Scottish Parliament Region: Glasgow

Cases 200600740 & 200701011: A Medical Practice, Greater Glasgow and Clyde NHS Board and Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Diagnosis; treatment

Overview

The complainant, Mrs C, raised a number of concerns about her husband (Mr C)'s consultations with various GPs from his GP Practice (the Practice) and from the Greater Glasgow and Clyde NHS Board's GP Out of Hours Service (the Service) prior to his admission to hospital where, sadly, he died of heart problems.

Specific complaints and conclusions

The complaints which have been investigated are that;

(a) Mr C's heart problems were not diagnosed by GP 1 and GP 2 from the Practice at consultations on 20 October, 28 October and 11 November 2005 (*not upheld*);

(b) Mr C's heart problems were not diagnosed by GP 3 and GP 4 from the Service at consultations on 30 November and 1 December 2005 (*not upheld*); and

(c) the Practice did not deal with Mrs C's complaint properly (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Practice;

(i) apologise to Mrs C for failing to deal with her complaint properly; and

(ii) reflect on their complaints policy, review their complaints protocol and discuss how to respond to complaints from non-patients.

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

The Ombudsman has no recommendations in respect of Greater Glasgow and Clyde NHS Board.

Main Investigation Report

Introduction

1. Mr C was 79 at the time of the events in this report. He had had a number of health problems over the years. Several basal cell carcinomas had been removed from his face. He had mental health problems which had been diagnosed as a personality problem some years before. He had been a smoker for many years. Mr C had become partially sighted due to macular degeneration. He had carcinoma of the prostate and had had a transurethral section of prostate and subsequent hormone therapy, which had seemed successful in controlling his prostate cancer. Mr C's wife (Mrs C) said that Mr C had been feeling unwell for some time and she called Mr C's GP Practice (the Practice) for a home visit on 20 October 2005. This was the first of several consultations Mr C had with GPs from the Practice and from the Greater Glasgow and Clyde NHS Board (the Board)'s GP Out of Hours Service (the Service) following calls to NHS24 but it was not until 2 December 2005 that Mr C was admitted to hospital. After admission, Mr C developed heart failure and, sadly, he died on 11 December 2005. There was no post-mortem done to determine the cause of death but the consultant in charge considered that there may have been a myocardial rupture. Mrs C complained to the Practice and to the Service that Mr C's heart problems had not been diagnosed by the GPs who had seen him in the weeks before his admission to hospital. Although both the Practice and NHS24 responded to the complaints, Mrs C remained dissatisfied and she complained additionally that the Practice had not dealt with her complaint properly.

2. Mrs C submitted this complaint to the Ombudsman on 3 June 2006 and I very much regret that, for a variety of reasons, our consideration of this complaint has taken longer than it should have. For that I apologise sincerely to Mrs C, the Practice and the Board.

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

(a) Mr C's heart problems were not diagnosed by GP 1 and GP 2 from the Practice at consultations on 20 October, 28 October and 11 November 2005;

(b) Mr C's heart problems were not diagnosed by GP 3 and GP 4 from the Service at consultations on 30 November and 1 December 2005; and

(c) the Practice did not deal with Mrs C's complaint properly./

Investigation

4. In order to investigate this complaint I have had access to Mr C's clinical records from both the Practice and the Service (from NHS24), recordings of telephone calls to NHS24 and the complaint correspondence from both the Practice and NHS24. I have received clinical advice from the Ombudsman's adviser who is a GP (the Adviser). 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 and a glossary of terms is in Annex 2. Mrs C, the Practice and the Service were given an opportunity to comment on a draft of this report.

(a) Mr C's heart problems were not diagnosed by GP 1 and GP 2 from the Practice at consultations on 20 October, 28 October and 11 November 2005

5. Mrs C said that she had called for a home visit for Mr C on 20 October 2005 because of severe pains in his back, shoulders and arms and acute indigestion. GP 1 attended.

