Scottish Parliament Region: Mid Scotland and Fife

Case 200501436: A GP, Fife NHS Health Board

Summary of Investigation

Category

Health: Family Health Services; Clinical treatment

Overview

The Complainant (Mr C) had a heart attack in December 2002. Mr C said that as he was 55 years old at that time, a heavy smoker, and always complaining of chest pain his GP (GP 1) should have sent him to a specialist to check his heart condition.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) inadequate care and treatment led to Mr C having a heart attack (*not upheld*);

(b) GP 1 inappropriately prescribed venlafaxine (*not upheld*);

(c) GP 1 inappropriately suggested on a number of occasions that Mr C take ibuprofen (*not upheld*);

(d) GP 1's record keeping was not of a professional standard because there were significant omissions (*not upheld*); and

(e) GP 1's record keeping was not of a professional standard because parts of the record were illegible (*upheld*).

Redress and recommendations

The Ombudsman recommends that GP 1 takes action to ensure that he produces records that are legible.

GP 1 has accepted the recommendation and will act on it accordingly.

Main Investigation Report

Introduction

1. On 2 September 2005 the Ombudsman received a complaint from a man, referred to in this report as Mr C, about the care and treatment he received from his GP 1.

2. Mr C had a heart attack in December 2002. Mr C was 55 years old at that time and a heavy smoker. He says he was always complaining of chest pain. He asserts that GP 1 should have sent him to a specialist to check his heart condition.

3. The complaints from Mr C which I have investigated are that:

(a) inadequate care and treatment led to Mr C having a heart attack;
(b) GP 1 inappropriately prescribed venlafaxine;
(c) GP 1 inappropriately suggested on a number of occasions that Mr C take ibuprofen;
(d) GP 1's record keeping was not of a professional standard because there were significant omissions; and
(e) GP 1's record keeping was not of a professional standard because parts of the record were illegible.

4. In light of these findings the Ombudsman recommends that GP 1 takes action to ensure that he produces records that are legible.

5. GP 1 has accepted the recommendation.

Investigation

6. The investigation of this complaint involved obtaining and reading all the relevant documentation and medical records. I obtained advice from a clinical Adviser to the Ombudsman, an experienced GP (the Adviser). I have set out below my findings of fact and conclusions. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. A list of abbreviations used in this report is given at Annex 1 and an explanation of the medical terms used is at Annex 2. Mr C and the Practice have been given the opportunity to comment on a draft of this report.

(a) Inadequate care and treatment led to Mr C having a heart attack

7. In the summer of 2000 Mr C had a cardiac assessment at a hospital. The hospital found no evidence of ischaemic heart disease.

8. Mr C became a patient of GP 1 in late 2000, and had his first consultation as a new patient in November 2000. At that time he was 53 years old and was a heavy smoker. Over the next two years Mr C consulted with GP 1 on a number of occasions about various problems.

9. In December 2002 Mr C had a heart attack.

10. Mr C complains that the symptoms he presented to GP 1 should have led to earlier referral to a specialist and that this may have prevented his heart attack.

11. Mr C has drawn particular attention to the following consultations which are recorded in the notes. On 21 May 2001 a weight gain of one stone in six months is recorded. On 19 November 2001 a cholesterol level of 6.5 is recorded. On 22 October 2002 Mr C consulted GP 1 about a four week history of pains in his left upper abdomen, left side of his chest and left jaw tightness.

12. The notes for the appointment on 22 October 2002 also record, among other matters, that the chest pains appeared to start after dosage of lansoprazole was reduced, that walking, even uphill, did not affect discomfort, and that milk of magnesia alleviated symptoms. The record says the heart sounded normal on examination; that a full chest examination was normal; and that an abdominal examination was normal. In the notes GP 1 wrote that that the symptoms sounded like reflux disease and depression.

13. There is disagreement between Mr C and GP 1 as to whether Mr C reported chest pain on other occasions. Mr C has particularly drawn attention to a consultation on 13 August 2002 where he requested a full medical examination. Mr C says that this request is evidence of the concern he felt about his health at the time, and in particular that he had symptoms which could indicate heart disease. No reasons for this request are recorded in the notes, but, while several other symptoms are recorded there is no record on that date of chest pain or other symptoms relevant to possible heart disease.

