Scottish Parliament Region: Glasgow

Case 200501233: Two GPs, Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: GP; Care and Treatment

Overview

The complainants, Mr and Mrs C, complained about the care and treatment provided by two GPs (referred to in this report as GP 1 and GP 2) to their son, Mr A, who died on 12 September 2004, aged 15.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) GP 1 and GP 2 failed to investigate Mr A's symptoms and should have done so, even while waiting for referral elsewhere (*upheld*);

(b) GP 1 and GP 2 failed to progress a diagnosis of Mr A's condition (*upheld*);

(c) GP 1 failed to note the symptom of breathlessness in the records (*no finding*); and

(d) GP 1 did not take Mr A's pulse (*upheld*).

Recommendations

The Ombudsman recommends that:

(i) GP 1 and GP 2 apologise to Mr and Mrs C for the shortcomings identified in the report; and

(ii) GP 1 raises complaints (a), (b) and (d) and GP 2 raises complaints (a) and (b) as issues at their annual appraisal and take them into account in their Continuing Professional Development.

GP1 and GP 2 have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. Mr A attended his General Practice (the Practice) on four occasions between May and August 2004. On his first three visits he saw GP 1, who referred him to a psychiatrist and then to a gastroenterologist. On the fourth visit, while awaiting an appointment to see the gastroenterologist, he saw GP 2. When he attended on a fifth occasion on 27 August 2004 he was seen by another GP (GP 3) who sent him straight to hospital where he was admitted. Unfortunately, his condition deteriorated and, sadly, Mr A died on 12 September 2004. The cause of his death was stated on his death certificate to be multi-organ failure due to cardiomyopathy.

2. Mr and Mrs C complained to the Practice about GP 1 and GP 2 on 25 October 2004. They considered that, if GP 1 and GP 2 had reacted appropriately to Mr A's symptoms, his heart condition might have been diagnosed more quickly and he might have been able to have transplant surgery before his condition worsened and excluded the possibility. There was an exchange of correspondence between Mr and Mrs C and GP 1 and GP 2, followed by a meeting on 18 April 2005. Mr and Mrs C remained dissatisfied, however, and wrote to the Ombudsman on 6 August 2005.

3. The complaints from Mr and Mrs C which I have investigated are that:

(a) GP 1 and GP 2 failed to investigate Mr A's symptoms and should have done so, even while waiting for referral elsewhere;
(b) GP 1 and GP 2 failed to progress a diagnosis of Mr A's condition;
(c) GP 1 failed to note the symptom of breathlessness in the records; and
(d) GP 1 did not take Mr A's pulse.

4. This report contains some technical terms, which are explained in the glossary of terms at Annex 2.

Investigation

5. In order to investigate this complaint I have had access to Mr A's GP and hospital records, the post mortem report, the complaint correspondence, the significant event analysis and statements from Mr A's older sister. I have corresponded with Mr and Mrs C and with the Practice. I obtained clinical advice from two of the Ombudsman's professional advisers, one a GP (the

GP Adviser) and the other a Consultant Cardiothoracic Surgeon (the Surgical Adviser).

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr and Mrs C and the Practice were given an opportunity to comment on a draft of this report.

(a) GP 1 and GP 2 failed to investigate Mr A's symptoms and should have done so, even while waiting for referral elsewhere

7. On 26 May 2004 Mr A attended GP 1 with his sister. Mr A's sister said that she told GP 1 that Mr A had been sick almost every day for the previous three weeks and was losing weight. Both she and their mother were very worried about him. She said that she told GP 1 that Mr A had palpitations and was worrying and panicking. Mr A's sister said that GP 1 weighed Mr A and measured his height. GP 1 then wrote a prescription for Mr A and asked him to come back in a month.

8. In her initial response to the complaint, GP 1 agreed that Mr A's sister told her that Mr A had been regularly sick for three weeks, was being harassed by other boys and had palpitations and headaches. She weighed him and prescribed a beta blocker and referred him to the Adolescent Psychiatry Unit.

9. The clinical notes record vomiting of three weeks' duration and the fact that Mr A was being harassed by other boys, which was affecting his friendships. There is a note of the palpitations and his refusal to go out alone. Mr A's weight was recorded as eight stone 11 pounds and there is a note of the prescription and referral. The referral letter also said that Mr A was experiencing regular headaches.

