Investigation of a complaint against a GP Practice

Report Reference: 202004496

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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Appendix 1 – The Principles of Good Administration

Case Reference: 202004496
Listed Authority: A GP Practice

SUMMARY

The patient raised a complaint about the actions of the Practice when she attended for a gynaecological examination on 8 March 2023. The Practice offered the patient a chaperone. However, she became upset and said that having a chaperone present made her feel '*embarrassed and humiliated'*. She said the Practice '*forced*' her to proceed with a chaperone.

The investigation identified guidance that doctors should follow when offering chaperones to patients. It found the Practice failed to act in accordance with this guidance as it did not clarify that the patient had a choice as to whether she wanted a chaperone during the examination. The Practice also did not inform her that she could reschedule her appointment with a doctor who was comfortable conducting the examination without a chaperone present. I considered the Practice's failure to provide the patient with sufficient information that would have allowed her to make an informed decision on whether to proceed was a failure in the patient's care and treatment.

The complaint was also about the Practice's decision to remove the patient from its Patient List in March 2023. The patient believed the Practice unfairly removed her without following guidance. The investigation found that the Practice's actions were not in accordance with relevant legislation. It also found its decision to remove the patient was unfair and disproportionate. I considered this maladministration. However, the investigation did not find that the Practice took the decision to remove the patient because she submitted a complaint.

I recommended that the Practice apologise to the patient for the injustice caused to her. I also recommended actions for the Practice to take to prevent these failures from reoccurring.

THE COMPLAINT

1. This complaint was about care and treatment provided by the Practce to the patient in March 2023. It was also about the Practice's decision to remove the patient from its Patient List.

Background

2. The patient booked a rapid access clinic appointment[1] for a gynaecological examination at the Practice. The patient was worried about the examination as she had a family history of ovarian cancer, and she was concerned she was showing symptoms.

3. The patient attended the Practice for the appointment on 8 March 2023. Prior to the examination, the doctor requested that a nurse be present in the room to act as a chaperone. The patient initially disagreed to the chaperone. However, she later agreed when the doctor informed her she could not continue without someone present.

4. While in the waiting room, the patient raised concerns about the length of time she had waited for the appointment. The Practice stated it was during this time the patient's behaviour became inappropriate. The patient submitted a complaint to the Practice on 14 March 2023. She later received a letter from the Practice, also dated 14 March 2023, informing her that it decided to remove her as a patient.

Issues of complaint

5. I accepted the following issues of complaint for investigation:

    Issue 1: Whether the Practice appropriately assigned a chaperone to the patient for her examination.

[1] The Practice explained this is a list of patients to be seen by a doctor anytime between 10:00am and 11:00am each day.

Issue 2: Whether the Practice's removal of the patient from its list of registered patients was carried out appropriately and in line with relevant guidance.

INVESTIGATION METHODOLOGY

6. In order to investigate this complaint, the Investigating Officer obtained from the Practice all relevant documentation together with its comments on the issues the patient raised.

Independent Professional Advice Sought

7. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor (IPA):

    - A General Practitioner (IPA) with experience in primary care.

    I enclose the clinical advice received at Appendix two to this report.

8. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

9. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

    The general standards are the Ombudsman's Principles[2]:

    - The Principles of Good Administration
    - The Principles of Good Complaints Handling

10. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative

[2] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

functions and professional judgement of those individuals whose actions are the subject of this complaint.

The specific standards and guidance relevant to this complaint are:

- The General Medical Council's[3] Guidance on Intimate Examinations and Chaperones, updated November 2020 (the GMC Chaperone Guidance);
- The General Medical Council's Ethical Guidance: Decision Making and Consent, November 2020 (GMC Consent Guidance);
- The Health and Personal Social Services (General Medical Services Contracts) Regulations (NI) 2004, Schedule 5, Part 2 (HPSS Regulations)[4];
- British Medical Association's Removing Patients from your Practice List, Updated 7 September 2020 (BMA Guidance);
- General Medical Council's Guidance on Ending your Professional Relationship with a Patient, Published 25 March 2013 (GMC Ending Relationship Guidance); and
- The Practice's Comments, Complaints and Suggestions (Practice complaint procedure).

