S.19/03-04

Scottish Public Services Ombudsman Act 2002

Report by the Scottish Public Services Ombudsman of an investigation into a complaint against Fife Acute Hospitals NHS Trust (the Trust)[1]

Complaint as put to the Ombudsman

1. In this report I refer to the complainant as Mr Y and to his wife as Mrs Y. The account of the complaint provided by Mr Y is that on 16 November 1998, he took his wife to the Accident and Emergency Department at Queen Margaret Hospital, Dunfermline. Mrs Y had complained of being unwell, with peripheral sight loss, and had a pain behind her left eye. Mrs Y was admitted to the hospital and was placed under the care of a Consultant Physician (the Physician) and a Consultant Ophthalmologist (the Ophthalmologist). Mrs Y was told that she had lost peripheral vision in her left eye and a diagnosis of hypertension was made. She remained in hospital for a few days for tests and received medication to control her high blood pressure. She was discharged and subsequently attended the medical clinic and eye clinic. Mrs Y's sight continued to deteriorate and she was completely blind by Christmas 2000. Her GP arranged for a MRI scan to take place in May 2001 and the diagnosis was made that she had a pituitary gland tumour. The tumour was removed four days after the MRI scan. Mr Y took the view that the tumour would have been present in November 1998, and that had medical staff performed further investigations at that time, the tumour would have been removed and Mrs Y would have retained her sight. Mr Y complained to the Trust that medical staff should not have focussed solely on the explanation that high blood pressure was the cause of Mrs Y's sight problems and they should have undertaken further investigations. Mr Y was dissatisfied with the Trust's response to his complaint and requested an independent review.

[1] Fife Acute Hospitals National Health Service Trust was established by The Fife Acute Hospitals National Health Service Trust (Establishment) Order 1998 which came into force on 2 November 1998. The Trust was dissolved under The Fife National Health Service Trusts (Dissolution) Order 2003 which came into force on 1 October 2003. On the same date an Order transferring the liabilities of the Trust to Fife Health Board came into effect.

A review was held and its report was issued on 16 April 2003. Mr Y remained dissatisfied and complained to me.

2. The complaint subject to investigation was that following Mrs Y's presentation in November 1998, medical staff failed to investigate correctly her symptoms and diagnose that she was suffering from a pituitary tumour.

Investigation

3. The statement of complaint for the investigation was issued on 16 June 2003. The Trust's comments were obtained, and relevant papers were examined. Oral evidence was taken from Mr Y and Trust staff. Two professional assessors - a consultant physician and a consultant ophthalmologist - were appointed to advise on the clinical aspects of the case. Their report is reproduced in full at paragraph 14. A glossary of medical terms used in this report is set out in Annex A. I have not included in this report every detail investigated, but I am satisfied that no matter of significance has been overlooked.

Mr Y's evidence

4. **Mr Y** said that prior to November 1998, he could not recall his wife saying that she had had problems with her vision. She had never attended the GP about sight problems or for high blood pressure and in fact she hardly ever attended the GP. However, on 16 November, Mrs Y started to complain about a painful left eye and a severe headache, so much so that she nearly collapsed into a chair. Mr Y took his wife to the hospital later that night and the diagnosis was made that she was suffering from hypertension. She was admitted that evening and was subsequently examined by staff from the Ophthalmology Department. She was in hospital for a few days and received medication for her high blood pressure and was told to take plenty of rest. Mrs Y's prime concern was for her health and the reasons for her worrying loss of sight. On the day prior to discharge, the family dog died and Mrs Y told staff that she wanted to go home to be with her family. Mrs Y was not particularly anxious about being in hospital or having tests performed. If a doctor said they were required then she would agree to such a request. Mrs Y

was then discharged into the care of the Medical Outpatient Clinic and the Ophthalmology Outpatient Clinic.

