Learning Line

The medical directorate at NHS England (South East) receive and respond to a wide range of clinical issues covering the scope of general medical practice. There are some recurring themes (such as the use of chaperones, record keeping and confidentiality) but some are more unusual. Below are some cases together with the lessons learnt which we can share with you. Some of the case details have been changed to maintain anonymity.

“The state of the nation”

There are a team of 15 clinical advisers supporting NHS England in the Southeast. All are experienced GPs working in General Practice. Much of their work involves providing a clinical response to complaints that come to NHS England and require a response. Many of the complaints are about access to appointments which will not be a surprise to any of you. There are two themes which are becoming more frequent. The first is failure to visit a patient to assess their condition. When there have been difficulties, this usually follows an incomplete telephone consultation where the patient needs have not been appropriately assessed. A second theme relates to the use of paramedic and nurse practitioners. We all know what a good service they provide, but there have been occasions when there have been delays in diagnosis when these health professionals have been involved. It is worth remembering that GPs are the experts in managing complex patients and diverse presentations and less experienced colleagues may not recognise the different presentations.

Beware of the error of Blind Obedience to perceived authority, or to technology.

Recently, a GP following the recommendations in a consultation letter from a urologist regarding a patient with anabolic steroid induced hypogonadism, read the instruction "I have suggested to him to start with Nebido 1000 mg and I would be grateful if you could arrange for him to have this injection. After 4 weeks of injections he should have a serum testosterone check to see whether the levels have come up and it then needs to be repeated at 8 weeks," as give four injections at weekly intervals instead of one injection then repeat testosterone level after 4 weeks.

Suggestion to avoid this type of medication administration error:

Always review prescribing information in the BNF when:

1. You have never prescribed the medication previously.

2. You are following the recommendations of another clinician whether consultant or GP.

3. Overdose (or under dose) of the medication carries serious risks.

4. In any other case where you are uncertain, e.g., children as dose weight dependent.

Delayed diagnosis (Respiratory examples)

There are occasions when it is apparent that a delay in diagnosis has occurred. This can arise for several reasons. Two respiratory cases illustrate this.

A patient presented with increasing shortness of breath. CXR and a CT scan suggested pulmonary fibrosis and COPD. The patient was not referred at the time of diagnosis but received management in the Practice for her COPD. She was referred for a respiratory specialist opinion, but her pulmonary fibrosis was too advanced to receive any treatment.

A second patient with known COPD became shorter of breath. This was treated as an exacerbation of her COPD for some months until she was investigated further and found to have advanced carcinoma of the lung. The causative agent of COPD and carcinoma of the lung is shared, so be aware that a deterioration may be due to a lung carcinoma.

The importance of good clinical notes – sore throat

Sore throat is a common condition. Many settle without treatment but detecting those that require antibiotics can be a challenge. There are several decision support tools that can help. Centor is one of these. FeverPAIN is another. If you choose not to use these, ensure that you do record the appearance of the tonsils, any lymphadenopathy, temperature and how long the symptoms have been present. We are encouraged not to use antibiotics, but there are a few patients that will require them. NHS England received a complaint from a patient about the management of her sore throat. She developed a quinsy and required surgery. Because the clinical notes were comprehensive, NHS England was able to respond and support the care the GP Practice provided.

Relationships with patients

From time to time NHS England investigates allegations of inappropriate relationships with patients. These allegations may come from patients, safeguarding, colleagues, police and occasionally family members. Inappropriate relationships of an emotional or sexual nature, often involve male rather than female doctors. There can be serious repercussions for doctors who find themselves involved in such circumstances. On occasions, allegations are made which cannot be proven. Even so this can be extremely distressing for all concerned. To avoid these, consider:

- Use chaperones for any intimate examination
- Be careful in your use of social media
- Do not text patients or give your mobile phone number unless you can justify this.
- If you feel that you are forming a personal relationship with a patient seek advice from a colleague, LMC or NHS England.

An anonymous complaint raised a possibility that a GP had behaved inappropriately during an intimate examination. Fortunately, the practice had a Chaperone Policy and always adhere to this. You never know when a patient may complain, so having a policy and strictly adhering to it is crucial. The MPS state:

Regardless of the patient's role, the guidelines from medical regulatory bodies are clear: it is always the doctor's responsibility to manage and maintain professional boundaries – utilising chaperones effectively is a way of managing relations with patients, where the ultimate responsibility for ensuring that relations remain on professional footing rests with you.

Don't forget the possibility of TIAs

A man in his sixties gave a history of transient weakness in his right arm and leg over several weeks. His GP thought that this may be due to a musculoskeletal condition and referred the patient urgently to the MSK service. The following day the patient had a stroke and was admitted to hospital. While TIAs generally do not cause permanent brain damage, they are a serious warning sign that a stroke may happen in the future and should not be ignored. Studies conducted between 1997 and 2003 estimated that the risk of stroke or an acute coronary syndrome was 12 to 20% during the first 3 months after a transient ischemic attack (TIA) or minor stroke. An $ABCD^2$ score of 6 or 7 were each associated with more than a doubling of the risk of stroke.