S.47/01-02

Scottish Public Services Ombudsman Act 2002

Report by the Scottish Public Services Ombudsman
of an investigation into a complaint against
Tayside University Hospitals NHS Trust (the Trust)

Complaint as put to the Ombudsman

1. The account of the complaint provided by Mr H was that on 16 August 1998 his wife, Mrs H, was admitted to Ninewells Hospital, Dundee (the hospital) suffering from extreme abdominal pain. On 18 August she was discharged without diagnosis. On 27 August Mrs H was readmitted to the hospital with the same problem and was found to be suffering from total intestinal blockage. She was discharged on 9 September by which time she had lost three stone and had a chest infection. On 23 October Mrs H was admitted to King's Cross Hospital, Dundee where she was diagnosed with pneumonia, asthma and a chest infection. A chest x-ray showed a shadow on the left side of her chest. A bronchoscopy led to the discovery of a large malignant tumour. Mrs H received a course of radiotherapy treatment at Ninewells Hospital which finished on 25 November. On 31 December a Consultant Radiotherapist and Oncologist (the Clinical Oncologist) referred Mrs H to a Consultant Medical Oncologist (the Medical Oncologist) to arrange chemotherapy. After hearing nothing for six weeks Mr H tried to contact the Medical Oncologist. Her secretary told him that the Medical Oncologist would telephone him. Another week went by and Mrs H became increasingly unwell. Her GP contacted the Medical Oncologist and an outpatient appointment was arranged. At the appointment the Medical Oncologist told them that she had received the referral letter from the Clinical Oncologist and that Mrs H must have 'slipped through the net'. She arranged further x-rays to take place that day and suggested Mr H telephone her the following day. The x-rays went missing and had to be taken again. On 20 February 1999 Mrs H was readmitted to Ninewells Hospital by which time her condition had deteriorated greatly. She underwent further radiotherapy treatment and was discharged on 2 March

with an outpatient appointment for 18 March with a view to seeing whether she could have chemotherapy. Mrs H died at home on 9 March.

2. The matters investigated were that:

(a) the medical assessment, investigation and management of Mrs H's care during her admission to the hospital on 16 August were inadequate;

(b) the loss of the referral letter and x-rays further delayed Mrs H from being considered for chemotherapy; and

(c) there was a failure to address the issue of resuscitation at an appropriate time during Mrs H's last admission to hospital.

Investigation

3. The statement of complaint for the investigation was issued on 7 September 2001. The Trust's comments were obtained and relevant documents including Mrs H's clinical records were examined. The Ombudsman's investigating officer took evidence from Mr H and the Medical Oncologist. Two professional assessors were appointed to advise on the clinical issues in this case and their report is attached as appendix A. A glossary of the medical terms used is attached at appendix B. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

Complaint (a) Adequacy of the assessment, investigation and management of Mrs H's care during her admission on 16 August

4. In correspondence with the Trust concerning his complaint and at interview **Mr H** said that his wife was ill for about five days before her GP arranged her admission to the hospital. She was in discomfort, bent forward and rocking backwards and forwards. On 18 August she was discharged with a diagnosis of a urinary infection. Mr H said that an x-ray report showed that she was suffering from constipation but the Consultant did not even bother to tell the GP that in the discharge letter. Later at a meeting the Consultant said that he had not mentioned it to the GP because constipation usually clears itself.

5. Mr H said that as a consequence of his wife not receiving any treatment for constipation, she was not able to go to the toilet between the time of her discharge from hospital and her readmission on 27 August. She was in distress and she could not sleep and eventually began vomiting. The GP gave her injections of morphine now and then which helped for a while but did not last long. After readmission she endured a further week and a half of treatment to relieve the symptoms. It was then decided to take her to theatre to remove the blockage but her bowels opened ten minutes before she was due to be taken to theatre. She was discharged home on 8 September having lost three stone and she was suffering from a chest infection.

6. Mr H said that his wife was admitted to Kings Cross Hospital on 23 October when she was diagnosed with pneumonia, asthma and a chest infection. A chest x-ray showed a shadow on the right side of the chest. Three weeks later a further chest x-ray showed a shadow on the left side of the chest. A bronchoscopy the following week revealed a large well-established tumour which was constricting her windpipe. She underwent radiotherapy which finished on 25 November.

7. Mr H said that the reports of x-rays taken on 27 August and 3 September were not done until 14 September – six days after Mrs H was discharged from hospital. One of the x-ray reports (relating to the x-ray taken on 3 September) suggested 'an infection or a more sinister possibility'. The Consultant responsible for Mrs H's care during that admission told Mr H at a meeting that he had not seen this x-ray report. Mr H thought that during the admission on 27 August, although the symptoms and x-rays taken at that time did not necessarily indicate that his wife had a tumour, the doctors should have recognised that she was ill and investigated her condition further particularly in view of the fact that she had a history of TB and chest problems and also because the radiologist apparently saw something on one of the x-rays.

<u>Extracts from Mrs H's hospital medical records</u>

8. The x-ray taken on 16 August was reported on 18 August. **The x-ray report** includes:

'Abdomen: There is considerable faecal loading throughout the length of the colon around to the rectum …'.

