Scottish Parliament Region: Lothian

Case 200604027: A Medical Practice, Lothian NHS Board

Summary of Investigation

Category

Health: GP surgery, delay to diagnosis

Overview

The complainant (Mr C) felt that his GP practice (the Practice), did not take his illness seriously, that they were slow to carry out and follow-up tests and that the diagnosis of his cancer was subsequently delayed.

Specific complaint and conclusion

The complaint which has been investigated is that the diagnosis of Mr C's condition was unnecessarily delayed (*not upheld*).

Redress and recommendation

The Ombudsman recommends that the Practice review their procedures for recording and tracking the dispatch and receipt of blood tests.

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

Main Investigation Report

Introduction

1. On 9 January 2007, the complainant (Mr C) visited his GP practice (the Practice), as an emergency patient. He reported feeling bloated, intermittent abdominal pain and nausea since mid-December 2006. He was prescribed medication and asked to return to the Practice for a blood test. Over the following two months, Mr C had a number of consultations and tests at the Practice and other local medical centres. In early March 2007, he was diagnosed by staff at the Royal Infirmary of Edinburgh as having small bowel cancer.

2. Mr C lodged a formal complaint to the Practice that examinations carried out by their staff were not sufficiently thorough and that subsequent tests were unnecessarily delayed. He was not satisfied with the response that he received from the Practice and complained to the Ombudsman on 19 March 2007. In his complaint to the Ombudsman, Mr C acknowledged that 'better care' from the Practice would not have prevented his cancer, however, he felt that a quicker diagnosis of his condition would have improved the chances of him responding positively to treatment.

3. The complaint from Mr C which I have investigated is that the diagnosis of Mr C's condition was unnecessarily delayed.

4. In his complaint to the Ombudsman, Mr C also raised concerns over the attitude of and service provided by the Practice's staff. I did not investigate these issues, as there was a lack of verifiable evidence on which to reach any conclusions. This was explained to Mr C early in the complaints process.

Investigation

5. In order to investigate this complaint, I have reviewed all of the complaint correspondence between Mr C and the Practice. I have also sought professional advice from the Ombudsman's clinical adviser (the Adviser) and corresponded with the Practice.

6. The dates and details of certain consultations vary between Mr C's account of events and that of the Practice. For clarity, I have used the Practice's timeline and account of consultation details in this report, as this

evidence was supported by clinical notes taken at the time. Where appropriate, I have noted significant points that are disputed.

7. 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.

Complaint: The diagnosis of Mr C's condition was unnecessarily delayed

8. Mr C visited the Practice on 9 January 2007 having been unwell since mid-December 2006. In his complaint to the Ombudsman's office, Mr C said that he advised the GP (GP 1) that he had been vomiting at least twice per day and that he had lost around 10lb in weight. The clinical records specifically note that Mr C had no weight loss or vomiting, however, they do record that he had intermittent symptoms of nausea and that he felt bloated. Mr C was examined by GP 1 who noted in the clinical records for this visit that Mr C had no abnormalities or changes in his bowel habits and that his abdomen was soft, non-tender, with no masses. GP 1 prescribed a course of Lansoprazole – a drug for reducing stomach acid - and told Mr C to book a follow-up appointment and a further appointment for a blood test to be taken to test for Helicobacter Pylori.

9. Mr C was given a follow-up appointment for 17 January 2007 and a bloods appointment for 24 January 2007. He visited the Practice as an emergency patient, before this, on 11 January 2007 and was seen by a different GP (GP 2). He had been vomiting throughout the previous night and his overall condition had worsened. GP 2 prescribed a course of Buscopan to relieve spasms and sickness.

10. Mr C attended the 17 January 2007 appointment and was seen by GP 1. He was examined again and his ongoing vomiting was recorded along with weight loss and epigastric tenderness. He was not due to have a blood test for another week, however, GP 1 arranged for the bloods appointment to be brought forward to the following day and for Mr C to telephone for the results on 19 January 2007. A follow-up appointment with GP 1 was arranged for 31 January 2007.

11. On 31 January 2007, Mr C attended his appointment but was advised that the blood test results had not yet arrived. GP 1 told him that these would be

chased the following day. Mr C felt that the results should have been chased in advance of his appointment rather than afterward.

12. Mr C's blood test results were chased on 1 February 2007 and it was discovered that they had never reached the laboratory. The clinical records contain an entry dated 18 January 2007, the day that Mr C was due to have his blood test carried out, which stated 'bloods as requested'. There is, however, no mechanism to track the movement of the blood test from the Practice to the laboratory. The Practice were confident that the test was carried out and dispatched via the laboratory van service, however, they acknowledge that there is no way to confirm this. The Practice contacted Mr C on the same day to advise him of the loss of his blood test and to ask that he attend the surgery that afternoon so that another test could be taken. He did this and made a further appointment to learn the results of his blood test with another of the Practice's GPs on 19 February 2007.

13. The test results came back to the Practice and were positive for Helicobacter Pylori. Mr C was contacted and told that one week's prescription of antibiotics would be left at the Practice reception for him. The appointment for 19 February 2007 was rescheduled for 26 February 2007 to give the antibiotics a chance to work.

