Scottish Parliament Region: Mid Scotland and Fife

Case 200500980: A Medical Practice, Forth Valley NHS Board

Summary of Investigation

Category

Health: Clinical Care and Treatment by a GP Practice

Overview

The complainant (Mr C) raised concerns about the care and treatment given to his late father (Mr A) during a consultation with a GP (GP 1) at a medical practice (the Practice) on 5 April 2005, as Mr A died approximately one hour after the consultation.

Specific complaint and conclusion

The complaint which has been investigated is that GP 1 should have recognised that Mr A was suffering from coronary heart disease, realised the severity of his medical condition and taken appropriate action (*not upheld*).

Redress and recommendation

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 9 August 2005 the Ombudsman received a complaint from Mr C that a GP (GP 1) had failed to diagnose that his father (Mr A) had coronary heart disease. Mr A had died from a heart attack approximately one hour after he was seen by GP 1 at his medical practice (the Practice). Mr C stated that Mr A had complained to GP 1 of several symptoms suggestive of a heart attack. These included chest pains, tiredness, shoulder and back pain and, in Mr C's view, Mr A also had a grey, drawn appearance. Mr C also stated that Mr A had complained of a persistent cough. Mr C believes that, because of these symptoms, GP 1 should have recognised that Mr A was suffering from coronary heart disease, realised the severity of his condition and taken urgent appropriate action. Instead, GP 1 diagnosed and treated Mr A for a respiratory tract infection and prescribed amoxicillin.

2. The complaint from Mr C which I have investigated, is that GP 1 should have recognised that Mr A was suffering from coronary heart disease, realised the severity of his medical condition and taken appropriate action.

Investigation

3. The investigation of this complaint involved obtaining and reading all the relevant documentation, including correspondence between Mr C the Practice and Forth Valley Primary Care NHS Trust. I have had sight of Mr A's medical records and the Autopsy Report. The investigation was aided by one of the Ombudsman's clinical advisers (the Adviser) who provided a detailed report of the complaint. The Adviser reviewed all relevant documentation and medical records.

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 the Practice were given an opportunity to comment on a draft of this report.

Complaint: GP 1 should have recognised that Mr A was suffering from coronary heart disease, realised the severity of his medical condition and taken appropriate action

5. Mr A, a 51-year-old man, attended the Practice unaccompanied on 5 April 2005 to be seen at 16:15. Mr C stated that, earlier on that day, Mr A had telephoned and requested an appointment to see a doctor, as he was suffering

from chest pains. According to Mr C, during the consultation, Mr A complained to GP 1 of several symptoms suggestive of a heart attack, including chest pains, tiredness, shoulder and back pain and he also had a grey, drawn appearance. In Mr C's view GP 1 should have recognised and diagnosed the seriousness of Mr A's medical condition and taken appropriate action, (such as sending Mr A for an ECG) that may have stabilised his condition and prevented his death.

6. According to Mr C, when Mr A returned home after his consultation with GP 1, he told a friend of his dissatisfaction at the adequacy of the consultation and stated that GP 1 'seemed unconcerned throughout regarding his condition'.

7. Sadly, Mr A died approximately one hour after he left the Practice.

8. According to the consultation note entry at 5 April 2005, GP 1 noted Mr A had a flu-like illness, pain above the sternum, several days cough, spit, sweats and - 'over last 3/7 several episodes pain just above sternum – lasts 5-10 mins at a time, no heart problems, dyspepsia etc doesn't feel needs antacid for pain, throat inflamed++, ears and chest clear….' GP 1's consultation notes concluded 'advised to have BP checked – nurse in 1-2/52'.

9. Following Mr C's complaint to the Practice about Mr A's consultation with GP 1 on 5 April 2005, a Senior Partner at the Practice (GP 2), conducted an investigation. This included taking a statement from GP 1. Within this statement GP 1 explained that, in her view, Mr A was bright and happy as he entered the surgery on 5 April 2005 and there were no signs of distress. He was not pale or cyanosed and he spoke freely of his symptoms. GP 1 described Mr A's symptoms as having several days history of cough, dirty spit and sweats. He had been a heavy smoker, more than 20 a day for many years. He did not have any accompanying breathlessness or wheeze. Mr A complained to GP 1 of a sore throat, worse on swallowing, and coughing exacerbated it. Mr A described sweating episodes and tiredness which, according to GP 1, were common symptoms of flu.

10. According to GP 1's statement, when she discussed the pain (paragraph 8) with Mr A, he commented 'as long as it's not my heart doctor'. According to GP 1, she told him that it was not impossible but that cardiac pain was typically lower in the chest than he described, often relating to exertion and often accompanied by breathlessness, none of which Mr A was experiencing.

11. Within GP 1's statement about the consultation on 5 April 2005, GP 1 had taken two blood pressure (BP) readings: the first reading was 170/100 and towards the end of the consultation the reading was 190/100, which GP 1 noted was not uncommon. GP 1 added that the consultation lasted for 16 minutes and she diagnosed and treated Mr A for a respiratory tract infection. Mr A was given a prescription for amoxycillin and GP 1's statement concluded that she had advised him to see the Treatment Room nurse for a review of his BP in the next one to two weeks and to make another appointment with a GP should his symptoms persist (paragraph 8).

