SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

SPSO
4 Melville Street
Edinburgh
EH3 7NS

Tel **0800 377 7330**

SPSO Information **www.spso.org.uk**

SPSO Complaints Standards **www.valuingcomplaints.org.uk**

Scottish Parliament Region: Highlands and Islands

Case ref: 201400930, A Medical Practice in the Highland NHS Board area
Sector: Health
Subject: GP and GP practices: clinical treatment/diagnosis

Summary

Ms C complained to us on behalf of her client (Mr A) that doctors did not reasonably diagnose that his late wife (Mrs A) had cancer. In late 2012, Mrs A had breast cancer surgery, during which an extremely large high-grade tumour was removed. She contacted the practice some seven months later complaining of back pain and spasms. She also then developed a wheeze and cough. Between 29 July 2013 and 19 August 2013 she had four telephone consultations with three GPs at the practice, who prescribed and adjusted pain relief medication, and later provided Mrs A with an inhaler. The day after the last consultation, she contacted NHS 24 because she was having problems breathing. They arranged for an out-of-hours doctor to visit, who diagnosed pneumonia and said Mrs A should contact her GP. She did this the same day, and saw another GP from her practice, who referred her straight to hospital because of her history of breast cancer. She was found to have cancerous growths and a build-up of fluid in her chest. She was admitted to hospital but died before cancer treatment could be started.

When Mr A complained to the practice they concluded that they did not identify early enough that Mrs A was as unwell as she was, and that it would have been better if she had been more fully assessed. They said that this might have been partly due to a breakdown in communications, apologised for the standard of care provided and said that they would carry out a Serious Event Analysis (SEA) of Mrs A's case. Mr A was not satisfied with this, and took the complaint further, latterly with the help of Ms C. The final outcome was that although the practice agreed that with hindsight things could have been done better, they said that they had found nothing that needed remedy.

I took independent advice from one of my medical advisers, who is a GP. She said that the medical histories taken during the telephone consultations were sparse and that Mrs A's clinical history should have made doctors suspect that the cancer might have come back. The surgeon had told the practice that it was not possible to say whether surgery had achieved a long term cure. Given all the circumstances, my adviser said that Mrs A should have been physically

assessed at the time of the first call, and certainly when the pain did not resolve after painkillers were provided. My adviser had several concerns about the lack of assessment before prescribing treatments, and these are detailed in my report. She also pointed out although that the SEA report showed some evidence of reflection on and learning from Mrs A's case, the practice also appeared to have suggested that some of the responsibility lay with Mrs A for not explaining just how much pain she was in.

I upheld Ms C's complaint, as I found that a combination of errors led to an unreasonable delay in diagnosing Mrs A's condition. She should have been seen face-to-face and assessed much earlier, and elements of her care fell below General Medical Council standards. Although the practice accepted that they did not physically assess her early enough and have introduced a new telephone protocol, my adviser identified some other serious failings, especially around prescribing medication without adequate knowledge of the patient's health. I was also concerned that in handling the complaint the practice appeared to ascribe some of the blame to Mrs A, which suggests to me that they had not fully accepted that their handling of her case was not of a reasonable standard. They also appeared to minimise fault on the part of the doctors, and I found the tone of some of their letters inappropriate.

Redress and recommendations

I recommended that the Practice:	*Completion date*
(i) apologise to Mr A for the failure to identify the recurrence of Mrs A's cancer;	20 May 2015
(ii) ensure that this complaint is discussed during the next annual appraisals of GP 1, GP 2 and GP 3;	3 June 2015
(iii) raise awareness amongst all doctors at the Practice of the signs and symptoms of cancer recurrence; and	3 June 2015
(iv) refer this case to the Board for further discussion with their clinical support group to avoid a recurrence of similar events in future.	17 June 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and

departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002. Under the Act, the Ombudsman can publish a public report and lay this before the Parliament where he considers that there is a public interest in the matter and it is appropriate to do so. The Act says that, generally, reports of investigations should not name or identify individuals, so in the draft report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Main Investigation Report

Introduction

1. The complainant (Ms C) has raised a number of concerns on behalf of her client (Mr A). Mr A's complaint relates to the treatment that his late wife (Mrs A) received from doctors at their local health centre (the Practice) which is in the Highland NHS Board (the Board) area.

