Scottish Parliament Region: Glasgow

Case 200604106: A GP, Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: GP

Overview

The complainant (Mr C) raised a number of concerns about the treatment his late mother (Mrs A) received from her General Practitioner (the GP) during 2006. These included issues such as a failure by the GP to action treatment for Mrs A's reported concerns of nausea and weight loss and a failure to diagnose that she was suffering from fluid on her lungs. In addition, Mr C complained that the GP failed to call an ambulance when Mrs A took ill at the Practice on 29 September 2006. Mrs A was taken to hospital later the same day by ambulance from her home but sadly did not recover from a coma and died two weeks later.

Specific complaints and conclusions

The complaints which have been investigated are that the GP:

(a) failed to provide treatment for Mrs A's reported concerns of nausea and weight loss and failed to diagnose that she was suffering from fluid on her lungs (*not upheld*); and

(b) failed to call an ambulance when Mrs A took ill at the Practice on 29 September 2006 *(not upheld).*

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 28 March 2007 the Ombudsman received a complaint from Mr C about the treatment his late mother, Mrs A, received from her GP (the GP) during 2006. The complaint included issues such as a failure by the GP to action treatment for Mrs A's reported concerns of nausea and weight loss and a failure to diagnose that she was suffering from fluid on her lungs. In addition, Mr C complained about an incident on 29 September 2006 when Mrs A took ill at the GP Practice (the Practice) and an ambulance was not called. Mr C complained to the Practice but remained dissatisfied with their response and subsequently complained to the Ombudsman.

2. The complaints from Mr C which I have investigated are that the GP:

(a) failed to provide treatment for Mrs A's reported concerns of nausea and weight loss and failed to diagnose that she was suffering from fluid on her lungs; and

(b) failed to call an ambulance when Mrs A took ill at the Practice on 29 September 2006.

Investigation

3. In writing this report I have had access to Mrs A's GP clinical records and the complaints correspondence from the Practice. I obtained advice from one of the Ombudsman's professional medical advisers who is a GP (the Adviser) 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. Mr C and the Practice were given an opportunity to comment on a draft of this report.

(a) The GP failed to provide treatment for Mrs A's reported concerns of nausea and weight loss and failed to diagnose that she was suffering from fluid on her lungs

5. On 3 February 2007, Mr C complained to the Practice about the treatment which the GP had provided to Mrs A in 2006. In particular, Mrs A had been admitted to the Western Infirmary, Glasgow (the Hospital), in February 2006, having expressed her discomfort to the GP some weeks previously, where it was found that she had fluid on her lungs. Mr C said a nurse at the Hospital

told him that Mrs A's GP should have realised this. Mr C commented that a few weeks later Mrs A was again admitted to the Hospital with fluid on the lungs which the GP had again failed to diagnose. Mr C was also concerned that the GP had prescribed beta-blockers (medication to treat heart disease and high blood pressure) for Mrs A, which left her incapacitated, and that when she attended the Hospital the family had been told by a doctor that the dosage of beta-blockers was too strong and it was reduced. Mr C also mentioned that his sister had complained to the GP that Mrs A was constantly feeling nauseous and had lost weight. Mr C said the GP told them that Mrs A's weight loss was nothing to be concerned about. However, Mr C said that, at Mrs A's next hospital visit, the doctor prescribed medicine which put an end to her nauseous feeling and she regained weight.

6. The GP responded to Mr C's concerns about the prescribing of beta-blockers. He explained that the medication (bisoprolol) is used to strengthen the heart where the muscle is weakened and/or to control an abnormally fast heart rate. The dosage can range from 1.25mg to 10mg. The standard dosage is 5mg and Mrs A was commenced on 2.5mg daily on 2 July 1999 at the behest of the Cardiology Department at the Hospital. The dosage remained unchanged until 21 September 2005, when the Cardiology Department found Mrs A to have a fast irregular heartbeat and weakness of the heart muscle. The Cardiologist Specialist Registrar requested that the GP increase the dosage of bisoprolol in steps to an eventual target dose of 10mg daily. The dosage was on course to level at 7.5mg on 20 February 2006, however, before this Mrs A was admitted to the Cardiology Day Unit which was prearranged so that she could undergo treatment to correct her abnormal heartbeat. Mrs A was then admitted to Hospital with an acute episode of fluid in the lungs. On discharge from hospital on 17 February 2006, the dose of bisoprolol had been reduced to 2.5mg daily, which the GP presumed was as a result of the acute illness which followed the treatment for the abnormal heartbeat. The GP felt that the Practice had closely monitored each dose change and acted on the advice provided by the cardiologists.

