Scottish Parliament Region: Glasgow

Case 200501333: A Medical Practice, Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category
Health: GP; cancer

Overview
The complainant (Mrs C) complained that the GP Practice (the Practice)'s late diagnosis of her mother (Mrs A)'s colon cancer could have been avoided by their greater consideration of her symptoms. Mrs A died in hospital in June 2003, about a month after diagnosis, aged 76.

Specific complaints and conclusions
The complaint which has been investigated is that the Practice should have investigated more fully than they did (*upheld*).

Redress and recommendations
The Ombudsman recommends that the GPs in question:
(i) apologise in writing to Mrs C, acknowledging that further investigation should have been done in mid 2002; and
(ii) inform the Ombudsman what steps they have taken and/or are taking to learn from, and try to avoid a recurrence of, this serious case, for example, by discussing it at their general practitioner appraisals and discussing other relevant cases with the clinical governance lead of the appropriate Community Health Partnership.

The Ombudsman is pleased that the Practice have accepted the recommendations and are taking action on them.

Main Investigation Report

Introduction

1. Mrs C's complaint was received by the Ombudsman on 7 October 2005. Her mother (Mrs A)'s GP Practice (the Practice) had been seeing her for a number of years for a variety of symptoms. In March 2003 the Practice arranged urgent hospital investigation of a possible mass in her abdomen, and in April 2003 the hospital discovered terminal colon cancer. After a brief period out of hospital in May 2003, Mrs A was re-admitted as an emergency on 1 June, and, sadly, she died in the hospital on 9 June 2003, aged 76.

2. The complaint from Mrs C which I have investigated is that the Practice should have investigated more fully than they did.

Investigation

3. I was assisted in the investigation by two clinical advisers, who are GPs and are referred to here as the Advisers. Their role was to explain, and comment on, some of the medical aspects of the complaint. We examined the papers provided by Mrs C and complaint correspondence, GP clinical records and other information provided by the Practice. We also examined the Scottish Executive[1] guidelines which were produced in April 2002 – *Scottish Referral Guidelines for Suspected Cancer*. I refer to these as the Guidelines and I refer to the GPs collectively as the GPs or the Practice. In line with the practice of the Ombudsman's office, the standard by which the events were judged was whether they were reasonable. By that, I mean whether the decisions and actions taken were within the boundaries of what would be considered to be acceptable practice in terms of knowledge and practice at the time in question. In other words, we do not apply a standard of perfection, nor do we judge events with the benefit of hindsight.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Practice were given an opportunity to comment on a draft of this report. A reminder of the abbreviations is at Annex 1. Annex 2 summarises part of Mrs A's GP clinical records.

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[1] On 3 September 2007 Scottish Ministers formally adopted the title Scottish Government to replace the term Scottish Executive

Complaint: The Practice should have investigated more fully than they did

5. Annex 2 summarises part of the GP clinical records. Essentially, Mrs C's concerns were that her mother presented to the Practice over a long period of time with many signs that should have prompted investigation. She believed that such investigation could have diagnosed Mrs A's colon cancer earlier. She was particularly concerned by her mother's iron deficiency anaemia, explaining in her complaint to the Ombudsman's office that this indicated internal bleeding and, particularly in older people, required urgent investigation. She considered that the very low haemoglobin level of 6.9 (Mrs A's lowest known level, on 8 July 2002 – see Annex 2) in itself should have prompted serious attempts to identify the cause of the anaemia. Mrs C also felt the combination of her mother's symptoms should have prompted investigation into the cause. For example, her mother was elderly and, at various times, presented to the Practice with anaemia, mild bowel problems, nausea, vomiting, abdominal pain, weight loss, anorexia (a lack or loss of appetite for food) and indigestion. Mrs C considered that the Practice did not consider the whole picture of her mother's condition, simply treating separately each different symptom. Mrs C also considered that the Practice did not follow the Guidelines.