2. Mrs A had a history of breast cancer and had undergone a left sided mastectomy (an operation to remove the breast) in December 2012. An extremely large tumour, some 30 centimetres in diameter, was removed during this surgery and although neither chemotherapy nor radiotherapy were considered to be beneficial at that time, Mrs A remained under review as an out-patient at a Board hospital. While there was no indication that cancer had spread elsewhere in Mrs A's body in December 2012, the Practice were advised by the surgeon who carried out Mrs A's mastectomy (the Consultant) that spread may not occur via lymphatic channels (the network of channels which drain the lymph fluid that surrounds the body's cells) and that it was impossible to say whether surgery had achieved a long term cure.

3. Mrs A contacted the Practice on 29 July 2013 and had a telephone consultation with GP 1. She reported back pain with spasms and painkillers were prescribed to treat these symptoms along with diazepam. A further telephone consultation took place with GP 2 a few days later on 5 August 2013 as Mrs A's pain was not much better. She requested stronger painkillers which were prescribed (in the form of dihydrocodeine, naproxen and diazepam) and GP 2 noted that her condition would need assessment if there was no improvement. No red flags (warning signs for more serious conditions) were recorded.

4. Mrs A had another telephone consultation with GP 2 on 15 August 2013. Problems she was experiencing with her pain relief were discussed and it was recorded that Mrs A had developed a wheeze and a cough. No shortness of breath was noted but Mrs A advised GP 2 that she was struggling with the cough and her back pain. A salbutamol inhaler (a medicine used to treat asthma and other airways-related problems) was prescribed to relieve this and the strength of her pain relief adjusted. A further telephone call took place on 19 August 2013 with GP 3 and back spasms were reported again. It was noted

that diazepam was not helping much with the pain and baclofen (a medicine which can be used for muscle spasm) was tried instead.

5. Mrs A spoke with NHS 24 at 04:27 on 20 August 2013 as she was suffering with difficulty in breathing. She advised that she had hurt her back around three weeks previously whilst riding a bike. Mrs A was unable to attend an out-of-hours clinic and so a home visit was arranged. A doctor arrived a short time later and diagnosed right sided pneumonia secondary to hypoventilation (shallow breathing) in right lung post back injury. Antibiotics were prescribed and she was advised to contact the Practice for a follow up.

6. Mrs A was seen by GP 4 later on 20 August 2013 and he referred her directly to hospital. In the referral he noted that Mrs A had a history of breast cancer and had strained the right side of her chest whilst riding a bike. GP 4 went on to state that she had not been examined until the previous night when right sided pneumonia was diagnosed. He questioned whether her symptoms were mainly due to pneumonia or if there was more going on, particularly given her mastectomy.

7. Mrs A was admitted to hospital that day where she was found to have a large right sided pleural effusion (a build-up of fluid between a lung and the chest wall) which had drained into the chest. A diagnosis of malignant phyllodes sarcoma (smooth, hard lumps of tissue that grow in the supportive tissue of the breast) was later made and she was moved to an oncology ward. Mrs A's condition deteriorated and she sadly passed away on 5 September 2013 before any cancer treatment was started.

8. Mr A wrote to the Practice on 24 September 2013 to complain about the way that they had dealt with Mrs A's care. A response was provided by the Practice on 4 October 2013. In this letter, the Practice outlined their understanding of Mrs A's contact with them. They stated that GP 1 had full access to Mrs A's medical records and that he was aware of her previous history when he made his assessment during the telephone call of 29 July 2013. The Practice advised Mr A that although his wife's back pain was not much better during the next telephone contact on 5 August 2013, there were no other symptoms to suggest any problem other than muscular back pain. They explained that during the next call on 15 August 2013, a cough with a slight wheeze was discussed and that an inhaler was prescribed to avoid the cough exacerbating the back pain. The Practice also informed Mr A that Mrs A

had denied any problems other than pain at that time and that GP 3 agreed with the diagnosis made previously of muscular back pain.

9. The Practice concluded that they appeared not to have identified that Mrs A was as unwell as she was at an earlier stage and said that while it may not have made any difference to her long terms prognosis, it would have been much better if she had been assessed more fully. They advised Mr A that it was unclear why this had not happened but that it appeared to be due, in part, to a failure in communication between them and Mrs A. The Practice informed Mr A that they took failures such as this seriously. They advised that they would be reviewing Mrs A's care as part of a Serious Event Analysis (SEA) and apologised for the standard of care provided to Mrs A over this period.

10. Mr A wrote to the Practice again on 13 October 2013 as he was unhappy with their response and received a further reply dated 18 October 2013. As Mr A continued to be dissatisfied with the Practice's position on his concerns, he contacted Ms C to help him take his complaint forward. Ms C wrote to the Practice on 23 March 2014 and received their final response dated 4 April 2014. This concluded that no fault or system failure had been found that required remedy and that whilst in retrospect things could have been done differently, they believed that there had been a failure in communicating the problem clearly and understanding the issues between all parties involved. The SEA was subsequently carried out by the Practice on 19 November 2013.

