Scottish Parliament Regions: Central Scotland and Glasgow

Cases 200501777 & 200600202: Lanarkshire NHS Board and Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospitals; Oncology

Overview

The complainant, Mr C, raised a number of concerns about the care and treatment provided to his mother, Mrs A at Monklands Hospital (the Hospital) and the Beatson Oncology Centre (the Centre). The Hospital is managed by Lanarkshire NHS Board (Board 1). The Centre is managed by Greater Glasgow and Clyde NHS Board (Board 2).

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was an unacceptable delay in the Hospital making a correct diagnosis (*upheld*);
(b) the Hospital's decision to operate on Mrs A was incorrect (*upheld*);
(c) Mrs A's prognosis was not adequately explained to the family by either the Hospital or the Centre (*partially upheld*); and
(d) Mr C's complaints about the conditions in the Hospital ward were not dealt with appropriately (*upheld*).

Redress and recommendations

The Ombudsman recommends that Board 1 apologise to Mr C for the delay in making the diagnosis and for making the incorrect decision to operate.

The Ombudsman recommends that both Boards apologise to Mr C for the fact that Mrs A's prognosis was not adequately explained to the family and review the way that a poor prognosis is explained to patients and their families.

The Ombudsman will send a copy of this report to SIGN for their consideration when Guideline 61 on post-menopausal bleeding is reviewed later this year.

Main Investigation Report

Introduction

1. In March 2004, Mrs A, who was 64 years old at the time, attended her GP with post-menopausal bleeding. Mrs A's GP referred her to Monklands Hospital (the Hospital) in Lanarkshire NHS Board (Board 1)'s area and she was seen at the Gynaecology Clinic (the Clinic). Following tests, Mrs A was diagnosed with cancer and the Consultant Gynaecologist (the Consultant) performed a hysterectomy in October 2004. The result of one of the tests was not known until after the operation and it disclosed that Mrs A's cancer was advanced. Mrs A was referred to the Beatson Oncology Centre (the Centre) in Greater Glasgow and Clyde (Board 2)'s area and subsequently was treated with radiotherapy. During the surgery Mrs A's ureter was severed but this was not diagnosed for five weeks, during which time Mrs A became very unwell. Attempts to pass a tube through the damaged ureter were unsuccessful and Mrs A required further surgery to repair the damage. Following this further surgery, Mrs A was found to have contracted MRSA. Mrs A's condition continued to deteriorate and she was admitted to a hospice in May 2005 where, sadly, she died on 6 June 2005.

2. The complainant (Mr C) complained to the Hospital and the Centre in June 2005. He complained to the Hospital that there was a delay in making a correct diagnosis; his mother had an operation which should not have been performed; and she was caused pain and suffering which should have been avoided. Mr C complained that the Hospital and the Centre had failed to explain the extent of his mother's cancer. Mr C said that his mother had been in continuous pain and misery from the date of her operation until her death. The treatment his mother received had made the last seven months of her life a 'living hell'. In his complaint, however, Mr C paid tribute to his mother's GP and the staff at his surgery for their work and care during the period leading to Mrs A's death.

3. Both the Hospital and the Centre responded to Mr C's complaints. Mr C also attended a meeting at the Hospital on 18 August 2005 but he remained dissatisfied and in October 2005 he complained to the Ombudsman.

4. The complaints from Mr C which I have investigated are that:

(a) there was an unacceptable delay in the Hospital making a correct diagnosis;

(b) the Hospital's decision to operate on Mrs A was incorrect;

(c) Mrs A's prognosis was not adequately explained to the family by either the Hospital or the Centre; and
(d) Mr C's complaints about the conditions in the Hospital ward were not dealt with appropriately.

Investigation

5. In order to investigate this complaint I have had access to Mrs A's clinical records from both the Hospital and the Centre and the correspondence relating to the complaints. I have corresponded with Mr C, the Hospital, the Centre and Mrs A's GP. I have identified relevant guidelines and have received advice from four of the Ombudsman's advisers, a Consultant Oncologist (Adviser 1), a Consultant Gynaecological Oncological Surgeon (Adviser 2), a Nursing Adviser (Adviser 3) and a Consultant Obstetrician and Gynaecologist (Adviser 4). Adviser 4 and I also attended a meeting on 19 November 2007 with representatives of Board 1 and Board 1 subsequently provided me with copies of their policies and procedures.

