Scottish Parliament Region: Highlands and Islands

Cases 200600019 & 200601311: Western Isles NHS Board and a GP at a Medical Practice, Western Isles NHS Board

Summary of Investigation

Category

Health: Hospital and GP

Overview

The complainant (Mr C) was concerned that his 86-year old late uncle (Mr A)'s chances of survival were compromised by the GP's late referral to hospital and by Uist & Barra Hospital (the Hospital)'s care and treatment. His uncle died during his time in the Hospital.

Specific complaints and conclusions

The complaints which have been investigated concern:

(a) the timing of the hospital referral (*no finding*); and

(b) the Hospital's care and treatment (*not upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. I shall refer to the complainant as Mr C and his uncle as Mr A. Western Isles NHS Board are referred to as the Board, the general practitioner as the GP, Uist & Barra Hospital as the Hospital, and the Ombudsman's adviser as the Adviser. A reminder of terms used is at Annex 1. On 3 April 2006 the Ombudsman received Mr C's complaint.

2. The complaints from Mr C which I have investigated concern:

(a) the timing of the hospital referral; and

(b) the Hospital's care and treatment.

Investigation

3. I was assisted in the investigation by one of the Ombudsman's clinical advisers, a consultant physician. His role was to explain, and give an opinion on, the clinical background to the complaint. We examined clinical records produced by Mr A's GP and the Hospital (including Hospital x-rays), the Board's file of Mr C's complaint and other information from the GP's Practice and the Board. To identify any gaps and discrepancies in the evidence, the content of some of these papers was checked against information elsewhere on file and also considered against my own and the Adviser's knowledge of the issues concerned. I am, therefore, satisfied that the evidence has been tested as robustly as possible. However, I have to add that the GP in question died before being able to give me his account of his actions, which has limited the evidence. The Adviser's advice has also been checked to ensure that it was clear, that (where appropriate) it was based on the evidence and that his conclusions followed logically from his views. Therefore, I accept the Adviser's advice. Finally, in line with the practice of the Ombudsman's office, the standard by which the complaint was judged was whether the events were reasonable, in the circumstances, at the time in question.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C, the GP's Practice and the Board were given an opportunity to comment on a draft of this report.

(a) The timing of the hospital referral

5. Mr C's account was that Mr A, an 86-year old, asked for a GP visit because he had been experiencing breathlessness on exertion and, soon after

lying down, back pain. Mr C said that Mr A told him that the GP, who visited on 31 August 2005, did not physically examine him but simply took blood for testing and advised him to get a new bed for the back pain. On 9 September Mr A's home help telephoned Mr C, concerned about Mr A's continuing deterioration. Mr C telephoned the GP twice, eventually persuading him to take action. The GP visited (that day) and called an ambulance, admitting him to the Hospital. Mr C considered that the GP should have referred his uncle to the Hospital on 31 August.

6. In replying to Mr C's complaint to him (which was made through the Board), the GP's account is that on 31 August, Mr A described having a pain in his back and his left side, starting soon after going to bed each night and disappearing as soon as he got up. When asked, Mr A denied having any other symptoms, such as breathlessness. The GP briefly examined him, finding slight tenderness in the muscles of the lower thoracic spinal area. When the GP pressed this area, Mr A said that that was the pain that he had been experiencing. He did not listen to Mr A's chest as there was no clinical need to do so. He told Mr A that the pain seemed to be muscular in origin and, as it only occurred in bed, his bed was probably responsible. As it was many years old, the GP advised a new one. The GP added that he took a blood sample because, only having met Mr A once before, he checked Mr A's records before the visit and noted a previous minor thyroid abnormality, so decided to use the opportunity to re-check it.

7. The GP's account of the events of 9 September is that he told Mr C that he (the GP) could not simply turn up unexpectedly at a patient's home and the GP suggested that Mr C ask his uncle to telephone the GP. When Mr C telephoned again, the GP offered to telephone Mr A. Mr A told the GP that, while waiting for his new bed, he had changed to another (also old) bed and that his pain was unchanged. He said he was very tired and had been breathless for two or three days. The GP decided to visit that day. During that visit, the GP's questioning revealed that Mr A had become increasingly breathless over the past four or five days and was now breathless on very mild exertion. The GP said he examined Mr A's chest and found signs of pneumonia and told Mr A he would need to go into the Hospital as he was quite ill and could not look after himself at home. Hospital admission was arranged for that day (9 September). The GP's referral letter to the Hospital indicated that the cause was not clear but looked as though it might be pneumonia or pleural effusion. (Pleural effusion is a collection of fluid between the chest wall and the lung.)

