Scottish Parliament Region: South of Scotland

Case 201200492: A Medical Practice in the Borders NHS Board area[1]

Summary of Investigation

Category

Health: FHS – GP & GP Practice; clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised concerns about the inadequate care and treatment her daughter (Ms A) received at her previous medical practice (the Practice). The complaint concerns the lack of investigation into a lump on Ms A's neck and her symptom of tiredness. Ms A had several consultations with two GPs at the Practice, Doctor 1 and Doctor 2, between July and December 2010. When she registered with a different medical practice in early 2011 it was identified after further investigation that she had cancer of the thyroid. Ms A subsequently underwent treatment, including a thyroidectomy[2] and radioactive iodine treatment.

Specific complaint and conclusion

The complaint which has been investigated is that Doctor 1 failed to adequately assess Ms A's reported symptoms of a lump in her neck and tiredness on 10 August 2010 *(upheld)*.

Redress and recommendations

The Ombudsman recommends that:	*Completion date*
(i) Doctor 1 and Doctor 2 apologise to Ms A for the failings identified in this report; and	17 July 2013
(ii) Borders NHS Board ensures that Doctor 1 and Doctor 2 reflect on the failings that have been identified in this report at their next appraisal.	11 August 2013

[1] The medical practice closed down and Borders NHS Board agreed to assist with investigation of the complaint.
[2] Surgery to remove part or all of the thyroid gland.

Main Investigation Report

Introduction

1. Mrs C complained to Borders NHS Board (the Board) on 28 December 2011 about the lack of care and treatment her daughter (Ms A) received at her medical practice (the Practice) regarding her on-going symptoms of tiredness and neck lump. After Ms A registered with a different medical practice, it was established that she had cancer of the thyroid that had spread to her lymph glands. Mrs C is of the view that less invasive surgery could have resulted had her GP (Doctor 1) fully investigated Ms A symptoms.

2. The Board responded to Mrs A's complaint on 5 January 2013 and explained that it is standard practice for a medical practice to investigate and respond to complaints about care and treatment they have provided. However, the Board agreed to investigate the complaint as the Practice had permanently closed in June 2011.

3. The complaint from Mrs C which I have investigated is that Doctor 1 failed to adequately assess Ms A's reported symptoms of a lump in her neck and tiredness on 10 August 2010. However, as the investigation progressed, my complaints reviewer also identified issues concerning the care provided by another GP at the Practice (Doctor 2).

Investigation

4. All the available information provided by Mrs C and the Board has been taken into consideration. Advice has also been obtained from an independent adviser to the Ombudsman, namely a general medical practitioner (the Adviser). 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 Board were given an opportunity to comment on a draft of this report.

Complaint: Doctor 1 failed to adequately assess Ms A's reported symptoms of a lump in her neck and tiredness on 10 August 2010

5. Mrs C explained in her complaint to the Board that Ms A had attended the Practice on 30 July 2010 due to a problem she was having with bleeding between periods. At this time, Doctor 2 noticed a lump at the front of Ms A's neck and arranged for blood tests to investigate further. Mrs C further explained that Ms A returned to the Practice on 10 August 2010 for the results and was advised by Doctor 1 (her regular doctor) that the results were normal

and the lump was nothing to worry about. Mrs C said that her daughter had several more consultations with Doctor 1 regarding her irregular periods and symptom of on-going tiredness. However, Mrs C said that no investigations or examinations were carried out in an attempt to establish the cause of the symptoms and the only suggestions Doctor 1 made were contraceptive related.

6. Mrs C advised that her daughter moved house and subsequently registered with a different medical practice. Further investigations of Ms A's on-going symptoms of tiredness and neck lump were carried out by this medical practice. Ms A was also referred to an endocrinologist[3] and after a biopsy of the lump was taken, it was identified that she had cancer of the thyroid. Further tests also showed that the cancer had spread to Ms A's lymph glands.

7. The Board thereafter sought statements from both Doctor 1 and Doctor 2 in response to the issues Mrs C had raised in her complaint.

8. Doctor 2 explained in his statement that when he saw Ms A on 30 July 2010 in relation to a different matter for which she needed a minor surgical procedure, Ms A had told him that she was suffering from tiredness, dizziness and inter-menstrual bleeding. Doctor 2 thereafter identified a swelling on Ms A's neck and arranged for blood tests to check her thyroid function. Doctor 2 also said that he had asked Ms A to make another appointment in order to discuss the results. Doctor 2 further explained that he only worked at the Practice two days a week and that it was routine to ask patients to book an appointment to discuss the results of the blood tests with the doctor on duty any particular day. Doctor 2 said that when he saw Ms A again on 19 August 2010 in order to carry out some minor surgery at the Practice, he had enquired about the thyroid swelling but was informed by Ms A that she had since seen Doctor 1 and discussed the results and on-going symptoms. Doctor 2 also said that, as Ms A had told him that she was going to see Doctor 1 for further review, he decided not pursue the issue any further. Doctor 2 also commented that he saw Ms A on 26 August 2010 and on 2 September 2010 for wound review in relation to the minor surgical procedure. Doctor 2 concluded that he was 'very upset and feel that I could have been more proactive but at the same time I respected [Ms A's] choice of seeing her own doctor for further care'.