6. In line with the practice of the Ombudsman's office, the standard by which I have judged the actions of the medical staff 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 by the medical profession in terms of knowledge and practice at the time. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1, a glossary of terms is in Annex 2 and a list of policies considered is in Annex 3. Mr C, Board 1 and Board 2 were given an opportunity to comment on a draft of this report.

(a) There was an unacceptable delay in the Hospital making a correct diagnosis

7. On 16 March 2004 Mrs A's GP referred her for a routine appointment to the Clinic with post-menopausal bleeding whilst on HRT (hormone replacement therapy). In his letter the GP also said that Mrs A suffered from cirrhosis, the cause of which was not known and had a raised alkaline phosphatase level. When the Hospital received the referral it was upgraded from 'routine' to 'soon' and Mrs A was seen by the Gynaecological Registrar (the Registrar) on 19 April 2004. Following this appointment, the Registrar wrote to Mrs A's GP to say that she would be seen at the Hysteroscopy Clinic. The Registrar also said that the

GP could refer such patients as Mrs A directly to this clinic without sending them to Gynaecological Outpatients first.

8. The Registrar saw Mrs A at the Hysteroscopy Clinic on 13 May 2004. He noted that her bleeding continued as before. He said that hysteroscopy had been difficult but 'no gross abnormality was seen'. A Pipelle sample had been taken and he had advised her not to take HRT. He said he would see her again in the Gynaecological Outpatient Department in three months time. (The Pipelle sample proved to be insufficient for diagnosis and the Adviser's comments about this are at paragraph 14).

9. On 25 June 2004 Mrs A's GP wrote to the Consultant. He said that, although Mrs A was pleased that her hysteroscopy was negative, she continued to bleed every day and was rather perturbed by this. He asked if she could be seen more quickly and what treatment the Consultant would advise. As a result of this letter, Mrs A's appointment was brought forward and she was admitted on 31 August 2004 for hysteroscopy under general anaesthetic on 1 September 2004 (the first suggested date being unsuitable due to Mrs A being on holiday at that time).

10. The Consultant dictated a letter to Mrs A's GP on 8 September, although it was not typed until 16 September 2004. He said that a poor view had been obtained at Hysteroscopy. Mrs A had a large mobile uterus (possibly a fibroid) and possibly endometritis for which he had prescribed antibiotics. Further tests on the samples taken, however, showed that Mrs A had adenocarcinoma and in view of that he would arrange to see her back at the Gynaecological Outpatients Clinic to arrange a hysterectomy.

11. On 30 September 2004 the Consultant saw Mrs A again. He told her that she had endometrial cancer and said that he would arrange for her to be admitted for hysterectomy. In the meantime he arranged an MRI scan which was performed on 14 October 2004 but the results of this were not known until 29 October 2004, two days after Mrs A's operation. I am advised that the MRI scan showed a large tumour of the uterus with evidence of local spread into the pelvis. Mrs A had a bone scan on 9 December 2004, which showed that cancer had spread to her bones.

12. SIGN's publication *'Report on a recommended Referral Document'* states that, in relation to referral letters from GPs, adequate clinical information is

essential to allow the Consultant to assess clinical need and urgency. I asked Mrs A's GP why he had referred Mrs A for a 'routine' appointment at Gynaecological Outpatients. The GP replied that he had not previously experienced long delays like this in the past and did not feel that a 'soon' or 'urgent' referral was necessary. The GP said that he was not aware at that time that GPs could refer patients direct to the Hysteroscopy Clinic.

13. In response to my enquiries, Board 1 said that the GP's referral had been forwarded to the Gynaecological Department. It was noted that Mrs A's post-menopausal bleeding had occurred whilst she was on HRT. This was not considered to be an unusual symptom or usually associated with any significant pathology. Mrs A was, therefore, given the first available 'soon' appointment.

