Scottish Parliament Region: Lothian

Case 200502314: A Medical Practice, Lothian NHS Board

Summary of Investigation

Category

Health\FHS: GP & GP Practice\Communication; staff attitude; dignity; confidentiality

Overview

The complainant (Mrs C) raised a number of concerns that her GP Practice (the Practice) withheld information from her when she requested copies of her medical records, initially by not supplying the full records, then by refusing to give written explanations of them and that they wrote misleading and inaccurate referral letters to specialists because they do not believe she had a heart attack.

Specific complaints and conclusions

The complaints which have been investigated are that the Practice:

(a) manipulated Mrs C's medical care via misleading and inaccurate referral letters *(not upheld)*; and

(b) withheld medical information from Mrs C *(not upheld)*.

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 4 January 2006 the Ombudsman received a complaint from Mrs C that her GP Practice (the Practice) had withheld information from her, neglected her health and written misleading and inaccurate letters to consultants and specialists about her that had the effect of manipulating their treatment of her health.

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

(a) manipulated Mrs C's medical care via misleading and inaccurate referral letters; and

(b) withheld medical information from Mrs C.

Investigation

3. The investigation of these complaints involved obtaining and examining the relevant medical records and complaint file from the Practice. I have reviewed the copies of correspondence and comments submitted to this office by Mrs C. I have contacted the consultants and specialists involved and obtained evidence from them and I have sought the views of medical advisers to the Ombudsman (the Medical Adviser and the GP Adviser). I have set out my findings of fact and conclusion. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. The terms used to describe other people referred to in the report are noted in Appendix 1 and a glossary of the medical terms used is noted in Appendix 2. Mrs C and the Practice have had an opportunity to comment on a draft of this report.

4. Mrs C underwent surgery in 1996. Following the surgery she awoke suddenly with great pain in her chest and received painkilling injections.

5. In October 2003 Mrs C underwent an unconnected operation, in preparation for which an electrocardiogram (ECG) was taken. The anaesthetist informed Mrs C that the ECG had revealed some problems, but nothing that would prevent the operation from occurring. The anaesthetist advised Mrs C to consult her GP for tests for high blood pressure and blood lipids. Mrs C was distressed at receiving this information and was supplied with an operation report to give to her GP. This operation report states 'ECG suggestive of old inferior infarct [inferior infarction]. Advised to attend for blood pressure control

and blood lipids measurement'. An inferior infarction is produced by the total closure of the dominant right coronary artery. If an inferior infarction is confirmed then that part of the heart's arterial system is damaged.

6. Mrs C has told me that the GP she made an appointment to see (GP 1), who was not her usual GP, was unavailable and she was seen by a locum. Mrs C believes that the locum told her that she had had a heart attack at some point in her life. I have had sight of the GP records for this appointment. The records make no reference to this. Mrs C believes that she had a heart attack following her operation in 1996. At an appointment on 7 November 2003 GP 1, did not agree that Mrs C had had a heart attack at any point in her life. When Mrs C asked GP 1 for a second opinion she was referred to a cardiologist (Cardiologist 1).

(a) The Practice manipulated Mrs C's medical care via misleading and inaccurate referral letters

7. GP 1 sent a referral letter (Letter 1), dated 11 November 2003, to Cardiologist 1 before Mrs C attended a consultation on 26 November. Mrs C has told me that at the consultation, Cardiologist 1 showed her a referral letter from GP 1 which stated that GP 1 had no intention of treating Mrs C for any blood pressure problems and that she had been unfit to undergo a general anaesthetic before her operation in October 2003. Mrs C believes that the letter she was eventually supplied by the Practice was a different version of this letter, as it does not include these points. Furthermore, Mrs C does not believe the letter she was supplied can be accurate, as she feels GP 1 claimed to be more familiar with her than he could have been as it had been rare for Mrs C to see GP 1 on her visits to the Practice.

