Scottish Parliament Region: Central Scotland

Case 200401686: Lanarkshire NHS Board

Summary of Investigation

Category
Health: Out-of-Hours, General Practitioner Service

Overview
The complaint concerns the care and treatment of the complainant (Mr C)'s late wife (Mrs C) by a doctor (Doctor 1) from an out-of-hours General Practitioner Service (the Service) in December 2002.

Specific complaint and conclusion
The complaint which has been investigated is that Doctor 1 failed to provide Mrs C with adequate care and treatment during a home consultation on 31 December 2002 *(upheld)*.

Redress and recommendations
The Ombudsman recommends that:
(i) Doctor 1 issue Mr C and his family with a full formal apology for the failures identified in this Report; and
(ii) the apology should be in accordance with the Ombudsman's guidance note on 'apology' (which sets out what is meant and what is required for a meaningful apology).

Doctor 1 has accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. In December 2004 the Ombudsman received a complaint from the complainant (Mr C). The complaint concerned the care and treatment provided to his terminally ill wife (Mrs C) by a doctor (Doctor 1) who was acting for an out-of-hours General Practitioner Service (the Service).

2. In January 2003 Mr C made a complaint to NHS Lanarkshire Primary Care Division (the Trust), now Lanarkshire NHS Board (the Board). Mr C complained that he and his family were unhappy with the care and treatment Mrs C had received from Doctor 1 on 31 December 2002. Mrs C died on 2 January 2003.

3. As part of the Trust's investigation of Mr C's complaint, the Lanarkshire Area Medical Out-of-Hours Committee (the Committee) considered the complaint. In 2004, the Committee determined that there were several deficiencies in the Service provided to Mrs C and her family and sought from the Service details of remedial action to be undertaken and/or planned to ensure improvement in the way the Service delivered care in the future.

4. Mr C was unhappy with the Service's response to the Committee's findings. The Convener, after he sought independent advice, decided not to hold an Independent Review of Mr C's complaint. Thereafter Mr C complained to the Ombudsman's office.

5. The complaint from Mr C which I have investigated is that Doctor 1 failed to provide Mrs C with adequate care and treatment during a home consultation on 31 December 2002.

Investigation

6. The investigation of this complaint involved obtaining and reading all of the information and documents submitted to the Ombudsman's office by the complainant and the Board. During my investigation of Mr C's complaint, I have had access to Mrs C's clinical records and the Board's complaint file. I have obtained and accepted advice from two independent clinical advisers to the Ombudsman, an experienced GP and a senior nursing adviser. Their role is to explain and give an opinion on the clinical aspects of the complaint. Doctor 1 and Doctor 2 (a partner in the Service) were interviewed by me and the Ombudsman's GP clinical adviser. The Ombudsman's senior nursing adviser

and I met with Mr C, his son, (Mr D) and Mrs C's niece, (Mrs E) who were all present when Doctor 1 attended Mrs C on 31 December 2002.

7. 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 Doctor 1 were given an opportunity to comment on a draft of this report.

Background

8. In May 2002 Mrs C was diagnosed with a malignant brain tumour. In June 2002 she underwent surgery and had palliative radiotherapy treatment. At that time the prognosis was that 'her overall survival prospects' were less than one year. In December 2002 Mrs C had a number of consultations with her own doctor. Mrs C was admitted to Wishaw General Hospital on 23 December 2002 and discharged to the care of her family on 27 December 2002. An application to have Mrs C admitted to a hospice for terminal care was made on 30 December 2002.

9. On the morning of 31 December 2002 Mrs C was visited at home by her own doctor and a district nurse. Later that afternoon, at 16:45 according to the Service's records, a member of Mrs C's family telephoned the Service and requested that a doctor visit Mrs C. That evening, at 19:30 according to the Service's records, Doctor 1 attended at Mrs C's home.

10. In January 2003 Mr C made a formal complaint to the Trust about Doctor 1's care and treatment of his wife on 31 December 2002.

11. The Trust arranged for Mr C and his two sons to meet with Doctor 1 and Doctor 2, who is also a practising GP, to discuss the complaint. The meeting took place in April 2003. Mr C was dissatisfied with the outcome of the meeting and asked for an Independent Review of his complaint.