14. Adviser 2 said that post-menopausal bleeding should always be treated as 'urgent'. The Gynaecological Department should have recognised that a 'soon' grading would result in a four week delay in Mrs A being seen. It would, therefore, have been appropriate to grade Mrs A as 'urgent'. Adviser 2 was also concerned that the Gynaecological Department did not appear to have made it clear previously to GPs that patients such as Mrs A could be referred directly to the Hysteroscopy Clinic rather than being referred through Gynaecological Outpatients. This resulted in a further three week delay, as Mrs A was not seen by the Hysteroscopy Clinic until 13 May 2004. (Board 1 later told me that when the Hysteroscopy Clinic was being set up the Consultant Gynaecologist responsible personally visited all of the local GP practices to explain its purpose and the referral mechanism.) Adviser 2 noted that, despite the fact that the hysteroscopy was described as 'technically difficult' and the sample obtained proved insufficient to allow a diagnosis to be made, the Registrar arranged for Mrs A to be reviewed in three months time. Adviser 2 said that this decision was premature as the cause of Mrs A's bleeding was not known and three months is too long to wait with undiagnosed post-menopausal bleeding. Adviser 2 said that further tests should have been undertaken.

15. In the event, Mrs A's GP wrote again and Mrs A was seen on 1 September 2004; Mrs A, meanwhile, having been reassured, incorrectly as it turned out, by the Registrar's letter to her GP. Mrs A underwent a further hysteroscopy and endometrial biopsy at this appointment. This biopsy showed that Mrs A had endometrial cancer. The Consultant explained the finding to Mrs A on 3 September 2004. Adviser 2 noted that this was six months after the original referral to the Hospital.

16. Adviser 2 noted that the biopsy results suggested that the carcinoma was poorly differentiated. Adviser 2 said this was suggestive of a high grade aggressive tumour. Mrs A had an MRI scan on 14 October but it was not reported until 29 October 2004. Adviser 2 said that it was 'quite disgraceful' for an MRI scan in such an important case to take 15 days to report. It was this MRI scan which allowed the diagnosis of widespread cancer but it was not until Mrs A had a bone scan in December 2004 that the cancer was correctly staged (that is, that it was graded on the basis of how much it had grown and spread).

17. At the meeting on 19 November 2007 (paragraph 5) Board 1 said that Mrs A's case had acted as a catalyst. They were changing things anyway but this case made change happen more quickly. Detailed tracking arrangements are now in place for cancer referrals from GPs to be sent electronically or by fax and arrangements are in place to discuss with GP practices any instance where referrals were taking time to reach the acute service. Board 1 considered that Mrs A's case was complicated by the fact that she had been on HRT but Adviser 4 noted that Mrs A had been advised to stop taking HRT at the Clinic on 13 May 2004 and said that, after a month or so, she was in the same position as a patient who was not taking HRT. Board 1 agreed with Adviser 4 and said that patients referred with post-menopausal bleeding who are on HRT are now categorised as 'urgent'. Board 1 referred to the relevant guideline (SIGN 61) and suggested that action had been taken in Mrs A's case more quickly than the guideline indicated. (The time indicated in the guideline is six months but Board 1 agreed with Adviser 4 that things had moved on since the guideline was issued some years ago and that this time limit was no longer satisfactory.) Adviser 4 said that in Mrs A's circumstances he would have brought her back more quickly for review or carried out a hysteroscopy and curettage. Board 1 agreed that the time to obtain the MRI scan and the delay in reporting the results were unacceptable but said that both had since been significantly improved.

