Clinical Advice Form

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Provision of Clinical Advice for Public Services Ombudsman for Wales
Background Information
Case Identifier (Case Reference): 20210XXXX
Clinical Adviser's Name and Qualifications: Dr X MB ChB FRCGP FRCP
Relevance of qualifications and/or experience to clinical aspects of this case: [Relevant qualifications provided]
Conflict of Interest (clarification of any links with Body or clinicians complained about): Nil
Confirmation that the Ombudsman's Clinical Standards [insert link] have been applied in the provision of the advice I confirm that the Ombudsman's Clinical Standards have been applied in the provision of the advice.
Please confirm the chronology provided by the Caseworker in requesting this advice is correct and correctly identifies the relevant clinical events I confirm the chronology referred to by the Investigation Officer in requesting this advice is correct and correctly identifies the relevant clinical events.

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Documentation Reviewed:

Ms C's clinical record until the time of her death in February 2020, with details of consultations, medications prescribed and blood tests.

Copies of correspondence relevant to this case from specialists involved in her case to her GP Practice

A letter of complaint to the PSOW from the CHC on behalf of Ms C's brother, dated 27 May 2021.

Two letters from the Investigation Officer to the Practice Manager at the Practice dated July 2021.

A letter of reply from the Practice to the Investigation Officer dated 22 July 2021.

A letter of reply from the Practice to the Complainant dated 16 March 2021.

Statements from the GPs involved in Ms C's care.

A copy of the Significant Event Analysis meeting held by the Practice on 16 March 2020 to discuss the care Ms C received from the Practice.

Questions and Responses:

1. **Was it reasonable to have treated Ms C for a chest infection in December/January?**

In summary, in my clinical experience, it was reasonable to have treated Ms C for a chest infection in the period from December 2019 to January 2020.

On 27 December 2019 Ms C consulted Dr M, a GP at the Practice. The GP recorded that Ms C had a chesty cough for one week, was feeling unwell and had pains across her lower chest due to excess coughing. The GPs clinical examination was appropriate for the presenting symptoms. The vital signs were normal but Dr M heard crackles in the lower part of the left lung. Most GPs in this clinical situation would have concluded that Ms C had a chest infection and would have treated her with antibiotics i.e., the same diagnosis and management plan reached by Dr M. Ms C had consulted GPs with a similar clinical scenario several times previously, most recently on 12 April 2019 when her symptoms resolved with a course of the same antibiotic. Furthermore, Ms C did not consult again after 27 December 2019 until 29 January 2020, over a month later, implying that her symptoms had improved with the course of antibiotics. None of Ms C's symptoms or clinical examination

findings on 27 December 2019 would have alerted a GP working within the range of appropriate clinical practice that Ms C's cancer was the cause of her symptoms or had progressed in any way.

2. **Should the Practice have considered that Ms C's symptoms in December-February were due to a recurrence of her cancer?**

Ms C had three consultations with a GP at the Practice in the period between 1 December 2019 and her death in February 2020. In summary, in my clinical experience, a GP working within the range of appropriate clinical practice would have considered that Ms C's symptoms on 29 January 2020 may have been due to a recurrence or progression of her cancer.

The first consultation Ms C had with a GP in the period between 1 December 2019 and her death in February 2020 was on 27 December 2019 with Dr M. I have explained in my answer to Question 1 that a GP working within the range of appropriate clinical practice on this date would have concluded that Ms C had a chest infection and would not have thought that her symptoms may have been due to a recurrence of her cancer.

The second consultation in this period was on 29 January 2020 with the same GP, Dr M. Ms C had been vomiting and suffering from watery diarrhoea for one week. She had been vomiting several times a day, was experiencing abdominal cramps and felt her abdomen was bloated. Dr M's examination of Ms C's abdomen was unremarkable. Dr M concluded that Ms C was suffering from a viral gastroenteritis and prescribed medications to help her symptoms. These were Dioralyte to replace the electrolytes lost with the vomiting, loperamide for the diarrhoea and Buscopan for the abdominal cramps. If a GP prescribes three medications for acute gastroenteritis it implies that the GP considers it to be severe. There is no mention in the medical record, or in Dr M's statement made after Ms C's death, or in the description of the event in the Significant Event discussion at the Practice on 16 March 2020 that Dr M gave Ms C any safety netting advice at this consultation i.e. did not advise her when her symptoms should start to improve, what symptoms to look out for which would indicate that her condition was worsening or the diagnosis was incorrect, or what to do in these circumstances.