6. In a letter responding to the complaint on 20 February 2006, the Practice wrote that when GP 1 saw Mr C he had pains in both arms, across the back of the neck and down the back. He also had upper abdominal pain which he described as being like a ball of wind. These symptoms came on after having coffee and cheese and biscuits when he got up in the night. GP 1 felt the symptoms were due to indigestion and she prescribed lansoprazole to treat these symptoms.

7. The Adviser said that from the clinical records it appeared that this was a difficult consultation. The notes started by noting that Mr C was very anxious and it was difficult to obtain a clear medical history from him. GP 1 had also recorded two weeks malaise and pain in both arms and across the back of the neck and down the back. Mr C had felt shivery. On examination Mr C's colour was recorded as good, blood pressure 160/90, pulse 56, chest clear, abdomen tender. GP 1 wrote that it was probably indigestion. The Adviser said that it appeared that Mrs C's call had been triaged by a nurse before GP 1 went out to see Mr C. She noted that Mr C had felt unwell since a flu jab and mentioned chesty pain in his back and arms and that he was breathless.

8. The Adviser said that patients can experience pain from the heart prior to a heart attack, representing some kind of warning. In retrospect, the Adviser

considered it possible that some of the pain experienced by Mr C in his back going into his arms may have been cardiac pain. The Adviser said, however, that it was far from typical in nature. The Adviser would have expected the pain to be felt in the centre of the chest or around the chest like a band. It may radiate the neck or the arms, particularly the left arm. The pain which Mr C felt in his arms could fit in with cardiac pain but the sharply localised back pain would not. The Adviser said that heart problems can present atypically, however, and the question was whether it was reasonable for GP 1 not to have considered heart problems. Other features which might help make a diagnosis were associated sweating and shortness of breath. Anxiety and fear may also be present. Risk factors should also be considered, such as age and whether the patient is a smoker. The Adviser said that atypical heart pain can present like indigestion and at this consultation there was a group of symptoms which sounded like indigestion. The Adviser said that GP 1 found the taking of a good history difficult and that may have been due either to mental health problems or could possibly have been anxiety related to a developing heart problem. The Adviser said that this was a difficult judgement to make. With hindsight, one might think that the diagnosis should have been considered. At the time, however, taking into account all of the presenting symptoms, it would not have been obvious that Mr C's heart was the problem and on balance, therefore, he considered that it would not be reasonable to expect GP 1 to have diagnosed a heart problem at this consultation.

9. Mrs C said that Mr C saw GP 2 on 28 October and 11 November 2005, when he complained of nausea, agitation, fear, breathing problems and distress.

10. In response to Mrs C's complaint, GP 2 wrote to her on 20 February 2006. She said that Mr C had come to see her on 28 October 2005 complaining of low mood, tearfulness and anxiety symptoms – fearfulness and dread. As he was already taking sertraline for anxiety symptoms, she suggested that he increase the dose and add in a short course of some low dose 2mg diazepam to relieve the anxiety symptoms, whilst waiting for the sertraline to take effect, and she asked Mr C to return in two weeks. GP 2 said that Mr C returned on 11 November 2005, at which time he told GP 2 that he had only taken two diazepam as it had caused side-effects but he felt much better with the increased dose of sertraline. GP 2 said that she arranged to see Mr C again in a month.

11. The Adviser said that, from the records, Mr C went to see GP 2 on 28 October 2005 with low mood, tearful and with anxiety feelings. GP 2 felt this was a mental health problem. Mr C was already on the anti-depressant sertraline, of which GP 2 increased the dose, and gave a small amount of diazepam to use as well if needed. When Mr C returned on 11 November 2005 GP 2 noted that he was generally feeing better although he had found that diazepam had not agreed with him. GP 2 arranged to see Mr C again in a month. The Adviser said that at both of these consultations mental health issues predominated and it was understandable that a heart problem was not considered to be the problem at these consultations.