18. Board 1 outlined the changes made in process to minimise the potential for recurrence; in particular, that a clinical division responsible for Women's Cancer and Diagnostic Services across Board 1's area had been created. Board 1 have since told me that, since the meeting, the management of cancer services has been further strengthened, with the appointment of a Head of Cancer Services responsible for delivering service improvement across the various cancers including gynaecological cancers. Gynaecological in-patient

services have been concentrated at one hospital and a standardised approach agreed. The Radiology Departments now work more closely together and a lead Consultant Radiologist for Gynaecology has been identified. Two Consultant Radiologists now report pelvic MRI scans specific to the hospital concerned and there is a guaranteed turnaround from referral to reporting of two weeks, although it is frequently done more quickly. An additional hysteroscopy/scanning clinic has been established at the Hospital and the process whereby consultants vet GP referrals tightened up and standardised. Consideration is being given to removing the 'soon' appointment category and funding has also been made available for a Gynaecology Nurse Specialist to better co-ordinate the service.

(a) Conclusion

19. Mrs A's GP referred her to the Hospital for a 'routine' appointment. He said that he had not previously encountered delays as in this case. Previously (eg, 200502165) the Ombudsman noted that it was reasonable for a GP not to request an urgent appointment, leaving that decision to the hospital, provided the hospital is put in possession of all of the relevant facts to allow them to make a correct prioritisation decision. That is why it is important that referral letters contain sufficient detail to allow a full evaluation to be made, which this letter did. Adviser 2, however, identified various delays and failures which occurred after the letter was received by the Hospital. These included a delay in offering Mrs A an initial appointment and failure by the Hospital to ensure that GPs knew that direct referral to the Hysteroscopy Clinic could be made which resulted in further delay. The anticipated time of three months to review Mrs A was shortened due to the GP writing to the Consultant. I commend the GP for his action. Although the initial diagnosis of endometrial cancer was made following endometrial biopsy at that appointment on 8 September 2004, delay in reporting the MRI scan meant that the nature of the cancer was not appreciated until after Mrs A's operation on 27 October 2004. Mrs A's cancer was not appropriately staged until she had a bone scan in December 2004. I agree with Adviser 2 that these delays were unacceptable and, therefore, I uphold this complaint.

(a) Recommendation

20. At the meeting on 19 November 2007, Board 1 made it clear that Mrs A's case had been a catalyst which had hastened significant and far-reaching changes being made in the way that cases such as hers are dealt with. Adviser 4 has taken the opportunity to review the changes and the new policies and procedures which have been put in place. He said he was happy with the changes in clinical practice which had been instituted. In view of the changes which have been made and which are designed to avoid unacceptable delays in diagnosis in the future, the Ombudsman has no further recommendations to make concerning the reasons for the delays identified in the report. The Ombudsman recommends, however, that Board 1 apologise to Mr C for the delay in making the diagnosis in Mrs A's case. Finally, with regard to this aspect of the complaint, the Ombudsman will send a copy of this report to SIGN for their consideration when Guideline 61 is reviewed later this year.

(b) The Hospital's decision to operate on Mrs A was incorrect

21. On 27 October 2004 the Consultant performed a hysterectomy on Mrs A. The Consultant said that he carried out the operation without waiting for the MRI report, on the assumption that this was the appropriate treatment for Mrs A's condition. The Consultant said that, in hindsight, this may have been an error of judgement. The Consultant said that he was very aware of the delay in diagnosing Mrs A and he was keen to progress her treatment as quickly as possible. He said that all gynaecological cancer cases are routinely referred to the West of Scotland Managed Clinical Network for Gynaecological Cancer (the multi-disciplinary team). In cases of endometrial cancer such as Mrs A's, the Consultant tends to refer cases after performing a hysterectomy and this is the usual management within the area. In cases where it is suspected that the cancer is spreading, patients are referred to a Gynaecological Oncologist and to the multi-disciplinary team prior to treatment. Although ultrasound scans could be performed within the clinic, there was some debate about their usefulness in women using HRT and hysteroscopy was the preferred option. However, if an ultrasound scan had been carried out on Mrs A it may have increased the level of concern relating to Mrs A's bleeding.

