Scottish Parliament Region: North East Scotland

Case 200601627: A GP, Tayside NHS Board

Summary of Investigation

Category

Health: GP

Overview

The complainants (Mr and Mrs C), complaining on behalf of Mrs C's late mother (Mrs A), raised concerns regarding an alleged failure by Mrs A's General Practitioner (the GP) to take urgent and appropriate action to investigate and treat problems she was suffering from between May 2006 and July 2006.

Specific complaint and conclusion

The complaint which has been investigated is that the GP failed to take urgent and appropriate action to investigate and treat problems Mrs A was suffering from between May 2006 and July 2006 (*not upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 22 August 2006, the Ombudsman received a complaint from a man and a woman, referred to in this report as Mr and Mrs C, about the care and treatment of Mrs C's late mother (Mrs A) by her GP (the GP). Mr and Mrs C were concerned that the GP had not done enough to investigate and treat the problems Mrs A was suffering from between May 2006 and July 2006.

2. The complaint from Mr and Mrs C which I have investigated is that the GP failed to take urgent and appropriate action to investigate and treat problems Mrs A was suffering from between May 2006 and July 2006.

Investigation

3. The investigation of this complaint involved obtaining copies of all the correspondence between Mr and Mrs C and the GP. I also obtained copies of Mrs A's clinical records (the Records). I sought advice from the Ombudsman's Adviser (the Adviser) regarding the clinical aspects of the case and asked him to let me know whether, on the basis of the evidence contained in the Records, he considered the GP's actions to be reasonable.

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 and Mrs C and the GP were given an opportunity to comment on a draft of this report.

Complaint: The GP failed to take urgent and appropriate action to investigate and treat the problems Mrs A was suffering from between May 2006 and July 2006

5. Mr and Mrs C's complaint concerned the care and treatment provided to Mrs A by the GP between 25 May 2006 (when the family noticed Mrs A's condition started to deteriorate) and 11 July 2006 (when Mrs A was referred to hospital). On 10 July 2006, Mrs A was referred to the Care for the Elderly Team at the Royal Victoria Hospital (the Hospital). On 11 July 2006, Mrs A was referred to Social Services. On 17 July 2006, she was seen as a day patient at the Hospital and, thereafter, she was reviewed at the Hospital once a week for ongoing review by a multi-disciplinary health team. On 15 August 2006, she was admitted to the Hospital as an in-patient. Sadly, on 29 September 2006, Mrs A died while an in-patient at the Hospital. The cause of death was

recorded as secondary metastases from an unknown primary, which meant that she died of a cancer that had spread to her brain from an unknown source.

6. As well as being generally concerned that the GP did not do enough to investigate Mrs A's problems and treat them, Mr and Mrs C raised a number of specific concerns:

- Mr and Mrs C believed that after two falls and given Mrs A's age and health problems, she should have been referred to hospital with urgency for investigation and for x-rays.
- On 11 June 2006, an 'out-of-hours' service doctor attended Mrs A at home and sent a report of the visit to the GP. Having seen the report, Mr C believed the GP should have arranged a priority visit at the earliest opportunity given Mrs A's history, age and deterioration in health.
- Mrs C stated that the GP was happy for Mrs A to wait for two months for a referral to hospital, despite the fact that Mrs A was an elderly woman who struggled to get out of bed, to cook and who needed both hands to get herself up.
- Mr and Mrs C believed that the GP should have acted with urgency on her belief that there was a possibility that Mrs A had Parkinson's disease.