12. In July 2003, following Mr C's complaint, the Trust arranged for Mr C's complaint to be raised with the Committee, who had a remit to monitor delivery of care by out-of-hours Services in Lanarkshire. Meanwhile, the Chief Executive of the Trust wrote a letter of apology to Mr C on 4 August 2003.

13. The Committee met on two occasions and determined that there were 'several deficiencies' that needed to be raised with the Service. The Trust informed the Service of this in a letter dated 19 February 2004. The

deficiencies included the following: (a) that Mrs C's own GP practice provided the Service with details of Mrs C's condition as per the protocol for terminally ill patients but this was not taken into account when the Service prioritised the call; (b) Doctor 1's attitude and manner in responding to Mrs C's needs and her family's questions were not appropriate in the situation; (c) the time taken from the initial call to eventual care outcome was excessive and problematic leading to greater stress to Mrs C and her family; (d) the poor response to Mrs C's needs and excessive time taken to deal with the call and resulting clinical outcomes inappropriately put an excessive level of responsibility on the district nursing Service; (e) on the information available, the Committee agreed that the matter suggested an inadequate response to pain management; (f) the Service's response to the complaint was protracted and inadequate.

14. The Trust thereafter sought from the Service details of remedial action undertaken and or planned to ensure improvement in the way the Service delivered care in the future. On the same date, the Trust wrote to Mr C informing him of the Committee's decision.

15. The Service, 'after a full discussion' with Doctor 1, replied to the Trust's letter on 29 February 2004. The letter stated that 'unfortunately it had turned out to be a bad consultation from the beginning'. Doctor 1 accepted that the consultation 'did not go well'. The letter continued that Doctor 1 had apologised to Mr C and his family 'unreservedly for any misunderstanding and management'. Mr C was dissatisfied with the Service's response and requested an Independent Review of his complaint. The Convener sought an independent opinion from another general practitioner who found an unacceptable delay in visiting and implementing treatment and that communication could have been better.

16. The Convener decided not to hold an Independent Review and gave his reasons in a letter dated 30 November 2004. In that letter he said that it had been unreservedly accepted by all those involved with Mr C's complaint that the delays in (i) the response to his call to the Service on 31 December 2002 (ii) obtaining the necessary drugs and (iii) commencing his wife's treatment were unacceptable. As Doctor 1 had apologised and assurances been given that action had been taken to address these issues he had decided not to hold an Independent Review of his complaint.

Conclusion

17. Having considered all of the written evidence received from the Board and Mr C, it appeared to me that there were conflicting accounts of what occurred during Doctor 1's consultation with Mrs C on 31 December 2002, which in Mr C's view had not been resolved by the Trust's investigation of his complaint. Further, Mr C sincerely felt that he had not received an adequate explanation of the events which led to his complaint.

18. Where there is a dispute about what happened, I must try and decide what occurred on the balance of probabilities, that is what is more likely to have happened than not. Where possible, I have, therefore, made my decision about what is most likely to have happened based on the available evidence and on the advice I have obtained from the Ombudsman's professional advisers.

19. I considered that, because of the conflicting evidence, it would assist my investigation to interview the parties concerned. Although a considerable period of time had elapsed since the events complained about, all of the parties appeared to have clear recollections of what they say occurred.

20. When I met with Mr C and his family, he firstly told me that until the events complained about on 31 December 2002 he had no complaints about the treatment his wife had received from the doctors and nurses who had treated her throughout her illness. Indeed, he praised his wife's treatment up until that day.

21. However, it was apparent that the events of 31 December 2002 are, understandably, still a source of distress to him. It was also evident that Mr C was still very upset by some of the comments made by Doctor 1 concerning these events when they met to discuss the complaint in April 2003. Rather than resolve matters, it appears that this meeting only served to cause Mr C further distress. He did not consider he had received an appropriate apology.

22. When I met with Doctor 1, he told me that over the years he has attended many terminally ill patients. He has been a community paediatrician and a named child protection officer. He has also worked with vulnerable families for more than 20 years. He said that this was the first complaint made against him in 30 years as a practising doctor. Doctor 2 told me that he had known Doctor 1 for 20 years and this was the first complaint he had received about him.

23. It appeared to me that Doctor 1 has been affected by Mr C's complaint. He clearly has had time to reflect on matters and was conscious of the distress caused to Mr C and his family.