The **discharge letter**, dated 27 August, sent from Ninewells Hospital to Mrs H's GP includes:

'… Urinalysis had shown some evidence of urinary tract infection. The patient was treated with analgesics and [trimethoprim] and the pain subsided. We were due to arrange for a blood test for parathyroid hormone to check on whether she had hyp[er]-parathyroidism but unfortunately she left the ward before any of this could be done.

'… No follow up arrangements have been made by us but I will copy this letter to the Urologist and ask him to see her in the outpatient clinic'.

The Trust's official response

9. In his official response to the Ombudsman's statement of complaint the Trust's **Chief Executive** included:

'[Mrs H] was admitted to ward 15 … on 16 August 1998 at the General Practitioner's request. [Mrs H] had had a 48 hour history of increasing nausea and epigastric pain. She had already been seen twice by her General Practitioner over that weekend and had been given intravenous analgesia and antibiotics.

'On admission, [Mrs H] was examined by … [a] Senior House Officer, who recorded the gradual onset over 2 days of colicky epigastric pain which was not relieved by anything. It is recorded that [Mrs H] had not had any previous similar episodes, that she had no urinary symptoms but that she was constipated. Chest and abdominal x-rays were requested and [Mrs H] was given morphine which appeared to relieve her pain. The initial diagnosis was of gallstones or gastritis.

'[Mrs H] was seen by … [the Consultant] on 16 August 1998 who suggested that [Mrs H] should be given nil by mouth and that an abdominal ultrasound should be carried out. Later that day [Mrs H] was transferred to Ward 6 … On transfer, it is recorded in the nursing

records that [Mrs H] had a regular bowel pattern and micturition although prone to constipation.

'The chest and abdominal x-rays and ultrasound scan were reported on 18 August 1998. The chest x-ray report stated "no focal active lung lesion seen" and that there had been no change since the previous examination in May 1996. The abdominal x-ray was noted as reporting considerable faecal loading throughout the length of the colon. The abdominal ultrasound scan was normal except for a slightly tender area in the region of the right kidney.

'[Mrs H's] urine samples showed signs of protein and blood which suggested a urinary tract infection. Analgesia and antibiotics were prescribed. Of the blood samples taken … only a moderately raised serum calcium level was of note. A gastroscopy was undertaken on 17 August 1998 and no abnormalities were seen.

'On 18 August 1998 [the Consultant] saw [Mrs H] during his ward round when the urine results and the raised [serum] calcium level was noted. Therefore, a possible diagnosis of urinary tract infection, with a possible kidney stone, was documented at that time. It was decided that [Mrs H] could be discharged with an outpatient referral to Urology. However, it was also noted that [Mrs H] had gone home before blood could be taken to check for parathyroid hormone [the implication was that her calcium was increased because of an over-activity of the parathyroid gland, in producing parathyroid hormone].

'Later that day [the Consultant] has recorded that [Mrs H] had been reviewed on the ward round and that her pain had resolved. Also, the fact that [Mrs H] had no pain overnight is recorded in the nursing records. However, [the Consultant] noted that there was "a new history" since admission of right loin and suprapubic pain and that the urinalysis showed blood and protein ... Although [the Consultant] noted that the abdominal x-ray required to be reviewed there is nothing to indicate that he did so nor is there any mention of this in the discharge letter dated 27 August to the General Practitioner.

'… [the] investigations revealed little apart from the fact that [Mrs H] was constipated; she had blood and protein in her urine; she had tenderness over the area of her right kidney; and her serum calcium was raised. A provisional diagnosis was of urinary tract infection or renal colic for which she was given antibiotics and analgesia. On discharge, [Mrs H's] pain was documented as being resolved and she was referred to the Urologists for an opinion relating to the possibility of the presence of renal stones.

'Although [Mrs H] left without having the blood tests for parathyroid hormone or [the Consultant] apparently reviewing the abdominal x-ray, the Trust considers that her assessment, investigations and management were appropriate during this admission.

'[Mrs H] was readmitted on 27 August 1998 with a 48 hour history of colicky lower abdominal pain with vomiting and [a] diagnosis of constipation was made. This apparently responded to laxatives and enemas and [Mrs H] was discharged on 9 September 1998'.

Evidence of the Trust Staff

10. The **Consultant** said that the initial diagnosis made on Mrs H's admission was constipation. Further investigation was made because Mr H was unhappy with the diagnosis. A laxative was considered on the day of Mrs H's discharge from hospital. However, as the pain for which she had been admitted had resolved, along with the fact that she was being put on an antibiotic for a possible urinary tract infection, it was thought that the combination of a laxative and an antibiotic which may have produced diarrhoea was not appropriate.

Findings (a)

11. In reaching my findings I have been guided by the advice provided by the Ombudsman's professional assessors. Mr H complained that despite the x-ray showing clearly that Mrs H was constipated she was discharged from hospital on 18 August without appropriate treatment. The result was that she suffered from severe constipation until 7 September which caused her pain and distress. Mr H was also concerned at what he regarded as the lack of treatment and action taken between 27 August and 8 September given the result of the chest x-ray taken on 3 September. The Trust

consider that the assessment, investigations and management of Mrs H was appropriate and say that the investigations carried out during the admission on 16 August revealed only that Mrs H was constipated and point out that by the time of her discharge her pain had resolved. The assessors consider that there was a failure to diagnose constipation as a cause of Mrs H's pain and consequently failure to prescribe appropriate treatment. They are clear in their opinion that there was nothing at this time to suggest a diagnosis of cancer.

