Scottish Parliament Region: Mid Scotland and Fife

Case 200501879: A Medical Practice, Fife NHS Board

Summary of Investigation

Category

Health: General Practice; complaint handling

Overview

The complainant, Ms C, raised a number of concerns about what happened when she attended her GP Practice (the Practice) and about what happened when she subsequently made a complaint.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the treatment provided to Ms C when she attended the Practice on 2 August 2004 was inappropriate (*not upheld*);

(b) Ms C's removal from the Practice list was unfair (*not upheld*).

Redress and recommendations

The Ombudsman recommends that:

(i) the Practice apologise to Ms C for the shortcomings identified in this report;

(ii) the Practice undertake training on complaint handling and the guidance and Regulations governing the removal of patients from the Practice list and, following this training, the GPs and the Practice Manager meet to discuss and draw up a Practice protocol for complaint handling and, specifically, for removal of patients from their list, a copy of which to be sent to the Board's Medical Director for approval and to the Ombudsman for her information; and

(iii) GP 1 discusses the issue of how he dealt with this complaint at his next annual appraisal as part of his continuing professional development.

The Practice and GP 1 have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. Ms C attended the Practice on 2 August 2004 with chest pain. The GP who saw her (GP 1) called an ambulance and she was taken to hospital and admitted. Ms C said that the ambulance paramedics and staff at the hospital indicated to her that she had not been treated appropriately by the Practice. She subsequently made a complaint to the Practice but was dissatisfied by their response and on 6 October 2005 complained to the Ombudsman. Ms C also complained that, as a result of making her complaint, she had been unfairly removed from the Practice list.

2. The complaints from Ms C which I have investigated are that:

(a) the treatment provided to Ms C when she attended the Practice on 2 August 2004 was inappropriate; and

(b) Ms C's removal from the Practice list was unfair.

Investigation

3. In order to investigate this complaint I have had access to Ms C's GP and hospital records and the correspondence relating to the complaint. I have corresponded with Ms C and with the Practice. I have considered relevant guidelines and Regulations and I have received advice from one of the Ombudsman's clinical advisers, who is a GP (the Adviser).

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. A glossary of the medical terms used in this report can be found in Annex 2. Ms C and the Practice were given an opportunity to comment on a draft of this report.

(a) The treatment provided to Ms C when she attended the Practice on 2 August 2004 was inappropriate

5. Ms C said that she had attended the Practice as an emergency, with chest pains. GP 1 had arranged for her to be admitted to the Coronary Care Unit (CCU) at the hospital but she had had to wait some time for the ambulance to arrive. She had been very afraid during this period and said the paramedics had told her that they had not been told she was an emergency. If they had known she was so seriously ill they would have 'blue-lighted' the ambulance journey to the Practice to collect Ms C. Ms C said that they were also surprised

to discover that she had received no medication. Ms C subsequently raised her concerns about this with the Practice but said her concerns about this had not been dealt with by the Practice.

6. The Practice Manager responded to Ms C's complaint in a letter dated 14 December 2004 which Ms C said did not address the issues which she had raised and merely stated that the Practice had concluded the investigation and had found the complaint to be groundless.

7. From the clinical notes Ms C attended the emergency appointment at 11:30. GP 1 prepared a referral letter for the Cardiology Registrar giving Ms C's symptoms. I have obtained the Scottish Ambulance Service's Patient Report Form for Ms C's journey to the Hospital on 2 August 2004. It records that an emergency ambulance was called at 12:00 noon and arrived at the Practice at 12:12. The ambulance left the Practice with Ms C at 12:25 and arrived at the hospital at 12:39. GP 1 said that it may well have seemed a long time to Ms C but it was only a few minutes.

8. It may be helpful if I explain that General Practitioners are obliged by the 'terms of service' in their contract to have in place and operate a practice-based complaints procedure for the NHS services they provide, which complies with directions issued by the Scottish Executive[1]. Guidance on the NHS complaints procedure, issued by the Scottish Executive in 2005, states:

> 'NHS Scotland aims to operate a complaints procedure which is credible, easy to use, demonstrably independent, effective and sensitively applied. Making a complaint can be stressful both for those making the complaint and for the staff involved. Local arrangements must, therefore, be fair to both sides, supporting the person making the complaint and the staff named in the complaint. They must also ensure that the NHS can learn and grow positively from the experience.'