5. Mrs Y's medical records indicated that there had been an improvement in her sight in April and June 1999. Mr Y said that as far as his wife was concerned, she did not notice an improvement, although her sight had not deteriorated further. The medical advice given at that time was that Mrs Y should attend an optician - which she did - but the glasses which were prescribed were not much help. Mr Y could not recall when his wife had missed appointments at the eye clinic (see paragraph 11) but they had always been rescheduled. As far as he was aware, Mrs Y was still on the patient list at the eye clinic in June 1999 and he assumed they would send notification of her next appointment. However, no review appointment was received. He thought that after his wife's last eye clinic appointment in June 1999 and subsequent appointment with the optician to arrange glasses, her eye problems remained relatively stable. He noticed that she tended to put more lights on as she moved around the house and when she was reading etc. Mrs Y's sight deteriorated rapidly a couple of weeks prior to Christmas 2000. She was completely blind in her left eye and only partially sighted in her right eye by the time she contacted her GP in March 2001 and was totally blind by the time the MRI scan took place in May 2001.

6. Mr Y could understand that medical staff had to investigate his wife's hypertension and that they had managed to bring it under control. However, on a couple of occasions, he asked what had caused the hypertension and medical staff told him that they could not find the cause. Mr Y had concerns that in February 1999, the Physician had not acted on a suggestion from the Endocrine Unit at the Western General Hospital that perhaps he should arrange a MRI scan for Mrs Y. He thought it was strange that the Physician had chosen to discount the suggestion, which would have discovered the pituitary tumour, as he had previously described the Unit as a Centre of Excellence. The Physician had also discussed the possibility of a MRI scan with Mrs Y on 2 February 1999. His decision not to follow this line of action related to the Physician's suggestion that Mrs Y had problems with claustrophobia: Mr Y stated that this reference to the presence of claustrophobia was disputed.

In a meeting on 31 May 2002, the Physician acknowledged that this was his own shorthand description to reflect Mrs Y's anxiety. Mr Y hoped that this investigation would result in him and his wife finally receiving an explanation as to why Mrs Y had lost her sight and whether or not medical staff should have investigated the possibility of a tumour at an earlier date.

Evidence from Trust staff

7. The **Physician** said he was aware from the clinical records that when Mrs Y was admitted to the Ward from the Accident and Emergency Department there was no indication of proteinuria. However, it was possible to have accelerated phase hypertension and changes to a patient's eyes without there being protein in their urine. The absence of protein at that time did not put him off a diagnosis of malignant hypertension. He was comfortable with the diagnosis which had been made. The Physician said that Mrs Y's symptoms of progressive loss of vision over two months with a painful red eye would not have been typical in a case of malignant hypertension. However, in cases of high blood pressure, it was not unusual to notice changes in the back of the eye. He could not recall seeing Mrs Y's visual field charts (FOV) while she was under his care. The Trust covers the Queen Margaret Hospital in Dunfermline and the Victoria Hospital in Kirkcaldy and each have their own set of notes. He would not routinely expect to see the notes from both hospitals at a clinic or on a ward. The Physician thought that even if he had seen the FOV charts, his first priority would have been to deal with Mrs Y's hypertension, but he would have expected to discuss the matter with the Ophthalmologist.

8. Mrs Y was referred to the Endocrinology Unit at the Western General Hospital in Edinburgh for an opinion on her high blood pressure. The Physician noted that at no time did the Endocrinology Unit suggest that there was the possibility of a pituitary tumour. Had they done so, he would have arranged for an immediate CT scan rather than a MRI scan. The Endocrine Unit had suggested a MRI scan to look for an extremely rare cause of Mrs Y's hypertension. He had considered the comments made by the Endocrine Unit and decided that there would be no benefit in arranging a MRI scan. In his view, even if the MRI scan had taken place

and had established that cause of the hypertension, that would not have made any difference to his treatment of Mrs Y.

9. The Physician stated that his main concern was to treat Mrs Y's hypertension and this was completed satisfactorily. He had no reason to discuss her treatment with the Ophthalmology Department but he thought that Mrs Y's notes and papers would have been copied to both Departments. He thought that Mrs Y appeared anxious when she attended his clinics but he was not aware that she had problems in attending when required.