6. At paragraphs 6 to 14, I set out the views of the Practice, summarising comments they made either to me or, previously, as part of the NHS complaints process. The Practice considered that they did view Mrs A's symptoms as part of an overall picture, in the light of her general health and remarks each time. They said that dyspepsia (indigestion) was commonly associated with ibuprofen (a pain reliever, which Mrs A was taking for her knee pain) and that, indeed, Mrs A's symptoms of dyspepsia in April 2002 (see Annex 2) did initially resolve when her ibuprofen was stopped: that suggested that it had been the cause of those symptoms. The clinical records for 24 May 2002 (see Annex 2) say that blood tests were to be arranged. The Practice told me that, at that home visit, the GPs advised Mrs A to attend the surgery for the blood tests but that Mrs A did not do so. In relation to 8 and 9 July 2002 (see Annex 2, which indicates that there was at that time a picture of iron deficiency), the Practice acknowledged to me that the 6.9 haemoglobin blood test result was a key clinical event. They said that, for that reason, the GPs asked the hospital registrar who was on call at the time for advice about immediate hospital admission and further investigation but were advised simply to treat the low haemoglobin with iron and to check the vitamin B12 and folate levels, because

Mrs A was generally feeling quite well and was not showing other symptoms (see Annex 2: 8 and 9 July 2002).

7. The Practice also said that they did review the common causes of anaemia to try to establish what was happening in Mrs A's case, for example, in August 2002 (see Annex 2). In relation to the consultation of 20 August, the Practice told me that, on return from holiday, the GPs again considered the cause of the low haemoglobin, exploring the possibility of upper or lower bowel blood loss. The question about anaemia (see Annex 2 – 'Why is she anaemic?') was written in the clinical records precisely because the GPs were considering the possible and likely causes for the unexplained iron deficiency anaemia and because they recognised this as a significant clinical event. Upper alimentary bleeding and colon cancer were the GPs' greatest concerns. The note about appetite and bowels (see Annex 2: 20 August 2002) was written because the GPs thoroughly enquired about these areas as they were the most likely source of Mrs A's blood loss. The Practice said that at that time, the only significant symptom was some dyspepsia, and they told me that this had only been revealed because they closely questioned Mrs A. The GPs noted that Mrs A had been prescribed ibuprofen for several months at a higher dose than normal because of the severity of her knee pain. As she had been noted to be pale and unwell in May 2002, the GPs felt, on balance, the blood loss was most likely to be caused by this high ibuprofen use. Indeed, Mrs A's well-being and her good response to a few weeks of iron supplement reassured the GPs that there was unlikely to be a sinister underlying cause. The Practice added that, at this time, Mrs A felt completely well.

8. The Practice felt Mrs A could well have been prompted by the knee pain to continue to use the ibuprofen from time to time beyond March 2002, when she had her last prescription of it. However, I have not taken account of this speculation because, in her complaint to the Ombudsman's office, Mrs C said that her mother had only been taking the ibuprofen occasionally and that she stopped it completely no later than March 2002. The facts cannot be established, and all one can say for sure is that the clinical records say that Mrs A was advised on 3 April 2002 to stop the ibuprofen (see Annex 2).

9. The Practice also commented to me that they would not have expected such a quick improvement after just a few weeks of taking an iron supplement if Mrs A had had colon cancer at the time.

10. I told the Practice the Advisers' initial thoughts that a referral for upper and lower bowel endoscopy (a procedure using an instrument to see inside the body) would have been appropriate at around July/August 2002. They replied that the 6.9 haemoglobin result in July 2002 had prompted them to consider this at that time but that they were influenced by the hospital (see paragraph 6) not to do this. They felt they were probably also influenced by Mrs A's apparent well-being on 20 August 2002.

