Scottish Parliament Region: Mid Scotland and Fife

Case 200502165: A Medical Practice, Forth Valley NHS Board

Summary of Investigation

Category

Health: GP; Care and treatment

Overview

The complainant Mr C raised a number of concerns about the care and treatment provided by two General Practitioners (GP 1 and GP 2) to his mother (Mrs A) prior to her death.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) GP 1 and GP 2 failed to respond appropriately to Mrs A's symptoms (*upheld*);

(b) GP 1 failed to refer Mrs A to the pain clinic quickly enough (*not upheld*); and

(c) GP 1's letter referring Mrs A to the pain clinic was inadequate (*upheld*).

Redress and recommendations

The Ombudsman recommends that:

(i) both GP 1 and GP 2 raise this case at their annual appraisal with a view to incorporating further training on recognising the progress of cancer into their continuing professional development;

(ii) GP 1 raises this case at her annual appraisal to ensure that she fully understands which information should appropriately be included in referral letters.; and

(iii) the Practice apologise to Mr C for the shortcomings identified in this report.

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

Main Investigation Report

Introduction

1. Mr C's mother, Mrs A was diagnosed with cervical cancer in 1998. She was treated with surgery and radiotherapy at that time. Mrs A saw GPs from NHS 24, a locum GP, GP 1 and GP 2 between April and September 2004 because she was experiencing increasing amounts of pain. On 29 September 2004 another GP sent Mrs A for a chest x-ray which showed an abnormality. Further investigations found that Mrs A had compression of her spinal cord caused by a large tumour in the area of her kidneys. She also had tumours in her lungs. Mrs A required urgent radiotherapy for the spinal cord compression. Sadly, on 17 January 2005 Mrs A died of metastatic (widespread) cancer.

2. On 11 April 2005 Mr C complained to the GP Practice (the Practice). He said that his mother had been diagnosed and treated for sciatica. She had been virtually housebound suffering agonising pain over a period of some ten months before she was sent for the chest x-ray. He considered that the delay in referring his mother led to her suffering unnecessarily. He also complained of delay in referring her to the pain clinic and the fact that when she was referred the referral was considered 'routine'. In the event, Mrs A did not live long enough to attend the appointment.

3. The Practice responded to Mr C's complaint on 26 May 2005 but he remained dissatisfied and on 4 November 2005 Mr C complained to the Ombudsman.

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

(a) GP 1 and GP 2 failed to respond appropriately to Mrs A's symptoms;
(b) GP 1 failed to refer Mrs A to the pain clinic quickly enough; and
(c) GP 1's letter referring Mrs A to the pain clinic was inadequate.

5. This report contains some technical terms which are explained in the glossary of terms at Annex 2. In line with the practice of the Ombudsman's office, the standard by which I have judged the actions of the doctors who looked after Mrs A was whether they were reasonable. By that, I mean whether the decisions and actions taken were within the boundaries of what would be considered acceptable practice by the medical profession in terms of knowledge and practice at the time.

Investigation

6. In order to investigate this complaint I have had access to Mrs A's clinical records and the correspondence in relation to the complaint. I have corresponded with both Mr C and the Practice. I have obtained clinical advice from the Ombudsman's adviser who is a General Practitioner (the Adviser). I have also had access to the Scottish Intercollegiate Guidelines Network's publication *'Report on a recommended Referral Document'* (1998). 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 Practice were given an opportunity to comment on a draft of this report.

(a) GP 1 and GP 2 failed to respond appropriately to Mrs A's symptoms

7. On 16 April 2004 Mrs A saw a locum GP. She said that she had been in pain for three months, at first intermittently, but becoming persistent. He examined Mrs A and gave her painkillers. He arranged to review her in two weeks time.

