Scottish Parliament Region: Lothian

Case 201003214: A Medical Practice, Lothian NHS Board

Summary of Investigation

Category

Health: GP Practice; clinical treatment and diagnosis

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment provided to her late mother (Mrs A) by the Medical Centre she attended for several years (the Practice), leading up to her death from cancer in June 2010. Mrs C is supported in her complaint by Mrs A's husband (Mr A) and her sister (Mrs D).

Specific complaints and conclusions

The complaints which have been investigated are that the Practice:

(a) did not listen to the concerns raised (*not upheld*);

(b) failed to carry out adequate tests and investigations (*upheld*); and

(c) did not take adequate steps to help with the diagnosis of Mrs A's cancer (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Practice:	*Completion date*
(i) undertake a significant event review of Mrs A's care and treatment from March 2010 onwards and consider lessons that can be learned for future practice;	28 March 2012
(ii) ensure that Practice records comply with NHS record-keeping guidelines; and	14 March 2012
(iii) apologise for the failures identified in this report.	14 March 2012

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

Main Investigation Report

Introduction

1. Mrs A had a complex past medical history and also suffered from back, leg and hip pain over several decades. Mrs A attended her medical practice (the Practice) in November 2009 and complained of increased back pain and night sweats. The Practice undertook a number of tests but nothing was found immediately to suggest any new serious problem. A number of referrals were also made for Mrs A at this time. Mrs A continued to seek help from the Practice throughout the period from November 2009 to May 2010 for a number of ongoing symptoms that latterly included constipation. On 13 May 2010, a home visit was requested, however, before this happened, her family became so concerned about Mrs A's condition that they called an ambulance and Mrs A was admitted to hospital that morning.

2. Following her admission to hospital on 13 May 2010, a number of tests were carried out to try to find the cause of Mrs A's back pain and other symptoms. The initial thought was that Mrs A had a respiratory tract infection. None of the initial tests showed any conclusive results and further tests were conducted. A bone marrow test was carried out on 25 May 2010 and Mrs A was diagnosed with metastatic adenocarcinoma (secondary cancer in her glandular tissue) on 27 May 2010. The primary cancer site was thought to be in the gut, however, the exact site was never found. Palliative treatment (particularly for pain relief) was provided. Mrs A was transferred to a hospice on 2 June 2010 and died there on 17 June 2010. Mr A, supported by Mrs C and Mrs D, complained to the Practice on 15 June 2010 about the care they provided to Mrs A and received a response on 23 June 2010. Mrs C remained unhappy with the response and complained to this office on 10 November 2010. Mrs C is supported in this complaint by Mr A and Mrs D.

3. The complaints from Mrs C which I have investigated are that the Practice:

(a) did not listen to the concerns raised;
(b) failed to carry out adequate tests and investigations; and
(c) did not take adequate steps to help with the diagnosis of Mrs A's cancer.

Investigation

4. In her investigation into this complaint, my complaints reviewer obtained and examined Mrs A's clinical records relevant to this complaint (the Records) and the complaint correspondence from the Practice. My complaints reviewer

also obtained and reviewed Mrs A's hospital records from 13 May 2010 to 2 June 2010. She sought advice from one of my professional advisers, a general practitioner (the Adviser). My complaints reviewer and the Adviser also met with Mrs C, Mr A and Mrs D to discuss their concerns about the care and treatment Mrs A received from the Practice.

5. 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) The Practice did not listen to the concerns raised

6. Mrs C stated that the Practice had failed to listen to the numerous serious symptoms and presenting problems raised by Mrs A and her family over several years. Mrs C said that a number of her mother's symptoms, such as night sweats, were consistent with a diagnosis of cancer. She felt that doctors at the Practice had simply assumed everything was related to Mrs A's hip and back problems and had not investigated her symptoms properly. Mrs C was concerned that the Practice would not make house calls to Mrs A who she said had great difficulty in attending the Practice and Mrs C also said that the Practice had dismissed Mrs A as a hypochondriac.

7. In their response to Mr A dated 23 June 2010 the Practice stated they carried out house calls to Mrs A when these were requested, including on 11 May 2010, which had resulted with a referral to the district nurses to offer more support to Mrs A. The Practice also outlined that they would encourage patients wherever possible to attend surgery, as it is more practical to assess and treat people in the surgery.

8. The Adviser stated that house calls were planned and did occur. He said he saw no specific instance in the Records of house calls being refused. He added that during 2008 there was an acute incident which involved Mrs A and an emergency ambulance was called, rather than for a GP visit to take place, but this was appropriate action. The Adviser noted that a GP visit had been intended on 13 May 2010. However, he noted the family became concerned by Mrs A's condition and called for an emergency ambulance. This happened before the GP could visit Mrs A at home.

9. The Adviser reviewed Mrs A's Records over several years and also the hospital medical records relevant to the period of Mrs A's admission. He noted

that a number of her symptoms were attributed to her chronic health problems; however, he noted that the Practice had not suggested that these were not real symptoms. It was his view that there was nothing in the Records to suggest that the Practice regarded Mrs A as a hypochondriac.