From my clinical experience, this consultation was outside of the range of appropriate clinical practice for several reasons. A GP working within the range of appropriate clinical practice would have been concerned there may have been another cause for Ms C's symptoms other than viral gastroenteritis. Her symptoms were severe and had been present for 7 days without any improvement. Seven days is a reasonably long time for a viral gastroenteritis although not implausible. Two and a half years previously Ms C had undergone extensive abdominal surgery and chemotherapy for an advanced stomach cancer which had a high risk of recurrence. The GP should

have considered that her abdominal symptoms of seven days duration may have been related to this, rather than a viral gastroenteritis. Some GPs would have asked Ms C to provide a stool sample for culture for viruses and bacteria. A GP working within the range of appropriate clinical practice would have given Ms C appropriate safety netting advice. This would have been to have a further consultation if her symptoms had not significantly improved within a specified time, such as 3 days, and sooner if her symptoms worsened or she developed new symptoms. It is also worthy of note that, according to her medical notes, Ms C also had other longstanding problems. She was described as having borderline low IQ, was registered partially sighted and was taking the anti-psychotic drug risperidone for Charles Bonnet syndrome. In Charles Bonnet syndrome, people with impaired vision have visual hallucinations, seeing things that aren't there. Because of these other longstanding medical conditions, a GP working within the range of appropriate clinical practice would have safety netted even more rigorously or would have shared the safety netting advice with one of Ms C's close family members.

The third and final consultation in the period under consideration was on 10 February 2020 with Dr A who was a GP Registrar. This was 5 days after Ms C had seen her stomach cancer surgeon who had assessed her and had requested an urgent CT scan of her abdomen. Therefore, when Dr A saw Ms C there was already a very strong suspicion that her symptoms were related to her stomach cancer. Dr A assessed Ms C's symptoms, carried out an appropriate clinical examination and discussed the findings with the GP Partner who was his clinical supervisor that day. Dr A's clinical management on 10 February 2020 was appropriate and I will discuss this further in my answer to questions 3 and 4.

3. **If so, should her treatment have been different?**

In my clinical experience, the treatment given to Ms C at each of the 3 consultations between 27 December 2019 and 10 February 2020 was within the range of appropriate clinical practice. What was not within this range, however, was a lack of consideration of other possible diagnoses and lack of appropriate safety netting during the consultation of 29 January 2020, as I have explained in my answer to question 2.

4. **In particular, should the Practice have referred Ms C to gastroenterology/arranged for her admission to hospital at any time?**

In summary, if the consultation of 29 January 2020 had been within the range of appropriate clinical practice, it is possible that Ms C would have been referred to gastroenterology or admitted to hospital by a GP before 13 February 2020, the date that Ms C died. Sadly however, it is unlikely that this would have prevented Ms C dying or would have significantly prolonged her life.

Without the benefit of hindsight, there was no indication prior to 29 January 2020 that Ms C should have been referred to gastroenterology or admitted to hospital. On 29 January 2020, if the GP had considered possible diagnoses other than viral gastroenteritis and given appropriate safety netting advice to Ms C and/or a family member, it is possible that Ms C would have returned for a further consultation within a short period of time. Ms C was instead reviewed by her Consultant Surgeon 7 days later on 5 February 2020 following a phone call from Ms C's niece. This indicates that the family thought Ms C's problem may have been related to her stomach cancer rather than viral gastroenteritis. At this consultation, Ms C had obvious ascites (an abnormal accumulation of fluid in spaces within the abdomen) which made it extremely likely that she had a recurrence of her cancer. On 29 January 2020 it was not obvious to the GP that Ms C had ascites, although she was very likely to have had some ascites at that time. If Ms C had been seen at the Surgery sometime between 29 January 2020 and 5 February 2020 it would have been very likely that the GP would have detected ascites, indicating that the diagnosis of viral gastroenteritis was incorrect and instead indicating the clinical findings were most likely related to Ms C's stomach cancer.

