Scottish Parliament Region: North East Scotland

Case 200501555: A Medical Practice, Grampian NHS Board

Summary of Investigation

Category

Health: GP & GP Practice; Clinical Treatment; Diagnosis

Overview

The complainant (Miss C), an advocacy worker, complained on behalf of a man (Mr A) regarding the treatment received by his late wife (Mrs A) at her GP Practice (the Practice). Mr A complained about the Practice's failure to promptly diagnose Mrs A's secondary cancer and he considered that the overall treatment provided to her was inappropriate. The specific points of complaint are listed below.

Specific complaints and conclusions

The complaints which have been investigated are that the Practice:

(a) failed to diagnose and properly treat Mrs A's illness (*not upheld*);
(b) provided inaccurate information about waiting times for an ultrasound scan (*upheld*);
(c) inaccurately completed an out-patient appointment form (*not upheld*);
(d) delayed arranging blood tests and only did so upon Mrs A's request *(no finding)*;
(e) delayed admitting Mrs A to hospital *(not upheld)*;
(f) failed to respond to Mrs A and her family sympathetically and empathetically *(not upheld)*;
(g) caused distress by asking Mrs A why she needed a medical certificate *(no finding)*; and
(h) dealt inefficiently with a request for a repeat prescription *(not upheld)*.

Redress and recommendation

The Ombudsman recommends that the Practice considers putting procedures in place to regularly check prevailing waiting times for relevant out-patient services/clinics and does not continue to rely on historic data which may no longer be accurate.

The Practice have accepted the recommendation and will act on it accordingly.

Main Investigation Report

Introduction

1. On 8 September 2005, the Ombudsman received a complaint from an advocacy worker (referred to in this report as Miss C) on behalf of a gentleman (referred to in this report as Mr A) regarding treatment provided to his late wife (Mrs A) by her local GP surgery (the Practice).

2. Mrs A first presented with abdominal pain in July 2004 which she had continually experienced from February 2005. She was referred for an ultrasound scan on 23 March 2005 and was subsequently diagnosed as suffering from secondary cancer of the omentum (see Annex 2). Sadly, she died on 6 November 2005.

3. Mr A expressed dissatisfaction with the standard of care Mrs A received from the Practice and specifically with their failure to promptly diagnose her illness.

4. The complaints from Miss C which I have investigated are that the Practice:

(a) failed to diagnose and properly treat Mrs A's illness;
(b) provided inaccurate information about waiting times for an ultrasound scan;
(c) inaccurately completed an out-patient appointment form;
(d) delayed arranging blood tests and only did so upon Mrs A's request;
(e) delayed admitting Mrs A to hospital;
(f) failed to respond to Mrs A and her family sympathetically and empathetically;
(g) caused distress by asking Mrs A why she needed a medical certificate; and
(h) dealt inefficiently with a request for a repeat prescription.

Investigation

5. In writing this report I have had access to Mrs A's medical records and the complaints correspondence with the Practice. In addition, I obtained advice from one of the Ombudsman's GP advisers (the Adviser).

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

(a) The Practice failed to diagnose and properly treat Mrs A's illness

7. At the request of Mr A, a meeting to discuss his concerns was held at the Practice on 16 June 2005. In attendance were the doctors who were treating Mrs A (GP 1 and GP 2), the Practice Manager, Mr A and his daughter (Miss A). Further to the minutes of the meeting, the points of discussion were clarified in a letter to Mr A from GP 2 dated 7 July 2005.

8. Mr A and Miss A observed that the out-patient appointment request form, and the Practice's referral letter to a private hospital, mentioned distension of the abdomen, a dragging sensation in the lower abdomen and admitted uncertainty over the cause of these symptoms. In response to this, they asked why atypical symptoms did not set alarm bells ringing regarding the seriousness of the problem and they asked if GP 1 had asked for advice from another GP. GP 1 responded by saying that a continuous pain is less likely to be serious and, therefore, she was not so concerned. GP 2 stated that atypical symptoms do not necessarily imply serious underlying causes and he confirmed that GP 1 had indeed discussed the case with another GP.

9. Mrs A's family pointed out that Mrs A had specifically made a point of saying that all the tablets and medication were just masking the symptoms and not finding the cause. GP 1 merely commented that she remembered Mrs A making this statement. GP 2 advised that the medication was prescribed to try to relieve distressing symptoms whilst awaiting the results of investigations and he stated that it would have been utterly wrong not to do this.

10. Mrs A's family asked for an admission that the Practice had failed Mrs A totally when abdominal pain had been reported as far back as 26 July 2004 and then repeatedly from 25 February 2005. GP 2 responded in his letter by saying that they were very sorry indeed regarding Mrs A's diagnosis and the whole family's distress, however, he disagreed with the view that they had failed Mrs A totally and he maintained that she was managed in an appropriate manner.

11. Mr A responded to GP 2's letter in a letter dated 17 July 2005. He acknowledged GP 2's sympathy regarding Mrs A's diagnosis, however, he disagreed with the statement that she was managed in an appropriate manner.

