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: Mid Scotland and Fife

Case ref: 201800708, A Medical Practice in the Fife NHS Board area
Sector: Health
Subject: GP & GP Practices / Clinical treatment / diagnosis

Summary
Ms C complained about the care and treatment provided to her late partner (Mr A) by their GP practice (the Practice) prior to his diagnosis of non-small-cell lung cancer stage 3 (advanced cancer).

Mr A had attended the Practice on a number of occasions during a five month period with symptoms of unresolving shoulder pain. Ms C said Mr A had seen a number of GPs during the period and that a request for a CT scan was refused initially. She also said that the GPs repeatedly prescribed painkillers which were ineffective. When Mr A was finally referred for a CT scan the diagnosis of cancer was made. Ms C felt that the failure of the GPs to refer Mr A for a CT scan had led to a delay in the diagnosis of cancer.

We took independent advice from a general practitioner, which we accepted.
We found that four of the six GPs involved in Mr A's care and treatment had failed to take appropriate action in an effort to determine the cause of Mr A's shoulder pain. Mr A's symptoms had not improved with different types of painkilling medication and after being referred for physiotherapy. A chest X-ray had been taken which was reported as normal. We found that the GPs had failed to consider the complete picture in that Mr A had attended the Practice on numerous occasions within a short timeframe and they dealt with the symptoms reported at the time of the consultations. They had not fully considered the previous consultations which would have allowed them to be better informed of the situation.

We also found that one of the GPs involved had incorrectly advised Mr A that he absolutely did not have cancer, which was an inaccurate statement to have made as at that stage a specialist opinion had not been obtained. This would have given Mr A false reassurance.

We also found that two of the GPs involved in Mr A's care took appropriate action when considering Mr A's reported symptoms and proposed reasonable investigations in an effort to reach a diagnosis.

We upheld Ms C's complaint.

Redress and Recommendations

What we are asking the Practice to do for Ms C:

What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
There was an unreasonable delay in referring Mr A for a specialist opinion in view of his presenting symptoms	Apologise to Ms C for the failure to refer Mr A for a specialist opinion at an earlier stage	A copy or record of the apology. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance By: 21 November 2018

We are asking The Practice to improve the way they do things:

What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
There was an unreasonable delay in referring Mr A for a specialist opinion in view of his presenting symptoms	All doctors at the Practice should be aware of the Scottish Cancer Referral Guidelines. Any doctors who were involved in the complaint and are no longer at the Practice should be made aware of and sent a copy of this report	Evidence that the findings of this case have been used as a training tool for staff and that this decision has been shared and discussed with the relevant staff in a supportive manner. This could include minutes of discussions at a staff meeting or copies of internal memos/emails By: 21 November 2018
Doctor 4 unreasonably gave Mr A an assurance that he definitely did not have lung cancer	Doctor 4 should be aware of the importance of accurate communication with patients in accordance with General Medical Council Good Medical Practice guidelines	Evidence that doctor 4 has reflected on their actions and that the matter has been shared and discussed with them in a supportive manner. This could include minutes of discussions at a meeting or copies of internal memos/emails By: 21 November 2018

Feedback

Points to note

As highlighted by the Adviser, the SPSO investigation notes there is evidence of good medical practice by Doctors 1 and 6 in that they took appropriate action when considering Mr A's reported symptoms and proposed reasonable investigations in an effort to reach a diagnosis. In reflecting on this complaint, we strongly urge the Practice to share and learn from the positive aspects of the treatment.

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 Ms C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Ms C complained to me about the care and treatment provided to her late partner (Mr A) by their GP practice (the Practice) prior to his diagnosis of non-small-cell lung cancer stage 3. Mr A had attended the Practice on a number occasions between March and August 2015 complaining of unresolving shoulder pain. He had seen multiple GPs during that period and, when a referral was made for a specialist opinion, it was then that an accurate diagnosis was made.