10. The **Ophthalmologist** explained that she holds eye clinics at both the Queen Margaret Hospital and the Victoria Hospital. The clinic notes are kept in separate files and are usually photocopied or manually transferred in time for the next clinic appointment. She saw Mrs Y at the Victoria Hospital on 18 January 1999 but at that time she did not have the notes from her attendance at Queen Margaret Hospital. These notes would have included the FOV charts. The plan was for the Ophthalmologist to review Mrs Y in a further six weeks and arrange for a further FOV test to be undertaken. Although the Ophthalmologist had not seen the FOV chart of 17 November 1998, the Senior House Officer (the SHO), who in her view was very experienced, had discussed the matter fully with her. She could not recall what was actually said but she entirely agreed with the action which the SHO had taken and proposed in the clinical notes. At that time, the medical staff were proceeding on the basis that malignant hypertension was the diagnosis. Similarly, the Ophthalmologist had not seen the FOV chart which was taken on 1 December 1998. It was appropriate that the SHO had repeated the FOV chart but it had been only two weeks since the previous FOV test. The time between the two FOV tests would not be sufficient to arrive at a definitive diagnosis for the sight problems. Ideally, the gap between FOV tests would be six weeks and had the condition remained unchanged then a CT scan would have been considered.

11. The Ophthalmologist stated that it was the intention of Ophthalmology staff to arrange further FOV tests but Mrs Y did not attend for these. The usual procedure is that FOV tests are scheduled about a

week before the eye clinic appointment so that the results would be available for the clinician to consider. Throughout the period January to June 1999, Mrs Y attended the eye clinic on three occasions but did not attend for any FOV appointments. However, when she did attend the eye clinic, examination revealed that there had been no deterioration in her sight from when she first presented at hospital in November 1998. In fact, the hemianopic field defect which had been present in December 1998 appeared to have resolved by June 1999. (Note: The hemianopic field defect was tested clinically; a FOV test was not performed.) Mrs Y's condition was complicated in that she had two medical problems, both of which could cause sight problems. The first was the life-threatening malignant hypertension, and the other was the pituitary tumour. If Mrs Y had presented at the hospital without the very high blood pressure readings then a CT scan would have been taken immediately.

12. The Ophthalmologist said that the failure of patients to attend for clinic appointments was a problem at all hospitals. The procedure in her Department was that the clinicians reviewed cases where the patient did not attend a review appointment. It would be for the clinician to decide on the appropriate course of action. If it was <u>not</u> imperative for the patient to keep further appointments, the Ophthalmologist would write to the patient with an explanation that if their condition deteriorated they should contact their GP. She would also send the GP a copy of the letter. If it <u>was</u> important that the patient should attend for further clinic appointments the Ophthalmologist would write a strong letter to the patient pointing out the potential seriousness of the situation. She would also keep the patient's GP informed. The Ophthalmologist was led to believe that Mrs Y had contacted the Medical Records Department following her scheduled clinic appointment in January 2000 to tell them to stop sending further clinic appointments. It appears that this information was not passed on to the clinicians and therefore they were not in a position to send a final letter to either Mrs Y or her GP. (Note: The Trust subsequently advised my Officer that the code inputted into the Patient Records System at that time indicated that Mrs Y must have contacted the Trust to request that no further clinic appointments be sent. They were unable to establish how Mrs Y contacted the Trust as there is no note of a telephone call or a letter having been received. My Officer

contacted Mr Y for his comments and he denied that he or his wife had ever contacted the Trust to cancel further clinic appointments. Further, Mrs Y was not aware of the existence or contact details of the Medical Records Department. Mr Y questioned why, if the Trust held information that no further clinic appointments had been requested, this had not come to light earlier in the course of handling the complaint.)

13. The Ophthalmologist was confident that while Mrs Y was her patient, she had been thoroughly examined by experienced staff who had monitored her condition and proposed appropriate further action. The SHO and an Associate Specialist had kept the Ophthalmologist fully informed of their actions and she was in full agreement. Even if she had seen the FOV charts of 17 November 1998 and 1 December 1998 it would have been too soon to reach a definitive diagnosis given that Mrs Y was suffering from malignant hypertension at that time. The only difference would have been that she would have been more forceful in advising Mrs Y that she should attend for further FOV tests.

Assessors' report

14. I reproduce next, in its entirety, the report prepared by the professional assessors who were appointed to give advice on the complaint.

Basis of report

(i) This report is based on the documentation provided which included copies of Mrs Y's hospital records and correspondence from the Trust relating to the complaint, and also a report of the interviews with the Ophthalmologist and the Physician. An Assessor was present at each interview.

Matters considered

(ii) The matters subject to investigation were that there was an unacceptable delay in diagnosing a pituitary tumour with the unfortunate consequence of irretrievable blindness, and in arranging CT brain scan or MRI brain scan which would have led to that diagnosis.