9. In addition, the General Medical Council (GMC) also includes material on dealing with complaints in its publication *Good Medical Practice*. This states, at paragraph 29, under the heading of 'Complaints and Formal Enquiries':

[1] On 3 September 2007 Scottish Ministers formally adopted the title Scottish Government to replace the term Scottish Executive. The latter term is used in this report as it applied at the time of the events to which the report relates.

'Patients who complain about the care and treatment they receive have a right to expect a prompt, open, constructive and honest response. This will include an explanation of what has happened.'

10. The Adviser noted from Ms C's medical records that she had been attending the Practice with chest pain. She had been referred to cardiac out-patients and was waiting for an appointment. Ms C was eventually diagnosed with heart valve disease. The Adviser said that, when Ms C attended the Practice on 2 August 2004, GP 1 considered that she may have been suffering from unstable angina but he recorded in the notes that he needed to exclude the possibility that Ms C had had a heart attack. The Adviser said that patients who may have suffered a heart attack were often transported by emergency ambulance. Medication which could be considered included GTN (glyceryl trinitrate) spray, aspirin or pain killing injection such as morphine and the administration of oxygen. The Adviser said that it could have been that GP 1 did not consider heart attack a likely possibility and, in those circumstances, it would have been reasonable to take a more relaxed approach. GP 1, however, had never explained his thinking on this to Ms C (see paragraph 6). The Adviser said that he thought that it would have been reasonable for GP 1 to have done so.

11. I asked GP 1 for his comments. He said that when he saw Ms C that day he thought that her symptoms could have been caused by an exacerbation of angina, unstable angina, possible small heart attack, a small pulmonary embolism or even GORD (Gastro-oesophageal reflux disease). He did not give Ms C aspirin because she was already taking it; he did not use a GTN spray because she already had one, which had had variable results. Ms C did not require painkillers when he saw her because the pain had already gone. He did not consider that she was anxious enough to require sedation. Ms C's cardiopulmonary status was stable; there was no nausea or dyspnoea; she was undistressed, pink, warm and well perfused. He added that opening an IV line or administering oxygen were, therefore, not indicated. What was necessary was that Ms C was transferred to the CCU and that is what he had done.

(a) Conclusion

12. It is clear from what the Adviser said that the action taken by GP 1 in arranging for Ms C to be sent to hospital was appropriate in the circumstances and, therefore, I do not uphold this complaint. I am concerned, however, that Ms C's concerns about her treatment were not addressed by the Practice in

their response to the complaint. When I asked GP 1 for his comments, he had no difficulty in providing me with a comprehensive and reasonable explanation which justified his thinking and decision making on the day he saw Ms C. I can find no reason why this explanation was not provided to Ms C when she raised her concerns. The guidance sets out what action NHS bodies should take when a complaint is received and the Practice clearly failed in this regard and for this I strongly criticise them.

(a) Recommendation

13. The Ombudsman recommends that the Practice apologise to Ms C for failing to respond to her concerns about her treatment.

(b) Ms C's removal from the Practice list was unfair

14. Ms C wrote to the Practice Manager on 18 October 2004. She said that on 2 August 2004 she had been seen at the surgery by GP 1, who had diagnosed either a severe angina attack or a heart attack. GP 1 had not given her any medication to alleviate her condition. Ms C said that the paramedics and hospital staff at the CCU had been shocked by this lack of treatment. Ms C said that she did not want to be treated by GP 1 again. She had always found the other partners in the Practice to be professional and competent. The Practice Manager wrote to Ms C on 29 October 2004. She said that Ms C's complaint was being dealt with through the complaints procedure.

15. On 25 October 2004 GP 1 wrote to the Consultant Cardiologist at the CCU. He said that he had sent Ms C to the CCU on 2 August 2004 and she had been in hospital on a couple of occasions since then. GP 1 wrote:

> 'You probably won't remember her and there is no particular reason why you should. However, we have received from her a complaint with regard to her treatment prior to her admission on 2 August. We are in absolutely no doubt that she has no grounds for complaint whatsoever and firmly believe the communication to be vindictive.'

