Scottish Parliament Region: Central Scotland

Case 201200068: A Medical Practice in the Forth Valley NHS Board area

Summary of Investigation

Category

Health: General Practice; clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns that her sister, Ms A, reported to her GP practice (the Practice) symptoms of increasing chest, neck and back pain which were not properly investigated. Strong analgesia had little or no effect but the practice continued to issue prescriptions for morphine without physically assessing Ms A. In late December 2011 Ms A was referred to hospital by a GP from NHS 24 where bone cancer was diagnosed.

Shortly following the diagnosis, in early January 2012, one of Ms A's vertebra in her neck collapsed and she is now paralysed from the neck down. She has been told that her cancer is terminal and in May 2012 was told that she only has months to live.

Specific complaints and conclusions

The complaints which have been investigated are that the Practice:

(a) unreasonably failed to make timely and appropriate investigations to establish the cause of the symptoms reported by Ms A (*upheld*);

(b) unreasonably failed to make any referrals for specialist opinions in view of Ms A's symptoms (*upheld*); and

(c) inappropriately issued prescriptions for morphine without physically assessing Ms A (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Practice:	*Completion date*
(i) issues a written apology for the failings identified in this report;	24 November 2012
(ii) carry out a Significant Event Audit (SEA) on this case;	24 January 2013
(iii) carry out a review of a case note sample to assess	24 January 2013

	the quality of examinations conducted and the information recorded; and	
(iv)	completes the review of how acute prescriptions are issued and put a robust monitoring system in place.	24 November 2012

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

Main Investigation Report

Introduction

1. The complainant, Mrs C, raised concerns about the care and treatment provided to Ms A when she attended the Practice on a number of occasions between August and December 2011 reporting increasing chest, neck and back pain. Mrs C also complained that the Practice inappropriately prescribed morphine to Ms A without physically assessing her.

2. The complaints from Mrs C that have been investigated were that the Practice :

(a) unreasonably failed to make timely and appropriate investigations to establish the symptoms reported by Ms A;
(b) unreasonably failed to make any referrals for specialist opinions in view of Ms A's symptoms; and
(c) inappropriately issued prescriptions for morphine without physically assessing Ms A.

Investigation

3. Investigation of the complaints involved reviewing the Practice's medical records for Ms A. My complaints reviewer also obtained advice from a professional medical adviser (the Adviser).

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained at Annex 1. A further glossary of terms used in this report is contained at Annex 2. A list of the relevant prescriptions referred to in this report can be found at Annex 3. Mrs C and the Practice were given an opportunity to comment on a draft of this report.

(a) The Practice unreasonably failed to make timely and appropriate investigations to establish the cause of the symptoms reported by Ms A

5. Ms A started to suffer pain in various areas of her body during the summer of 2011 and attended the Practice on a regular basis from 17 August 2011 complaining of worsening chest, neck and back pain. Strong analgesia had little or no effect. She was sent for chest and cervical spine x-rays in September 2011 but nothing of significance was seen in these reports.

6. Ms A continued to attend the Practice reporting increasing pain, particularly in her neck which was of relatively new onset but became persistent. She also, in November 2011, complained of being sleepy; losing feeling in her hands and legs; stumbling and dropping things; and having difficulty getting up and down stairs.

7. Mrs C stated that despite her increasing pain, Ms A was not sent for any further investigations but was given increasing amounts of pain killers which still had little effect. On 24 December 2011 Ms A's pain was so bad that her family called NHS 24 and they were asked to take Ms A to the out-of-hours clinic located at Sauchie Community Hospital. Ms A was seen there by a GP in the early evening. After a short examination, the NHS 24 GP told the family that Ms A needed to go straight to the Forth Valley Royal Hospital.

8. When Ms A attended the hospital she was admitted and x-rayed that night and on the following day (Christmas Day) Ms A was given an emergency Computerised Tomography (CT) scan. A doctor spoke to Ms A and her family later that evening and told them that Ms A had terminal bone cancer. The doctor also said that one of the vertebra in Ms A's neck had 'crumbled'. Within a few days Ms A was unable to walk or use her hands.