24. Doctor 2 told me that he had set up the Service in partnership with another general practitioner in or about 1988. For the period concerned with Mr C's complaint, the Service covered 25 to 30 GP practices within the Lanarkshire area. The period of cover was from 18:00 to 08:00 on weekdays and also throughout the weekend. As well as home visits, the Service operated a walk-in centre for patients.

25. The Service used premises belonging to another medical practice and employed their own staff. It normally operated with two doctors and one doctor on standby, two telephone/radio operators and two drivers with two/three cars on the road. The Service had a pool of between 10 to 15 doctors working for them.

26. When a patient telephoned their own GP practice out of normal opening hours, they would hear a recorded message telling them to contact the Service. When the Service received a telephone call from a patient, the operator would record the patient's details on the top half of a call message sheet. If a doctor was out on call when a message from a patient was received, the operator would radio the car. It was up to the doctor to prioritise the patient's call. The second part of the form was completed by the doctor once s/he had seen the patient. A copy of the form was faxed the next morning to the patient's own practice and the Service retained a copy for their records. In addition a further copy was also hand delivered by courier to the patient's practice the next day.

27. My examination of the Service records for 31 December 2002, a telephone call sheet, shows that the Service received a telephone call concerning Mrs C on 31 December 2002 at 16.45. The top half of the sheet was completed by one of the Service's operators, as confirmed to me by Doctor 1 and Doctor 2 when I spoke with them. The call to the Service concerning Mrs C is shown as being 'Call No 12' received at '16:45' on '31/12/2002'. Alongside the word 'complaint' the telephone operator has written 'CANCER TERMINAL IN PAIN'.

28. Doctor 1 said that he started work with the Service at 18:00. He had six calls waiting for him when he started, including the call to visit Mrs C. He had to prioritise the calls which he normally tried to do by geographical area. However,

this could change depending on the calls received.

29. Mr C and his family were clearly of the view that Mrs C's doctor had left instructions with the Service concerning Mrs C's condition and treatment, should her condition deteriorate. This is confirmed in the hand written notes made by Doctor 1 at the end of his consultation with Mrs C which state 'seen by GP AM. According to patient's relatives GP has left notes for deputising doctor to start syringe driver'. A syringe driver is a method of delivering continuous subcutaneous pain killing drugs and other medication such as anti-nausea drugs and sedatives. It is commonly used at the end stage of terminal care. It appears from my examination of the Board's file that a doctor from Mrs C's own GP practice did leave a message with the Service. However, because of differing accounts, I am unable, on the balance of probabilities, to make a finding as to what that message was.

30. I accept Doctor 1's evidence to me that, when he called at Mrs C's home, he personally was unaware of any arrangement either to contact her own doctor or to start a syringe driver. In my view, all he knew about Mrs C's condition was the information which was written on the top half of the telephone call sheet. This was that Mrs C was suffering from 'terminal cancer' and was 'in pain'.

31. The family were, in my view, therefore, understandably upset, at what was clearly a very distressing time for them, on learning that Doctor 1 did not know about a message from Mrs C's own doctor concerning the syringe driver. Their distress was then exacerbated by Doctor 1's clinical assessment of Mrs C. In his opinion, Mrs C was not in pain and not distressed. She appeared to be in a deep sleep. She did not respond when he called her name. Therefore, he did not consider he needed to give her a morphine injection. This is confirmed in his hand written notes which were made by him immediately following his consultation with Mrs C. The notes state 'On examination generally well. Colour okay. Cardiovascular system regular. Respiratory system few crepitations. This is diagnosis cancer terminally ill'.

32. When I met with Doctor 1, he still stood by his clinical assessment of Mrs C's condition that evening.

33. Doctor 1's clinical opinion was very different to Mrs C's family's understanding of her condition and the treatment they considered she needed at that time. Mrs C's family, and I am mindful that Mrs E is a nurse experienced

in palliative care, considered that Mrs C was in pain, she was slipping in and out of consciousness and suffering from pneumonia.

34. I am satisfied from the evidence that the suggestion to use a syringe driver came from Mrs E. This was because, and I accept her evidence, that it was she who considered a syringe driver was necessary, particularly as Doctor 1 had told her that he would not revisit Mrs C every three to four hours. Also, the hand written notes made by Doctor 1 at the time of the consultation state 'relative is a hospice nurse. Wants to start syringe driver'.