10. At the meeting attended by my complaints reviewer, the Adviser, Mrs C, Mr A and Mrs D, the family stated they had raised issues with the Practice regarding their concerns about Mrs A's vomiting, that she had anaemia, abdominal swelling and possible jaundice.

11. The Adviser stated the Records do not detail such discussions and accordingly, it is not possible to confirm or refute these statements.

12. The Adviser found evidence in the Records of a number of appointments, telephone calls and house calls, each with various reported symptoms noted and discussed. In his view, these were acted on in an appropriate way. The Adviser concluded that the Practice staff were responsive to the symptoms presented by Mrs A.

(a) Conclusion

13. The Adviser's view is that there is no evidence that the Practice did not take Mrs A's symptoms seriously and no evidence to suggest that they regarded Mrs A as a hypochondriac. I have taken account that there is no evidence that Mrs A had not been listened to by the Practice and, along with the Adviser, I conclude that the Practice acted in response to the symptoms described to them by Mrs A and her family. I have not seen evidence that house calls were either refused when requested or not made by the Practice. Taking all these factors into account, I do not uphold this aspect of the complaint.

(b) The Practice failed to carry out adequate tests and investigations

14. Mrs C complained that the Practice had not arranged the appropriate tests or investigations for her mother's symptoms and, consequently, they had failed to diagnose several cancers and other serious problems until it was too late to act. Mrs C said Mrs A was in considerable pain and distress for many years.

15. The Adviser considered that the various tests and further specialist examinations arranged by the Practice before and immediately following November 2009 were all reasonable and appropriate. He noted that these had

led to the diagnosis of a number of medical conditions, including carpal tunnel syndrome and a hearing problem, all of which were unrelated to Mrs A's cancer. In particular, the Adviser commented that magnetic resonance imaging (MRI) of the spine arranged in 2008 showed no evidence of cancer.

16. However, the Adviser noted that there was a significant deterioration in Mrs A's health and reported symptoms from March 2010 onwards. In particular, he noted that her constipation and related symptoms were attributed to the effects of analgesia and no further investigation was carried out. He concluded that this change should have promoted the Practice to reconsider its earlier findings. Such reconsideration should have included repeating blood tests between the period March and May 2010 which, he stated, would have noted an abnormality and have prompted further investigation and/or earlier referral to hospital, which may have allowed for an earlier diagnosis to be made. The Adviser stated that he found no blood test results present in the records after 17 December 2009. He said that the care given to Mrs A was deficient, in that the Practice did not investigate her on-going and progressive symptoms with sufficient vigour.

17. In his review of the Records the Adviser additionally noted that, from November 2009 onwards, some notes showed a lack of specifics in history; for example, as to site, type and duration of Mrs A's pain. He also stated that while it was clear that Mrs A's condition had deteriorated between March and May 2010, there was little evidence that the Practice noted this or acted upon it. In this regard, he stated that there were a number of interactions between the family and the Practice at that time.

(b) Conclusion

18. The Adviser told me that the Practice acted appropriately in response to Mrs A's various symptoms up to and including those reported in November 2009. However, he stated that Mrs A's condition and symptoms had suffered a marked deterioration from March 2010 onwards; however, the Practice had not considered whether earlier tests should be repeated or other avenues explored. For this reason, he considered that the Practice had not acted appropriately. From the evidence I have seen, I consider that the Practice should have been more proactive in organising tests and/or other follow-up referrals for Mrs A from March to May 2010. For these reasons, I uphold this aspect of the complaint.

(b) Recommendations

19. I recommend that the Practice:	*Completion date*
(i) undertake a significant event review of Mrs A's care and treatment from March 2010 onwards and consider lessons that can be learned for future practice; and	28 March 2012
(ii) ensure that Practice records comply with NHS record-keeping guidelines.	14 March 2012

(c) The Practice did not take adequate steps to help with the diagnosis of Mrs A's cancer

20. Mrs C, Mr A and Mrs D assert that Mrs A had symptoms of cancer for many years, which the Practice did not diagnose. The family contends that if the Practice had been more proactive then the diagnosis of cancer could have been reached sooner.

21. The Adviser explained to my complaints reviewer that the diagnosis of secondary cancer in Mrs A's case could only have been made in a hospital setting and, furthermore, it had not been possible for the hospital to diagnosis the site of Mrs A's primary cancer despite several tests and investigations.

22. A number of tests were carried out at the hospital before Mrs A's actual diagnosis was made. The Adviser noted that Mrs A's confirmed diagnosis of cancer was not made until two weeks after her hospital admission, as it was not immediately obvious what Mrs A's underlying medical problem was.

23. The Adviser noted from the hospital records that Mrs A's cancer was diagnosed by a bone marrow biopsy. At that point the primary source of the cancer was unknown, however, the pathology report states that the primary site was most likely colo-rectum.