12. Although the care provided during the admission on 27 August is not the subject of the investigation I draw the Trust's attention to the assessors comments (paragraphs viii and ix of their report) that there was a delay in reporting the x-ray taken during that admission and the results were not conveyed to the GP who should have been told that Mrs H should receive antibiotics for a chest infection (although the GP had already commenced appropriate treatment). I **recommend** that the Trust consider the assessors suggestion that the process for returning x-ray reports should be reviewed and x-ray reports should be signed and dated to indicate their receipt before they are filed. The assessors do not believe that the failure to treat constipation and failure to communicate the results of the chest x-ray to the GP on the second admission had any material effect on the course of Mrs H's illness. However, the failure to give a laxative did lead to further days of constipation and pain which could have been relieved. The assessors confirm that the right-sided pneumonia was on the opposite side to Mrs H's lung cancer and not related to the lung cancer. This therefore would not have led to an earlier diagnosis of her lung cancer. I hope that Mr H will take comfort from the assessors' expressed opinion that the diagnosis and treatment of Mrs H's cancer was appropriate and timely. I uphold the complaint to the extent that during the admission on 16 August there was a failure to treat constipation.

<u>Complaint (b) Loss of the referral letter and x-rays</u>

13. **Mr H** said that his wife was last seen by the Clinical Oncologist on 30 December when he told them that he would write to the Medical Oncologist with a view to Mrs H receiving chemotherapy. The Clinical Oncologist explained that the radiotherapy would continue to work for about 20 days and he seemed quite happy with Mrs H's progress at that stage. Mr H expected his wife to be seen within the 20 day period so that

her suitability for chemotherapy could be assessed. During that period she appeared quite well and was able to go out shopping. Having heard nothing by the second week in February Mr H tried to contact the Medical Oncologist on 9 February and spoke to her secretary. The secretary advised him that the Medical Oncologist would contact him on Monday or Tuesday (9 or 10 February) but by Friday (13 February) he had still heard nothing. Over the weekend Mrs H became increasingly unwell and on Tuesday (17 February) her GP contacted the Medical Oncologist. The Medical Oncologist had no knowledge of Mrs H's case but arranged an appointment for 18 February. On 18 February the Medical Oncologist said by then she had received the Clinical Oncologist's referral letter and showed it to Mr and Mrs H. She said there had been either a secretarial or clerical problem to account for the delay in receiving the letter but did not explain further. She sent Mrs H to have chest x-rays taken. The Medical Oncologist told them she would take the x-rays to Kings Cross Hospital later that day to discuss at a meeting. She asked Mr H to telephone her the following morning. The next morning she told him that she arrived late for the meeting and missed it. She said that she would meet with the other doctors that morning to discuss the x-rays. Later that day Mr H telephoned the Medical Oncologist and then she told him that she had been unable to find the x-rays and that they might have been sent to Mrs H's GP. Mr H felt that the Medical Oncologist lied to him by saying she had missed the meeting when in fact the x-rays had gone missing and also that the x-rays might have been sent to Mrs H's GP when GPs only received x-ray reports - not x-rays. On the afternoon of 19 February Mrs H had to go back to Ninewells Hospital for repeat x-rays. She then saw the Medical Oncologist who kept her in hospital.

14. Mr H felt that the Clinical Oncologist would not have referred Mrs H for chemotherapy if he did not think it would have given her an extended life. However, by the time they saw the Medical Oncologist she said that the tumour had started to grow again. Mr H had not expected chemotherapy to cure his wife but he felt that it could have extended and improved the quality of her life but that was denied her because of the delay in her being seen by the Medical Oncologist.

<u>Trust's official response</u>

15. In the Trust's official response to the Ombudsman's statement of complaint the **Chief Executive** included:

> '[Mrs H] was admitted to Kings Cross Hospital on 23 October 1998 with shortness of breath and was diagnosed as having pneumonia in the right lung but also a narrowing of the left bronchus was noted. Therefore, a probable underlying tumour was suspected but initially [Mrs H] was too unwell to undergo a bronchoscopy to confirm this diagnosis. However, the bronchoscopy was undertaken on 11 November 1998 and the results 2 days later confirmed the presence of a squamous cell cancer which was obstructing the left main bronchus. Surgical intervention was not possible. [Mrs H] had a course of radiotherapy at Ninewells Hospital and this treatment resulted in a great improvement in her condition. Therefore, …[the Clinical Oncologist] referred [Mrs H] to [the Medical Oncologist] for consideration for palliative chemotherapy.
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> 'The referral letter from [the Clinical Oncologist] was dictated on 11 January 1999 but unfortunately [the Medical Oncologist] did not receive this letter. The reason for this is unknown. Although [the Medical Oncologist] has pointed to the fact that she had been working single-handed with only ad-hoc secretarial support at that time as her own secretary was on long term sick leave.
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> '[The Medical Oncologist] has indicated that [Mr H] had telephoned on 15 February 1999 to find out what was happening as had [Mrs H's] General Practitioner the next day. As a result of these telephone calls an urgent outpatient appointment was made for [Mrs H] to see [the Medical Oncologist] on 18 February 1999. On that day penetrative x-rays were taken with the intention of discussing these at a multidisciplinary meeting at Kings Cross Hospital. However, the x-rays had been misplaced and could not be found.
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> 'In the meantime [Mrs H] was admitted to ward 31, Ninewells Hospital on 19 February 1999 when it was confirmed that she had increasing shortness of breath over the past few weeks and also had been experiencing pain in her right hip, groin and knee. Further penetrative x-rays were taken and these were reviewed by … [a

consultant radiologist] on 20 February 1999. [The Medical Oncologist] has documented that there was no obvious obstruction in the main bronchus but clear cut deviation to the right just above the tracheal bifurcation.

