MDU

Cautionary Tales

It's been a challenging year to say the least. Our members have worked tirelessly during the pandemic and we have been here to support you day and night. In 2020, we answered over 25,000 calls to our 24-hour advice line and over 99% were connected to a specialist adviser within 20 seconds.

The following selection of cases highlight the challenges some doctors have faced, the medico-legal advice we have given and learning points for managing similar situations in future. Some details have been changed to ensure anonymity.

If you need our help, the medico-legal team is available 8am-6pm Monday to Friday and provides an on-call service for medico-legal emergencies or urgent queries 24 hours a day, 365 days a year.

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> *“The GP’s colleague was concerned about the patient’s presentation and suggested that she go to hospital. She was subsequently diagnosed with appendicitis and underwent surgery.”*

Remote consultations and delayed diagnosis

The scene

A GP contacted the MDU requesting advice after receiving a complaint from a patient. The patient alleged that she had phoned the surgery on two occasions requesting an appointment for ongoing abdominal pain but had not been seen in person, and that this had led to a delay in being diagnosed with appendicitis.

The patient complained that the delay in diagnosis made her appendectomy more difficult and caused her to have a more protracted post-operative course.

MDU advice

The GP contacted the MDU for guidance. He explained that because of the COVID pandemic, the practice clinicians were conducting telephone or video reviews in the first instance, and only seeing patients in person where there was an urgent need to do so.

The GP said he had spoken with the patient, who described a one week history of waxing and waning grumbling pain in her lower abdomen. She denied any chance of pregnancy. The GP suspected that the patient had a UTI and asked her to drop off a urine sample, prescribing an antibiotic. The urine sample tested positive for red blood cells and leukocytes.

A week later the patient called back and spoke to the same GP. She explained that her abdominal pain came and went but was becoming more constant and persistent. The GP prescribed a different antibiotic. Four days later the patient phoned the surgery for the third time. She spoke with another doctor and an appointment was made to review her in person. The GP’s colleague was concerned about the patient’s presentation and suggested that she go to hospital. She was subsequently diagnosed with appendicitis and underwent surgery.

The MDU adviser empathised with the challenges imposed by the pandemic and the difficult balancing act faced by the GP in deciding which patients required face-to-face review. The adviser suggested the GP respond to the complaint by explaining why he had suspected a UTI, and setting out the factors that led him to this conclusion.

The adviser recommended that the practice hold a significant event review to consider whether, in hindsight, the GP and his colleagues felt that it might have been appropriate to review the patient in person when the patient described persistent symptoms. The adviser explained that if, after discussion with his colleagues, the GP concluded it would have been helpful to arrange to see the patient in person, it would be appropriate to say so and to explain how the GP’s practice had changed in light of these events. However, if the GP and his colleagues were content that he had provided suitable care, it would be appropriate to sensitively explain this.

The outcome

With the assistance and support of the MDU adviser, the GP wrote a response to the patient expressing his regret that she had undergone a worrisome and difficult experience. In the letter, the GP described each telephone consultation and detailed his thought process. He explained that in order to learn from these events, the practice had reviewed the concerns raised in an anonymised way. The GP acknowledged that, in hindsight, it might have been helpful to have seen the patient when her symptoms did not settle.

The GP explained that he had reflected on these events at length and concluded that he would now have a lower threshold for reviewing a patient with persistent symptoms in person, in order to make sure a similar situation did not arise in future. The patient did not pursue the complaint.

Need help writing a complaint response?

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Assessing capacity for COVID vaccination

The scene

A GP was contacted by the manager of a local care home because a resident's daughter objected to her mother receiving the COVID-19 vaccine. The daughter, who had a lasting power of attorney (LPA) for health and welfare decisions, claimed the vaccine was untested and posed an unnecessary risk, but other family members disagreed.

According to her medical records the patient had recently been diagnosed with early-stage vascular dementia and had a 10 year history of type 2 diabetes. She had been compliant about taking medication for this and had always been willing to receive an annual flu vaccination.

The GP called the MDU for advice.

MDU advice

The MDU adviser agreed this was a sensitive situation but that the GP's overriding objective should be to determine what course of action would be of overall benefit to the patient.

The first thing the GP needed to do was make their own assessment of the patient's capacity to decide whether to be vaccinated, bearing in mind that capacity is time and decision specific and capacity might fluctuate in a patient with early-stage dementia.

Even if the patient's condition meant that she was unable to understand the relevant information or make an informed decision, as set out in the two-part test in the Mental Capacity Act, it was important to consider practical ways to help her make a decision – doing the capacity assessment at a time of day when she was most alert, for example - and giving the patient every opportunity to be heard.

The assessment and discussion should be clearly documented, including the information given to the patient, what questions were asked, her response and the outcome.

If the patient was assessed as lacking capacity, the next stage was to determine whether vaccination was of overall benefit. Although the daughter had an LPA, she could not simply veto treatment that was felt to be clinically necessary and which aligned with her mother's needs, preferences, values and priorities.

In order to reach a decision, the GP needed to take into account all relevant circumstances, including evidence of the patient's past and present wishes, such as the fact the patient had previously consented to having flu vaccines, as well as the views of her daughter and others interested in her welfare.

As the issue had become so contentious, the GP should call a best interests meeting, involving relatives and care-home staff to discuss the options, risks and benefits and see if an agreement could be reached. If this was not possible, the GP would have to seek legal advice about making an application to the court of protection.

The outcome

Unfortunately, a consensus could not be reached during the best interests meeting so the GP was obliged to ask the CCG to apply to the court of protection for a decision. After hearing evidence from all parties, the court decided it was in the patient's best interests to have the vaccination and this went ahead without further objection from her daughter.

"The assessment and discussion should be clearly documented, including the information given to the patient, what questions were asked, her response and the outcome."

> *They suggested the member might consider inviting the patient to call the practice to discuss his concerns about wearing a face mask and, bearing that in mind, how best to deal with the issue of his ingrown toenail.*

Patient's refusal to wear a face mask

The scene

A GP member contacted the MDU advice line after seeing an adult male patient of the practice, who had presented with an ingrown toenail. During this initial consultation the patient declined to wear a face mask, stating he was exempt.

