, ranging from thorough consultations with good documentation, to substandard care (see below). Practice systems are satisfactory. However, continuity of care is reduced because of the practice size and structure, the number and seemingly transitory nature of doctors employed and the lack of a specific clinician with overall responsibility for care of the patient. I consider that, for such a practice, systems for ensuring continuity for patients with chronic problems, and dealing with incoming

documents, are mildly deficient. Patient care appears to be largely episodic and focussed only on the presenting problem.

If not covered above, please answer the following with reasons for your view:

2. *Please comment on the standard of clinical assessments/examination that [Mrs A] received at The Palms between March and November 2007.*

My opinion regarding the standard of consultations between [Mrs A] and The Palms doctors between these dates can be summarised as follows:

Date 2007	**Doctor**	**History**	**Examination**	**Assessment**	**Management**	**Comments**
25/3	[Dr C]	Satisfactory	Appropriate	Satisfactory	Appropriate	Past history recorded. Exercise sheet given
6/5	[Dr D]	Satisfactory	Brief or absent. Reflexes / sensation not tested	No assessment recorded	Plan/follow-up not recorded. X-ray ordered	Also dealt with UTL X-ray done 9 July
9/7	[Dr E]	Good	Good	Good	Appropriate	Follow-up 1 wk after XR
27/7	[Dr F]	Satisf	Satisf	"Pleuritis" recorded	Satisf	No consideration of wider diagnoses
20/8	[Dr B]	Brief Inadequate	Nil recorded	Nil recorded	Appropriate referral	No record of patient discussion/ followup
27/8	[Dr B]	Nil	Nil	Nil	Referral made	No clinical record
19/9	[Dr B]	Inadequate	Nil recorded	Brief	Medication but no plan/ follow-up	Inadequate mental health assessment. Other problems not assessed
25/10	[Dr G]	Satisfactory	Not recorded	Nil recorded	Inappropriate non-acute referral	Patient presumably not known to this Dr

Specific consultations and events relating to [Mrs A's] care

25 March 2007, [Dr C]. The records for this consultation are satisfactory and indicate an appropriate standard of history taking, examination, assessment and management. The patient was advised to return if symptoms did not settle.

6 May 2007, [Dr D]. At this consultation the shoulder pain and a respiratory infection were addressed. Regarding the shoulder, although the history and management (ordering cervical spine X-ray, and analgesic medication) were satisfactory, no examination findings, assessment, or follow-up plan was recorded. As noted by Dr Tiller, it is not clear if the reference to 'no apparent weakness' was history or examination. Appropriate examination of the respiratory system was recorded. Three medications were prescribed for the shoulder, including tramadol (a strong analgesic). This suggests that the pain was moderately severe.

The recording of this consultation is inadequate, and suggests that the overall standard of care was sub-optimal, particularly with regard to examination and clinical assessment. Follow-up arrangements were not clear, and there is no record of a review of the X-ray result. It appears that two months elapsed before the X-ray was done, and ideally in this situation an 'alert' or recall should alert the doctor that no report had been received in a reasonable time.

9 July 2007, [Dr E]. Comprehensive records indicate a consultation of high standard, and appropriate management and follow-up arrangements. There appeared to be no clinical evidence of sinister pathology. The only examination deficit noted was lack of testing of reflexes in the upper limbs. The follow-up visit did not take place after a week as suggested, but this may have been because the normal X-ray report (done on 9 July) became available to [Dr E].

27 July 2007, [Dr F]. A brief focused history, examination and assessment led to a provisional diagnosis of 'pleuritis' and the patient was managed appropriately. There was no comment on the previous visits, and current symptoms regarding the shoulder/neck problem. I agree with Dr Tiller that ideally, in view of the previous complaints, additional diagnoses should have been contemplated, and a wider examination, with possibly blood tests and chest X-ray, should have been performed. This constitutes care mildly below general practice standards.

8/9 August 2007. The incoming summary of the second medical practice consultation and blood tests ordered came to [Dr B's] in-box. The summary noted 'review in a week' without clarity on who was to do this review. In view of the symptoms and signs reported, ideally [Dr B] should have ensured follow- up arrangements were in place, as well as arranging for review of the abnormal lymphocytosis, mildly elevated CRP, and thyroid tests. No comments are made in the practice records by [Dr B] regarding these points.

