TS.64/03-04

Scottish Public Services Ombudsman Act 2002

Report by the Scottish Public Services Ombudsman
of an investigation into a complaint against

Two General Practitioners (GP 1 and GP 2) in the Lanarkshire area

Complaint as put to the Ombudsman

1. The account of the complaint provided by Mr C was that in November 2000 his mother, Mrs C, had a blood test arranged by GP 1 which indicated a slight abnormality in her kidney function. She had a history of hypertension and leg oedema and was on treatment with Inderal LA, Accuretic and frusemide. No monitoring or follow up tests were arranged.

2. Mrs C did not see a GP again until 17 July 2002. On 17 July Mr C telephoned GP 2 and asked for a home visit. Mr C explained to GP 2 that his mother was suffering from episodes of memory loss, confusion and agitation. She was also incontinent of urine and had not been able to leave her home for six months. Mrs C also had ulcers on her legs but Mr C's main concern was about his mother's mental state. GP 2 agreed to visit Mrs C at home where she examined Mrs C briefly and arranged for a District Nurse to visit the following day to take a blood sample. On 19 July the test results, which were abnormal, were passed by telephone to the GPs' Health Centre by the laboratory. GP 2 telephoned Mrs C's husband and advised that Mrs C should stop some of her medication which she did. GP 2 went on holiday on the same day (19 July 2002) and further blood tests were arranged for one week's time. On 23 July another home visit was requested. Another GP (GP 3) attended and arranged an emergency admission to hospital for Mrs C. She died in hospital later that day.

3. The matters subject to investigation were that:

a) the prescribing for, and monitoring of, Mrs C's condition between November 2000 and July 2002 was inadequate; and

b) GP 2's clinical management of Mrs C's presentation in July 2002 was not of a reasonable standard.

History of the complaint within the NHS

4. On 14 August 2002 Mr C met with GP 2 to discuss his concerns. He remained dissatisfied and GP 2 responded to him in writing on 31 August. On 9 September Mr C applied to Lanarkshire Primary Care NHS Trust (now Lanarkshire Health Board) for his complaint to be considered by an independent review panel (IRP). The IRP hearing took place on 22 January 2003. The IRP report was issued on 30 April 2003. The IRP's Terms of Reference were to review the diagnosis and treatment of Mrs C's condition by GP 2 particularly between 17 and 19 July 2002. The IRP concluded that there were concerns about GP 2's continuity of patient care and that the family's concerns about Mrs C's health on 17 July 2002 were justified. In their report the panel recommended that as a matter of urgency GP 2 took steps to ensure that the following procedures were introduced, implemented and routinely monitored by the Practice:

> 'i Hand-over protocols to ensure continuity of care.
>
> In cases such as [Mrs C]'s arrangements should be put in place to ensure that the patient's clinical condition is brought to the attention of another doctor prior to a GP going on leave.
>
> Time be allocated by the Primary Care Team to discuss how patients such as [Mrs C] who are prescribed medication but have not attended the Surgery over a period of years or kept hospital appointments are identified/monitored and receive appropriate care and support.
>
> ii The routine monitoring and reassessment of repeat prescriptions.'

Investigation

5. The Statement of Complaint for the Ombudsman's investigation was issued on 12 February 2004. Comments were obtained from GP 1 and GP 2 and relevant documents, including Mrs C's medical records, were examined. Two independent professional assessors were appointed to advise on the clinical issues in this case. Their report is reproduced at paragraph 15. An interview was conducted with GP 2. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. The medical terms used in this report are explained in the attached glossary.

Written evidence of Mr C

6. In correspondence with the GP Practice and Lanarkshire Primary Care NHS Trust (now Lanarkshire NHS Board) Mr C said:

> '... I feel that the advanced renal failure was due to a combination of prolonged use of the medication Accuretic without periodical monitoring checks ... frusemide is particularly useful for people who have impaired kidney function and increases potassium loss. ... a high potassium concentration level is bad for the heart and may, if extreme, prove fatal, which it did in my mother's case. An ECG and close monitoring of the situation should have been done on 19 July 2002 when the results of the first blood tests were known ...'.
>
> *In a letter received on 19 August 2002*
>
> '... Why did [GP 2] not refer my mother straight to hospital, especially as she (GP) was going on holiday the next day and would not be around to supervise and monitor [Mrs C]'s treatment after getting such a high blood test result of potassium and other kidney functions. Instead she left her at home with no proper support or care for a further four days until I had to call another GP [GP 3] who diagnosed kidney failure and admitted her into hospital but by then it was too late to seriously stand any chance of a recovery ...'.