7. The Adviser reviewed Mrs A's GP records and noted there was reference to a letter from the Hospital that the admission for cardioversion (treatment to correct an abnormal heartbeat) in February 2006 had triggered an episode of fluid overload in the lungs. The Adviser could see no evidence that the Practice had been remiss in the diagnosis that Mrs A had suffered fluid overload in the lungs. The Adviser explained that great care has to be taken with the

administration of bisoprolol as it can, in certain cases, worsen a patient's heart condition. He noted that the Hospital gave clear instructions that bisoprolol should be introduced at a low level and gradually increased. The Adviser felt that the Practice had followed hospital advice appropriately and managed the dosage which Mrs A received in line with conventional medical practice.

8. The Adviser told me that Mrs A's medical management was not straightforward as she had significant medical problems and was also significantly anxious about her heart condition which meant her assessment was difficult. The Adviser noted an appropriate urgent referral when Mrs A had onset of atrial fibrillation (irregular heart rhythm) in August 2005. He also noted in September 2005 that Mrs A reported nausea, which was thought to be due to the aspirin she was taking and appropriate additional medication was added. It was recorded that on 14 November 2005 Mrs A was experiencing breathlessness, which was thought to relate to the atrial fibrillation and a decision was made to wait for a cardiology opinion. The Adviser noted that on 3 February 2006 there is reference in the records to nausea with weight loss. The weight loss was recorded and a plan made to address the nausea by adding an appropriate medication for the symptom. He also commented that the level of Digoxin (medication to strengthen or slow down the rate of the contraction of the heart) in Mrs A's blood was checked in May 2006, which was an example of good medical practice as an excess dosage can cause symptoms of nausea and malaise. In addition, on 24 July 2006 it was noted that Mrs A's liver function tests were worsening and that she was losing weight. A comment was made to consider a hospital referral. The Adviser noted that a few days later Mrs A was reviewed, after she had been seen at the Accident and Emergency Department. Antibiotics were provided and an adjustment was made to the Digoxin as suggested by hospital staff. The Adviser was also aware of further blood testing, with arrangements to review after a short period of time.

9. The Adviser commented that there was evidence of appropriate history taking and examination on 11 August 2006 and concern noted about Mrs A losing weight. The GP requested the Practice nurse to check Mrs A's weight and informed the Hospital, which the Adviser regarded as good medical practice. Further abnormalities were noted as a result of blood tests taken on 12 September 2006 and it was also noted that there was persistent nausea and concern that Mrs A was losing weight. The Adviser thought the plan to arrange an ultrasound scan (diagnostic technique which uses high frequency sound

waves to create an image of internal organs) and to arrange a referral for Mrs A to see a geriatrician for a medical opinion was appropriate. The reason for the next scheduled consultation at the Practice was on 29 September 2006, where it was planned that the Digoxin levels be rechecked to see if that was contributing to the nausea. The Adviser could find no evidence that Mrs A's symptoms of nausea and weight loss were ignored.

(a) Conclusion

10. Mr C had complained that the GP failed to take appropriate action on Mrs A's reported concerns of nausea and weight loss and that there was a failure to diagnose that she had fluid on her lungs. The advice which I have received and accept is that Mrs A had significant medical problems and that the assessment of them would have been difficult. The evidence from the clinical records indicated that the Practice were fully aware of Mrs A's problems and that appropriate treatment was provided to Mrs A, taking into account the specialist advice provided by hospital staff. I have seen no evidence that the GP provided inadequate treatment and, as such, I do not uphold this complaint.

(a) Recommendation

11. The Ombudsman has no recommendations to make.

(b) The GP failed to call an ambulance when Mrs A took ill at the Practice on 29 September 2006

12. Mr C complained that, on 29 September 2006, Mrs A attended the Practice with her granddaughter for an appointment at 10:00. Mrs A was examined by another doctor and was allowed to leave the Practice after having her pulse and chest examined. Shortly after leaving the Practice, Mrs A felt weak and went to sit in a cafe. Her granddaughter suspected she might be having a stroke and as they were still close to the Practice, they returned there so that action could be taken quickly. Mr C believed that Mrs A was told that the GP was busy and that she was told to wait in the reception area. Mr C said the GP passed Mrs A and her granddaughter in the waiting area and told them that Mrs A was unwell and that she was having a mini stroke. Mr C was told that the GP said to Mrs A and her granddaughter that he would send a fax to the stroke clinic for an appointment the following week but that Mrs A could go home in the meantime but added that if the same thing happened again then they should call an ambulance.