7. The GP responded to Mr and Mrs C's complaint stating that (the following are relevant excerpts from the GP's letters responding to the complaint):

> 'It is generally felt that with elderly patients with problems such as [Mrs A]'s, admission to an acute medical unit is not the most appropriate way to manage their problems. Problems such as reduced mobility and falls often have several contributing factors and they are best addressed with input from a number of services including social work, occupational therapy and physiotherapy. This is often best done in the familiar environment of the patient's home or in an out patient assessment unit run by specialists in care for the elderly.
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> Every doctor when assessing a patient has the responsibility of making the decision as to whether or not his or her patient requires urgent admission. None of the doctors involved in [Mrs A]'s care including those assessing her at [the Hospital] felt that this was appropriate at the time of assessment …

I have also reviewed the initial assessment letter from [the Hospital], [Mrs A] was seen and assessed one week after referral on 17.07.06 … the assessing clinician did not consider that Mrs A needed an urgent admission to hospital and arranged for her to be reviewed in the Day Hospital …

On 11.6.06 a call was made by [Mrs C's sister - Mrs E] to the out of hours service requesting a house call for her mother stating that she felt the back pain was getting worse. The doctor at that time who visited her at home comments that there was no history of recent injury and no worrying symptoms. He examined her, found nothing abnormal and suggested that [Mrs A] continue with the analgesia which she had been prescribed on 9.6.06. There was no indication for or request from the out of hours service for [Mrs A] to be seen at a house visit the next day. We also have no record of a house call for [Mrs A] being requested on that day from either [Mrs A] or another family member …

[Mrs E] asked [the GP] how long it would be until [Mrs A] would be seen at the hospital, [the GP] explained that this depends on waiting times and also how urgent the clinician at [the Hospital] feels the problem is when they receive the referral letter. [Mrs E] asked again how long it would take and [the GP] advised this can sometimes take up to two months but reiterated she was unable to give an accurate time scale …

[Mrs E] asked again what [the GP] thought the problem was. [The GP] explained that if the blood tests were inconclusive then it would be her intention to refer [Mrs A] to an out patient clinic for further investigations. [The GP] said that she felt an illness like Parkinson's disease may be a possibility but this was not at all certain and that she would review [Mrs A] when the blood results were available …'

8. It should be noted, for the record, that Mr and Mrs C believe many parts of the GP's response are inaccurate and they dispute the way events and conversations were represented in the GP's response. I gave careful consideration to Mr and Mrs C's comments prior to launching this investigation but concluded that there was no way, on the basis of objective, independent and factual evidence, that I would be able to determine whether the GP's version of events or Mr and Mrs C's version was accurate with regard to un-witnessed conversations and other subjective matters. In pursuing this

investigation I, therefore, focused on the complaint about Mrs A's clinical care, which was capable of investigation through the analysis of the medical records.

9. To that end, I asked the Adviser whether, in general as well as with specific regard to the areas of concern highlighted by Mr and Mrs C (see paragraph 6 above) the GP's actions were reasonable. I should explain that the standards by which the Adviser was asked to judge the reasonableness of the GP's actions against were the standards that could be reasonably expected to be in place at the time. The Ombudsman does not judge the reasonableness of actions on the basis of how they might appear with hindsight.

10. The Adviser, based on his consideration of the Records, set out the relevant history of the care and treatment provided to Mrs A. Paragraphs 11 to 22 below summarise that history.

11. Mrs A was 72 years old and living alone in sheltered housing. She was diagnosed as suffering from Giant Cell Arteritis (an inflammatory disease of the arteries) and Polymyalgia Rheumatica (an inflammatory disease of the muscles). She also suffered from Diverticulitis (a disease of the large intestine). She was seen four times in 2006 prior to May and she was in relatively good health until then. Around May 2006, there was some deterioration in Mrs A's health.

12. On 25 May 2006, Mrs E called the GP stating that Mrs A had become withdrawn over the previous ten to 14 days and also had intermittent diarrhoea with possible rectal bleeding. On 26 May 2006, the GP visited Mrs A and noticed a low mood. Mrs A complained of reduced urination and some insomnia. She said that she had had some diarrhoea and small amounts of rectal bleeding for two weeks. The GP's examination revealed a soft abdomen with normal bowel sounds and no masses. A rectal examination was normal. The GP prescribed an antibiotic, considering that the presenting symptoms were a flare up of Mrs A's Diverticular disease. The GP also gave Mrs A a prescription of Citalopram (an anti-depressant) and said she would review her in two weeks.