[3] A medical professional who specialises in the treatment of hormone related disorders

9. Doctor 1 outlined in her statement that she was deeply sorry to hear that Ms A had been diagnosed with thyroid cancer. Doctor 1 explained that she saw Ms A on 10 August 2010 regarding problems she was having with painful periods, menstrual irregularities, and emotional problems. Doctor 1 said that she had discussed these issues with Ms A and carried out a gynaecological examination which was found to be normal. Doctor 1 outlined that the consultation was longer than the average appointment and said that she could not recall any discussion or examination of Ms A's neck lump or any comments by Ms A that she was suffering from fatigue.

10. Doctor 1 was sent a copy of Ms A's medical records in order to respond to the complaint. Doctor 1 noted that Ms A was seen by Doctor 2 on 30 July 2010 where an assessment was carried out on a neck lump. Doctor 1 also noted that Doctor 2 had arranged blood tests and had advised Ms A to make a follow-up appointment in order to discuss the results. Doctor 1 noted that Ms A's medical records also included a copy of a summary sheet that listed all of Ms A's consultations. Doctor 1 commented on an entry that had been made by the receptionist at the time the appointment on 10 August 2010 was made which stated 'Discuss recent blood test results & lump in neck'. Doctor 1 explained that when Ms A booked the appointment for 10 August 2010, the receptionist must have made the entry on the computer system and that:

> 'Such messages were entered occasionally by the reception staff as a pointer to the reason for requesting the consultation, but I did not routinely check for them, as I was guided by the history given by the patient at the time of the consultation. The message could only be viewed after opening the patient's computer records. As the practice was still using a manual system of recording consultations it was not necessary to open the computer records prior to consultation.'

11. Doctor 1 further outlined that during two further consultations she had with Ms A on 15 September and 2 November 2012, there was no mention of the lump in Ms A's neck or that she was suffering from fatigue. Doctor 1 said that at these appointments, Ms A's menstrual and emotional problems were noted to be improving. In addition, Doctor 1 commented that she had advised Ms A to have her blood pressure checked after she moved to the new medical practice as it was slightly raised.

12. The Board informed Mrs C that they were not directly responsible for Doctor 1 and Doctor 2's responses to the complaint or for immediate follow-up

actions, because it was a complaint about the care and treatment of a general medical practice. The Board advised Mrs C that if she remained unhappy with the responses, then she could raise the matter with my office.

13. Mrs C wrote again to the Board on 30 March 2011 in response to the comments Doctor 1 had made in her statement. Mrs A said that her daughter did mention the lump on her neck at the consultation with Doctor 1 on 10 August 2010 as this was the reason for the appointment. In addition, Mrs C said that her daughter did not mention the lump again at any further consultations at the Practice because Doctor 1 had advised her on 10 August 2010 that it was nothing to worry about[4].

14. As explained earlier in this report, independent advice was sought from a general medical adviser (the Adviser). The Adviser reviewed the medical records and complaint correspondence in relation to the care and treatment Ms A received from both Doctor 1 and Doctor 2.

15. The Adviser noted that the Practice were documenting consultations by way of handwritten records. The Adviser said that the handwritten notes by Doctor 2 on 30 July 2010 are clear in that there was an intention to follow-up on Ms A's symptoms of tiredness and the neck lump after the test results were available. The Adviser explained that the handwritten note of the consultation on 10 August 2010 by Doctor 1 commenced on the same page in the medical records and it was reasonable to assume that Doctor 2's consultation of 30 July 2010 could be clearly seen by Doctor 1. However, Doctor 1 had said she could not recall that the neck lump was mentioned by Ms A despite Ms A being adamant that the issue had been discussed.

16. The Adviser considered whether or not Doctor 1 should have been aware of the neck lump. On 10 August 2010, there were clear hand written medical notes from the previous consultation of 30 July 2010 available to Doctor 1. In addition, there was an entry in the Practice's computerised appointment system next to the appointment on 10 August 2010 that mentioned the neck lump. Therefore, it is reasonable to conclude that review of the lump formed part of the intention at the time the appointment for 10 August 2010 was booked.

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[4] In commenting on a draft of this report, Doctor 1 said that she would not have advised any patient that there was nothing to worry about with regard to a neck lump that had not been fully investigated.