13. Mr C continued that immediately Mrs A arrived home she suffered another stroke and that an ambulance was called. While in hospital, Mrs A suffered further strokes and went into a coma from which, sadly, she never recovered. Mr C said that, when staff at the Hospital were told about the GP's response to Mrs A on 29 September 2006, they were astonished. Mr C felt that, had the GP acted in a professional prompt and competent manner, Mrs A's subsequent death could have been prevented.

14. The GP responded that on 29 September 2006, Mrs A attended for a follow up to previous appointments in which the main concerns were unexplained chest pains, nausea and weight loss. The doctor at the Practice who saw Mrs A had discussed and reviewed Mrs A with the GP so that he was fully aware of her symptoms, examination findings and concerns from both the patient and medical perspective. It had been agreed that Mrs A's symptoms had not been fully explained, notwithstanding the known serious heart condition which she suffered from and a referral for an assessment had been made to the Medicine for the Elderly. The GP continued that Mrs A returned to the Practice with a complaint of sudden onset of left facial weakness and slurred speech. This was evident to the GP as he saw Mrs A some five minutes later. The GP had been aware of Mrs A's presence by the receptionist. The GP said that he then took Mrs A into his consulting room and conducted an appropriate clinical assessment, which included a brief history of recent events, and he took her pulse and blood pressure. The GP stated that Mrs A's facial weakness and speech disorder completely resolved at that time and that he took action in accordance with local procedures and national guidance. The procedure which was followed was that where the localised symptoms had fully resolved then there is no need for an immediate emergency hospital referral but that a faxed referral is made to the Fast Track Stroke/TIA clinic at the Hospital, who aim to see patients within two working days for further investigation. The GP explained that the guidance further states that if the symptoms return within 24 hours the patient should immediately be referred to hospital for acute care and investigations. The GP commented that he had passed this information on to Mrs A and her granddaughter. The GP felt that he followed standard medical procedures and that he was not aware of any alternative action which he could have taken which would have altered the outcome.

15. The Adviser commented that it appeared that Mrs A had suffered a Transient Ischaemic Attack (a disturbance of the blood and oxygen supply to the brain like a stroke but, unlike a stroke, it resolves fully within 24 hours) (TIA),

which he noted from the GP records had resolved completely by the end of the consultation with the GP. The Adviser confirmed that the GP's explanation, regarding the procedures carried out in this regard, was appropriate and that it was reasonable to allow Mrs A to go home and not to admit her to hospital. Likewise, the Adviser felt that the advice given by the GP to call an ambulance should there have been further episodes of TIA was both appropriate and correct. The Adviser continued that the management of Mrs A's TIA followed standard practice. It would not be standard practice to admit all patients to hospital with a resolved TIA but to arrange their urgent investigation.

(b) Conclusion

16. Mr C felt that, had the GP called an ambulance when Mrs A returned to the Practice after becoming unwell, the final outcome could have been different. I can understand Mr C's concerns that an ambulance was not called, however, I have to be guided by the advice which I have received, which is that the action taken by the GP that day was appropriate because Mrs A's symptoms had completely resolved. As such, there was no requirement for an emergency hospital admission. The GP also acted appropriately by following accepted procedures, by ensuring that a faxed referral was made to the Fast Track Stroke/TIA clinic who aim to see the patient within two working days and that the GP gave advice that should the symptoms return within 24 hours then Mrs A should be referred to hospital for treatment. As a result, I have decided not to uphold this complaint.

(b) Recommendation

17. The Ombudsman has no recommendations to make.

21 November 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs A	Mr C's mother
The GP	Mrs A's General Practitioner
The Practice	The Medical Practice where Mrs A was a registered patient
The Adviser	One of the Ombudsman's professional medical advisers who is a GP
The Hospital	Western Infirmary, Glasgow
TIA	Transient Ischaemic Attack