MDU

Case scenarios, advice and tips

For new GPs

Being a GP will test your clinical knowledge and professional skills in a wide range of situations. The valuable experiences and feedback gained during your training will help you develop as a doctor, build your confidence and will probably stay with you throughout your career.

We have developed this guide primarily to support GPs in training, although some of the scenarios may also be of general interest to GP trainers and recently qualified GPs.

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Making introductions

A GPST examined a patient who had a rash on her torso. He didn't think it was anything serious, telling her to return in a couple of weeks if it hadn't cleared up. However, when he discussed the case with his trainer, she recommended arranging some tests.

The trainee informed the patient but she was upset at having to take more time off work. She said that if she had known her appointment was with a trainee, she'd have asked to see someone more qualified instead.

The GPST apologised for the misunderstanding and inconvenience. He arranged for the patient to see one of the GP partners at an evening surgery, to avoid her needing to take time off work.

Following the incident, the practice instigated a system where the receptionist would tell patients that their appointment was with a GP trainee and offer them an alternative. The patient was satisfied with the explanation and apology and pleased to note that changes had been made to procedures as a result of her concern.

MDU advice

- Make sure your GPST status is clear from the beginning of a consultation, especially when meeting a patient for the first time. You should also tell them if you need to discuss their case with your trainer.
- The GMC says 'Other examples of information that might be relevant and, if so, should be shared with patients include: the names and roles of key people who will be involved in their care, and who they can contact (and how) if they have questions or concerns.' (***Decision making and consent,*** 2020).

A social media slip-up

A GPST saw blood test results for an elderly patient with a significantly raised tumour marker. Later that evening, he posted the patient's blood test result on a closed forum for doctors and asked for advice on breaking bad news.

Another GP in the group, whose father had just been told that he required an urgent biopsy, realised that the GPST had been describing her father's case. As the test result figure was the same she was able to confirm her suspicions by looking at his user-profile.

Having been told about the forum post by his daughter, the patient subsequently complained to the practice. He was concerned that his confidentiality had been breached and was upset that his illness was discussed with people not involved in his care.

The GPST responded to say that he was sincerely sorry for his post and the distress he had caused. He reflected carefully on what had happened, explaining that he now realised that even anonymised information could identify a patient and that his first port of call for advice should have been his trainer at the practice.

The GPST advised that in future he would be even more cautious about posting anything on professional internet forums. The practice also held a significant event meeting and considered whether the breach was reportable to the ICO.

MDU advice

- Social media can be a valuable tool but your ethical responsibilities still apply online, including the need to respect patient confidentiality and behave professionally.
- Be extremely cautious when using membership-only professional sites to seek advice. Even if you are confident that an individual post has been sufficiently anonymised, bear in mind that someone close to the patient may still be able to identify them.
- Before posting online, even in closed groups, consider what the purpose of the post is and who might read it.

Wrong patient

A husband called their practice to request a home visit for his wife who had decided to be at home during her final days. The GPST who was triaging home visits that day misread the receptionist's note and accidentally pulled up the records for another patient with a similar surname. When he called to make the visit, he was surprised to find no one at home.

The patient's husband complained to the practice that he had eventually needed to call the out-of-hours service to provide symptom control for the patient in the final hours before her death.

The practice reviewed the records for all the patients triaged that day to see how the mix-up had occurred. It emerged that the GPST, who had recently joined, had not been aware of the practice's protocol in which GPs called to confirm the address with the patient/carer when arranging a home visit.

In its response to the complaint, the practice apologised to the patient's husband. The letter explained what had gone wrong and the steps it had taken to tighten its procedures. The husband was satisfied that lessons had been learned and did not take matters further.

MDU advice

- When you start a new placement, ensure the practice provides a suitable induction which should usually include running through key policies and procedures, computer systems, who to contact for help and the handover/referral of patients.
- If you are made aware of a complaint then you must cooperate with any formal inquiry or complaints procedure. This is likely to require a statement of your involvement in the incident and you may find it easier and reassuring to contact the MDU's medico-legal advisers for advice at the outset.
- Try to take something positive from mistakes. Your reflections on what went wrong, why and how you will do things differently next time are a useful addition to your ePortfolio.

Missed diagnosis

A GPST saw a six-month old infant who presented with a temperature of 38.2°C with a recent history of diarrhoea and vomiting. She found no rash and noted that the child was alert and his chest was clear and there was no evidence of respiratory distress although his throat was mildly inflamed.

Diagnosing a viral illness, the GPST advised the baby's mother about some of the major 'red flag' symptoms and how to seek further help if her son's condition deteriorated. She considered seeking the opinion of her supervisor but the practice was short-staffed that day and she didn't want to waste his time.