11. The complaint from Ms C which I have investigated is that the Practice did not reasonably diagnose Mrs A's condition *(upheld)*.

Investigation

12. Investigation of the complaint involved reviewing the information received from Ms C, the Practice's medical records for Mrs A and their complaint file for this case. My complaints reviewer also obtained independent advice from a medical adviser (the Adviser) who is a General Practitioner (GP).

13. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Practice were given an opportunity to comment on a draft of this report.

Complaint: The Practice did not reasonably diagnose Mrs A's condition

14. Mrs A had four telephone consultations with doctors at the Practice between 29 July 2013 and 19 August 2013 as a result of pain in her back. She was prescribed pain relief and other medication without being seen in person or examined. Following her call to NHS 24 in the early hours of 20 August 2013, Mrs A was diagnosed with pneumonia and referred to hospital by GP 4 later that day. GP 4 was concerned that Mrs A's symptoms could have been linked to her previous cancer diagnosis. Mrs A was admitted to hospital where a diagnosis of malignant phyllodes sarcoma was made.

Advice received

15. The Adviser noted that Mrs A was within just eight months of being diagnosed with breast cancer at the time of these events. She further noted that the Practice had been advised by the Consultant on 21 December 2012 that there should be a low threshold for further investigation and that a cure could not be confirmed. The Adviser considered that this should have alerted the doctors to the possible recurrence of cancer.

16. The Adviser said that from the perspective of general practice there are certain points in Mrs A's clinical history which should have raised a high index of suspicion for possible recurrence of cancer. The Adviser considered that the high grade of Mrs A's tumour was significant. She explained that the histologic grade refers to how much the tumour cells resemble normal cells when viewed under a microscope and that the higher the grade, the greater the chance is of recurrence. The Adviser noted that Mrs A's cancer type was a high grade phyllodes tumour thus having a higher chance of recurrence.

17. The Adviser also considered the size of the tumour to be relevant. She advised that in general, the larger a tumour is, the greater the chance of recurrence. The Adviser noted that Mrs A's tumour was over 30 centimetres in size whereas most phyllodes tumours are three to five centimetres.

18. A further factor which the Adviser considered to be of relevance was the high mitotic activity of the tumour (a measure of how fast cancer cells are dividing and growing). She explained that the nuclear grade of a tumour is the rate at which cancer cells divide to form more cells. The Adviser said that cancer cells with a high nuclear grade are usually faster growing and that it was noted that Mrs A's tumour had high mitotic activity.

19. The Adviser said that a patient who presented with back pain with a recent history of a very large, rare tumour which was high grade with high mitotic activity and whose surgeon had stated that he could not guarantee a cure, should have raised a high index of suspicion in the doctors who spoke to her. She advised that having reviewed the relevant clinical entries and correspondence in the medical records that would have been available to the Practice, she considered that Mrs A should have been physically assessed to rule out any signs suggestive of tumour recurrence at the time of the first telephone call. The Adviser said that by default, she would expect them to have had the possibility of a tumour recurrence at the forefront of their differential diagnosis and as such, this should have been ruled out first as a matter of priority. She did not find that this was the case.

20. The Adviser highlighted a number of issues of concern with the four telephone consultations in this case. In relation to the clinical histories recorded by GP 1, GP 2 and GP 3, the Adviser considered these to be sparse and lacking in detail. She noted that they did not describe the position or site of the pain. The Adviser also commented that reference was made to red flag signs being absent. She explained that red flags are symptoms that suggest a serious condition and advised that these can be numerous. The Adviser said that there was no reference to what diagnosis they were trying to exclude and that in terms of cancer, a past history of cancer is noted to be an established red flag sign in National Institute of Health and Care Excellence (NICE) guidelines.

21. The Adviser was also concerned that Mrs A was prescribed an increasing strength of analgesia when she stated that the previous pain relief was not effective. She considered that it would have been reasonable for Mrs A to have been physically assessed to look for an underlying cause of her persistent pain if she had not responded to analgesia after one week. The Adviser said that pain is a symptom of an underlying illness and not a diagnosis in itself. She considered that Mrs A's symptom of pain should have been investigated.

22. The Adviser noted that Mrs A was given an salbutamol inhaler when she complained of a cough with a wheeze. There was no previous history of asthma or regular use of inhalers and the Adviser commented that no diagnosis was made before Mrs A was prescribed with the inhaler. She commented that although GP 2 had noted that this was for symptomatic relief, no assessment had been made of the cause of the wheeze and cough. Again, the Adviser

explained that a wheeze and cough are symptoms of an underlying illness and not a diagnosis. She considered that Mrs A should have been investigated to find the underlying cause and said that the prescribing of salbutamol in Mrs A's case was not of a reasonable standard.