13. On 1 June 2006, the GP visited Mrs A at home. Mrs A complained of pain under her right breast, but said that she did not have a cough, shortness of breath, nausea or vomiting. The GP noted that Mrs A was not unwell and had no gastro intestinal symptoms. The GP checked her pulse and noted that her

chest was clear and her right breast was normal. The GP noted that there were one or two very small areas of redness which she thought might have been early shingles. The GP noted that Mrs A should be reviewed if a rash developed. The GP prescribed Co-codamol (a painkiller).

14. On 9 June 2006, Mrs A was seen by the GP again. The pain in her right chest had resolved, although Mrs A was now complaining of lower back pain with numbness radiating down her left leg. The GP noted that the pain was constant and woke Mrs A early. Mrs A was recorded as getting on the examination couch with ease and the straight leg raising test that was performed was normal for both legs. Mrs A was recorded as having full movement of the left hip. The GP noted that she still looked in a low mood and wondered whether the pain could be related to her mood. The GP increased the dose of Citalopram and asked to see her again in three weeks.

15. On 11 June 2006, Mrs A was seen by a GP from the out-of-hours service (GP 2). He noted that Mrs A was still complaining of back pain, but there were no positive findings on examination. There was nothing in GP 2's note of the visit that suggested a follow-up call was required the next day.

16. On 13 June 2006, Mrs C called to request that a urine sample be taken. She also queried the absence of a doctor the previous day.

17. On 19 June 2006, an urgent visit was requested by one of Mrs A's daughters and one of the GP's practice colleagues (GP 3) attended. GP 3 noted that Mrs A was not distressed, although she was complaining about the same lower back pain along with tremors and pain in her legs. Mrs A's legs were noted as having a full range of movement. GP 3 suspected that there was a lot of psychological overlay, which meant that she suspected some of Mrs A's symptoms resulted from her low mood rather than from physical ailments. GP 3 prescribed Amitriptyline (an anti-depressant, which can also control pain) and Mrs A was told to continue with the anti-depressants and the painkillers previously prescribed.

18. On 28 June 2006, the GP visited Mrs A at home. Mrs A complained of back pain and disturbance of sensation in her left leg. Mrs E was noted as saying that Mrs A had lost weight. Mrs A complained of tiredness and did not believe that the anti-depressants had improved her mood. The GP recorded that although Mrs A could mobilise around the house she preferred to stay in

bed. The GP recorded that Mrs A had some constipation but no urinary symptoms. The GP's examination revealed some signs of Parkinson's disease such as disease rigidity and slight intention tremor. Mrs A's abdomen was recorded as being normal, the chest clear and heart signs also normal. The GP increased the dose of anti-depressant.

19. On 3 July 2006, the Records note a telephone call from the GP, presumably to Mrs A, in which it is noted that the Plasma Viscosity (PV) - a test which reveals general inflammation and unwellness) was raised. The GP decided to increase Mrs A's dose of Prednisolone (a steroid which is used to control Polymyalgia Rheumatica). Raising the dose of steroid was an appropriate response to the increase in the PV, which would correctly have been interpreted as a sign that the control of the Polymyalgia Rheumatica was not adequate.

20. On 5 July 2006, the Records note 'DNA' (did not attend), which suggested that Mrs A had an appointment with the GP but did not arrive. It is probable that she was too unwell to attend the GP's practice, in which case the fact that the GP visited Mrs A the next day was appropriate.

21. On 6 July 2006, the GP visited Mrs A and noted that there had not been much change and that she still had pain in her left hip, thighs and calves. The Records noted that sensation in the soles of her feet was disturbed. Mrs A is recorded as having been constipated but as having had a bowel movement that morning. The GP noted that Mrs A seemed well although she noted her unsteady gait. Examination of the legs revealed full movement of the left hip and normal power and tone. The reflexes of her toes were normal and there was no muscle wasting. The GP increased the dose of Prednisolone and organised for her to have further blood and urine tests.

22. On 10 July 2006, the GP visited Mrs A, and noted that she looked better, although there was no improvement in her blood tests. As a result, the GP decided to refer Mrs A to the Care for the Elderly Service and to the Community Rehabilitation Team on 11 July 2006.