Mr C brought his complaint to me because he said that although the IRP outlined certain protocols and procedures that needed to be changed and the IRP findings were acceptable as far as they went, they did not go far

enough. He said that GP 2 failed to take appropriate action in light of the abnormal blood test results resulting in the death of his mother. GP 2 had not accepted responsibility for that and instead blamed system failures and Mr C's mother by suggesting she was uncooperative. The IRP failed to comment on GP 2's failure to act appropriately on the test results.

Written evidence of GP 1

7. In his reply to the Ombudsman's Statement of Complaint GP 1 included:

> 'I saw [Mrs C] on 29 November 2000 with bilateral chronically swollen legs. Her right leg was weeping. She was already taking frusemide 40mg daily, and I advised her to double this to 80mg. … I reviewed [Mrs C] on 8 December 2000. … I advised her to continue on frusemide. … The blood test taken on 29 November showed a slightly raised urea level, 14.3, and I accept that this should have been checked at some time. …'.

8. In a later letter to the Ombudsman's office GP 1 included:

> 'In November 2000, we were still using a manual repeat prescribing system. Drugs for repeat were written on a separate sheet, and a note of prescription dates was kept for each drug. Review dates were written at the bottom of the sheet, however, we had to rely on the vigilance of the receptionists to monitor this. Blood reports at that time were stamped by the receptionist and seen by at least one but normally all three GPs before filing. If a report was abnormal, or if we wished to repeat it, this was written on the form by the GP, and the patient was told of this by the receptionist when they 'phoned for the result.
>
> Our present system is a bit different. Prescriptions are now computerised, and the computer default is set at a 6 month review for repeat prescribed drugs. The computer automatically adds a message to the prescription asking the patient to make an

appointment if it is more than 6 months since their prescriptions were reviewed.

Abnormal blood results are seen by the GPs as before, and any action to be taken noted on the report form. Abnormal results are kept in a separate file until the patient has been informed and then filed. We will 'phone the patient with results if they do not contact us and if we cannot contact them by 'phone we will send a letter. Urgent problems are dealt with in a similar vein, however if we cannot contact the patient by 'phone, either a GP or nurse will visit. Abnormal results that we wish repeated by the community district nurses are passed to them on a written request.

Patients who are being visited by the district nurse will have their BP [blood pressure] checked by the nurse. Most patients on anti-hypertensive drugs would attend the surgery for routine BP checks.'

Evidence of GP 2

9. In her reply to the Ombudsman's Statement of Complaint GP 2 included:

'... I was asked to speak to the son of [Mrs C] on the morning of Wednesday 17 July 2002. The request had been for a house call and I spoke to [Mrs C]'s son to find out the reason why. The information gleaned from the son over the telephone was that his mother had been deteriorating for some months with a combination of poor mobility, intermittent confusion and ulceration of the leg. I asked initially if [Mrs C] could come to the surgery but this was not possible. I do not recall any mention of incontinence in my conversation with [Mr C]. I did not keep records of this conversation as I had agreed to visit [Mrs C] later that morning.

I undertook a house visit on 17 July and there met [Mrs C] and her husband in the sitting room. [Mrs C] was unknown to me at that time as I had never seen her before. [Mrs C]'s regular GP was [GP 3] in the Practice. However, I did have the case notes with me and noted both from the notes and from my conversations with

[Mrs C] that she had been unwell for some time with a combination of poor mobility, intermittent confusion and chronic ulceration of the legs. [Mrs C] was a very reluctant patient and I realised that she was unhappy that the doctor had been asked to call. I also noted the medication she was on including Accuretic, Inderal LA and frusemide 40mgs daily.

I examined [Mrs C] and found her blood pressure was 100/70 and auscultated her chest and heart but found nothing abnormal. The plan that I formulated was to speak to the district nurses to restart the dressing of the leg ulcers which had been a chronic problem with [Mrs C]. The nurse had been attending until some months previously and I undertook to restart that. I also considered whether a Zimmer might be of use and even possibly a wheelchair. It was clear from the medical notes that [Mrs C] suffered from chronic lymphoedema and had in fact been offered appointments to attend dermatology out-patients which she had not taken up.

