Scottish Parliament Region: Central Scotland

Cases 201003835: A Medical Practice, Lanarkshire NHS Board

Summary of Investigation

Category

Health: FHS - GP and GP Practice; clinical treatment; diagnosis

Overview

The complainant (Ms C) raised concerns about the care and treatment provided by her GP Practice (the Practice) over a two-year period in that the Practice failed to act on the 'red flag' symptoms she had of a brain tumour within a reasonable time and diagnose her condition.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Practice failed to properly investigate Ms C's symptoms within a reasonable time; (*upheld*) and

(b) the failure by the Practice to diagnose Ms C's condition was not reasonable (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Practice:	*Completion date*
(i) review their practice to ensure they refer for specialist advice within a reasonable time;	14 February 2012
(ii) ensure their record-keeping complies with General Medical Council guidance;	14 February 2012
(iii) update their knowledge of diagnosis and management of persistent upper limb symptoms; and	14 February 2012
(iv) apologise to Ms C for the failures identified.	14 January 2012

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

Main Investigation Report

Introduction

1. Ms C complained about the care and treatment provided by her GP (the GP) Practice (the Practice). On 2 March 2007, Ms C complained to the Practice of abnormal sensations in her left arm, which became progressively worse and the 'attacks' increased in frequency and severity. On 12 August 2008, the Practice diagnosed Ms C with disc degeneration and entrapment. After further consultations with the Practice, Ms C was referred to an orthopaedic specialist in December 2008 and April 2009, and a neurologist specialist in April 2009. In July 2009, Ms C was diagnosed with meningioma (a brain tumour) following an Magnetic Resonance Imaging (MRI) scan. Shortly after, Ms C underwent an operation to remove the meningioma. Ms C said the Practice failed to act on the 'red flag' symptoms she had and that she should have been diagnosed and referred by the Practice to a specialist sooner. Ms C now has several disabilities including post-operative epilepsy which affected her everyday life and she believed these may have been avoided if she had been referred before the tumour had a chance to grow so large.

2. Ms C complained through the Citizens Advice Bureau to the Practice on 28 September 2010. On 21 December 2010, the Practice responded to Ms C's letter of complaint. Ms C remained dissatisfied with the Practice' s response and complained to my office on 21 February 2011.

3. The complaints from Ms C which I have investigated are that:

(a) the Practice failed to properly investigate Ms C's symptoms within a reasonable time; and

(b) the failure by the Practice to diagnose Ms C's condition was not reasonable.

Investigation

4. During the course of the investigation into this complaint, my complaints reviewer obtained and examined Ms C's clinical records and complaint correspondence from the Practice. She also obtained advice from one of the Ombudsman's professional advisers specialising in general practice (the Adviser).

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

Relevant guidance

6. The General Medical Council (GMC)'s guidance on good medical practice states that:

> 2. Good clinical care must include:
>
> (a) adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient
>
> (b) providing or arranging advice, investigations or treatment where necessary
>
> (c) referring a patient to another practitioner, when this is in the patient's best interests.
>
> 3. In providing care you must: …
>
> (f) keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment

Clinical background

7. On 2 March 2007, Ms C (who was 68 at the time) went to the Practice complaining of paraesthesiae and numbness in her left arm. The GP found that Ms C's neck movements were restricted and diagnosed nerve impingement. Ms C returned to the Practice on 26 March 2008. The GP found that turning her neck to the left was severely restricted and diagnosed cervical nerve entrapment syndrome and arranged for physiotherapy.

8. On 12 August 2008, Ms C consulted the Practice with left arm paraesthesiae and was diagnosed with disc degeneration and nerve entrapment. Ms C returned to the Practice on 10 December 2008 complaining of attacks of numbness and weakness in her left arm radiating to the nose. A week later, the Practice made a routine referral to orthopaedics at the hospital saying that in between the attacks, Ms C was dropping things with her left hand and felt that her left arm was weaker than her right and that she had an awkward grip on her left hand. Ms C next attended the Practice on 27 January 2009 with left arm paraesthesiae.

9. Ms C failed to attend the orthopaedic appointment in March 2009. Ms C said that she had been in France at the time of her appointment and felt that she needed to see a different specialist. The GP noted that Ms C's grip was reduced in the left hand and that she had a left dropped foot and paraesthesiae in the right hand. A routine neurology appointment was sent on 17 April 2009.

