Scottish Parliament Region: Central Scotland

Case 200801621: A Medical Practice, Lanarkshire NHS Board

Summary of Investigation

Category

Health: General Practitioner

Overview

The complainant (Mrs C) complained that her son (Mr A)'s General Practitioner (GP 1) failed in his duty of care by not referring Mr A for an immediate ultrasound scan when he presented with severe pain and swelling in his left testicle. She also complained that a medical practice (the Practice) failed to meet the requirements of their Practice Complaints Procedure in the way they dealt with her complaint.

Specific complains and conclusions

The complaints which have been investigated are that:

(a) GP 1 failed in his duty of care by not referring Mr A for an immediate ultrasound scan (*not upheld*); and

(b) the Practice failed to meet the requirements of their Practice Complaints Procedure in the way they handled Mrs C's complaint (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Practice:

(i) formally apologise to Mrs C for the failure to follow the Practice Complaints Procedure, and

(ii) take steps to ensure that Practice staff who deal with complaints are fully conversant with the time standards within the Practice Complaints Procedure and respond in accordance with these time standards.

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

Main Investigation Report

Introduction

1. In bringing her complaint to the Ombudsman, Mrs C explained that her husband had died 12 years previously as a result of testicular cancer. Following this she had sought advice from GP 1 in relation to the probability of her son, Mr A, contracting testicular cancer in the future. She was advised that her son should examine himself regularly and if he had any concerns he should consult his doctor immediately, as early diagnosis is crucial.

2. In May 2005 Mr A attended the Practice and consulted with another General Practitioner (GP 2) regarding a scrotal lump on his right side. GP 2 recorded 'lump is Right epididymis' and reassured Mr A that there was no cause for concern. Two years later, on 23 May 2007, Mr A again attended the Practice. He had been experiencing scrotal pain since the beginning of the month and presented with a painful swelling in his left testicle. The notes of this consultation reflect that GP 1 diagnosed epididymitis, prescribed antibiotics and recorded that the situation should be reviewed if it did not settle.

3. The pain returned after the antibiotic course. Mr A, therefore, went to the out-of-hours NHS 24 Service on 23 June 2007, where he was referred back to the Practice to organise an ultrasound scan. On 5 July 2007 he had the ultrasound scan which indicated a tumour, subsequently confirmed as malignant. On 10 July 2007 he underwent an operation to remove his left testicle. Subsequent to this, Mr A underwent a course of chemotherapy and further surgery in February 2008, following the spread of cancer to the lymph nodes at the back of his abdomen.

4. Mrs C thought that GP 1 had failed in his duty of care by not referring Mr A for an immediate ultrasound scan on 23 May 2007. She considered that GP 1 had incorrectly diagnosed epididymitis and she felt that if Mr A had been referred for an immediate ultrasound scan, the cancer cells would not have spread and he would not have had to undergo chemotherapy treatment or further surgery.

5. Mrs C remained dissatisfied with GP 1's response to her complaint. She was also concerned that the Practice failed to meet the requirements of their Practice Complaints Procedure in the way they handled her complaint and she asked the Ombudsman to investigate these matters.

6. The complaints from Mrs C which I have investigated are:

(a) GP 1 failed in his duty of care by not referring Mr A for an immediate ultrasound scan; and

(b) the Practice failed to meet the requirements of their Practice Complaints Procedure in the way they handled Mrs C's complaint.

Investigation

7. In considering this complaint I examined the complaints correspondence, together with Mr A's medical records and the Practice Complaints Procedure. My staff spoke with Mrs C, Mr A, GP 1 and the Practice Manager and I took advice from the Ombudsman's independent medical adviser (the Adviser).

8. 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) GP 1 failed in his duty of care by not referring Mr A for an immediate ultrasound scan

9. On 23 May 2007 Mr A consulted with GP 1 regarding pain discomfort and swelling in his left testicle. GP 1 diagnosed epididymitis and prescribed a course of ciprofloxacin antibiotics. In his notes of the consultation GP 1 recorded in Mr A's medical records 'R epididymitis, treat and review if not settling'. The reference to 'R', meaning on the right side was incorrect, as the swelling was on Mr A's left side. In paragraphs 15 and 25, I consider this point in more detail.

