SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: North East Scotland

Case ref: 201403542, A Medical Practice in the Tayside NHS Board area
Sector: Health
Subject: GP & GP Practices; clinical treatment; diagnosis

Summary

Mrs C complained about the care and treatment that her late mother-in-law (Mrs A) received from her medical practice over the two-year period before her death. Mrs A first contacted the practice in November 2011 about her hip pain. She was prescribed painkillers but the pain persisted, and an x-ray was taken in summer 2012 which suggested that she had osteoarthritis. Mrs A's pain increased so, in October 2012, the practice made a referral for her to see an orthopaedic consultant (who specialises in the musculoskeletal system).

In January 2013, Mrs A reported to the practice her weight loss of ten kilograms over two to three weeks. She saw the orthopaedic consultant, who thought that her pain was muscular and at the base of her spine, rather than caused by arthritis in her hip. Mrs A received physiotherapy and stronger painkillers, neither of which helped to reduce her worsening pain. She was re-referred to orthopaedics, and saw the consultant, who arranged a scan for the end of August 2013. Before the scan, Mrs A's condition deteriorated further. She was in regular contact with the practice, and prescribed different pain medications. She found the scan very painful and did not get the results in the time-frame she was expecting.

Mrs A's mobility decreased in September 2013 until she was mostly bed-bound, and a home visit from the practice was requested. The scan results showed an abnormality at the base of her spine and, in light of her deterioration, the practice arranged Mrs A's hospital admission. She was told soon after that she had widespread secondary cancer to her hip and pelvic bone area. She died in October 2013.

In investigating Mrs C's complaints, I obtained independent advice from a GP adviser. She was concerned that Mrs A's pattern of contact with the practice, her symptoms and abnormal test results should have led to a referral for an assessment for a potential underlying problem. The adviser said that Mrs A's rapid weight loss should have been investigated as it was unlikely to be only caused by nausea from her medication. The Scottish Referral Guidelines for

Suspected Cancer say that unexplained or persistent weight loss of over three weeks should be referred for investigation, which did not happen. She also noted that Mrs A's haemoglobin level and liver function should have been rechecked after getting abnormal test results.

My adviser said that Mrs A's medical records showed her increased rate of contact with the practice during the two-year period before her death and, particularly, between July and September 2013. She said that the practice should have been alert to this pattern of contact. She also noted that over half of Mrs A's consultations in this period were over the telephone. She recognised the established place in patient care for telephone contact, but she felt the symptoms Mrs A described (increasing pain, reduced function and increased weight loss) meant that she needed clinical re-examination. She felt Mrs A’s symptoms were sufficient for the practice to have considered an alternative diagnosis and further investigation.

In view of the clear medical advice I received about Mrs A's pattern of contact with the practice, her symptoms and her test results, I consider more could reasonably have been done by the practice to reassess her diagnosis and investigate other possible causes of her condition. I upheld this complaint and made several recommendations.

Redress and recommendations

The Ombudsman recommends that the Practice:		*Completion date*
(i)	apologise to Mrs C for the shortcomings identified in this report;	28 October 2015
(ii)	discuss this matter as a significant event within the Practice (with particular reference to Mrs A's pattern of contacts, the number of telephone consultations and Mrs A's increasing pain and immobility prior to her hospital admission);	25 November 2015
(iii)	review and consider their use of telephone consultations to ensure they are not overly dependent on them; and	25 November 2015
(iv)	ensure they are familiar with the Scottish Referral Guidelines for Suspected Cancer and also the Scottish Intercollegiate Guidelines Network Guidance for pain management.	25 November 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, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the 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.

Introduction

1. Mrs C complained to the Ombudsman about the care and treatment her late mother-in-law (Mrs A) received from her medical practice (the Practice) in the Tayside NHS Board (the Board) area. The complaint from Mrs C I have investigated is that GPs at the Practice failed to provide Mrs A with appropriate and timely treatment for the symptoms which she presented with *(upheld).*

Investigation

2. In order to investigate Mrs C's complaint, my complaints reviewer examined all of the information provided by Mrs C and reviewed copies of Mrs A's clinical records and the Practice's complaint file. They also obtained independent advice from an experienced general practitioner adviser (the Adviser) on the clinical aspects of the complaint. In this case, we have decided to issue a public report on Mrs C's complaint because the failings I found led to a significant personal injustice to Mrs A and to ensure there is no recurrence.

3. 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.

