S.171/01-02

Scottish Public Services Ombudsman Act 2002

Report by the Scottish Public Services Ombudsman
of an investigation into a complaint against
a general practitioner (GP) in the Lothian area

Complaint as put to the Ombudsman

1. The complaint was put to the Ombudsman by a man on behalf of his father. In this report I refer to the complainant as Mr E junior and to his father as Mr E. The account of the complaint provided by Mr E junior was that on Thursday 4 January 2001 Mr E visited the GP because of visual disturbances. The GP was unsure of the cause but arranged for him to attend an eye clinic that day. After examination, a doctor there decided to refer Mr E to a neurovascular clinic. Mr E and his daughter visited the GP on Monday 8 January to report further disturbances. He gave the GP a note of the times and duration of these and mentioned a loss of power in his hand, but these issues were not noted in the medical records. Nor did the GP note in the records that Mr E had contacted Healthcall, the surgery's out-of-hours service. As Mr E was unclear about the referral from the eye clinic, the GP obtained this information from the clinic. Pending his appointment at the neurovascular clinic, Mr E suffered a stroke on 11 January while playing golf. This left him with communication and mobility difficulties. Mr E junior was concerned about what had happened and he met and corresponded with the GP about this. Remaining dissatisfied, he complained to the Lothian Primary Care NHS Trust and then to the Ombudsman.

2. The matters investigated were that the GP's care and treatment of Mr E between 4 and 11 January 2001 were inadequate and that the medical records were incomplete. The actions of the eye clinic and neurovascular clinic are outside the scope of the investigation.

Investigation

3. The statement of complaint for the investigation was issued on 14 February 2002. The GP's comments were obtained and relevant documents including Mr E's clinical records were examined. The

Ombudsman's investigating officer took evidence from the GP and from Ms E, Mr E's daughter. Mr E was not interviewed because of the continuing speech difficulties caused by his stroke. Two professional assessors were appointed to advise on the clinical issues in this case and their report is reproduced in paragraph 33 below. I have not included in my report every detail investigated, but I am satisfied that no matter of significance has been overlooked.

Clinical background

4. Transient ischaemic attacks (TIAs) are spasms or temporary occlusion in the blood feeding the brain, often lasting only a few minutes. They are an indicator of a possible circulatory problem and of a possible stroke. Indeed, they may be referred to as mini strokes. Amaurosis fugax is a variant of a TIA. It is a temporary interference in vision, related to a fatty degeneration in part of the blood vessels which supply the brain. A carotid bruit is an abnormal sound, heard with a stethoscope over the carotid artery in the neck, which indicates a narrowing of the vessel. The significance of this is that patients with significant carotid narrowing can present with multiple episodes of TIAs before developing a major stroke. Early investigation is necessary, and carotid artery surgery may be required to prevent a major stroke.

National guidance

5. The Scottish Intercollegiate Guidelines Network (SIGN) produce national clinical guidelines which they recommend for use in Scotland. One of these concerns the management of patients with clinically suspected recent stroke or TIA. It includes the following:

> 'Adequate investigation of patients with recent stroke or transient cerebrovascular symptoms requires rapid access to hospital-based facilities via either hospital admission or a fast track clinic.
>
> 'Patients who have sustained minor strokes or [TIAs] and who are not admitted to hospital require urgent assessment. The risk of a further more serious stroke is highest in the few weeks immediately following a [TIA]. The aim should be for all such patients to be assessed at fast track outpatient clinics as soon as possible after recognition of the [TIA], and within two weeks.

> ‘Patients with suspected [TIA] or minor stroke who are not admitted to hospital should have rapid access for urgent assessment and investigation (CT brain scanning, carotid Doppler examination and echocardiography).’

6. The General Medical Council (GMC), doctors’ regulatory body, produces guidance on good medical practice. On the subject of record keeping it says that doctors must keep ‘clear, accurate … contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed.’