The following day the child was admitted to A&E with fits and was subsequently diagnosed with pneumococcal meningitis. Fortunately, he made a full recovery but his parents accused the GPST of failing to make a proper assessment and failing their son by not arranging for him to be admitted to hospital.

The practice investigation found that the GPST had made a meticulous record of her examination, including her negative findings and the advice given. However, she carefully reflected on what had happened and explained to her supervisor her regret at not seeking input from a more experienced colleague and admitted she was not familiar enough with the relevant NICE guidelines on assessing fever in the under-5s.

The practice response to the complaint included the GPST's honest and insightful comments, along with her apology for what had happened, and it also emphasised what had been learnt. The parents accepted the apology and explanation; they were particularly reassured that the GPST had clearly understood the lessons from the incident.

MDU advice

- You have an ethical duty to recognise and work within the limits of your competence. Seek advice if you encounter something in which you have little experience or if you are unsure of how to proceed.
- Meningitis is notoriously difficult to diagnose in its early stages because the signs are similar to many other common illnesses. With any diagnosis, it helps to have a detailed record of the examination, positive and negative findings and advice. This will assist colleagues who may subsequently see the patient and will be important if the standard of your care is called into question.

A disclosure dilemma

A newly qualified GP saw a 70-year old man for a medication review. The patient had type 2 diabetes and early-stage vascular dementia but was still living independently with help from his wife. During the appointment, the patient confided that he was still driving and vowed he would never voluntarily give up his license.

The GP was concerned about the risk the patient might represent to other road users as his disease progressed, so she contacted the DVLA's medical advisers for confidential advice.

On the basis of this advice, the GP explained to the patient that he had a legal responsibility to inform the DVLA as his dementia may impair his ability to drive. She tried to reassure him that this wouldn't automatically mean he would be disqualified from driving, but warned that doing nothing might affect his insurance cover and risk a fine. The patient promised he would notify the DVLA and the GP explained how he could do this.

A week later, the practice receptionist told the GP she had seen the patient make several attempts to park while she was on her way to work. When the GP called, the patient blamed narrow parking spaces but admitted he had not yet 'got around' to notifying the DVLA. At this point, the GP advised she had a duty to report the matter if he would not, because he was putting the public at risk.

The patient was upset but after talking to his wife, he agreed to notify the DVLA himself. Once notified, the DVLA made contact with the practice for further information on his condition. This was provided, with the patient's consent, and following a driving assessment he was allowed to keep his license subject to annual review.

MDU advice

- Doctors owe patients a duty of confidentiality, but it might be necessary to disclose information about a patient, even without their consent, to protect individuals or the wider public from serious harm - for example, if you suspect a child is at risk.
- You must be able to justify disclosures in the public interest, particularly if they are made without the patient's consent. Seek advice and keep a careful record of any discussions with the patient and decision-making process.
- Keep such disclosures of identifiable information to the minimum necessary and be sure not to compromise the confidentiality of others.

Following guidelines

A female patient asked a newly qualified GP to check a mole on her leg that had bled after she had caught it shaving. The patient revealed that she used to be a regular user of tanning salons, but had stopped after her aunt was diagnosed with skin cancer.

The GP, who had recently started at his first practice, carefully examined the mole and reassured the patient that it was almost certainly benign. He advised the patient to keep an eye on it and return if it changed size, shape or colour.

A month later, the patient returned to say that the mole was itching and had become inflamed. The GP made an urgent referral to the fast-track dermatology clinic where it was removed and sent for analysis. This revealed the patient had a malignant melanoma which required wide local excision, although further tests fortunately showed that the cancer had not metastasised.

The GP looked back on his notes with the practice owner, which established that he had not followed the checklist for assessing skin lesions as recommended by NICE. To address this gap in his knowledge, he enrolled in professional development courses on the diagnosis and referral pathway for melanoma. He also completed a piece of reflective writing about the value of national guidelines.

However, the GP was dismayed to find himself the subject of a series of different investigations into his error. This began with a complaint from the patient, who said the GP should have made an urgent referral at her first appointment. She also reported him to the GMC, which began an investigation. The GMC notified the case to NHS England, which then asked the local performers advisory group (PAG) to consider whether any action needed to be taken on the GP's inclusion on the Performer's List. The GP was invited to submit comments.

In its response to the complaint, the practice included an apology from the GP and reported what he was doing to learn from the incident. The practice also explained it was implementing its own protocol for suspected skin cancer to ensure they were fully in line with national guidelines. The patient did not take her complaint further but later moved to another practice.