2. The complaint from Ms C which I have investigated is that there was an unreasonable delay in referring Mr A for a specialist opinion in view of his presenting symptoms (*upheld).*

Investigation

3. I and my complaints reviewer considered the information provided by Ms C and the Practice. This included Mr A's relevant medical records and the Practice's complaints file. I also obtained independent advice from a medical adviser specialising in general practice (the Adviser).

4. In this case, I have decided to issue a public report on Ms C's complaint due to the serious failings identified and the significant personal injustice suffered by Mr A and his family by the delayed diagnosis.

5. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered but I can confirm that all of the information provided during the course of the investigation was reviewed. Ms C and the Practice were given an opportunity to comment on a draft of this report.

Background

6. Ms C said Mr A had reported as having severe shoulder pain to a number of GPs from the Practice from March 2015 and he was told it was muscular and given cocodamol. The symptoms persisted and at another appointment Mr A was prescribed cream to rub on his shoulder. The cream did not help and Mr A was not sleeping because of the pain. At an appointment with a GP Ms C requested a CT scan but this was refused by the GP and a referral was made for an X-ray. The X-ray was reported as being clear and Mr A was referred to Physiotherapy. In between GP appointments, Mr A attended Accident and Emergency and was again told the problem was muscular and that there was no need for a CT scan. Mr A attended the Practice again. He saw a different GP

who agreed that the pain had gone on long enough and changed his medication and made a referral for a CT scan. The results of the scan in October 2015 showed Mr A had non-small-cell lung cancer stage 3.

Key concerns

7. Ms C complained that the Practice did not treat Mr A's symptoms seriously enough. She said that Mr A had attended a number of GP appointments over a six month period. The GPs involved had prescribed painkilling medication and made a referral for physiotherapy but Mr A's shoulder pain was not resolving. Ms C felt that Mr A should have been referred for a CT scan at an earlier stage and that this would have led to an earlier diagnosis of his lung cancer.

The Practice's response

8. The Practice said that Mr A had first contacted the Practice on 5 March 2015 with left sided upper back and shoulder pain. Doctor 1 arranged a chest x-ray which was reported as normal and also wrote to Cardiology for an update as there had been no follow-up since Mr A suffered a myocardial infarction (MI - heart attack) in 2014. Mr A was taking cocodamol at the time.

9. The Practice explained that Mr A:

- had a routine cardiovascular check on 12 March 2015 where the results were essentially within normal limits;
- saw Doctor 2 on 2 April 2015 and was advised to continue with cocodamol as it was helping with the pain. Doctor 2 thought the pain was musculoskeletal in view of the negative test findings and because Mr A's occupation involved heavy lifting;
- saw Doctor 3 on 20 May 2015 who changed the medication to tramadol and paracetamol and made a referral to Physiotherapy;
- attended Accident and Emergency on 14 June 2015 with intermittent pain and again this was diagnosed as being musculoskeletal;
- reported some side effects on 19 June 2015 and his medication was changed back to cocodamol;
- had his first physiotherapy appointment on 9 July 2015. The physiotherapist felt the pain could be coming from Mr A's neck;
- saw Doctor 4 at the Practice on 27 July 2015 who said that they did not think the symptoms were related to lung cancer. Doctor 4 prescribed amitriptyline which is often used for neuropathic pain; and

- saw Doctor 5 on 31 August 2015 who felt that further investigations were required and this led to the diagnosis of lung cancer.

10. The Practice said there seemed to be a delay in onward referral for further investigation but it was assumed this was because Mr A was otherwise well and his pain initially was helped with analgesia. There was also a lack of signs of serious disease on examination or as a result of investigations carried out by the Practice.

Relevant guidance

11. Healthcare Improvement Scotland's *Scottish referral guidelines for suspected cancer* provide guidance to doctors on cancer referrals. Of relevance in this is the Urgent suspicion of cancer referral which sets out that

> "any symptoms or signs detailed above [chest/shoulder pain] persisting for longer than 6 weeks despite a normal chest x-ray"

should be referred urgently to a respiratory clinician.