22. Adviser 2 said that he was very concerned that Mrs A did not have proper procedures carried out before her operation. He noted that a clear view was not obtained at the first hysteroscopy and the samples obtained were insufficient for diagnosis. Adviser 2 said that an ultrasound scan at this stage would have been a useful preliminary and non-invasive investigation. He said that it was

poor clinical practice to obtain an MRI scan and then not use it and it was his view that Mrs A's case should also have been discussed by the multi-disciplinary team prior to surgery. Had all of this information been available, Adviser 2 considered that it should have been clear that Mrs A had at least Stage 3 cancer. She might also, in the light of the findings of the MRI scan, have had a bone scan which would have shown that she was, in fact, Stage 4. Adviser 2 said that this operation should not be performed on someone with Stage 4 cancer. Adviser 2 was also concerned as to whether the Consultant was the correct person to perform the surgery (see paragraph 27).

23. Guidelines issued by the Royal College of Obstetricians and Gynaecologists state that women with gynaecological cancer should receive their care in cancer centres and be managed by the relevant multi-disciplinary team. The Guidelines further state that all women diagnosed with endometrial cancer should be carefully investigated to assess the degree of myometrial invasion and tumour histopathology, including degree of differentiation.

24. Adviser 1 explained that multi-disciplinary team meetings are designed to make decisions regarding the management of cancer patients before treatment is started. In this case, the management plan had been decided by the team after surgery.

25. The MRI scan was reviewed by the Consultant Radiologist, who said that the bone on the right side of the pelvis did not seem completely normal. When the MRI scan was subsequently reviewed on 24 November 2004 by the radiology experts in the multi-disciplinary team, they concluded that the images suggested that the cancer had spread to the pelvic bones.

(b) Conclusion

26. The advice I have received is that the circumstances in which the decision to operate came to be made were inappropriate. In particular, Adviser 2 was concerned that when the endometrial biopsy showed poorly differentiated endometrial cancer, Mrs A was not referred to the multi-disciplinary team. The Consultant said that this was common practice in the area but it appeared to be contrary to the Royal College's Guidelines and the purpose of multi-disciplinary teams, which is to make a collective diagnosis and an agreed management plan. In light of the result of the review of the scan by the multi-disciplinary team, it appeared likely that the team would have raised the possibility of more advanced cancer if consulted prior to surgery. The Consultant said that if he

had received the results of the MRI scan beforehand he would have cancelled Mrs A's operation. Adviser 2 considered that to proceed to surgery before the results were obtained was poor clinical practice. Adviser 2 was also concerned that the Consultant was not the appropriate person to undertake this surgery. In addition, consideration did not appear to have been given to performing an ultrasound scan following the first hysteroscopy, given that the samples obtained were insufficient for diagnosis, despite there being facilities to perform ultrasound scanning in the Clinic. In all of the circumstances, I uphold this complaint.

27. At the meeting on 19 November 2007, Board 1 agreed that Mrs A should not have been operated on prior to the MRI scan results being made available to the Consultant. Board 1 agreed with Adviser 4 that only low grade, less aggressive tumours should be operated on by generalists (surgeons who are not specialist cancer surgeons) and in Mrs A's case her tumour did not satisfy these criteria. Board 1 noted Adviser 2's view that Mrs A should have had a transvaginal ultrasound scan. Board 1 said that such scanning is now available at out-patient clinics and is carried out routinely. Networking and communication with the multi-disciplinary team had been improved and a secretary from each of the hospitals had been given the responsibility for placing cases on the agenda. Weekly teleconferencing facilities had been made available so that discussions could take place as to what surgery would be carried out and where. Board 1 said that there is now a computerised theatre system, with the facility to directly type in operation notes. (Adviser 4 had commented that the Consultant's operation note was largely illegible and that he had omitted to record tasks which he had in fact undertaken.)

28. In his complaint, Mr C said that the decision to proceed to surgery resulted in the damage to his mother's ureter. This required further surgery, which led to his mother contracting MRSA. Mr C considered that that led to his mother having no quality of life following initial surgery and to her life being shortened. In response to the complaint, Board 1 said that Mrs A died of an advanced and aggressive cancer.