I also noted that [Mrs C] had electrolyte blood tests done in December 2000 and decided to arrange for the district nurse to do a full blood screen. I left the house at that point and there was no suggestion of any unhappiness with my visit although [Mrs C] remained a reluctant patient.

The district nurse called on 18 July 2002 and took blood for analysis of a full blood count, U&Es, LFTs, TFTs and Glucose. I noted from biochemistry previously that there was a raised urea and creatinine level.

On 19 July 2002 the Practice received a telephone call from the laboratory indicating that the electrolyte results were abnormal and that there was a high urea and creatinine levels indicating a chronic renal failure but also there was a high potassium level of 7.3. The upper limit of normal for this laboratory was 5. I received this information and decided that the potassium value itself may have been inaccurate because of a sampling error ie haemolysis. I ‘phoned the family as soon as I received the information and spoke

to [Mrs C]'s husband and then to [Mrs C] herself. I recall asking [Mrs C] how she was feeling and that she replied that she was much the same though maybe a little better. I asked about her medication and why she was taking it. [Mrs C] told me that she was on Accuretic and Inderal for her blood pressure and frusemide for her legs. During this discussion I suggested getting another doctor to see [Mrs C] (at this time I was thinking of requesting a geriatric domiciliary visit) but [Mrs C] declined this. I then suggested that she stop her Accuretic and frusemide and that the Practice would recheck her bloods the following week. I told her that if she felt any worse or if she was not getting any better she should re-call the surgery.

[Mrs C] had been started on the frusemide for leg oedema on 16 November 1998. The patient still had gross leg oedema therefore the frusemide did not appear to be helping this condition. Also it is generally accepted that frusemide is not very useful for leg swelling. I therefore considered stopping it. The patient's blood results (U&E's) also suggested that she may be dehydrated and this would be worsened by frusemide. Another factor that I took into account was the patient's blood pressure which was at the time normal and the frusemide would not be needed to assist in that regard. It is also my experience that patients with chronic renal failure require large doses of frusemide to maintain their urinary output and as [Mrs C] was only taking 40mgs of frusemide daily, it would be safe to stop it at least temporarily to see if her urea and creatinine would improve. [Note GP 1 said (see paragraph 7) that on 29 November 2000 [Mrs C] was advised to double the frusemide to 80mg. GP 2 was asked to clarify this issue and said that the information that [Mrs C] was taking 40mg of frusemide came from [Mrs C] and was supported by their computer records, in that, she was prescribed frusemide 40mg one in the morning and 28 tablets were issued at a time. She received these prescriptions on 1 July 2002 and on 6 June 2002, which would support her taking one daily.]

Taking all these matters into account I thought it appropriate to stop the frusemide to see how [Mrs C] progressed. There were no positive reasons for continuing it.

I then went on holiday on the same day having made arrangements for the district nurses to attend over the weekend for dressings and to repeat the blood estimations early the following week. It was not possible to take the blood samples over the weekend either on a Saturday or a Sunday.

There was no telephone call from the family or concerns raised by the district nurses over the weekend and it was not until 23 July when [GP 3] was asked to attend because of a sudden deterioration in her condition that [Mrs C] was admitted to hospital.

I had no contact with [Mrs C] after the telephone call on 19 July after which I went on leave.

The relatives made a complaint to the Practice and subsequently requested an Independent Review. The Independent Review Panel did suggest to the Practice that there were some deficiencies in the way that matters had been handled in the case. These matters have all since been addressed.

I am clear in my own mind that my initial reaction to the raised potassium level was to seek a repeat estimation of that value. I was clear that [Mrs C] was not severely ill, as far as I could determine, and that the results of the electrolyte estimation may have been affected by dehydration but did indicate chronic renal failure. I did not think from [Mrs C]'s condition nor from the blood tests themselves that there was an immediate need for hospital admission. Even if there had been a clinical reason for admitting [Mrs C] I am not sure if at this stage she would have agreed to this as she would not agree to my arranging a domiciliary visit.