12. General Medical Council Good Medical Practice guidance to doctors on communication states at 31 that

> "You must listen to patients, take account of their views, and respond honestly to their questions."

Medical advice

13. The Adviser said that during the period March to September 2015 Mr A had ten consultations either at the Practice or by telephone which involved a number of different GPs. On 5 March 2015 Mr A presented to Doctor 1 with an eight week history of chest and shoulder pain which failed to resolve with strong analgesia. Doctor 1 had appropriately arranged a chest X-ray which would be in line with the Scottish Cancer referral guidelines (as the patient was presenting with unexplained/ persistent symptoms of chest/shoulder pain for more than three weeks). The assessment and referral was appropriate and evidence of reasonable care. The Adviser had no concerns about Doctor 1's actions.

14. The Adviser continued that Mr A was then seen by Doctor 2 on 2 April 2015; Doctor 3 on 20 May 2015; and by Doctor 4 on 27 July 2015. The Adviser noted that all of these clinicians advised Mr A to continue with the analgesia without

documenting a clear differential diagnosis or suspected reason for the pain. In the Adviser's opinion, this was unreasonable practice. The Adviser explained that a GP has to have a working differential diagnosis and even though Mr A had an eight week history of irretractable pain with a normal chest X-ray there seemed to be no working diagnosis as to further investigate the situation. There was also no acknowledgement that this presentation would fulfil criteria for urgent referral as per Scottish Cancer Referral guidelines.

15. The GPs seemed to be advising that it was musculoskeletal pain and Doctor 3 had referred Mr A to Physiotherapy despite the pain not being aggravated by exercise or activity and despite Mr A having a good range of movement in his shoulder. As stated in the Scottish Cancer Referral guidelines, Mr A should have been referred urgently to a respiratory clinician for investigation as he had chest/shoulder pain persisting for longer than six weeks despite a normal chest X-ray. This referral did not occur and the Adviser felt these consultations were unreasonable in terms of the care provided to the patient.

16. In regards to communication, the Adviser noted that on 27 July 2015 Doctor 4 had documented that he informed Mr A:

> "Told absolutely that it is not lung cancer because if it was, after 6 months., he'd be moribund. Seemed to get a degree of reassurance from this."

17. The Adviser commented that this was both inaccurate advice and poor communication. Doctor 4 had no way of confirming that there was '*absolutely*' no chance of Mr A having lung cancer and had given false reassurances without ensuring Mr A had seen a specialist. A diagnosis of lung cancer is made by specialist and not a GP. Doctor 4's communication in this regard was poor and not in line with General Medical Council Good Medical Practice.

18. The Adviser saw that on 30 July 2015, during a telephone conversation with Doctor 6 they had noted Mr A's history and the ongoing symptoms. Doctor 6 also reviewed the previous records to clarify that not all possible tests had been carried out and that the Practice should be considering further investigations for the pain.

19. Doctor 6 then made an appointment for Mr A and had documented that in their opinion further investigations and referrals were necessary. The Adviser deemed the assessment by Doctor 6 was appropriate and was evidence of

reasonable care. However, Mr A saw Doctor 3 later that day and they failed to arrange any further referral or investigation despite the symptoms described, despite the clinical entry from Doctor 6. In the Adviser's opinion, this was unreasonable as a reasonable GP would have recognised the significance of these symptoms rather than restarting prior analgesia which had not previously resolved the pain and arranging a review in three to four weeks.

