Scottish Parliament Region: South of Scotland

Case 200801379: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospital; oncology; clinical treatment; diagnosis

Overview

The complainant (Mr C) had part of a lung removed following a diagnosis of cancer at Crosshouse Hospital (Hospital 1). He was subsequently found not to have cancer and Mr C complained that the treatment had been unnecessary. Mr C also said that staff at Hospital 1 had delayed in communicating the change in diagnosis to him and had not answered his questions fully. In addition, Mr C complained that there had been a delay in putting him back on the kidney transplant waiting list and that the response to his complaints by Ayrshire and Arran NHS Board (the Board) had been inadequate.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there had been an error in the diagnosis of cancer, which led to an unnecessary operation (*upheld*);

(b) there were problems with the communication to Mr C about the new diagnosis and the response to his questions about this (*upheld*);

(c) there had been an unreasonable delay in ensuring Mr C was put back on the kidney transplant list (*upheld*); and

(d) the responses to Mr C's complaints were inadequate (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) undertake a short, focussed audit of lung fine needle aspirations (FNA)s carried out by the department;

(ii) review, as a matter of urgency, the clinical use of such FNAs by Hospital 1;

(iii) emphasise to clinical staff involved the importance of taking and documenting a full clinical history; this matter should be confirmed with Consultant 1 as part of his annual appraisal;

(iv) emphasise to staff involved the importance of timely and open communication;
(v) alert staff to the need to ensure appropriate communication with patients and file management, in an effort to prevent the situation recurring, where a patient could be concerned about information placed in his/her file which has not been discussed with him/her;
(vi) undertake a full review of the operation of their complaints process and the relationship of this to clinical governance, as a matter of urgency;
(vii) establish why an incident review was not considered and this matter not re-considered by the lung cancer multi-disciplinary team and take appropriate steps to ensure that their own policies and procedures are followed by clinical and complaints handling staff; and
(viii) make a full apology to Mr C for the failings identified in this report.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. Mr C regularly attended Crosshouse Hospital (Hospital 1) for dialysis. He was on the kidney transplant waiting list. In June 2007 he had a CT scan of his abdomen. This revealed a mass in the chest. A CT scan of the chest area was subsequently carried out on 17 July and on 6 August 2007 a CT guided Fine Needle Aspiration (FNA) was carried out of the mass on the right lung. Mr C was told he had cancer and met with a lung cancer nurse on 14 August 2007. His condition was discussed at a multi-disciplinary team (the Team) meeting on 20 August 2007. Mr C was subsequently told that an operation was necessary and, because of his kidney condition, that this would require to be undertaken at a hospital in a different Board area (Hospital 2).

2. On 14 September 2007 Mr C had a right lower lobectomy (removal of one of the lobes of the lung). A pathology report on 17 September 2007 indicated that no malignant cells were found and a detailed report of 28 September 2007 confirmed that there was no cancer and identified the lump as a benign rounded atelectasis (a benign mass caused by collapsed lung complicating thickening of the pleural lining of the lung). This was communicated to Hospital 1.

3. Mr C was informed of the new diagnosis on 17 October 2007. He has said this was only after repeated requests for further information, after he saw a note referring to the diagnosis in his clinical records on 12 October 2007. Mr C wrote a formal complaint letter on 23 March 2008 and raised concerns about: his notes; communication with doctors being untimely and dismissive; and that the error in diagnosis was not being discussed or admitted.

4. A number of meetings were held between Hospital 1 staff and Mr C to discuss Mr C's concerns and a final response sent on 26 June 2008.

5. In responding to Mr C's complaint, Ayrshire and Arran NHS Board (the Board) accepted there were delays in discussing the pathology report with Mr C but said this occurred because they had sought to verify this report before doing so. They also explained they had difficulty investigating some of the events because correspondence was not properly date stamped. However, they said that, even with the benefit of hindsight, the consultants involved remained of the view that the operation had been necessary as the lesion (the mass identified on the CT scan) could not safely have been left for a period of observation.

Mr C remained concerned and, on 18 August 2008, he complained to the Ombudsman.

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

(a) there had been an error in the diagnosis of cancer, which led to an unnecessary operation; and

(b) there were problems with the communication to Mr C about the new diagnosis and the response to his questions about this.