10. On 23 June 2007, with his symptoms not having cleared, Mr A consulted an NHS 24 out-of-hours service doctor. He was advised to return to the Practice to arrange an ultrasound scan. Following contact with another General Practitioner (GP 3) at the Practice, he underwent an ultrasound scan on 5 July 2007, following which a malignant tumour was found. As a result, Mr A's left testicle was removed on 10 July 2007.

11. In October 2007 Mr A attended hospital for chemotherapy. Thereafter, a further scan revealed cancer had spread to the lymph nodes at the back of his abdomen. He then underwent surgery on 13 February 2008 to remove the lymph nodes.

12. Mrs C complained to the Practice regarding Mr A's consultation in May 2007. She considered that given Mr A's age, family history (Mr A's father died from testicular cancer) and symptoms, he should have been referred immediately for an ultrasound scan.

13. In making her complaint, Mrs C explained that following surgery it had been hoped that Mr A would not need to undergo any further treatment; however, he subsequently had to undergo a course of chemotherapy. It was then found that cancer had spread to the lymph nodes at the back of Mr A's abdomen, resulting in the further surgery in February 2008 referred to in paragraph 3.

14. In order to gain a better understanding of Mr A's consultation with GP 1 in May 2007, my staff met with Mr A to discuss his recollection of events. His wife (Mrs A), Mrs C and the Adviser were also present.

15. Mr A confirmed that, when he attended the consultation on 23 May 2007 with GP 1, the swelling was definitely on the left side. The significance of this is that the medical record completed by GP 1 refers to 'R epididymitis', and so confirms a typographical error by GP 1 in his recording of the consultation.

16. Mr A also recalled having previously visited the Practice in May 2005 with a scrotal lump and said that he was satisfied that the lump then had been on the 'other side' to the lump identified in May 2007, ie, his right side.

17. Mr A said that in May 2007 GP 1 conducted a very short examination. He did not use a torch to transilluminate the swelling and he did not ask Mr A how long he had had the symptoms or if he had any other symptoms.

18. Mr A said that GP 1 explained that it was epididymitis and it may take up to six months to clear. He asked GP 1 what caused it and said that GP 1 told him that it could be caused through sex with someone who had a sexually transmitted disease, a remark which had caused some upset for Mr A and his then fiancée.

19. Mr A also said that he was advised to take hot baths and GP 1 prescribed a course of antibiotics, advising Mr A that he should 'get back to him' if the symptoms persisted. Mr A said he understood this to mean that he should get back to GP 1 for more antibiotics.

20. During the discussion, Mrs C explained that she had conducted wide research on the subject of testicular cancer. She said that she had consistently found that, where there is a family history, it is recommended that an immediate ultrasound scan be completed.

21. She provided my staff with a document which contained extracts from different organisations, sourced from the internet, highlighting that men with a father who has had testicular cancer have a higher risk of developing the disease.

22. My staff also met with GP 1 to discuss the complaint; the Adviser was also present.

23. GP 1 acknowledged that the outcome was devastating for Mr A and his family. In terms of the consultation on 23 May 2007, GP 1 said that he could not recollect the consultation or, indeed, of meeting previously with Mrs C about what Mr A should do in terms of self care. He acknowledged, however, that the advice he had apparently given to Mrs C (see paragraph 1) seemed reasonable and confirmed that it was certainly the kind of advice that he would provide in those circumstances.

24. Referring to the consultation on 23 May 2007, GP 1 explained that he saw approximately 35 patients per day and said that while he did not recall the consultation with Mr A he could speak to it from the note of the consultation in the medical records.

25. GP 1 said that his notes were always made contemporaneously, in that they were completed either during, or immediately after, consultations. In referring to his record of the consultation on 23 May 2007, as entered by him onto the computerised records, he immediately acknowledged a typographical error in the way his notes of the consultation were recorded, explaining that 'R epididymitis' should have been 'L epididymitis'.

26. He confirmed that in preparing for a consultation with a patient he viewed the 'previous encounter' screen of the Practice computerised medical records system, which shows patients' previous consultations with the Practice. He acknowledged that he would have been aware of the entry made by GP 2 in

May 2005, which indicated a scrotal lump on Mr A's right side and noted that his father died of testicular cancer.