9. Ms A is now paralysed from the neck down and was told in May 2012 that she has only a few months to live.

10. The Practice responded during a meeting with the family that they accepted that the complaint was valid and that all the GPs in the Practice were shocked when they found out Ms A's diagnosis.

11. The Practice also said that the recent spine x-ray had not shown myeloma or anything suspicious. One of the GPs told the family that myeloma does not show up until near the end as it softens the bones until they collapse. He also commented on the fact that the prescription of opiates (ie morphine) for neck pain is very unusual.

12. The Practice have said that they have learned from these events and are now more aware of this condition and would be actively looking for triggers in patients who present with similar symptoms.

13. I asked the Adviser if the Practice should have carried out further investigations into Ms A's symptoms. In his response, the Adviser said that he was struck by the fact that the symptom of neck pain was of new onset and then became persistent. The pain was difficult to control and was clearly affecting Ms A's daily life.

14. The Adviser also commented that there is scant detail of examinations in the medical notes and that the entry on 10 November 2011 includes: '… I agreed to x-ray but I think this is muscular …'

15. On the matter of the note of the consultation that Ms A had at the Practice on 20 December 2011, the Adviser commented that the note is poor. Specifically that there are no examination findings and particularly no assessment of upper limb neurology (numbness in the hands that Ms A was complaining of at the time). The Adviser commented that in his overall view there had been a deficiency in the care given to Ms A by the Practice.

(a) Conclusion

16. I have carefully considered all the evidence available and the Adviser's comments and have concluded that there was a failure by the Practice to fully investigate the cause of Ms A's symptoms in a timely and appropriate manner. There is a lack of detail in some of the clinical notes and a lack of urgency or openness to consider that there may have been a cause of Ms A's symptoms other than a muscular problem.

17. In view of the above I uphold this complaint.

18. As I have stated above, I was concerned on reviewing the evidence and the advice from the Adviser that there appeared to be a lack of urgency by the Practice to investigate Ms A's symptoms. Nor did the Practice appear to be willing to consider alternative diagnoses. While I note that the Practice have acknowledged that they failed Ms A in this case and that they will now be more aware of this condition, I do not consider that this goes far enough.

(a) Recommendations

19. I recommend that the Practice:	*Completion date*
(i) carry out a Significant Event Audit (SEA) on this case; and	24 January 2013

(ii)	carry out a review of a case note sample to assess the quality of examinations conducted and the quality of the information recorded.	24 January 2013

(b) The practice unreasonably failed to make any referrals for specialist opinions in view of Ms A's symptoms

20. Mrs C has stated that despite repeated visits and telephone calls to the Practice they failed to make any referrals for specific specialist opinions on the symptoms reported by Ms A. Mrs C has stated that where referrals were made, they were done at the request or insistence of Ms A.

21. One of the GPs and the Practice Manager met with members of the family on 12 January 2012 to discuss the complaint. When the family raised the issue of Ms A not being referred for specialist opinion the GP present responded that the recent spinal x-ray had shown no myeloma or other suspicious results. The GP also pointed out that Ms A had been seen by a neurosurgeon and that the Practice had received 'false reassurance' by his report. (See also paragraph 29.)

22. The GP present commented that the prescribing of such strong painkillers as Ms A was receiving for her neck pain was 'very unusual' but also explained that myeloma does not show up until 'near the end' when the bones are by then so soft that they collapse.

23. The Adviser has commented that it was reasonable for the Practice to refer Ms A for the chest and cervical spine x-rays. He also commented that the clinical notes on 10 November 2011 state: '… I agreed to x-ray but I think this is muscular …'

24. The Adviser commented that the chest x-ray showed nothing suspicious and the cervical spine x-ray showed only degenerative changes in the lower cervical spine. He also noted the referral to the Neurosurgeon who commented in his letter to the Practice dated 5 December 2011: '… At the present time I do not think there is any indication of need for an MRI scan of her cervical spine and I am happy to discharge her to your care …'.