10. On 28 June 2004 Mr A saw GP 1 again. He was accompanied by his sister and also by Mrs C. Mrs C said that she told GP 1 that Mr A was having difficulty walking up stairs without being out of breath and that his heart rate was very fast.

11. In her initial response to the complaint, GP 1 said that the appointment was to review the effectiveness of the beta blocker, which she was told was helping a bit.

12. In a further response to the complaint on 5 January 2005 GP 1 said that, at both this appointment and the following one, the focus was on Mr A's 'psychological problems and the recognised physical symptoms of anxiety which were a rapid beating of his heart and difficulty with breathing'.

13. On 16 March 2005, however, GP 1 wrote to Mr and Mrs C to clarify that she did not mean that she had been told that Mr A was breathless. She said that her statement was a general comment that rapid heartbeat and breathlessness were recognised physical symptoms of anxiety and panic. She did recall, though, that Mrs C had told her that Mr A was suffering from a rapid heartbeat.

14. The clinical note records that Mr A was still not going out, except to school, and the beta blocker was helping a bit.

15. In response to my enquiries, GP 1 reiterated that she was not told that Mr A was breathless and he did not appear to be breathless during any of the consultations she had with him.

16. Mrs C remains adamant that she reported Mr A's breathlessness to GP 1 at the consultation on 28 June 2004 (see paragraph 10).

17. Mr A attended the Adolescent Psychiatry Unit with Mrs C and sister on 28 July 2004. In a letter sent to GP 1 on 30 July 2004 the Adolescent Psychiatry Unit concluded that Mr A was not suffering from any specific psychiatric disorder. They advised Mr A to stop taking the beta blocker. They said that they had told the family that they would relay the family's concerns about Mr A's weight loss, vomiting and two episodes of haematemesis (blood in vomit) to GP 1. They said that if those problems persisted they felt they may require further investigation.

18. On 6 August 2004 Mr A attended an appointment with GP 1. He was again accompanied by his mother and his sister. Mrs C said that she repeated her previous concerns and additionally reported Mr A's lack of appetite and energy.

19. GP 1 said that at this appointment she was told about the continued vomiting and occasional blood in the vomit. She weighed Mr A and found that he had lost ten pounds since May. She had received the psychiatrist's letter

and felt that Mr A should be referred urgently to the gastroenterologist. She prescribed a treatment for acid-related conditions such as stomach ulcer.

20. The clinical note refers to the fact that Mr A was still vomiting and not eating. He had haematemesis and had lost weight. The prescription and referral were noted.

21. In response to my enquiries, GP 1 said that she could think of no further investigations which she could or would have undertaken, given the symptoms which were described to her. She awaited the result of the specialist consultations for which she had referred Mr A.

22. In the significant event analysis which GP 1 prepared following Mr A's death, however, she said that she had learned to examine for all physical symptoms even if they were associated with apparent psychological problems. GP 1 said that routine blood tests should probably have been done for weight loss at the last appointment but that she had decided to refer Mr A so they had not been done.

23. On 24 August 2004 Mr A, accompanied by his sister, attended an emergency appointment with GP 2. Mr A's sister said that she told GP 2 that Mr A had been sick every day for the previous four months and was getting worse. Mr A told GP 2 that he took painkillers for headaches which he got about once a week. GP 2 examined Mr A's eyes and stomach. GP 2 read Mr A's notes and noted that Mr A had been referred to the gastroenterologist. GP 2 told Mr A to stop taking the painkillers and take a different stomach medicine. He said that the gastroenterology appointment wouldn't take much longer and opened the door for them to leave. Mr A's sister said that she told GP 2 that they were really worried about Mr A as he had no energy and was sleeping a lot. She asked GP 2 how long Mr A could survive on milkshakes and toast and being sick everyday. She advised that GP 2 said 'weeks'.

24. GP 2's account in his first response to the complaint largely agrees with Mr A's sister's account apart from the fact that he does not mention being told that Mr A had no energy and was sleeping a lot nor his response as stated above. GP 2 said that he examined Mr A's central nervous system and the back of his eyes which all seemed normal to him. He checked Mr A's weight to get a baseline weight reading. He hoped that stopping one medicine and starting another would settle Mr A's abdominal symptoms. Three days later, on

27 August 2004, GP 3 asked GP 2 to come into his room to see Mr A again. It was noted that Mr A had developed a bluish tinge to his complexion (cyanosis). GP 2 said that had not been present when he saw Mr A on 24 August 2004. It was at this point that GP 3 sent Mr A straight to hospital (see paragraph 1).