16. GP 1 quoted part of Ms C's letter then went on to ask the Consultant Cardiologist to check with his team and confirm that no such derogatory statements were made about the treatment she had received at the Practice. He apologised for having to bother him with 'this nonsense'. On 3 November 2004 GP 1 wrote to the Scottish Ambulance Service Area Manager in similar terms.

17. The Consultant Cardiologist replied on 3 November 2004. He said that he was sorry if GP 1 had been given the impression that a member of staff had been less than complementary about Ms C's management. From their records it was obviously difficult to know what was said to the patient. Although he could not confirm or refute what staff had said to Ms C at the time, he would agree that she had been appropriately managed both in general practice and at presentation to hospital.

18. On 23 November 2004 the Practice Manager told GP 1 that Ms C had been in touch with the Patient Liaison Manager at Fife NHS Board because the Practice had not written to her. GP 1 emailed the Practice Manager. He said:

> 'I would be delighted if we can threaten (or bring) legal action but I suspect there is no facility for this and it is expected that we are soft targets who never shoot back. Even if there is such a precedent it would be better to keep such a threat in reserve as we are rather assuming that the ambulance investigation will also draw a blank and it just may not.'

19. On the same day, the Practice Manager wrote to Ms C that the Practice were still investigating her complaint.

20. On 8 December 2004 the Scottish Ambulance Service Area Manager wrote to the Practice. He said that he had spoken to the crew and at no time had they discussed GP 1's treatment with Ms C or the CCU staff and they had not heard anyone else talk about it. It had been a routine job with no problems at all.

21. On 14 December 2004 the Practice Manager wrote to Ms C. She said that:

> 'Clearly the trust between yourself and this practice has broken down and we feel it would be in your best interests to register with another practice. If you have any difficulties with this you should contact Practitioner Services who will allocate a practice to you.'

22. On the same day GP 1 wrote to the Patient Liaison Manager at Fife NHS Board. He said that;

> 'Ms C's so called complaint is a malicious fabrication from start to finish.'

23. Ms C said that when she received the Practice Manager's letter she telephoned the Practice to say that she had an appointment with another of the

Practice's GPs on 21 December 2004. She attended that appointment and the GP told her to come back in three weeks time. When she went to the desk to book that appointment, she was told that appointments could only be booked up to two weeks ahead and she should come back the following week. When she returned home, the Practice Manager telephoned and told her not to come back as the Practice would not treat her. They were sending her notes to Practitioner Services. Ms C said that she had been removed from the Practice list unfairly.

24. I asked the Practice to comment on Ms C's removal from the Practice list and, in particular, whether her removal complied with the Regulations governing the removal of a patient from the list. The Regulations state that, other than in cases where the patient is violent (which was not relevant in this case), patients must be given a warning that they are at risk of removal and written records kept of the circumstances. The Practice Manager said that Ms C had left the list of her own accord. The Practice Manager also said that she did not recall the telephone conversation with Ms C.

25. In response to my further enquiries, another GP within the Practice wrote to me. He said that, regardless of who Ms C saw after her discharge from hospital, she had been advised that the trust between her and the Practice had broken down and it was in her best interests to seek registration with another practice. Ms C had subsequently removed herself from the Practice list. There was a note on their system to this effect.

26. The Adviser said that, technically, Ms C had not been removed from the Practice list as no request appears to have actually been made to Practitioner Services to remove her. However, he could quite understand from the terms of the letter sent to Ms C that she thought that was what was intended. The Adviser drew my attention to guidance from the GMC in *Good Medical Practice* at paragraph 24 where it states:

> 'Rarely, there may be circumstances, for example, where a patient has been violent to you or a colleague, has stolen from the premises, or has persistently acted inconsiderably or unreasonably, in which the trust between you and the patient has broken and you find it necessary to end a professional relationship with the patient. In such circumstances, you must be satisfied your decision is fair and does not contravene the guidance in paragraph 5 (which deals with discrimination); you must be prepared to justify your decision if called upon to do so. You should not

end relationships with patients solely because they have made a complaint about you or the team …'

27. In June 1997 the Royal College of General Practitioners (RCGP) issued guidance for members on the removal of patients from GPs' lists. A section listing those situations in which GPs should not normally consider removal of a patient from a list includes 'where a patient complains through the in-house complaints system'.