25. I asked the Adviser if any further referrals should have been made and he commented that there was no clear working diagnosis in the notes. There was a suggestion that muscular pain or cervical spondylosis were being considered

and there were attempts to manage the symptoms. However, the Adviser also stated that the lack of data within the clinical notes did not allow him to say what, if any, other specific referrals to specialist colleagues should have been made.

26. The notes also reveal that Ms A saw one of the GPs at the Practice on 29 September 2011 who suggested that Ms A could refer herself to a private physiotherapist. On 26 October 2011 the notes include: '… refer physio[therapist] …'.

27. Ms A was seen at the Practice on 21 November 2011 and the note of the consultation includes that an Orthopaedic referral was to be made. Again Mrs C has stated that this referral was only made at the request of Ms A. A 'Routine' referral was completed on 22 November 2011 but no appointment was received before Ms A's condition deteriorated.

(b) Conclusion

28. I have reviewed the evidence provided by the family and the Practice, including the clinical records. I have also been guided by the advice from the Adviser and I conclude that some referrals were made for Ms A. She was referred for two x-rays which the Adviser tells me show little or no suspicious results. Ms A, on the advice of one of the GPs, self-referred to a private physiotherapist and was later referred by the Practice to a NHS physiotherapist.

29. I also note that although Ms A was provided with a referral letter from the Practice to a neurosurgeon, Mrs C stated that this was at the request of Ms A herself who had already booked the appointment privately. There is nothing in the clinical notes to confirm who made the suggestion of this referral. The report to the Practice from the Neurosurgeon did not suggest that there was any major cause for concern.

30. I also note that, Mrs C stated that it was at her own request, Ms A was referred to Orthopaedics but was not seen before she was hospitalised. Again the clinical notes do not record who made the suggestion of a referral to the Orthopaedic specialists.

31. I note that during the meeting with the family on 12 January 2012 the GP at the meeting said that they had had 'false reassurance' from the Neurosurgeon. However, I have also referred previously to the comment made

by the GP who attended the meeting with the family on 12 January 2012 regarding the prescribing of morphine for neck pain as being 'very unusual'. I wonder that this in itself did not trigger further action.

32. In light of Ms A's continuing, debilitating and unresolved symptoms I do not understand why no further investigations or referrals were made. It seems that, as I have mentioned at (a) above, the GPs at the Practice were of the view that the symptoms Ms A was experiencing stemmed from a muscular problem and they were not open to any alternative scenarios.

33. To the extent that I have identified failings in this, I uphold this complaint. Given the recommendations made above, I make no further recommendations here.

(c) That the practice inappropriately issued prescriptions for morphine without physically assessing Ms A

34. Mrs C expressed concern that the Practice repeatedly issued prescriptions for morphine following telephone requests either from her or Ms A. She was concerned that this was done without Ms A's condition being assessed.

35. The clinical notes record that morphine was first requested during a telephone call between Mrs C and one of the GPs on 25 November 2011. The GP prescribed oral morphine at 10 milligrams to be taken 'four hourly when required'; 28 tablets were prescribed. At a maximum of six tablets per day, this was enough for almost five days.

36. The same GP had seen Ms A at the Practice some four days previously on 21 November 2011. Ms A was seen again at the Practice on 2; 16; and 20 December 2011 and there was a telephone discussion of the letter from the Neurosurgeon on 9 December 2011.

37. The GP records note that prescriptions for morphine were printed from their system on 25 and 28 November 2011; and then on 2; 5; 7; 12; 16; and 19 December 2011 (twice on this last date). This is a total of nine prescriptions but see also paragraphs 44 to 45.

38. Mrs C has stated that every time more morphine was requested it was given 'without question' as to why it was required and/or why Ms A was taking so much morphine. The first prescription was issued on 25 November 2012 for

sufficient medication for almost five days at the maximum dosage. However, the records show that another prescription for morphine was printed on 28 November 2011 only three days later.