11. I expressed an initial surprise to the Practice about the clinical record for 17 February 2003 (see Annex 2). That is, that, despite the combination of recurrent, significant, anaemia, weight loss and general unwellness, Mrs A's condition on this date could be seen by the Practice as being caused by the aftermath of the 24-hour diarrhoea and vomiting in mid January. The Practice replied to me that the history on 17 February was not this obvious: Mrs A had been well from August to November 2002. Nausea in December 2002 was thought to be linked to the iron supplements, and the GPs did not consider her at that time to be significantly unwell – thus, the plan to check her again in January 2003 (see Annex 2). On 14 January 2003, Mrs A reported diarrhoea and vomiting which had only been present for a day and so was given routine advice to avoid solid food and milk for two days and to contact the Practice if there was no improvement in a few days. It was only on 17 February 2003 that Mrs A presented with significant weight loss, a feeling of unwellness for four weeks and anorexia (a lack or loss of appetite for food). The GPs were concerned on that date that there might be some sinister underlying problem, but they wished to be as reassuring as possible to Mrs A.

12. Turning to the Guidelines, the Practice also said that they had been aware of the Guidelines, which were produced in April 2002, and that they specifically considered Mrs A's condition against the Guidelines in August 2002. In hindsight, the Practice said they felt investigations might have been done earlier if Mrs A's condition had not varied so much: until March 2003, there was a pattern of presentation with one symptom, then improvement, followed by presentation with another symptom, then improvement. The Practice commented to me that the main complex of significant symptoms presented themselves between December 2002 and March 2003. Of these, they took no investigative action because it would have been unusual to have investigated the nausea and diarrhoea (December 2002) or one episode of diarrhoea and vomiting (January 2003). The Practice considered that the first really worrying

signs were in February 2003, with weight loss, general unwellness and anorexia without abdominal pain.

13. The Practice told me that they knew Mrs A well and would often speak with her at chance encounters in the street. (I note that Mrs C considers this to have been highly unlikely but I make no further comment as the facts cannot be established.) The Practice said they felt Mrs A was often seeking reassurance, rather than investigation, and told me that this possibly helped to influence them away from further investigation at times. The Practice told me they thought there was a possibility that Mrs A had developed a malignancy by Spring 2002 (although not as early as 2000, as Mrs C had suspected) because of the low haemoglobin level that was found in July 2002. However, on requesting hospital admission for further investigation, they said they had been reassured by the hospital advice (see paragraph 6) simply to give an iron supplement and to check vitamin B12 and folate levels. The Practice acknowledged to me that, in hindsight, they were overly influenced away from their own concerns by that hospital advice, although they felt they had also been influenced by Mrs A's well-being on 20 August 2002.

14. The Practice added to me that, to suggest that Mrs A had signs that indicated colon cancer before February 2003, was to view her history with the benefit of hindsight, rather than to view it in the way that it presented to the Practice at the time.

Conclusion

15. As explained at paragraph 3, I discussed this case with the Advisers. I include in this conclusion their main comments.

16. The haemoglobin level of 6.9 (see Annex 2: 8 and 9 July 2002) represented a very significant anaemia, which is often related to blood loss. This was a pivotal moment in Mrs A's condition. It is impossible to say whether investigation at that stage would have influenced the sad outcome for her. However, the Advisers say that this is a cancer type which has reasonable prospects of a good response to surgery if early diagnosis is made. As the disease advances, the prospects reduce significantly. It is, therefore, possible that investigation and early diagnosis in this case might have led to a different outcome. Whatever the case, this haemoglobin result is where the shortcoming arose. The clinical records (see Annex 2: 8 and 9 July 2002) give a brief description of the Practice's discussion of the 6.9 result with a hospital registrar.

Considering the severity of the 6.9 level, such brevity is surprising. We do not consider that the Practice's conversation with the registrar should have influenced further investigation or referral to the degree that it did, nor that the Practice should have been influenced to such a degree by Mrs A's apparent well-being (see paragraph 6). Indeed, it seems unlikely to the Advisers that a medical registrar would advise that anaemia of this level did not require fuller investigation to consider the possibility of gastrointestinal malignancy or disease. It is possible that the registrar advised against an immediate (ie that day) admission and that the Practice mistakenly interpreted this as an overall reassurance. In the absence of evidence, I cannot establish the facts about the registrar's advice.

