Scottish Parliament Region: South of Scotland

Case 200600307: A Medical Practice, Borders NHS Board

Summary of Investigation

Category

Health: GP; Diagnosis of back-pain and Handling of Complaint

Overview

Mrs C complained that Medical Practice 1 had failed to diagnose the cause of her back-pain accurately or in a timely manner. She also complained that the Practice had not dealt with her complaint in accordance with the NHS Complaints Procedure and that GP 1 had made inaccurate entries in her medical record.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Medical Practice 1 failed to properly or promptly diagnose the cause of Mrs C's back-pain *(not upheld)*;

(b) Medical Practice 1 failed to handle her complaint in accordance with the NHS Complaints Procedure *(upheld)*; and

(c) GP 1 made an inaccurate entry in her medical record *(not upheld).*

Redress and recommendations

The Ombudsman recommends that Medical Practice 1:

(i) reflect on the Advisers' comments regarding the recording of examination findings and use such advice to inform good practice; and

(ii) provide Mrs C with a written apology for their failure to properly follow the NHS Complaints Procedure.

Main Investigation Report

Introduction

1. On 28 April 2006 the Ombudsman received a complaint from the complainant (Mrs C). Mrs C complained that her GPs (Medical Practice 1) had failed to diagnose the cause of her back-pain accurately or in a timely manner and that this had put her at a considerable risk of paralysis only resolved when her true condition was diagnosed by a new GP Practice (Medical Practice 2) which resulted in her requiring an emergency operation. She also complained that Medical Practice 1 had not dealt with her complaint in accordance with the NHS Complaints Procedure and that GP 1 had made inaccurate entries in her medical record for 21 October 2005.

2. The complaints from Mrs C which I have investigated are that:

(a) Medical Practice 1 failed to properly or promptly diagnose the cause of her back-pain;

(b) Medical Practice 1 failed to handle her complaint in accordance with the NHS Complaints Procedure; and

(c) GP 1 made an inaccurate entry in her medical record.

Investigation

3. Investigation of this complaint involved obtaining and reviewing Mrs C's clinical records from Medical Practice 1 & 2 and Borders NHS Board (the Board). I have reviewed Medical Practice 1's complaint file and correspondence. I have sought the views of both a GP (Adviser 1) and Hospital (A&E) (Adviser 2) medical advisers to the Ombudsman. I have made brief written enquires of Medical Practice 1. I have reviewed the relevant guidance and procedures issued by the Scottish Executive Health Department in relation to Complaints about the NHS.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and Medical Practice 1 were given an opportunity to comment on a draft of this report.

Brief Chronology

5. Mrs C had a known medical history of sciatica diagnosed in 2003. In July 2005 Mrs C had severe back pain and pain in her legs which her GP (GP 2)

diagnosed as recurring sciatica. In October 2005 the pain returned and Mrs C visited the out-of-hours service on 16 October 2005 and was prescribed pain killers. On 18 October 2005 Mrs C had an appointment with another GP at Medical Practice 1 (GP 3) and sciatica was diagnosed again and a pain killer was prescribed. GP 3 noted that Mrs C had previously been asked to move practice because she was no longer living in the area usually covered by Medical Practice 1. The pain did not improve and Mrs C made a further appointment at Medical Practice 1, this time with GP 1, on 21 October 2005. GP 1 did not alter the diagnosis of sciatica and gave an increased prescription of pain killers. Mrs C was away from home on the weekend of the 22 and 23 October 2005 but on her return on 24 October 2005 found the pain to be so severe that she attended Accident and Emergency (A&E) at Borders General Hospital (Hospital 1). Mrs C had an x-ray and the possibility of having a scan later if organised by her GP was discussed. Mrs C was offered the option of an overnight stay but preferred to return home. At approximately 13:00 on 28 October 2005 the pain had become so severe that Mrs C called Medical Practice 1 to request an appointment but was advised by the receptionist that this was not possible and was reminded that she had been asked to change practice. Mrs C was in considerable pain and her partner (Mr A) made an appointment for her to be seen at Medical Practice 2 that afternoon at 15:15. Mrs C received a call from Medical Practice 1 advising that she could in fact be seen at 14:30 but she declined this as she was already due to leave for the appointment at Medical Practice 2.