Clinical history (Medical)

(iii) *Mrs Y attended the Accident and Emergency Department of Queen Margaret Hospital, Dunfermline on 16 November 1998 at 23.05 hours and was admitted under the Physician's care in the early hours of 17 November 1998. She had had a painful left eye for two days and had seen her GP two days before and was prescribed eye drops. She had also noticed gradual diminution in vision in her left eye for two months.*

(iv) *She was found to have extremely high blood pressure (280/185 in the left arm and 220/145 in the right), with Grade IV hypertensive retinopathy including papilloedema. Initially there was no proteinuria but this appeared within a short time. Malignant hypertension was diagnosed and in view of the seriousness of this condition, Mrs Y was admitted as an emergency for treatment of her blood pressure. She was also referred to the Ophthalmology team on the day of admission and was seen by an experienced junior ophthalmologist. Investigations for possible underlying causes of the severe hypertension were initiated and subsequently the results of these excluded the possibility of Cushing's syndrome, Conn's syndrome or Phaeochromocytoma and also Renal Artery Stenosis being responsible for the hypertension.*

(v) *Treatment of the hypertension was started on admission and by 19 November the blood pressure had come down to 190/103.*

(vi) *Mrs Y was very anxious to go home and although her blood pressure was still raised, she was allowed home on 22 November 1998 with a letter asking her GP to monitor her blood pressure until her next outpatient appointment.*

(vii) *The blood pressure came under control and by June 1999 was very satisfactory.*

(viii) *During investigations for possible causes of hypertension, Mrs Y was found to have a slightly unusual steroid profile, although not suggestive of a pituitary lesion. She was referred to the Western*

General Hospital, Edinburgh, for a Specialist Endocrine opinion and was seen by a Senior Registrar. The Senior Registrar made no mention or suggestion that Mrs Y might have a pituitary tumour. He suggested that a MRI scan of the brain be arranged to look for a rare cause of hypertension but with no mention of pituitary disease. The Physician did not arrange this as he felt it would not alter his treatment.

Questions

- *Should a pituitary tumour have been diagnosed on initial clinical findings?*

- *Should either CT or MRI scans have been arranged during the initial medical management?*

- *Were the medical treatment and investigations appropriate and thorough?*

The facts (Ophthalmology)

(ix) *Mrs Y was seen as an emergency in Dunfermline Eye Casualty Department on 17 November 1998. Her complaint at that time was that her left eye had been painful for two days and that her vision had been blurred for two months. The vision at that time was recorded as 6/12 in the right eye and 6/36 in the left eye. Mrs Y was diagnosed as having malignant or accelerated phase hypertension, a potentially fatal condition.*

(x) *This diagnosis was made on the basis of:*

1. *Measuring the blood pressure*
2. *Examining the eyes which had the typical retinal changes associated with this diagnosis.*

(xi) *Mrs Y was therefore admitted to the medical wards and appropriate treatment instituted. Visual fields performed on that day are grossly abnormal. In view of Mrs Y's potentially fatal medical condition and*

the changes in her eyes, it was felt appropriate to repeat these visual fields. This decision is entirely appropriate on clinical grounds.

(xii) *The visual fields were repeated on 1 December 1998. They show no further progressive change from the original fields on 17 November 1998. It is recorded in the case notes that the findings were discussed with the Ophthalmologist.*

(xiii) *On the basis of a subsequent interview with the Ophthalmologist, it is clear that she was aware that the visual fields were abnormal and it was her clinical judgment that they should be repeated once the eye signs of an accelerated phase hypertension had had a chance to clear.*

(xiv) *Mrs Y attended the Eye Clinic again on 18 January 1999 and was examined by the Ophthalmologist personally. This examination took place at the Victoria Hospital in Kirkcaldy but at that time the Ophthalmologist did not have the notes from her attendance at the Queen Margaret Hospital. These notes would have included the field of vision charts. It is understood that the clinic notes from Dunfermline and Kirkcaldy are kept in separate files, hence the lack of availability of the visual fields. It should be noted that Mrs Y had not attended for a repeat field of vision on 18 December which is indeed unfortunate.*

(xv) *It appears from the case notes that subsequent attendances at the Eye Department were not accompanied by a formal visual field examination and, indeed documented in the notes are eight occasions when Mrs Y apparently could not attend the Eye Clinic. On at least three of these, visual fields were scheduled to be performed. It was quite clearly the Ophthalmologist's intention to have the visual fields formally repeated and undoubtedly failure to have the visual fields repeated led to the catastrophic experience that Mrs Y endured. There is documentation that the Medical Records Department received notification from Mrs Y that she did not wish attendances to continue from January 2000. Unfortunately, the Trust is unable to verify this. Perhaps it should be policy that a note is made in the*

patient's case notes if patients do make contact requesting no further appointments.