The GMC was critical of the GP's failure to follow the relevant NICE guidance. However, it also noted this was a single incident and in the light of the GP's efforts to remediate, it concluded the case with a letter of advice. After being informed of the outcome of the GMC's investigation, the PAG allowed the GP to continue on the Performer's List.

MDU advice

- While guidelines do not replace the knowledge and skills of GPs, you are expected to be familiar with any nationally recognised guidelines and take them into account when exercising your clinical judgment.
- A GP may be subject to many investigations arising from a single clinical incident – patient complaint, disciplinary inquiry, GMC complaint, claim for negligence and even a police investigation. We call this multiple jeopardy.

  Our members can call on us for assistance before a trial, fitness to practise panel or coroner's inquest/FAI, and get help to prepare statements and arrange legal representation if needed.

Changing the record

A patient went to see her GP because she had been feeling anxious and depressed following the breakdown of her marriage. The GP was new to the practice, so he looked back through the clinical record and noticed the patient had attempted suicide five years ago after an argument with her husband.

However, when he asked the patient about this, she became angry and denied that she had ever tried to kill herself. She demanded that the GP remove this entry from the record because she had a legal right to correct inaccurate information and it would cause doctors to judge her unfairly.

The GP sought advice from the practice's data protection officer. She explained that as a data subject, the patient had the right to correct data if it is factually inaccurate or incomplete, such as a misspelt name, but this does not extend to clinical opinions.

At her suggestion, the GP went back to the patient to explain the situation and suggest an alternative course of making an additional note that she disagreed with the content. He also reassured her that he had made no judgment about her based on the record. He was only interested in whether she would benefit from mental health support.

The patient was disappointed but accepted his suggestion. She also agreed to the GP's proposal to refer her to a counsellor.

MDU advice

- Records must never be overwritten, inked out or deleted. Factual errors can be corrected but it must be immediately obvious what has been changed, who made the amendment and the time and date it was changed.
- If you forget to include something significant in your records, you can make an additional note, but it should be clear when you added the information and why. This way your honesty cannot be called into question.
- Familiarise yourself with your practice's data protection policies and procedures so you know how to manage subject access requests, report a data breach and respond to queries. You should also know the name of your practice's data protection officer so you can seek further advice if needed.

Safety netting

A patient with with chronic obstructive pulmonary disease (COPD) who had smoked for many years saw a new GP about a persistent cough. The GP made a brief note of the consultation: 'cough, no signs, likely exacerbation of COPD, for antibiotics and steroids, see as needed.'

Six months later, the patient returned after losing a significant amount of weight and the GP sent her for urgent tests, which led to a diagnosis of lung cancer.

The patient's family complained to the GMC, whose expert report criticised the medical records and the GP's failure to have provided any safety netting advice in a patient with risk factors for lung cancer.

The GP recognised that her record-keeping was inadequate at the first appointment and accepted she should have documented the examination and a thorough history. She also agreed that she should have specifically advised the patient to return for a re-assessment if the symptoms were not settling.

Noting that she had shown insight, the GMC case examiners agreed undertakings with the GP, including a commitment to complete further training and work under supervision pending a further review of her practice. These undertakings would stay on her record for 10 years.

MDU advice

- Many patients present to the GP with ambiguous symptoms that may or may not turn out to be something serious. Safety netting helps ensure they receive appropriate advice and that systems are in place to provide safe monitoring and follow-up.
- Be specific about when and how patients should seek further attention, a likely timescale to expect improvement, the 'red flag' symptoms to watch for, and how to access medical advice, especially in an emergency.
- As with any diagnosis, make a detailed record of the examination, positive and negative findings, and the advice you give. This will help colleagues who may see the patient after you, and will be important if your care is called into question.

Top tips

1. **Know your limits** and don't be nervous of asking for help from your supervisors or GP colleagues. Remember, you can also call the MDU's free 24-hour helpline for confidential advice on ethical matters such as patient consent, confidentiality or assessing capacity.

2. **Mind the gap!** State indemnity only covers clinical negligence claims, so you will need MDU membership for advice and assistance with other matters, including patient complaints, GMC referrals, ombudsman investigations, performers' list actions, coroners' inquests/fatal accident inquiries, media inquiries and criminal investigations.

3. Make the most of **your support network,** whether this is your new practice colleagues, your friends or family or the MDU. They will help you stay on top of things and maintain your work-life balance.

4. Keep up the good habit of **reflecting on your practice** after qualifying as a GP. Reflection can help you identify areas for improvement and gaps in your knowledge, which will help you become a better GP.

5. Focus on your **communication skills** as this will help you and your patients get the most from each consultation. Many patients want a GP who listens without interrupting as much as they want a diagnosis.

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with real-life experience of the pressures and challenges faced in practice

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