8. GP 1 visited Mrs A at home on 21 April 2004 because Mrs A was passing blood in her urine. GP 1 prescribed antibiotics for a presumed infection but made a note that Mrs A had had a previous diagnosis of radiation cystitis (a side effect from radiotherapy for cancer of the cervix). GP 1 also noted 'If persists will need re-referral to urology'.

9. On 30 April 2004 Mrs A again complained to the locum GP about the pain she was suffering. The locum GP noted that Mrs A's pain was controlled by analgesics. Mrs A was worried about the pain and a possible recurrence of cancer. The locum GP arranged for Mrs A to have an x-ray of her spine and pelvis. The x-ray showed severe degenerative disease of the spine as well as an incidental finding of a small abdominal aortic aneurysm (swelling of the main blood vessel running down the back wall of the abdomen).

10. On 14 May 2004 the locum GP explained the results of the x-ray to Mrs A and changed her painkillers.

11. GP 1 saw Mrs A on 26 May 2004. GP 1 also discussed the results of the x-ray with Mrs A. GP 1 referred Mrs A for an ultrasound scan of her abdomen for further investigation. Mrs A told GP 1 that her pain was disturbing her sleep.

GP 1 adjusted Mrs A's painkilling medication. GP 1 noted that 'blood investigations may be needed' but they were not done at that stage.

12. On 2 June 2004 GP 1 treated Mrs A for a respiratory infection and on 28 June 2004 Mrs A was given more painkillers because she had run out.

13. On 26 July 2004 GP 1 told Mrs A that the ultrasound scan had found no abnormality. Mrs A informed GP 1 of tiredness, heartburn, oral thrush and said that she had lost weight. GP 1 arranged for blood tests to be done. Blood for testing was taken on 30 July 2004.

14. On 13 August 2004 GP 1 noted that Mrs A was eating better and her oral thrush had cleared. GP 1 told Mrs A that her blood tests were satisfactory apart from an ESR (Erythrocyte Sedimentation Rate, an indication of inflammation) being raised at a level of 62. GP 1 made a note that the test should be repeated with a similar blood test for C reactive protein (CRP). There is no indication in the notes that this was ever done.

15. GP 1 visited Mrs A at home on 26 August 2004. Mrs A complained of increasing neuralgia (nerve pain). GP 1 again made changes to Mrs A's painkilling medication including prescribing a specific painkiller which may help with neuralgia pain.

16. Mrs A complained again to GP 1 about her pain at an appointment on 31 August 2004. GP 1 referred Mrs A to the pain clinic by letter dated 1 September 2004.

17. On 15 September 2004 Mrs A was seen by GP 2. GP 2 noted that Mrs A had been seen by NHS 24 on 11 September 2004 for pain. New medication had been prescribed to try to help this pain but it was ongoing. GP 2 noted that Mrs A had suffered further weight loss.

18. On 29 September 2004 Mrs A was seen by another GP. Mrs A complained that she had been coughing up blood. The GP arranged a chest x-ray which was carried out on 1 October 2004. It showed shadowing suggestive of cancer. Following a CT scan Mrs A was diagnosed with cancer.

19. The Adviser considered whether the care provided to Mrs A was reasonable given what was known at the time. The Adviser said that the care in

April, May, June and July was of a reasonable quality. The GPs involved were keen to investigate the cause of Mrs A's pain and gained some reassurance (false as it turned out) by the x-rays showing significant degeneration in the spine but no sign of cancer.

20. In August and September, however, more information was obtained. This included an abnormal ESR result. The Adviser pointed out to me that the tests carried out on the blood taken on 30 July 2004 also showed that Mrs A had an alkaline phosphatase level of 292. This was a further abnormal result and the Adviser was concerned that GP 1 had not noted that. The Adviser explained that alkaline phosphatase is an enzyme normally found in the blood. If it is there in higher than usual concentrations it often denotes a problem either of the liver or of the bones. The Adviser said that the elevated alkaline phosphatase level appeared to have been overlooked. Taken together with the abnormal ESR result that should have alerted GP 1 to the fact that something more was going on. The Adviser noted that a plan had been made to deal with the elevated ESR. The Adviser said the plan to repeat the test was a reasonable one but was never carried out. The Adviser said that more could have been done at this stage to look into the reasons for Mrs A's pain. He noted that, rather than doing this, at consultations during August and September 2004 GP 1 and GP 2 concentrated on adjusting Mrs A's painkillers to try to achieve more pain relief, although that did not appear to have been very successful.