(a) Conclusion

12. The Adviser said that the pain which Mr C felt in his arms when he was seen by GP 1 on 20 October 2005 would fit in with cardiac pain but the sharply localised back pain would not. It was also possible that the symptoms might have had other causes, for example, indigestion or mental health problems. Mr C did not complain of pain in the centre of his chest or like a band round his chest, which would be the usual indication of a heart problem. There were factors which made it more likely, for example, Mr C's age and the fact that he had smoked in the past. Mr C, however, also had pre-existing problems which could explain some of his symptoms. The Adviser agreed that Mr C had a group of symptoms which sounded like indigestion. Although an atypical heart problem can present like indigestion, the Adviser considered that it was reasonable at this consultation for GP 1 to conclude that indigestion was what Mr C was suffering. The Adviser stated that, with hindsight, it is possible that Mr C was suffering from a heart problem but Mr C's presentation was not typical. GP 1 had to make a decision based on what was known at the time. The Adviser considered that it would not have been obvious at the time that Mr C had a heart problem.

13. I note that Mrs C said that when Mr C saw GP 2 he was complaining of nausea and breathing problems in addition to mental health problems. There is no evidence, however, either from the clinical notes or from the complaint correspondence, that these additional symptoms were reported to GP 2 when Mr C attended for his appointments on 28 October and 11 November 2005. Mr C appeared to have concentrated on the mental health difficulties which he was experiencing. In those circumstances, the Adviser considered that it was reasonable for GP 2 not to consider that Mr C was suffering from a problem with his heart. Accordingly, in all of the circumstances and in considering the advice

I have received, I do not uphold the complaint that GP 1 and GP 2 failed to diagnose heart problems at these consultations.

(b) Mr C's heart problems were not diagnosed by GP 3 and GP 4 from the Service at consultations on 30 November and 1 December 2005

14. Mrs C said that she required to call NHS24 for an emergency out-of-hours GP on 30 November 2005 because Mr C was suffering severe pain between his shoulder blades, over his shoulders and down his arms to his wrists. He was also suffering from severe indigestion and was very breathless. Mrs C said that GP 3 attended and prescribed stronger painkillers but he did not say what he thought was wrong with Mr C.

15. In response to the complaint, the Clinical Director of the Service wrote on 30 May 2006. He said that GP 3 noted that Mr C was complaining of a four week history of pain in his back and chest which was radiating down both arms and was gradually getting worse. Mr C explained that the pain was slightly better when he was standing or slowly walking round the house. Mr C did not complain of central chest pain. On examination, GP 3 noted that Mr C did not have a raised temperature, his blood pressure was 135/85 and his pulse was 78 per minute. Examination of Mr C's heart, lungs and abdomen were normal and he was not breathless. GP 3 noted that Mr C had moderate curvature of the thoracic spine and his pain was between his shoulder blades. GP 3 diagnosed Mr C as suffering from osteoarthritis of the spine and he prescribed strong painkillers. At a subsequent meeting on 22 November 2006, the Clinical Director apologised if GP 3's diagnosis was not provided or explained at the time.

16. The Adviser noted that GP 3 considered that Mr C's pain arose from his spine and he gave Mr C strong painkillers. The Adviser said that sharply localised back pain would not be a symptom of a heart problem. He considered that Mr C's symptoms fitted with his having a problem with his spine.

17. Mrs C said she thought that Mr C was breathless and had indigestion in addition to the pain in his back. I have listened to the recording of Mrs C's call to NHS24 that evening. Mrs C said that Mr C had had pain in his back and both arms for 24 hours. The nurse adviser then spoke to Mr C, who confirmed that the pain had become much worse recently and had been unremitting since the night before. The nurse adviser asked Mr C if he felt breathless but Mr C said that he was not short of breath and didn't feel any tightness in his chest related

to breathlessness. Mr C repeated this later in the conversation. Mr C told the nurse adviser that he felt his general health was quite good and he had no pain in his legs or anywhere else. Mr C also denied having any pounding in his heart or any other symptoms.