8. In the Hospital, an x-ray suggested possible pneumonia, but further clinical and radiological evidence revealed that Mr A was suffering from a pleural effusion which was pushing aside blood vessels and nerves in Mr A's chest. After further deterioration and a period of deep unconsciousness, sadly, Mr A died on 20 September 2005. The Adviser does not feel that there was any real evidence that Mr A had pneumonia; however, he considers that the absence of such evidence cannot be taken as firm evidence that there was no pneumonia because, for example, the clinical and radiological signs of pneumonia can be completely masked by pleural effusion. A further complication is that, on the one hand, pneumonia can cause pleural effusions yet, on the other hand, compression of the lung by a pleural effusion can result in pneumonia. In other words, the pneumonia/pleural effusion aspects were not straightforward. The primary cause of death was recorded as bronchopneumonia, but the Adviser has explained that this is often used as a broad, all-inclusive, expression to include respiratory failure from many causes, particularly in situations with many contributory factors.

9. The Adviser expressed surprise that, at the 31 August home visit, the GP did not check Mr A's respiratory system by examining his chest. He has added that it is simply not possible to say whether hospital referral at that time, rather than nine days later, would have improved Mr A's chances of survival.

(a) Conclusion

10. Where we have a possible criticism, the practice of the Ombudsman's office is to give the doctor the chance to respond to it. In some cases, such a response has shown us, for example, that the criticism was unfounded or was a less serious point than had initially seemed to be the case. Sadly, during the course of my involvement in this complaint, the GP, who had been on long term sickness absence from the Practice, died, without ever having had the opportunity to comment to me on the complaint. This meant that the Adviser's comment (see paragraph 9) could not be fully and fairly investigated. I note also the Adviser's view that one cannot say whether hospital referral on 31 August would have made a difference for Mr A. After careful thought, and discussion with the Adviser, I have decided that it would be unfair to the GP to uphold the complaint without his having had the chance to put his case to me. I have, therefore, decided to make no finding on this complaint.

(b) The Hospital's care and treatment

11. Mr C considered that poor clinical practice at the Hospital compromised his uncle's chances of survival. In reply to my enquiries, the Board said that the medical staff of the Hospital, which is a community hospital on a remote island, accessible only by air and boat, comprised five general practitioners who had been doing this work for many years and that it was usual for them to admit, and manage, acute illness up to the level of their competence. The Board added that if those doctors felt that a patient's condition was beyond that competence, they would arrange air ambulance transfer to a hospital with more appropriate facilities. The clinical records show the first days of Mr A's admission as spent in assessing Mr A and conducting tests. There was a progressive deterioration from 9 to 17 September. On 17 September the records indicate a marked worsening, with the following days as described at paragraph 8. The records for 19 September 2005 state that Mr A was considered to be too ill for transfer. It was clear to the Adviser that the Hospital's facilities were necessarily very limited and that it would not be appropriate to judge care and treatment there by the same standards as those expected in a large hospital on the mainland.

(b) Conclusion

12. From the evidence, the Adviser considers that Mr A was too ill for the journey that a transfer would involve. As indicated at paragraph 3, my judgement of a complaint must take account of the circumstances of the particular case. In this case, the circumstances were that a man who would best have been cared for in a hospital with more facilities could not be given that option because his condition was too poor to move him to such a facility. In other words, the Hospital was not the best place for Mr A but he was unable to be moved to a place with better facilities.

13. Against that background, the Adviser considers that the Hospital did what they reasonably could for Mr A during the time he spent there and that they cannot be criticised for Mr A's being too ill for transfer. He said that it is not possible to say whether Mr A would have been likely to have lived if he had been in a larger, better equipped, hospital. In this case, that means I must give particular consideration to the fact that the Hospital could not be judged by the standards which would apply to many other hospitals. I note the Adviser's view that the Hospital did what they reasonably could and that the evidence gives a clear picture of Mr A as being too ill for transfer. In all the circumstances, I do not uphold the complaint.

27 March 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mr A	The complainant's late uncle
The Board	Western Isles NHS Board
The GP	Mr A's general practitioner
The Hospital	Uist & Barra Hospital
The Adviser	The Ombudsman's clinical adviser

Annex 2

Glossary of terms

Pleural effusion	Collection of fluid between the chest wall and the lung