12. Miss C wrote to Grampian NHS Board (the Board) on 21 July 2005, reiterating the family's concerns and restating their belief that the doctors had failed to treat Mrs A properly. The Practice advised the Board that they felt they had fully explained the points raised and that they had nothing further to add. The Board sympathised with Mrs A's situation but stated that there was no further action that they were able to take.

13. Miss C addressed the family's concerns to the Ombudsman in a letter dated 5 September 2005. In the attached complaint form, Mrs A stated that GP 1 had failed to diagnose her or admit that she did not know what was wrong with her and that GP 1 was happy to continually give strong painkillers, nausea tablets and laxatives. Mrs A believed that GP 1's competence should be called into question.

14. The Adviser reviewed the notes and confirmed the fact that the Practice had failed to diagnose the illness and that GP 1's referral letters had mentioned irritable bowel syndrome. However, he stated that, due to the primary source of the cancer never having been identified, it would have been almost impossible to identify symptoms which needed referral. He advised that Mrs A developed pain from secondary cancers in the omentum and that this was a rare problem in medicine, let alone in general practice. He noted that the initial consultation for abdominal pain was 26 July 2004 but that the following four entries in the notes concerned low back pain and an abdominal problem was not mentioned again until 25 February 2005. In this consultation it was mentioned that Mrs A had had the problem 'for many weeks' and the Adviser noted that the out-patient's referral letter was dated 25 March 2005. He felt that this four week timescale from consultation to referral was reasonable as there had been no real clinical indicators of serious disease recorded, such as moderate loss of weight, bleeding, severe loss of appetite etc. Indeed, he commented that this could be considered to have been an early referral.

15. The Adviser observed that the ultrasound was not very helpful in reaching a diagnosis and that Mrs A was subsequently referred to the gastroenterology (see Annex 2) department by way of a referral letter dated 11 May 2005. Again, the Adviser accepted the speed of this referral, following receipt of the ultrasound result, to have been appropriate. He summarised by stating his opinion that Mrs A's rare illness was managed appropriately by the GP.

(a) Conclusion

16. The advice which I have received, and accept, indicates that the Practice took acceptable action in attempting to diagnose what turned out to be a rare illness and that, in light of the symptoms presented, the referral timescales were reasonable. As I can find no evidence to indicate that Mrs A was treated inappropriately, I do not uphold this complaint.

(b) The Practice provided inaccurate information about waiting times for an ultrasound scan

17. In the meeting of 16 June 2005, Mr A pointed out that GP 1 had advised Mrs A that there was currently a six week waiting period for ultrasound scans. Mr A stated that Mrs A had been prepared to pay for the scan to be carried out privately if the waiting time was too long, however, she was willing to wait the advised six weeks. As no contact had been received from the radiology department after five weeks, Mrs A telephoned the surgery and was advised that this was not unusual but that she could contact the radiology department directly if she was concerned. It is noted that GP 1 stated that she had offered to chase up the referral, but Mrs A said she would do so herself as she worked in the hospital. When she did so, she was advised that the waiting time when her application was received had been 16 weeks and that this had been the case for some time. Mr A asked why Mrs A had been misinformed as to the waiting time and he enquired as to when the Practice had last checked the waiting period.

18. GP 2 was unable to advise when the waiting period had last been checked. She stated that it had been six weeks when she had last booked a patient appointment but she was unable to confirm when this was. When Mr A asked GP 2 why she could not have called for up-to-date information, she advised that this would not be feasible and that it was impractical to check up continually on the progress of waiting times.

19. In GP 2's follow-up letter of 7 July 2005, he advised that GP 1 accepted that she had made a mistake regarding the probable waiting time but that she had based this on information she had been given some time previously. He reiterated that it was not feasible to continually check waiting times and stated that doctors can expedite investigations when it becomes clinically necessary, as happened in Mrs A's case. He pointed out that Mrs A did in fact have her scan within six weeks.

20. In his response letter of 17 July 2005, Mr A stated that Mrs A expedited the investigations which led to her scan being carried out within the six week period and she received no assistance from the Practice. He advised that the Practice were unable to provide an extension number for the clinic and they suggested that Mrs A should telephone the switchboard, however, they did not provide details of the specific clinic at which her appointment had been requested. This resulted in Mrs A being transferred to four different departments within the hospital.

21. In Miss C's letter to the Board of 21 July 2005, she reiterated the family's concerns and again asked when the Practice had last checked the waiting period for radiology appointments and why Mrs A had been given incorrect information when she had made it clear that she was willing to pay for the procedure privately. Miss C advised that Mrs A had, in fact, telephoned a private hospital for information regarding their waiting times. As confirmed in paragraph 12, the Board did not add anything to the Practice's response.