10. Ms C went to the Practice on 29 April 2009 with paraesthesiae in the left arm and left leg. Ms C was advised that she must attend her orthopaedic appointment and that an MRI scan of the cervical spine was needed. Ms C attended the hospital in early July 2009 and was diagnosed with meningioma following a brain MRI scan. Ms C subsequently had an operation on her brain to remove the meningioma.

The Practice's response

11. The Practice said that the eventual diagnosis of Ms C's condition was extremely unexpected. Ms C first presented on 2 March 2007 with intermittent symptoms of pins and needles and numbness in the left arm, which fitted with a classical picture of nerve impingement from the neck. There was no neurological deficit or progression of her symptoms in March and August 2008 and she was referred to physiotherapy. Surgical intervention for cervical spine issues was only indicated if the disease was progressive because the outcome from surgery was often disappointing, hence a referral to a specialist service was clinically felt unnecessary. The Practice said that this decision was made jointly with Ms C. When Ms C attended the Practice on 10 December 2008, she was referred to hospital for an orthopaedic appointment as her symptoms had progressed to transient weakness in the left arm.

12. The Practice went on to say that the timescale of two years seemed long, but there was no progression of symptoms during this period and physical examination on each occasion was consistent with nerve impingement from cervical spine. Ms C had not complained of headaches and there was no evidence of neurological dysfunction until her presentation in April 2009. By then she had started to lose grip in her left hand and noticed a slight weakness in the left leg. On that occasion, she was immediately referred to a neurologist who diagnosed meningioma. When the diagnosis had been made, her GP telephoned and apologised to Ms C and she was given full support before, during and after surgery.

13. The Practice concluded that in hindsight this had been a very unusual presentation of a meningioma. The signs and symptoms of a brain tumour only first appeared in April 2009 and Ms C was referred immediately for further investigations. Paraesthesiae in the upper arms was not an uncommon symptom in primary care due to cervical nerve impingement and most patients settled down with conservative management. The outcome following neurosurgery for cervical decompression was, in their experience, disappointing. The Practice apologised to Ms C for the delay in the diagnosis and the distress resulting from this.

(a) The Practice failed to properly investigate Ms C's symptoms within a reasonable time

Advice received

14. My complaints reviewer asked the Adviser if the Practice had properly investigated Ms C's symptoms within a reasonable time. The Adviser's view was that although an appropriate diagnosis of nerve impingement was made when Ms C first went to her GP in March 2007, a management plan should have been documented. At the least, a review date should have been agreed as the symptoms had already been occurring for some time. Had Ms C been seen for a doctor-generated review later in 2007, the persistence of symptoms should have prompted a proper investigation and referral to hospital at that time.

15. The Adviser went on to say that an x-ray of the cervical spine would not have been of value. In any 68-year-old, with or without neck symptoms, radiological changes would have undoubtedly been present and this test was no longer recommended in this situation. An MRI should be carried out if nerve compression was suspected. In the event, no investigations were carried out until 2009.

16. The Adviser said that further opportunities for referral to hospital occurred in both March and August 2008. The Practice said they did not refer Ms C because the outcome from cervical spine surgery was poor, but there was no evidence in Ms C's medical notes of the discussion between Ms C and the GP about not proceeding with the referral in August 2008. In the Adviser's opinion, Ms C was, therefore, deprived of the possibility of the correct diagnosis being made as she would undoubtedly have been given an MRI at that time. Ms C was referred to an orthopaedic specialist 21 months after her initial presentation. The referral letter stated that she was dropping things, that Ms C

felt weakness in her left arm and had an awkward grip. It was the Adviser's view that these were not features of straightforward cervical spondylosis and should have raised concerns as they were 'red flag' features of a brain tumour. The Adviser also said that this referral should have been urgent.

17. The Adviser added that the failures by the Practice in this case were contrary to GMC guidance on good medical practice in that Ms C's condition was not adequately assessed, Ms C was not referred at an appropriate time and when a referral was made, it was without the necessary degree of urgency. In addition, there were failures in record-keeping in that both the treatment plan and the significant discussion which the Practice said they had with Ms C over the issue of referral was not recorded.