27. GP 1 said that in diagnosing epididymitis, he could state that his findings on examining Mr A would have included recent onset of a painful hot testicle which, on examination, was tender. These would be the typical findings upon which he would diagnose epididymitis.

28. He also confirmed that epididymitis would have been the most likely diagnosis, in terms of weighing Mr A's symptoms and the probability of one diagnosis over other potential diagnoses.

29. He could not say whether or not he made reference to the possibility of a sexuality transmitted disease during his consultation with Mr A. Although urinary tract infections can cause epididymitis, he confirmed that he would not have routinely asked questions about lifestyle.

30. He said that part of his normal examination of a scrotal swelling is to attempt to transilluminate it, however, as previously stated, he did not recall the specifics of the consultation with Mr A. He also said that transillumination would not necessarily distinguish between epididymitis and testicular cancer.

31. When asked if he could have said that it could take months for the symptoms to reduce or disappear, GP 1 said this was not the case and he would never have said that. He also said that there was no way that if Mr A had returned to the surgery after 10 days he would have been prescribed with more antibiotics, rather he said that, by definition, he would have then begun to exclude epididymitis and Mr A would have been referred urgently to urology at that stage.

32. GP 1 said that in terms of family history of testicular cancer, his understanding was that there was no clear pattern of inheritance. He said that he understood that, while statistically the chances of a son contracting testicular cancer where his father had the disease may be slightly greater, the chances were still very low.

33. With regard to the quality of the notes recorded in relation to Mr A's consultation, GP 1 considered that, while the record of the consultation could have been more specific, the notes were nonetheless clear and, in using the

phrase 'review if not settling', his advice to Mr A had been to return to the surgery if the symptoms did not improve with the antibiotics prescribed.

34. However, GP 1 acknowledged that, having reflected on the content of his note keeping, he was now putting more detail into the record of his consultations. He also confirmed that the circumstances of the complaint had been discussed at Practice meetings and, at the conclusion of the Ombudsman's investigation, the Practice would again review the complaint and how it was handled.

35. In concluding his comments on the consultation, GP 1 again acknowledged that the outcome was devastating for Mr A and his family but also said that he considered the action he took was eminently reasonable, given the circumstances at that time.

36. I asked the Adviser to comment on the case. He considered that the written record of Mr A's consultation with GP 1 was sparse (see paragraph 9), noting that the entry in the medical notes ('R epididymitis, treat and review if not settling') contained little describing the symptoms or signs.

37. The Adviser said that it would have been helpful to record what GP 1 found on examination, if this was done. He said that the notes should have recorded the history of the testicular swelling. He also said that GP 1 should have recorded what he told Mr A and the instructions he had given, particularly about when and if to return. He said that, in his opinion, Mr A should have been reviewed by GP 1 until the swelling had gone down or indeed until GP 1 realised that the swelling had not gone down, following which Mr A should have been sent for an ultrasound scan.

38. The Adviser told me that he considered GP 1 could have been more assertive in ensuring that Mr A returned to the Practice, however, he agreed with GP 1's decision to treat with antibiotics. He said that, although with hindsight the swelling was cancer and not epididymitis, it was still the right decision to treat with antibiotics at that time.

39. I asked the Adviser to comment specifically on the issue of a family history of testicular cancer and state whether, in the circumstances, Mr A should have been referred for an immediate ultrasound scan. He said that, although testicular cancer has a genetic component, the overall incidence of a positive

family history in testicular cancer was still low and he considered that this risk was not in itself a reason for referring a patient for an immediate ultrasound scan.

40. He said he did not believe that the delay between Mr A being seen in May 2007 by GP 1, and in June 2007 by the NHS 24 out-of-hours service, would have had a major effect on the spread of the disease.

(a) Conclusion

41. It is wholly understandable, given the family history, that Mrs C would have expected Mr A to have been referred for an immediate ultrasound scan on identifying a scrotal lump. In considering the merits of this complaint, however, it is not appropriate for me to use hindsight in my determination, rather, the issue for me to consider is whether the course of action taken by GP 1 at the consultation on 23 May 2007 was reasonable in the circumstances at the time.

42. Mr A was clear in his recollection of the consultation, whereas GP 1, who sees around 35 patients per day, acknowledged that he could not recall the events of the day. Both are understandable.