6. On examining Mrs C the GP from Medical Practice 2 expressed concern at her inability to use her left foot (foot drop) and asked Mr A to take Mrs C directly to Hospital 1. Following her examination at Hospital 1 she was advised to attend Hospital 2 the next day where an MRI scan was performed and emergency surgery for a prolapsed disk was performed.

(a) Medical Practice 1 failed to properly or promptly diagnose the cause of back-pain

7. Mrs C told me that the surgeon at Hospital 2 told her that the prolapsed disk had compressed and damaged her spinal chord and a cough or sneeze could have resulted in her being in a wheelchair for life. Mrs C was very distressed at this and complained to Medical Practice 1, having first approached the Board on

17 January 2006, that they had failed to properly diagnose her condition. Mrs C received a written response from Medical Practice 1 on 6 February 2006.

8. In their response Medical Practice 1 expressed their sympathy for the distress experienced by Mrs C but stated that the diagnosis of sciatica by GP 3 on 18 October 2005 was correct and that the treatment offered for this was also correct. The letter noted that GP 1 had not observed foot drop on 21 October 2005 or any other symptom of progressive neurological deterioration which would have suggested the alternative cause of the pain and the need for referral to hospital. The letter also noted that these symptoms were also absent when she was present at Hospital 1 on 24 October 2005. The letter concluded by apologising in writing for the mix-up over the availability of an appointment on 28 October 2005 and noting that the problem had been discussed within the Practice and steps taken to try to ensure there was no repeat of the problem.

9. Adviser 1 has told me that the GP record for the examination of 18 October 2005 clearly records that the presence of Red Flag Symptoms (symptoms which if present require an immediate referral to hospital) was checked for and noted not to be present. The notes for 21 October 2005 indicate that no physical examination was undertaken by GP 1 and records that the situation was as before with no new symptoms. Mrs C does not agree with this view and told me that she mentioned to GP1 that the numbness in her calf had spread to her foot. Adviser 1 told me that Medical Practice 1 noted in their response letter that GP 1 observed Mrs C walking down the corridor and moving her left foot up and down and that this was an entirely appropriate method of examining a patient without the patient necessarily realising that it formed part of the examination. I note that GP 1 has not recorded any detail of examination in the contemporaneous medical notes.

10. Adviser 1 stated that the medical notes from Hospital 1 are particularly helpful in this complaint as they clearly show that there were no Red Flag Symptoms present at that date, some three days after the appointment with GP 1. This supports the view of GP 1 that there were no Red Flag Symptoms present on 21 October 2005. Adviser 1 noted that Mrs C would not have been allowed to return home that night had there been any Red Flag Symptoms present. Adviser 1 also told me that Mrs C's condition was a progressive one and it was logical that

the symptoms were not present on 21 October 2005 as they were not present on 24 October 2005.

11. Adviser 1 concluded that the consultation with GP 3 on 18 October 2005 was appropriate and that the evidence from Hospital 1 indicated that the consultation on 21 October 2005 was also appropriate. Adviser 1 noted that it would have been good practice for GP 1 to have physically examined Mrs C at the 21 October consultation and to have reassessed all the clinical signs, although he considers that, in this case, it would probably not have shown any difference to the previous examination.

12. Adviser 2 has confirmed for me that the records for Hospital 1 indicate an appropriate and thorough examination was carried out on 24 October 2005. There was evidence of significant nerve root irritation but not of loss of function and doctors did not detect any Red Flag signs. Adviser 2 concluded that the Red Flag Symptom of foot drop developed between 24 and 28 October 2005. Adviser 2 told me that most cases of low back and leg pain resolve with the treatment being offered by Medical Practice 1 and the need to watch out for the rare occurrence of a more serious condition (as experienced by Mrs C) was appreciated by the GPs in Medical Practice 1, although he also felt GP 1 should have carried out and recorded a more thorough examination on 21 October 2005.

