**Scottish Parliament Region: Highlands and Islands**

# Cases 200603988 & 200701202: Highland NHS Board and a Medical Practice, Highland NHS Board

## Summary of Investigation

### *Category*

Health: Hospital; treatment
Health: General Practitioner; treatment and referral

### *Overview*

The complainant (Mrs C) raised a number of concerns about the diagnosis of her husband (Mr C) and his treatment for small bowel obstruction. Specifically, she raised concerns that Mr C's GP Practice (the Practice) had delayed referring him to hospital and that the treatment provided by Highland NHS Board (the Board) was inadequate.

### *Specific complaints and conclusions*

The complaints which have been investigated are that:

(a) the Practice failed to timeously diagnose Mr C with small bowel obstruction and to refer him to hospital for treatment (*upheld*); and
(b) the Board failed to provide appropriate care and treatment for Mr C (*not upheld*).

### *Redress and recommendations*

The Ombudsman recommends that the Practice:

(i) apologise to Mrs C for their failure to review Mr C following her telephone call on 1 August 2006;
(ii) review their protocol for telephone consultations to ensure that patients are seen by a doctor when necessary in order to exclude more serious diagnoses; and
(iii) consider the management of severe abdominal pain over the telephone.

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

The Ombudsman has no recommendations in respect of the Board.

## Main Investigation Report

### Introduction

1. On 24 July 2007, the Ombudsman received a complaint from a woman (Mrs C) about the care and treatment received by her husband (Mr C) at a GP Practice (the Practice) and at Raigmore Hospital (Hospital 1) within Highland NHS Board (the Board).

2. Mr C became ill with severe stomach pains on 29 July 2006. He went to the Town and County Hospital (Hospital 2) in the evening of 31 July 2006. Mr C was advised to continue taking medication for indigestion and Paracetamol. He was told to contact the Practice if he felt no better the following day.

3. On 1 August 2006, Mrs C telephoned the Practice in the morning and advised the receptionist that there had been no change in Mr C's condition. Mrs C explained that Mr C had attended Hospital 2 the previous evening. A GP (GP 1) called back. Mrs C told me that GP 1 advised her that Mr C should drink flat cola or cold tea. This did little to improve Mr C's condition and he continued to suffer from enormous thirst. Mr C later vomited a black liquid.

4. The following day Mr C was still vomiting, thirsty and had a low appetite. Mrs C telephoned the Practice first thing in the morning and requested a home visit. A GP (GP 2) attended at approximately 10:30. Mr C's stomach was distended and GP 2 sent him to Hospital 1.

5. At Hospital 1, an intravenous drip was inserted. Mrs C told me that Mr C's hands, feet, legs and arms felt cold to touch but that he was sweating profusely. She also told me that his abdomen was distended and tight. Mr C was taken for x-ray and Mrs C told me that, upon his return, Mr C was extremely distressed. Shortly after his return Mr C told Mrs C that he could not breathe and then violently vomited black liquid. Shortly after this, Mr C died.

6. Mrs C attended a meeting at the Procurator Fiscal's offices on 2 October 2006 and asked for further information about the treatment which Mr C received prior to his death. Mrs C was not satisfied with the answers which she was given and complained to the Board on 18 December 2006. The Board responded to her complaint on 19 March 2007.

7. When Mrs C contacted the Ombudsman's office, she had not complained to the Practice. The Practice arranged to meet Mrs C and discuss her complaints on 4 December 2007.

8. I decided to investigate this complaint on 6 December 2007.

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

(a) the Practice failed to timeously diagnose Mr C with small bowel obstruction and to refer him to hospital for treatment; and

(b) the Board failed to provide appropriate care and treatment for Mr C.

**Investigation**

10. During my investigation of this complaint, I considered Mr C's medical records from Hospital 1, Hospital 2 and the Practice; the complaints correspondence supplied by Mrs C, the Board and the Practice; and the notes which Mrs C kept about the events. I discussed this complaint with GPs from the Practice and I obtained advice from the Ombudsman's medical adviser (the Medical Adviser) and the Ombudsman's GP adviser (the GP Adviser).