43. Mr A recalled that GP 1 conducted a very short examination; he did not transilluminate the swelling and he did not ask Mr A how long he had had the symptoms or if he had any other symptoms. GP 1, however, stated that his normal examination of a scrotal swelling is to attempt to transilluminate it and he was clear that if Mr A had returned to the surgery after 10 days he would have then begun to exclude epididymitis and would have referred Mr A urgently to urology.

44. GP 1 also acknowledged that he was aware of Mr A's family history; however, he considered that despite a slightly greater risk of Mr A contracting testicular cancer, the chances were still statistically low. He believed that, in the circumstances, his initial diagnosis of epididymitis was reasonable.

45. Although brief, GP 1's record of the consultation in the medical records indicates his advice was to 'treat and review if not settling'. GP 1 confirmed that this meant that Mr A should return to the surgery if the symptoms did not improve with the antibiotics prescribed. Mr A, however, said he understood from the consultation that the swelling could take months to reduce and that he should return to GP 1 for more antibiotics if required.

46. The Adviser was critical of the brevity of the record of the consultation. GP 1 has already reflected on this and, as reported in paragraph 34, is now putting more detail into the records of his consultations. The Adviser also considered that GP 1 could have been more assertive in ensuring that Mr A returned to the Practice if the swelling did not reduce. Importantly, however, he agreed with GP 1's initial diagnosis of epididymitis and the decision to treat with antibiotics.

47. The Adviser also confirmed that, although there is a slightly increased risk where there is a family history, the likelihood of the cancer being passed from father to son remains small. As GP 1 had diagnosed epididymitis, the Adviser did not consider that the family history together with the symptoms and Mr A's age was reason for an immediate referral for an ultrasound scan.

48. It is clear that there was a misunderstanding between GP 1's intention that Mr A should return to the Practice if the antibiotics did not reduce the swelling and Mr A's understanding, which was that the swelling may take months to reduce.

49. Mr A did, however, seek further medical advice on 23 June 2007, some four weeks after the consultation. The Adviser told me that he did not consider that the delay between Mr A being seen in May 2007 by GP 1 and in June 2007 by the NHS 24 out-of-hours service would have had a major effect on the spread of the disease.

50. In bringing my examination of the complaint to a conclusion, the question I have been asked to consider is whether GP 1 failed in his duty of care by not referring Mr A for an immediate ultrasound scan. I do not consider this to be the case. In taking account of the Adviser's comments I agree that the course of action taken by GP 1 at the consultation on 23 May 2007 was reasonable in the circumstances at that time. I do not, therefore, uphold the complaint.

51. While I do not uphold the complaint, in light of the Adviser's view that GP 1 could have been more assertive in ensuring that Mr A returned to the Practice if the swelling did not reduce, and taking account of GP 1's comment that the Practice will review the circumstances of the case on the conclusion of the Ombudsman's investigation, I would ask that the Practice gives due consideration to the management of testicular swellings in future.

(b) The Practice failed to meet the requirements of their Practice Complaints Procedure in the way they handled Mrs C's complaint

52. Mrs C complained by letter to the Practice on 8 April 2008. On 13 June 2008 she again wrote to the Practice stating that although she had received a telephone call from the Practice Manager, she had not received a response to her complaint.

53. The Practice Manager responded on 16 June 2008, apologising that a response had not been sent and acknowledging that this was due to an oversight on her part. A request for a signed mandate from Mr A, authorising Mrs C to complain on his behalf, was made in order to allow the Practice to respond to the complaint in more detail.

54. Mrs C responded on 30 June 2008, enclosing the mandate as requested. She asked that the Practice now follow the correct procedure for dealing with her complaint. By 8 September 2008, however, Mrs C had not received a response to her complaint and so asked the Ombudsman to intervene.

55. Following contact from the Ombudsman, the Practice issued a response to Mrs C's complaint on 19 September 2008. The Practice Manager accepted that Mrs C's complaint had not been handled appropriately; she acknowledged that Mrs C had been let down as a result of her failure to respond to the complaint as she had agreed to do; and she apologised to Mrs C for this service failure.