18. Mrs C said that Mr C's pain became worse and she called NHS24 again in the early hours of 1 December 2005. Mrs C said that GP 4 attended but he said there was nothing wrong with her husband except bad posture. He brought in a nebuliser for a few moments, left small red tablets and a prescription for an inhaler.

19. In response to the complaint, the Clinical Director wrote to Mrs C on 30 May 2006. He said that GP 4 had attended Mr C on 1 December 2005 because his back pain, which had been present for six months and which was between his fourth and fifth vertebrae, had got worse. Mrs C had explained to GP 4 that Mr C had had a loss of height since the pain began. GP 4 said that Mr C did not complain of chest pain. He had a history of prostate cancer, although it was unclear from the history if Mr C had bone secondaries which would have explained his chronic back pain. GP 4 noticed that Mr C was breathless and Mrs C confirmed that he had been breathless at times in recent weeks and it interfered with his sleep. On examination, Mr C had wheeziness throughout both lungs. There was no evidence of pulmonary oedema or chest infection. Mr C's blood pressure was 160/90 and pulse was 74 per minute, normal and regular. GP 4's diagnosis was that Mr C was suffering from pain due to either bone deposits from his prostate cancer or osteoporotic collapse of his vertebral spine. GP 4 gave Mr C 100mg tramadol intramuscularly for the pain and nebulised him with salbutamol 5mg, which relieved the wheeziness. Mr C was commenced on 40mg prednisolone daily for five days and provided with an inhaler. Mr C was advised to see his own GP later in the day for review. The Clinical Director said that GP 4 had contacted Mrs C later that morning and was advised by her that Mr C had settled down.

20. Mrs C and the Clinical Director met on 22 November 2006. At that meeting, Mrs C said that she had not understood the instructions for giving her husband the tablets which GP 4 had left, due to language difficulties. She also said that when she collected the prescription for the inhaler the next day it stated in the accompanying leaflet that it was not suitable for patients suffering from high blood pressure. She was, therefore, reluctant to give it to her husband. Mrs C said that at no time did she see GP 4 refer to her husband's

medical history or make any notes about his condition or the medication prescribed. Mrs C also disputed that she had received any further call from GP 4 as, within a few hours, her husband was admitted to hospital. The Clinical Director offered Mrs C his unreserved apologies for the language difficulties experienced by Mrs C. He explained that clinical notes were made electronically on a computer in the vehicle while travelling between patients. He showed Mrs C the report completed by GP 4 at the time and explained/ discussed what it contained in detail with Mrs C. With regard to the telephone call, the Clinical Director apologised to Mrs C for the inaccuracy and said that he would take the matter up with GP 4.

21. Mrs C telephoned NHS24 at approximately 02:30 on 1 December 2005 and I have listened to a recording of that telephone call. Mrs C said that Mr C's pain was worse and he had terrible indigestion. This was noted by the nurse adviser. Mr C was not well enough to speak to the nurse adviser on the telephone so Mrs C answered the nurse adviser's questions about Mr C's medication. Mrs C said that included lustral (the trade name for the anti-depressant sertraline). The nurse adviser added depression to Mr C's past medical history on the form which was passed to GP 4. GP 4 arrived at 02:55 on 1 December 2005. The Adviser said that GP 4 considered that Mr C had spinal bone pain, possibly caused by spinal cancer. The Adviser said that the treatment provided by GP 4 was standard treatment. Although salbutamol requires to be used with caution in patients who have high blood pressure and Mr C took tablets for high blood pressure, his blood pressure was noted by GP 4 to be normal at the time of the consultation.