The GP had a discussion with the patient but was unable to ascertain why he felt he was exempt from the requirement to wear a face mask. Nonetheless, the GP assessed the patient's toenail and advised that removing it would be the appropriate treatment, and that the procedure would take around thirty minutes.

The GP told the patient that the procedure could be carried out at the practice at a later date and attempted to discuss the possibility of the patient wearing a face mask for the procedure, but the patient was dissatisfied with this and left the practice abruptly.

MDU advice

The GP sought MDU advice on what further steps he and his colleagues should consider. The MDU adviser explained that if urgent treatment is needed, a doctor should do whatever is necessary, regardless of whether a patient is able or willing to wear a face mask.

The MDU adviser and the member agreed that removing the patient's ingrown toenail was a non-urgent matter, so the adviser suggested the member and his colleagues take time to reflect on and explore all possible avenues for treatment, both within the practice and any other services available locally. The adviser suggested looking into the availability of NHS podiatry services locally and seeking information about how those services are provided, in terms of the extent of protective measures in place within the service.

The adviser also provided information about government requirements in the member's region of the UK around face mask exemptions. They suggested the member might consider inviting the patient to call the practice to discuss his concerns about wearing a face mask and, bearing that in mind, how best to deal with the issue of his ingrown toenail.

The outcome

The member contacted her local NHS podiatry service, who explained they had acrylic protective screens in place that would allow the patient to have his procedure carried out there without needing to wear a face mask. They would be able to carry out the procedure, but the patient would have to wait longer to have it done than he would if it were carried out within the GP practice.

The patient responded to the member's request that they talk on the phone to explore possible options for treatment. They discussed the patient's objections to wearing a face mask, with the patient clarifying he simply preferred not to wear a face mask if at all possible as he found it uncomfortable.

The GP explained the details of the measures in place in the local NHS podiatry service and the timescales involved in being referred there to have the procedure performed. After a discussion, the patient agreed to be referred to the local podiatry service where he was able to have the procedure carried out without needing to wear a face mask.

Criticism at a coroner's inquest

> *"The GP had not expected to be aggressively questioned, and felt unable to point out that while she had not attached all of the information that she had intended to, the patient's history was well known to the trust."*

The scene

A patient attended his GP, concerned about symptoms of chest pain and shortness of breath. He was known to have ischaemic heart disease, and had previously been under the care of a cardiologist at the local secondary care trust. He was on maximal medical therapy.

The GP was concerned that his presentation represented a progression of his disease and made an urgent referral to the same cardiologist. She included a brief history in the referral letter, and had intended to send copies of previous correspondence and a summary sheet including the patient's past medical history as attachments.

Unfortunately, she inadvertently omitted to do this, and the cardiologist only received the brief covering letter which did not contain all of the relevant clinical information. The cardiologist was on leave, and the referral was downgraded to 'routine' by a different cardiologist who did not review the previous medical records.

Several weeks later the patient had a myocardial infarction and died.

Inquest

The GP was then asked to attend an inquest by the coroner. She was also an experienced forensic medical examiner and had often attended inquests in that capacity. Because of this, she felt comfortable doing so again and did not seek MDU advice before attending the inquest, although the context of her attendance in this case was different.

At the inquest, the patient's family and the secondary care trust were both legally represented. The barristers for the family and the barrister for the trust both questioned the GP robustly about the content of her referral letter, suggesting that if it had been more complete or if the intended attachments had been sent, the referral would not have been downgraded and the patient would have been seen before his fatal heart attack.

The GP had not expected to be aggressively questioned, and felt unable to point out that while she had not attached all of the information that she had intended to, the patient's history was well known to the trust and was extensively documented in the trust's own records. The coroner echoed the barristers' criticism in the final determination.

MDU advice

The GP contacted the MDU for help. The MDU's medico-legal adviser explained that the GMC must be notified if a doctor is criticised by an official inquiry. This includes criticism at a coroner's inquest, if that criticism relates to serious matters that could call the doctor's fitness to practise into question.

The MDU adviser suggested that the GP discuss the case with senior colleagues, including her responsible officer (RO). The MDU also instructed a solicitor to consider the implications of the coroner's comments.

Having done so, and having reflected on the case and taken steps within the practice to minimise the chances of a similar oversight in future, the GP decided that the threshold for a referral was not met in this case. The GP's RO discussed the case with a GMC employment liaison adviser, and agreed with the GP's decision.

Learning points

Attending an inquest can be a challenging experience, even for doctors who are familiar with acting as a witness. It is always worth contacting the MDU before you attend an inquest, or before you provide a statement for the coroner. We can discuss the case with you and determine if there are possible vulnerabilities you had not considered, and whether it is worth instructing a solicitor to represent your interests.

Upsetting comments on social media

The scene

A GP contacted the MDU advice line after a receptionist showed her comments about the practice on a social networking site. The individual had described a consultation with the GP inaccurately, and made disparaging remarks about the GP's appearance, as well as her clinical abilities. The GP also felt threatened, because the individual had stated that the GP needed to have her "arrogant smile wiped off her face".

The GP was understandably upset. She explained that she knew which patient had written this, because she recalled the consultation that had been described, and it matched the name of the social media user. The GP was particularly upset because the patient had not shown any indication of being unhappy with the consultation at the time, and had not contacted the practice directly with their concerns.

The GP had discussed the case with her colleagues, who strongly felt that the patient's behaviour warranted removal from the practice list. The GP was seeking advice on how to respond to the comments.

MDU advice

The MDU adviser agreed that the comments were offensive and worrying. The adviser warned that although it was tempting to respond directly via the same social network, the GP needed to remember her duty of confidentiality. The GMC says doctors must not use publicly accessible social media to discuss patients or their care with those patients or anyone else.

The adviser pointed out that any response could generate further interest in the post, and therefore the GP could choose not to respond at all on the site. However, another option that might be appropriate would be to reply to the comment, apologising if they are not happy with their treatment and inviting them to get directly in touch to discuss any concerns.

The adviser also suggested that the GP consider contacting the site's administrators to report the comments. If the comments contravened its community standards, the site could take action to remove them.

Finally the MDU adviser suggested the GP discuss with her colleagues whether the comments justified sending the patient a warning letter, before removal from the practice list, in line with the practice's zero tolerance policy and on the basis of a breakdown in the doctor patient relationship. The adviser also explained that if the GP felt physically threatened by this patient, then they could justify reporting their concerns to the police.