12. On 6 April 2005, the day after Mr A's death, a Senior Partner from the Practice (GP 3) carried out a bereavement visit at the family home. In his statement dated 10 May 2005, also given to GP 2 as part of his investigation into Mr C's complaint, GP 3 explained that he was trying to help the family to understand and come to terms with Mr A's death. Thereafter, several discussions took place between the family and the Practice but these failed to convince Mr C that 'all that could and should have been done during Mr A's consultation on 5 April 2005, was done'.

13. GP 2 concluded the investigation into the circumstances surrounding Mr A's death and on 18 May 2005 wrote to Mr C with her findings. With a copy of the results of her investigation, she included a review of GP 1's original consultation note of 5 April 2005 and enclosed copies of statements taken from GP 1 and GP 3 and a copy of the Consultant Pathologist's Report, who had carried out an autopsy on Mr A. Within the Consultant Pathologist's Report, the post mortem found severe narrowing of an artery but no damage to the heart muscle.

14. Within her investigation report, GP 2 considered that the symptoms Mr A presented to GP 1 on 5 April 2005 were typical of a flu-like illness involving the upper respiratory tract and stated that:

> 'GP 1's conclusions and actions were consistent with the history and findings presented to her and could be considered consistent with what other doctors given similar symptoms and signs would conclude.'

15. As part of her investigations, GP 2 had examined Mr A's medical notes and stated there was no history of cardiac problems within his medical records. She concluded that, in her view, GP 1 had taken appropriate action during the

consultation with Mr A and also with the arranged follow-up, with regard to Mr A's raised blood pressure.

16. As part of my investigation, I asked the Adviser for his assessment of this aspect of the complaint.

17. The Adviser stated he took account of all the medical symptoms as presented on 5 April 2005 by Mr A and recorded by GP 1 (paragraph 8) and also considered Mr A's responses to GP 1's questions, (for example, about the episodic periods of pain he had experienced). The Adviser also made reference to the Consultant Pathologist's findings that Mr A died from an arrhythmia and stated:

> 'The letter from the Consultant Pathologist indicates that Mr A had one heart artery (out of four) that was severely narrowed at one point. This narrowing had not led to damage of the heart muscle (no underlying fibrosis). This tends to the conclusion that Mr A's heart was coping with this single vessel narrowing and that it would be likely that Mr A had no symptoms of angina (pain in the chest on exertion, easing with rest). The human heart copes well with damage - indeed cardiac surgeons will not operate on a single vessel disease, and often on double vessel disease, but will do so for triple or quadruple vessel disease (by-pass surgery).'

18. Addressing the clinical matters, the Adviser considered that, following his review of the consultation records of 5 April 2005, GP 1's action following the diagnosis of a respiratory tract infection (which may have been bacterial or viral) seemed reasonable. This included the prescribing of an antibiotic for a probable bacterial infection, and in view of the raised blood pressure, suggesting that Mr A return soon to have his pressure further checked. The Adviser added 'These [recorded] symptoms essentially rule out the possibility of a heart problem, and the most likely diagnosis would be a respiratory problem – which is the conclusion GP 1 came to – and treated appropriately'. Noting from GP 1's statement that the consultation lasted some 16 minutes – which is longer than average consultation (10 minutes), the Adviser regarded this indicated that GP 1 did take time to consider Mr A's situation. The Adviser noted that there is no written record that Mr A was (as Mr C believed) grey and drawn or had complained of shoulder and back pain.

19. The Adviser concluded that, during the consultation on 5 April 2005, there was an absence of symptoms which would have led GP 1 to have diagnosed a

heart condition (paragraph 8). The Adviser believed that the symptoms Mr A presented indicated an infection of the respiratory tract and he concluded that GP 1 had treated Mr A appropriately and the care she provided was reasonable.

20. In the final statement of his Report the Adviser said that he believed that GP 1:

> 'acted appropriately in this consultation, and that Mr A suffered an untimely death, but the pathological process causing death took place, on the balance of probabilities, after he left GP 1.'

21. The Adviser also stated that in his opinion, GP 2 had conducted a full investigation of the complaint and stated (see paragraph 13) that it 'would seem one of the most open responses to a complaint I have seen'.

Conclusion

22. It was understandable, given the association of chest pains with heart conditions and the closeness of Mr A's death following his appointment with GP 1, that Mr C believed that GP 1 should have diagnosed heart disease. It appears from GP 1's statement and her consultation note that GP 1 did consider heart disease but had ruled this out. However, given the evidence outlined above, and having reviewed all the relevant documentation, I share the Adviser's view there was nothing to lead GP 1 to diagnose that Mr A was suffering from coronary heart disease during the consultation on 5 April 2005. I acknowledge that we do not know, and have no way of knowing, what was said between GP 1 and Mr A during the consultation that was not recorded within the consultation notes. Given the clinical advice I have received and the circumstances of this case, I consider that GP 1 acted appropriately towards Mr A during the consultation on 5 April 2005. I, therefore, do not uphold this complaint.

Recommendation

23. The Ombudsman has no recommendations to make.

24 October 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
GP 1	Practice doctor the complainant's late father consulted before he died
Mr A	The complainant's late father
The Practice	Mr A's Medical Practice
The Adviser	The Ombudsman Clinical Adviser
GP 2	The Practice Senior Partner, who carried out the investigation
GP 3	The Practice Senior Partner, who made the bereavement visit to the family

Annex 2

Glossary of terms

Arrhythmia	Irregular heart beat
Sternum	Breast bone