39. My complaints reviewer made enquiries about the number of prescriptions for morphine issued to Ms A and the Practice responded in a letter dated 18 June 2012. The letter stated that the prescriptions for morphine were issued as requested and were issued as 'acute' (meaning to treat symptoms of rapid onset and brief duration) rather than 'repeat' (used for chronic or long-term and on-going symptoms).

40. The letter went on to say that acute prescriptions are reviewed by a GP at the time of the request (unlike repeats which are only reviewed on a six or twelve monthly basis). The letter also confirmed that each prescription was for 28 tablets. The letter also enclosed comments from one of the GPs at the Practice who saw Ms A most frequently and who issued the first morphine prescription.

41. The GP stated that during the telephone discussion with Ms A's sister on 25 November 2011, having seen Ms A four days previously, he felt it was not unreasonable to try morphine if the drugs Ms A was already on were not helping her pain.

42. As I have recorded at (a), during the meeting with the family which took place on 12 January 2012, the GP present, who was not the GP referred to above, commented that 'opiates' (that is strong, controlled drugs such as morphine) being prescribed for neck pain was 'very unusual'.

43. In later emails to my complaints reviewer dated 3 and 9 July 2012 the Practice stated that when the details of the prescriptions were checked with the local health board, it was found that although nine prescriptions are recorded as being printed off, only six of these were actually issued. The Practice went on to say that they are not certain how this happened but are assuming that prescriptions had been requested via the reception staff and were printed out for a GP signature. If the prescription was not subsequently signed by a GP it was not then removed from the system.

44. The Practice told my complaints reviewer that they were now changing the way acute prescriptions are issued and they will no longer be printed out by the

reception staff. Any request will be passed directly to a GP who will assess the request and either print out and sign the prescription or ask the patient to make an appointment for review.

45. The records show that Ms A was on a combination of several drugs in an attempt to address her pain. The drugs included strong pain killers; non-steroid anti-inflammatory drugs; and drugs normally used as anti-convulsants or anti-depressants which have been found to help with long-term and consistent pain.

46. The Adviser said that the prescription frequency, including that of the morphine, suggested poor pain control and that this should have prompted review and further investigations.

47. The Adviser commented that given the level of pain suffered by Ms A and the lack of control with the other analgesia she had been on, a prescription for morphine was not unreasonable in the circumstances. However, the Adviser said that he would have preferred to have seen this as part of a comprehensive plan of care. This would include regular physical assessments of the patient and reviews of pain control and possible side effects of the drugs prescribed.

48. In order to demonstrate the level and frequency of the drugs prescribed for Ms A I attach at Annex 3 to this report a list of the prescription drugs, including morphine, recorded as being issued to her (but see also paragraphs 44 to 45). The list covers the period between August and December 2011 in an attempt to address her pain and the related side effects of some of the drugs.

(c) Conclusion

49. I was concerned that the Practice appeared to be giving regular prescriptions for increasingly strong analgesia without detailed reviews being recorded. I was even more concerned that they also appeared not to know how many requested prescriptions for a controlled drug were actually issued.

50. I acknowledge that this latter issue is currently being addressed by the Practice. However it remains a concern to me that even if, as the Practice now say, only six of the nine prescriptions for morphine were issued, Ms A was only actually seen by a GP on two of those dates.

51. On neither occasion was the prescription for morphine printed off by the GP that saw Ms A on that date nor was the prescription printed at or near the time she was seen by the GP. Nor do the notes of the two consultations make any reference to a review of Ms A in respect to her overall pain control.

52. I also note that the first prescription was issued following a telephone call from Mrs C some four days after the GP had actually seen Ms A. Ms A was not seen again by a GP until a further seven days had passed by which time a further two prescriptions for morphine had been recorded.

53. The Adviser has commented upon the general lack of pain control demonstrated by the increasing 'cocktail' of progressively stronger drugs being prescribed for Ms A and that this did not trigger further investigations. I share this concern.