It was clear that there was perhaps a lack of communication among the partners in the sense that I did not formally hand over [Mrs C]'s

care to [GP 3]. Both my husband [GP 1] and myself were on holiday at the same time. This formal handover of patients who may have acute problems has now been addressed by the Practice and an informal protocol now exists where written information will be transmitted between partners on occasions when doctors may go on leave, if a direct meeting is not possible.

In conclusion I would submit that I did visit [Mrs C] as requested and took appropriate measures to take a history, examine her and to undertake appropriate investigation. I also sought to ensure that over the weekend [Mrs C] was being attended to treat her leg ulcers and also to take a further blood sample early in the week. It appears clear that [Mrs C] deteriorated quite suddenly at or around 23 July and sadly died shortly after admission to hospital. I was shocked and surprised at [Mrs C]'s rapid demise. I certainly was not aware that this was likely and if I had been I would have admitted [Mrs C] immediately. I sent my condolences to the family at the time and can only reiterate my sadness and sorrow at the death of [Mrs C], particularly in this tragic way.

I do not believe that the complaints about my treatment of [Mrs C] are in any way justified other than those that have already been dealt with to prevent future recurrence.'

Oral evidence of GP 2

10. At interview during the Ombudsman's investigation GP 2 confirmed that she had worked at the Practice for 12 years. Her normal hours were from 8.00am to 1.00pm. She said that blood samples obtained from patients at home are brought to the Practice then sent to the laboratory in a van at 1.30pm each week day. It is common for abnormal blood test results to be telephoned through to the Practice from the hospital laboratory. She confirmed she was aware that if the outcome of a test was affected by haemolysis then this would be recorded on written results reports. She did not know whether the laboratory would mention that when telephoning results to the Practice. It was common for the laboratory not to process results until the day after receiving blood samples, as happened in this case. She agreed that, in that case, the

laboratory would probably centrifuge the sample to prevent haemolysis occurring.

11. It was noted that the blood test result report indicated that the result had been telephoned to the Practice at 11.26am on 19 July 2002. GP 2 thought that she had still been taking a surgery which would have finished at 11.00am, when she received the result. She was going on holiday that day but the time factor did not in any way influence her decision on what action to take. It was in fact a fairly quiet day. The results were Sodium 146, Potassium 7.3, Chloride 111, Urea 49.6 and Creatinine 415. She considered a urea level of 49.6 to be important but said that immediate action would only have been required if the condition (renal failure) was acute. Normal practice on receipt of a result like this was to repeat the test. She conceded that since the result had been received at 11.26am at the latest and the van taking samples to the laboratory did not leave until 1.30pm then the blood test could have been repeated that day given that Mrs C lived within about 5 minutes of the surgery.

12. GP 2 said that Mrs C obviously needed attention but she was very resistant to treatment, in that, on 17 July she needed lots of persuading to allow the District Nurse to call to obtain a blood sample and on 19 July during her telephone conversation with Mrs C, GP 2 suggested that she should see a geriatrician but Mrs C refused. The point of a geriatrician visit would have been to persuade Mrs C to accept treatment. GP 2 felt that if she had suggested a hospital admission to Mrs C then Mrs C would have put the telephone down on her. She found Mrs C to be lucid at all times in her dealings with her, despite a history of intermittent confusion. There was also no history of an acute problem and Mrs C had apparently been no more unwell than she had been since Christmas. She did not consider exercising her right to send an ambulance to take Mrs C to hospital and, if necessary, have her sign a form refusing to go. GP 2 was asked to justify her interpretation that the result was affected by haemolysis and her decision to delay the second blood test. She said that Mrs C had been ill since Christmas and she had been told that nothing had changed since then. As for the grossly abnormal blood result, she felt she responded to that appropriately at the time. She felt that given her

assessment that Mrs C had been in her current condition for some time and was not unduly unwell, hospital admission would have been a soft option meaning that it was something that would have to be dealt with but that it did not have to be dealt with at that time. She believed Mrs C was in chronic renal failure which needed treatment but that Mrs C would need to be persuaded.