Documentary evidence

7. Entries made by the GP in Mr E’s medical records between 4 and 10 January read:

> ‘4.1.01 … H[istory] of altered vision in L[eft] eye. Went blind, then resolved. Then became poor vision. Then resolved again. Now ok. VA [visual acuity] 6/9 L[eft]; 6/12 R[ight], no temp[oral] art[ery] tenderness – refer [eye clinic].
>
> ‘8.1.01 … Seen by [eye clinic], apparently due to be referred to specialist. ?who. Getting episodes of visual loss every day at present – to chase up next referral to neuro[vascular clinic].’

8. The local hospital which had admitted Mr E because of his stroke on 11 January wrote to the GP’s practice on 19 January. The letter includes:

> ‘[Mr E] was admitted … having collapsed whilst playing golf. He was found to have right-sided weakness and was unable to speak. There has been a preceding history of 2 episodes of possible amorosis fugax in his left eye … He also had an extensive vascular history …
>
> ‘… He was living alone with no Social Services and maintained an active life playing golf regularly.
>
> ‘On examination … no carotid bruits audible …’

9. On 2 March 2001, the GP wrote to Mr E junior:

> '[On 4 January there] was no associated pain or other eye symptoms and at the time he attended the surgery he had no other symptoms. Examining his eyes on that day was unremarkable, his vision was slightly better in his left eye … and there were no other findings that were of note … [On 8 January he] stated that he had had a further episode of visual disturbance over the weekend and was a little unclear as to the follow up arrangements from the [eye clinic]. He was otherwise well and again had no other symptoms at that time.
>
> 'My senior receptionist contacted the [eye clinic] who stated that he had been referred to the neuro-surgeons at … for their opinion on a bruit they had heard in his neck and that he would hear directly from [the neuro-surgeons].'

10. The notes of a meeting between Mr E junior, the GP and others on 25 April 2001 say that Mr E junior expressed concern that 'the system relied on feedback from the patient as to what was happening' as 'the doctor therefore had to rely on what was said by the patient, his 74-year-old father, when [the GP] saw him on … 8 January'. [Mr E junior] 'felt something could have been done sooner, given his repeated attacks … He was critical of the GP's advice to go and play golf …'. Mr E junior referred to his father as having had a stroke, six incidents of sight loss within a week and two occasions of loss of power in his hand. Mr E junior asked why, given this, the GP had not recognised the possibility of a stroke. The GP is shown as replying that:

> 'there was ambiguity about what had happened and … the main problem was loss of vision. The [eye clinic] had made an assessment that a bruit was heard and referred to the neurovascular clinic … He stated that the recommended guidelines are that a patient should be seen within 2 weeks at the specialist clinic. He did not know if that was always possible.'

11. The meeting notes record that when asked if the risk of a TIA was the same whether or not a patient had previously had a stroke, the GP replied that:

> 'there was no more risk. He stated that TIAs are narrowing of the arteries. Experiencing attacks does not indicate whether a stroke will happen that week. Treatment which is considered is carotid endarterctomy, but only for patients who have stenosis (narrowing) of more than 70% … The presence of a bruit … doesn't necessarily [indicate] that a stroke will occur.'

12. The GP also confirmed that, immediately following a hospital consultation, it was normal procedure to rely on the patient for feedback as to what was happening. In this case, however, the surgery had taken steps themselves to establish what the eye clinic had done.

13. The notes of the meeting record the GP as acknowledging that his letter of 2 March 2001 (paragraph 9) was incorrect in that it referred to Mr E as having reported only one loss of vision over the weekend of 6 and 7 January. The GP said that there was no record of Mr E having mentioned loss of power in one hand when attending on 8 January. Nor did the records include any copy of his referral letter to the eye clinic: this was normal practice because it was a handwritten letter for an acute referral. There was no record of feedback from Healthcall because, although they usually faxed details of contact to the surgery the following morning, nothing was received on this occasion.

14. On 14 June 2001, the GP wrote to Mr E junior:

> '… Given your father's extensive past medical history … I was uncertain as to whether his presentation with eye symptoms was a diabetic problem, a retinal one or a variant of a [TIA]. Because of this … I admitted him to the [eye clinic] that morning. I knew that if they felt this to be a circulatory problem they would then refer him on to the appropriate specialist in the usual manner. The [eye clinic] indeed felt that this was amaurosis fugax (a TIA variant) and referred your father to the neurovascular clinic for their opinion.

