CASE NOTE 00HDC06972: No routine screening suggested to prevent sudden cardiac death of woman with diabetes

Right to services of an appropriate standard – Reasonable care and skill – General practitioner – Death – Missed diagnosis – Cardiology – Ischaemic heart disease – Hypertension – Diabetes – Gastrointestinal – Investigations – Screening – ECG – Complementary therapies – Herbal remedies – Right 4(1)

A complaint was made by a man about the services provided to his late mother by two general practitioners. The patient, who died suddenly aged 57, had a history of high cholesterol and diabetes, was overweight and had high blood pressure. Her diabetes, which required management by the GP and the diabetes clinic, was poorly controlled. A few months prior to her death, the patient consulted the GP with symptoms of shortness of breath, tightness in her chest and indigestion-type pains. The GP suggested she take herbal digestive tablets. The GP did not perform an ECG or prescribe any other investigations to rule out blockage of her coronary arteries. A post-mortem examination showed ischaemic heart disease associated with atherosclerotic coronary disease. The patient's son complained that if the GP had referred the patient for cardiac investigation, the blockage of her coronary arteries might have been detected sooner and appropriate treatment initiated.

The Commissioner held that the GP did not breach Right 4(1) of the Code in not undertaking an ECG or referring the patient for cardiac investigations. The Commissioner reasoned, after receiving independent expert advice from a general practitioner, that although the patient had several risk factors for cardiovascular disease, there had been no symptoms suggestive of ischaemic heart disease at any previous consultations with the GP or his locums, nor was this possibility raised in any of the correspondence received following hospital admission and hospital clinic attendances. The GP kept thorough and extensive medical records, and there was no record of symptoms suggesting ischaemic heart disease, so there was no reason for the GP to arrange further cardiological investigations, including an ECG.

The Commissioner's advisor commented that while an exercise ECG may have been useful, it would be recommended only for patients with specific cardiac symptoms. Non-invasive screening methods, such as exercise testing, lack sufficient sensitivity and specificity for routine use in patients with diabetes, while invasive methods, such as coronary angiography, are too risky for screening.

Even if coronary artery disease had been detected, there is insufficient evidence to show that invasive (surgical) action is helpful in diabetic patients, unless there are already symptoms of ischaemic heart disease, thus it was not necessary for the GP to have ordered other cardiac investigations in the time that he was the patient's general practitioner.

The Commissioner also held that the locum GP did not breach Right 4(1) because, although he recognised that the patient was at risk of developing cardiac disease, her chest symptoms were not primarily the reason for her consultation, and so he did not consider that she warranted urgent referral.