I enclose relevant sections of the guidance considered at Appendix three to this report.

11. In investigating a complaint of maladministration, my role is concerned primarily with an examination of the Practice's administrative actions. It is not my role to question the merits of a discretionary decision. That is unless my investigation identifies maladministration in the Practice's process of making that decision.

12. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

[3] An independent body that oversees doctors in the United Kingdom (UK).
[4] Covers the removal from GP Patient Lists in a range of scenarios.

13. A draft copy of this report was shared with the patient and the Practice for comment on factual accuracy and the reasonableness of the findings and recommendations. In response to draft report comments were received from the complainant and the Practice. These were fully considered.

THE INVESTIGATION

Issue 1: Whether the Practice appropriately assigned a chaperone to the patient for her examination.

Detail of Complaint

14. The patient said the Practice doctor told her she '*needed a chaperone'* present to proceed with the examination on 8 March 2023. She explained the doctor '*refused to do the exam without someone there*' so she felt '*forced*' to proceed with a chaperone present.

15. The patient said this caused her upset as she was '*embarrassed and humiliated*.' She said she never had an '*audience*' for other gynaecological examinations.

Evidence Considered

Legislation/Policies/Guidance

16. I considered the following policies and guidance:
    - GMC Chaperone Guidance;
    - GMC Consent Guidance; and
    - Practice Notice.

The Practice's response to investigation enquiries

17. The Practice stated the doctor's request to have a chaperone present for the patient's examination '*was not an attempt to humiliate'* her or make her '*feel like a crazy person*' as indicated by the patient at the time. Having a chaperone is a '*safeguarding measure'* for both the patient and clinician, which several of its clinicians implement. The chaperone during the patient's examination was a nurse. The doctor explained to the patient the reason for the chaperone and the patient '*consented*.'

18. It stated it displayed notices about chaperones in the waiting room and it referred to GMC Guidance[5].

19. The Practice doctor who conducted the examination said she acted in line with guidance. She said she offered the patient '*an alternative date within 24 hours'* but the patient did not want to postpone and consented to the chaperone. She felt she acted '*in the patient's best interests*.'

Relevant Practice records

20. I enclose relevant extracts of records considered at Appendix three to this .report.

Analysis and Findings

The chaperone

21. The patient said she told the doctor she did not want a chaperone present during the examination. However, as the doctor '*refused*' to continue without a chaperone, she said she felt '*forced*' to proceed with one present.

22. I refer to the Practice's record of the examination on 8 March 2023. It documents '*consent for examination given*' and a '*chaperone offered*.' It also documents the patient was '*initially v upset as felt this was because she had been agitated and was being treated now as some sort of psychopath*'. The IPA advised that it was clear from the record that the doctor offered the patient to have a chaperone present. This was in accordance with the GMC Guidance on Intimate Examinations, which states, '*Before*' a practitioner conducts an intimate examination, they should '*offer the patient a chaperone*[6].'

23. The guidance also states, '*A chaperone should be offered to the patient as an 'option.*' The use of the word 'option' indicates the patient had a choice to refuse to have a chaperone present. However, I do not consider the records evidence that the doctor explained this to the patient. In the absence of this evidence, I cannot be satisfied the doctor presented both options in accordance

[5] As enclosed in Appendix three to this report.
[6] The guidance describes this as an '*impartial observer*.'

with the guidance. Given the patient's obvious upset, I consider there was even more reason for the doctor to explain she had the option' to refuse a chaperone.

24. The GMC Guidance also states that if a practitioner does not want the examination to proceed without a chaperone, but the patient has declined, the practitioner '*must explain clearly*' why they want a chaperone present. The record documents the doctor '*explained*' it was '*normal practice to offer a chaperone for [a] gynae exam*'. The IPA advised this evidenced the Practice *'explained'* the need for the chaperone, which was '*in accordance with GMC [Chaperone] guidance*.'