'[The Medical Oncologist] has indicated that there is usually one month's delay between radiotherapy and chemotherapy and that a patient needs to be fit enough to withstand the rigours of chemotherapy. The purpose of chemotherapy is to improve the quality of life but which often does not increase life expectancy. [The Medical Oncologist] has stated that she did not consider that [Mrs H] was fit for chemotherapy when she first saw her on 18 February 1999. Therefore, the delays relating to the x-rays had no impact on the decision about chemotherapy. Nonetheless, we acknowledge that because [the Medical Oncologist] did not receive the referral letter from [the Clinical Oncologist] there was a delay in [Mrs H] being considered for chemotherapy. Therefore, the Trust accepts that this part of the complaint is justified.

'We can confirm that [the Medical Oncologist] now has permanent dedicated secretarial support. Also, in an attempt to improve communication and provide a more cohesive service for patients there are plans currently being formulated so that Oncologists, Medical Oncologists and Clinical Oncologists work together as site specific teams. This would ensure that the delay experienced by [Mrs H] would not occur in the future.'

Evidence of Trust staff

16. **The Medical Oncologist** confirmed that she did not have a secretary from November 1998 to May 1999 because her secretary was on sick leave and ultimately resigned. As a consequence she had to open letters, deliver tapes for typing to the Head of the Secretariat, look out case notes and hand write requests for scans. She was also the sole medical oncologist from May 1998 to August 1999 and she did not have a registrar. She did not receive the referral letter from the Clinical Oncologist and when Mr H telephoned her about it she set up an emergency appointment for Mrs H for 18 February. The Medical Oncologist obtained a copy of the letter from the Clinical Oncologist's secretary. The referral letter was dated 11 January.

The earliest appointment she could have given Mrs H, if she had received the referral letter within a day or two, would have been 27 January. That may have eased Mr H's concerns but it would have made no difference to the outcome of the case.

17. The Medical Oncologist said that on 18 February she told Mr and Mrs H that after Mrs H was x-rayed she would discuss the x-rays with the Radiologists and the Clinical Oncologists later that day (18 February) at Kings Cross Hospital. She had asked for penetrative x-ray views and would have asked for these to be reported as they are difficult to interpret. She expected that by the time her clinic finished either the x-rays and report would have arrived or that she would go to the x-ray department and find them. At the end of her clinic the x-rays had not arrived and she went to the x-ray department but was unable to find them. A Consultant Radiologist told her that the x-rays may have been sent to Mrs H's GP because he had also requested an x-ray. The Medical Oncologist thought that unlikely because normally GPs receive x-ray reports but not x-rays. She went to Kings Cross Hospital in the hope of discussing Mrs H's case in general but by the time she arrived the meeting had broken up.

18. The Medical Oncologist explained that Mrs H had squamous cell non-small cell lung cancer. If chemotherapy is considered appropriate in such cases, it is provided to improve the quality of life but would be unlikely to extend life expectancy. Over the last four years numbers of patients with non small cell lung cancer in Tayside receiving chemotherapy varied between 27% and 38%. Patients must be fairly fit, have reasonable lung, heart and kidney function and not have lost too much weight. Mrs H had in fact put weight on but when the Medical Oncologist saw her on 18 February she had been too poorly to undergo chemotherapy. The Medical Oncologist could not say what would have happened if she had seen Mrs H three weeks earlier. However, she noted that Mrs H's radiotherapy course finished at the end of November 1998 and by the beginning of the year she was breathless indicating that the radiotherapy treatment had only been effective for a short period. Therefore chemotherapy, even at that time, would have been unlikely to increase her life expectancy. She emphasised that chemotherapy is given to improve the quality rather than the quantity of life.

19. An **Administrative Assistant** with the Department of Oncology and Haematology at the hospital provided the following information:

> 'In January 1999, [the Medical Oncologist]'s secretary had actually resigned after long term sick leave. This post was advertised with very little response. The post was offered to the applicant who accepted the post and then a week later she turned down the offer. During the period of sick leave, and the vacancy following resignation and until the post was filled, [the Medical Oncologist]'s work was shared among the secretaries and then [the Clinical Oncologist]'s full-time secretary provided cover for both him and [the Medical Oncologist] … The post was then offered to [the Clinical Oncologist]'s secretary … (she continues to work with [the Medical Oncologist]). This left a vacant secretarial post within the department once more. After this post was advertised, the successful candidate started in May 1999. This improved the secretarial staffing levels greatly after being understaffed since October 1998.
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> 'The current procedure for secretarial cover during sick leave and annual leave are and will be much improved and staffing levels are set to improve with the employment of two new secretaries …'

20. A **Clinical Team Manager** with the Clinical Radiology Department at the hospital provided the following information:

> '… [Mrs H] was x-rayed on the 18 February for a chest and thoracic and lumbar spines … [Mrs H] was again x-rayed on 20 February for a pelvis, right hip, right knee and chest. According to our computer records Mrs H's films were sent to Ward 31 on the 20 February. It is not possible to say however if all the films were sent. The films from the 18 [February] were reported and verified on the 2 March.
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> '… the main avenues for film packet movements for … out patients [are]:
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> 'Patients arriving from outpatient clinics – films are retained so that they can be reported by a radiologist, the exception to this is if the patient has to return to the clinic with their films. In this case the

films are usually returned later for reporting. Once reported the report is dispatched to the appropriate clinic and the films are filed in the x-ray film file. Film packets are requested by the outpatient clinics for patients who are attending the clinics …'.