The outcome

The GP felt that after considering this advice, she would report the post to the site's administrators, and then proceed with sending a warning letter making clear that a repetition of the behaviour within a year could result in removing the patient from the practice list. There were no further comments from the patient.

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> *"The GP had discussed the case with her colleagues, who strongly felt that the patient's behaviour warranted removal from the practice list."*

Notifiable or not? Reporting safety incidents

The scene

A 72-year old female patient attended the practice with weight loss, malaise and temporal headache. During the consultation, the GP discovered she had experienced some pain in the neck and shoulders over recent months. The GP then performed a physical examination, which revealed some tenderness over the temples and a reduced range of movement of the neck and shoulders.

Blood tests including FBC, renal and liver profile and ESR were requested.
The patient had the bloods done just before the Easter bank holiday weekend and the results were received by the practice the day before the Good Friday bank holiday. The bloods were normal apart from a raised ESR of 60 mm/hour.

The results were viewed by a locum GP the following week and a text message was sent to the patient two days later asking her to book an appointment to discuss her results.

The same day as the text message was sent to the patient, she attended A&E with loss of vision in her right eye. A diagnosis of temporal arteritis (giant cell arteritis) was made and the patient was started on high dose prednisone.

MDU advice

The GP who had initially seen the patient called the MDU advice line to discuss the case and determine what action the practice should take. The MDU adviser explained that in addition to the ethical duty on all doctors to be open and honest with patients when things go wrong, the practice should also consider whether the statutory duty of candour applied.

The statutory duty was introduced in 2014 for NHS bodies (such as trusts and foundation trusts) in England, and was extended in April 2015 to cover all other care providers registered with the CQC, including GP practices. The duty applies to organisations rather than individuals, but staff should cooperate to make sure the organisational obligation is met. Patients should be told of a 'notifiable safety incident' as soon as is practical. A notifiable safety incident has two statutory definitions, depending on whether the healthcare organisation is an NHS body or not.

For non-NHS bodies - such as the GP practice - a notifiable patient safety incident is defined as something unintended or unexpected occurring in the care of a patient that, in the reasonable opinion of a healthcare professional, appears to have resulted in:

- their death (not relating to natural progression of the illness or condition)
- impairment of sensory, motor or intellectual function, lasting or likely to last for 28 days
- changes to the structure of the body (e.g. amputation)
- prolonged pain or psychological harm (defined as experienced or likely to be experienced for at least 28 days)
- shortening of life expectancy
- the need for treatment to prevent death or the above adverse outcomes.

The outcome

The practice decided that the statutory duty applied and they apologised to the patient for the delay in reviewing and acting upon the raised ESR result. A notification was made by the practice to the CQC. The patient accepted the practice's apology and appreciated that changes had been made to how blood test results were managed as a result of her experience.

> *"Patients should be told of a 'notifiable safety incident' as soon as is practical."*

> *“Although it wasn’t a breach of confidentiality to listen to her, the member should make clear that he might need to tell the patient about information he received from her.”*

Speaking to a spouse

The scene

A GP MDU member saw a male patient who had been struggling with his mood for some weeks, and on two occasions described feeling low and at times irritable at home. The GP agreed to start him on an antidepressant, but the patient was concerned that no one should find out he was unwell.

A few days later the patient’s wife left a message asking to speak to the GP about her husband, and the doctor called the MDU’s advice line to ask if he could do so.

MDU advice

Speaking to the MDU adviser, the GP explained that he was concerned about possibly breaching the patient’s confidentiality if he spoke to the wife. The adviser explained that it was possible the wife may have information that would be helpful in the member’s care of the patient. Although it wasn’t a breach of confidentiality to listen to her, the member should make clear at the outset that he might need to tell the patient about information he received from her.

The adviser directed the member to the GMC’s confidentiality guidance, which also tells doctors to consider whether listening to others may be deemed a breach of trust by the patient. In this situation, the GP member felt that the patient hadn’t asked him not to listen to his wife, but didn’t want others to know he was ill.

The adviser explained that the member should be careful not to inadvertently disclose information in his call with the wife - for example, by confirming that he was seeing the patient or that he had prescribed medication.

The member also asked where he should document the call with the patient’s wife as he was worried the patient might see it. The adviser explained that in *Good medical practice* (2013), the GMC sets out what information should be documented in the clinical records; this includes relevant clinical findings, decisions made and actions agreed, as well as information given to the patient. If the information provided by the patient’s wife could influence the care and treatment of the patient in the future, it was clearly relevant for it to be in the record.

Under the Data Protection Act 2018, however, the identity of the wife would be a third party reference, and could be withheld if a disclosure was requested by the patient and she had not provided her consent to its disclosure.

The outcome

The member spoke to the patient’s wife and learned that she was particularly concerned about her husband’s behaviour. She said that he was drinking heavily at home, to the extent that he was sometimes unable to go to work.

She was worried about him driving and also the effect it might have on their children.

She believed her husband would agree to her accompanying him to his next appointment. As such, when they were seen together the GP member was able to address the issues raised in a way that allowed a fuller discussion of the support needed by the patient and his family.

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An altered fit note

The scene

A practice manager called the MDU's advice line after being contacted by the HR administrator of a large local employer, who asked whether a fit note issued by the practice was genuine.

The practice manager asked the HR department for a copy of the fit note and could see that it was issued for a patient of the practice; it had the surgery stamp and appeared to be genuine. However, when he reviewed it with the issuing GP, it was clear from the records made at the time that the note had been altered.

The GP recorded a condition of 'depression' and that the patient was not fit to work for four weeks. However, the fit note stated a period of 14 weeks and the condition had been changed to 'stress at work'.

The member asked whether he or the GP were allowed to tell the employer anything at all.

MDU advice

The employer was alerted to question the fit note's veracity by its duration; the maximum period a fit note can cover in the first six months of absence is three months.

The MDU adviser explained to the member that they could confirm whether the note was as written to anyone properly entitled to hold it, but that providing further information - such as the actual diagnosis - may amount to a breach of confidentiality. Of course, once the practice confirmed the note to be not as it had been written, it would become clear to the employer that it was altered. It would then be for the employer to decide how to manage this with their employee.