Complaint: GPs at the Practice failed to provide Mrs A with appropriate and timely treatment for the symptoms which she presented with

Mrs C's complaint to the Practice

4. Mrs C complained about the treatment Mrs A received from the Practice over a two year period. She referred to Mrs A's consultation in November 2011 about hip pain that persisted in the coming months; an x-ray taken in the summer of 2012 pointed to possible arthritis and led to the Practice making an orthopaedic referral.

5. Mrs C explained that Mrs A's pain continued to increase and she had difficulty sleeping, a reduced appetite and was nauseated from her medication. She said the Practice attended Mrs A's home in late 2012 but they did not feel there was a serious underlying condition; when she saw an orthopaedic consultant (the Consultant) in January 2013, Mrs A was told that her pain was muscular (at the base of her spine) and not arthritis.

6. Mrs C said the physiotherapy that followed did not help Mrs A and she remained in contact with the Practice. She felt Mrs A was given increasing pain relief throughout 2013 without the Practice attempting to address the underlying

cause; Mrs A saw the Consultant again in July 2013 and he arranged a scan for 28 August 2013.

7. Mrs C explained that Mrs A deteriorated throughout August 2013 and was in regular contact with the Practice, in which time different doctors prescribed different pain relief. In terms of Mrs A's scan of 28 August 2013 (a procedure which she found extremely painful and uncomfortable), Mrs C said that Mrs A understood the Practice would give her the result. She said Mrs A's mobility decreased further in September 2013 – she lacked the energy to get dressed – and, when Mrs A contacted the Practice on 9 September 2013, Mrs C said Mrs A was told that this was not an inordinate time to wait for a test result.

8. Mrs C explained that Mrs A was largely bedbound by 11 September 2013 and the Practice arranged a home visit at Mrs C's husband's request on 12 September 2013. Mrs C said her husband was told to contact the hospital for the scan result upon asking about it and, when he did so, the hospital said that a follow up appointment had been arranged for 8 October 2013 and it would be confirmed in writing. Mrs C said the Practice acknowledged at their home visit of 12 September 2013 that they had been treating Mrs A for arthritic pain and she pointed out that the Consultant had not thought Mrs A had arthritis. By that point the Practice had reviewed the scan result which, although inconclusive, showed an abnormality at the base of Mrs A's spine. Mrs A was taken to hospital that day and, following investigations, was told soon after that she had widespread secondary cancer to her hip and pelvic bone area. Sadly, Mrs A passed away on 9 October 2013.

9. Mrs C asked why it took so long for Mrs A to see the Consultant (she felt Mrs A was simply given painkillers prior to this), why the Practice had not sought to discuss her increasing pain with the Consultant thereafter and whether they even considered cancer during her two years of increased contact. Mrs C felt the Practice sought to treat the symptom, not cause of Mrs A's illness and that they should have liaised with the Consultant about the scan result.

The Practice's response

10. The Practice offered their condolences and outlined Mrs A's contact from November 2011 onwards. They said her symptoms initially suggested hip osteoarthritis, explained the pain relief she was given in the coming months and said her x-ray from summer 2012 suggested osteoarthritis. The Practice

thought that accounted for Mrs A's pain which, as it worsened, led to their orthopaedic referral in October 2012.

11. They said they took steps to manage Mrs A's pain and that blood tests from November 2012 were normal; Mrs A's symptoms remained consistent with hip osteoarthritis at that time and so, when her weight loss was reported in January 2013 along with her lack of eating for two to three weeks due to nausea from her medication, they did not feel they were missing anything because of those normal blood test results. They said Mrs A was not clinically underweight at that time and they planned to see if her weight stabilised and pain improved.

12. The Practice explained that the Consultant, following Mrs A's appointment of January 2013, did not feel there were severe problems with her hips but that her pain stemmed from her lower back and sacroiliac joints. They said they expedited Mrs A's physiotherapy appointment and, when this did not help and her pain worsened despite strong painkillers, Mrs A was re-referred to orthopaedics. The Practice outlined the pain relief Mrs A was given in the coming months and said, following the scan arranged by the Consultant in July 2013, Mrs A had thought he would contact her within seven to ten days with the result; as this had not been forthcoming, they contacted his secretary to progress this (and again in the coming days). In light of Mrs A's deterioration by their home visit of 12 September 2013, the Practice arranged her hospital admission.