21. From Mrs A's clinical records I noted that Mrs A was seen by GP 1 on 13, 26 and 31 August 2004. GP 2 saw Mrs A on 15 September 2004. I asked the Practice to obtain comments from GP 1 and GP 2 about the points made by the Adviser.

22. GP 1 agreed that an elevated ESR result always raises the question of a possible serious underlying cause. Mrs A had recently had an x-ray which had failed to show any evidence of serious bone disease or spread of disease from another part of the body. GP 1 said that she had requested an ultrasound in response to the comment about the aortic aneurysm and, although it had focussed on the aorta, it also showed no serious abnormality. In light of this GP 1 had wondered if the elevated ESR might be due to an infection so she had planned to repeat the ESR test after a short interval along with a CRP test to investigate it further. When GP 1 saw Mrs A on 13 August 2004, GP 1 had told her about the plan to repeat the blood tests when she next attended. The

next time GP 1 had seen Mrs A, however, was at her home on 26 August 2004 when she was unable to attend the surgery. Mrs A's next visit to the surgery was on 31 August 2004 in the late afternoon. The laboratory only processes ESR tests on the day they are taken and the van picks up the samples before 14:00. It was, therefore, too late to have it done. GP 1 said that it had been her intention to repeat the alkaline phosphatase test although she had not documented it. The relevance of the result was not clear as there were no other alkaline phosphatase test results on record. If it had remained elevated along with the ESR then she would have considered a bone scan despite the lack of serious findings in the radiographic investigations done so far.

23. GP 2 said that she visited Mrs A on 15 September 2004 when she complained of ongoing hip pain. GP 2 said that she had Mrs A's clinical notes and was aware of the previous investigations and that she had been referred to the pain clinic. GP 2 also noted that Mrs A had lost weight and had recorded this for future reference. GP 2 had suggested that Mrs A try an increased dose of the painkillers prescribed by the out-of-hours service.

24. I asked the Adviser if he was reassured by the responses I had received from GP 1 and GP 2 but he said that he was not. The Adviser said that the ESR should have been repeated. It could have been done on 13 August 2004. The Adviser said that as this was 13 days after the previous test he would have expected the level to have gone down, even if not to normal, after this time interval if it was due to an infection. The Adviser said that if GP 1 did not do the test that day, arrangements should have been made for the test to be done in the surgery at an appropriate time or a nurse or phlebotomist should have been sent to Mrs A's house to collect a sample if she was not well enough to attend the surgery. Neither GP 1 nor GP 2 had made such arrangements. The Adviser said that he found GP 1's remarks about planning to repeat the alkaline phosphatase test unconvincing because she wrote in Mrs A's clinical notes 'Bloods ok, apart from ESR 62'. GP 1 did not write a plan to deal with it and the Adviser remained of the opinion that the alkaline phosphatase result was overlooked. The Adviser said that the raised alkaline phosphatase level along with a raised ESR and continuing, difficult to control pain and weight loss should have alerted the GPs to the fact that more needed to be done. The Adviser was of the view that consideration should have been given to repeating the blood tests, hospital referral, arranging a bone scan or chest x-ray or a combination of these actions. Another possibility would have been to explore the nature of the alkaline phosphatase with a further blood test to find out whether the problem

was in the liver or the bone. The Adviser considered that the failure of the GPs to take further action in the light of the blood test results and clinical features demonstrated a lack of clinically joined up thinking.