29. Ureteric damage and MRSA are both recognised hazards of abdominal hysterectomy but Mrs A would not have been exposed to these risks if she had not undergone surgery. While there is no evidence that Mrs A's life was shortened by the treatment, there is no doubt that Mrs A was caused

considerable, unnecessary pain and suffering as a result of the initial decision to proceed to operate.

(b) Recommendation

30. In his complaint to the Ombudsman, Mr C said that he would like a review of the surgical and administrative procedures to ensure that the mistakes which occurred in treating his mother were not allowed to happen again. Board 1 have since reviewed their procedures and completely changed the way that cases such as Mrs A's are dealt with. Adviser 4 said he is satisfied that the new procedures allow for the early involvement of the multi-disciplinary team and the other changes which had been made drastically reduce the chance of any recurrence of the problems suffered by Mrs A. The Ombudsman, therefore, has no recommendations to make concerning clinical treatment but does recommend that Board 1 apologise to Mr C for the incorrect decision to operate on his mother.

(c) Mrs A's prognosis was not adequately explained to the family by either the Hospital or the Centre

31. The context in which this head of complaint has to be considered is that the results of the MRI scan carried out on 14 October 2004 and the bone scan carried out on 9 December 2004 (paragraph 16) led the clinicians to conclude that Mrs A's prognosis was much poorer than they had previously thought. The issue on which I have to reach a view is whether that was adequately explained to her and her family.

32. Mr C said that the Consultant initially told him that endometrial cancer had a favourable treatment success rate of around 80 percent, and that five years life expectancy would not be over-confident following hysterectomy and radiotherapy for such a condition. It is clear to me that Mr C is referring here to discussion with the Consultant in September 2004, after Mrs A had been diagnosed as having endometrial cancer and before she had undergone either the hysterectomy or the MRI scan. When the Consultant referred Mrs A to the Centre (after the MRI scan) she was seen by the Consultant in Clinical Oncology (the Consultant Oncologist). Mr C said that the Consultant Oncologist appeared to agree with the Consultant's initial favourable view and he suggested chemotherapy in addition to radiotherapy. Bone scans were subsequently performed, which showed that the cancer had spread round Mrs A's body but it was only after she was admitted to the hospice that Mrs A and

her family were told that her condition was terminal, which had come as a severe shock.

33. I have reviewed the correspondence between the Consultant and the Consultant Oncologist. The Consultant's initial referral letter contains a good history of Mrs A's case. The Consultant subsequently wrote to the Consultant Oncologist on 16 December 2004. He said that Mrs A's bone scan had shown probable metastatic disease in the right hemi-pelvis and sacro-iliac joint. He continued:

> 'I have discussed this with both her and her husband. They are obviously taken aback at this turn for the worse and I have explained to them that her cancer is not curable but that we may get good symptom control with chemotherapy.'

34. Thereafter the Consultant Oncologist wrote to the Consultant each time he reviewed Mrs A. He explained his findings and proposed treatment. Both the Consultant's letter and the Consultant Oncologist's letters give details of discussions they have had with Mrs A and members of her family and indicate that Mrs A's cancer was not curable but was treatable.

35. In response to the complaint, the Consultant said that if a patient was told they had terminal cancer this was often understood by patients to mean untreatable. However, if they are told that their cancer is treatable it leaves a glimmer of hope.

36. In response to my enquiries the Consultant Oncologist said that he had discussed the treatment options with Mrs A and her husband. He had explained that the treatment was palliative and that the cancer was not curable but was treatable. Four radiotherapy treatments had been given between 4 and 7 January 2005. The Consultant Oncologist had reviewed Mrs A again on 9 February 2005. He had discussed chemotherapy at length. Both Mrs A's husband and Mr C were present. The Consultant Oncologist felt that all present were clear that the treatment would be for symptom control.