23. Based on his analysis of the Records, the Adviser considered that the GP's actions were reasonable. He told me that it would not have been appropriate for Mrs A to be admitted to hospital urgently for investigation and x-

rays. He said that acute medical admitting units were not appropriate to treat the problems Mrs A was suffering from.

24. The Adviser told me that the GP's actions in investigating and treating Mrs A's problems were appropriate at every stage. He said that the decision on when a referral should be made was always difficult, but that in this case the timing of the referral was highly reasonable. The Adviser told me it was likely that the GP had hoped that Mrs A's symptoms were the result of her Polymyalgia Rheumatica and that, when the PV did not respond to increases in steroids, the GP then decided that another cause for the symptoms had to be explored and that it was appropriate to make a referral at that time.

25. The Adviser told me that it was not normally necessary to refer patients urgently if Parkinson's disease was suspected as it was a slow but progressive disease for which treatment was only successful in reducing symptoms. The Adviser told me that the referral to the Care for the Elderly team was an adequate response to any concern that Mrs A might have been suffering from Parkinson's disease.

26. In commenting on a draft of this report, Mr C stated that Mrs A was diagnosed with several extensive brain tumours and, as those tumours were a secondary cancer, that meant that an active cancer in her body was missed. I asked the Adviser for his advice regarding Mr C's comments and asked him whether the GP could reasonably have been expected to diagnose that Mrs A had cancer.

27. The Adviser explained that it was not unknown for the primary source of a cancer never to be found, and for only its secondary manifestations to be known. The Adviser said that the fact that the cancer Mrs A died of was secondary did not indicate any fault on the GP's part and did not indicate that the GP failed to do anything she could reasonably be expected to do. The Adviser explained that it was unlikely that the GP would have been able to spot that Mrs A was suffering from cancer and he repeated that all the GP's actions in investigating and treating Mrs A were reasonable.

Conclusion

28. I accept the Adviser's comments. I conclude that there was no failure on the GP's part to urgently and appropriately treat and investigate the problems

Mrs A was suffering from. I am satisfied that the GP acted reasonably in this case and, consequently, I do not uphold the complaint.

29. The only point that requires further comment relates to Mr and Mrs C's concern about what they saw as the GP's willingness to wait two months for an appointment for Mrs A. I note that Mr and Mrs C and the Practice disagree over what was said during a conversation about the possible time Mrs A would have to wait to get an appointment. Mr and Mrs C believe that the GP was happy to wait two months, whereas the GP's view of events was that she was simply highlighting how long an appointment could take. I consider that, given that the GP did make an urgent referral, there was little more she could be expected to do. By explaining that it was possible that such a referral could take a long time, the GP was acting reasonably in trying to manage the expectations of Mrs A and her family. I note that an urgent referral was made and that the length of time a patient would have to wait was in the hands of the body the referral was made to, rather than the GP. I conclude that the GP's actions in this regard were reasonable.

19 September 2007

Annex 1

Explanation of abbreviations used

Mr C and Mrs C	The complainants
Mrs A	The aggrieved, Mrs C's late mother
The GP	Mrs A's General Practitioner
The Records	The clinical records
The Adviser	The Ombudsman's Adviser
The Hospital	Royal Victoria Hospital
Mrs E	Another of Mrs A's daughters
GP 2	A General Practitioner from the out-of-hours service
GP3	The GP who attended Mrs A on 19th June
PV	Plasma Viscosity

Annex 2

Glossary of terms

Amitriptyline	An anti-depressant, which can also be used to control pain
Citalopram	An anti-depressant
Co-codamol	A painkiller
Diverticulitis/ Diverticular disease	A disease of the large intestine
Giant Cell Arteritis	An inflammatory disease of the arteries
Metastases	Transfer of cancer cells from one organ to another
Plasma Viscosity	A test which reveals general inflammation and unwellness
Polymyalgia Rheumatica	An inflammatory disease of the muscles
Prednisolone	A steroid used to treat Polymyalgia Rheumatica
Straight leg raising test	A test to check leg mobility