7. During the course of the investigation, Mr C became concerned that he did not know whether he had been returned to the kidney transplant waiting list. He sought confirmation of this. Mr C underwent blood tests in October 2008 and was reinstated in December 2008. He said he should have been reinstated earlier and that the response to his complaint on this point by the Board had been confused. Mr C brought this complaint to the Ombudsman's office and, given its close connection to the matter already under investigation, I therefore informed the Board and Mr C that the investigation would additionally consider whether:

(c) there had been an unreasonable delay in ensuring Mr C was put back on the kidney transplant list; and

(d) the responses to Mr C's complaints were inadequate.[1]

Investigation

8. In investigating this complaint, I have had access to Mr C's clinical records and the complaints correspondence from the Board. I obtained advice from one of the Ombudsman's professional medical advisers (Adviser 1) and a consultant pathologist (Adviser 2). The Board were asked to comment on the advice and interviews were held with Board staff.

9. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

[1] This heading considers both the response to his original complaint and this second complaint.

(a) There had been an error in the diagnosis of cancer, which led to an unnecessary operation

10. The decision to refer Mr C for an operation was made at the Team meeting on 20 August 2007. The letter from the Board to Mr C in response to his complaint said that:

> 'One of the reasons for the Lung Cancer Multidisciplinary Team meeting is to ensure that the full history and all other investigation results are brought together to arrive at a more definitive diagnosis and appropriate treatment plan.'

11. Such teams are recommended by the relevant Scottish Government guidance for managing suspected lung cancers (SIGN 80). At the meeting on 20 August 2007, the Team had available the CT scan and a pathology report. At interview, it was discussed with clinical staff whether there should have been a review of the scan only prior to the decision to undertake the FNA, as the FNA pathology report would have affected how the scan would be seen. It was explained, however, that this could lead to delay and consultants would often instruct further investigations such as a FNA prior to this Team meeting. There was no documented evidence of a full clinical history being taken by the consultant with primary responsibility for Mr C's care (Consultant 1). Adviser 1 said, for example, there was no information about Mr C's smoking history or possible exposure to asbestos.

12. Adviser 1 reviewed the scan. The diagnosis of rounded atelectasis could have been suggested from the appearances. However, he said this was a difficult diagnosis and, while it could be spotted, he would not expect it always to be recognised. The second piece of evidence was the pathology result. The subsequent pathology showed that the diagnosis made was wrong. However, it is sometimes the case that such errors are reasonable because of difficulties in diagnosing certain conditions. Adviser 2 criticised the initial pathology report. He said no malignant cells were present and it is clear from his comments that, in his view, this was an error the original pathologist (Consultant 2) should not have made.

13. At interview Consultant 1 said he had requested and preferred a biopsy to FNA, this being more likely to produce clear results. This was evidenced in his clinical note of his meeting with Mr C on 14 August 2007. However, the investigation made was an FNA. It was explained that two radiologists were involved in investigations at Hospital 1. One would only undertake FNAs

(Radiologist 1). This was the only radiologist available on 6 August and he had undertaken this procedure. In response to a draft of this report, the Board confirmed there had been a verbal request for a lung biopsy to a second radiologist (Radiologist 2) but produced an internal hand written letter dated 23 July 2007 from a senior house officer, which had been faxed to Radiologist 2. The letter asked if the scans could be reviewed to see whether a biopsy/FNA could be performed. There was no explanation why this letter did not reflect the verbal request. The choice was, therefore, left to the preference of the radiologist.

14. Consultant 2 accepted, with hindsight and the knowledge of the final histology report, that the reporting of the pathology was wrong and said, as a result, he had reflected on his practice and also the practice of the department to ensure this did not recur. He said that FNAs of such lesions were now rare and he was concerned that neither he nor the other pathologists were seeing sufficient numbers to ensure that their skills at undertaking and reviewing these remained at an appropriately high standard.

15. Adviser 1 reviewed the pathology report. While this indicated a squamous carcinoma as a diagnosis, it also had a number of cues that this diagnosis was uncertain. Consultant 2 had referred to 'scanty cells' which were 'highly atypical' and 'in keeping with' carcinoma rather than diagnostic of this.

16. The decision of the Team was reported by letter to the surgeon who would be undertaking the operation (the Surgeon) at Hospital 2. Consultant 1 also said he spoke to the Surgeon by telephone. Adviser 1 said the letter did not include clinical history and the letter also said, wrongly, that the investigation of the lump had been by biopsy and not FNA. Consultant 1 said at interview that he considered that, even if the pathology had been reported accurately as atypical but not conclusive, the lesion would still have required an operation to ensure the best possible clinical outcome for Mr C.