20. The Adviser continued that on 31 August 2015 Doctor 5 had noted Mr A's seven month history of left shoulder pain and had arranged to repeat the chest X-ray and also to arrange a shoulder X-ray. In addition, they had requested tests to investigate for Myeloma. (Myeloma is a type of cancer that can lead to chronic back pain (usually lower back pain). On 11 September 2015 Doctor 5 had noted no change in Mr A's symptoms but there was a new symptom of unexplained weight loss. Despite this they increased his painkillers, repeated a blood test and again arranged a further review appointment in a week. The Adviser felt this was unreasonable as Doctor 5 should have arranged an urgent referral when they saw Mr A on 31 August 2015. The Adviser said a reasonable GP would have recognised the significance of these symptoms rather than increasing / changing analgesia and arranging repeated reviews.

21. Mr A needed specialist assessment and investigation and it was unreasonable that Doctor 5 did not arrange this until 18 September 2015.

22. The Adviser said they had no concerns about the care provided by Doctor 1 or Doctor 6.

23. However they considered the care provided by Doctor 2, Doctor 3, Doctor 4 and Doctor 5 to be below a reasonable standard. The Adviser noted that while the history and examination taken from Mr A was both appropriate and reasonable, their concern related to their clinical decision-making and lack of recognition of the signs that could be consistent with lung cancer necessitating specialist referral.

24. The Adviser concluded that a review of the records had identified that there was a lack of continuity of care in that each GP appeared to be treating the symptoms described during the consultation rather than looking at and treating the symptoms within the whole patient journey. There was also a lack of:

- knowledge/familiarity with Scottish Cancer referral guidelines and about the typical presentation of Pancoast tumour (non-small-cell lung cancer) ; and
- a working diagnosis to steer their ongoing management and care.

25. The Adviser's view was there was a delayed referral to a specialist which delayed ongoing management. The Adviser was also concerned about the poor communication from Doctor 4 in telling Mr A that it *'absolutely'* was not cancer and lack of acknowledgement or action by Doctor 3 regarding the clinical entry made by their colleague which had raised significant concerns about a possible underlying cancer.

Decision

26. The basis on which I reach decisions on is reasonableness. My investigations consider whether the actions taken, or not taken, were reasonable in view of the information available to those involved at the time in question. I do not apply hindsight when determining a complaint.

27. Although my investigation has identified a number of failings within the Practice it is encouraging to note that it also identified examples of good medical practice provided by Doctor 1 and Doctor 6. They took reasonable action when assessing Mr A's condition and took appropriate action in an effort to reach a definite diagnosis.

28. The underlying concern I have, is in relation to the continuity of care by the Practice. I am aware that patients prefer to see the same GP when attending their medical practice to report their continuing symptoms as this gives them the reassurance of continuing care without having to repeat the same information again and again. It also allows the GP to familiarise themselves with the whole situation so that they can offer alternative treatments in an effort to resolve the problem.

29. I am also aware that, due to the pressures on the NHS, it is often the case that a patient will *not* see the same GP for a continuing medical problem. This can be frustrating as it means they will have to repeat their medical history on a number of occasions. Therefore, it is critically important in such situations that the GPs involved are familiar with patients' records and medical notes, and listen to them. This is in order to gain a better understanding of what treatments or investigations have been attempted before so that treatment is not given in isolation, in each consultation.

30. The advice I have received and I accept from the Adviser is that overall there was a failure by the Practice to take appropriate action in an effort to determine the cause of Mr A's shoulder pain. Mr A's symptoms did not improve despite being him being prescribed different types of painkilling medication, being referred for physiotherapy and having a chest X-ray reported as being normal. The guidance is clear that in Mr A's circumstances it would have been appropriate for the Practice to have referred him for a specialist opinion at a far earlier stage than he was. This would have led to an earlier diagnosis.

31. I am concerned that a number of GPs who were involved in Mr A's care failed to consider the complete picture in that Mr A had attended the Practice on numerous occasions within a short timeframe and his condition had not resolved. The GPs appeared to deal with the symptoms reported at the time and not considered the previous consultations which would have enabled them to be better informed.

32. I am also concerned that Doctor 3 failed to take appropriate action when Doctor 6 clearly stated in Mr A's records earlier that day that they felt further investigations and referrals were required. Doctor 3 did not arrange the further investigations or referrals but rather reinstated medication which had previously not been successful and arranging a further review in three to four weeks.