21. A **Clinical Nurse Specialist** said that multidisciplinary meetings are held weekly and, if possible, attended by three consultant chest physicians, two consultant oncologists, a consultant radiologist and the Clinical Nurse Specialist or one of her colleagues. The commitment in 1998/1999 was variable but it is much improved now and a Co-ordinator was appointed in August 2002. The aim of the meetings is to discuss all patients going through investigation for lung cancer and also some patients with lung conditions other than cancer. It is not always possible to discuss all patients. If an oncologist cannot attend then decisions about patients' care are still made and, if appropriate, patients are referred to the Medical Oncologists.

Findings (b)

22. Mr H expected his wife to be seen by the Medical Oncologist within 20 days after she was last seen by the Clinical Oncologist on 30 December so that her suitability for chemotherapy could be assessed. He had not expected chemotherapy to cure his wife but felt it could have extended her life and improved the quality of her life which was denied her because of the delay in her being seen by the Medical Oncologist. The Medical Oncologist said that even if she had received the Clinical Oncologist's referral letter within a day or two of it being sent the earliest she could have seen Mrs H would have been on 27 January – 23 days earlier than she did see her. The Trust say that the referral letter was not received by the Medical Oncologist possibly because of the lack of secretarial support. Mr H said that the Medical Oncologist had the letter when he and his wife saw her on 18 February and told them that she had 'got it'. I accept that in fact the Medical Oncologist obtained a copy of the letter after being contacted by Mr H and the GP. I agree with the assessors that the Medical Oncologist had no way of knowing about the letter until she was contacted by Mr H. The assessors consider that the Medical Oncologist acted promptly and provided appropriate palliative treatment when she became aware of the referral. The assessors comment (paragraph ix of their report) that had Mrs H's case been discussed at a multidisciplinary meeting the resulting

problem caused by the missing referral letter might not have occurred. I should also draw attention to the assessors' comments (paragraph xvi of their report) on the importance of all patients with lung cancer being discussed at multidisciplinary meetings. The assessors also suggest that it should be routine for confirmation of an appointment to be made to the person who made the referral, on receipt of a referral letter which should lead to resubmission of the referral letter if no such confirmation is received within two weeks of the referral being made.

23. Mr H said that because the x-rays taken on 18 February went missing his wife had to return to the hospital the following day to have repeat x-rays. The Trust acknowledge that the x-rays were misplaced and later found. The assessors noted that it took 12 days to produce a report on the x-rays which they consider unacceptable and suggest that consideration should be given to the measures already suggested in paragraph 12 of this report.

24. I uphold this aspect of the complaint to the extent that the loss of the referral letter resulted in a delay to Mrs H being considered for chemotherapy. I am pleased to note that the secretarial support for the Medical Oncologist, the lack of which may have been the cause of the loss of the referral letter, has improved. I **recommend** that the Trust consider the assessors' suggestion concerning confirmation of appointments made as a result of referrals and their comments relating to multidisciplinary meetings.

<u>Complaint (c) Failure to address the issue of resuscitation at an appropriate time</u>

25. **Mr H** said that he found out after his wife's death that an instruction that she was not for resuscitation had been put in her medical records on 20 February. The day after the instruction was given his wife was up and about in the ward and showering. He accepted that the issue of resuscitation perhaps should not have been discussed with his wife as she had not wanted to know anything about her prognosis but he thought that it should have been discussed with him or one of their sons who visited their mother regularly. Mr H said his wife was very brave and willing to undergo any treatment necessary and with the appropriate treatment, he

felt, she might have had a longer life and a better quality of life but the instruction not to resuscitate potentially denied her even that possibility.

Guidelines

26. The Trust's **guidelines** (issued in 1993 and still in use in 1999) on when to initiate and stop CPR (Cardiopulmonary Resuscitation) include:

> 'Judgement is needed as to how much to involve patients and relatives in such decisions … relatives … should be made aware of what is going on …'

Trust's official response

27. In the Trust's official response to the Ombudsman's statement of complaint the **Chief Executive** included:

> 'It is recorded in the records that [Mrs H] had stated explicitly that she did not want to know anything about her current situation. In the evening of 20 February … it is documented that [Mrs H] was "distressed", sweating profusely and very anxious about her condition. She was seen at 22.55 hours by [the Medical Oncologist] and appeared to have improved slightly. However, [the Medical Oncologist] has documented that "in the event of an acute problem, not for resuscitation in view of appalling prognosis". Nevertheless, the next morning [Mrs H] was well enough to have a shower although her chest was still fairly wheezy. [The Medical Oncologist] spoke to both [Mr and Mrs H] and explained that another course of radiotherapy would be the best option, as whilst chemotherapy might shrink the tumour, it could also bring substantial risks of infection which could have been fatal for [Mrs H].
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> '[Mrs H] had a course of radiotherapy from 23 February until 1 March 1999 by which time she had greatly improved. [Mrs H] had become much more mobile and was able to do without oxygen for short periods. [The Medical Oncologist] documented that if the improvement continued then consideration would be given again to chemotherapy. Mrs H was discharged home on 2 March 1999 and very sadly died on 9 March 1999.