25. The clinical note of the consultation with GP 2 on 24 August 2004 records vomiting for four months, especially after eating; that Mr A was to stop taking the painkillers and start new stomach medicine; that he was a non smoker and non drinker; that he had headaches; the examination by GP 2; Mr A's weight; and the fact that he was awaiting a gastroenterology appointment.

26. The GP Adviser said that an urgent referral to gastroenterology was undoubtedly a sensible plan but more should have been done. The GP Adviser said that a loss of ten pounds in weight, vomiting, haematemesis, loss of appetite and palpitations is unusual in a 15-year-old young man of previously good health. It would have been reasonable to expect the GPs to deduce that this was something significant and out of the ordinary. In such a situation, a general physical examination should be done either to provide leads on what the problem could be or, often as important, to exclude other conditions. The GP Adviser would have expected comments on the presence or absence of jaundice, anaemia, cyanosis, clubbing or oedema. An examination of the lymph glands might have helped to exclude a general malignancy. Haematemesis should have prompted the taking and recording of a pulse and blood pressure. A series of blood tests could have yielded additional information, again either providing leads or excluding conditions. The GP Adviser said that it would be reasonable to expect the GPs to consider these steps. The GP Adviser said that he agreed with Mr and Mrs C that more should have been done whilst waiting for Mr A's gastroenterology referral. In this kind of situation, further physical examination and investigations such as blood tests may provide evidence to consider more urgent action with the hospital, such as speeding up an out-patient appointment or going for admission. In this case, a more detailed physical examination may well have yielded evidence of heart failure, for which a cause would have been very vigorously sought in this young patient.

(a) Conclusion

27. It is clear from the evidence that Mr A's symptoms of vomiting for three weeks, palpitations, stress due to harrassment and headaches were brought to the attention of GP 1 at the first appointment. Mr A's awareness of his rapid heartbeat was disclosed at the second appointment. The letter from the

Adolescent Psychiatry Unit excluded any specific psychiatric disorder and drew attention to two additional symptoms, ie two episodes of blood in Mr A's vomit and a poorer appetite. A ten pound weight loss was measured at the third appointment with GP 1.

28. There is some confusion about whether Mr A's breathlessness was mentioned. Mrs C is adamant that it was. GP 1 said that it wasn't. GP 1's letter mentions Mr A's difficulty with breathing but she later said this was a general remark (see paragraph 13). That is not the impression that I got from the letter. However, I accept that in the absence of a truly independent witness it is not always possible to reach a view on what was said.

29. I note that GP 1, in the significant event analysis, and Adviser 1 agree that a series of blood tests should have been taken when the symptoms of a loss of ten pounds in weight, vomiting, haematemesis, loss of appetite and palpitations were known, ie at Mr A's appointment with GP 1 on 6 August 2004 or his appointment with GP 2 on 24 August 2004. The GP Adviser considered that haematemesis should have prompted the taking and recording of Mr A's pulse and blood pressure, with a blood count being considered but that did not happen at either of these appointments. The GP Adviser also thought that Mr A should have had a general physical examination. GP 2 did a limited examination of Mr A's central nervous system, back of his eyes and abdomen but a complete physical examination was not performed. For these reasons, I uphold this complaint.

(a) Recommendation

30. The Ombudsman recommends that GP 1 and GP 2:

(i) apologise to Mr and Mrs C for their failure to investigate Mr A's symptoms: and

(ii) raise this complaint as an issue at their annual appraisal and take it into account in their Continuing Professional Development.

(b) GP 1 and GP 2 failed to progress a diagnosis of Mr A's condition

31. At the first appointment Mr A's sister asked GP 1 if Mr A could have counselling, as he would not go out except with their mother in the car. Mr A's sister said that GP 1 asked Mr A if anything was worrying him and questioned him about his friends and school. Mr A had replied that he didn't go out except to school because some weeks before a boy had chased him with a knife. GP 1 asked Mr A if his friends could help but Mr A replied that they could not,

as the boy had a bad reputation and his friends were scared of him. They complained that GP 1 and GP 2 attributed Mr A's symptoms solely to anxiety rather than exploring other physical conditions.