22. From the clinical notes, Mr C was seen again at home by GP 2 on 2 December 2005. She gave him a morphine injection and arranged for his admission to hospital. By that time GP 2 said that Mr C was in significant distress with the pain and she was concerned that he either had bone cancer or a fracture of a vertebra. GP 2 said that letters from the hospital later indicated that Mr C had suffered a heart attack and then went on to develop heart failure. At the meeting attended by Mrs C on 9 May 2006, it was suggested that part of the problem was that Mr C had been seen by several doctors. The Adviser said that may be relevant but, on the other hand, the fact that four different doctors had seen Mr C and none of them considered a heart problem to be the cause of his pain could be regarded as evidence that it was not at all obvious. The Adviser said that, from the clinical records and test results, it appeared that Mr C's heart attack took place around or perhaps slightly before the time of his

admission to hospital. Because of this uncertainty and because of the atypical presentation, the Adviser said he considered it reasonable that GP 4 did not diagnose heart problems.

(b) Conclusion

23. From the clinical notes, the nurse adviser spoke to Mrs C and Mr C between approximately 18:40 and 19:00. GP 3 arrived at their home at 19:19. It seems likely that when GP 3 arrived Mr C's symptoms were similar to those he described in his telephone conversation with the nurse adviser. In that conversation Mr C confirmed that he was not breathless. I have listened carefully to the recording and Mr C did not sound breathless when he was speaking to the nurse adviser. He also denied having any other pain other than the very sharp pain in his back going down his arms. The Adviser said that such a pain would not be typical of a heart problem.

24. GP 4 attended Mr C after the painkillers prescribed by GP 3 earlier the same night were ineffective. The information provided by Mrs C in her telephone call to NHS24 was recorded on the form passed to GP 4. It is clear that, by the time of the consultation, Mr C's symptoms had changed from those he had presented with earlier that same night. In addition to the increased pain in his back, he had indigestion and was breathless. The Adviser said that shortness of breath was a feature which could make a heart problem more likely. On the other hand, Mr C did not have the type of pain which would indicate that the problem was his heart. Rather, Mr C's symptoms fitted a spine problem. Mrs C complained of language difficulties and that she did not understand the instructions regarding the tablets and the Clinical Director apologised for this. The Adviser was satisfied, however, that the treatment given to Mr C was reasonable. Mrs C thought that Mr C was admitted to hospital later that day but it is clear from the evidence that admission did not occur until the following day. The Adviser said that it is possible that the pain that Mr C was suffering when GP 4 saw him was caused by a heart problem prior to a heart attack but he could not be sure. There is nothing in the clinical records to indicate whether or not GP 4 called Mrs C later, however, it is clear that Mr C was advised to consult his own GP, which he did the following day. By then, his condition had again deteriorated and he was admitted to hospital but even at that stage he did not have the typical presentation of a heart problem. I am, therefore, unable to uphold the complaint that GP 3 and GP 4 failed to diagnose the heart problem at the time they saw Mr C.

(c) The Practice did not deal with Mrs C's complaint properly

25. Mrs C said that, following Mr C's death, she was unhappy about aspects of his care so she telephoned the Practice on 24 January 2006 and asked for an appointment to see GP 2 to discuss what had happened. Mrs C said that the receptionist told her that as she was not a patient of the Practice she could not have an appointment, however, the receptionist would pass on Mrs C's request to GP 2. GP 2 telephoned Mrs C the following day and said that she would not see her. The Practice Manager then contacted Mrs C. Mrs C said that the Practice Manager told her that GP 2 was not in a position to see Mrs C but that she should put her complaint in writing.

26. Mrs C wrote to the Chief Executive of the Board on 13 February 2006. She described the circumstances of her husband's death. She said that after Mr C died she asked for a meeting with GP 2 to discuss what both she and Mr C were convinced was a misdiagnosis. The Practice had denied this request and also denied her request to see Mr C's medical records. Mrs C copied her letter of 13 February 2006 to the Practice.