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

**(a) The Practice failed to timeously diagnose Mr C with small bowel obstruction and to refer him to hospital for treatment**

12. Mr C suffered from abdominal pain and vomiting for two days before he accessed medical care on the evening of 31 July 2006 when he was seen by a GP (GP 3) at the out-of-hours service at Hospital 2. GP 3 examined Mr C and made a presumptive diagnosis of viral gastritis. He suggested that Mr C be reviewed by his own GP the following day if he was no better.

13. Mrs C telephoned the Practice the following morning and was given advice about continuing gastritis. Mr C's medical records states 'severe stomach pain since 29/7 – slightly better but still vomiting'. Mr C was not seen or examined at this time.

14. GP 1 explained to me that the primary presenting symptom was vomiting rather than severe pain and that Mr C's pain had got better. GP 1 stated that she had also reviewed the out-of-hours sheets that morning and that these had

provided some reassurance about Mr C's condition. She considered that Mr C had a typical history of gastritis and that advice had been given accordingly.

15. The GP Adviser informed me that someone who has had severe abdominal pain for three to four days should have had the state of their abdomen reassessed despite the normal signs from the evening before. GP 1 should have organised to examine Mr C's abdomen to exclude an acute abdomen. She should have either organised for him to come to the Practice or to have a home visit. She would then have been able to put herself in a position to exclude a more serious cause of his abdominal pain. The GP Adviser stated that it was quite possible that the findings would have been similar to those of GP 3 and that she would have given the same advice as she gave over the telephone. However, it is also possible there would have been signs of an obstruction which would have led Mr C to be admitted the day before he was. The GP Adviser advised that, although it is not possible to state with certainty what would have happened in this event, this may have changed the outcome.

16. Mrs C telephoned the Practice again on 2 August 2006. GP 2 visited Mr C at home and found him to have a distended abdomen. GP 2 diagnosed a possible intestinal obstruction and referred him to Hospital 1.

*(a) Conclusion*

17. When Mrs C telephoned the Practice, Mr C had been suffering from severe abdominal pain for three to four days. The Ombudsman recognises the importance of telephone consultations. However, in this case, GP 1 should have put herself in a position to exclude a more serious cause of Mr C's abdominal pain. She did not do this and gave advice over the telephone. I, therefore, uphold this complaint. However, it is not possible to determine what the findings and advice would have been had Mr C been seen by GP 1 or whether subsequent events would have been different had he been examined by GP 1.

*(a) Recommendation*

18. The Ombudsman recommends that the Practice apologise to Mrs C for their failure to review Mr C following the telephone call on 1 August 2006. The Ombudsman also recommends that the Practice review their protocol for telephone consultations to ensure that patients are seen by a doctor when necessary in order to exclude more serious diagnoses. In particular, she

recommends that the Practice consider the management of severe abdominal pain over the telephone.

**(b) The Board failed to provide appropriate care and treatment for Mr C**

19. Mr C was referred to Hospital 1 by GP 2 on 2 August 2006 with continuing abdominal pain and vomiting, and a markedly distended abdomen. When seen and examined at Hospital 1, a clinical diagnosis of intestinal obstruction was made. Mr C was treated with intravenous fluids and an x-ray of his abdomen was arranged. Mr C returned from the x-ray department at 16:30. The Medical Adviser advised me that the x-rays show characteristic signs of small intestinal obstruction. At 16:40 Mr C's observations showed a degree of restlessness. At 16:45 he began to vomit copiously and suffered from a cardiac arrest from which he could not be resuscitated.

20. The Medical Adviser stated that the diagnosis of small bowel obstruction was appropriately and immediately made on the basis of the history and physical signs at the time of his admission to Hospital 1. He advised that the x-ray confirmed the diagnosis in the most appropriate and immediate way. Mrs C raised concerns that sophisticated scanning by ultrasound, CT or MRI was not used. The Medical Adviser informed me that these scanning techniques are less easily available and would delay the confirmation of diagnosis. Furthermore, he advised that these are unlikely to produce any more information than is available by plain abdominal x-ray.

21. The Medical Adviser stated that in Hospital 1, Mr C's blood tests confirmed a degree of dehydration. He advised that this was managed appropriately by intravenous fluid replacement. On confirmation of the diagnosis, the Medical Adviser has no doubt that naso-gastric suction would also have been commenced ('drip and suck') but, sadly, Mr C did not survive long enough following the x-ray confirmation of his diagnosis for this to be commenced.