(xvi) *For whatever reason Mrs Y was not seen from 14 June 1999 until 23 April 2001 when she was re-referred by her GP. At that time she stated that she had failing vision in both eyes for some time. This was confirmed and a MRI scan was organised. MRI scanning was performed on Friday 11 May 2001 indicating a pituitary tumour. Mrs Y was subsequently referred by Neurosurgery where the tumour was excised. Unfortunately, the vision did not improve and Mrs Y has been left permanently blind.*

Discussion (Medical)

(xvii) *There seems no doubt that Mrs Y had malignant hypertension with extremely high blood pressure and classical changes in the eyes seen on direct ophthalmoscopy. This is a life-threatening condition. The investigations into possible causes were extremely thorough. Referral to the Specialist Ophthalmology team was prompt and the changes in visual fields at the initial and subsequent assessment were thought by them to be consistent with anterior ischaemic optic neuropathy (a complication of the extremely high blood pressure). The medical team sensibly concentrated on investigating and treating the malignant hypertension. They reasonably left follow-up of the eye condition to the Ophthalmologist, who tried to arrange repeat visual field testing and follow-up appointments. Neither CT nor MRI scanning of the brain were indicated for investigation of malignant hypertension. It was also reasonable not to pursue MRI following the referral to the Western General Endocrine Unit as they, who specialise in pituitary disease, had made no mention of the possibility of a pituitary tumour. Once the blood pressure was controlled it was reasonable to leave follow-up of the hypertension to the GP.*

Discussion (Ophthalmology)

(xviii) *Mrs Y is indeed extremely unfortunate in that she undoubtedly presented to the Ophthalmologist with two pathologies, namely malignant hypertension – a potentially fatal condition, and in retrospect a pituitary tumour. Mrs Y was managed in an entirely*

appropriate manner in that she was referred immediately to the Physician for the management of her hypertension. The Ophthalmic staff informed the Ophthalmologist of their findings and a clinical decision was made to allow the eye signs to improve before repeating visual fields. It is clear from the case notes that Mrs Y did not have her visual fields repeated. It is documented that Mrs Y failed to attend for these appointments and indeed it has been suggested that from early January 2000, Mrs Y requested that no further appointments be sent. Mrs Y's management might well have been improved by the Ophthalmologist having the visual fields available to her when she saw Mrs Y in January 1999. However, they were apparently filed in another set of notes. It is to be hoped that this practice could be remedied perhaps by combining notes or ensuring all relevant information is in both sets of notes.

(xix) *It is also unfortunate that there is no written evidence to support the claim that Mrs Y requested no further appointments be made. A simple written note in the case sheets would have clarified this situation and avoided any dispute.*

<u>Should the Ophthalmologist have been suspicious of a pituitary tumour at an earlier stage?</u>

(xx) *In retrospect, the visual fields are suspicious of intracranial pathology and I am sure if these field defects had persisted beyond December 1998, once the eye signs had improved, then Mrs Y would have had her scan at an earlier stage. The Ophthalmologist has clearly indicated at interview that she made a clinical decision to repeat the fields and this indeed had been arranged for 18 December 1998. If Mrs Y had had her visual fields performed on that date, then perhaps the outcome would have been different.*

<u>Findings and Conclusions (Medical)</u>

(xxi) *It is extremely sad that Mrs Y had two simultaneous serious medical conditions. I think the Physician and his team, provided an adequate level of treatment, based on the symptoms which Mrs Y presented with, and as such would not have been expected to diagnose the pituitary tumour.*

Conclusions (Ophthalmology)