(a) Conclusion

25. I accept the Adviser's opinion that the care provided to Mrs A between April and July 2004 was reasonable and showed that the GPs were trying to discover what was causing Mrs A's pain. When the x-ray and ultrasound failed to identify the problem the decision to take blood tests was correct. The Adviser is clear, however, that the GPs failed to act appropriately on receipt of the results of the tests, focussing on attempts to control Mrs A's pain rather than asking for further investigation to discover the cause of her pain. I, therefore, uphold the complaint that GP 1 and GP 2 failed to respond appropriately to Mrs A's symptoms for the period between when the blood test results were received by the Practice until 29 September 2004 when Mrs A was referred to hospital.

(a) Recommendation

26. I have upheld this complaint for the period during which Mrs A was seen by GP 1 (three times) and GP 2 (once). The Ombudsman recommends that both GP 1 and GP 2 raise this case at their annual appraisal with a view to incorporating further training on recognising the progress of cancer into their continuing professional development.

(b) GP 1 failed to refer Mrs A to the pain clinic quickly enough

27. In his complaint Mr C said that his mother had asked earlier to be referred to the pain clinic but GP 1 said that it would do her no good.

28. In response to the complaint GP 1 said that referral to the pain clinic had been discussed when she visited Mrs A on 26 August 2004. Mrs A was started on a new medication frequently recommended by the pain clinic for similar types of pain. GP 1 said that she did not say that the pain clinic would not do Mrs A any good but wished to try the new drug initially as she was aware that there might be some waiting time for an appointment. When GP 1 next saw Mrs A on 31 August 2004, Mrs A said that she was still in a lot of pain. GP 1 had, therefore, made the decision to refer Mrs A to the pain clinic because the new medication was not sufficiently effective. Pain clinics are run by a multi-disciplinary team who focus on pain management including a consideration of treatment options. They assess the patient comprehensively and decide on the

type and severity of pain being experienced and are most often dealing with chronic pain but not exclusively. GP 1 wrote for an appointment for Mrs A the following day.

29. The Adviser said that the attempts made to control Mrs A's pain from April to the end of July 2004 were reasonable and logical. The next time that GP 1 saw Mrs A was on 13 August 2004. There is no evidence that Mrs A's pain was discussed at that appointment. On 26 August 2004 GP 1 visited Mrs A at home because of increasing neuralgia. The Adviser said that GP 1 changed Mrs A's painkilling medication to Gabapentin which is a specific painkiller which might help neuralgia type pains. When Mrs A returned to the surgery complaining of pain on 31 August 2004, however, GP 1 decided to refer Mrs A to the pain clinic. The Adviser said that the pain suffered by Mrs A was obviously distressing for her and for her family but he considered it was reasonable to try to control the pain before referring Mrs A to the pain clinic.

(b) Conclusion

30. The clinical records show that Mrs A's painkillers and the doses prescribed for her were changed frequently in response to the pain she reported. When Mrs A first complained of the pain in April 2004 she said that it had been intermittent but was becoming more persistent. The Adviser said that the painkillers which were tried were appropriate. When Mrs A reported neuralgia type pains in August, the painkiller which was prescribed was appropriate for that type of pain. Unfortunately it was not effective and GP 1 then referred Mrs A to the pain clinic. I accept the Adviser's advice that it was reasonable to try to manage Mrs A's pain by changes of painkiller first. I do not uphold this complaint.

(c) GP 1's letter referring Mrs A to the pain clinic was inadequate

31. Mr C complained that his mother suffered pain for an excessive period. In his letter to the Ombudsman he said that his mother had been in constant pain which had led to her on occasions being on all fours and crying like a child but GP 1 had only asked the pain clinic for a 'routine' appointment for Mrs A. His mother had been so desperate when she learned that she would not be seen at the pain clinic until the following January that she had asked her local Councillor to visit her to try to help her to get an earlier appointment. In the event, Mrs A died on 17 January 2005 before she could attend the appointment.