14. Mr C complained about the standard of GP 1's notes, and this is addressed below. However, I have read through the notes and there is no other record of chest pains before or after 21 October 2002. There is a record on 29 August 2002 saying 'no chest pains' and one on 29 October 2002 saying 'no more chest discomfort on increased dose lansoprazole'.

15. The Adviser has told me that the diagnosis of ischaemic heart disease is essentially a clinical diagnosis based on the history. He commented that the clinical history recorded by GP 1 in Mr C's records demonstrated a high standard of general practice. It was evident from the records that GP 1 did not rush to conclude that Mr C's symptoms were due to gastrointestinal problems and his diagnoses and action taken were reasonable. The Adviser said that it is not possible, even at this time, to say whether the symptoms presented at that time were due to ischaemic heart disease.

(a) Conclusion

16. I have noted that the cardiac assessment in 2000 did not indicate any problems. The Adviser said that the notes indicate that GP 1 gave a good standard of care to Mr C. I have also noted that heavy smoking at Mr C's age is a risk factor for reflux disease as well as for heart disease.

17. Studying the note of 21 October 2002 indicates that the GP took an appropriate history of Mr C's symptoms which did not indicate that the cause was likely to be heart disease. Furthermore the notes of 21 October 2002 and 29 October 2002 taken together indicate a correlation between Mr C's chest pain and the dosage of lansoprazole which would tend to confirm a diagnosis of reflux disease. While I accept that some of the symptoms highlighted by Mr C could be indicative of heart disease, I do not accept that there was indication of need for further cardiac investigation or referral between December 2000 and December 2002. In all the circumstances I do not uphold the complaint.

(b) GP 1 inappropriately prescribed venlafaxine

18. When Mr C was discharged from the hospital cardiology unit in December 2002, following his heart attack he was being prescribed 150 mg of venlafaxine to be taken twice daily. His blood pressure was monitored at the out-

patient cardiology unit which he attended regularly and was satisfactory. Correspondence in the records shows that Mr C's cardiologist was aware he was on venlafaxine, and its dose, and that he advised no change in Mr C's medication.

19. In December 2004 the Committee on the Safety of Medicines issued a warning of contraindications for the use of venlafaxine for patients with heart disease. On 7 January 2005 GP 1 wrote to Mr C about his use of venlafaxine in the light of these concerns. GP 1 thought Mr C should be moving to an alternative product if one was still needed by Mr C.

20. Mr C said that the entry in the British National Formulary (BNF) published in March 2003, in relation to venlafaxine, included 'Cautions. History of Myocardial Infarction or unstable heart disease. Blood pressure monitoring advisable if dose exceeds 200ml daily.' Mr C questioned whether the advice contained in GP 1's letter of 7 January 2005 should have been given sooner.

21. The Adviser commented that as Mr C was under review for heart disease after his heart attack in December 2002. The package of care then considered appropriate for a patient on venlafaxine was to ensure monitoring of ECGs and blood pressure. This package was in place for Mr C.

22. The Adviser described GP 1's response to the new safety issues highlighted by the Committee on the Safety of Medicines, by writing to Mr C and providing appropriate advice, as a high standard of care.

(b) Conclusion

23. There were cautions about the use of venlafaxine in place long before January 2004. However, these were cautions advising monitoring and were not contraindications. Mr C was monitored in line with the cautions.

24. The warning from the Committee on the Safety of Medicines in December 2004 suggested contraindications to the use of venlafaxine for patients with heart disease. This was new information not previously available and GP 1 reacted promptly and appropriately in his letter to Mr C of 07 January 2005. In these circumstances I do not uphold this complaint.

(c) GP 1 inappropriately suggested on a number of occasions that Mr C take ibuprofen

25. Mr C took 75 mg of aspirin once daily for his heart condition.

26. Mr C said that at each his appointments on 6 January, 6 February and 9 March 2004 GP 1 advised him to take ibuprofen for pain relief. On each occasion Mr C told GP 1 that he had read that, while taking heart medication, ibuprofen had a negative effect. GP 1 agreed that Mr C was correct and suggested he take paracetamol instead.

27. In a letter to Mr C dated 30 April 2004, GP 1 said that he had not recorded suggesting ibuprofen to Mr C but accepted that he probably had suggested ibuprofen. GP 1 said that there was a possible interaction between ibuprofen and aspirin which he had overlooked. He also said that it was difficult to remember all the possible drug interactions and that the interaction between ibuprofen and aspirin had only just become known. He said that he usually used the Practice computer system to add medication and one of the benefits of this is that it would have flagged up the interaction for him. However, he accepted that his advice was not good and apologised.