'[The Medical Oncologist] has explained that the decision about resuscitation was made late in the evening on 20 February 1999. [Mrs H's] fluctuating condition had been giving cause for concern and the staff caring for her needed a decision about resuscitation. [The Medical Oncologist] has indicated that since [Mrs H] had categorically stated that she did not wish to know anything about her situation, discussion with [Mrs H] at that time would have been inappropriate.

'Therefore, [the Medical Oncologist] made a clinical decision based on the facts available to her that resuscitation would have been inappropriate in the circumstances. Also, [the Medical Oncologist] took into consideration the fact that [Mrs H] had indicated on several occasions her concern about how her husband was coping with her illness. Therefore, [the Medical Oncologist] took the decision not to discuss resuscitation with [Mr H] late at night on 20 February 1999, or subsequently, as it did not appear appropriate or necessary at that juncture. Hence the Trust does not accept that this part of the complaint is justified, as [the Medical Oncologist] was acting in what she considered to be the best interests of [Mr and Mrs H]. However, we acknowledge that this is a very sensitive issue which always requires very careful handling and decision making.'

Evidence of the Trust staff

28. **The Medical Oncologist** said that while Mrs H was an inpatient Mr H was with her most of the time. He tended to answer questions for her and it was difficult to find out how she felt. Mrs H was being reviewed three or four times per day. The Medical Oncologist told Mrs H that her condition was fairly serious and that they were trying to keep her as comfortable as possible. The Medical Oncologist put the instruction not to resuscitate in the notes after a day when Mrs H's condition became progressively worse throughout the day. She was on 100% oxygen and the working diagnosis was that she had pulmonary emboli. The Medical Oncologist explained that lung emboli are clots which go to the lungs and can come in small showers or a large single embolus. A large embolus can cause death. Mrs H was prescribed Heparin which is the best way to stop large emboli forming. However, if a large embolus had reached her lungs and the cardiac team had been called it would have been necessary to ventilate her. She was not

a suitable candidate for ventilation and therefore it would have been wrong to begin that process and would not have been in Mrs H's interests.

29. The Medical Oncologist said that the amount of information she gives to patients is dependent on how the patient feels, what they ask and what they want to know. It was necessary to consider the consequences of treatment and the quality of life for the patient after that. Mrs H had explicitly said that she did not want to know anything about her situation. The Medical Oncologist did not discuss the issue of resuscitation with Mr H because of concerns expressed by Mrs H on several occasions about how her husband was coping with her illness. The issue was not discussed with Mrs H's sons because, as far as she was aware, there was no contact by them with medical staff.

Findings (c)

30. Mr H said that the day after the instruction not to resuscitate was entered in his wife's notes she was fit enough to get up for a shower. He accepted that it may not have been appropriate to discuss the decision with his wife given that she had made it known that she did not want to know her prognosis, however, he felt that the decision should have been discussed with him or one of their sons. He thought that with the appropriate treatment Mrs H had the chance of a longer life and a better quality of life but that instruction had potentially denied her that right. The Trust and the Medical Oncologist have explained in detail (paragraphs 27 to 29) why the decision was made. The assessors advise that the decision was appropriate. I accept that advice. The Trust consider that the decision not to discuss the matter with Mr and Mrs H was in their best interests. However, the Trust acknowledged that this is a very sensitive issue which always requires very careful decision making and handling. The question is whether Mr H or another member of the family should have been consulted. The Trust and the Medical Oncologist say that the decision was not discussed with Mr H because of Mrs H's concerns about how he was coping with her illness. The assessors acknowledge that the 'not for resuscitation' decision without discussion with or informing the family is in keeping with much oncology practice in Scotland even though it is not in keeping with National Guidelines which were in place then or which are in place now. The assessors differ in their view on whether the decision should have been discussed with the family before being made, however, they agree that

once the decision was made it should have been discussed at the first possible opportunity. The Trust's policy on cardiopulmonary resuscitation (CPR) says that relatives should be aware of what is going on. I therefore uphold the complaint. I **recommend** that the Trust remind clinicians of the terms of the Trust's policy on CPR in relation to discussion with relatives.

Conclusions

31. I have set out my findings in paragraphs 11, 12, 22 to 24 and 30. The Trust has asked me to convey – as I do through my report – its apologies to Mr H for the shortcomings I have identified and has agreed to implement the recommendations in paragraphs 12, 24 and 30.

