Scottish Parliament Region: Glasgow

Case 200500885: General Practitioner in Greater Glasgow and Clyde NHS Board's area[1]

Summary of Investigation

Category

Health: General practitioner, clinical treatment

Overview

The complainant was concerned that his then general practitioner would not arrange appropriate treatment at a time when he was at risk of committing suicide.

Specific complaint and conclusion

Inappropriate treatment by a GP in February 2005 *(not upheld)*

Redress and recommendation

The Ombudsman has no recommendation to make.

Introduction

1. I shall refer to the complainant as Mr C. On 28 June 2005 the Ombudsman received his complaint that his then general practitioner (referred to as the GP) would not arrange appropriate treatment at a time when he was at serious risk of committing suicide.

2. The complaint from Mr C which I have investigated, therefore, was whether the GP's care and treatment during a telephone call on 15 February 2005 and a consultation on 16 February 2005 were appropriate.

[1] On 1 April 2006 the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by Argyll and Clyde Health Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of Argyll and Clyde Health Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to Greater Glasgow and Clyde Health Board as its successor.

Investigation

3. I was assisted in the investigation by one of the Ombudsman's clinical advisers, a senior GP. His role was to explain, and give an opinion on, the clinical aspects of the complaint. We examined the papers provided by Mr C, the complaint file of the GP's Practice and GP and hospital clinical records. Additional information was also obtained from the GP. To identify any gaps and discrepancies in the evidence, the content of some of the papers on file was checked against information elsewhere on file and also considered against my own and the adviser's knowledge of the issues concerned. I am satisfied that the evidence has been tested as robustly as was possible, bearing in mind the difficulty of establishing the facts in a complaint about what someone said, when there are no witnesses. In line with the practice of this office, the standard by which the complaint was judged was whether the events were reasonable, in the circumstances, at the time in question. I have not included in this report every detail investigated, but I am satisfied that no matter of significance has been overlooked. Mr C and the GP were given an opportunity to comment on a draft of this report.

4. I turn now to the events of the complaint. A reminder of the abbreviations used is at Annex 1. Mr C was aged 55, with a long history of depression, suicidal thoughts and deliberate self harm (a clinical term to describe deliberately and physically harming oneself). On 15 February 2005 he telephoned the GP's Practice because of suicidal feelings and he spoke to the GP. Mr C considered that he needed treatment that day and he wanted the GP to refer him to a Community Psychiatric Nurse (CPN) or a doctor at a local mental health hospital (the hospital), or to put him in contact with the Samaritans voluntary organisation. Mr C said that the GP replied that he should have called earlier as there were now no appointments available. The GP told Mr C he would write a prescription for diazepam (a drug for short-term use for anxiety) and see Mr C the next morning. Mr C said he tried to convince the GP about the strength of his suicidal feelings but was simply told that the GP had several thousand patients and that this was the best he (the GP) could do at that time. Mr C said that in desperation he contacted a community centre, who put him in touch with someone to whom he could talk. Mr C made contact and was helped by having a 45-minute consultation.

5. In his account of Mr C's telephone call on 15 February, the GP told me he

knew from experience of the local mental health services that it would be virtually impossible to obtain the referral which Mr C wanted for around two or three days. Therefore, he offered a prescription to help him cope with that day and told him he would see him the next morning. He confirmed to me that he did mention the number of patients to Mr C but that it was in the context of doing his best to obtain a consultation for Mr C, despite there being many thousands of patients who needed both his own and the mental health system's services. The GP also said that he told Mr C that the Practice did not refer patients to the Samaritans. (This is because people who wish to use the Samaritans approach them directly, rather than through doctors.)

6. On 16 February 2005 Mr C kept his appointment with the GP. Mr C said that the GP's manner was unsympathetic and that he refused to refer Mr C because he had had 45 minutes of counselling the day before. He said that the GP was prepared to do nothing more than give him a daily prescription. The GP's clinical records say that, although Mr C said that the previous day's 45 minutes of counselling had been helpful, he also wanted an urgent referral to a hospital duty psychiatrist on the 16th and would take an overdose if he (the GP) would not arrange it. The GP's records say that, after some discussion about events in Mr C's life, he told Mr C that he should at least try a change of medication but that Mr C said he was ending the consultation because the GP would not help him and that Mr C then left. Mr C's account is that he repeated that he needed the referral, stood up and left the consultation.