'You then questioned what system the practice has in place to make sure that a patient receives an appointment at an appropriate time or has been referred by a third party for a[n] appointment with a specialist … We like virtually every other general practice do not routinely check with our patients to see if they have received an appointment nor do we chase up a third party (i.e. the hospital) to see if they have made a further appointment for a patient.

'When your father returned to the surgery on the Monday morning after he had been seen at the [eye clinic], you questioned why I did not admit him to hospital for observation at that time. As I pointed out on both the occasions when I had seen your father he was well and symptom free, as he had been at the [eye clinic] when he attended. Few hospitals would accept a well symptom free patient for admission for observation. As I tried to explain to you at our meeting the presence of a TIA is indicative of a possible circulatory problem but does not imply that a stroke is about to follow. The current SIGN guidelines on stroke and TIA management suggest as I explained that a patient having had a TIA should be referred to an appropriate clinic for assessment and this is what happened with your father.'

15. On 9 September 2001 Mr E junior wrote to the Trust's convener setting out his continuing concerns. These included:

'My father … returned to [the GP] on 8 January as he had experienced further incidents of TIA. My father gave [the GP] a note of the times and duration of these attacks. My father also mentioned loss of power in his right hand. My sister remembers that [the GP] made reference to previous loss of power. My father also advised [the GP] that he had contacted [a doctor] at Healthcall on 7 January. There is no record in my father's medical notes of the frequency of TIA, nor is there any reference to loss of power in one hand or feedback from Healthcall.

'It should be noted that the [eye clinic] detected "a significant Bruit in the Carotid Artery". [The GP] has confirmed that he did not check the Carotid Artery [on 4 January], nor is there any reference

to such checks in my father's medical notes. [The GP] did not appear to suspect TIA as … there was no expression of urgency. [The GP's] record … was incorrect. In his reply of 2 March he states that my father reported only one loss of vision over the weekend and no other symptoms. [He] has clearly failed to make accurate records … [He] did not keep a record copy of the [eye clinic] referral letter.

'[The GP] stated … that he was unsure as to why my father was having this visual disturbance. He commented that it could have been a circulatory problem a diabetic problem or a retinal problem. He chose to refer to an ophthalmologist rather than to a neurovascular clinic. With regard to the diabetes, this was not a significant health problem for my father, as can be shown by the fact that he was not on medication. [The GP] seems to have failed to take note of the fact that my father had a stroke in 1990 and that this might have had some bearing on where he chose to refer him.

'What is a matter of more concern … is the action … on 8 January. My father had had 6 attacks by the 8 January resulting in loss of sight and on two occasions temporary loss of power in his hand. Together with a history of stroke, this should … have resulted in an immediate referral to hospital for medical assessment. My father's symptoms were persistent and, I would suggest that, had the SIGN Guideline been fully considered then the appropriate referral should have been the Neurovascular Clinic and not the [eye clinic]. Despite our meeting in which I reminded [the GP] that my father had handed him a note of the attacks and loss of power in his hand, [the GP] maintains in his last letter that my father was well and symptom free.

'[The GP] goes on to state that few hospitals would accept a well symptom free patient. I can only repeat that my father was not symptom free as shown by the above evidence.

'My father's condition had become worse by 8 January, yet [the GP] chose to go along with his assessment made on 4 January. He did

not revise his opinion. I believe that the signs and symptoms warranted this reassessment. In fact on 8 January he was not even sure what the [eye clinic] had done, as my father was not altogether clear what action they had taken. It was only the next day that they were able to find out from the [eye clinic] that a referral had been made to the Neurovascular Clinic.

'[The GP] seems to have taken the view that as the [eye clinic] had referred my father to the Neurovascular Clinic there was nothing further he could do.