Gillian Stewart
Senior Investigating Officer
duly authorised in accordance with
paragraph 11 of Schedule 1 to the
Scottish Public Services Ombudsman Act 2002

10 March 2003

Appendix A

Report by the Professional Assessors to the Scottish Public Services Ombudsman of the clinical judgments of staff involved in the complaint made by Mr H

Basis of report

(i) *The report is based on Mrs H's clinical records and background documents and correspondence relating to the complaint provided by the Ombudsman.*

Background based on the clinical chronology

(ii) *Mrs H was under the care of medical staff at King's Cross Hospital and Ninewells Hospital in Dundee with squamous cell lung cancer from mid-August 1998 until her death in March 1999. Her first admission was on 16 August 1998 to Ninewells Hospital under the care of a Consultant with a complaint of abdominal pain. Subsequent events indicated that this was due to constipation as a consequence of treatment with several constipating drugs including Tramadol, Diltiazem and Prothiaden without a laxative being prescribed along with these agents. This diagnosis was not made while Mrs H was an inpatient on this admission and she was discharged home, still without any appropriate laxative. Provisional diagnoses of urinary tract infection, renal colic and possibly hyperparathyroidism were made although a midstream specimen of urine for culture and sensitivity appears not to have been sent to the laboratory nor was blood taken for parathyroid hormone level. There was no radiological evidence in favour of renal calculus, and the corrected calcium was barely elevated at 2.66 mmols per litre.*

(iii) *Mrs H was readmitted under the care of another Consultant on 27 August 1998 with further abdominal pain where a diagnosis of constipation and sub-acute obstruction was made. This was treated appropriately with laxatives, nasogastric suction and intravenous fluids. A further problem was experienced on this admission insofar as an x-ray report of pneumonia was not received until after Mrs H was discharged and possibly was not available at the time a discharge summary was dictated to the GP. Accordingly no*

comment was made on this radiological appearance in that summary.

(iv) *Mrs H was admitted for a third time under the care of a third Consultant at King's Cross Hospital on 23 October. By this time her radiological changes reported in early September had been recorded as right basal pneumonia. This was appropriately treated with antibiotics. A clinical suspicion of lung cancer was apparent at an early stage. This was confirmed by bronchoscopy and by bronchial biopsy on 12 November. Mrs H received a ten day course of palliative radiotherapy at Ninewells Hospital for this diagnosis, under the care of the Clinical Oncologist. She was reviewed by the Clinical Oncologist at his outpatient clinic on 31 December. At that point a referral, typed on 11 January, was made to the Medical Oncologist at Ninewells Hospital for a medical oncology opinion but this letter was never received.*

(v) *Mrs H was admitted a fourth time on 18 February at Ninewells Hospital under the care of the Medical Oncologist because of further deterioration in her breathing consequent upon her lung cancer. She was felt to be unfit for chemotherapy and received a further course of palliative radiotherapy, apparently with good effect. She was discharged home but died there a week later on 9 March 1999. A further problem on this admission was that a decision not to resuscitate Mrs H in the case of cardiac arrest was made by the Medical Oncologist but was not discussed with or communicated to Mrs H or her family.*

Comments on the actions of clinical staff

(vi) *There was a failure to diagnose constipation as a cause of Mrs H's pain and consequently failure to prescribe appropriate treatment in the form of a laxative. We consider that any doctor should be aware that a laxative must always be considered and, in the majority of cases, prescribed when an opioid analgesic such as Tramadol is prescribed. This was an omission on the part of both the person who initially prescribed Tramadol and the hospital team looking after her. There was nothing at this time to suggest a*

diagnosis of cancer. The serum calcium level was not significant as it was barely elevated.

(vii) *The only problem that we can identify with the admission on 27 August is in the process of reporting radiology and making these reports available to the doctors looking after the patients. This is a common problem. The simplest solution is the Addenbrooke's model where one clinical member of staff and one secretary are permanently reporting x-rays from outpatients or the ward and producing these reports in a typed form before the processed x-ray is returned to outpatients or the ward. In that hospital all x-rays are collected from the wards at 9.00 am for reporting and returned to the same ward at 5.00 pm the same day. We think it appropriate to review the process currently in place in Ninewells Hospital for returning x-ray reports to the ward and ensuring that this delay of almost two weeks between the x-ray being taken and the report being processed does not still occur.*

(viii) *It is not clear from the notes when the x-ray report was finally received but it does not appear to have been acted upon in terms of telling the GP that the patient should have received antibiotics for a chest infection. It would appear from subsequent events that the GP had already commenced this treatment on clinical suspicion without the x-ray report being available to him but the hospital should have communicated this report to the GP once it was available. It is not possible from the notes to determine when the report was received. It should be policy that such reports are signed and dated to indicate their receipt before they are filed.*

(ix) *The only problems which we could identify with the admission on 23 October were a failure to record whether Mrs H was discussed, as she should have been at the Thursday evening multidisciplinary team meeting for patients with lung cancer (also see paragraph xvi), and a failure to supply a discharge summary to the GP. The diagnosis and treatment of Mrs H's cancer appear to be appropriate and timely. If she had been discussed at the multidisciplinary team meeting then subsequent problems with the loss of a referral letter might otherwise not have happened. The notes suggest that she*

was discussed at the meeting on 18 December, after the diagnosis had been made, and that the Medical Oncologist was not present at this meeting.