37. Both Board 1, at the meeting on 19 November 2007, and Board 2, in correspondence of 8 August 2007, commented that it is not expected that a clinician could or should say how long a person has to live. The Centre said that bone disease alone in other cancers can allow a patient a longer and hence indeterminate prognosis. While they accepted that there were various ways to

discuss prognosis, they did not consider they could have been more specific. It is only when there are biochemical or other evidence of organ failure that it becomes possible to predict death. They considered that averages were unhelpful and could raise or lower hopes wrongly. In further correspondence, the Centre said that the Consultant Oncologist explained to Mrs A and her husband in easily understandable terms the implications of stage 4 disease, ie, that it was incurable but treatable.

(c) Conclusion

38. The scans undertaken at the Hospital led to a change of view about Mrs A's prognosis and the initial responsibility for explaining that to her and her family lay with the Consultant. It is apparent from his letter of 16 December 2004 to the Consultant Oncologist (see paragraph 33) that he felt he had done so successfully. He wrote that he had explained that Mrs A's cancer was not curable and that she and her husband were 'obviously taken aback at this turn for the worse'. However it is clear from the subsequent correspondence between Mr C and both Board 1 and Board 2, and from the complaint to this office, that Mrs A and her family did not appreciate what this actually meant. For example, Mr C has said that he formed the impression that the Consultant Oncologist shared the relatively optimistic view expressed by the Consultant prior to the MRI scan. Similarly, Mr C seems to have taken the fact that the Consultant Oncologist suggested both chemotherapy and radiotherapy as indicating the prospect of cure rather than merely, as was the case, symptom control.

39. This was a particularly complex case where, following the MRI scan in October 2004, the relatively optimistic view of Mrs A's prognosis previously conveyed to her and her family changed to one where her condition was seen as incurable (although, at that stage, no firm view could be reached on how long she was likely to have to live). That news would have been devastating and difficult for her and her family to absorb. In these circumstances, all of the clinicians communicating with her and her family had a particular responsibility to ensure that they understood the seriousness of the situation and that the treatment that was being offered was not potentially curative but was only for the purposes of symptom control. I have no doubt that both the Consultant and the Consultant Oncologist sought to give Mrs A and her family a clear account of the situation and to explain to them the basis for future treatment and what outcome was expected. However, it is also clear that the information they sought to convey was not fully understood and, on that basis, I partially uphold

this complaint. From the correspondence, it appears that both the Consultant and the Consultant Oncologist discussed the position with Mrs A and her family and said that her cancer was not curable but was treatable. I have noted, however, that both the Consultant and the Consultant Oncologist used the same form of words in their discussions, ie, that Mrs A's cancer was not curable but was treatable. It may be that this form of words is appropriate in most cases but in cases such as this one, where the initial prognosis given changed markedly, Mrs A's actual condition should have been communicated unambiguously. It should have been made clear that in the light of further information, what the family had been told initially was, in fact, wrong.

(c) Recommendation

40. The Ombudsman recommends that both Boards:

(i) apologise to Mr C for the fact that Mrs A's prognosis was not adequately explained to the family; and

(ii) review the way that a poor prognosis is explained to patients and their families.

(d) Mr C's complaints about the conditions in the Hospital ward were not dealt with appropriately

41. At the meeting he attended on 18 August 2005, Mr C raised concerns about the conditions in the ward in which his mother was treated. Mr C said that one night there were 30 visitors in the ward for three patients. The shower areas were so dirty his mother would not use them and on one occasion he had brought cleaning material into the hospital and cleaned the shower area for his mother. He said that there was no alcohol gel available. Mr C acknowledged that he had not brought his concerns to the attention of the staff at the time.

42. The General Manager of the Hospital said that there were regular cleaning programmes in place. They tried hard to keep the areas clean but the Hospital was in need of upgrading. Notices were on display regarding the numbers of visitors at beds but staff were met with verbal aggression when trying to enforce them. Notices had been displayed regarding the importance of hand washing and every bed in every ward was supplied with alcohol gel but this was going missing and it was assumed that visitors were taking it home.

43. Adviser 3 said that the additional aspects of Mr C's complaint relating to the ward environment contributed to the grief felt by Mrs A and witnessed by her son. Adviser 3 was concerned that no action was identified to reassure Mr C

that these issues would be looked at and staff asked to deal with them as a matter of urgency. It would appear from what Mr C said that the state of the toilets, in particular, went far beyond what would be expected by simply being in daily use by patients.

