Scottish Parliament Region: Lothian

Case 200602086: A Medical Practice, Lothian NHS Board

Summary of Investigation

Category

Health: GP

Overview

The complainant (Mrs C) raised a number of concerns about the treatment which her son (Mr A) received from the GP Practice (the Practice) and that doctors failed to diagnose that he was suffering from pneumonia which resulted in an emergency hospital admission.

Specific complaint and conclusion

The complaint which has been investigated is that doctors at the Practice provided Mr A with inadequate treatment and failed to diagnose that he was suffering from pneumonia *(partially upheld)*.

Redress and recommendations

The Ombudsman recommends that the Practice shares this report with the GPs concerned to reflect on the lessons learned in relation to the importance of chest examination in diagnosing chest disease and the difficulties of assessment of patients with communication difficulties. The Ombudsman further recommends that GP 2 shares the case with his/her appraiser at annual appraisal if this has not already been done.

The Practice have accepted the recommendations and will act on them accordingly

Main Investigation Report

Introduction

1. On 20 September 2006 the Ombudsman received a complaint from Mrs C about the treatment which her son (Mr A) received from the GP Practice (the Practice) and that doctors failed to diagnose that he was suffering from pneumonia which resulted in an emergency hospital admission. Mrs C complained that Mr A was showing the clinical signs of pneumonia yet the doctors did not diagnose the condition. Mrs C complained to the Practice but remained dissatisfied with their response and subsequently complained to the Ombudsman.

2. The complaint from Mrs C which I have investigated is that doctors at the Practice provided Mr A with inadequate treatment and failed to diagnose that he was suffering from pneumonia.

Investigation

3. In writing this report I have had access to Mr A's GP clinical records and the complaints correspondence. I also obtained Mr A's hospital records for the emergency admission. I obtained advice from one of the Ombudsman's professional advisers (the Adviser), who is a GP, regarding the clinical aspects of the complaint.

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

Clinical History

5. Mr A is 36 years old and lives in supported accommodation. He has Down's Syndrome and suffers from epilepsy which is controlled by medication. He has communication difficulties and has difficulty describing his symptoms. Between 4 March 2006 and 20 April 2006 Mr A had eight contacts with the Practice (by telephone or consultation). Mr A's symptoms included vomiting; diarrhoea; sore throat; coughing and abdominal tenderness. During this time GPs at the Practice took blood tests and prescribed medication. On 25 April 2006 contact was made with Lothian Unscheduled Care Service (LUCS) and a doctor visited Mr A and advised that Mr A should take paracetamol. (Note: Mrs C has complained about the actions of [deleted at this

stage for confidentiality reasons] and that is subject to a separate Ombudsman's investigation – See 200601874). On 26 April 2006, Mr A's sister was concerned about his condition and took him to the Accident and Emergency Department at St John's Hospital where a diagnosis of pneumonia was made.

Complaint: Doctors at the Practice provided Mr A with inadequate treatment and failed to diagnose that he was suffering from pneumonia

6. Mrs C complained that Mr A almost died due to the untreated pneumonia and had to have a major chest operation in order to deal with the condition which developed over the period he was receiving treatment at the Practice. Mrs C felt that Mr A's condition must have taken some time to develop and had doctors examined Mr A properly then he would have been admitted to hospital earlier. She said that on 6 April 2006 a GP (GP 1) noticed crackling on Mr A's right lung and prescribed antibiotics. This was not followed up by another GP (GP 2) at the next consultation on 20 April 2006. Mrs C said Mr A was showing symptoms such as a persistent chesty cough; sore chest; difficulty eating and swallowing food; severe distress and crying on occasions; significant unexpected weight loss and difficulty breathing. Mrs C said that Mr A would normally describe all his ailments as a 'sore tummy'. Mrs C felt that in patients with learning difficulties, who are unable to fully describe their symptoms, then doctors should rely more heavily on clinical tests and refer the patient to hospital if there was uncertainty about the cause of their condition.

7. A doctor at the Practice (GP 3) responded to Mrs C after discussing Mr A's treatment with the consultants who treated him in hospital. GP 3 explained that he felt the GPs treated Mr A appropriately in view of the symptoms which were presented. GP 3 said that it was not documented in the notes that Mr A tended to describe all his physical ailments as a 'sore tummy'. This had not been mentioned previously by Mr A or his carers but would be noted for future reference. GP 3 continued that on 6 April 2006, GP 1 examined Mr A's chest and found evidence of a lower respiratory tract infection. This was treated appropriately with antibiotics. It was accepted that no follow-up was arranged for the chest infection as doctors would rely on Mr A's carers to advise if there was no resolution or his condition deteriorated. Similarly on 20 April 2006 it was felt that Mr A's condition had improved.

