Scottish Parliament Region: Glasgow

Case 201300692: A Medical Practice in the Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health FHS: GP and GP Practice; clinical treatment; diagnosis

Overview

On 2 April 2013, the complainant (Miss C) telephoned her mother (Mrs A)'s medical practice (the Practice) and requested a house call Mrs A. However, she said that when the GP (the Doctor) visited, she failed to examine Mrs A or ask her whether she was in pain. Miss C said that the Doctor disregarded the symptoms she reported; refused to give Mrs A anything to help her sleep; and called her by an incorrect name. Miss C complained that had Mrs A been examined and told treatment in hospital was necessary, the outcome for her could have been different. Mrs A was subsequently taken to hospital where she died.

Specific complaint and conclusion

The complaint which has been investigated is that, in relation to a house call on 2 April 2013, the Doctor unreasonably failed to examine Mrs A, leading to a delay in admitting her to hospital for tests and treatment *(upheld).*

Redress and recommendations

The Ombudsman recommends that the Practice:	*Completion date*
(i) ensures that the Doctor make a formal apology to Miss C for her failure in this matter; and	3 March 2014
(ii) ensures that the Doctor completes appropriate professional training so that she is fully appreciative of the seriousness of abdominal pain in the elderly and the importance of conducting a thorough history and examination.	29 April 2014

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

Main Investigation Report

Introduction

1. Miss C wrote to my office on 23 May 2013 concerning the death of her late mother (Mrs A). She said that on 2 April 2013 she contacted Mrs A's medical practice (the Practice) asking for a house call, as Mrs A had a very swollen stomach and was constipated. Mrs A appeared very ill, but Miss C said that when the Doctor attended, she failed to examine Mrs A or to question her about her condition. Miss C said that the Doctor disregarded the symptoms she reported for Mrs A and refused to give her anything to help her sleep. She said she called Mrs A by an incorrect name.

2. Miss C said she called the Practice again on 3 April 2013 and spoke to the Doctor asking for advice, as Mrs A was being sick. A further telephone call was made on 4 April 2013, after which Mrs A was admitted to hospital. Regrettably, Mrs A died there on 6 April 2013. The discharge letter subsequently sent to the Practice (on 9 May 2013) referred to Mrs A's initial examination on admission to hospital. It said that she was dehydrated and cachectic (suffering general ill-health with emaciation); her abdomen was grossly distended and generally tender; an x-ray showed faecal loading; and a CT scan taken later showed massive constipation with dilation of the small and large bowel. The letter confirmed Mrs A's cause of death as being due to bowel stasis (stoppage or reduction of the flow of bowel contents) and dilation.

3. In the meantime, on 18 April 2013, Miss C made a formal complaint to the Practice and the Doctor replied on 24 April 2013. The Doctor maintained that she had examined Mrs A while Miss C was out of the room but admitted that she had not checked Mrs A's pulse or blood pressure (BP), nor had she assessed her further. The Doctor said that she should perhaps have reassessed Mrs A after the telephone call on 3 April 2013.

4. A Significant Event Analysis (SEA) was subsequently completed by the Practice in July 2013 and this concluded that more time could have been spent with Mrs A and on explaining the diagnosis and red flags. With the benefit of hindsight, the report said Mrs A should have been reviewed after the telephone call on 3 April 2013. It was emphasised that it was important to follow proper consultation procedure at all times.

5. The complaint from Miss C which I have investigated is that, in relation to a house call on 2 April 2013, the Doctor unreasonably failed to examine Mrs A, leading to a delay in admitting her to hospital for tests and treatment.

Investigation

6. The investigation of this complaint involved obtaining and reading all the relevant documentation, including the complaints correspondence and Mrs A's relevant clinical records. Together with independent general practice advice obtained from a specialist adviser (the Adviser), all the available documentation was given careful consideration.

7. While this report does not include every detail investigated, I am satisfied that no matter of significance has been overlooked. Miss C and the Practice were given an opportunity to comment on a draft of this report.

Complaint: In relation to a house call on 2 April 2013, the Doctor unreasonably failed to examine Mrs A, leading to a delay in admitting her to hospital for tests and treatment

8. Miss C maintained that the Doctor had not carried out any examination at her house call on 2 April 2013 and believed that had she done so, she would have called an ambulance for Mrs A's admission to hospital. However, in the SEA, the Doctor maintained that she had examined Mrs A, but that this was when Miss C was out of the room. The Doctor said she noted that Mrs A's stomach was distended and she was tender on her left side. She concluded that Mrs A was constipated. However, she admitted that she had not checked her pulse or BP. The Doctor said that after Miss C's call on 3 April 2013 it may have been beneficial to have made a further assessment.