23. The Adviser also did not consider the decision to prescribe a trial of baclofen for Mrs A's back spasms to be of a reasonable standard. The Adviser did not find that Mrs A was adequately assessed before this prescription was issued after 22 days of alternative medication that had not worked. In relation to the decision to prescribe salbutamol and baclofen to Mrs A, the Adviser referred to the General Medical Council (GMC) guidance 'Good Medical Practice' which states:

> 'You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:
>
> a. adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient
>
> b. promptly provide or arrange suitable advice, investigations or treatment where necessary
>
> c. refer a patient to another practitioner when this serves the patient's needs.'

24. The Adviser noted that GP 2 had recorded on 5 August 2013 that Mrs A would need assessment if she did not improve, however, when GP 2 spoke to Mrs A again on 15 August 2013, no assessment was arranged. Given that this was the patient's third contact with the Practice about the same complaint, the Adviser did not consider that the decision to reduce the strength of Mrs A's analgesia and add in salbutamol to be a reasonable response to the clinical picture shown. The Adviser said that assessment should have been arranged.

25. My complaints reviewer asked the Adviser to comment on Mrs A's explanation that she had injured herself on a bike. The Adviser said that the GP medical records from 29 July 2013 onwards do not refer to Mrs A blaming her pain on an injury. She noted that Mrs A had informed the out-of-hours GP who visited her on 20 August 2013 of lumbar pain after pedalling on a bike, however, there was nothing in the records to suggest that this history was given to the doctors who spoke to her during the four telephone consultations. The Adviser

said that regardless of this, even if the doctors had been informed, it still should not have led them to dismiss cancer recurrence as a differential diagnosis.

26. The Adviser was also asked to comment on the SEA report that the Practice undertook following Mr A's complaint. She advised that the SEA showed evidence that the Practice had accepted that they needed to be vigilant when dealing with patients with a past history of cancer and question why problems are presenting atypically or not resolving as expected. The Adviser noted that the Practice agreed in retrospect that Mrs A should have been seen and examined before she was. She also noted that learning had been identified, in that if a patient telephones on more than two occasions with the same problem, they will be assessed in person. The Adviser found that although this showed some evidence of reflection and learning, the Practice had also referred blame to Mrs A for not directly communicating the severity of her pain. The Adviser said that the Practice should have been alert to the possibility of cancer recurrence regardless of whether Mrs A was immobilised with pain or not.

27. The Adviser concluded that the Practice did not provide Mrs A with a reasonable standard of care and said that their failure to diagnose her cancer recurrence timeously led to an extended period of unmanaged pain and distress in the weeks prior to her death.

Decision

28. The advice I have received is that there is no evidence in the medical records for 29 July 2013, 5 August 2013, 15 August 2013 and 19 August 2013 that any of the doctors took a full history; considered Mrs A's past diagnosis of cancer and the possibility of cancer recurrence; or treated her in a reasonable manner in terms of assessment, prescribing or management. I am particularly concerned by the advice that elements of the care provided to Mrs A fall below the standard expected in the GMC guidance on good medical practice.

29. In relation to assessment, the advice received is that Mrs A should have been seen in person following her first telephone consultation on 29 July 2013. There has clearly been a failure to arrange a timely face-to-face assessment of Mrs A's condition. The Practice have accepted this and in addition to apologising to Mr A for the standard of care that was provided to his wife, I note that a new telephone protocol has been introduced. However, I remain concerned that despite this, the Practice have not identified some of the serious

issues highlighted by the Adviser in her comments on this case, particularly around the issue of prescribing drugs without adequate knowledge of the patient's health. In their response to Mr A of 18 October 2013, the Practice stated:

> 'You make the point that the Doctors were “diagnosing and prescribing drugs purely on what my wife was telling them”. We do this a lot of the time and this happens face to face or over the telephone equally. It is impossible to prove that a person has pain, for instance, and we have to rely to a great extent on what we are told in response to our questioning.'

This suggests that even if Mrs A had been assessed face-to-face, there was a possibility that the care and treatment she received would not have changed unless further information was offered up during the consultation.