8. Cardiologist 1 wrote to GP 1 on 5 December 2003. In the letter he concurs with GP 1's opinion that there is no evidence to support Mrs C's belief that she had suffered a heart attack. Mrs C was given sight of this letter, and wrote to Cardiologist 1 on 4 January 2004 giving details of her own medical history, her family's medical history, some concerns she had about the consultation on 26 November 2003 and requesting that further tests be undertaken.

9. Cardiologist 1 responded to Mrs C's letter on 15 March 2004, stating that he would refer her to another cardiologist (Cardiologist 2). On the same date Cardiologist 1 wrote to Cardiologist 2 requesting that he see her 'for a second

opinion'. Cardiologist 1 said that there were notes of his consultation with Mrs C but that 'sometimes it is helpful to see patients without any prior clinical records to prejudice any second opinion'. He enclosed a copy of Letter 1.

10. I have requested and received copies of Letter 1 from Cardiologist 1, Cardiologist 2 and Mrs C's current GP Practice. All of these copies are identical to the copy Mrs C supplied to me. This letter does not contain the information Mrs C said she saw at the consultation on 26 November 2003.

11. Mrs C had a consultation with Cardiologist 2 on 26 April 2004. Cardiologist 2 wrote to GP 1 on 28 April 2004, in the letter he concurs with GP 1 and Cardiologist 1's opinion that there is no evidence to support Mrs C's belief that she had suffered a heart attack.

12. On 30 July 2004 Mrs C had a consultation with another GP at the Practice (GP 2). Following this consultation GP 2 referred Mrs C to a specialist in respiratory medicine (Specialist 1) as he suspected that Mrs C may be suffering with hyperventilation. Mrs C believes the referral letter sent by GP 2 to Specialist 1 (Letter 2) was misleading and that by mentioning hyperventilation in the letter it may have had an effect on Specialist 1's diagnosis.

13. On 17 August 2004 Mrs C had a consultation with Specialist 1. Specialist 1 wrote to the Practice in a letter dictated on 17 August 2004. Specialist 1 indicated that the pain Mrs C had been experiencing best fitted musculoskeletal pain but that it was not typical of that. He commented that 'it certainly did not sound like cardiac pain'. His provisional diagnosis was atypical chest pain and possible hypertension. He arranged a formal hyperventilation test and an x-ray of her thoracic and cervical spine.

14. Mrs C attended another consultation with Specialist 1 on 26 October 2004. Following this Specialist 1 wrote to GP 2 and advised that he had diagnosed hyperventilation syndrome. He wrote that he believed Mrs C did not accept this diagnosis and was 'absolutely convinced that she has had a heart attack'.

15. On 8 February 2005 Mrs C had a consultation with GP 2. Following this consultation GP 2 referred Mrs C to the hypertension clinic at the Western General Hospital in Edinburgh. GP 2 wrote a referral letter for Mrs C on 9 February 2005 (Letter 3). Mrs C believes that this letter was misleading because it mentions her belief that she had suffered a heart attack, her referrals

to Cardiologist 1, Cardiologist 2 and Specialist 1 and states that her blood pressure had 'suddenly shot up … having been reasonably well controlled'. Mrs C believes her blood pressure had always been high.

16. On 30 March 2005 Mrs C attended a consultation with a consultant physician at the cardiovascular risk clinic (Consultant 1). Consultant 1 wrote to GP 2 on 26 April 2005 stating that Mrs C's blood pressure was well controlled on her current medication and that he had arranged a test to exclude a phaeochromocytoma.

17. On 9 May 2005 Mrs C attended a consultation with GP 2. She asked for an open referral letter that she could take to a cardiologist of her choice. Initially GP 2 refused this, and recommended that Mrs C await the outcome of the test Consultant 1 had arranged. Mrs C was not satisfied with this and GP 2 agreed to provide her with an open referral letter.

18. GP 2 prepared this referral letter (Letter 4) on 10 May 2005 and Mrs C collected it from the surgery. Mrs C was upset by this referral which she felt was inaccurate and misleading.