The member asked whether there was anything else they should do about the patient having altered the note.

The adviser explained that although they were under no obligation to tell the patient, they may still choose to do so. It would be an opportunity to explore why the patient had altered it and also for the practice to make clear that they had told the employer that it was not what they had written. Unless the patient gave consent, the practice would be unable to discuss the diagnosis with the employer unless a failure to do so would lead to so serious a risk that it outweighed the patient's privacy interest.

The outcome

After a later discussion with the patient it became clear that he'd felt he might be treated adversely if his employer learned of his mental health problems, and the GP wanted to know if she was obliged to put a detailed diagnosis on a fit note.

The adviser subsequently explained that the government guidance asked for 'as accurate a diagnosis as possible, unless the doctor thinks a precise diagnosis will damage the patient's wellbeing or position with their employer'. The adviser also drew the doctor's attention to the GMC guidance in *Good medical practice* (2013), which states that a doctor must be honest and trustworthy when completing and signing forms and must make sure any such documents are not false or misleading. While the doctor may decide that a more broad description of the condition was appropriate, she should remain able to justify her diagnosis.

> *"Unless the patient gave consent, the practice would be unable to discuss the diagnosis with the employer unless a failure to do so would lead to so serious a risk that it outweighed the duty of confidentiality owed to the patient."*

Refusal to prescribe off-label

> *"While patients with capacity can refuse any treatment if they choose, they cannot demand specific treatment unless the doctor feels it is suitable for their needs."*

The scene

A GP member contacted the MDU advice line after a patient with chronic fatigue syndrome (CFS) had come into the practice. The patient had said she had seen a specialist doctor who had recommended she take thyroxine, and she wanted the GP to prescribe it.

She produced a headed letter from the specialist with a handwritten note saying "thyroxine 50 micrograms", but there was no further information or a reason why the specialist wanted this given. The GP had taken blood for thyroid function tests and arranged to see the patient with the results in a week's time.

The GP had looked at NICE and NHS guidance which said that thyroxine should not be used in CFS. He said the thyroid function tests were normal, and that he had looked up the 'specialist' on the GMC website and found he was not registered with the GMC. The GP asked what he should do as the patient was insistent that he prescribe thyroxine.

MDU advice

The MDU's medico-legal adviser explained that doctors are responsible for prescriptions they sign and that they should be happy that the medicine serves the patient's needs.

While patients with capacity can refuse any treatment if they choose, they cannot demand specific treatment unless the doctor feels it is suitable for their needs. In its guidance on prescribing[1] the GMC sets out a process for handling patient requests for medicines that the doctor does not think will benefit them.

In line with this guidance, the adviser recommended that the GP explore why the patient wanted the medication, their understanding of the risks and their expectation of the benefit. If after this discussion the doctor still thinks the treatment would not serve the patient's needs, then he should not prescribe it.

The GP was advised to explain to the patient that national guidance from both NICE and the NHS says that thyroxine and other drugs should not be used for CFS, and that an individualised approach to other treatments should be made up.

He should also offer the patient a referral to an NHS CFS specialist.

The adviser said the GP may wish to explain that as far as they can see, the 'specialist' is not on the GMC register - which is in the public domain - and therefore cannot work as a doctor in the UK. They also cannot prescribe medication in this country or ask anyone else to prescribe the medication on their behalf.

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The outcome

Following the conversation with the MDU's adviser, the GP declined to prescribe the thyroxine after a discussion with the patient about the risks. The patient then made a complaint via NHS England, which the GP answered with further assistance from the MDU adviser. NHS England did not uphold the complaint.

The patient was referred to an NHS specialist in CFS and an individualised management plan was formulated for their treatment going forward.

[1]Good practice in prescribing and managing medicines and devices, GMC (2021)

Parental responsibility and disclosure to a solicitor

The scene

A practice manager called the advice line on behalf of several doctors at the practice. They had received a request from a solicitor acting for the mother of three children, seeking disclosure of the children's records. The children mainly lived with their father, although the mother had some limited access.

The practice manager said she was aware that those with parental responsibility generally have a right to access their child's records and they had no concerns about providing the records of the youngest child (aged six), whose records contained only entries about minor childhood illness, routine development checks and routine immunisations. But she was uncertain what to do about the other two records and had a specific question about disclosure of the teacher's name which appeared in the records.

The second child was nearly 10, and had recently attended with his father and disclosed his reluctance to visit the mother. Apparently he had also had some outbursts at school after spending time with his mother. During the consultation the doctor assured the boy of the confidentiality of the discussion. The father had asked the doctor to phone the boy's teacher, who had been generally reassuring that things now seemed to have settled down.

> *"Divorce or separation does not affect parental responsibility, but the MDU's experience is that children of separated parents may make disclosures relating to difficulties in their parents' relationship."*

The third child was 16. A year earlier, before the parents separated and while she was 15, she had attended alone and disclosed she'd had sex on one occasion with her boyfriend a couple of weeks earlier and she was worried about being pregnant. The doctor had established that the boyfriend was in the same school year and that the sex was consensual, and a pregnancy test was negative. The girl had attended a follow-up appointment to discuss contraception but had said the relationship had ended.

MDU advice

The adviser confirmed that someone with parental responsibility can ask for the child's records. The Information Commissioner's Office makes clear that the right of access belongs to the child, but that parents may exercise that right on behalf of the child if it's clear this is in their best interests.

The adviser also confirmed that children with capacity can access their own records and can allow or prevent others, including their parents, from accessing the information. In Scotland, anyone aged 12 or over is assumed to have capacity to make their own decision on access to their own records and to allow or prevent access by others including their parents. Although this law does not apply in England, Wales or Northern Ireland, the information commissioner indicates that this is a reasonable approach in the other jurisdictions.

Children younger than 12 may have capacity to make such a decision and their views should be taken into account. If a child has been assured of confidentiality or given information in confidence, you should not normally disclose that information without their consent.

Divorce or separation does not affect parental responsibility, but the MDU's experience is that children of separated parents may make disclosures relating to difficulties in their parents' relationship that they are particularly concerned about, to avoid their parents knowing. GMC guidance also makes clear that a doctor may withhold information if they consider it would be against the child's interests to disclose it, whether or not the child has capacity to make the decision themselves.