17. It was not reasonable for the Practice to absolve themselves of the responsibility to investigate appropriately by simply saying that Mrs A was feeling quite well and had no other symptoms and that the registrar had advised vitamin testing and iron. In a sense, the Guidelines are not the crucial point here: it is, rather, that the Advisers simply cannot envisage a case where it would not be appropriate to refer a patient with significant anaemia for investigation (unless the patient was not fit to undergo such investigation).

18. At the 20 August 2002 consultation, the GPs did ask themselves why Mrs A was anaemic (see Annex 2). However, a haemoglobin of 6.9 required actual investigative tests and/or referral as well as the detailed history taking. Vitamin checking is helpful in the face of anaemia. However, anaemia which is due to lack of iron or bleeding (internally or externally) is characterised by a so-called microcytic hypochromic picture. This is the picture shown by Mrs A's blood film at this time. It is different to a picture of anaemia which is due to vitamin deficiency. So, simply from the evidence of the blood film, one could tell that Mrs A was likely to have an anaemia which was due either to insufficient iron being absorbed by the body or iron being lost by bleeding. The Advisers are clear that this is the kind of thought process that was lacking but that the GPs should have been going through on asking themselves why Mrs A was anaemic.

19. Still looking at the August 2002 clinical records, the Advisers are concerned that the GPs seemed to feel (see paragraph 7) that asking about appetite and bowels could reassure one about the possibility of underlying cancer that exists with the type of anaemia indicated in Mrs A's blood film. The Advisers are also concerned that the GPs considered (see paragraphs 7 and 9)

that a rapid response to an iron supplement suggests that there is no sinister underlying factor. The Advisers explain this by saying that, if a patient has lost blood very slowly over a long period of time, they can become anaemic. Giving iron can rapidly improve the blood count, resulting in a feeling of well-being, although the underlying condition is still present. The patient can, indeed, feel well (as did Mrs A at this time) for a while, until the anaemia recurs or some other factor of any cancer which is present asserts its presence by new symptoms (as in this case).

20. As advised by the registrar, the vitamin testing was done, with a fairly normal result. It is surprising that this did not prompt any further consideration of the cause of the anaemia. It is not appropriate to explain the anaemia (see paragraph 7) as being related to ibuprofen which had stopped being prescribed several months before.

21. The subsequent consultations compound this initial failure to investigate when the 6.9 haemoglobin level was discovered in July 2002. For example, after improving over the months to a level of 11.7 in September and October 2002, Mrs A's haemoglobin worsened to 10.6 in January 2003, but no investigations appear to have been considered then.

22. The Practice said (see paragraphs 12 and 14) that, for various reasons, Mrs A's first really worrying signs did not present until February 2003 and that to view matters otherwise was to use hindsight. It is not the practice of the Ombudsman's office to do so (see paragraph 3), and we do not accept that it was used in this case. The Advisers are particularly concerned from this that, even at a late stage in the investigation, the Practice did not appear to have accepted that the haemoglobin level of 6.9 in July 2002 should have prompted serious investigation. We are pleased that the Practice have now acknowledged that they should have investigated further at that time.

23. To summarise, I should say that the Advisers and I carefully considered the Practice's reasoning and explanations carefully. In line with the practice of this office, the standard by which the Practice's actions were judged was whether they were reasonable, in the circumstances, at the time in question. It is clear to us that at around July 2002, Mrs A's haemoglobin level of 6.9 should have been investigated further. The Advisers do not consider that the Practice acted within the boundaries of what would have been considered to have been reasonable practice, in the circumstances, at the time in question. I accept the

Advisers' advice, including their opinion (see paragraph 16) that, although no one can know, it is possible that earlier investigation and diagnosis could have produced a different outcome for Mrs A. In all the circumstances, I conclude that the Practice should have investigated more fully than they did and, therefore, I uphold the complaint.