(xxii) *It is my opinion that Mrs Y received appropriate medical care in that she was suffering from a potentially fatal condition and was referred entirely appropriately to the physicians. The Ophthalmologist was kept fully informed of Mrs Y's condition and the Ophthalmic staff who initially examined her were appropriately experienced and qualified. It is my opinion that the Ophthalmologist would, if she had been given the opportunity to see subsequent visual fields, have referred Mrs Y earlier for a scan. I feel that Mrs Y has to hold some responsibility for the tragic loss of vision in that she failed, for whatever reason, to attend for subsequent visual field tests. I feel also that the Trust should perhaps address the question of two separate case sheets for Dunfermline and Kirkcaldy and that they should address a method of clearly documenting in the patient's notes if a patient telephones requesting no further appointments.*

Findings

15. Mr Y took his wife to the hospital in November 1998 because she was complaining of a painful left eye and a severe headache. She received treatment from medical and ophthalmic staff and attended their clinics. A diagnosis of hypertension was made but staff did not diagnose that she was also suffering from a pituitary tumour. Mr Y complained that if the tumour had been discovered in November 1998, or had a MRI scan been performed in February 1999, as suggested by the Endocrine Unit, then his wife might not have lost her sight in May 2001.

16. In reaching my findings and conclusions I have taken into account the views of the assessors. They have explained that when Mrs Y was admitted to the hospital in 1998, it was appropriate that she was seen by staff from the medical and ophthalmology departments. Staff from both specialties took appropriate action in order to put them in a position to arrive at a diagnosis. It was unfortunate that Mrs Y was suffering from severe hypertension and also the pituitary tumour. The symptoms that Mrs Y presented with at the hospital resulted in a diagnosis of severe hypertension which had to be addressed. Staff dealt with this and Mrs Y was able to be discharged from the medical clinic in October 1999 into the

care of her GP. It is accepted that staff did not diagnose the pituitary tumour, but should they have carried out further investigations which would have resulted in them discovering the tumour? I note that the Endocrine Unit did suggest a MRI scan but that was for an extremely rare cause of the severe hypertension. The assessors are of the view that it was reasonable not to pursue MRI scanning at that stage as the Endocrine Unit had made no mention of the possibility of a pituitary tumour.

17. The assessors are also of the opinion that the Ophthalmology Department approached Mrs Y's symptoms in a reasonable manner. She was seen by experienced junior staff, and the Ophthalmologist, and arrangements were made to see her at the eye clinic. It is noted that Mrs Y did attend appointments at the eye clinic but not when FOV tests were due to be carried out. Had tests been conducted the results might have led to a scan being performed at a much earlier date.

18. I have reviewed the evidence and the advice obtained from my professional advisers. I can see why Mr Y considers that had a MRI scan been carried out much earlier in Mrs Y's treatment, then the existence of a pituitary tumour would have been identified sooner. The problem was, of course, that she was suffering from two simultaneous serious medical conditions. Given the seriousness of Mrs Y's hypertension, it is understandable that this became the focus of her treatment when she was admitted to hospital.

19. While I consider that it was reasonable that a MRI scan was not carried out initially, I am concerned that the system as a whole failed Mrs Y to some extent. My concern centres around the crucial evidence with regard to Mrs Y's non-attendance at the eye clinics and the absence of further FOV test results, and the alleged cancellation of all future appointments. Even if a MRI scan had not been conducted, changes in visual fields may have alerted staff to the other cause of Mrs Y's loss of vision. Indeed the assessors have stated that 'undoubtedly failure to have the visual fields repeated led to the catastrophic experience that Mrs Y endured' (paragraph 14, (xv)). The question that remains to be answered is why were these visual field tests not repeated?

20. There are different interpretations with respect to the attendance for appointments and the failure to carry out FOV tests. The assessors refer to documentation in the notes that Mrs Y could not attend the eye clinic on eight occasions (paragraph 14, (xv)), when on at least three of these visual fields were scheduled to be performed. Mr Y's evidence is that only one appointment was missed, that a further four were re-arranged and that his wife attended four appointments. There is a dispute also as to the reason why Mrs Y did not attend the eye clinics after June 1999. The Trust maintain that Mrs Y had contacted them to cancel any further appointments but cannot provide confirmation of how these instructions were received by the Trust. It is possible that the wrong code was entered when Mrs Y allegedly cancelled the scheduled clinic appointment in January 2000 but this cannot now be settled for certain. Mr and Mrs Y denied that they had contacted the Trust to cancel further appointments. As far as they were concerned, Mrs Y was still on the eye clinic patient list and should have been sent a further appointment letter.