The outcome

In this case the adviser suggested that the practice should arrange for one of the doctors to discuss the mother's request separately with the two older children.

If the 10-year old agreed to the information being given to the mother, there would be no need to redact the teacher's name. It is generally reasonable to disclose the names of education or social work professionals, whose information appears in a person's records because of their professional role with that person - as with healthcare professionals whose names would not be redacted.

The practice manager was invited to call again or write in if they were not able to resolve this readily, as particularly when there are legal teams involved, it can be intimidating receiving solicitors' letters containing demands.

In cases like these, remember that the MDU can assist with drafting responses and with any further steps that might be necessary.

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A request from the magistrate's court

The scene

A GP received an email from the criminal justice mental health liaison team at the magistrate's court. It said a patient she had seen recently was remanded in custody awaiting trial later that day, and asked for information about any history of mental health problems or medication prescribed.

The GP noted that the request came from a community psychiatric nurse (CPN) with an NHS email account, but was unsure about disclosing information without consent from the patient. She told the MDU adviser that she was not sure about the role and remit of a CPN working for the criminal justice mental health liaison team, and so had decided to seek MDU advice.

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MDU advice

The MDU adviser agreed that the starting point was to understand the role of the CPN, and explained that criminal justice mental health liaison teams are more simply known as 'Liaison and Diversion' (L&D) services in many areas of the UK.

L&D service professionals can be psychiatrists, CPNs or social care professionals and are found in police stations and magistrates courts. Their role is to help people with mental health problems, learning disabilities or substance misuse problems at their first contact with the criminal justice system.

L&D services aim to improve overall health outcomes (often by referring people on for appropriate health or social care) and support people in the reduction of re-offending. L&D professionals can share information with the judiciary, probation service and the police, with the person's consent. This can inform decisions about case management and sentencing.

The adviser and the GP discussed the GMC's guidance on confidentiality, which would support the GP in relying on implied consent to share information with those providing direct care to the patient. Implied consent might be relied upon if, for example, a GP were contacted by a CPN after an admission to a hospital or a referral to community mental health services.

While the L&D professionals might use the information to provide (or support the provision of) direct care to the patient, the adviser reiterated that they might also use the information for other purposes (to inform the decisions of the court). In this situation, explicit consent from the patient would be required.

The outcome

After discussing the role of the L&D service with the MDU adviser, the GP contacted the CPN to clarify how any information shared would be used, and to request explicit written consent from the patient if the information was to be used for anything other than providing direct clinical care.

The CPN replied saying they were making a referral for the patient to have ongoing support with his mental health, but also that information from the GP could additionally be shared with the magistrates. After this discussion, the CPN provided written consent from the patient allowing the GP to share the information requested.

> *"While the L&D professionals might use the information to provide (or support the provision of) direct care to the patient, the adviser reiterated that they might also use the information for other purposes (to inform the decisions of the court)."*

Delayed diagnosis of bowel cancer

> *“The GP called the MDU after receiving an angry letter of complaint from the patient, through NHS England, criticising her for not referring him to a specialist at the first consultation.”*

The scene

A 47-year-old man went to see his GP after noticing bright red blood on the toilet paper when wiping his bottom. The GP asked about his symptoms, particularly whether he had experienced any recent change in bowel habit, pain or unexplained weight loss. None of these symptoms were reported although the patient was unsure of his weight. The GP examined him and found haemorrhoids. She also arranged a routine blood test and for the patient to be weighed.

The patient’s blood count was normal and his weight was 75 kilos, which was around the same as when he registered with the practice two years before. Satisfied the patient’s symptoms were consistent with a diagnosis of haemorrhoids, the GP reassured him there was no reason to suspect cancer and gave advice on how to alleviate the problem.

Aside from a telephone consultation nine months later about an unrelated matter, there was no contact from the patient for 18 months. When he returned, he complained that his stools had been loose and dark in colour for several weeks and his weight had fallen to 70kg. The GP arranged an urgent referral and the patient was later diagnosed with bowel cancer, which required rectal surgery and a colostomy.

The GP called the MDU after receiving an angry letter of complaint from the patient, through NHS England, criticising her for not referring him to a specialist at the first consultation and not asking about his bowel health during the telephone consultation. He accused the GP of allowing his cancer to develop and blamed her for him having to use a colostomy bag at only 48, which could have been avoided “if she had done her job”.

MDU advice

The adviser explained the complaints procedure and the open response expected by NHS England. They suggested that it would be helpful to discuss the complaint as a significant event at the practice and to review and reflect on the relevant NICE guidelines on suspected colorectal cancer recognition and referral.

The guidelines recommend that GPs consider an urgent cancer pathway referral for adults aged under 50 who have rectal bleeding and any unexplained abdominal pain, change in bowel habits, weight loss or iron deficiency anaemia. The practice concluded their colleague’s diagnosis was reasonable, as she had specifically asked the patient whether he had these other symptoms during the consultation and arranged a weight check and blood count. While the patient’s letter was upsetting, they understood that it was not unusual for a patient to respond with anger to a diagnosis of cancer.

With help from the MDU, the GP drafted a response that explained her actions while also highlighting that she had taken the concerns seriously. She acknowledged that while the telephone consultation was about a different matter, on reflection it offered a missed opportunity to follow up. However, with regards to the referral she was able to reference the NICE guidelines.

The outcome

In line with the NHS complaints procedure, the response was sent to NHS England who were managing the complaint. They sought an opinion from one of their clinical advisers who was supportive of the GP’s actions. He noted that she had kept clear records of what had taken place during each interaction with the patient, including the steps she had taken to exclude anything more concerning and her relevant negative findings. This showed that she had followed the appropriate NICE guidelines.

The patient did not take his complaint further.

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Remote prescribing

Watch our webinar on prescribing:
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The scene

An endocrinology consultant was overseeing the treatment of a 40-year-old woman who had been diagnosed with mild Graves Disease the previous summer. The patient started a 12-month titration regime of carbimazole, which would be reviewed every six weeks initially. However, shortly afterwards she moved to another part of the country to take up a temporary job and was unable to return because of the pandemic.