17. Having reviewed the clinical notes and considering the discussions at interview, Adviser 1 said that he was of the view that the operation was not inevitable and that a number of cues could have led to a decision that the most appropriate clinical position was further investigation or to leave for observation. In any event, the discussion with Mr C about options would have been very different.

18. The points identified by Adviser 1 were as follows: the Team did not see the CT scan in isolation before deciding to investigate and any view on this would have been affected by the pathology report; the pathology was mis-reported but the caution in this could also have been picked up; a full clinical history may have led to an altered decision. There was no clinical history about Mr C's background when the Team were making the decision. Finally, the Surgeon was not given the full picture and had been given wrong information about the investigations that had been undertaken.

19. Adviser 1 noted that Positron Emission Tomography (PET) scanning was only available to a limited extent in Scotland at the time of this complaint. Adviser 1 explained that if a PET scan had been taken there would have been a negative finding and this would likely have led to a different decision being made on treatment. PET was now available in Glasgow and the Team could refer there more easily. This means that the situation Mr C experienced is less likely to recur. He did not criticise the Team for not referring for a PET, given the resource issues at the time. However, he concluded that there was still enough remaining evidence to say that the decision to proceed was not inevitable and may have been unnecessary.

(a) Conclusion

20. It is generally accepted that possible cancers should be treated as quickly as possible. However, removal of part of a lung is a major operation and Mr C also had a number of complex pre-existing conditions. It was understandable that he queried whether this had been necessary, following the change in diagnosis.

21. At interview, Consultant 2, the Chair of the Team and the Medical Director were all very honest about the problems and the issues which arose in Mr C's case. I would like to thank them for their honesty and openness.

22. It is accepted that the pathology report was wrong. Consultant 2 has accepted, with the evidence from the subsequent histology and on the basis of hindsight, that this was an error and explained his concerns about his department's capacity in relation to CT guided FNA of the lung. It has been suggested that even if this had been reported correctly the operation would have needed to proceed. However, the view of Adviser 1 (referred to in more detail below) is that this was not inevitable and that further investigations could have been appropriate and, certainly, the discussion with Mr C surrounding this

would have been very different. The Board have provided a hand written request from a senior house officer which did not specify preference for either biopsy or FNA. However, I have been advised at interview that Radiologist 1 would only undertake FNAs and this was the only radiologist available on 6 August 2004. I remain concerned that the type of investigation can depend on the radiologist available – while I accept this may relate to skills and training – this is not an acceptable position.

23. While the error in the pathology was critical, this was not the only problem and Adviser 1 has pointed to a number of points which could have led to Mr C's case being dealt with differently.

24. The first was the CT scan which, according to Adviser 1, could have been reported as rounded atelectasis. I accept that, while possible, this would have required a high degree of awareness and I do not criticise Radiologist 1 for not doing so but this case now provides a useful case study for the Team in considering such diagnoses. It was discussed at interview whether the CT scan should have been seen at a Team meeting without the pathology report, as the positive pathology report would have affected how the CT scan was viewed. However, this would still have been a difficult diagnosis and this needs to be balanced against the need to make quick and efficient diagnoses and I, therefore, make no specific recommendation on this point.

25. However, I was concerned on some additional points. The Team, when making the decision that surgery was appropriate, did not have a clear clinical history and there is no evidence that a full clinical history was ever taken by Consultant 1. The Surgeon who undertook the operation had not been given the full details and the referral letter was inaccurate. In the circumstances, I uphold the complaint and, in light of the problems identified in this report, the Ombudsman makes the following recommendations.

(a) Recommendations

26. The Ombudsman recommends that the Board:

(i) undertake a short, focussed audit of lung FNAs carried out by the department;

(ii) review, as a matter of urgency, the clinical use of such FNAs by Hospital 1; and

(iii) emphasise to clinical staff involved the importance of taking and documenting a full clinical history; this matter should be confirmed with Consultant 1 as part of his annual appraisal.

(b) There were problems with the communication to Mr C about the new diagnosis and the response to his questions about this

27. Mr C suffered post-operative complications following the lobectomy on 14 September 2007 at Hospital 2. He was transferred to Hospital 1 on 27 September 2007. On 12 October 2007, a cancer nurse noted that the pathology report had been received – this was placed in the medical notes for the attention of medical staff. At that time, Mr C was still an in-patient in Hospital 1 and was given his notes while being sent for investigations. He saw the note and asked staff to discuss this with him. Renal staff who were then treating Mr C, did not wish to discuss this in detail and Consultant 1 was contacted. He informed clinical staff that he did not wish to discuss this with Mr C until the following week when he would have confirmed the position with the Surgeon.

