Scottish Parliament Region: Glasgow

Case 200501821: A GP Practice, Argyll and Clyde NHS Board[1]

Summary of Investigation

Category

Health: GP

Overview

The complainant (Mr C) considered that his father (Mr C senior)'s death in February 2005, aged 69, was hastened by his care and treatment by a GP Practice (the Practice) that month, for example, that they did not treat his illness appropriately and treated him less well because of prejudice about his alcohol history. The GPs had said his father had gastritis (inflammation of the stomach lining), but, less than a fortnight later, he was dead from multi-organ failure, heart attack, pancreatitis and alcoholic liver disease.

Specific complaint and conclusion

The complaint which has been investigated is that the Practice's care and treatment on 17 and 18 February 2005 were inadequate *(not upheld)*.

Redress and recommendation

The Ombudsman has no recommendations to make.

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[1] Argyll and Clyde Health Board (the former Board) was constituted under the National Health Service (Constitution of Health Boards) (Scotland) Order 1974. The former Board was dissolved under the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 which came into force on 1 April 2006. On the same date 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 the former Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of the former 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 the former Board or Greater Glasgow and Clyde Health Board as its successor. However, the recommendations within this report are directed towards Greater Glasgow and Clyde Health Board.

Main Investigation Report

Introduction

1. I shall refer to the complainant as Mr C. Annex 1 is a reminder of the terms in this report. On 6 October 2005 the Ombudsman received Mr C's complaint about his late father (Mr C senior)'s treatment by two general practitioners (GP 1 and GP 2) at his GP Practice (the Practice). He considered that their inadequate treatment meant that Mr C senior was taken into hospital as an emergency case, dying there a few days later. Mr C also wanted the GPs to answer 13 questions. I arranged this and sent Mr C their reply. I also sent him our adviser's queries about the reply and the Practice's further response, which the Adviser (see paragraph 3) considered to be satisfactory.

2. The complaint which has been investigated is that the Practice's care and treatment on 17 and 18 February 2005 were inadequate.

Investigation

3. I was assisted in the investigation by one of the Ombudsman's advisers, a senior GP (the Adviser). His role was to explain to me, and comment on, the clinical aspects of the complaint. We examined the papers provided by Mr C, the Practice's complaint file, Mr C senior's GP clinical records and the Practice's reply to enquiries which I put to them. To identify any gaps and discrepancies in the evidence, the content of relevant correspondence on file was checked against information in the clinical records and was compared with my own and the Adviser's knowledge of the issues concerned. I am, therefore, satisfied the evidence has been tested robustly. In line with the practice of this office, the standard by which the events were judged was whether they were reasonable, in the circumstances at the time in question. By reasonable, I mean whether the decisions and actions taken were within the boundaries of what would be considered to be acceptable practice by the medical profession in terms of knowledge and practice at the time. 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 Practice were given an opportunity to comment on a draft of this report.

Complaint: The Practice's care and treatment on 17 and 18 February 2005 were inadequate

4. At paragraphs 4 and 5, I give Mr C's account. His father, a man of 69, stopped eating on around 10 February 2005. As there was no improvement, Mr C asked the Practice on 16 February 2005 to visit. GP 1 visited on 17 February 2005 and diagnosed gastritis (inflammation of the stomach lining). Mr C senior later told his son that GP 1 had seemed more interested in his social circumstances than his medical condition. As Mr C was worried when he saw his father on 18 February 2005, he asked for another home visit. GP 2 answered and reluctantly agreed to visit that evening. Mr C was present and he and his father pointed out the severe stomach pain, jaundiced (yellow in colour) skin and breathlessness. GP 2's examination was brief – a quick look at his stomach and a comment that the poor light made his skin colour difficult to see but that, even if Mr C senior was jaundiced, that would still be consistent with GP 1's diagnosis of gastritis. GP 2 suggested vaguely that it might be worth doing some blood tests and said they should not be worried by the loss of appetite.

5. Mr C senior's condition worsened rapidly: he stopped going out and lost bladder and bowel control. Mr C wanted to take him to hospital but thought he had better not do so because the Practice had not seemed to think anything was seriously wrong. On 22 February 2005, he arrived at the house to find that his father had been found on the floor by friends and taken to hospital. Sadly, Mr C senior died in the hospital on 25 February 2005. He had had multi-organ failure and a heart attack and had been suffering from pancreatitis and alcoholic liver disease. (Pancreatitis is an inflammation and malfunction of the pancreas, a condition which is often associated with alcohol use.) Mr C felt guilty because his trust in the Practice caused him not to take his father to hospital earlier, which he considered could have saved his father's life or at least spared him the pain of his last days. In particular, he felt that the Practice's treatment would have been different if they had not been prejudiced by his father's long term alcohol difficulties.