35. Doctor 1 told me that he was initially reluctant to agree to the use of the syringe driver but did eventually agree to its use. However, he said his decision was based not on a purely medical assessment of Mrs C but because of the situation he found himself in with the family. He said the family were angry and so he gave in.

36. Having agreed to the use of a syringe driver, Mrs C's family were clearly under the impression that Doctor 1 would organise both this and the related medication and that he would also contact the district nurses. Mr C and his family have maintained this stance throughout the course of the complaint against Doctor 1.

37. Doctor 1 told me that his understanding was that Mrs E was going to get the syringe driver that evening and that once she had obtained it he would prescribe the morphine. However, when reviewing the evidence, there are various discrepancies in Doctor 1's recollection of events. Doctor 1, in a written statement in March 2003 following Mr C's complaint to the Trust, stated that Mrs E 'said [she] would get everything from [the] Hospice to start a syringe driver'. Further, in March 2003, Mrs F (the Service's Business Manager) wrote that Doctor 1, following his consultation with Mrs C, was planning to revisit her a few hours later to assess her condition. In my interview with Doctor 1, he told me that he did not tell Mr C and his family before he left their home that he would revisit Mrs C. He said he told them that if there were any problems they were to call the Service.

38. A letter dated 29 January 2004 from the Service states that Doctor 1 did not know how to access a syringe driver and could not leave a prescription. However, Doctor 1 told me that he did know where to access a syringe driver at the time. He said he would have contacted the local hospice, or the accident

and emergency department of the local hospital. Doctor 2 also told me that although it was unusual to obtain a syringe driver for a patient, the Service or one of their deputising doctors would have known to obtain one from the local hospice.

39. Doctor 1, during my meeting with him, accepted that there had been a problem in the way he communicated with Mr C and the other members of his family who were present during his consultation with Mrs C.

40. Therefore, on the balance of probabilities, I accept Mr C and his family's evidence that Doctor 1 led them to believe that he would make the necessary arrangements for the setting up of the syringe driver including obtaining the necessary medication and contacting the district nurses.

41. The clinical advice I have received from the Ombudsman's GP adviser is that it would not fall below a reasonable standard for an out-of-hours doctor if they did not organise a syringe driver where a patient seemed undistressed, Nevertheless, in a patient such as Mrs C, even if she was pain free, it would have been good practice to organise a syringe driver to prevent problems occurring later.

42. I accept that Doctor 1, whilst a deputing doctor, had never previously been asked to organise a syringe driver for a patient. However, the clinical advice I have received, and with which I agree, is that Doctor 1 having agreed a syringe driver for Mrs C, should have taken responsibility for organising one and issuing a prescription for the relevant controlled drugs.

43. Doctor 1 should also have left a prescription at Mrs C's house. In not doing so, this necessitated the district nurses having to contact Doctor 1 later that evening and travel to the Service's base to collect the prescription, causing further delay. Doctor 1 should also have been aware that district nurses at that time stopped work at 22:00. Therefore, there was a time element in this.

44. Further, Doctor 1 should not have left the local terminal care services to sort out Mrs C's drug prescription on his behalf. When I asked Doctor 1 why he had not left a prescription for morphine with Mrs C's family he said that with hindsight he accepts that he should have done so. He said he accepts that he should have taken control of the situation in relation to obtaining both the syringe driver and the relevant drugs.

45. In my view, a difficult and stressful situation was further made worse with Doctor 1's suggestion that Mrs C be given a liquid nutritional supplement drink. Doctor 1 told me that he had only mentioned Mrs C should be given a liquid drink as part of the general care and management of the patient. He said the family had mistaken his suggestion of the drink as being an alternative to pain relief for Mrs C and that Mr C and his family had taken his comments out of context. However, as stated above, Doctor 1 has accepted that there was a problem in the way he communicated with Mr C and the other members of his family who were present during his consultation with Mrs C. Therefore, I understand why it appeared to Mrs C's family that Doctor 1 was recommending she be given a liquid nutritional drink as opposed to pain relief.

46. Despite Doctor 1's explanation, the clinical advice I have received from the Ombudsman GP adviser is that even if Mrs C was not in pain, as she was semi-comatose, there did not appear any rationale for giving her a liquid nutritional drink.