25. While I acknowledge the IPA's advice, I do not accept that the records evidence the doctor clearly explained to the patient her reasons for preferring to have a chaperone present. I do not consider an explanation of it being '*normal practice'* an appropriate rationale in this situation. This is especially given the guidance allows for the patient to have a choice. Furthermore, I consider a full and clear explanation was necessary given the patient was extremely upset.

26. The GMC Guidance provides that if the patient and doctor cannot agree on whether a chaperone should be present, the doctor may wish to consider referring the patient to a colleague who is willing to examine the patient without a chaperone, '*as long as a delay would not adversely affect the patient's health*.' I note the Practice stated that the doctor offered the patient an alternative appointment within 24 hours. The patient refuted this.

27. I considered the record. It documents the Practice offered the patient the option to '*rebook*' her appointment when she arrived into the consultation '*very upset*' due to her waiting time in reception. It further documents that '*After long discussion*' the patient '*decided wanted to have exam today'* as she '*has put off for months and worries about history*.' However, I note the doctor offered this alternative appointment before the patient declined a chaperone for the examination. The records[7] do not evidence that the Practice offered the patient

[7] Detailed in paragraph 22 of this report.

an alternative appointment within 24 hours. Furthermore, there is no evidence it offered the patient an appointment with another doctor who was happy not to have a chaperone present during the examination. I do not consider this in accordance with the GMC Guidance.

28. Based on the evidence available, I am not satisfied the Practice acted in accordance with the GMC Guidance during the patient's examination on 8 March 2023. I consider this a failure in the patient's care and treatment. I am satisfied this caused the patient to sustain the injustice of upset, distress, and frustration. I uphold this element of the complaint.

Consent

29. The patient said she felt '*forced*' to continue with the examination with a chaperone present. The IPA advised the record documents the '*patient agreed*' to have a chaperone after the doctor provided her explanation. Therefore, she identified '*no concern*' from the evidence provided.

30. I appreciate the IPA's and the Practice's position that ultimately the patient '*consented*' to have a chaperone present. This is evident from the record. However, the NHS states[8], '*For consent to be valid, it must be voluntary and informed…*' Therefore, I must consider how the doctor obtained the patient's *'consent'*.

31. In doing so, I considered the GMC Consent Guidance. The language used in both this guidance and that on Intimate Examinations, such as '*offer*,' '*option*' and '*make a decision*,' specifies the requirement for practitioners to provide the patient with a **choice** regarding their care and treatment. Principle 4 of the GMC Consent Guidance[9] places an express duty on practitioners to meet this standard.

32. The GMC Guidance states that when obtaining consent, doctors should listen to the patient and provide the information required to enable them to make a decision. I have already identified that the doctor did not fully explain to the

[8] As enclosed in Appendix three.
[9] 'Doctors must…'

patient the option of declining a chaperone or of arranging another appointment with another doctor. I cannot be certain that this would have impacted the patient's decision. However, I am not satisfied the doctor provided the patient with all of the information she needed to make an informed decision.

33. The guidance also requires doctors to '*find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action'*. I consider it would have been helpful for the doctor to have discussed the patient's concerns with her, with a view to understanding why she did not wish to have a chaperone present. However, there is no evidence in the records to suggest that this conversation occurred.

34. The guidance further states, '*You must not put pressure on a patient to accept your advice.'* The patient said the doctor refused to examine her without a chaperone present. Therefore, she felt '*forced*' to proceed. The IPA advised that from the records '*there is no evidence to suggest that the doctor refused to do examination if patient did not want chaperone*.' I accept this advice. I do not consider there is sufficient evidence for me to determine the doctor put pressure on the patient to continue with the examination.

35. However, based on the evidence available to me, I cannot be satisfied that the doctor acted in accordance with the GMC Guidance on Consent. I consider this a failure in the patient's care and treatment. I am satisfied this caused the patient to sustain the injustice of uncertainty and a loss of opportunity to have knowledge of all options available to her. I uphold this element of the complaint.