28. The Adviser said that one of the key features of the guidance was that the circumstances must not be just in relation to a complaint. There must be persistent inconsiderable or unreasonable behaviour on the part of the patient and there was no evidence that this was the case. The Practice appear to have very quickly decided that trust had broken down and wrote to Ms C to that effect. One is left with the impression that the lodging of the complaint was the trigger to ending the relationship and suggesting Ms C should register elsewhere.

(b) Conclusion

29. I accept that, technically, Ms C was not removed from the Practice list, as no letter was actually sent to Practitioner Services, but I can well understand why Ms C thought that was what was happening. The letter of 14 December 2004 from the Practice Manager puts considerable pressure on her to re-register with another practice. I have considered carefully the Practice's actions under this head of complaint and the letter sent to Ms C on 14 December 2004. I have also taken into account the advice I have received. In the circumstances, on balance, I have decided not to uphold this complaint, given that Ms C was not in fact removed from the Practice list. Nevertheless, in dealing with this matter, I have concluded that the Practice did not take into account GMC or RCGP guidelines. In considering the sequence of events, it is clear that the lodging of the complaint acted as a catalyst culminating in the letter of 14 December 2004 advising Ms C to register at another practice, as the doctor/patient relationship had broken down. While GMC and RCGP Guidelines are not mandatory, they contain core values and behaviours for clinicians and I can see no good reason in this case why the guidance was not followed. In all of the circumstances, I believe that the actions of the Practice in this regard were unreasonable and show a lack of awareness and understanding of the guidance governing situations where the Practice feel the relationship with a patient has broken down.

30. I also have concerns about the tone and content of some of GP 1's correspondence with other professionals involved. I can fully understand why GP 1 wrote to the Consultant Cardiologist and the Scottish Ambulance Service to establish whether they had any concerns about the way the Practice managed Ms C on 2 August 2004. Their responses would have provided valuable additional information which the Practice could have used to formulate their formal response to the complaint. However GP 1's letters to them indicated that the Practice had already reached a view on the complaint and that it was unfounded. Had GP 1 set out his enquiry letters in an open and non biased manner, without the need to include information that the Practice had already reached a view on the complaint, this would have demonstrated that the Practice were prepared to deal with the complaint openly and fairly. This is what patients who complain about the care and treatment they receive have a right to expect.

(b) Recommendation

31. The Ombudsman recommends that:

(i) the Practice apologise to Ms C for their actions in regard to this complaint;

(ii) the Practice undertake training on complaint handling and the guidance and Regulations governing the removal of patients from the Practice list and, following this training, the GPs and the Practice Manager meet to discuss and draw up a Practice protocol for complaint handling and, specifically, for removal of patients from their list, a copy of which to be sent to the Board's Medical Director for approval and to the Ombudsman for her information; and

(iii) GP 1 discusses the issue of how he dealt with this complaint at his next annual appraisal as part of his continuing professional development.

32. The Practice and GP 1 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

Ms C	The complainant
The Practice	Ms C's General Practice
GP 1	The General Practitioner who saw Ms C
The Adviser	
CCU	Coronary Care Unit
GMC	General Medical Council
GTN spray	Glyceryl trinitrate spray
RCGP	Royal College of General Practicioners

Annex 2

Glossary of terms

Angina	Chest pain caused by inadequate delivery of blood and oxygen to the heart muscle, typically coming on with exertion
Dyspnoea	Shortness of breath
GORD	Gastro-oesophageal reflux disease, typically causing indigestion-like symptoms
GTN (glyceryl trinitrate) spray	A type of medicine used to relieve the pain of angina
Pulmonary embolism	A blood clot in the pulmonary artery

Annex 3

List of legislation and policies considered

The Regulations	The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004
GMC guidance	General Medical Council Good Medical Practice (May 2001)
RCGP guidance	Royal College of General Practitioners Removal of Patients from GPs Lists (June 1997)