28. Mr C tried to discuss this with clinical staff again on 15 October 2007 and it was not until 17 October that Consultant 1 noted in the clinical records that he had discussed this with Mr C. At the start of the note, Consultant 1 said that Mr C understood there was no alternative to surgery. He also said, in that note, that Mr C had asked for a copy of the discharge letter but he had decided not to pass this on to him. Nursing notes on the day say that Mr C was still very angry following this consultation. In their response to his complaint, an apology was given for the delay in discussing this with Mr C.

29. Mr C sought and obtained copies of his clinical records and meetings were held between clinical staff and Mr C. I have only seen notes from Consultant 1 of one meeting held on 8 April 2008. This indicated Consultant 1 informed Mr C the decision had been made by the Team and he had also said he was only briefly able to discuss the opinions of clinicians outside his specialty, in particular, the initial pathology report.[2]

(b) Conclusion

30. Mr C was an in-patient when the information was sent to Hospital 1 about the new diagnosis. There were then two key failings in the way this was

[2] I deal in more detail with the handling of Mr C's complaints below.

communicated to him. The first was that information was placed on his clinical records without consideration being given about the timing of the communication to him. In-patients are regularly given their clinical records when they are moving around hospitals and consideration should have been given to this. The second is that no clinician was prepared to discuss the situation with Mr C until 17 October 2007. This undoubtedly caused Mr C distress and anxiety. The Board have already apologised for the delay and they also indicated they considered there were specific reasons for this. While internal documents indicated they upheld a complaint about communication and, in particular about the failure of any individual to take the lead, this is not fully reflected in the letter which apologised largely for Mr C's perception of the communication.

31. I accept that seeking confirmation and discussion with the Surgeon was appropriate. However, nothing prevented Consultant 1 from explaining this to Mr C on 12 October 2007. The refusal of any form of contact with a clinician on this point until 17 October 2007 led Mr C to feel that staff were being overly defensive and I feel this was not an unreasonable assumption, given the delay and the notes of the meeting with Mr C on 17 October 2007. There is no indication that he was offered an opportunity to consider the information and respond with questions. Mr C was not informed, despite a direct question, that he could obtain copies of information held on his records on request. There is no evidence that Mr C received an apology for the way he found out about the situation, through a note on file.

32. In all the circumstances, I uphold this complaint and the Ombudsman makes the following recommendations.

(b) Recommendations

33. The Ombudsman recommends that the Board:

(i) emphasise to staff involved the importance of timely and open communication; and

(ii) alert staff to the need to ensure appropriate communication with patients and file management, in an effort to prevent the situation recurring, where a patient could be concerned about information placed in his/her file that has not been discussed with him/her.

(c) There had been an unreasonable delay in ensuring Mr C was put back on the kidney transplant list

34. Prior to his diagnosis with cancer, Mr C had been on the kidney transplant list. The list was held by a centre in another Board area. Following the diagnosis of cancer, he was removed from the list. Mr C was ill for some time following the operation in September 2007. In early 2008, he asked about reinstatement. On 10 April 2008 a letter was sent from a clinician at Hospital 1 asking that Mr C be reinstated. It is accepted that Mr C was not reinstated until December 2008.

35. On 23 October 2008, a nurse noted in the records that Mr C was concerned about his transplant status. It is not clear what the sequence of events was following this but on 25 November 2008 the transplant co-ordinator (based in the other Board area) requested further information in response to a faxed request from Hospital 1 and said that, as soon as it was confirmed by Hospital 1 that this was appropriate, Mr C would be reinstated. It appears that formal confirmation occurred in a telephone call on 8 December 2008.

36. The Board said, in a letter dated 20 January 2009 to Mr C, that the fact there was no formal resolution until November 2008 was unsatisfactory and communication could have been better. The Board have also said that Mr C took time to recover from his operation and was unwell with ongoing medical problems throughout 2008, which would likely have led to him being unsuitable for transplant[3].

37. The Board said they put in place a number of actions in response to the problems identified. Transplant status was now being checked regularly and a monthly report sought from the co-ordinator, who was based in another Board area. The Board had committed to purchasing an electronic patient record for dialysis patients, which would detail current status on the front page.

(c) Conclusion

38. The Board have accepted that the situation which occurred was unsatisfactory. I agree with this. There was no follow-up to the letter in April 2008 to ensure Mr C had been reinstated. In addition, discussions around reinstatement in early and late 2008 only occurred when this was questioned by

[3] Some, but not all, of these problems were a result of Mr C's operation.