13. The Practice felt they had taken Mrs A's condition seriously and that they acted in line with guidance for management of back and hip pain. They said patients would not generally be referred to orthopaedics for osteoarthritis until they could not manage the pain or it affected sleep and that they tried to expedite Mrs A's secondary care. The Practice said her symptoms, signs and x-ray pointed to osteoarthritis and they had been upset to learn of her cancer but her symptoms would not have caused them to have considered this as the cause of her pain. They felt they did their best to liaise with secondary care and they said it would normally be for the consultant who ordered an investigation to report the result to the Practice (the Practice, when commenting on the draft copy of this report, indicated that it should have been reported to Mrs A, not the Practice). Although the scan from when Mrs A was ultimately admitted to hospital suggested that her principal tumour was likely to have been in her lung or breast, they noted that she had not complained of respiratory or breast

symptoms and, in the absence of that, they felt it unlikely that they would have identified her diagnosis sooner.

Subsequent correspondence between Mrs C and the Practice

14. Beyond the issues detailed above, Mrs C asked whether the Practice considered another option when the Consultant felt Mrs A's condition was not hip related and why they continued treating her for arthritis. She also, among other things, questioned whether they sought to expedite secondary care and pointed to the time between their orthopaedic re-referral of 8 May 2013 and Mrs A's appointment of 30 July 2013. Mrs C reiterated that Mrs A's pain continued to increase throughout August 2013 yet it did not prompt a hospital admission; she was unhappy that the Practice had not checked the Board's electronic result system for the scan result despite her family's keenness to know the result (available from 29 August 2013) and she did not accept, given Mrs A's deterioration, that they could not have interpreted and relayed it to Mrs A. Ultimately, Mrs C felt it unreasonable that the Practice had not considered cancer in light of Mrs A's symptoms in the two years prior to her death. She did not agree that Mrs A's care had been appropriate, that they had liaised with secondary care appropriately or they had attempted to identify the underlying issue.

15. The Practice said hip arthritis had been Mrs A's working diagnosis and her x-ray appeared to confirm this. They pointed to four contacts with secondary care and said their orthopaedic re-referral was received by the hospital the day after it was sent (the Practice could not practically chase up every such letter but would do so if it had evidently gone missing). They did not think there had been obvious signs of bone cancer, outlined Mrs A's medication and said there was no obvious reason for a hospital admission in August 2013 (a scan had already been scheduled). The Practice reiterated that it was normally for the doctor who requested a test – the Consultant – to pass on the result and, although it had been visible and reported on by the radiologist, it would have been inappropriate for them to have commented without the Consultant's report (hence they contacted him twice). The Practice said the scan's result was inconclusive and needed specialist review which they tried to expedite and they pointed to the relative expertise of a GP, an orthopaedic consultant and a radiologist. They said Mrs A was referred to orthopaedics twice because of her symptoms and pain.

16. Mrs C's complaint to my office outlined her dissatisfaction with the Practice's explanation and questioned why cancer was not considered as a possible underlying cause of Mrs A's pain. She explained how Mrs A had declined and the impact this had on Mrs A and her family who saw her condition deteriorate. Mrs C hoped lessons would be learned as she felt it unacceptable for someone to be treated with painkillers for an extended period without an attempt to identify the underlying issue.

Medical advice

17. My complaints reviewer asked the Adviser to comment upon the appropriateness of the Practice's actions given Mrs A's presenting symptoms. The Adviser said that their orthopaedic and physiotherapy referrals were appropriate, reasonable and not unduly delayed. She also noted that they had acted to speed up Mrs A's physiotherapy appointment and had requested an earlier orthopaedic review in May 2013.

18. The Adviser was, however, concerned that Mrs A's pattern of contacts, symptoms and abnormal results - viewed as a collective clinical picture - should have led to a referral to assess for a potential underling malignancy (although she explained that the Practice would not refer a patient directly to oncology as it is tertiary care). The Adviser specifically pointed to:

- the weight loss reported in a telephone consultation of 9 January 2013 (Mrs A lost 10 kilograms over two to three weeks). The Adviser said that level of weight loss in that time would be very concerning regardless of whether it meant someone was clinically underweight. She said a serious underlying pathology should have been ruled out; at the very least, an examination, a review and planned reassessment of Mrs A's weight should have been recorded. The Adviser said the Scottish Referral Guidelines for Suspected Cancer1 say unexplained or persistent weight loss of over three weeks should be referred for an urgent chest x-ray, which did not happen. While Mrs A's weight loss was for a period of two to three weeks, the Adviser said such weight loss in that short time should have prompted further investigations as it was unlikely to be caused by nausea due to tablets alone;
- Mrs A's haemoglobin level fell from November 2012 to May 2013. The Adviser said this should have been investigated but was not – initially by

