Revalidation Support Team

Supporting doctors to provide safer healthcare

Responding to concerns about a doctor's practice

Case study 4
Primary care

July 2012
www.revalidationsupport.nhs.uk

Confidentiality and anonymity

This case study has been created to illustrate factors to be considered when addressing concerns about a doctor's practice.

In the interest of protecting the identity of individuals, this report has been compiled from several different cases. All details relating to individuals have been changed.

Source document

Supporting doctors to provide safer healthcare: responding to concerns about a doctor's practice (RST, 2012)

Case study 3
Primary care

Bullying, inappropriate behaviour and health

Dr D was a 46-year-old GP, who for the previous four years had been teaching medical students at the practice. She had been a long-standing member of the Local Medical Committee and was well-known within the medical community for her strong views on the NHS.

Dr D had developed an approach to teaching in which she tasked the students with presenting cases to her every morning. A stickler for detail, however, Dr D regularly became irritated if she felt that the cases had not been presented exactly to her standards. In these situations, Dr D threatened to fail the students in their assessments, to encourage them to try harder. Dr D also insisted that the students make her coffee and go out to buy her lunch.

There were a number of reports from students who had been taught at the practice, stating that they felt intimidated by her, although no formal complaints had been made.

On one occasion two attached students became distressed as they felt that Dr D had been rude to a patient. She had also examined a male patient's genitalia in front of the two female students in a manner they felt was disrespectful, without any discussion of chaperones. The patient in question did not complain to the practice.

Both students subsequently accompanied Dr D to a nursing home, where again an intimate examination on a male patient was performed, without any consent or explanation. When one of the students raised this with Dr D, she sent them both home and instructed them never to return to the practice.

Dr D then wrote to the course organiser at the primary care department of the university stating that in clinical terms the students were the worst she had ever encountered and that she was refusing to sign them off for their attachment. As a result, both students had to attend a progress committee hearing.

The students spoke to the postgraduate dean. They felt they had been bullied and that Dr D had some attitudinal and behavioural issues.

That week, the PCT medical director also received a letter from the GMC, asking for information about Dr D. A patient had written complaining that a cervical smear test had been undertaken with neither dignity nor consent. The procedure had also caused pain, for which Dr D had refused to apologise.

The medical director held five previous attitudinal complaints against Dr D on file. Two of these had been managed by his predecessor and related to consent to examine issues.

Dr D was seen jointly by the medical director and the course organiser. She admitted that the students had been academically excellent. Following receipt of a letter from the GMC Dr D took sick leave for five months. She attended an occupational health assessment and was subsequently treated for obsessive-compulsive disorder and depression.

On Dr D's return she agreed to attend chaperone and consent training and to keep a log of chaperone codes for her appraisal. She also attended communication skills training and worked with a coach. The GMC did not proceed further with the case.

Indicative costs

- Assessment = £6,000.
- Training and coaching = £10,000.
- Sickness absence paid by insurance policy = £58,000.
- Human/hidden costs not quantifiable; costs to patients suffering and harm, costs to students' emotional health.

Total cost = £74,000 (plus hidden costs).

Key messages

- Medical schools should have mechanisms in place so that medical students can raise concerns about doctors they encounter during their training. Local processes should facilitate the triggering of concerns by patients, which in turn should maximise the opportunity to manage concerns locally.
- There is value in remaining alert to the possibility of a health issue being at the root of a concern.

- Formal investigation should confirm the nature of the concern, its categorisation and its level of risk. It should indicate whether there is a need for assessment to decide a suitable intervention.
- Recognising such problems offers an opportunity for appropriately targeted intervention.
- Formal review to confirm that a concern has been resolved should help reduce the likelihood of its resurfacing in the future. At such review, the option of ongoing management through further development, ongoing supervision or amendment of scope of work may be appropriate.