32. GP 1 said that her interpretation of this history was that Mr A was having panic attacks as a result of harassment. The letter from the Adolescent Psychiatry Unit had excluded any specific psychiatric disorder and GP 1 said that at the third appointment she felt that Mr A should be referred urgently to gastroenterology for investigation of vomiting, bleeding and weight loss.

33. GP 2 said he expected that Mr A would have a gastroenterological appointment in the following few weeks.

34. The GP Adviser said that, once the mental health route had been embarked upon, he could understand how that became the primary focus of future consultations. From the psychiatric assessment it appeared that, although there was no specific psychiatric disorder, there was significant stress from harassment which could explain some of the features. He had some sympathy for GP 1 as the problem with harassment was a red herring that made identifying the problem more difficult. When any specific psychiatric disorders were excluded, however, while it was not unreasonable to refer Mr A to the gastroenterologist, no other investigations were done to progress the matter.

35. The death certificate states that Mr A died from idiopathic (of unknown cause) dilated cardiomyopathy. The Surgical Adviser said that the symptoms can vary but in Mr A's case he gradually worsened. The Surgical Adviser said that Mr A was probably experiencing significant cardiac decompensation in the months prior to his admission to hospital but it wasn't picked up. At post mortem there was evidence of pulmonary hypertension (raised pressure in the blood vessels of the lungs) which suggests that Mr A had suffered from a heart problem for some time. The Surgical Adviser said that if a diagnosis of heart failure (or even serious illness) had been made earlier in the course of Mr A's illness, with appropriate referral to a Cardiologist, then the outcome may well have been different. It is possible that the natural history of the cardiomyopathy could have been altered, either by anti-failure drugs, intensive care or transplantation, in escalating order of levels of intervention. The Surgical Adviser went on to say that with appropriate and timely specialist help Mr A may

have survived although that is by no means definite and there is no way of knowing what would have happened at that stage.

(b) Conclusion

36. It appears from the evidence that it was not unreasonable for GP 1 to have diagnosed Mr A as having panic attacks at the first appointment. After it was known that this was not the cause, however, the GP Adviser and the Surgical Adviser consider that GP 1 and GP 2 failed to do simple things like general physical examination and simple blood tests which could have helped, either to progress a diagnosis or to exclude other possibilities or help to give a guide as to how urgently hospital care required to be sought. This is a tragic case and I can appreciate Mr and Mrs C's concerns that, had an earlier referral and diagnosis been made their son may have been able to have a transplant. The advice I have received is that with appropriate and timely specialist help Mr A may have survived. I, therefore, uphold this complaint.

(b) Recommendation

37. The Ombudsman recommends that GP 1 and GP 2:

(i) apologise for their failure to progress a diagnosis of Mr A's condition; and

(ii) raise this complaint as an issue at their annual appraisal and take it into account in their Continuing Professional Development.

(c) GP 1 failed to note the symptom of breathlessness in the records

38. Mr and Mrs C requested a copy of Mr A's clinical notes. They complained that GP 1 had failed to keep adequate records in that there was no mention of Mr A's breathlessness.

39. GP 1 disagreed that the records were inadequate. She said that she had taken a relevant history from Mr A and from either his mother or sister. The symptoms noted by GP 1 were sickness for three weeks, palpitations, harassment, headaches (mentioned in the referral letter), haematemesis and weight loss. GP 1 later remembered that Mrs C told her that Mr A was suffering from rapid beating of his heart.

(c) Conclusion

40. With the exception of 'rapid beating of the heart' which could arguably be covered by 'palpitations', all of the symptoms which I am satisfied were mentioned to GP 1 are recorded in Mr A's clinical notes, with the exception of the issue of breathlessness. It is important to keep accurate records in order

that the patient's progress can be monitored. There is a difference of opinion, however, as to whether the symptom of breathlessness was mentioned at the consultation with GP 1. In all of the circumstances and in the absence of any other evidence I am unable make a finding in relation to this complaint.

(d) GP 1 did not take Mr A's pulse

41. Mr and Mrs C said that Mr A's pulse was not taken.

42. GP 1 did not respond to this issue in her initial response to the complaint on 8 November 2004 but said that, in future, she would always check the pulse and heart of anyone who complains of palpitations. In a subsequent letter of 5 January 2005, however, she said that prior to prescribing the beta blocker she had checked Mr A's pulse, which was normal.