(x) *No attempt at staging Mrs H's lung cancer by CT scanning or by other means, appears to have been made. However this may reflect the decision that her poor performance status or her vocal cord palsy implying at least Stage III disease precluded any curative therapy. If this were the case then the decision is not recorded in the case notes.*

(xi) *Mrs H's major problem appears to have been the Medical Oncologist's failure to receive or act upon the referral letter from the Clinical Oncologist and the Medical Oncologist's subsequent action because of this missing referral letter. We do not see how the Medical Oncologist could have been aware that this letter was missing. When she was aware of it she seems to have acted promptly to provide appropriate palliative treatment for Mrs H although not within stated time limits ie delay from 23 January to 18 February. We would suggest that it should become routine in all NHS departments, on receipt of a referral letter, for confirmation of the appointment made to be sent to the referring consultant, and that this should lead to a resubmission of the referral letter if no such confirmation is received within two weeks of the referral being made.*

(xii) *There was a further episode of x-rays being lost during the admission on 18 February. We also note from the evidence of the Clinical Team Manager that it took 12 days to report Mrs H's films. We consider this delay to be completely unacceptable. The same comments apply to this as were made above (paragraph viii) with reference to the admission of 27 August.*

(xiii) *The Medical Oncologist's action in making a 'not for resuscitation' decision without discussing this with or informing the family is probably in keeping with much oncology practice in Scotland. It is not in keeping with guidelines then or now from the Department of Health. One of us feels that no such decision should have been*

made until discussion had occurred with the patient or family, while the other is happy that the decision was made. Given that the decision was made, it should have been discussed at the first possible opportunity. We accept that there are issues relating to such decisions in patients with advanced cancer that differ from those in patients who are being admitted for elective procedures.

(xiv) *In summary we think that the only issues in Mrs H's management which were in error were the failure to diagnose constipation on the first admission and a failure to communicate to the GP the result of the chest x-ray on the second admission. Neither of these omissions had any material effect on the outcome of Mrs H's illness but if diagnosed and managed could have reduced her suffering from abdominal pain. As has been pointed out by previous reviewers, the right-sided pneumonia was on the opposite side to Mrs H's lung cancer and not related to that lung cancer. This would not have led to earlier diagnosis of her lung cancer.*

There are three other areas on which we would like to comment

(xv) *If there are difficulties with secretarial support for individual consultants we think it appropriate that the department should ensure that there is central co-ordination of appointments so that problems with missing referral letters or of not having secretaries to act upon those referral letters, do not happen again.*

(xvi) *We think it important that all patients with lung cancer be discussed at multidisciplinary meetings in keeping with the Leicester model. These meetings should be documented and whenever possible, <u>all</u> participating members of the multidisciplinary team should attend those meetings. If key members of the team are not available on a particular occasion then patients appropriately should be reconsidered at the following meeting. We note from the evidence of the Clinical Nurse Specialist that the situation has improved since 1998.*

(xvii) *It would seem that there are some problems with the process of the complaints procedure at Ninewells Hospital. If there are multiple*

consultants involved in a complaint we see no reason why photocopies of the notes should not be made available for those consultants to speed up the process of comment and reply. Meetings with a complainant should be prepared in advance and consultants should not find themselves unexpectedly meeting such individuals, as appears to have been the case here.

(xviii) *We think it unacceptable to appoint a consultant to a post without adequate support for that post, both in the form of secretarial support and of adequate consultant rotas and junior support. None of these seems to have been in place at the time of the Medical Oncologist's appointment. We note from the Administrative Assistant's reply that secretarial numbers were such that there was still a need for further appointments to be made in July 2002.*

(xix) *We think some comment is necessary on the comments provided by the Trust regarding CPR decision-making which we think misses the point. There is no dispute that cardiopulmonary resuscitation would have been inappropriate in Mrs H's case, nor that the chances of success would have been minimal. The issue is whether it is reasonable in clinical practice to discuss this with the patient and family or not.*

(xx) *Finally, the relationship between a patient with advanced lung cancer and their medical carers is different from that which pertains to patients admitted as emergencies to medical wards who were previously not known to medical staff. Patients with advanced lung cancer would be aware that they have an incurable condition and that deterioration is likely. They will have had discussions with medical staff about the aims of care which may involve improvement in quality or quantity of life. This discussion will almost always involve relatives as well. There are, in addition, questions about the right of the patient and the family to discuss issues around the patient's death, both in terms of improving the quality of the patient's final days or weeks of life and in aiding the grieving process of the relatives. In this situation we think it should be the norm to discuss CPR issues with a patient or their family or both. Although we would try to dissuade either party from making*

decisions which we thought were inappropriate this decision must ultimately be that of the patient and their family. Failure to follow this practice results in situations like the present where complaints are being discussed four years after the patient's death. It should also be noted that the failure to inform Mr H of the CPR decision in his wife's case seems to contradict the Trust's own policy in use in 1998, which says that even though relatives should not have the burden of deciding on attempts at resuscitation, 'they should be made aware of what is going on'.

Appendix B

Glossary of medical terms

analgesia	pain relievers
bronchoscopy	a diagnostic procedure in which a tube with a tiny camera on the end is inserted through the mouth into the lungs
gastritis	an inflammation of the lining of the stomach
gastroscopy	an examination of the stomach and abdomen with a gastroscope
hyper-parathyroidism	excessive production of parathyroid hormone by the parathyroid glands caused by enlargement of one or more of the glands or in response to abnormally low calcium levels in the blood or by production of hormone from lung cancer (eg ectopic hormone production)
micturition	the passage of urine
renal calculus	kidney stone
tracheal bifurcation	branching of the windpipe (trachea) into right and left bronchi