If a GP had detected ascites at any time between 29 January 2020 and 5 February 2020, there would have been various management options. The GP may have referred Ms C urgently to gastroenterology or may have requested urgent imaging of Ms C's abdomen, such as a CT scan, as well as requesting blood tests. A third possibility would have been to admit Ms C to hospital, although it is of note that the Consultant Surgeon on 5 February 2020 did not think admission at that time was appropriate. Which management option a GP would choose if they had detected ascites would depend on the local availability and waiting times for the different options.

On 5 February 2020 the Consultant Surgeon did not think that Ms C required admission that day but wrote in his letter to the GP Practice 'if her symptoms deteriorate she may need hospital admission'. On 10 February 2020, Dr A carried out an appropriate clinical assessment and concluded that Ms C's clinical condition had not deteriorated since the consultation with the Consultant Surgeon. This decision was within the range of appropriate clinical practice. Dr A's decision to request blood tests and provide safety netting advice was appropriate.

Ms C died three days after the consultation with Dr A. I am a generalist GP, not a cancer specialist, but it is my opinion that if a GP had referred Ms C to a gastroenterologist or arranged her admission to hospital sometime between 29 January and 5 February 2020 it is unlikely that Ms C would have lived significantly longer.

5. **Generally, was the care given by the Practice during this period reasonable?**

In general, the care given by the Practice during this period was reasonable, other than the aspects of the consultation of 29 January 2020 which I have discussed above. I note that the complainant asserts that it was very difficult to book appointments at the Practice but I am unable to give a view on this because of a lack of objective information.

6. **Please let me know if, in considering my questions, you identify any other relevant clinical matter that gives you cause for concern.**

I have not identified any other relevant clinical matter in this case that has given me cause for concern. I also note that Ms C died on 13 February 2020 which was 15 days before the first case of Covid-19 was recognised in Wales and over a month before the first Covid lockdown in Wales. Therefore, changes in the provision of healthcare as a result of the Covid pandemic was irrelevant in this case.

Recommendations:

Conclusions:

1. Ms C, who was born in 1958, had stomach cancer which was treated with extensive surgery in October 2017 followed by chemotherapy. There was a significant risk of recurrence of the cancer.

2. Ms C was also registered as partially sighted and was treated with the anti-psychotic drug risperidone because she had Charles Bonnet syndrome, with visual hallucinations as a result of her poor sight.

3. On 27 December 2019 Ms C consulted Dr M, a GP at her Practice, who concluded she had a chest infection and treated it appropriately. This consultation was within the range of appropriate clinical practice.

4. Ms C's next consultation at the Practice was also with Dr M on 29 January 2020 because she had symptoms for 7 days consisting of vomiting, diarrhoea, abdominal bloating and cramps. Dr M made a diagnosis of viral gastroenteritis and prescribed three different medicines to treat Ms C's symptoms.

5. This consultation was not within the range of appropriate clinical practice because Dr M did not give adequate consideration that the symptoms may have been due to an alternative diagnosis, including being related to Ms C's previous cancer, and did not provide Ms C or a family member with appropriate safety netting advice.

6. Ms C had a consultation with her Consultant Surgeon on 5 February 2020. At this consultation, Ms C had obvious ascites (an abnormal accumulation of fluid in spaces within the abdomen), so it was extremely likely her cancer had recurred. The Consultant requested an urgent CT scan of Ms C's abdomen.

7. Ms C consulted Dr A, a GP Registrar at the Practice, on 10 February 2020 because of persistence of her symptoms. Dr A's assessment and management plan was within the range of appropriate clinical practice.

8. Ms C sadly died on 13 February 2020 as a consequence of her stomach cancer.

Name & Signature: Dr X

Date: 22 October 2021