17. Whilst Mrs C did not raise any concerns about the care and treatment her daughter received from Doctor 2, the Adviser considered that Doctor 2 should have followed-up Ms A's neck lump. The Adviser commented that although Doctor 2 worked part-time, this should not have precluded follow-up if he remained working in the Practice. With reference to Section 2 of the British Thyroid Association – Thyroid Cancer Guidelines (the National Guidelines), the Adviser explained:

> 'My practice would have been to establish thyroid function by blood testing and then to re-examine with a low threshold for referral. If I confirmed a solitary lump related to the thyroid gland I would have referred the patient. A number of diagnostic possibilities exist here but one of these is recognised to be thyroid cancer.'

18. My complaints reviewer asked the Adviser what communication would have been expected between Doctor 1 and Doctor 2 in relation to the neck lump. The Adviser said that the main mode of communication within a medical practice about patients is through the medical records as it is not possible to discuss every patient seen in the course of each doctor's work. The Adviser also commented that whilst it is not mandatory to use computers to record clinical notes, it is his understanding that the vast majority of medical practices across Scotland were doing so by 2010. The Adviser said that, occasionally markers within the computer system can be used, but he was uncertain as to the full extent the computerised system was being used by the Practice.

19. My complaints reviewer also noted that there was an entry on the Practice's computerised appointment system next to the appointment that took place with Doctor 2 on 19 August 2010 that also stated 'Discuss recent blood test results and lump in neck'. As set out in paragraph 8 above, Doctor 2 said that he had enquired about the neck lump with Ms A. My complaints reviewer noted that Doctor 2 had made a written record of the minor surgery that he had carried out on 19 August 2010 but no record was made about the neck lump.

20. Whilst the blood test results were noted to be normal, the Adviser concluded that both Doctor 1 and Doctor 2 showed deficiencies in the care of Ms A. The Adviser said that deficiencies in the Practice's systems, including the use of computerised records, may have allowed messages to go unnoticed and caused a failure to follow-up Ms A's neck lump. The Adviser also said that Doctor 2 should have been more proactive in his care and Doctor 1 should have

consulted the handwritten records from the previous consultation on 30 July 2010 along with the computer entries.

Conclusion

21. Ms A and her family have endured much distress and upset regarding all that has happened in this case. I have taken into account the handwritten records made by both doctors between 30 July and 6 December 2010, along with the computer entries for the appointments on 10 and 19 August 2010. I have also noted Ms A's version of events presented by Mrs C, along with the statements provided by Doctor 1 and Doctor 2 in response to the complaint. Independent clinical advice was also sought on the care and treatment provided to Ms A.

22. There is no evidence in the medical records to support that Ms A's symptoms had been followed up by either Doctor 1 or Doctor 2 despite several consultations having taken place with them between July and December 2010. Based on the clinical advice I have received, there was a failing in Ms A's care in that her symptoms should have warranted referral even although the blood tests results showed no abnormality. In line with the National Guidelines, it would also have been appropriate to have referred Ms A for further assessment of the neck lump.

23. From the information available, I consider it more than likely that Ms A had mentioned the neck lump and tiredness at the consultation with Doctor 1 on 10 August 2010 because there is clear evidence from the previous handwritten record of 30 July 2010 that both these symptoms were discussed and Ms A had been advised by Doctor 2 to make a follow-up appointment in order for the blood results to be discussed. Furthermore, the Practice's computer records clearly indicated the reason why the appointment of 10 August 2010 had been arranged, that is to discuss the blood test results and neck lump.

24. I consider it would have been reasonable for Doctor 2 to have checked what follow-up had been done in relation to the neck lump as it was clear from the handwritten record made by Doctor 1 on 10 August 2010 that there was no evidence of it having been reviewed.

25. In view of the above, I uphold the complaint.

Recommendations

26. I recommend that the:	*Completion date*
(i) Doctor 1 and Doctor 2 apologise to Ms A for the failings identified in this report; and	17 July 2013
(ii) the Board ensure that Doctor 1 and Doctor 2 reflect on the failings that have been identified in this report at their next appraisal.	11 August 2013

27. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant and mother of Ms A
The Board	Borders NHS Board
Ms A	Mrs C's daughter
The Practice	A general medical practice that has since permanently closed down
Doctor 1	A GP at the Practice
Doctor 2	A GP at the Practice
The Adviser	A general medical adviser to the Ombudsman
The National Guidelines	Section 2 of the British Thyroid Association – Thyroid Cancer Guidelines

Annex 2

Glossary of terms

Endocrinologist	a medical professional who specialises in the treatment of hormone related disorders
Thyroidectomy	surgery to remove part or all of the thyroid gland

Annex 3

List of legislation and policies considered

British Thyroid Association – Thyroid Cancer Guidelines – Section 2.2 - diagnosis