6. At paragraphs 6 to 8, I give the Practice's account. When GP 1 visited on 17 February 2005 because of Mr C's request, Mr C senior said he had had stomach pain for a few days and had lost his appetite, but had continued his normal routine, was about to make his lunch and would be going to the pub that afternoon. GP 1's examination revealed only mild upper abdominal discomfort. As

usual, GP 1 encouraged him to stop or reduce his alcohol intake. He raised the idea of Social Work help with housework but Mr C senior indicated he was happy with his life as it was. GP 1 made a working diagnosis (that is, an initial diagnosis, not necessarily a final one) of gastritis, secondary to alcohol consumption, and prescribed a drug to reduce stomach acid.

7. GP 2 had not been reluctant to visit on 18 February 2005 but, in line with normal practice, had to consider whether a home visit was necessary. Mr C senior said he had nausea, upper abdominal discomfort and loss of appetite. His drinking history was highly relevant to his symptoms. For example, he said he had had several drinks that day. GP 2 examined Mr C senior and moved him to the window to assess his skin colour. GP 2 did not feel he was obviously jaundiced but noticed that the whites of his eyes were tinged. Abdomen examination and taking Mr C senior's pulse revealed nothing abnormal and Mr C senior was not breathless. From Mr C's account and the examination, GP 2 felt that he probably did have gastritis. GP 2 believed blood tests would be useful to indicate any wider damage caused by the alcohol and was going to arrange for the district nurse to do them; however, Mr C said he would bring his father to the Practice as Mr C senior would not want to wait at home for the nurse. As far as she could remember, GP 2 felt she advised them to come in on the Monday or Tuesday (this being a Friday). She told them to tell her of any change in Mr C senior's condition. On her return to the surgery, GP 2 arranged the blood tests and told the receptionist to fit in Mr C senior on the Monday or Tuesday.

8. In conclusion, the Practice did not consider there was anything to indicate the need for a hospital admission. For example, at neither of the visits was there any indication, such as breathlessness, of any more serious condition. Mr C senior's symptoms were consistent with a long history of alcohol use, and the Practice emphasised they provided the same standard of care to Mr C as to patients without such a history. As was usual with serious events, the Practice had discussed Mr C senior's case as a team after he passed away. They considered it would be helpful to have contact details for certain patients' next of kin. For example, in this case, the Practice could then have offered to answer any questions which Mr C had (before he made his complaint). In the discussion the Practice also felt, although the clinical record keeping was acceptable, it could have been helpful for the GPs to have recorded more detail about their thinking.

9. I now summarise the Adviser's comments. The clinical records indicate that Mr C senior had a long history of excessive alcohol use and was known to have had problems with a fast heart rate. GP 2's statement (see paragraph 7) about needing to check whether a home visit was necessary was entirely appropriate: GPs must use their resources sensibly and cannot visit patients simply on demand. As 18 February 2005 was a Friday, it was reasonable for GP 2 not to arrange immediate blood tests. This is because slight jaundice in someone with an alcohol history, whose general condition is not particularly poor, would not necessitate immediate action, such as hospital admission, by GPs. Mr C should not feel guilty for not having arranged immediate hospital admission himself. However, people with jaundice can become unwell very quickly, and it was, therefore, appropriate for GP 2 to arrange for testing to be done early the next week. It is not possible to know whether any jaundice was present on 17 February 2005. As there is no evidence that Mr C senior was treated inappropriately, one cannot say that his alcohol history prejudiced his treatment. However, the fact that GP 2 intended to do blood tests indicated that the Practice were actively treating Mr C senior.

Conclusion

10. I said at paragraph 3 that I was satisfied the evidence had been tested robustly. That includes the Adviser's advice, which was checked to ensure it was clear and, where relevant, was clearly and logically based on the evidence. Therefore, I accept that advice. From the evidence available, the Adviser does not consider that the care and treatment given to Mr C senior fell outside the bounds of reasonableness described at paragraph 3. In all the circumstances, I do not uphold the complaint.

Recommendation

11. The Ombudsman has no recommendations.

19 December 2006

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mr C senior	Mr C's father
The Practice	Mr C senior's general practitioner Practice
GP 1	The GP who visited Mr C senior on 17 February 2005
GP 2	The GP who visited Mr C senior on 18 February 2005
The Adviser	Adviser (a senior GP) to the Ombudsman