13. GP 2 said that she had now changed her practice so that if she gets high potassium results she sends the patient to the Hospital Casualty Department for a repeat blood test. She changed her procedure because of the circumstances she found herself in as a result of the complaint (going through an IRP and Ombudsman's investigation) not because her actions at the time were inappropriate. Even in hindsight she feels that Mrs C's condition was chronic rather than acute. In deciding to stop Mrs C's frusemide she did take account of the possibility that the blood test might be accurate but, because she believed Mrs C's condition to be chronic, that decision was appropriate. GP 2 was asked whether there was any possibility she had misinterpreted the result or simply misread it. She denied that this had been the case. She told the IRP that she felt she followed normal acceptable practice and, she said, that was still her position.

14. GP 2 said that she had acted on all the recommendations made by the IRP in that:

- They had completed a search of the records to identify patients on repeat prescriptions who had not been followed up. These patients were telephoned or visited to arrange follow ups;
- The computer system was changed so that it now says on all repeat prescriptions that the patient should make an appointment for follow up in six months time;
- When going on holiday the GPs either have a face to face handover meeting, or if that is not possible, they leave the case notes out with a note of the plan for the patient; and
- A GP now always speaks to people requesting a house call and records the discussion in the notes.

Assessors' report

15. I reproduce next, in its entirety, the report prepared by the professional assessors who were appointed to give advice on the complaint.

1st Assessor

A principal in general practice for 25 years with wide experience of urban practice in both group and single handed practice. Past chairman of the Local General Practitioner Committee, Local Medical Committee, Locality Practices and Local Health Care Co-operative as well as past member of the Scottish General Practitioner Committee – specific experience as a past member of the local Medical Services Committee and adviser to Independent Review Panels.

2nd Assessor

A principal in general practice in urban/rural settings for 30 years. Past chairman of the Area Medical Committee and long term member of the GP Sub Committee and Local Medical Committee. Clinical governance lead to the Local Health Care Co-operative. Trainer in general practice. Practice and accreditation assessor for the Royal College of General Practitioners. Long experience and member of Service Committees and adviser to Independent Review Panels.

Basis of the report

i. This report is based on the documentation provided which included copies of Mrs C's medical records and background correspondence relating to the complaint, and also a report of the interview with GP 2. Both Assessors were present at the interview.

Matters considered

ii. We were asked to provide our views on (a) the prescribing for and monitoring of Mrs C's condition between November 2000 and July 2002 in relation to its adequacy and (b) GP 2's management of Mrs C's presentation in July 2002 in relation to it being of a reasonable standard.

iii. We found that, on 29 November 2000, the patient, Mrs C, underwent an estimation of her urea and electrolytes which was abnormal, showing a urea of 14.3 and a creatinine of 145.

iv. In spite of the fact that Mrs C was on both a diuretic and an ACE inhibitor, these tests were not repeated, even though the patient was seen by the district nurses, had her full blood count carried out on 14 June 2001, and received 7 prescriptions for antibiotics during the period 14 December 2000 and 27 September 2001.

v. On 17 July 2002, she was visited on request by GP 2 who carried out an assessment and arranged for the district nurse to pay a second visit the following day, in order to take a number of appropriate blood tests.

vi. These included urea and electrolytes, which were sent to the local laboratory, retained overnight (presumably spun – a process under-taken to prevent haemolysis), and assessed the following day.

vii. The normal range of values for urea, potassium and creatinine are 3.7 to 9, 3.5 to 5.0 and 0 to 97 respectively. Since the urea, potassium and creatinine were grossly abnormal (49.6, 7.3 and 415 respectively) (in the absence of haemolysis), the results were telephoned to the Practice. The laboratory recorded the time of the call as being 11.26 am but GP 2's recollection was that she was advised of these results while still in surgery which would have finished earlier than then.

viii. In spite of the fact that she was going on leave from lunchtime that day, GP 2 was not unduly busy and was able to give the results her full attention.

ix. She considered that the most likely explanation for the elevated potassium was that the sample was haemolysed (although the laboratory had not said so). She considered that the most likely explanation for the elevated urea was chronic (not acute or even acute-on-chronic) renal failure and that, while the tests needed to be

repeated, this did not need to be done until the following week. She also allowed her judgement as to the management of the situation to be influenced by the patient's reluctance to receive medical help.