32. Mr C enclosed a copy of a letter the Councillor sent to the Patient Relations Officer dated 23 September 2004 and a copy of the reply from the Director of Nursing dated 21 October 2004. In that letter the Director explained that the decision about how long a patient has to wait to be seen is based on clinical priority. Based on the clinical information and history supplied in GP 1's referral letter, the Consultant allocated a clinical priority rating.

33. The SIGN Guidelines state that in relation to referral letters adequate clinical information is essential to allow the Consultant to assess clinical need and urgency.

34. The Adviser said that GP 1's referral letter does not contain a classification but any referral letter which does not contain a request for a 'soon' or 'urgent' appointment is treated as 'routine'. GPs can request 'soon' or 'urgent' appointments but the out-patients department decides how long patients have to wait. This is usually done by adding names to the end of the waiting list unless the Consultant prioritises cases to be seen more quickly. The Adviser said that it is reasonable for a GP not to request an urgent appointment, leaving that decision to the hospital, provided the hospital is put in possession of all of the relevant facts to allow them to make a correct prioritisation decision. That is why it is important that referral letters contain sufficient detail to allow a full evaluation to be made.

35. The Adviser said that the letter which GP 1 wrote described significant problems with pain and concern about the recurrence of cancer. It said that Mrs A was taking some strong medication but despite that she remained 'fairly miserable'. The Adviser said that painted a picture of someone with significant pain problems but the majority of people referred to a pain clinic have been in significant pain for some time. The Adviser said that the letter did not mention the increasingly severe nature of the pain, the weight loss, the raised ESR or the abnormal alkaline phosphatase level. All of those are pointers to the possibility of serious underlying disease and the Adviser considers that mentioning these would have increased Mrs A's chances of being placed higher on the hospital's priority list and of receiving an earlier appointment.

(c) Conclusion

36. It must have been extremely distressing for Mrs A to have suffered such pain and for her family to have watched her try to cope with it. It is not possible to say for sure what difference a fully informed referral letter would have made

but it is clear that not all of the relevant facts were included in the referral letter which GP 1 sent to the pain clinic. The pain clinic were, therefore, unable to make a fully informed decision regarding Mrs A's clinical priority. I uphold this complaint.

(c) Recommendation

37. The Ombudsman recommends that GP 1 raises this case at her annual appraisal with a view to ensuring that she fully understands which information should appropriately be included in referral letters and that the Practice apologise to Mr C for the shortcomings identified in this report.

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

18 July 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs A	Mr C's mother
The Practice	The GP Practice attended by Mrs A
GP 1	The GP who saw Mrs A on 13, 26 and 31 August 2004
GP 2	The GP who saw Mrs A on 15 September 2004
The Board	Forth Valley NHS Board
The Adviser	The Ombudsman's Independent Professional Adviser

Annex 2

Glossary of terms

Abdominal aortic aneurysm	Swelling of the main blood vessel running down the back wall of the abdomen
Alkaline phosphatase	An enzyme normally found in the blood. If it is there in higher than usual concentrations it often denotes a problem either of the liver or of the bones. (Normal range is 40 – 280 IU per litre)
Aorta	The main artery which runs from the heart
C reactive protein	This blood test is used as an indicator of acute inflammation. Normally C-reactive protein should be negative in the bloodstream
CT (computed tomography) scan	A special radiographic technique that uses a computer to assimilate multiple x-ray images into a cross-sectional image
ESR (Erythrocyte Sedimentation Rate)	An indication of inflammation. (Normal range is 5 to 15 mm per hour in women)
Neuralgia	A characteristic pain usually caused by a problem with a nerve. Infiltration or pressure from a cancer growth is one possible cause
NHS 24	The out-of-hours service
Radiation cystitis	An inflammation of the bladder caused by radiotherapy that can give rise to troublesome symptoms