The patient was reluctant to register with another GP practice and continued to contact the endocrinologist by email to request repeat prescriptions. She usually did this a few days before her supply ran out. When asked, the patient assured the doctor that she had no adverse reaction to carbimazole and ignored requests to attend her local hospital for thyroid function tests.

After twice sending FP10 prescriptions to the patient, the endocrinologist contacted the MDU because he was worried about the implications of continuing to prescribe, without being able to assess the patient.

MDU advice

The MDU adviser sympathised that the doctor had been placed in a difficult position and agreed he was right to be concerned, as he was responsible for every prescription he signed.

The adviser drew the doctor's attention to the GMC's updated prescribing guidance, which included relevant sections on safe remote and repeat prescribing. They discussed the difficulties of repeat prescribing safely from a distance without arrangements in place for another suitably qualified healthcare professional to monitor the patient. The doctor recognised this was a particular risk given the drug regimen the patient was on and the fact she was still of child-bearing age.

While it was impossible for the patient to travel back for a face-to-face consultation, the adviser suggested that the doctor talk to his head of department about alternatives, such as transferring the patient's care to another hospital trust or making a shared care arrangement with a local GP practice. The doctor resolved to explore these options and to explain the situation to the patient.

The outcome

After seeking the opinion of his department lead, the endocrinologist contacted the patient to say that it was unsafe for him to issue her further prescriptions without a review, given the potential risks and side-effects of her medication.

The endocrinologist explained that as it was difficult to predict when the patient would be able to return home, she would need to register as a temporary resident with a local GP practice so her condition could be properly monitored.

Once the patient had registered at a practice, the endocrinologist wrote to propose a shared care arrangement. He included relevant details about the patient, her medication and the monitoring required. The practice agreed to this approach and arranged for the patient to have a review and blood test, which was within the normal range.

When lockdown restrictions were eased, the patient returned home and the endocrinologist resumed responsibility for her treatment.

> *"The doctor recognised this was a particular risk given the drug regimen the patient was on and the fact she was still of child-bearing age."*

Work pressure concerns

The scene

A patient was admitted with acute pyelonephritis on a Friday afternoon and was started on a course of intravenous gentamicin. Unfortunately, the scales on the ward were incorrectly calibrated and the patient was given an excessive dose.

While a pre-dose level was checked after 24 hours and the result available soon afterwards, this was not acted upon and the patient received three excessive doses before a foundation doctor spotted the excessive gentamicin level and contacted the supervising consultant. By this point the patient had already reported headache and joint pain and further tests showed they had developed moderate renal impairment.

The foundation doctor was distraught because he had been on call on the Saturday night and had not reviewed the result nor mentioned it during the shift handover on Sunday morning. When the incident was deemed to meet the duty of candour threshold and the trust began an investigation, the doctor became extremely anxious.

In the following days, the doctor found it increasingly difficult to cope and put off writing the statement requested by the trust. He could no longer focus at work and was struggling with some tasks, while obsessively re-checking test results he had already acted upon.

He started to fall behind on his ward responsibilities, and after a consultant criticised him one day for his note taking and a patient complained about his abrupt bedside manner, the doctor decided to call the MDU helpline.

“In the following days, the doctor found it increasingly difficult to cope and put off writing the statement requested by the trust.”

MDU advice

The foundation doctor was extremely worried about the ongoing investigation into the original patient safety incident, which he felt would be critical of him. He was convinced this and more recent concerns would result in a disciplinary investigation and he would not be allowed to continue his training.

The adviser listened to the doctor’s concerns and reassured him that everyone made errors, especially when they were still training. However, it was important to recognise that most adverse events were caused by a combination of organisational or systems errors, as well as human factors. The trust’s incident investigation would consider all the contributory factors, such as the faulty scales and the result also being overlooked by the nursing staff, so lessons could be learned for the wider team.

For his part, it was essential that the doctor produced a statement detailing his involvement while his memory was still fresh. The GMC expects doctors to contribute to patient safety inquiries, and not doing so was more likely to cause problems for the doctor than any errors he might have made. The adviser explained how the doctor should approach writing his statement and offered to review it once he had finished. He also suggested that the doctor discuss the incident with his educational supervisor and document his reflections on the incident and the learning points he had taken from it in his training log.

The adviser also asked about the foundation doctor’s wellbeing, as he was struggling to control his emotions during the call. They listened to him as he spoke about the impact the investigation was having on his mental health and encouraged him to seek professional help. His educational supervisor could provide support and he might also reach out to his GP.

The adviser explained that it was important for the doctor to act promptly, as suffering in silence was affecting his performance and was making things worse. If he felt unfit to continue working at the time, he should discuss this with his educational supervisor and GP. The adviser also emailed the doctor a link to the relevant resource page on the MDU’s website signposting the different sources of mental health support available to doctors.

Take our e-learning module on health and wellbeing:
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The outcome

After being encouraged to express his concerns on the advice line, the foundation doctor found it easier to confide in his educational supervisor. They arranged for him to receive additional support during his shifts and arranged for him to see a local mental health support service, where he was able to obtain therapy for his panic attacks and anxiety.

With assistance from the MDU, the foundation doctor wrote his statement for the trust. The investigation report acknowledged that the overlooked high test result should have also been flagged to the clinical staff by the laboratory, and recommendations were made to update training for the doctors and ward staff on the trust’s gentamicin monitoring protocol.

Complaints over candour

The scene

During a patient's procedure for cataracts, the consultant ophthalmic surgeon inserted an incorrect lens, based on the biometry for the other eye. When the patient returned to clinic for review, her vision was very blurry and the optometrist explained that the surgeon would need to see her again. The consultant reviewed his records and immediately realised what had happened. Thinking it was best to break the news to the patient in person, he dictated a letter asking her to return for a further appointment.

Meanwhile, the patient sought an urgent second opinion after feeling fobbed off by the clinic. After being told that her replacement lens had the wrong refractive power, the patient immediately contacted the trust to complain.

The treating consultant was called to a meeting with the medical director who was angry that the consultant's response had not followed the trust's duty of candour policy. He warned him to expect a disciplinary investigation and threatened to report him to the GMC. The meeting left the consultant shaken and he called the MDU for advice.