x. *GP 2 did not consider it necessary to repeat the test that day (although there would have been time to do so) and considered referral/admission to hospital to be a "soft option" in view of her assessment that the patient had been in her current condition for some time and was not unduly unwell.*

xi. *GP 2 recalled considering arranging a Consultant domiciliary visit in order to reinforce the need for hospitalisation – but did not do so.*

xii. *Clearly, GP 2 had no intention of taking any action prior to going on leave and throughout the interview, in spite of being pressed to reconsider her position, steadfastly held to her view that her actions – or inaction – were fully justified by her diagnosis.*

<u>Opinion</u>

xiii. *Mrs C needed periodic clinical reassessment and blood tests to check on renal function (by U&E testing). This was necessary in view of her clinical condition, the drugs she was taking and the documented previous mild abnormality of renal function in 2000. It is our view that the prescribing for, and monitoring of, Mrs C's condition between November 2000 and July 2002 was inadequate. This was largely due to the fact that the Practice was somewhat late in introducing a computerised control system for both, although this has now been introduced.*

xiv. *It is our view that GP 2's clinical management of Mrs C's presentation in July 2002 was not of a reasonable standard. We are certain that on receipt of Mrs C's abnormal results the appropriate course of action would have been to admit her to hospital as an emergency for further assessment and treatment. In our view the results suggested a diagnosis of acute renal failure which should be managed in a hospital setting. The significantly raised potassium level added to the clinical urgency of the situation. Patients with*

acute renal failure and/or significantly raised potassium levels are at risk of suffering severe medical consequences and rapid deterioration and death. If there was doubt about the validity of the blood tests, at the very least, they should have been repeated and acted upon the same day. What the prognosis would have been, had this course of action been followed remains uncertain, but there is at least a likelihood that some successful treatment would have been possible. Given that the patient survived without intervention for a further few days it seems likely that hospital treatment during that time might have affected the tragic outcome in this case. The patient however was extremely unwell and this could have been by no means certain. GP 2 undoubtedly performed poorly in this clinical situation. However her firm belief that she did not, gives cause for significant ongoing concern.

Recommendations

xv. It is our recommendation that GP 2 be dealt with appropriately under the auspices of the arrangements for poorly performing doctors.

Findings

16. Mr C complained that the prescribing for, and monitoring of, his mother's condition between November 2000 and July 2002 was inadequate and that GP 2's clinical management of Mrs C's presentation in July 2002 was not of a reasonable standard. The Assessors agreed that the prescribing for, and monitoring of Mrs C's condition was inadequate. They consider this was due to the absence of a computerised control system which has now been rectified by the introduction of such a system. I uphold the complaint set out at 3(a) of this report.

17. For the reasons set out in paragraph xiv of their report, the Assessors considered that GP 2's clinical management of Mrs C in July 2002 was not of a reasonable standard. Their conclusion is that Mrs C should have been admitted to hospital and it is possible that prompt hospital treatment could have prevented Mrs C's sudden death. I accept their advice and uphold the complaint set out at 3(b) of this report.

Recommendations

18. I am pleased to note that the Practice has since taken action to prevent a recurrence of the shortcomings in the prescribing for, and monitoring of the condition of patients.

19. Like the Assessors, I am concerned that GP 2, even in hindsight, does not recognise that her management of Mrs C's condition was not appropriate. I agree with the Assessors' recommendation that GP 2 should be dealt with under the arrangements for poorly performing doctors.

Professor Alice Brown
Scottish Public Services Ombudsman

19 January 2005

Glossary of medical terms

Accuretic	A combination of quinapril and hydrochlorothiazide. Quinapril is an ACE (Angiotensin – converting enzyme) inhibitor used to treat blood pressure and heart failure. Hydrochlorothiazide is a diuretic used to treat oedema and, particularly with this low dose, blood pressure.
Acute	Having a sudden and severe onset
Auscultate	To listen, usually with a stethoscope
Chronic	Developing slowly or of long duration
Frusemide	A diuretic which promotes water excretion. It causes an increased potassium loss in the urine and a side effect can be lowered potassium levels
Haemolysis	The break down of red blood cells (which releases potassium thereby falsely raising the potassium level in the blood sample)
Hypertension	High blood pressure
Inderal LA	A slow release formulation beta blocker used for blood pressure control and angina control
Leg oedema	Fluid accumulation in the lower leg
LFTs	A test of liver activity
(liver function tests)	
TFTs	A check on thyroid activity
(thyroid function tests)	
U&Es	A test of kidney function
(urea and electrolytes)	