SPSO decision report

Case: **201201617, A Medical Practice in the Forth Valley NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr and Mrs C complained that the medical practice inappropriately prescribed their father (Mr A) anti-inflammatory medication on a long-term basis, without also prescribing gastric protection medication. Mr A had sciatica (lower back pain caused by pressure on a nerve) and osteoarthritis (the most common form of arthritis, affecting the joints) in his knees. He had been on a non-steroidal anti-inflammatory drug (NSAID) for a number of years when he attended hospital several times complaining of abdominal (stomach) pain. He was eventually admitted to hospital, where he was found to have a massive gastro-intestinal haemorrhage (severe bleeding in the stomach/intestine) because of a bleeding ulcer. Doctors were unable to control this, and although Mr A had emergency surgery, he did not survive.

Our investigation found that guidance in 2008 said that gastric protection medication should be prescribed with NSAIDs. We upheld the complaints, as we found that from 2008 onwards Mr A should not have been prescribed a NSAID without this protection. We noted that this was in fact picked up at a medication review that year, which noted that Mr A was over 65 and a smoker and was, therefore, at increased risk of stomach bleed. The review said that if the NSAID prescription was continued, gastric protection medication should be added. The NSAID was then removed from Mr A's repeat prescriptions. However, a year later, a NSAID was added to his repeat prescriptions without gastric protection medication. The practice apologised to Mr C for this after Mr A's death and carried out a significant event analysis.

Mr C also complained that the practice failed to diagnose and treat Mr A's ulcer. Mr A had attended the hospital with abdominal pain several times, and they had told the practice about this. We found that the practice were not required to follow this up unless the hospital specifically asked them to do so, and there was no evidence that Mr A attended the practice with abdominal problems until the day before his death. That said, we found that Mr A's abdominal pain, along with the fact that he was taking the NSAID without gastric protection, should have alerted the GP to the probability that the pain was being caused by an ulcer. We found that the GP should have prescribed gastric protection at that time, although it was unlikely that this would have prevented Mr A's death.

Recommendations

We recommended that the practice:

- make the GP who examined Mr A on the day before his death aware of our finding on this matter; and
- issue a written apology to Mr C for the failure to carry out a reasonable and appropriate consultation on that day.