47. I accept that Doctor 1, on the evening he visited Mrs C, was under time pressure because he had a lot of calls to make. Doctor 1 told me that although it was a holiday weekend and Mrs C's own GP practice was not due to open again for another two days, he did not think to contact the family again over the weekend. He left it to the family to contact him, which was his routine practice. However, with hindsight he accepts that he should have contacted the family and checked the situation. Also, he thought he should have contacted Mrs C's own doctor first thing the next morning. He said in a similar situation he would now do so.

48. Doctor 1 told me that looking back he realises now how distressed Mrs C's family were and he could have handled their distress better. He said that he feels he did not communicate effectively with the family and did not control the situation with them very well. He accepts that he could have done things better on his visit to Mrs C.

49. Therefore, taking into account all of the evidence, I uphold the complaint.

Recommendation

50. Following the complaint from Mr C's family, Doctor 2 informed me that a number of procedural changes were made by the Service. One of these was to contact the local hospice to make arrangements for accessing a syringe driver, should one be required for a patient.

51. However, since the events which led to Mr C's complaint, the Service has undergone major changes. Mr C's local out-of-hours Service became the responsibility of the Board in October 2004. The Service is for patients who need urgent medical care and cannot wait until their own GP surgery is open. All of the Board's out-of-hours calls are now handled by NHS 24, the telephone health advice, clinical assessment and referral Service.

52. Doctor 1 has told me that as a result of this change, there is better communication. In addition, I am also aware that NHS staff looking after a patient will soon be able to access important information about a patient's health, even if they cannot contact the patient's own GP surgery. This is because of changes in the way that the NHS will store patient's health records. Starting in May 2007, all patients will eventually have an Emergency Care Summary. This is a summary of basic information about a patient's health which might be important if they need urgent medical care when their GP surgery is closed. The Emergency Care Summary is copied from the patient's GP's computer system and stored electronically. NHS staff can then access their computer and find the patient's Emergency Care Summary quickly, if they need to see it. NHS staff will need to ask the patient if they agree to this before they can look at the information[1].

53. Further, McMillan nurses are now on call 24 hours a day for palliative care. Also deputising doctors have access to a syringe driver if they are needed outwith normal surgery hours.

54. It is, therefore, hoped that the circumstances which gave rise to this complaint, particularly in relation to a deputising doctor being aware of a

[1] If the patient is unconscious, NHS staff may look at the Emergency Care Summary without agreement. At present only doctors, nurses and receptionists in out-of-hours medical centres, staff at NHS 24 who are involved in the patient's care and staff in hospital accident and emergency departments will be able to look at the patient's Emergency Care Summary. In the future, ambulance staff may also be able to do so.

patient's condition and having ready access to a syringe driver and palliative care for a patient, will not recur under the new system of out-of-hours care.

55. Accordingly, in view of these changes, I have no recommendation to make regarding the Service.

56. I appreciate that Doctor 1 has 'apologised' in writing through the Service to Mr C on more than one occasion. However, it appears to me that these were qualified apologies because the letters containing the apology referred to matters concerning Doctor 1's visit to Mrs C which were disputed by Mr C and his family. I, therefore, consider that Doctor 1 should issue a personal apology direct to Mr C and his family.

57. The specific recommendation the Ombudsman is making resulting from this investigation is that Doctor 1 should issue Mr C and his family with a full formal apology for the failures identified in this report. The apology is to be in accordance with the Ombudsman's guidance note on 'apology' which sets out what is meant and what is required for a meaningful apology.

58. Doctor 1 has accepted the recommendations and will act on them accordingly.

23 May 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	The patient
Doctor 1	The doctor who is the subject of the complaint
The Service	The Out-of-Hours General Practitioner Service
The Trust	NHS Lanarkshire Primary Care Division
The Board	Lanarkshire NHS Board
The Committee	Lanarkshire Area Medical Out-of-Hours Committee
The Advisers	The Clinical Advisers to the Ombudsman
Mr D	The patient's son
Mrs E	The patient's niece
Doctor 2	The doctor who operated the Out-of-Hours General Practitioner Service
Mrs F	The Out-of-Hours General Practitioner Service's Business Manager

Annex 2

Glossary of Terms

Syringe Driver	A method of delivering continuous subcutaneous pain killing drugs and other medication such as anti-nausea drugs and sedatives. It is commonly used at the end stage of terminal care.