44. In response to my enquiries, the Divisional Chief Executive of Board 1 said that a structured programme of audit of cleaning standards was now in place. Notices, posters and leaflets had been distributed and displayed and alcohol gel was attached to the bottom of each bed. Posters asked for visitors to be kept to a minimum to help fight infection.

45. At the meeting on 19 November 2007, Board 1 said that gynaecological in-patient services have been concentrated at another hospital and, therefore, this problem would not arise in the future.

(d) Conclusion

46. Adviser 3 said that there was nothing in the Hospital's initial response which indicated that Mr C's complaints warranted attention. The importance of the conditions experienced by Mrs A in the ward was not recognised and, for this reason, I uphold this complaint.

(d) Recommendation

47. I note that the Hospital no longer deals with gynaecological in-patients. The Ombudsman, therefore, has no recommendations.

Annex 1

Explanation of abbreviations used

Mrs A	Mr C's mother
GP	General Practitioner
The Hospital	Monklands Hospital within the area of Lanarkshire NHS Board
Board 1	Lanarkshire NHS Board
The Clinic	The Gynaecology Clinic at Monklands Hospital
The Consultant	The Consultant Gynaecologist at Monklands Hospital
The Centre	Beatson Oncology Centre, within the area of Greater Glasgow and Clyde NHS Board
Board 2	Greater Glasgow and Clyde NHS Board
Mr C	The complainant
Adviser 1	The Ombudsman's adviser who is a Consultant Oncologist
Adviser 2	The Ombudsman's adviser who is a Consultant Gynaecological Oncological Surgeon
Adviser 3	The Ombudsman's adviser who is a Nursing Adviser
Adviser 4	The Ombudsman's adviser who is a Consultant Obstetrician and Gynaecologist

HRT	Hormone Replacement Therapy
The Registrar	The Registrar in Gynaecology
The multi-disciplinary team	In this case, the West of Scotland Managed Clinical Network for Gynaecological Cancer
The Consultant Oncologist	The Consultant in Clinical Oncology at Beatson Oncology Centre

Annex 2

Glossary of terms

Adenocarcinoma	A form of cancer which involves the lining of the walls of organs
Alkaline Phosphatase	An enzyme normally found in the blood. If it is there in higher than usual concentrations it often denotes a problem either of the liver or of the bones. (Normal range is 40 – 280 IU per litre)
Carcinoma	The malignant growth
Cirrhosis	Liver disease
Curettage	Taking scrapings from the wall of the uterus
Endometrial	Relating to the lining of the uterus or womb
Fibroid	A benign tumour in the uterus which may cause irregular bleeding
Hospice	An institution which provides care and support to terminally ill patients
Hysterectomy	In this case the surgical removal of womb, tubes and ovaries
Hysteroscopy	The examination of the inner cavity of the uterus through a fibreoptic telescope, inserted through the vagina and cervical canal
Magnetic Resonance Imaging scan (MRI scan)	A technique for imaging internal organs of the body

Methicillin Resistant Staphylococcus Aureus (MRAS)	Used to describe those examples of this organism which are resistant to commonly used antibiotics
Myometrial	Relating to the muscle of the uterus
Pipelle	A disposable polypropylene sheath with an inner plunger used for obtaining an endometrial sample
Poorly differentiated	Indicates cells which have changed more from normal cells and are more aggressive
Prognosis	A forecast of the probable outcome
Radiotherapy	Treatment with radiation
Staged	The process by which a cancer is graded, by how much it has grown and spread
Ultrasound	An imaging technique using high frequency sound waves
Ureter	The tube passing from each kidney to the bladder, for the conveyance of urine

Annex 3

List of legislation and policies considered

Investigation of Post Menopausal Bleeding SIGN September 2002

Key Standard 5: Gynaecological Cancer – Royal College of Obstetricians and Gynaecologists

'Report on a recommended Referral Document' SIGN (1998)

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