30. I am also concerned by the Adviser's comments on the Practice's consideration of why Mrs A was not seen in person. The Practice took the view that this was, at least in part, related to a lack of clarity in communication between Mrs A and the doctors involved. In the SEA the Practice noted that after the event, Mr A made them aware that his wife was immobilised by her back pain and that the out-of-hours records from 20 August 2013 showed that her sleep was significantly disrupted. However, the Practice went on to defend the actions of the doctors stating that appropriate questions about symptoms had been asked and red flags considered. The advice I have received is that this apportioning of blame to Mrs A suggests the Practice have not fully accepted that their management of this case was below a reasonable standard. Mrs A's symptoms and history should have raised the Practice's suspicion of cancer recurrence regardless of whether their patient was immobilised with pain or not. The advice has also highlighted that a previous cancer diagnosis can be a red flag alert in NICE guidelines.

31. Although I was not specifically asked to investigate the way the Practice handled Mr A's complaint, I am concerned by the tone of their written responses to his concerns. I found that although an apology had been offered and further action outlined in the letter of 4 October 2013, there were attempts to minimise fault on the part of the doctors who dealt with Mrs A. Issues with tone continued in the subsequent letter of 18 October 2013 where unhelpful phrases such as 'if you read my letter again …' and 'I will not repeat the information here but in my last letter …' also appeared. I was particularly concerned by the inclusion of the following statement in correspondence to a recently bereaved person:

> 'I have also apologised on behalf of the Practice and stated that we will be investigating the reasons behind this apparent failure, to try to learn lessons to prevent it happening in the future. I am not sure why this has made you "more angry" and what, if anything, we can do to help with the way you are feeling.'

I did not find that their approach changed when dealing with Ms C in their letter of 4 April 2014. The Practice should take this opportunity to reflect on the tone that is adopted when responding to complaints and how this affects the complainant, particularly in cases where a family member or other loved one has been lost.

32. Taking all the evidence into account, a combination of errors in the assessment and management of Mrs A resulted in an unreasonable delay in diagnosing her condition. This left her in poorly managed pain prior to her admission to hospital. In a patient with a recent history of such a large high grade tumour with high mitotic activity, it was not reasonable to assess and manage her care through telephone consultations. In view of these findings, I uphold the complaint.

Recommendations

33.	I recommend that the Practice:	*Completion date*
(i)	apologise to Mr A for the failure to identify the recurrence of Mrs A's cancer;	20 May 2015
(ii)	ensure that this complaint is discussed during the next annual appraisals of GP 1, GP 2 and GP 3;	3 June 2015
(iii)	raise awareness amongst all doctors at the Practice of the signs and symptoms of cancer recurrence; and	3 June 2015
(iv)	refer this case to the Board for further discussion with their clinical support group to avoid a recurrence of similar events in future.	17 June 2015

34. The Practice have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Practice are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	the complainant
Mr A	the aggrieved
Mrs A	the late wife of the aggrieved
the Practice	the health centre
the Board	Highland NHS Board
the Consultant	consultant surgeon
GP 1	a general practitioner at the Practice
GP 2	a general practitioner at the Practice
GP 3	a general practitioner at the Practice
GP 4	a general practitioner at the Practice
SEA	Significant Event Analysis
the Adviser	a general practitioner
NICE	National Institute for Health and Care Excellence
GMC	General Medical Council

Annex 2

Glossary of terms

baclofen	a medicine which can be used for muscle spasm
chemotherapy	a treatment where medicine is used to kill cancerous cells
diazepam	a medicine that can be used to treat muscle spasm
differential diagnosis	a systematic method of diagnosing a disorder that lacks unique symptoms or signs
dihydrocodeine	a medicine which is used in relieving post-operative pain and relieving moderate to severe pain
General Medical Council (GMC)	the body which registers doctors, allowing them to practice in the United Kingdom. Promotes and upholds standards for the medical profession
high grade tumour/histologic grade	refers to appearance of tumour cells and how much they resemble normal cells under a microscope
high mitotic activity/nuclear grade	a measure of how fast cancer cells are dividing and growing
hypoventilation	shallow breathing
lymphatic channels	the network of channels which drain the lymph fluid that surrounds the body's cells
malignant phyllodes sarcoma	cancerous smooth, hard lumps of tissue that

	grow in the supportive tissue of the breast
mastectomy	an operation to remove the breast
naproxen	a medicine that helps to reduce inflammation and to reduce pain
National Institute of Health and Care Excellence (NICE)	provides national guidance and advice to improve health and social care
pleural effusion	a build-up of fluid between a lung and the chest wall
pneumonia	swelling (inflammation) of the tissue in one or both lungs. Commonly caused by an infection
radiotherapy	a treatment using high-energy radiation
red flags	warning signs for more serious conditions
salbutamol inhaler	a medicine used to treat asthma and other airways-related problems