Recommendation

24. The Ombudsman recommends that the Practice:

(i) apologise in writing to Mrs C, acknowledging that further investigation should have been done in mid 2002; and

(ii) inform the Ombudsman what steps they have taken and/or are taking to learn from, and try to avoid a recurrence of, this serious case, for example, by discussing it at their general practitioner appraisals and discussing other relevant cases with the clinical governance lead of the appropriate Community Health Partnership.

19 September 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mrs A	The complainant's mother
The Practice	Mrs A's GP Practice
The Advisers	Clinical advisers to the Ombudsman
The Guidelines	Scottish Referral Guidelines for Suspected Cancer
GP/s	General practitioner/s

Annex 2

Summary of part of Mrs A's GP clinical records

- Aug 2001 – painful knee. Try … .
- Sep 2001 – no benefit for knee from … Prescribed ibuprofen.
- Oct 2001 – knee much improved. Repeat ibuprofen.
- 3 Apr 2002 – nauseated & heartburn. Related to ibuprofen? Stop in the meantime; prescribe … for knee pain.
- 24 Apr 2002 – a particular form was completed for an allowance. Reporting breathlessness. Lungs clear. Advised to slow down.
- 24 May 2002 – lower back pain for 2 mornings, improves during the day. Looks pale. Arrange blood tests.
- 5 Jul 2002 – feeling unwell in the mornings, nausea, no other symptoms. Arrange blood tests as suggested last time.
- 8 & 9 Jul 2002 – blood tests, haemoglobin 6.9. Picture of iron deficiency. Discussed with medical registrar. To start iron and have B12/folate checked.
- 19 & 23 Jul 2002 – blood tests, haemoglobin up to 8.7 [in other words, better than 6.9]. Continue iron. GP going on holiday, therefore check haemoglobin again 3 weeks.
- 13 Aug 2002 – blood tests, haemoglobin up to 10.6. Weight 63kg.
- 20 Aug 2002 – much improved on iron. Why is she anaemic? Appetite and bowels fine. Dyspepsia [indigestion, such as heartburn]. Have prescribed omeprazole [medication for indigestion].
- 10 Sep & 8 Oct 2002 - haemoglobin 11.7 on both dates. [A note for a consultation on 22 Oct 2002 says that two months of iron are to be given, with blood tests in Jan 2003.]

- 16 Dec 2002 – nausea and diarrhoea, epigastric pain. Stop the iron and restart omeprazole. Blood tests, Jan 2003.

- 14 Jan 2003 – diarrhoea and vomiting for 24 hours.

- 30 Jan 2003 – haemoglobin down to 10.6, iron down. Stopped the iron 6 weeks ago. Discuss with [other GP] restarting the iron. Not taking the omeprazole. [The hospital record of the blood test results says, 'suggest continue to monitor'.]

- 17 Feb 2003 – not feeling great. Weight loss about ½ stone, off food. No pain. Reason: debility after gastroenteritis 14 Jan? Continue the iron, blood tests in 3 weeks.

- 11 Mar 2003 – still not feeling well, abdominal pain after eating. Weight 57kg. Suggested stop the iron, review in 1 week.

- 18 Mar 2003 – feels great off the iron, eating good diet now. To see in 2 months, sooner if needed. Blood test results from 11 March show haemoglobin down to 10.5. [The hospital record of the blood test results says, 'suggest continue to monitor'.]

- 25 Mar 2003 – unwell, nausea, general abdominal discomfort. Bit of weight loss. On examination, possibly a caecal mass? – refer to surgical out-patients department.

- 4 Apr 2003 – above appointment arranged for 24 Apr. Still unwell, nauseated, constipated at times. Blood tests. [The hospital record of those tests says haemoglobin down to 9.5 [in other words, a significant worsening from the previous months] and adds, 'suggest continue to monitor'.]

- 14 Apr 2003 – not well, constipation. On examination, there was a mass, with rectal bleeding. In-patient hospital admission arranged. [end]