18. My complaints reviewer asked the Adviser what affect the delay in referring Ms C to a specialist had on the outcome. The Adviser responded that an earlier referral, which should have been made, may have improved the outcome in that as the nature of the symptoms transpired, it was likely that the effects of the meningioma would have been less severe.

(a) Conclusion

19. Ms C complained that the Practice failed to properly investigate her symptoms which she described as 'red flag' and that they were slow to arrange the medical referral Ms C needed. I have decided that the Practice did not refer Ms C to hospital within a reasonable time or with the necessary degree of urgency. The advice I have accepted is that the Practice failed to review Ms C's condition from when she first presented with symptoms in March 2007 and, as a result, there was a delay in properly investigating those symptoms and referring Ms C to hospital from late 2007. I am also concerned that when Ms C was eventually referred in December 2008, it was a routine referral despite her symptoms presenting as 'red flag' features of a brain tumour. The failures by the Practice meant that it was likely Ms C endured the symptoms of meningioma much longer than if she had been referred to hospital within a reasonable time. In the circumstances, I uphold the complaint.

20. I recommend that the Practice review their practice of referral in light of this report. I have also made a recommendation on record-keeping given the advice I have accepted on failures by the Practice in this area.

(a) Recommendations

21. I recommend that the Practice:	*Completion date*
(i) review their practice to ensure they refer for specialist advice within a reasonable time; and	14 February 2012
(ii) ensure their record-keeping complies with GMC guidance.	14 February 2012

(b) The failure by the Practice to diagnose Ms C's condition was not reasonable

Advice received

22. My complaints reviewer asked the Adviser if the time taken to make the diagnosis in Ms C's case was reasonable. As I said above, the Adviser's view was that given the nature and persistence of Ms C's symptoms, she should have been referred to hospital earlier. Cervical spondylosis was a very common disorder and symptoms were usually at nuisance level and managed with pain relief often benefiting from physiotherapy. Ms C repeatedly presented with the same symptoms and physiotherapy had been of no help. This should have raised concerns with the Practice.

23. Given the advice that Ms C should have been diagnosed earlier, my complaints reviewer asked the Adviser what difference an earlier diagnosis would have made on the outcome and in particular the persistent physical weakness and epilepsy Ms C has suffered from since the surgery. The Adviser said that it was not possible to say whether an earlier diagnosis would have made any difference to the outcome as the meningioma may have been present and growing slowly for many years. The risk of post-operative epilepsy was always a hazard of brain surgery and may still have occurred even had the diagnosis been made at an appropriate time.

(b) Conclusion

24. Ms C complained that the Practice failed to diagnose her condition and that the disabilities she now has could have been avoided. I have decided that the failure to diagnose Ms C's meningioma was not reasonable. The advice I have accepted is that Ms C repeatedly presented with the same symptoms which were not alleviated by physiotherapy and that this should have raised concerns. In view of this, I uphold the complaint. However, I have also accepted advice that even if the diagnosis had been made within a reasonable time, Ms C may still have developed post-operative epilepsy because this was a risk of brain surgery.

(b) Recommendation

25. I recommend that the Practice:	*Completion date*
(i) update their knowledge of diagnosis and management of persistent upper limb symptoms.	14 February 2012

General recommendation

26. I recommend that the Practice:	*Completion date*
(i) apologise to Ms C.	14 January 2012

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

Annex 1

Explanation of abbreviations used

Ms C	The complainant
The GP	Ms C's GP
The Practice	The GP practice in Lanark shire
MRI scan	Magnetic resonance imaging scan
The Adviser	The professional medical adviser to the Ombudsman
GMC	General Medical Council
The hospital	Nuffield Health Glasgow Hospital

Annex 2

Glossary of terms

Meningioma	A brain tumour, which is usually slow growing and benign. Larger tumours can cause symptoms including, amongst others, progressive weakness in legs and incontinence, and a range of motor, sensory symptoms etc. The treatment depends on a number of things and surgery is undertaken where possible for those tumours already causing symptoms
Paraesthesiae	Abnormal skin sensations such as tingling, itching or burning

Annex 3

List of legislation and policies considered

General Medical Council's *Good Medical Practice*