36. I note the Consent Guidance also states these standards '*describe good practice, and not every departure from them will be considered serious. You must use your professional judgement to apply the standards to your day-to-day practice. If you do this, act in good faith and in the interests of patients, you will be able to explain and justify your decisions and actions.*'

37. The Practice doctor stated that she was '*acting in the patient's best interests*.' The record documents that prior to the examination, the patient explained to the doctor that she '*wanted to have exam today'* as she had '*put off for months*' and was '*worried*' given her family's medical history. I consider this indicated that timing *'matters to [the patient]'* and that the doctor was aware of this. While I have identified failings, I do not doubt the doctor acted with the best intentions towards the patient based on previous knowledge of the patient's apprehension about the examination.

Issue 2: Whether the Practice's removal of the patient from its list of registered patients was carried out appropriately and in line with relevant guidance.

Detail of Complaint

38. The patient felt the Practice unfairly removed her from its Patient List. She said the Practice accused her of shouting and being abusive without conducting '*an actual investigation*' into the accusations which she denied. She said the Practice did not follow BMA guidelines.

39. The patient said she hand delivered her complaint letter[10] to the Practice on the morning of 14 March 2023. By letter dated the same day, the Practice informed her of its decision to remove her from its Patient List. She felt the Practice's decision to remove her was a '*reactive response*' to her complaint.

40. The patient said the Practice left her in an '*awful position*' without any healthcare at a time when she had been red flagged for cancer symptoms.

Evidence Considered

Legislation/Policies/Guidance

41. I considered the following legislation, policies and guidance:
    - HPSS Regulations;
    - BMA Guidance;
    - GMC Ending Relationship Guidance;
    - Practice Complaint Procedure; and

[10] Dated 9 March 2023.

- Practice Zero Tolerance Policy.

The Practice's response to investigation enquiries

42. The Practice stated it removed the patient from its Patient List due to a '*breakdown in doctor patient relationship*.' It did not issue the patient with warning prior to this. Its decision was in accordance with its Zero Tolerance Policy.

43. It stated its Practice Manager was on annual leave until 13 March 2023 and it made the decision to remove the patient the '*following afternoon*[11]*.*' The Practice confirmed it received the patient's complaint on 14 March 2023 but was '*unsure*' of the time. It added it had already informed the Business Services Organisation (BSO) of the patient's removal prior to receiving her complaint.

Relevant Practice records

44. I enclose relevant extracts of the Practice's records at Appendix four to this report.

Analysis and Findings

45. This issue of complaint was about the Practice's decision to remove the patient from its Patient List. In complaints of maladministration, my role is to identify the relevant statutory framework and consider whether the Practice applied those procedures that give effect to that framework appropriately. It is also to consider whether the Practice treated the patient fairly.

46. I considered the HPSS Regulations[12]. Schedule 5, Part 2 Paragraph 20(2)(b) permits removal on the grounds of an '*irrevocable breakdown*' in the patient and Practice relationship. It states that a Practice may only request a removal if it warned the patient, within the previous 12 months, they were at risk of removal. I note the Practice confirmed it did not issue a warning to the patient within the 12 months prior to her removal on 14 March 2023. Therefore, I am

[11] The Practice clarified this was the afternoon of 13 March 2023.
[12] Both BMA and GMC Guidance reiterate these Regulations.

satisfied the Practice did not act in accordance with this section of the Regulations when it made its decision to remove the patient.

47. In this event, I also considered whether it was appropriate for the Practice to remove the patient under Paragraph 21 of the Regulations, which states the criteria for removing a patient with '*immediate effect*[13]'. This can occur if '*the patient has committed an act of violence'* against a member of staff '*or behaved in such a way that any such person has feared for his safety*'.