21. The Ophthalmologist set out the procedure that was adopted within her Department when patients did not attend a review appointment (paragraph 12). The appropriate course of action is decided by clinicians and is determined by the importance of the specific case. However, in Mrs Y's case, no such information was conveyed to the clinicians even although it has been stated by the Trust that Mrs Y had contacted the Medical Records Department in January 2000 to request that they should stop sending her further clinic appointments. As a result the appropriate action was not triggered. In such circumstances, either the Trust was at fault for not conveying the relevant information to the clinicians; or if the information was conveyed then they failed to take the appropriate action. Whatever the explanation, there was a breakdown of communication which meant that Mrs Y did not receive either notification of further appointments, or a letter from the Ophthalmologist regarding the claim that she had requested no further appointments. Given the accepted seriousness of Mrs Y's condition, had she contacted the Trust as claimed, she should have received a strong letter from the Ophthalmologist pointing out the potential consequences of her decision, and her GP would have been informed. As no such letter was sent I have to conclude that there was fault in the Trust's administrative process.

22. I have some concerns, however, that Mrs Y did not contact the eye clinic when she did not receive notification about a further appointment especially as her sight was deteriorating. It would have been appropriate for her to either contact the eye clinic direct to establish when she would receive her next appointment or she could have contacted her GP who would have referred her to the hospital. It is a difficult area as to whether the responsibility for further follow-up lies with the patient, or as a part of the duty of care of the physician. In this instance, while I consider that Mrs Y does bear some responsibility for not contacting the eye clinic or her GP sooner, I am of the view that the breakdown in communication within the Trust played a significant part and was contrary to their stated procedure for following up a patient's decision to cancel further appointments.

23. In summary, I believe that staff in the medical and ophthalmic departments provided Mrs Y with reasonable treatment when she first presented in November 1998 and I do not find there were failures in diagnosis. I, therefore, do not uphold the complaint as put. However, I have identified a systems failure which contributed to the long delay before Mrs Y sought further treatment for her worsening eye condition which could have alerted staff to her other condition at an earlier stage.

Recommendations

24. I **recommend** that Fife Health Board, as successor to the Trust, apologise to Mr and Mrs Y for the distress caused in part by the administrative failure. In addition, the assessors have commented that the consideration should be given to documenting in the patient's clinical records, if they have requested that no further appointments be sent. I see that as a positive benefit as it would provide confirmation and also allow the clinicians the opportunity to consider whether the patient needs further advice or to ensure that their GP is informed. I **recommend** that the Board should address this matter in order to prevent a similar situation developing in the future. The assessors also commented on the separate case notes for the eye clinics at Dunfermline and Kirkcaldy. This issue was addressed during the independent review and I am advised that systems have been developed in the Ophthalmology Department which

ensure that all case notes for patients who attend clinics at different hospital sites are available for consultations.

Professor Alice Brown
Scottish Public Services Ombudsman

23 June 2004

CT Scan – A procedure that produces images of structures within the body created by a computer that takes data from multiple X-ray images and turns them into pictures on a screen.

Conn's Syndrome – Hormone (aldosterone) production by a tumour of the adrenal gland, producing high blood pressure.

Cushing's Syndrome – Hormonal abnormalities, including high blood pressure, due to either swellings of the adrenal gland or a pituitary tumour.

Hemianopic Field Defect – Loss of vision from one half of the visual field.

Hypertension – High blood pressure.

Hypertensive Retinopathy – Retinal disease due to abnormally high blood pressure.

MRI Scan – A MRI (Magnetic Resonance Imaging) scan is a radiology technique using magnetic radio waves, and a computer to produce images of body structures.

Malignant Hypertension – Rapidly progressive and very dangerous form of high blood pressure which if untreated leads to irreversible kidney failure, heart failure and stroke.

Phaechromocytoma – hormone (adrenalin) production by tumour of the adrenal gland, producing high blood pressure.

Proteinuria – Excess protein in the urine.

Renal Artery Stenosis – High blood pressure produced by abnormality of the blood flow through the kidney.

Visual Fields – the fields of vision of both eyes. It is tested by asking the patient to focus straight ahead and to record by pressing a button the moment a light appears at the side of their vision. This is tested in different directions and the results plotted on a chart show the visual fields.