28. In a letter to Mr C of 7 November 2005 GP 1 said that had the discussion of the use of ibuprofen progressed then he would have advised against it in view of Mr C's gastro-intestinal problems. He also said that even if there were no such problems he would have consulted his computer reference before confirming his suggestion and this would have shown him the problem.

29. The Adviser commented that the use of ibuprofen and aspirin together is regarded as relatively but not absolutely contraindicated. There is concern that using the two together will increase the risk of side effects, the most common being stomach and gastrointestinal problems. There is also concern but not very firm evidence that using ibuprofen may reduce the anti-platelet action of aspirin and, therefore, its usefulness in preventing heart attacks and strokes.

(c) Conclusion

30. The Adviser has commented that the use of ibuprofen and aspirin is not absolutely contradicted. The outcome of the consultations was that ibuprofen was

not in the end recommended by GP 1. GP 1 has accepted that the advice he provided was not good and apologised to Mr C for this before Mr C complained to the Ombudsman. I consider this an appropriate remedy. I have also noted GP 1's comments about what he might have done had the discussions progressed further. In all the circumstances I do not uphold the complaint.

(d) GP 1's record keeping was not of a professional standard because there were significant omissions

31. Mr C requested and received a copy of his GP medical records. He found that some of the dates and notes were not legible. He also said that some of the records are incomplete.

32. Guidance on record keeping produced by the General Medical Council (GMC) in May 2001 in a booklet entitled 'Good Medical Practice', includes that 'in providing care you must: … keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed'.

33. Mr C has identified omissions from the notes, such as the discussion of the suitability of ibuprofen, and the reasons why he asked for a medical on 13 August 2002. However, from the transcript of the notes, the Adviser told me he felt that the content was fuller and more thoughtful than the average GP, and this accords with my experience of reading GP notes.

(d) Conclusion

34. It may have been best practice to record the omissions indicated by Mr C, but I am not persuaded that the matters fall into any of the categories indicated by the GMC as needing to be recorded. In view of this and of the comments of the Adviser I believe that the contents of the record are satisfactory. I do not uphold this complaint.

(e) GP 1's record keeping was not of a professional standard because parts of the record were illegible

35. It is evident from the records that there were instances where hospital colleagues were unable to read the clinical notes. I found the notes difficult to read, but, although there are places where I could not read them, I found it possible

to make out most points. I have also checked a copy of the hand written notes against a typewritten transcript which GP 1 provided for Mr C and have found them to be in agreement.

(e) Conclusion

36. Mr C, hospital staff, the Adviser and myself found parts of the records were not legible. The GMC has said that records must be clear and legible. If records cannot be read they are not fit for purpose. I uphold the complaint.

(e) Recommendation

37. The Ombudsman recommends that GP 1 takes action to ensure that he produces records that are legible.

38. As noted in paragraph 5, GP 1 has accepted the recommendation and will act on it accordingly.

30 January 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
GP 1	Mr C's general Practitioner
The Adviser	Clinical Adviser to the Ombudsman
BNF	British National Formulary
ECG	Electrocardiograph
GMC	General Medical Council
NSAID	Non-steroidal anti-inflammatory drugs

Annex 2

Glossary of terms

Aspirin	Widely used non-steroidal anti-inflammatory drug (NSAID) that reduces swelling and inflammation and hence pain It has also been found, at a much lower dose, to reduce platelet adhesion in the blood and hence reduce the chance of blood clots forming. This has led to it being used in the prevention of ischaemic heart disease and cerebro-vascular disease, to prevent heart attacks and strokes
Cautions	In connection with drugs, issues to consider when prescribing
Contraindicated	In connection with drugs, inadvisable
Electrocardiograph	Test that shows a heart's rhythm by studying its electrical current patterns
Ibuprofen	Widely used non-steroidal anti-inflammatory drug (NSAID) that reduces swelling and inflammation and hence pain
Ischaemic heart disease	Angina or heart attacks.
Lansoprazole	A proton pump inhibitor used to inhibit gastric acid.
Venlafaxine	A selective serotonin reuptake inhibitor, a group of chemicals that have been found to have significant anti-depressant use.