7. Later on 16 February, Mr C contacted the duty CPN at a local mental health resource centre. The CPN arranged an immediate appointment with the duty doctor at the hospital, a consultant psychiatrist to whom Mr C was already known. Mr C was admitted to the hospital as an in-patient and discharged almost a fortnight later.

8. The GP said to me that when a patient raised thoughts of suicide, his practice would be to take a history about, for example, what was happening in the patient's life, the patient's feelings and the possible reasons for them and whether the feelings were becoming worse. He would then decide what action would be appropriate. He said that he was simply unable to do this adequately when he saw Mr C on 16 February because Mr C entered the consulting room with an

aggressive approach, clearly and firmly determined to obtain an immediate referral as a hospital in-patient. As far as any plan was possible, the GP intended to arrange an urgent consultation with a duty psychiatrist at the hospital and to give Mr C medication in the meantime to help him cope with the suicidal feelings. The GP told me that Mr C simply would not listen because of his determination to obtain an immediate in-patient hospital admission and that he himself became increasingly frustrated at his inability to obtain enough facts from Mr C to decide what to do. He said that, eventually, Mr C referred to him (the GP) as not going to help him and walked out of the consulting room.

9. The adviser considers that if a patient mentions suicide, a risk assessment should be done and recorded (even if briefly) in the clinical records. In this case the records contain no note of such an assessment. The GP told me that he did assess the risk of suicide on both 15 and 16 February. From over 20 years' experience, he considered that Mr C's voice, ability to express himself and overall behaviour and bearing did not suggest a risk of suicide. He accepted that it would have been more appropriate to note this assessment in the records but said that he had felt rather affected by the consultation on 16 February – partly because of its length (45 minutes) and partly because he had found Mr C's manner intimidating. He said that, in fact, he had needed ten minutes alone to recover from the consultation before he could see staff and other patients. In other words, he felt that his mind was so focused on the consultation that had just ended that he did not consider whether his record of it was adequate.

Conclusions

10. The fact that Mr C was admitted to hospital on 16 February is not evidence that the GP should have referred him. My role has been to consider whether the GP's actions were reasonable, in the circumstances, for example, whether he tried to take adequate account of Mr C's needs when trying to make a decision about what to do for Mr C, whether he tried to obtain the relevant facts in order to make a decision and whether he assessed the risk of suicide. I note that Mr C left the GP's consulting room on 16 February before the end of the consultation and, therefore, we cannot know what the GP might have said during the rest of the consultation. (As Mr C himself said that he had left the consultation before the end, I assume that to be accurate.)

11. No one witnessed the telephone call of 15 February 2005 or the consultation of the 16th. That means there is no firm evidence about the GP's actions. In the absence of firm evidence, the practice of this office is to try to reach a decision which is based on a balance of probability. On this basis, therefore, I have concluded that the GP was not unsympathetic to Mr C's needs. A patient cannot expect immediate consultations with a GP, so it was reasonable of the GP to say he could not see Mr C on the 15th. Both Mr C and the GP agree that the GP offered Mr C medication to help him cope with that day and offered to see him the next morning. Therefore, I assume that to be fact. These were reasonable actions by the GP. On a basis of the balance of probability, I have concluded that on 16 February, the GP did attempt to obtain the details which he needed from Mr C in order to decide what action to take. This is because one would expect any GP to ask some questions about the symptoms, feelings etc of a patient in order to decide what to do; one would not, therefore, imagine that the GP did not try to do so in this case. Again on a balance of probability, I am satisfied that the GP did conduct some form of risk assessment. This is simply because it is difficult to imagine that a GP would not wonder whether a reported risk of suicide seemed real. In line with good practice, it would have been preferable if the GP had recorded that he had carried out a risk assessment. However, I accept his explanation for not doing so. Finally, the adviser's view is that, as far as one can judge, the GP's actions on both days were reasonable. Therefore, I do not uphold the complaint.

Summary

Specific complaint and Conclusion
Inappropriate treatment by a GP in February 2005 (not upheld)

Redress and recommendation
The Ombudsman has no recommendation to make.

25 July 2006

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The GP	The general practitioner who is the subject of the complaint
The hospital	A local mental health hospital
CPN	Community Psychiatric Nurse