54. Based on the evidence I have seen and the advice I have received, I uphold this complaint.

(c) Recommendation

55. I recommend that the Practice:	*Completion date*
(i) completes their review of the issuing of acute prescriptions and put in place a robust monitoring system.	24 November 2012

General recommendation

56. I recommend that the Practice:	*Completion date*
(i) issues a written apology for the failings identified in this report.	24 November 2012

57. 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
Ms A	The aggrieved, the complainant's sister
The Practice	Clackmannan & Kincardine Medical Practice
The Adviser	The Ombudsman’s medical adviser
GP	General practitioner

Annex 2

Glossary of terms

Analgesia	Pain killers
Cervical spine	The backbone in the neck area
Cervical spondylosis	A spinal condition in the neck area caused by the degeneration of the intervertebral discs
Controlled drugs	A range of drugs, including opiates, which are subject to legal controls
Computerised Tomography scan (CT) scan	Specialised x-rays which use a computer to produce cross-sectional images
Degenerative changes	Slow and on-going changes often seen in chronic conditions such as arthritis with aging
Magnetic resonance imaging (MRI) scan	A diagnostic technique using a strong magnetic field and computer technology to 'map out' images. MRI is particularly useful for examining the central nervous system
Myeloma	Malignant disease of the bone marrow
NHS 24	A national health advice and out of hours medical service
Non-steroidal anti-inflammatory drugs (NSAID)	A large group of drugs used for pain relief, particularly in rheumatic disease. Possible side effects include gastric bleeding and ulcers

Neurosurgeon	A specialist in surgical treatment of diseases or injury of the brain or spinal cord
Opiates	A range of drugs derived from opium often used as strong pain killers
Significant Event Audit (SEA)	A review of any unexpected or unintended event that did or could have cause[d] harm to a patient. The event and any lessons learned should be recorded and discussed during annual appraisals

Annex 3

List of prescriptions to treat pain recorded in the GP notes – August to December 2011

Date	Drug and common usage
17/08/2011	Advised to take Ibuprofen – a NSAID used for pain relief, particularly in rheumatoid arthritis and muscle pain
29/09/2011	Co-Codamol – a mixture of paracetamol (pain killer) and codine (a derivative of opium used as a pain killer) Amitriptyline Hydrocloride – an anti-depressant also used in pain relief Ibuprofen – see above
26/10/2011	Amitriptyline Hydrocloride – see above Tramadol Hydrocloride – a pain killer used to relieve moderate to severe pain Paracetamol – see above
09/11/2011	Paracetamol – see above
21/11/2011	Paracetamol – see above Tramadol Hydrocloride – see above Amitriptyline Hydrocloride – see above Betahistine Dihydrochloride – ahistane analgesic used to treat dizziness
24/11/2011	Advised to increase the Amitriptyline Hydrocloride
25/11/2011	Morphine sulphate – an opiate used to treat moderately severe to severe pain
28/11/2011	Morphine sulphate – see above
02/12/2011	Amitriptyline Hydrocloride – see above Paracetamol – see above

	Morphine sulphate – see above
05/12/2011	Morphine sulphate – see above
07/12/2011	Morphine sulphate – see above
09/12/2011	Advised to stop ibuprofen and Diclofenac sodium prescribed – NSAID used for pain relief
12/12/2011	Amitriptyline Hydrocloride – see above Morphine sulphate – see above Paracetamol – see above
16/12/2011	Ms A reported suffering indigestion since starting the Diclofenac. Advised to stop or reduce the Diclofenac; Omeprazole prescribed – one of a group of proton pump inhibitors which reduces the amount of acid produced by the stomach Amitriptyline Hydrocloride – see above Diclofenac sodium – see above Morphine sulphate – see above
19/12/2011	Morphine sulphate – see above (two prescriptions recorded) Paracetamol – see above
20/12/2011	Advised to reduce the morphine and Gabapentin prescribed – an anti-convulsant