'[The GP] makes reference to the SIGN guidelines stating that a TIA does not imply that a stroke is about to follow. The guidelines actually state that "the risk of a further more serious stroke is highest in the few weeks immediately following a [TIA]". Given that my father had had a stroke in 1990 and had six TIAs within one week, there was clearly, in my view, a need to refer on 8 January to hospital for immediate admission.'

The GP's response to the statement of complaint

16. In a written response to the Ombudsman the GP said that on 4 January 2001 Mr E had attended, presenting a two-day history of altered vision in his left eye. As far as he could recall, the GP believed him to have reported two such episodes, describing the first as a total visual loss of about five minutes, followed by a full recovery, and the second as a misting of his vision, fully resolving after a few minutes. The GP said that Mr E showed no symptoms, visually or elsewhere. On examination, his visual acuity was good and there were no signs of temporal artery tenderness.

17. Mr E had a significant medical history. He had had a stroke in 1990, a radical prostatectomy for prostate carcinoma in 1994, a myocardial infarction in 1994, an angioplasty in 1995 and diabetes. He was also a smoker. The GP said he was therefore uncertain whether Mr E's present problem was diabetic, retinal or circulatory. He therefore decided to arrange for a local eye clinic to see him that day. He knew that if appropriate, the eye clinic would refer Mr E on to a more relevant clinic. He said that this was standard procedure in the Lothian area and complied

with the SIGN guidelines, which said that 'the aim should be for all such patients … to be assessed … within two weeks'.

18. On 8 January, Mr E and his daughter visited the GP, reporting further visual disturbances. Mr E knew the eye clinic had said he was to be referred to a specialist but he was unclear about the details. The GP said that, again, Mr E had no symptoms. The GP did not recall his mentioning loss of power in the hand but did remember his concern as to whether he could play golf that week. The GP told Mr E he would like to know to whom the eye clinic had referred him and that he would tell Mr E when he had found out.

19. The surgery phoned the eye clinic, who said they had referred Mr E to a neurovascular clinic for their opinion on a carotid bruit which they had heard and because they thought he probably had amaurosis fugax.

20. As Mr E had been unavailable when the GP phoned him on the 8th to tell him this, Mr E came into the surgery the next day and was informed of it by the GP.

21. On 11 January, a local hospital contacted the surgery to inform them that they had admitted Mr E, who had suffered a stroke while playing golf.

Evidence from Ms E

22. Mr E's daughter, **Ms E**, told the Ombudsman's investigating officer that on the weekend of 6 and 7 January 2001, the family had been concerned by her father's continuing visual problems. On the Sunday evening another daughter phoned Healthcall, where a doctor listened to her account and advised that Mr E visit his own GP in the morning, but did not indicate any urgency.

23. On Monday the 8th Ms E accompanied her father to the morning surgery, where he was seen by the GP. She was present throughout and felt the consultation lasted a reasonable time: she had no recollection of its being hurried. She could not clearly recall any examination but, because Mr E stood up at one point, she felt there must have been some sort of examination. She had a vague recollection of a stethoscope and possibly of Mr E being asked to unbutton something. She was fairly sure her father's eyes and neck were not examined.

24. Ms E recalled that the GP asked her father about his hand. She was unsure but felt that her father replied along the lines of 'much the same'. She did not think either man made much of the issue.

25. Mr E had written the specific times of the five TIAs which had occurred over the weekend. Ms E had rewritten them and she gave her list to the GP, who took it from her without discussion. She also described the Healthcall conversation to him. They did not discuss it, although she thought he might have said that he had no record from Healthcall.

26. Mr E and the GP discussed the visit of the 4th to the eye clinic and the GP said that, as Mr E was unclear, he would find out about the referral and tell Mr E that day. However, Mr E had gone out at about 4:30 pm and did not hear from the GP so he attended the surgery on the 9th to obtain this information.

Interview evidence from the GP

27. The Ombudsman's investigating officer, accompanied by the two professional assessors, interviewed the GP. **The GP** explained that he had seen many TIAs and strokes. He had joined the practice as a partner in 1995. At the time in question it had been a training practice and was now also a teaching practice.