24. The Adviser examined the hospital records from Mrs A's admission on 13 May 2010 to her diagnosis on 25 May 2010. He stated that initially the concern was that Mrs A had an infection possibly in her chest; however, as the days progressed her hospital records revealed she became more anaemic and her liver function tests became more abnormal. She was found to have signs of bone marrow infiltration on an MRI scan performed on 20 May 2010 – this scan used a previous scan in 2008 for comparison and noted 'the MR of 05/08

showed a normal bone marrow signal' (see paragraph 14). The original working diagnosis was of multiple myeloma (a cancer of blood cells) and a haematology opinion was sought, which led to the bone marrow biopsy. A computed tomography scan (CT scan) of the abdomen showed no focal cancer deposits in the liver and a scan of the thyroid gland showed a multi nodular appearance but no thyroid cancer. A CT scan of the head showed no cancer deposits in the brain or bony involvement of the skull. I have included my Adviser's detailed account of these hospital records as the family stated that, in their view, Mrs A had suffered from primary, secondary and third cancers for many years. They also stated that Mrs A had suffered from various cancers during her final illness, which included a brain tumour, thyroid cancer, ocular cancer of the eyes and bone, bowel, stomach gullet and liver cancer, as well as anaemia.

25. The Adviser stated that the list of cancers described by the family are those that are known to spread to bone and bone marrow. It is, therefore, logical that hospital staff explored these possibilities. This does not mean that staff thought that all of these sites were affected by cancer (see paragraph 24).

26. The Adviser noted from the hospital records that it was clear there were a number of conversations which involved general medical, haematology, oncology and palliative care staff about Mrs A's condition. Initially, the question was whether Mrs A had an infection perhaps in the spine but, as investigations progressed, a malignant disorder became more likely. The Adviser noted evidence in the hospital records that a primary cancer was being sought and a number of specialties were consulted, including haematology and respiratory medicine (see paragraph 21). A breast examination was recorded as normal and there was no entry in the notes which suggested the presence of cancer within the eye.

27. At the meeting the Adviser and complaints reviewer held with the family on 30 May 2011, Mrs C raised the issue of Mrs A suffering from hypocalcaemia and stated that her symptoms were consistent with this. The clinical syndrome associated with hypocalcaemia includes bone pain, abdominal pain, stone formation, nausea and vomiting. The Adviser stated that there was no evidence he had seen in the Records or hospital records that Mrs A suffered from this illness.

28. The family has asserted that Mrs A had symptoms for many years which they attribute to her cancer. The Adviser concluded that Mrs A had a long and

complex medical history and that her symptoms changed significantly in late 2009 (see complaint (b)). Given the rapid clinical deterioration between March and May 2010, he said it was unlikely that Mrs A had lived with the condition stated within this complaint for many years.

29. In their letter to Mr A dated 23 June 2010 which I have seen, the Practice stated that over the years they had ensured Mrs A had received thorough and appropriate investigations with blood tests, x-rays, MRI scan, ultrasound scans and nerve conduction studies. They also said they had referred Mrs A to various hospital specialists and nothing had come back which suggested any cause for concern and, in particular, there was no indication of cancer (see also complaint (b)).

30. The Adviser stated that, based on the collective symptoms Mrs A presented to the Practice on a regular basis; her ill health and decline from late 2009 to May 2010 (which would have been a gradual curve); all these factors should have prompted further blood tests being carried out by the Practice during this period. While the Adviser cannot say when any abnormalities may subsequently have appeared, he stated the Practice should have undertaken investigative tests as outlined in complaint (b).

31. The Adviser also considered that some of Mrs A's ongoing and progressive symptoms, notably between March 2010 and May 2010, were attributed by the Practice to her chronic health problems rather than being investigated as new symptoms.

(c) Conclusion

32. Mrs C complained the Practice did not take sufficient action in order to help with Mrs A's diagnosis of cancer. The Adviser is clear that Mrs A's cancer was appropriately diagnosed in hospital after several tests had been conducted there. He also states that Mrs A was unlikely to have suffered this cancer for many years.

33. While Mrs A's cancer was diagnosed at the hospital and this was the correct procedure, it remains that the Practice could have taken a more proactive role in her clinical care during the period late 2009 to May 2010, based on the deteriorating clinical condition she presented - most notably between March 2010 and May 2010. I consider that had the Practice taken this approach, it would have been possible for the Practice to make a more positive

and helpful contribution towards Mrs A's subsequent cancer diagnosis. Taking all these factors into account I uphold this complaint.

General Recommendation

34. I recommend that the Practice:	*Completion date*
(i) apologise for the failures identified in this report.	14 March 2012

35. 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

Mrs A	The aggrieved
The Practice	Mrs A's GP practice
Mr A	Mrs A's husband
Mrs C	The complainant, Mrs A's daughter
Mrs D	Mrs A's daughter
The Records	Mrs A's clinical records
The Adviser	A specialist GP adviser to the Ombudsman
MRI	Magnetic resonance imaging used in radiology
CT Scan	Computed tomography that uses special x-ray equipment

Annex 2

Glossary of terms

Hypocalcaemia	The presence of low serum calcium levels in the blood
Metastatic adenocarcinoma	Secondary cancer spread through glandular tissue