43. Mr A's sister, who accompanied him to the consultation, disputed that GP 1 took Mr A's pulse at the 26 May 2004 appointment prior to prescribing the beta blocker.

44. There is no pulse measurement recorded in the clinical records.

45. In response to my enquiries GP 1 said that she did take Mr A's pulse but she did not record a value as she did not count the number of beats. She merely ascertained that Mr A's pulse was not abnormal. A slow pulse would be a contraindication to prescribing a beta blocker. GP 1 said she found Mr A's pulse to be within normal limits of rate and character and that she would have recorded the pulse if she had considered it to be abnormal but she had not. GP 1 said she did not always record normal findings but, on reflection, perhaps she should have done so.

46. Adviser 1 said it was normal Practice to record the pulse if it is taken. He said that it is now recognised that the recording of normal results may be as important as the recording of abnormal factors. Adviser 1 said that he is unable to agree with GP 1 that a low heart rate would necessarily preclude prescription of beta blockers. In a young, fit, healthy athlete doing lots of physical training, for example, the pulse rate may well be below normal. Whenever the symptom of palpitation is mentioned, however, a GP should at least feel the pulse and consider listening to the heart. Quite apart from its diagnostic value, if it is normal and a symptom due to anxiety, that is of therapeutic reassurance to the patient. Adviser1 said that examination might have revealed that Mr A was in

atrial fibrillation although he could not be certain of that. The GP Adviser's view is that the symptoms presented created a requirement for examination of Mr A.

(d) Conclusion

47. There is no record of a pulse measurement in Mr A's clinical notes. GP 1 said that she would only have recorded it if it was abnormal. The GP Adviser said, however, that it is normal Practice to record it if it was taken. I note that GP 1 recorded Mr A's weight which was within normal limits. I can see no reason why she would not have recorded Mr A's pulse if it was taken. I consider that it is reasonable to imply from GP 1's remark that she would now always check the pulse of anyone who complains of palpitations, that she did not do so when Mr A complained of palpitations. This remark was made on 8 November 2004 and is closer in time than her subsequent letter of 5 January 2005 in which she said that she did so. Her recollection of events is likely to have been better when she wrote the first letter. On a balance of probabilities I, therefore, consider that GP 1 did not take Mr A's pulse. I uphold this complaint.

(d) Recommendation

48. The Ombudsman recommends that GP 1:

(i) apologises to Mr and Mrs C for her failure to take Mr A's pulse; and

(ii) raises this complaint as an issue at her annual appraisal and takes it into account in her Continuing Professional Development.

49. GP1 and GP 2 have accepted the recommendations and will act on them accordingly. The Ombudsman asks that they notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr A	Mr and Mrs C's son
The Practice	Mr A's general medical practice
GP 1	The General Practitioner who saw Mr A for the first three appointments
GP 2	The General Practitioner who saw Mr A for the fourth appointment
GP 3	The General Practitioner who saw Mr A for the fifth appointment and who sent him to hospital
Mr and Mrs C	The complainants
The GP Adviser	The Ombudsman's adviser on General Practice
The Surgical Adviser	The Ombudsman's adviser who is a Consultant Cardiothoracic Surgeon

Annex 2

Glossary of terms

Anaemia	Too little of the red pigment, haemoglobin, that carries oxygen in the blood
Beta blocker	A drug which slows the heart rate, reduces blood pressure and reduces anxiety
Cardiac decompensation	The inability of heart to maintain adequate circulation
Clubbing	Changes to the fingers initially involving the shape of the nail bed and, in advanced cases, thickening of the end of the finger
Contraindication	Any condition which renders some particular line of treatment undesirable
Cyanosis	A bluish discolouration associated with a low oxygen level in the blood
Cardiomyopathy	A disease of the heart muscle where it is weakened and cannot pump effectively excluding other heart diseases
Dilated	Enlarged
Gastroenterologist	A specialist in the diseases of the digestive system
Haematemesis	Blood in vomit
Jaundice	Yellowing of the skin often associated with liver disease

Lymph glands	Organs which act as drainage points for tissue fluids
Malignancy	Cancer
Oedema	The presence of abnormally large amounts of fluid in the tissues
Palpitations	Unpleasant sensations of irregular and/or forceful beating of the heart, which may result from abnormal heart rhythms
Psychiatrist	A doctor who specialises in mental health
Pulmonary hypertension	Raised pressure in the blood vessels of the lungs