28. The GP said that on 4 January the practice had had almost twice the average number of patients for a January Thursday. They had only reopened the previous day after the New Year holiday. Mr E reported two visual disturbances. On examination, his visual acuity was normal, with no temporal artery tenderness. Although he could not recall doing so, the GP felt he would have looked at the optic fundi. He did not do a full neurological examination, nor did he check for any carotid bruit. Although the GP was not Mr E's usual GP and had only seen him a few times in several years, he said he was clearly a remarkably well man, playing golf through the winter and living independently without help from Social Services. It was also clear that he had a significant medical history.

29. Because of this history, the GP was unclear of the cause of the visual loss. The practice routinely used the eye clinic as an open-access, 'casualty' department as they knew that they could get patients seen there without delay and that the clinic would refer patients on to other specialists if appropriate. Given no clear indication of the cause of Mr E's visual loss, the GP therefore arranged for him to visit the eye clinic that day. He phoned and obtained an immediate appointment then followed it up with a letter outlining Mr E's history and explaining that he did not know the cause of the problem.

30. The GP said that if he had referred Mr E direct to the neurovascular clinic, he would have asked for a routine appointment. If he had suspected TIAs, he would have ensured Mr E was taking aspirin (which he was, as this had previously been prescribed for him). As the neurovascular clinic had a different approach to the eye clinic regarding access, the GP felt that the appointment date of 30 January would have been no earlier had he himself made the referral there. Indeed, in his experience, four to six weeks from referral was a typical waiting time for the neurovascular clinic. The GP acknowledged that the SIGN guideline recommended that patients who had had minor strokes or TIAs and who were not admitted to hospital needed urgent assessment. However, the guidelines suggested such patients be seen within two weeks of recognition of the TIA. In this case, the TIAs had been recognised on 4 January by the eye clinic, which meant the waiting time would have been typical had Mr E not had his stroke and had therefore attended on the 30th.

31. The GP said that on 8 January, a Monday soon after the holiday season, attendance at the practice was about a third higher than normal. He could not recall whether he examined Mr E, whether loss of power in the hand was mentioned, or whether Ms E gave him a list of her father's latest attacks. If he had received such a list, he would expect to have placed it in the medical records. He explained that his concern at that meeting was more the referral than the clinical issues. Mr E still gave the impression of a fit, well, man, albeit with a concern about visual loss. He wanted to know if he could play golf later in the week. The GP thought he probably told Mr E that he could play golf then 'if it had all settled down'. The GP did not consider that hospital referral would have been

appropriate: he did not believe any Edinburgh hospital would have accepted Mr E in this apparent condition and without persistent symptoms. At the time Edinburgh had no acute stroke unit for fast tracking of patients with actual or suspected TIAs or cerebrovascular accidents. As Mr E was unclear about the referral, the GP undertook to find out more and to inform him. The practice contacted the eye clinic, who said they had heard a carotid bruit and had referred him to the neurovascular clinic in accordance with local guidelines. The GP did not believe he would have known at that time that the appointment date was to be 30 January: he would not have expected to know.

32. The GP said that while he accepted that his records (paragraph 7) were minimalist he considered that they gave an adequate overall picture of the relevant issues. Those for 4 January highlighted his observations and his actions, and those for the 8th highlighted the confusion about the referral. Regarding the family's call to Healthcall on the evening of 7 January, the GP said that the practice tried to find out at the time what had happened but Healthcall said they had no record of a contact.

Report by the professional assessors

33. I set out below the assessors' report.

Basis of report

(i) This report is based on the documentation provided by the Ombudsman's office. This included the original complaint documentation, medical records and other correspondence, together with the account of Ms E's oral evidence to the investigating officer. It is also based on the interview of the GP which was conducted by ourselves and the investigating officer.

Background

(ii) At the time in question Mr E was a 74-year-old, overweight but active man, playing golf during winter and driving a car. He had a past medical history of myocardial infarction, raised cholesterol, cerebrovascular accident, carcinoma of the prostate and non-insulin dependent diabetes. His long term medication included aspirin (used for prophylaxis in ischaemic heart disease), simvastatin (to reduce high cholesterol), Innovace (enalapril, an ACE inhibitor used in heart failure

and hypertension), ibuprofen (a NSAID used for muscular and joint pain), Tylex (a preparation containing paracetamol and codeine) and lactulose (a treatment for constipation).