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[1] Scottish Referral Guidelines for Suspected Cancer at page 12 (available online at: http://www.sehd.scot.nhs.uk/mels/HDL2007_09.pdf).

rechecking her level at a later date to see if it had persisted, improved or fallen further – and, depending on the results, Mrs A may have needed a referral for investigation;

- the Adviser said Mrs A's liver function test was normal in November 2012 but was raised in May 2013. She saw nothing to show this was rechecked or noted to have been concerning and she said these tests should have been rechecked and further investigation arranged if the abnormal result persisted or deteriorated;
- Mrs A had gone from being independent in her daily activities to bed bound and distressed, despite increasing pain relief; and
- the Adviser pointed to the record indicating that Mrs A was suffering from hair loss in May 2013. She said that could suggest general debility but appeared not to have been investigated nor considered a concerning sign and she also pointed to Mrs A's general sense of being unwell noted at that time.

19. The Adviser said the records showed that Mrs A contacted the Practice regularly in the two years prior to her death about her worsening condition (over 30 times, which was much more frequently than she had contacted them historically). She also pointed to Mrs A's significantly increased rate of contact within that two year period between 4 July 2013 and 12 September 2013 and said the Practice should have been alert to this pattern of contact. The Adviser felt the records pointed to Mrs A's increasing frailty and pain – not controlled by the combinations of medications prescribed – and, although she noted telephone contact's established place in patient care, she felt the symptoms discussed (increasing pain, reduced function and increased weight loss) meant Mrs A needed clinical re-examination. She noted that over half of Mrs A's consultations in that two year period were over the telephone.

20. The Adviser acknowledged that Mrs A had not displayed either breast or chest symptoms but felt the symptoms detailed above were sufficient for the Practice to have considered an alternative diagnosis. She did not, however, feel Mrs A had fallen between the cracks of primary and secondary care and she confirmed that it was for the Consultant to have followed up on the scan.

Decision

21. The medical advice I received was clear that the Practice's orthopaedic referrals were appropriate and that they had sought to speed up Mrs A's physiotherapy appointment. Although I have taken account of Mrs C's concerns

in this area – her complaint made it clear that Mrs A was a much loved family member - I am satisfied that the evidence indicates the Practice acted reasonably in this regard.

22. I am, however, concerned by the advice I received about Mrs A's subsequent pattern of contact with the Practice and that her symptoms and test results, viewed as a whole, did not prompt reassessment of her condition. Although both the Practice and the Adviser noted that Mrs A did not display breast or chest symptoms, the Adviser was clear that Mrs A's collective symptoms should have led to consideration of an alternative diagnosis and further steps to investigate any possible underlying condition. The Adviser also explained that, in light of the Scottish Cancer Referral Guidelines, it was not reasonable to have attributed Mrs A's weight loss to nausea from tablets without further investigations. In light of this clear advice, I consider more could reasonably have been done by the Practice to have investigated other possible causes of Mrs A's condition. I uphold this complaint.

Recommendations

23.	I recommend that the Practice:	*Completion date*
(i)	apologise to Mrs C for the shortcomings identified in this report;	28 October 2015
(ii)	discuss this matter as a significant event within the Practice (with particular reference to Mrs A's pattern of contacts, the number of telephone consultations and Mrs A's increasing pain and immobility prior to her hospital admission);	25 November 2015
(iii)	review and consider their use of telephone consultations to ensure they are not overly dependent on them; and	25 November 2015
(iv)	ensure they are familiar with the Scottish Referral Guidelines for Suspected Cancer and also the Scottish Intercollegiate Guidelines Network Guidance for pain management.[2]	25 November 2015

24. The Practice have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations and the Practice are

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[2] SIGN 136, Management of Chronic Pain (available online at: http://www.ckp.scot.nhs.uk/Published/PathwayViewer.aspx?id=609)

asked to inform us of the steps taken to implement them by the dates 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

Mrs C	the complainant
Mrs A	Mrs C's late mother-in-law
the Practice	a medical practice in the Tayside NHS Board area
the Board	Tayside NHS Board
the Adviser	a general practitioner adviser
the Consultant	an orthopaedic consultant in the Tayside NHS Board area

Annex 2

Glossary of terms

arthritis / osteoarthritis	a condition of pain, stiffness and sometimes swelling in the joints
orthopaedic	conditions involving the musculoskeletal system
physiotherapy	treatment to help restore movement and injury following injury, illness or disability
radiologist	a specialist in the analysis of images of the body
sacroiliac joints	the connection between the lower bones of the back and the pelvic bone