Mr C. Given that he was previously on the list, this should have been raised with him rather than the other way around.

39. The Board have said that, because of health issues which occurred in 2008, Mr C would not have been able to have a transplant operation. This does not excuse the accepted problems around monitoring this status and communication with Mr C about this. I, therefore, uphold this complaint.

40. While I am upholding this complaint, I note the actions taken by the Board to prevent a recurrence. The Ombudsman makes no additional recommendations under this heading but the letter of January 2009 did not amount to a full apology for this and the recommendation that an apology be made for all the failings identified (see paragraph 51) should include this aspect of Mr C's complaint.

(d) The responses to Mr C's complaints were inadequate

41. Mr C complained formally to the Board on 23 March 2008. A number of meetings had been held with clinical and other Board staff in an attempt to resolve this matter informally (see paragraph 28 and 29). A formal response was sent by the Board on 26 June 2008. This response largely repeated information provided by Consultant 1 and Consultant 2 in discussions with Mr C. The letter from the Board said that it was important to:

> 'recognise the impact of the situation you have experienced and develop a better way of handling this type of event based on your feedback and observations.'

42. The letter continued:

> 'I have therefore asked the Associate Medical Director, who leads on cancer for [the Board] to discuss this with the Cancer Multidisciplinary teams and encourage his clinical colleagues to take all necessary steps to ensure that patients feel that their diagnosis and treatment is always openly discussed and that their needs are fully recognised and supported.'

43. At interview, it was noted by the Chair of the Team that Mr C had only been discussed at one meeting and at no subsequent meetings. The Chair was surprised by this because it was part of the standard process that updates be given. He was clearly unaware of and made no comment about any contact made by the Associate Medical Director.

44. The Medical Director was also interviewed. He said he was surprised that he had only been made aware of Mr C's complaint and this investigation when I requested that he attend for interview. This was of particular concern, given that questions had been raised about a possible error in diagnosis and that, in the letter to the Board informing them of the investigation, I had raised significant concerns. He said that it was Board policy to review and consider the need for a critical incident review in such situations and this should have occurred at an early stage, well before the complaint reached the Ombudsman's office.

45. Mr C is first noted to have raised concerns about his inclusion on the transplant list in April 2008. Mr C raised this again in discussion with a nurse in late October 2008. In a discussion about his complaint in November 2008, he said he was still unclear whether he was or was not on the list and I asked the Board to confirm this to him. Mr C said he then received a call which he felt was inappropriate, asking if he had made a complaint.

46. On 5 December 2008, Mr C met with Board staff to discuss his concerns. A letter explaining their understanding of his concerns was sent on 12 December and Mr C commented on this in detail in a letter of 17 December 2008.

47. On 20 January 2009, Mr C was sent a letter with more information (see paragraph 36). At this stage it appeared that only one member of clinical staff had been consulted about the position. Mr C wrote again, on 26 January 2009, to say he felt this did not answer his concerns. A further response was sent on 2 March 2009 and, by this point, the nurse to whom Mr C spoke in late October 2008 had also been asked for a response.

(d) Conclusion

48. From the evidence I have seen, Mr C's initial complaint was not investigated. Instead, clinicians involved were asked to comment and a response was issued based on this. There appears to have been limited critical analysis of the events complained about. Given the problems identified by the Ombudsman office's investigation, I am critical of this. I have noted with concern that, instead of ensuring that lessons were learned following the change in diagnosis, Mr C's case was not dealt with in line with policy. No incident review was considered and his case was not re-discussed, in line with practice, at subsequent Team meetings.

49. In response to a draft report, the Board provided a copy of an internal email which raised the communication concerns that the Board had accepted from Mr C's complaint. The email said it was not important to describe this in detail and the concerns are very generally expressed. I was pleased to see this but it was not clear why this was not in the complaints file and why this did not fully reflect the reassurance to Mr C in the letter of 26 June 2008. This stated that it was important to 'recognise the impact of the situation and to develop a better way of handling this type of event based on your feedback and observations' and that the Associate Medical Director had been asked to discuss this with the cancer multi-disciplinary teams. The email was not a discussion and, given the level of information in the email, I have concluded it would have been difficult for the recipients to appreciate 'the impact of the situation and to develop a better way of handling this type of event'. The Board also maintained that the investigating office had carried out an appropriate investigation, including contacting a number of other clinicians. However, there was no evidence for this in the complaints file which had been provided to the Ombudsman's office. It was accepted this was not reviewed by the Team and that the negative histology report should have triggered an untoward occurrence report and consideration of the need for a critical incident review.