27. GP 2 wrote to Mrs C on 20 February 2006. She summarised the treatment provided to Mr C and went on to say that, at the time of the telephone conversation on 25 January 2006, she was not aware that she could allow Mrs C to see the records and she apologised for that. Following this, however, GP 2 spoke to GP 1, who clarified the situation. GP 2 then asked the Practice Manager to request Mr C's notes back from the Board and contact Mrs C to offer a meeting.

28. The meeting took place on 9 May 2006. Mrs C said that she felt that there was a long delay, some two and a half weeks, between GP 2's refusal to see her and the Practice Manager offering her a meeting. GP 2 explained that when Mrs C had initially requested a meeting she thought that Mrs C wished to see Mr C's medical records and at that point she was unsure of the legalities. It was only after she had spoken with one of the other partners in the Practice regarding this that it had been confirmed that the medical records could be provided to Mrs C. Arrangements were then made to obtain Mr C's medical records from the Board and arrange a meeting. Mrs C said that she had not wanted to see her husband's medical records. She had only wanted to talk to GP 2.

29. GP 2 sent Mrs C a copy of the minutes on 23 May 2006. She said that on reviewing the minutes there was a discrepancy between what Mrs C said that she had been told by the Practice Manager and what GP 2 understood to be the case. This had, unfortunately, given Mrs C the impression that GP 2 was not planning to see her, which was not her intention at that stage. They were looking at where the communication error had occurred to ensure the situation did not arise again.

(c) Conclusion

30. There was confusion regarding Mrs C's request for a meeting with GP 2, the Practice's responsibility for dealing with Mrs C's complaint and access to Mr C's medical records. It may be that the position was exacerbated by the fact that Mrs C was a patient of a different practice but, nonetheless, she appears to have been given misleading and conflicting information. There was also a delay when she did not know what was happening. This was clearly a most distressing time for Mrs C, when she was struggling to come to terms with the sudden death of her husband. Although Mrs C eventually did have the opportunity to attend a meeting, the initial difficulties she encountered in having her concerns addressed can only have added to her grief. I, therefore, uphold this complaint.

(c) Recommendations

31. The Ombudsman recommends that the Practice:

(i) apologise to Mrs C for failing to deal with her complaint properly; and

(ii) reflect on their complaints policy, review their complaints protocol and discuss how to respond to complaints from non-patients.

32. The Practice have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Practice notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	Mrs C's husband
Mrs C	The complainant
The Practice	Mr C's GP Practice
The Board	Greater Glasgow and Clyde NHS Board
The Service	The Board's GP Out of Hours Service
GP 1	The GP from the Practice who saw Mr C on 20 October 2005
GP 2	The GP from the Practice who saw Mr C on 28 October, 11 November and 2 December 2005
GP 3	The GP from the Service who saw Mr C on 30 November 2005
GP 4	The GP from the Service who saw Mr C on 1 December 2005
The Adviser	The Ombudsman's Adviser who is a GP

Annex 2

Glossary of terms

Bone secondaries	The spread of cancer cells to the bone
Diazepam	A benzodiazepine used for sedative and anxiety-relieving effects
Lansoprazole	One of a group of medicines known as proton pump inhibitors, used to treat certain conditions caused by too much acid being produced in the stomach
Malaise	A feeling of being generally unwell, run down or out of sorts
Myocardial rupture	This is where the heart wall, weakened by a recent heart attack, splits open
Osteoporotic collapse	Fractures caused by the weakened, demineralised (containing less calcium) condition of the bones
Prednisolone	A steroid effective against pain and inflammation
Pulmonary oedema	A build up of fluid within the lungs, which can be a sign of a heart problem
Salbutamol	A medicine used in lung related problems
Sertraline	A selective serotonin (a chemical messenger) re-uptake inhibitor drug used to treat depression
Thoracic spine	The thoracic spine is found in the chest region of the body and supports the ribs
Tramadol	A pain killer