33. A further matter of concern to me was that Doctor 4 had told Mr A that he absolutely did not have cancer when he had not received a specialist opinion by that time. It would be for the specialist to make a diagnosis and unfortunately a diagnosis of lung cancer was in fact made. While Doctor 4 may have been under the impression that lung cancer was unlikely and was trying to provide him with comfort and reassurance, unfortunately the manner in which this was expressed to Mr A was inappropriate and would have given Mr A false reassurance.

34. In the circumstances I have decided that there was evidence that Mr A's continuing shoulder problems were not resolving with the input of a number of GPs at the Practice and that in line with the national guidance he should have been referred to a specialist at a far earlier stage. I uphold the complaint.

35. We made a number of recommendations to address the issues identified. 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.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Practice to do for Ms C:

What we found	What the organisation should do	What we need to see
There was an unreasonable delay in referring Mr A for a specialist opinion in view of his presenting symptoms	Apologise to Ms C for the failure to refer Mr A for a specialist opinion at an earlier stage	A copy or record of the apology. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance By: 21 November 2018

We are asking the Practice to improve the way they do things:

What we found	Outcome needed	What we need to see
There was an unreasonable delay in referring Mr A for a specialist opinion in view of his presenting symptoms	All doctors at the Practice should be aware of the Scottish Cancer Referral Guidelines. Any doctors who were involved in the complaint and are no longer at the Practice should be made aware of and sent a copy of this report	Evidence that the findings of this case have been used as a training tool for staff and that this decision has been shared and discussed with the relevant staff in a supportive manner. This could include minutes of discussions at a staff meeting or copies of internal memos/emails By: 21 November 2018
Doctor 4 unreasonably gave Mr A an assurance that he definitely did not have lung cancer	Doctor 4 should be aware of the importance of accurate communication with patients in accordance with General Medical Council Good Medical Practice guidelines	Evidence that doctor 4 has reflected on his actions and that the matter has been shared and discussed with him in a supportive manner. This could include minutes of discussions at a meeting or copies of internal memos/emails By; 21 November 2018

Feedback

Points to note

As highlighted by the Adviser, the SPSO investigation notes there is evidence of good medical practice by Doctors 1 and 6 in that they took appropriate action when considering Mr A's reported symptoms and proposed reasonable investigations in an effort to reach a diagnosis. In reflecting on this complaint, I strongly urge the Practice to share and learn from the positive aspects of the treatment.

Terms used in the report **Annex 1**

Amitriptyline	antidepressant medication
analgesia	medication that acts to relieve pain
cardiology	medical specialty dealing with disorders of the heart
cardiovascular	relating to the heart and blood vessels
cocodamol	painkilling medication consisting of paracetamol and codeine
CT scan	(computerised tomography) scan uses x-rays and a computer to create detailed images of the inside of the body
Differential diagnosis	The process of differentiating between two or more conditions which share similar signs or symptoms
Doctor 1	a GP at the Practice
Doctor 2	a GP at the Practice
Doctor 3	a GP at the Practice
Doctor 4	a GP at the Practice
Doctor 5	a GP at the Practice
Doctor 6	a GP at the Practice
myocardial infarction	MI - heart attack
Mr A	the aggrieved

Ms C	the complainant
musculoskeletal	relating to the muscle and skeleton together
neuropathic pain	nerve pain
non-small-cell lung cancer	types of lung cancer
pancoast tumour	non-small-cell lung cancer
paracetamol	painkilling medication
physiotherapy	treatment for injury without drugs or surgery
the Adviser	a general practitioner
the Practice	a medical practice in the NHS Fife area
tramadol	pain killing medication

List of legislation and policies considered **Annex 2**

Healthcare Improvement Scotland: Scottish referral guidelines for suspected cancer

General Medical Council Good Medical Practice