Events of 4 and 8 January and the record keeping

(iii) Thursday 4 January 2001 was the second working day of the year and the surgery was almost twice as busy as usual. It was an open surgery and the GP was not Mr E's usual doctor but he had full access to the patient records. Mr E complained of altered vision with intermittent visual loss on two occasions. On examination the GP found normal visual acuity, no temporal artery tenderness and that the patient was well at the time. The GP cannot remember if he took any further history, eg headaches, weakness of limbs etc, nor if he examined further. There is nothing in the notes to suggest that he examined the optic fundi nor blood pressure. He did not do a full neurological examination. He was unsure as to the cause of the transient visual loss – ie whether it may have had a retinal, diabetic or neurovascular cause – and so referred him to the eye clinic, where the practice routinely sent acute ophthalmological problems and where he knew a further referral would be done if needed. He phoned for an appointment and Mr E was seen there that day.

(iv) On Monday 8 January, Mr E reattended the surgery, this time with his daughter, again complaining of further episodes of transient visual loss. The GP does not remember being given a list of these, and there is nothing in the notes. Nor is there anything regarding any loss of power in the hand. Mr E showed no symptoms and was asking if he could play golf. There is no evidence that he was examined. The GP was keen to find out what had happened at the eye clinic and arranged for his senior receptionist to find out. The eye clinic told her that they had found a carotid bruit and were making a routine referral to the neurovascular clinic. This finding was never confirmed and, as a bruit does not disappear, it must be presumed to be wrong. The GP was not sure but did not believe he knew at that point that the neurovascular clinic appointment was to be 30 January. Mr E attended the following day to find out about the referral.

(v) Regarding the GP's record keeping, his handwritten referral letter to the eye clinic was not photocopied, and there is no record of it in the

medical records. There is also an absence of any note of Healthcall contact on 7 January.

Comments

(vi) The prevention of stroke is largely a question of tackling the various risk factors. Mr E had a past history of stroke and myocardial infarction, which can both be due to arteriosclerosis. This made him more prone to a further stroke but he was on preventative treatment with aspirin and simvastatin. His diabetes, another risk factor for stroke, was being regularly monitored and seems to have been well controlled on diet alone. When he was last seen for a diabetic check in November 2000, his blood pressure was normal.

(vii) The GP's management on 4 January appears to us to have been satisfactory and acceptable: he was unsure of the cause of the visual loss and made an appropriate early referral. Examination and record keeping could have been more thorough, eg checking of blood pressure and noting that findings on examination had been normal. However, none of that would have affected his decision to refer to the user-friendly eye clinic. It is highly unlikely that Mr E would have been accepted into hospital as he was an exceptionally robust man for his age, playing golf in mid winter, and he had no signs of a cerebrovascular event. Edinburgh, at that time, did not have an acute stroke unit where patients could be fast tracked for investigation of cerebrovascular accident or TIA.

(viii) On the 8th the GP's examination could have been more thorough, although again we do not consider that would have had any bearing on events. It is impossible to comment on whether or not the GP was given a note of the times of the further loss of vision as there is a difference of recollection and no decisive evidence either way. We think the GP was correct in trying to find out Mr E's referral pathway. It is unlikely that he knew what date the appointment would be. The question is, should Mr E's appointment have been expedited? He was still having transient loss of vision - ***but*** *he was asymptomatic and was asking about golf. It is highly unlikely that hospital physicians would have admitted him with no symptoms and absolutely no positive clinical signs. Also, if a more urgent appointment had been requested, it seems extremely unlikely that this could have been arranged for a date before*

11 January, when Mr E had his major stroke. Therefore the clinical outcome would have been the same. The SIGN guidelines for cerebrovascular accident do recommend expert assessment within two weeks but such a service does not appear to have been available in Edinburgh. In any case, the SIGN guidelines describe a 'platinum' service, which it would not be reasonable to expect all GPs to be able to provide on every occasion.