22. Mrs C expressed concern that surgical treatment was not undertaken immediately. The Medical Adviser informed me that surgical relief of intestinal obstruction is certainly an important and commonly used treatment option but that it would be wrong to intervene by surgery immediately for several reasons. Treatment by 'drip and suck' will quite commonly be sufficient to relieve the obstruction and thus avoid unnecessary surgery. Furthermore, it is important firstly to resuscitate the patient with appropriate fluids and to decompress the obstructed bowel by naso-gastric suction. The Medical Adviser also advised

that associated factors, such as infections, need to be identified, assessed and controlled. These measures are essentially to reduce the risk of operative mortality and morbidity. He stated that, in Mr C's case, there were two potentially serious complicating factors: the electrocardiograph showed clear evidence of a probable recent myocardial infarction (heart attack) and the blood tests showed abnormally high levels of haemoglobin and red blood cells – a finding highly suggestive of a condition known as 'polycythaemia'. The Medical Adviser stated that both of these findings would significantly increase the risks associated with a surgical operation.

23. Mrs C raised concerns about the fact that she was told that Mr C's condition was not life threatening. This comment was apparently made in response to Mrs C's question relating to the seniority of the doctor who admitted Mr C to Hospital 1. The Board explained that the normal procedure is for the junior doctor on call to deal with the patient provided that the patient's condition 'has not been initially assessed as life threatening, as was the case with [Mr C]'. Although I can understand Mrs C's distress at this statement, particularly in the light of the eventual outcome, the Medical Adviser stated that this was an appropriate response and that Mr C required urgent investigation and treatment but not emergency treatment. He advised that Mr C's management at that stage was well within the abilities of qualified junior medical staff. Clearly, in retrospect, Mr C's condition proved to be life threatening, but this was not predictable upon his admission.

*(b) Conclusion*

24. The diagnosis made at Hospital 1 was appropriately and promptly made and was compatible with good practice. Mr C was a high surgical risk but this did not delay any possible surgical treatment as, sadly, he died within a few hours of admission before his treatment regimen could be established. I do not uphold this complaint.

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

26. The Ombudsman has no recommendations in respect of the Board.

**Annex 1**

**Explanation of abbreviations used**

| | |
|---|---|
| Mrs C | The complainant |
| Mr C | Mrs C's husband, the aggrieved |
| The Practice | Mr C's GP Practice |
| Hospital 1 | Raigmore Hospital |
| The Board | Highland NHS Board |
| Hospital 2 | Town and County Hospital |
| GP 1 | A GP from the Practice who spoke to Mrs C over the telephone on 1 August 2006 |
| GP 2 | A GP from the Practice who visited Mr C at home on 2 August 2006 |
| The Medical Adviser | The Ombudsman's medical adviser |
| The GP Adviser | The Ombudsman's GP adviser |
| GP 3 | A GP who saw Mr C at the out-of-hours service at Hospital 2 on 31 July 2006 |

**Annex 2**

## Glossary of terms

| | |
|---|---|
| Acute abdomen | An abdominal condition of abrupt onset usually associated with abdominal pain resulting from inflammation, perforation, obstruction, infarction, or rupture of intra-abdominal organs |
| Cardiac arrest | Stopping of the heart beat |
| CT | A procedure using x-rays to produce computerized images through the body |
| Drip and suck | A procedure where the patient is given intravenous fluids and naso-gastric aspiration |
| Electrocardiograph | A recording of the electrical activity of the heart |
| Haemoglobin | A constituent of red blood cells |
| Intestinal obstruction | A mechanical or functional obstruction of the intestine, preventing the normal transit of the products of digestion |
| Morbidity | Complications directly resulting from treatment |
| Mortality | Death |
| MRI | An imaging technique used to image internal structures of the body particularly the soft tissues |
| Myocardial infarction | A heart attack caused by damage to or death of heart muscle tissue due to insufficient blood supply |

| | |
|---|---|
| Naso-gastric suction | Removing solids, liquids or gasses from the stomach or small intestine by inserting a tube through the nose and suctioning the gastrointestinal material through the tube |
| Polycythaemia | An abnormal condition of the blood characterised by an increased number of red blood cells |
| Small bowel obstruction | Intestinal obstruction of the small bowel |
| Ultrasound | An imaging method in which high-frequency sound waves are used to outline a part of the body |
| Viral gastritis | Inflammation or irritation of the lining of the stomach caused by a viral infection |