14. Mr C's condition had not improved by the end of his course of antibiotics so he visited the Practice unannounced on 22 February 2007. He was told that he had been referred to a Community Treatment Centre (the Centre) for specialist assessment and that the Centre would contact him to arrange an appointment. The clinical records include the referral form sent by the Practice to the Centre. The referral was completed by GP 1 and marked as urgent. It was sent on 2 February 2007, requesting specialist investigation of Mr C's condition. This action was instigated prior to Mr C's blood test results being received. An appointment at the Centre was scheduled for 1 May 2007.

15. Mr C told me that his condition continued to worsen to the extent that he contacted NHS 24 on 25 February 2007. They changed his prescribed medication but this did not improve matters. He telephoned the Centre the following day to request a cancellation appointment and was able to secure one for 1 March 2007.

16. The Centre decided to perform an Upper Gastrointestinal Endoscopy on Mr C on 1 March 2007 which was clear. A CT scan was proposed, however, Mr C was advised that it could take up to one month for an appointment for this to become available.

17. Mr C learned after his Endoscopy that, had he not been able to secure a cancellation appointment, his scheduled appointment date would have been on 1 May 2007. He felt that this, and the fact that a further appointment could add another month, was an unacceptably long delay to his treatment. The Scottish Government Health Directorate publishes national standards for maximum waiting times. The maximum waiting time for an out-patient appointment following GP referral is 18 weeks and for further treatment to commence, the maximum waiting time is a further 18 weeks. Both of these appointments fell well within these targeted deadlines.

18. Mr C collapsed at home on 7 March 2007 and was admitted to the Royal Infirmary of Edinburgh as an emergency patient. Tests were carried out and it was discovered that Mr C had a blockage in his small bowel. He underwent surgery to remove a section of his bowel. Further investigation of the removed section found that he had small bowel cancer. Mr C was informed of this diagnosis prior to being discharged from hospital on 7 March 2007.

19. When investigating this complaint, I asked for the professional opinion of the Adviser. He advised me that small bowel cancer is extremely rare, and only accounts for 2% of all Gastrointestinal cancers. Most instances of small bowel cancer present, as in Mr C's case, as a small bowel obstruction. It is rarely possible to diagnose the condition without surgery. This increases the chance of a delayed diagnosis, resulting in a poor prognosis for patients.

20. Having reviewed the clinical records and the accounts of both parties as to what investigations were carried out to identify the source of Mr C's symptoms, the Adviser explained that all of Mr C's presenting symptoms were indicative of problems in the stomach and Upper Gastrointestinal area. Only upon exhausting the likely Upper Gastrointestinal causes would a GP have been led to suspect a root cause elsewhere.

Conclusion

21. The nature of small bowel cancer and the fact that it is so rare mean that it is not immediately obvious. Mr C presented with symptoms indicative of Upper

Gastrointestinal problems and it was reasonable for the Practice to pursue this line of investigation initially.

22. The treatment process followed a logical course with appropriate medication being prescribed as Mr C's symptoms developed. Although Mr C's account of the dates and details of certain consultations differ slightly to the Practice's version of events, this did not change the outcome for Mr C in terms of the overall time taken to diagnose his condition or the conclusion that I have reached.

23. As his condition failed to improve blood tests were arranged. I was concerned to learn of the loss of the blood test and the apparent lack of any system to track the dispatch of tests and the receipt of their results. Again, however, this did not have any impact on the time taken to diagnose Mr C's condition, as the next step in establishing the cause of his illness, a referral for specialist investigation, was submitted to the Centre prior to the Practice having received the test results. Once the blood test results were known, Mr C was prescribed the correct medication to combat his Helicobacter Pylori.

24. The Upper Gastrointestinal Endoscopy carried out by the Centre showed no abnormalities. Only at this point could Upper Gastrointestinal causes for Mr C's symptoms be ruled out. Accordingly, a CT scan was proposed to investigate other potential causes. Whilst I am sure that the time taken to reach this point was frustrating for Mr C, given the pain and discomfort that he was experiencing, I am satisfied that an appropriate course of treatment and investigation was carried out, allowing medication time to work and carrying out tests to eliminate possible causes, if not identifying the true source of Mr C's illness. Mr C was offered regular appointments to see a GP and the Practice were proactive in arranging tests at the Centre.

25. The CT scan appointment at the Centre ultimately proved to be unnecessary, as Mr C's condition deteriorated to the extent that he had to be admitted to the Royal Infirmary of Edinburgh's Accident and Emergency unit. His small bowel cancer was diagnosed soon after admission to the Royal Infirmary of Edinburgh. Although it had not been diagnosed prior to this, again I am satisfied that an appropriate course of testing was working toward this conclusion. It was only upon performing surgery that the obstruction in Mr C's small bowel was discovered, which is normal for this particular form of cancer. Mr C was unfortunate to develop a form of cancer that is rare and difficult to

diagnose without surgery. The Practice conducted their investigation into his symptoms in a timely manner and were proactive in arranging specialist appointments. I, therefore, do not uphold this complaint.

Recommendation

26. Although I have not upheld this complaint, I was concerned to learn of the delays that Mr C encountered when awaiting his blood test results and the Practice's lack of a process to track these.

27. The Ombudsman, therefore, recommends that the Practice review their procedures for recording and tracking the dispatch and receipt of blood tests and their results.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Practice	Mr C's GP practice
The Adviser	The Ombudsman's clinical adviser
GP 1	A General Practitioner at the Practice
GP 2	A second General Practitioner at the Practice
The Centre	A Community Treatment Centre