MDU advice

The adviser accepted that the consultant had wanted to talk to the patient in person about what had gone wrong, to offer a personal apology and explain he was going to rectify the error. The problem was that he had not called her immediately and had delayed reporting the incident, which meant he had now been overtaken by events. The consultant would now need to take steps to meet his professional obligations and show he had learned from what had happened.

Using the wrong lens during a cataract operation would constitute a notifiable patient safety incident under the statutory duty of candour, because the patient would experience an impairment of sensory functions and require additional treatment. In addition, use of the wrong implant would be considered as a never event by NHS Improvement and should be logged and reported through national reporting systems.

If this had not already happened, the consultant needed to report the adverse incident, ensuring it was logged as a never event and was being appropriately managed under duty of candour procedures. The statutory duty of candour applied to the organisation and not individual staff, but he would be expected to co-operate; for example, by acting as the trust's representative in meetings with the patient, saying sorry to the patient, offering reasonable support and contributing to further inquiries. This aligned with his own ethical duty to be honest and open with patients about errors and to apologise.

In addition, the consultant was also advised to liaise with the complaints department to investigate and respond formally to the patient's specific concerns.

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> *"The problem was that he had not called her immediately and had delayed reporting the incident, which meant he had now been overtaken by events."*

The outcome

The consultant immediately acted on the MDU's advice to ensure the adverse incident was being appropriately managed and cooperated with the trust's duty of candour procedures. As part of the process, he met the patient and he apologised to her for the error and the poor communication. He also arranged for her to receive remedial treatment by another senior ophthalmic consultant. She accepted his apology but decided to receive treatment at another hospital.

The consultant also wrote a detailed statement for the trust investigation based on his medical records, which expressed his regret for not acting as soon as he was aware of what had gone wrong. The trust accepted he had not deliberately tried to cover up the incident and had shown insight into how to improve his practice. The consultant eventually accepted a written warning but was not reported to the GMC.

Emergency re-admission

The scene

An elderly female resident of a care home with mild dementia was brought into A&E after an unwitnessed fall. The patient was seen by an FY2 doctor, who carried out a comprehensive assessment and examination and noted a wrist injury but nothing to suggest anything more serious.

X-rays confirmed the patient had a Colles fracture, which was stabilized before she was discharged. However, 36 hours later she was rushed back to A&E by ambulance after becoming short of breath and was admitted with a haemothorax.

The FY2 doctor found out about the admission when his consultant approached him to write an incident report. Anxious about the implications, he called the MDU advice line.

MDU advice

The adviser explained that since 2010, all NHS trusts had a statutory duty to identify, investigate and report all serious incidents to facilitate organisational and NHS-wide learning. The adviser reassured the doctor that such processes are not designed to be punitive, but empathised with his anxiety that an investigation could identify system or individual errors.

They recommended that the doctor write his report as soon as possible while the details were fresh in his mind and using his contemporaneous notes for reference.

Although the shift itself had been particularly busy and his recollection was somewhat limited, the doctor had written detailed notes which corroborated his holistic assessment of the patient.

During the call, the adviser explained how the doctor could approach writing the incident report to ensure it was comprehensive, open and provided a rationale for his actions at the time. The report, which should be capable of standing on its own, should include a factual chronology of the consultation, stating who he was and the capacity in which he was seeing the patient. Most importantly, the report should set out what the doctor found and what he looked for and did not find during his assessment.

The adviser forwarded written guidance to help the doctor draft his report and suggested he could send it to the MDU to review, to ensure it gave a sufficiently detailed and accurate account of his interaction with the patient.

The outcome

The FY2 doctor submitted his report, drafted with assistance from the MDU. The trust concluded its investigation without finding any errors or omissions in his individual practice.

The patient's haemothorax was successfully drained and she was discharged back to her care home.

> *"Most importantly, the report should set out what the doctor found and what he looked for and did not find during his assessment."*

Correcting the record

> *"While it was natural for him to be concerned about a possible complaint, covertly amending the records in retrospect was actually more serious as it could appear that he was dishonestly trying to cover up what had taken place."*

The scene

A foundation doctor had started work in a GI Unit and accompanied the on-call registrar to see a patient on the ward. The registrar explained that they needed to carry out an endoscopy to investigate the cause of the patient's stomach pain but the patient refused, saying he was frightened of choking.

The registrar tried to reassure the patient about the procedure and asked him to reconsider. He left promising that a doctor would see him again the next day but he collapsed and died that night.

The foundation doctor was saddened to hear of the patient's death and concerned to hear that his son had angrily disputed that his father would have refused an endoscopy. The doctor revisited his notes to confirm his memory of the consultation but was alarmed to discover that he had not recorded the name of the registrar and hurriedly corrected the record.

Soon afterwards the foundation doctor was called to attend a meeting with his consultant, who explained he had reviewed the records earlier and was surprised to note they had now changed. His consultant told him the registrar, who was a locum, could not be located and warned his actions were a real cause for concern. The worried doctor called the MDU for urgent advice ahead of a meeting with the clinical director.

MDU advice

The adviser and foundation doctor discussed why his decision to add to his record of the consultation was problematic, even if it was done with best intentions. While it was natural for him to be concerned about a possible complaint, covertly amending the records in retrospect was actually more serious as it could appear that he was dishonestly trying to cover up what had taken place.

It was important for patient care that the records authentically represented what had taken place during the consultation and were made at the same time as the consultation or as soon as possible afterwards, in line with GMC advice. Unexplained changes to the records at a later date would cast doubt on the integrity of the whole record and would make it harder to investigate adverse incidents or respond to complaints.

There might be occasions when a doctor genuinely believes that the records are not accurate, perhaps – as in this case - because they remembered something after writing them in a hurry or because they discovered that the patient's date of birth was wrong. In these situations, it is permissible to add to the records but it must be clear to others that this had happened in retrospect, perhaps by stating this in capital letters. The original entry should not be deleted or redacted. All additions should have the date and time of the new entry as well as the original consultation and be signed by the person making the amendment. It is also helpful to state the evidence used to make the note, for example if the note is made from memory, or from other written notes made at the time, such as a jobs list.

The outcome

During his meeting with the clinical director, the foundation doctor explained what he had done and his intentions when amending the record. He recognised that he should have spoken to his consultant if he wanted to clarify what was in the records but that he had panicked. He also pledged to undergo additional training to improve his record-keeping.