19. Mrs C continued to attend consultation with various specialists. On 21 September 2005 a consultation with Consultant 1 revealed what he described as 'an unexpected pericardial effusion'. However, further imaging subsequently showed that it had resolved.

20. I sought the advice of the GP Adviser and he has confirmed that all the referral letters GP 1 and GP 2 prepared in relation to Mrs C (see paragraphs 7, 12, 15 and 18) are accurate and consistent with the information contained in Mrs C's GP records and that the wording of these letters is appropriate. He has also commented: 'I think the letters are good with the relevant information in them. They seem to be a good introduction of the patient and her problems to the various consultant colleagues. It is my opinion that these letters represent a better than average standard or a higher than reasonable standard'. The Medical Adviser did not make specific comments on the individual letters, but he did note that 'I consider that the four referral letters are all accurate and consistent with the clinical information in the records'.

(a) Conclusion

21. As noted in paragraphs 7, 12, 15 and 18, Mrs C believed that the referral letters sent by GP 1 and GP 2 were misleading and inaccurate. As noted in paragraph 20, I sought the advice of the Medical Adviser and the specialist GP Adviser on these letters and they confirmed that the letters are accurate and consistent with the information contained in Mrs C's GP records and that the wording of the letters is appropriate. While I do not doubt the sincerity of Mrs C's belief that she has had a heart attack and that this is what is at the root of her concerns about the referral letters, this belief is not supported by evidence. Therefore, I concur with the opinions of the Medical Adviser and the GP Adviser and, accordingly, I do not uphold the complaint.

(b) The Practice withheld medical information from Mrs C

22. On 17 October 2005 Mrs C wrote a letter of complaint to the Practice Business Partner. In this letter she requested copies of all correspondence relating to her care from March 2003 onwards. This correspondence and printed copies of Mrs C's GP records were supplied to Mrs C on 25 October 2005. A meeting was held between Mr and Mrs C, the Practice Business Partner and the Practice's Office Manager, who made notes, on 4 November 2005. Mrs C advised me that at the meeting it was discovered that the information about some of her consultations with the GPs at the Practice had not been included in the information sent to her on 25 October 2005. Further information identified as missing was supplied to Mrs C at the meeting. I have had sight of the Practice's detailed note of this meeting.

23. I asked the Practice for their view on the supply of the requested records to Mrs C. The Practice Business Partner advised me that the Practice's view is that Mrs C received all the records that she requested in her letter of 17 October 2005. In addition at the meeting of 4 November 2005 she had full access to her paper and electronic record. She was given copies of records that had been received by the Practice in the period between their letter of 25 October and the meeting on 4 November 2005. The Practice also supplied me with a copy of their policy on information request handling. This indicates that a meeting will be offered in all cases to provide the patient with any clarification they may need in relation to the information in their file and that there will usually be a charge levied if any copies of letters require to be made. I note that in Mrs C's case these charges were waived, although Mrs C was prepared to meet these costs.

24. On 11 November 2005 Mrs C wrote to the Practice indicating that the medical record notes ‘contain a number of anomalies’. Mrs C did not provide any further detail of this until 27 November 2005 when she wrote three documents to the Practice outlining the anomalies she had found in the records and requesting explanations for them. On 29 November 2005 Mrs C wrote again to the Practice asking questions about her care and treatment.

25. On 2 December 2005 the Practice Business Partner left a telephone message for Mrs C indicating that the answers to her questions could best be given by an explanation and demonstration of the information systems of the Practice, and inviting Mrs C to call back to arrange a meeting where this could be undertaken.

26. Mrs C responded by email on 4 December 2005 stating that she found the message upsetting and that she was not prepared to attend another meeting.

27. The Practice Business Partner wrote an email to Mrs C on 5 December 2005 stating again that a lot of the issues Mrs C had raised were ‘computer driven’ and that a meeting would be the most helpful way to explain the issues. The Practice Business Partner also stated that she was not prepared to answer the whole contents of Mrs C’s letter in writing.