8. GP 3 explained that from his discussions with the hospital consultants he believed that Mr A's respiratory difficulty at the time of the hospital admission

was due to a large pleural effusion (fluid between the chest wall and the lungs) in the right side of his chest causing compression of his lungs. Investigations failed to reveal a clear cause for the large pleural effusion and CT scans (computerised x-rays) showed no evidence of pneumonic consolidation. GP 3 said the cause of the pleural effusion was most likely, but not certainly, to have been the lower respiratory infection treated by GP 1 on 6 April 2006. GP 3 felt it was unlikely the pleural effusion was present on 6 April 2006 as GP 1 would not have been able to hear crackles (sounds when air moves through fluid-fillied airways) in Mr A's chest (paragraph 6 refers). GP 3 wrote again to Mrs C and explained that it was accepted that doctors at the Practice were unfamiliar with Mr A and how he was normally and this proved difficult in assessing him and comparing him to his usual self. GP 3 said he would raise the matter of communication with patients with disabilities at the regular Practice meetings.

9. The Adviser reviewed the records and said that it appeared Mr A had some form of pneumonia which was complicated by a pleural effusion. He felt it was unlikely that any significant chest disease was missed prior to 6 April 2006. This was because Mr A's white blood cell count which was obtained on 17 March 2006 was normal and, therefore, a significant chest infection such as pneumonia was unlikely. The Adviser said he had no concerns about Mr A's management prior to the diagnosis of a chest infection on 6 April 2006. He also had no concerns about GP 1's actions on 6 April 2006 who found abnormal chest signs and prescribed standard treatment. The Adviser considered whether GP 1 should have arranged a follow-up to examine Mr A's chest again to see if the abnormal signs had gone, but as GP 1 had recorded that she was not sure that the chest infection was clinically significant then the decision not to follow-up was probably reasonable.

10. The Adviser considered whether GP 2 should have listened to Mr A's chest on 20 April 2006. He said that GP 2 had come to a reasonable conclusion in that increased dosage of medication was a likely cause of Mr A's illness and suggested that his medication be reduced. However, the Adviser felt that GP 2 should have listened to Mr A's chest in view of the previous abnormality which had been found and that Mr A continued to be unwell. The Adviser noted that when Mr A was admitted to hospital on 26 April 2006 he had marked chest signs which may have been present on 20 April 2006. The Adviser felt that GP 2 may have missed an opportunity to make an earlier diagnosis. The Adviser suggested that GP 2 be asked to reflect on the lessons learned in this case in relation to the importance of chest examination in

diagnosing chest disease and the difficulties of assessment of patients with communication difficulties.

Conclusion

11. Mrs C complained that doctors at the Practice should have diagnosed that Mr A was suffering from pneumonia before it led to the emergency hospital admission on 26 April. The advice which I have received and accept is that it is unlikely that Mr A would have been displaying relevant symptoms prior to 6 April 2006 as blood samples taken that day were found to be within normal limits. The actions of GP 1 on 6 April were entirely appropriate and the decision not to arrange any follow-up was reasonable. Likewise it is felt that GP 2's actions on 20 April 2006 were reasonable with the exception that GP 2 should have listened to Mr A's chest. However, even if GP 2 had listened to Mr A's chest it cannot be established with certainty whether the marked chest signs which were found on hospital admission on 26 April 2006 would have been present.

12. I am pleased that GP 3 has undertaken to raise the issue of communication with patients with disabilities at the regular Practice meetings and this should raise awareness with the staff. Insofar as the complaint which has been investigated I have decided to partially uphold the complaint to the extent that GP 2 should have examined Mr A's chest on 20 April 2006. If s/he had done so it may have been possible to detect marked signs of pneumonia at that stage.

Recommendation

13. The Ombudsman recommends that the Practice shares this report with the GPs concerned to reflect on the lessons learned in relation to the importance of chest examination in diagnosing chest disease and the difficulties of assessment of patients with communication difficulties. The Ombudsman further recommends that GP 2 shares the case with his/her appraiser at annual appraisal if this has not already been done.

14. The Practice have accepted the recommendations and will act on them accordingly

18 July 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr A	Mrs C's son
The Practice	The Medical Practice where Mr A was a registered patient
The Adviser	The Ombudsman's professional medical adviser
GP 1	The GP who examined Mr A on 6 April 2006
GP 2	The GP who saw Mr A on 20 April 2006
GP 3	The GP who formally responded to the complaint
LUCS	Lothian Unscheduled Care Service – Emergency Lothian NHS Service outwith normal hours