56. The Practice Complaints Procedure requires the Practice to acknowledge a complaint within three working days of receipt and to have investigated the matter within ten working days, to the point where the Practice shall be in a position to offer an explanation or a meeting with the Practice Manager.

57. The Practice Complaints Procedure mirrors the NHS complaints procedure, which seeks to provide prompt investigation and resolution of a complaint at local level. The NHS complaints procedure requires that, on receipt of a complaint, the Practice should write to the complainant within three working days to acknowledge the complaint and advise what action will be taken to look into the matters complained about.

58. A full response to the complaint should then be issued within ten working days. However, where more time is required to consider the matter before a full

response can be issued, the Practice should write to the complainant to advise them of the expected timescales for issuing the response. Thereafter, the complainant should be regularly updated on progress until a final response is issued.

59. In order to understand in more detail the administrative process followed by the Practice in dealing with Mrs C's complaint, my staff discussed the issue with the Practice Manager.

60. She explained that, erroneously, Mrs C's letter of complaint dated 8 April 2008 was not acknowledged upon receipt. It was passed to GP 1 between 12 and 14 April 2008 to allow him to consider the matter.

61. On 19 April 2008, the Practice Manager called Mrs C to discuss the complaint. They spoke at length regarding the matter. The call was concluded with the Practice Manager advising Mrs C that her complaint would be considered at the next Practice meeting, following which she would be advised of the outcome.

62. The Practice Manager told me that the complaint was indeed discussed at a Practice meeting, where it was considered that the action taken by GP 1 was reasonable in the circumstances. I examined an extract of the minutes of the Practice meeting held on 12 May 2008 and confirmed that Mrs C's letter of complaint was distributed to all partners for discussion. The minute indicated that 'It was agreed that [GP 1] took appropriate action by prescribing antibiotics together with the advice to return for review if things did not settle'. Unfortunately, however, this information was not communicated to Mrs C and her complaint remained without a formal response.

63. On receipt of a further letter from Mrs C, the Practice Manager responded by apologising for not having done what she said she would and requested the mandate from Mr A allowing Mrs C to act on his behalf.

64. Despite Mrs C returning the mandate as requested and asking that her complaint now be dealt with in line with the correct procedure, the Practice did not formally respond to her complaint until intervention by the Ombudsman's office in September 2008.

65. In her discussion with my staff, the Practice Manager accepted that she had not dealt effectively with Mrs C's complaint and she had not met the terms of the Practice Complaints procedure.

(b) Conclusion

66. It is clear, and accepted by the Practice Manager, that the requirements of the Practice Complaints Procedure were not met in this case.

67. What was equally clear, however, in my discussion with the Practice Manager was her deep sense of regret that she had let down Mrs C in the way the complaint had been handled.

68. Having spoken with Mrs C on the phone, then subsequently failing to follow up on the initial letter of complaint, the Practice Manager felt that she had personally let down Mrs C. Thereafter, she felt uncomfortable in contacting Mrs C as she felt that Mrs C would not wish to hear from her again.

69. Clearly, the Practice Manager felt personally responsible for letting down Mrs C in not responding to the complaint at an earlier stage. In my view, this acted as a barrier to the effective administration of Mrs C's complaint through the Practice Complaints Procedure to a conclusion.

70. The fact remains that Mrs C's complaint was not progressed in line with the Practice Complaints Procedure, or indeed with the national NHS complaints procedure. I, therefore, uphold this complaint.

(b) Recommendations

71. I recommend that the Practice:

(i) formally apologise to Mrs C for the failure to follow the Practice Complaints Procedure, and

(ii) take steps to ensure that Practice staff who deal with complaints are fully conversant with the time standards within the Practice Complaints Procedure, and respond in accordance with these time standards.

72. 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 C	The complainant; the mother of Mr A
Mr A	The patient who contracted testicular cancer; the son of Mrs C
GP 1	The General Practitioner who examined Mr A in May 2007 and diagnosed epididymitis
The Practice	Mr A's medical practice
GP 2	The General Practitioner who examined Mr A in May 2005 and diagnosed epididymitis
The Adviser	The Ombudsman's Independent medical adviser
GP 3	The General Practitioner who referred Mr A for an ultrasound scan in June 2007
Mrs A	Mr A's wife

Annex 2

List of legislation and policies considered

The Practice Complaints Procedure