The advice

9. As part of this investigation, specialist advice was obtained and the Adviser was asked specifically to provide advice about the house visit on 2 April 2013. In doing so, the Adviser reviewed Mrs A's relevant notes. He said that the notes did not show any detail of history taking nor of questioning Mrs A or Miss C for further information. He said that it was likely from the records (and confirmed by the SEA), that a 'cursory' examination had been performed by the Doctor.

10. The Adviser said that at the time the Doctor visited, Mrs A was lying on the sofa. He said this would have made examining her very difficult, however, there

was no mention either in the notes or in the SEA of the Doctor asking for Mrs A to be moved for examination. He commented that the examination was obviously very brief, as it was apparently performed when Miss C was out of the room getting a box of laxatives to show the Doctor. The Adviser added that there was no evidence in the records to show that any clothing had been removed or disturbed. He said no rectal examination was performed which, particularly in a case of a lower bowel problem, should have been mandatory. There was also no evidence that bowel sounds were listened for and he said this should have been a part of Mrs A's examination.

11. It was the Adviser's view, which he said was reflected in medical training over at least the last 50 years, that an abdominal examination should be performed in five parts, with a sufficient part of the abdomen uncovered to make examination possible. He explained that the five parts were:

- inspection (looking for anything abnormal or unusual);
- palpation (manual examination of the organs and the abdomen in general to elicit pain, masses, etc). This requires access to the skin of the abdomen;
- percussion (tapping out to determine whether there is fluid in the abdomen). Once again this needs access to the skin of the abdomen;
- auscultation (listening to the bowel sounds);
- completion (this includes observation of genitalia, rectal examination). He said in primary care it was usual to perform such an examination if there was a significant expectation that findings would influence management of the care of the patient. Finally, vaginal examination was also recommended if clinically indicated.

12. The Adviser went on to add that abdominal pain in patients over the age of 70 should always be taken seriously but, despite this, he said that it was clear to him that the Doctor took few if any of the steps (above) necessary to ensure that Mrs A was thoroughly examined.

13. Miss C was concerned that because her mother was not admitted to hospital sooner, her outcome was affected. Accordingly, the Adviser was asked whether the outcome Mrs A could have been different if the Doctor had acted as he would have expected. He said he could not be certain whether Mrs A would have accepted the need for hospitalisation on either 2 or 3 April 2013, given that he noted she had refused this previously and subsequently. Nevertheless, he

said that had the Doctor revisited, rather than dealing with the call on 3 April 2013 as a telephone consultation, this may have stressed the potential seriousness of Mrs A's condition. The Adviser went on to say, however, that when Mrs A was finally admitted to hospital she was initially observed overnight, and very little active clinical management was undertaken during her hospital stay.

14. The Adviser also pointed out that it was unusual for patients of this age to die from bowel stasis and from the information available to him it was unclear whether there was any underlying condition. He told me that in his opinion there would probably have been no difference to the outcome for Mrs A had the Doctor carried out a full examination or acted in any different way. Nevertheless, he said it may well have speeded up her hospital admission and reduced Miss C's concern.

15. The Adviser was also asked to consider the SEA which was carried out on 1 July 2013 and it was his view that to consider these events some three months later was too long in his experience. He commented that the first matter mentioned in the SEA report was the fact of the Practice being understaffed. He said that while this was unfortunate, as it placed staff under greater pressure, it was entirely inappropriate that it was allowed to affect patient care or influence the seriousness with which any failings in standards of care were treated. He further commented that there was no representative from the community care providers to discuss district nursing staffing issues, which were also identified as relevant to treatment in Mrs A's case.

Conclusion

16. Very careful account has been taken of all the evidence available and of the clinical advice obtained. With this in mind, I have concluded that the Doctor's examination of Mrs A was unreasonable and, in these circumstances, I uphold the complaint. The Doctor should now make a formal apology to Miss C for her failure in this matter. She should also undertake further professional training to ensure that she is fully appreciative of the seriousness of abdominal pain in the elderly and the importance of conducting a thorough history and examination.

Recommendations

17. I recommend that the Practice: *Completion date*

(i)	ensures that the Doctor make a formal apology to Miss C for her failure in this matter; and	3 March 2014
(ii)	ensures that the Doctor completes appropriate professional training so that she is fully appreciative of the seriousness of abdominal pain in the elderly and the importance of conducting a thorough history and examination.	29 April 2014

18. 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

Miss C	the complainant
Mrs A	the complainant's late mother
the Practice	Mrs A's medical practice
the Doctor	the GP
CT scan	computerised tomography scan
BP	blood pressure
SEA	Significant Event Analysis
the Adviser	a specialist adviser

Annex 2

Glossary of terms

Bowel stasis	stoppage or reduction of the flow of the bowel contents
Cachectic	suffering general ill-health with emaciation