(a) Conclusion

13. In light of the medical advice I have received I conclude that neither GP 1 nor GP 3 failed to properly or promptly diagnose the cause of Mrs C's back pain and I do not uphold this aspect of the complaint. I note, however, that both Advisers consider that it would have been better practice for GP 1 to have carried out a more thorough examination and recording of her findings on 21 October 2005. I would also note that recording of the findings of such an examination would have been of assistance in resolving this complaint.

(a) Recommendation

14. The Ombudsman recommends that Medical Practice 1 reflect on the Advisers' comments regarding the recording of examination findings and use such advice to inform good practice.

(b) Medical Practice 1 failed to handle her complaint in accordance with the NHS Complaints Procedure

15. Mrs C raised her concerns with Medical Practice 1 by telephone and was advised to write to the Board with her concerns. When Mrs C approached the Board she was advised that this was not correct and she should write directly to Medical Practice 1 concerned in line with the NHS Complaints Procedure. Mrs C was unhappy about this and also complained that Medical Practice 1 were displaying the incorrect complaints procedure.

16. The NHS Complaints Procedure was revised in April 2005 to remove the Independent Review stage for complaints and any involvement of the Board in directly responding to a complaint about an independent practitioner such as a GP Practice. The procedure on display in Medical Practice 1 at the time of this complaint had not been altered to reflect these changes. In response to my written enquiries Medical Practice 1 advised me that they would apologise to Mrs C for their failure to operate and display the correct complaints procedure as they had not been aware of the removal of the involvement of the Health Board. Medical Practice 1 provided me with a copy of their revised complaints procedure and I have confirmed that it has addressed the errors identified in this complaint.

(b) Conclusion

17. It is evident that Medical Practice 1 were displaying an out-of-date complaints procedure and I, therefore, uphold this aspect of Mrs C's complaint. However, the Practice have acknowledged this error, and have offered to make an apology to Mrs C and to take steps to address the error for the future. I consider such action to be appropriate.

(b) Recommendation

18. The Ombudsman recommends that Medical Practice 1 provide Mrs C with a written apology for their failure to properly follow the NHS Complaints Procedure.

(c) GP 1 made an inaccurate entry in Mrs C's medical record

19. Mrs C complained that Medical Practice 1's response of 6 February 2006 was inaccurate and in particular that GP 1 had lied in the medical records for 21 October 2005 in stating that Mrs C had attended to request stronger painkillers as she was going on holiday. Mrs C told me that GP 1 had increased the pain

killers without her specifically requesting this and without even examining her. Mrs C also noted that the holiday was only a weekend away in a caravan.

20. In response to my written enquires GP 1 stated that as Mrs C was complaining of pain on 21 October 2005 it was assumed she would wish to receive pain relief. In the absence of any Red Flag Symptoms this was an appropriate treatment plan. GP 1 also stated that she did not intend to imply any link between the weekend away and the request for pain relief and noted that the two matters were not linked in the medical notes.

(c) Conclusion

21. I do not consider that GP 1 intended to imply any link between Mrs C's attendance and her forthcoming weekend away or that she implied Mrs C expressly requested pain relief. I conclude that this amounts to a different perception of the record rather than the actual events themselves. There is no evidence to suggest GP 1 lied in the medical record. I do not uphold this complaint.

22. Medical Practice 1 have accepted the recommendations and have acted on them accordingly.

30 January 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr A	The complainant's partner
The Board	Borders NHS Board
GP 1	The GP from Medical Practice 1 who Mrs C attended on 21 October 2005
GP 2	The GP from Medical Practice 1 who Mrs C attended in July 2005
GP 3	The GP from Medical Practice 3 who Mrs C attended on 18 October 2005
Medical Practice 1	The Medical Practice where Mrs C was registered until November 2005
Medical Practice 2	The Medical Practice where Mrs C was registered from November 2005
Adviser 1	A GP Adviser to the Ombudsman
Adviser 2	A Hospital (A&E) Adviser to the Ombudsman
Hospital 1	Borders General Hospital
Hospital 2	The Hospital where Mrs C had her back surgery

Annex 2

Glossary of terms

Red Flag Symptoms	Symptoms which if present require an immediate referral to hospital
Sciatica	Pain along the sciatic nerve