(ix) We do have some difficulties with the GP's record keeping. For example, it is impossible to comment on Ms E's list. The GP states it is his usual practice to put this sort of note in the folder, and in this case there were strong reasons for so doing. Yet there is no record of such a list as having been provided. The GP feels that, if he had carried out certain examinations, he would have noted them and that the absence of a record of particular examinations indicated, not that the records were poor, but that he had not carried out those examinations. The GP accepts that the notes for the 4th and 8th were minimalist. However, he feels that what was written on the 4th was an adequate record of what he saw and what he did and that what was written on the 8th reflected what was happening, ie that Mr E was unclear about the referral. In our opinion, there is considerable importance in recording negative, as well as positive, findings. Given also that the practice was a training practice at the time and should have been setting an example, we would have expected fuller records.

(x) We note that no copy of the referral letter was put into the notes. Although it would be usual to do this, it is frequently not done in many practices and so we would be prepared to accept this as reasonable. The fact that Healthcall could not trace any contact with the family on 7 January is not the responsibility of the practice. Indeed, we would not expect a GP practice to chase up Healthcall.

Findings

34. I consider first the complaint about the GP's care and treatment of Mr E between 4 and 11 January. Mr E was overweight and had a significant medical history, particularly ischaemic heart disease, stroke and diabetes. It is clear from the medical records that his GPs were already managing the important risk factors for stroke: he was on aspirin

and a statin, his blood pressure was normal and the diabetes was well controlled.

35. On 4 January Mr E presented with no symptoms but with reports of visual disturbance. The GP had a choice of referring him for an assessment of the visual problem or for a neurological opinion. He decided to refer Mr E to the eye clinic, which he knew would see him immediately – unlike the neurovascular clinic - and would refer him on if necessary.

36. The Ombudsman's professional assessors consider that the GP's clinical judgments were reasonable. He considered the implications of referring Mr E to the eye clinic or to the neurovascular clinic. He considered the fact that Mr E had no symptoms on the 4th or the 8th when seen by him. He also considered the question of whether a hospital would be likely to admit Mr E. The assessors believe that the examination on both dates could have been more thorough but they are satisfied that that would not have altered the subsequent events. I also note that the GP took it upon himself to find out about the eye clinic's referral, although it would not be routine for a practice to track a hospital referral – and certainly not a tertiary referral, as in this case, and also took steps to pass that information on to Mr E. I do not uphold the complaint that the GP's care and treatment of Mr E between 4 and 11 January 2001 was inadequate.

37. I turn now to the complaint that the GP's medical records were incomplete. I note that the two days on which the GP saw Mr E were unusually busy. Given that, it would not be surprising if, as the GP has said, he kept 'minimalist' records. Nevertheless, in accordance with the GMC guidance (paragraph 6) those records should have been clear, reported the relevant clinical findings and decisions made and any information given to the patient. The GP has said that the records for 4 January record his observations and actions and that those for the 8th reflect the main focus of his mind then, which was the referral. The Ombudsman's assessors accept that it was reasonable for there to be no copy of the referral letter in the notes. However, they say they would have expected the records to be fuller and comment in particular that in their view there is considerable importance in recording negative as well as positive findings (paragraph 33(ix)). I note also that despite the GMC

guidance that records must report information given to patients there is no record at all of Mr E's visit on 9 January for information about his referral. To that extent, I uphold the complaint that the medical records were incomplete although, in the light of the advice I have received, I am satisfied that had no adverse impact on Mr E's treatment. Nevertheless, I **recommend** that the GP reviews his record keeping practice in the light of the Ombudsman's assessors' comments.

Conclusions

38. I have set out my findings in paragraphs 34 to 37. The GP has asked me to convey to Mr E and his family – as I do through my report – his apologies for the shortcomings I have identified and has agreed to implement my recommendation in paragraph 37.

Eric Drake
Deputy Ombudsman
duly authorised in accordance with
paragraph 11 of schedule 1 to the
Scottish Public Services Ombudsman Act 2002

December 2002