After talking to the consultant, the clinical director concluded that the foundation doctor had been unwise but not deliberately dishonest, and was impressed that he had reflected on what had happened and was committed to improving. The trust did not discipline the doctor, but the consultant ensured his note-taking was more closely supervised.

It later emerged that the patient had confided his fears about having an endoscopy to another family member and the patient's son did not make a complaint.

Time to speak up

The scene

One patient who was continent but immobile confided that nurses had given her an incontinence pad to sit on because they didn't have time to take her to the toilet and that several other patients had the same experience. Later that week, the doctor noticed that that four patients who were unable to feed themselves had had their meals taken away untouched because no one had time to help them.

She tried to speak to a charge nurse but they told her they were too busy and the consultant in charge was away.

Disturbed by what she'd found, the doctor called the MDU for advice on how best to raise her concerns.

MDU advice

The medico-legal adviser agreed the doctor had an ethical duty to act if she believed patients' dignity and comfort were being compromised. Deciding to raise concerns was an important first step but she needed to do this in the right way and satisfy herself the problem had been properly addressed.

The adviser suggested she could speak to her trust's Freedom to Speak up Guardian (FTSUG) whose role was to help staff raise concerns. Her report would be more powerful if she could provide examples and it was important to focus on patient care.

The outcome

The doctor went on to raise her concerns through the trust's freedom to speak up process, describing the incidents she had seen. She followed this up in writing and kept a record.

To the doctor's relief her concerns were taken very seriously and it turned out the doctor's predecessor had recently taken the same step. Soon afterwards, the trust announced it was appointing a new departmental lead and revising its minimum staffing policies on the elderly care wards.

Learning points

- You must raise concerns if you believe patient safety, dignity or comfort is compromised.
- Don't allow personal or professional loyalties to outweigh your duty to patients.
- Follow your employer's process first – seek advice if you are thinking of raising concerns outside the organisation.
- Put your concerns in writing and give examples.
- Keep a record and follow up to check something has been done.

Listen to our podcast on raising concerns:
themdu.com/raising-concerns

"The doctor went on to raise her concerns through the trust's freedom to speak up process, describing the incidents she had seen. She followed this up in writing and kept a record."

Talking risks

> *“Although the surgeon may have already had a detailed conversation with the patient, the adviser emphasised that consent should be an ongoing process based on meaningful dialogue with the patient, rather than a one-off exercise.”*

The scene

When a patient with Dupuytren’s contracture attended hospital for a fasciectomy, a nurse asked a foundation doctor to obtain their signature on the consent form because the patient had missed their appointment at the consent clinic, and the surgeon had been called to an emergency.

She said this would be straightforward because according to the records, the surgeon had already spoken with the patient about the procedure and discussed the risks and benefits.

However, when the foundation doctor met the patient, she seemed anxious about the prospect of surgery and bombarded him with questions about the speed of recovery and likelihood of nerve damage, which would affect her ability to play the piano. Unable to answer the patient’s questions, the foundation doctor excused himself and sought urgent advice from the MDU.

MDU advice

The medico-legal adviser reassured the doctor he had done the right thing by not trying to bluff his way through the conversation. They said it was wrong for someone to delegate this task to him without checking he was suitably trained and competent, had sufficient knowledge of the procedure and the skills to have a dialogue with the patient. While the surgeon retained overall responsibility for obtaining the patient’s informed consent, the foundation doctor would have to take responsibility for his involvement and needed to speak up if he was being asked to practise outside his competence.

Although the surgeon may have already had a detailed conversation with the patient, the adviser emphasised that consent should be an ongoing process based on meaningful dialogue with the patient, rather than a one-off exercise. The GMC’s consent guidance says doctors should listen to the patient and ask questions to explore their wishes, fears and expectations, and understand what is important to their quality of life. Equally, a patient should have the opportunity to ask questions and discuss concerns and to change their mind at any time.

Watch our webinar on consent:
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The outcome

The doctor spoke to an ST4 in the department with experience of the fasciectomy procedure and he agreed to talk to the patient about her concerns. After speaking with the specialty trainee, the patient signed the consent form and the surgery went ahead without complications.

Following this incident, the foundation doctor resolved to ask more questions the next time he was asked to carry out an unfamiliar task and ensure he had appropriate training and experience.

Learning points

- Be clear about the limits of your knowledge when communicating with patients.
- Tailor consent discussions to individual patients and focus on what matters to them to ensure they are able to give informed consent.
- Speak up if you are asked to do something which is beyond your training and competence.
- Understand the GMC’s seven principles of decision-making and consent and how these apply to your practice.

Inadequate records

The scene

A hospital consultant contacted the MDU for advice about using electronic records. The hospital where she was working was trying to move to a paperless electronic system, whereby all clinics would be carried out without paper records.

She was concerned as the system had not yet been fully implemented and not all the previous records had been uploaded onto the database. She was being asked to see patients and make clinical decisions in clinic without access to all past clinical records, which she felt might contain potentially relevant medical information that would influence her decision making.

MDU advice

The MDU adviser confirmed that the GMC guidance does say that in providing care, doctors must take account of a patient's history and check that the care or treatment provided is compatible with any other treatments the patient is receiving.

The GMC guidance also says that if patients are at risk because of inadequate resources, policies or systems, you should put the matter right if possible and raise a concern to the appropriate person or organisation.

The adviser suggested the doctor speak to her line manager and clinical director to make them aware of the situation and her concerns, and follow up the conversations with an email.

In the interim, the adviser suggested the member could propose that until the system is fully implemented, patients are seen with their paper records as well. Another alternative might be that if the doctor saw a patient who she didn't feel she could manage without access to their complete medical record, she could ask the patient to reattend or review the records when available, before again discussing with them a clear management plan as to the way forward.

The outcome

The consultant spoke to and emailed the outpatient manager and also the clinical director about her concerns. It transpired that those concerns were also shared by her colleagues. The hospital management team agreed to continue to make paper notes available for the clinics until such time it was felt that they were no longer needed by the clinicians seeing the patients and the transfer to use of electronic records had been completed.

> *"The adviser suggested the doctor speak to her line manager and clinical director to make them aware of the situation and her concerns."*