28. The Practice Business Partner also wrote to the Medical and Dental Defence Union Scotland on 5 December 2005 outlining the issues the Practice had had with Mrs C and seeking advice on how best to progress the issues. Following the receipt of advice from the Union, a letter was sent to Mrs C on 19 December 2005. This letter set out the Practice’s understanding of Mrs C’s health problems and their advice to her. It was signed by all of the Practice partners.

29. On 22 December 2005 Mrs C’s husband (Mr C) responded to the letter of 19 December 2005. He took issue with many of the points made in the Practice’s letter and stated ‘The [letter]…does not offer [Mrs C] any reassurances at all'.

30. On 16 January 2006 the Practice Business Partner wrote to Mr and Mrs C. In the letter she notes that, as Mr and Mrs C have indicated that they have no faith in the partners and staff of the Practice, there is ‘a complete breakdown’ in

the Doctor-Patient relationship and that they would be removed from the Practice's patient list with 28 days notice.

31. On 28 January 2006 Mrs C wrote to the Practice Business Partner stating that 'I am very tired of this most distressing situation and will gladly remove myself from this practice'. This letter was acknowledged by the Practice on 7 February 2006.

(b) Conclusion

32. As noted in paragraphs 23 and 24 Mrs C and the Practice have differing views on whether Mrs C received the information she requested in her letter of 17 October 2005. However, the information Mrs C has supplied me with does contain a complete and continuous record of her appointments with the Practice when compared to the copy of her GP records supplied by her current Practice. Similarly, the Practice's detailed note of the meeting of 4 November 2005 indicates that all the points raised in Mrs C's letter of 17 October 2005 were discussed at the meeting. Further, the Practice's views of the issues that seemed to most concern Mrs C were clearly laid out in their letter of 19 December 2005. The Practice reasonably explained to Mrs C why they were not prepared to provide a written response to her questions because they related to the way the information was stored. The Practice reasonably offered Mrs C the opportunity to meet with them again in order that her concerns could be addressed. Mrs C refused this reasonable offer. In view of this, I do not uphold the complaint.

19 September 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Practice	Mrs C's GP practice
The Medical Adviser	The medical adviser to the Ombudsman
The GP Adviser	A medical adviser to the Ombudsman specialising in GP issues
ECG	Electrocardiogram
GP 1	A general practitioner at the Practice
Cardiologist 1	The cardiologist Mrs C was referred to by GP 1
Letter 1	The referral letter sent by GP 1 to Cardiologist 1 dated 11 November 2003
Cardiologist 2	The cardiologist Mrs C was referred to by Cardiologist 1
GP 2	A GP at the Practice
Specialist 1	The specialist in respiratory medicine Mrs C was referred to by GP 2
Letter 2	The referral letter sent by GP 2 to Specialist 1 dated 30 July 2004

Letter 3	The referral letter sent by GP 2 to the hypertension clinic dated 9 February 2005
Consultant 1	The consultant at the Cardiovascular Risk Clinic Mrs C was referred to by GP 2
Letter 4	The open referral letter prepared by GP 2 and dated 10 May 2005
Mr C	Mrs C's husband

Annex 2

Glossary of terms

Electrocardiogram	A record of the electrical activity of the heart over time
Hypertension	High blood pressure
Hyperventilation	A state of breathing faster or deeper than necessary, thereby reducing the carbon dioxide concentration of the blood below normal levels producing, in turn, a number of unpleasant, distressing physical sensations
Inferior Infarction	Inferior infarction is produced by the total closure of the dominant right coronary artery. If an inferior infarction is confirmed then that part of the heart's muscle is damaged
Musculoskeletal pain	Pain of the bones, joints and muscles.
Pericardial Effusion	Fluid in the space between the heart and the sac that encloses it
Phaeochromocytoma	A usually benign tumour that arises from the centre of the adrenal gland. One of the effects of phaeochromocytoma is an unstable blood pressure which can rise to high levels suddenly