In fact the follow-up occurred with [the second medical practice] on 14 August and the report indicated that [the second medical practice] were planning follow-up in a month. It is reasonable at this point for [Dr B] to have taken no further action. However I agree with Dr Tiller, that the lack of documentation or indication of further action by [Dr B] constitutes mildly below-standard care.

17 August 2007, [Dr B]. Request for repeat thyroxine script referred to [Dr B] presumably by practice nurse. As noted by Dr Tiller, [Dr B] should have checked the abnormal thyroid test, and either repeated it, altered the dose, or arranged a review within about 3 months. This constitutes a mild departure from the care normally to be expected of a general practitioner.

20 August 2007, [Dr B]. The brief recorded history does not mention clinical information later included in the referral letter (e.g. lethargy 'hard to function'), and no examination findings, clinical assessment, or plan (apart from referral) are recorded. Further blood tests showed a mild abnormality, and [Dr B] changed his orthopaedic to an urgent rheumatology referral, presumably for this reason. The deficits in clinical notes are acknowledged by the practice (see p 48).

27 August 2007, [Dr B]. There is a note from [Dr B] to recall [Mrs A] on 27 August but there is no record of [Dr B] seeing her, despite the comment on 'Analysis of Event' (p 9 — document p 31, also p 49) that she was seen by [Dr B] on 27/8/07. However, further blood tests were ordered, and the referral was written on 28 August. Lack of a record of this consultation is considered to be poor practice.

1 September 2007, [Dr B]. The brief consultation record only referred to 'depression due to chronic illness', and antidepressants, along with further analgesics, were prescribed. There is no note that [Dr B] inquired about her upper limb/neck problem, or checked that she had seen the specialist. There is no evidence that an adequate mental health assessment was performed. This constitutes below standard recording and an inadequate overall standard of care. Below standard documentation is acknowledged by the practice (p 49).

17 October 2007, [Dr B]. Over this week a repeat prescription was written and information received regarding potentially serious pathology identified by the rheumatologist. [Dr B] would assume that management would now be continued at the hospital, but I agree with Dr Tiller that a concerned general practitioner would have contacted his patient to offer support and ensure arrangements were in place. If [Dr B] was away from 19–24 October as stated, a deputising doctor should have read the hospital documents and ensured support and follow-up.

25 October 2007, [Dr G]. It is not clear if [Dr G] viewed the second rheumatologist letter indicating [Mrs A] had been referred to the orthopaedic surgeons. The fact that she also made a referral suggests that she did not see

this letter. In any case, with major neurological signs suggesting spinal cord compromise (weakness extending to buttocks, urinary incontinence), an emergency admission was indicated, rather than an orthopaedic referral (not even marked urgent). There is no record of a clinical examination or diagnostic formulation. I agree with Dr Tiller that this consultation implies a major departure from normal general practice standards.

Subsequent events, [Dr B] & practice

Records indicate no response or communication with the patient following receipt of letters from consultants up to the time [Mrs A] left the practice on 15 November. This constitutes mildly deficient standard or care, as noted by Dr Tiller.

2(a). If applicable what further investigations/specialist referrals should medical staff at The Palms have requested during this period?

It is possible that if adequate examinations had been carried out on 27 August, 20 September, or 19 October, abnormal neurological findings (if present) would have led to earlier and more appropriate referral. However this is a speculative comment since it is not clear whether such examinations were not carried out, were inadequate, or were carried out and not recorded. Since the MRI or other imaging required is not usually available to general practitioners, the only investigation option available and not carried out was acute/urgent referral or admission by [Dr G] on 25 October (see comments above).

3. *Please comment on the timing of [Mrs A's] rheumatology referral. Should [Mrs A] have been referred to the Rheumatology Clinic at an earlier stage?*

As far as can be ascertained from the clinical records and other documentation, there was no clear indication for referral prior to 20 August.

4. *Was 'The Palms' standard of documentation of an appropriate standard?*

As detailed above, records made by [Dr B], [Dr G] and [Dr D] were not of an appropriate standard. This deficit is viewed with mild disapproval for [Drs G and D], and moderate disapproval for [Dr B].

5. *Please advise whether The Palms had adequate systems/processes in place to ensure continuity of care at the time of the events in question.*

Patients at The Palms are not enrolled with a particular doctor. Policies and protocols provided by The Palms indicate that patients are able to see the doctor of their choice unless the condition is judged to be urgent, in which case an appointment is made with whichever doctor is available. This policy allows rapid access for urgent problems, but runs the risk of loss of continuity of care. [Mrs A] saw six different doctors over the seven months in question,

which suggests that in most cases she opted to see the available doctor rather than waiting to see a particular one. The apparently rapid turn-over of doctors may also contribute to this problem.