50. I also have concerns about the handling of Mr C's second complaint. It is not clear why the nurse who spoke to him on 23 October 2008 and again in November 2008 was not consulted before February 2009. In response to a draft of this report, the Board said such consultation had occurred but this was not recorded or communicated to Mr C. However, there was also some confusion, caused in part by the Ombudsman's office ongoing involvement at this time with regard to Mr C's related complaint, and I have noted that actions were taken in response to problems identified by the Board (see paragraph 37). While I am less critical of the handling of the second complaint, it is clear that the Board were not investigating but responding to complaints (see paragraph 48). It remains unclear why this meant their own policies were not followed. In the light of the nature of the concerns raised in both of these complaints, this was not appropriate.

51. I have, therefore, fully upheld this complaint and the Ombudsman makes the following recommendations.

(d) Recommendations

52. The Ombudsman recommends that the Board:

(i) undertake a full review of the operation of their complaints process and the relationship of this to clinical governance as a matter of urgency; and

(ii) establish why an incident review was not considered and this matter not re-considered by the Team and take appropriate steps to ensure that their own policies and procedures are followed by clinical and complaints handling staff.

General recommendation

53. The Ombudsman further recommends that the Board make a full apology to Mr C for the failings identified in this report.

54. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Ombudsman's Observation

55. I have decided to include a personal observation about this complaint. This is the first time I have done so and I am doing so because in reviewing this complaint, one point caused me specific concern. I intend to make such observations in future reports when I feel it would be appropriate.

56. In reviewing this report on the problems experienced by Mr C and the information provided to my investigation at interview, I was particularly struck by the fact that it was possible for a member of staff to undertake an investigation (FNA) not because of clinical need but because that radiologist would only undertake FNAs. When the results were discussed at the multi-disciplinary team meeting no mention or comment was made of this and no mention of this was made in the Board's response to Mr C's concerns (see paragraph 5).

57. The recommendation to review the clinical use of such FNAs as a matter of urgency should ensure that this specific problem is resolved. It is also not the role of this organisation to investigate matters beyond the individual complaint. However, I know members of the public reading this report will be struck by and concerned that this situation was allowed to occur. Especially since it appears this problem was not solely linked to this complaint (see paragraph 13) and I am concerned that it has been tolerated and become, in effect, accepted practice. Combined with the failure to ensure that the error in diagnosis made in Mr C's

case was not directed through the Board's own procedures, this suggests to me a cultural problem within at least this team and possibly within the broader management of Hospital 1. I make no specific recommendations on this broader point but would ask the Board to reflect on this carefully and, in particular, to note the need to ensure that the public are reassured that the Board operate within a culture where such situations are not tolerated and it is possible for concerns to be highlighted and acted on.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Hospital 1	Crosshouse Hospital
Hospital 2	Hospital in another Board area where Mr C had his lobectomy
The Board	Ayrshire and Arran NHS Board
Adviser 1	Medical adviser to the Ombudsman
Adviser 2	Consultant pathologist
Consultant 1	The consultant with primary responsibility for the care of Mr C[4]
Consultant 2	The pathologist who reviewed the results from the FNA
Radiologist 1	The radiologist to whom the referral for further investigation was made
Radiologist 2	The radiologist who undertook the FNA
The Surgeon	The surgeon who operated on Mr C. This surgeon was based at Hospital 2
The Team	Lung cancer multi-disciplinary team

[4] This is in connection with Mr C's lung condition. Care for his kidney condition remained with the renal team.

Annex 2

Glossary of terms

Biopsy	Removal of tissue sample for microscopic examination of thin slices of it
Computed Tomography scan (CT Scan)	Scan combining more than one x-ray
Fine needle aspiration (FNA)	Fine needle aspiration: use of a needle to withdraw tissue cells for microscopic examination
Lesion	An abnormality in tissue
Lobectomy	Removal of one of the lobes of the lung – the right lung has three lobes
Positron Emission Technology (PET)	An imaging technique which can reveal more information about possible cancers in the lung
Rounded atelectasis	A benign mass caused by collapsed lung complicating thickening of the pleural lining of the lung
Squamous carcinoma	A cancer which begins in squamous cells: these cells are found in the skin and the lining of many organs

Annex 3

List of legislation and policies considered

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