48. The Practice removal letter to the patient described the patient's behaviour on 8 March 2023 as '*confrontational and aggressive*.' However, the Practice did not document that the patient '*committed an act of violence*' or that anyone '*feared for [their] safety*.' The Regulation also specifies that for immediate removal on the grounds of their behaviour, the Practice also had to have '*reported the incident to the police*.' The Practice confirmed that it did not do so. For the reasons outlined, I do not consider the situation met these criteria. Therefore, I am satisfied the Practice did not act in accordance with the HPSS Regulations when it made its decision to remove the patient.

49. As I stated previously, I must also consider if in making its decision, the Practice treated the patient fairly. I considered the patient's view that the Practice removed her because she raised a complaint.

50. The Practice's position was that its decision to remove the patient from its Patient List was not in a reaction to her submitting a complaint.

51. I considered the records. The Practice provided typed notes of a meeting it held on 13 March 2023 regarding the patient's attendance at the Practice on 8 March. The notes document: '*It was concluded that the interactions between [the patient] and the various members of staff was unreasonable and the relationship between dr and patient had broken down. It would be in the best interests of all parties if the patient was to be removed.'*

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[13] Without warning.

52. I note the patient confirmed that she delivered her letter of complaint to the Practice on 14 March 2023. However, the records evidence that the Practice took the decision to remove the patient on 13 March 2023 prior to receiving the patient's complaint the following day. Therefore, I am satisfied the Practice did not remove the patient in response to her complaint.

53. The first Principle of Good Administration, '*Getting it Right'* requires bodies to act '*in accordance with the law and relevant guidance, with regard for the rights of those concerned*.' The fourth Principle of Good Administration, '*Acting Fairly and Proportionately'* requires bodies to ensure its '*decisions and actions are proportionate, appropriate and fair*.' I consider the Practice's actions in removing the patient unfair and disproportionate. I am satisfied this constitutes maladministration and I uphold this element of the complaint. I consider this caused the patient to sustain the injustice of a loss of opportunity to access primary healthcare. I also consider it caused the patient to experience frustration and uncertainty.

54. I note the Practice referred to its Zero Tolerance policy, enclosed at Appendix three to this report. A Zero Tolerance Policy outlines to patients the behaviours a Practice expects when they deal with staff. It also informs patients of the consequences if they do not meet these standards, which may include removal. I considered the Practice's policy. While it provides a summary of expectations, it has shortcomings in complying with the regulations and guidance referred to above. I would ask the Practice to reflect on this and consider revising its own Zero Tolerance policy for its patients and staff.

CONCLUSION

55. I received a complaint about care and treatment provided to the patient on 8 March 2023. The complaint was also about the Practice's decision to remove the patient from its Patient List.

56. I upheld both issues of complaint for the reasons outlined in this report. I am satisfied the failures caused the patient to sustain the injustice of frustration, distress, upset, uncertainty and a loss of opportunity to have knowledge of all

options available to her. I also appreciate the worry the patient experienced during her examination, especially given her family history was likely forefront of her mind at that time.

Recommendations

57. I recommend that within **one month** of the date of the **final report**, the Practice provides to the patient a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the maladministration identified.

58. I further recommend for service improvement and to prevent future recurrence, that within **three months** of the date of the **final report** the Practice:

    I. shares the findings of this report with its Partners and relevant staff to provide them with the opportunity to reflect on the failings identified;
    II. provides training to relevant staff on the importance of informing patients of all options available prior to obtaining consent.
    III. provides training to relevant staff to include the removal of patients for the reason of a breakdown of the patient/Practice relationship in accordance with the HPSS Regulations.
    IV. The IPA advised the records evidence the patient had a '*poor experience.*' She advised the Practice should reflect on this and '*plan ahead*' to better inform patients of their chaperone policy '*prior to booking consultations*' for intimate examinations. It should also set out options for patients who do not wish to have a chaperone present. I recommend the Practice reviews its policy based on the IPA's advice.
    V. The Practice should implement an action plan to incorporate these recommendations. It should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any relevant policies).

MARGARET KELLY **November 2024**
Ombudsman

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.