For a practice with multiple doctors such as The Palms, particular attention to ensuring patient follow-up is important. Practice policies relating to follow-up and continuity of care include:

General practitioner (from Job Description):

- Order, check, and inform patients of results in a timely manner;
- GP: refer appropriately, consult and collaborate with colleagues; leading or delegating appropriately;
- Document care and education/information given to patients;
- Clearing in-boxes daily and delegating this task if absent.

Receptionist (Patient appointments protocol)

- Offer patient appointment ... with their preferred provider at the most suitable time for the patient and provider ... providing continuity of care for the patient and with the minimum of waiting for the patient;
- Patients are given the choice of booking with their preferred provider or consulting with another provider.

These policies are adequate, but lack clear mention of systems for managing deputising of care and incoming reports/results. A policy for ensuring clinical responsibility for patients with chronic [problems] lies with one specific clinician is also suggested for this practice.

5(a). (If applicable) Are there any systemic issues of concern that contributed to the outcome of [Mrs A's] case?

No additional contributing systemic issues are apparent.

6. *Please comment on the changes that The Palms have made since the events in question. In your view, have the concerns about [Mrs A's] case been adequately addressed?*

Areas of improvement identified by the practice, and to be documented and monitored include:

- More rapid processing (and monitoring of processes) for inward reports and results;
- Daily checking of in clips by doctors; monitoring of this criteria;

- Improved clinical records with monthly auditing for at least 6 months, and feedback to doctors;
- Monthly peer meetings to address issues;
- Follow-up phone calls and letters to patients to be 'looked into';
- Progressing Cornerstone accreditation;
- Further education for several doctors, leading to RNZCGP Fellowship;

If these quality improvement measures are carried out and sustained, and existing policies adhered to, most of the deficits in patient care identified will be addressed.

7. (If applicable) Please outline any recommendations you may have to address the concerns in this case.

Additional measures recommended are:

1. Assessing, and if necessary, up-skilling, clinical competence for all practice doctors through professional development, CME, further qualifications and regular peer review. Those doctors not vocationally registered should receive adequate oversight.

2. Reviewing protocols for managing test results and incoming reports, regular follow-up of patients with chronic problems, deputising arrangements and hand over patient care and improving communication systems with patients. Consideration should be given to ensuring regular patients have a specific clinician responsible for their clinical management.

8. Are there any aspects of the care provided by The Palms that you consider warrant additional comment?

The practice notes that no complaint, or explanation for her transfer, was made to the practice by [Mrs A]. Such a complaint would have enabled the practice to address some of the issues.

The practice also notes that the responsibility for following up investigations lies with the doctor ordering the test, unless transfer of care is clearly arranged. This is correct. However in my view this does not negate an obligation on a doctor being consulted to act urgently if clinically indicated (e.g. for the consultation by [Dr G] on 25 October).

The practice suggests that delays in diagnosis were related to the long periods between consultations. However, my opinions relate to clinical care carried out at each consultation, and action taken by the practice in between. The

length of time between consultations is not of relevance in reaching my opinion.

CONCLUSION

Although the overall standard of care provided by The Palms is satisfactory, several specific areas are below the expected standard for general practice and stand out as requiring attention:

(1) Competence and performance of individual doctors. Although poor recording makes assessment difficult, the clinical competence of [Dr G] with regard to managing acute neurological conditions is questioned. [Dr D's] and [Dr F's] clinical skills may also be mildly below acceptable standard. [Dr B's] notes also suggest minor deficits in clinical management. All doctors may require assistance to upgrade clinical performance and ensure a more holistic approach to patient management, such as dealing with issues other than the presenting problem.

(2) The Palms portrays itself as a general practice as well as an A&M clinic. I would comment that the consultation approach portrayed in several of the consultations is more akin to an A & M clinic dealing with acute problems than to a general practice responsible for ongoing clinical care. The standards applied in reaching my conclusions are however those expected of a general practice, although in my view clinical documentation should be of a similar standard in both types of practice.

(3) Clinical records made by [Drs B, D and G] fall below expected standards.

(4) Clear protocols for managing and actioning (with documentation) incoming reports and results, deputising patient care, and establishing clinical responsibility for individual patients, all need to be clarified and actioned."