22. The Adviser acknowledged that GP 1 had made a mistake when quoting six weeks, however, he agreed that it would not be feasible for the practice to continually check waiting times. Having said that, he advised that some areas produce fact sheets for GPs, which show the waiting times for out-patient clinics and investigations. If such fact sheets are not available in the Practice's area, the Adviser felt that it would be appropriate for them to check for the current waiting times for particular tests, clinics or investigations, if it has been some time since the GP was aware of a particular wait. The Adviser summarised by acknowledging that GP 1 had caused uncertainty by intimating that the delay might be six weeks and he suggested that it might have been more appropriate for her to have ascertained the waiting time, at the time of referral, rather than relying on old information.

(b) Conclusion

23. Whilst I agree that it may not be feasible for the Practice to continually check on current waiting times, it appears, from the evidence available, that GP 1 based the details she provided on information from some time in the past. Although it is acknowledged that the scan was carried out within the timescale quoted by GP 1, this was due to intervention on Mrs A's part and it would have been more appropriate for GP 1 to check the current waiting time at the time of making the referral. I, therefore, uphold this complaint.

(b) Recommendation

24. The Ombudsman recommends that the Practice considers putting procedures in place to regularly check prevailing waiting times for relevant out-patient services/clinics and does not continue to rely on historic data which may no longer be accurate.

(c) The Practice inaccurately completed an out-patient appointment form

25. During the meeting on 16 June 2005, Mrs A's family raised questions regarding the out-patient appointment form, including why certain boxes were not ticked and why it was not marked as an urgent appointment. They asked why the date of prescription, medicine, dose, frequency and duration of prescription were not filled in. Miss C stated her belief that all details should be completed to assist the department concerned

26. GP 1 stated that it was a multi-purpose form and not just specifically for radiology and that it was not necessary for Mrs A's medication to be added to the form. She advised that, at this first contact, there was nothing to suggest clinically that the referral was urgent.

27. In his letter of 7 July 2005, GP 2 reiterated GP 1's advice that the form was used for referrals to many different departments and he advised that it was quite usual not to tick boxes which were not specifically relevant to the investigation requested. He stated that medication information, for example, was not particularly relevant to an x-ray request.

28. In his response letter of 17 July 2005, Mr A again questioned why the first box was not ticked to indicate that an urgent appointment was required. He also pointed out that the form listed the prompt 'please list below all medicines used by the patient in the past two weeks, even if the medicines have no apparent connection with the patient's present complaint' and he stated his belief that this should have been completed as it would have been an important factor in assessing the required urgency.

29. Miss C wrote to the Board on 21 July 2005 and she advised that Mrs A's family did not understand why none of the boxes were filled in in the out-patient appointment form. She stated the family's belief that the form was very pertinent as it would have contributed to a speedier process in Mrs A's care and treatment. She also stated that the form could have told staff that Mrs A felt that

the medications such as laxatives, painkillers and anti-sickness tablets were only masking her symptoms.

30. In their response letter of 2 August 2005, the Board stated that there was no further action they were able to take as the Practice felt that they had already fully explained all the points raised.

31. The Adviser confirmed that the referral was for an ultrasound examination only and not for assessment by a clinical specialist. He advised that the essentials of the clinical symptoms had been entered and he stated that these would have assisted the radiologist in coming to a decision as to the required urgency of the appointment. He observed that GP 1 did not indicate any degree of urgency in the form, however, he stated that this was in agreement with the assessment of Mrs A's clinical condition and he pointed out that the probable diagnosis considered by GP 1 was that of irritable bowel syndrome.

32. The Adviser accepted that the form could have included the medications taken by Mrs A and also any allergies, however, he stated that these details were not required as the referral was purely for a radiological examination. He advised that such details would be required in a referral to a clinical specialist and he observed that the later referral to the gastroenterological department was full and complete and appropriately contained these details.

(c) Conclusion

33. I accept the advice I have received, which indicated that the clinical assessment at the time of referral did not suggest any required urgency and that sufficient details were included to allow an ultrasound referral to be processed. I have, therefore, deemed the form to have been appropriately completed, given the referral type and clinical situation at that time, and I do not uphold this complaint.

(d) The Practice delayed arranging blood tests and only did so upon Mrs A's request

34. During the meeting of 16 June 2005, Mrs A's family advised that her manager and work colleagues had repeatedly asked her if her doctor had taken blood tests, as this could eliminate several complaints. They stated that Mrs A eventually asked GP 1 about this and, at that stage, she agreed to take blood tests. The family asked why this was not done sooner and GP 1 stated that blood tests were only taken on the basis of knowing what you are looking for.

35. In GP 2's correspondence of 7 July 2005, it was advised that the blood tests were not instigated by Mrs A but by GP 1 when she felt it was clinically appropriate. It was also stated that the tests were not terribly helpful in providing a diagnosis.

36. In Mr A's response letter of 17 July 2005, he stated that it was untrue that GP 2 had instigated the blood tests and he asked why there had been no denial at the meeting when he had stated that the tests were instigated by Mrs A.

(d) Conclusion

37. Mr A stated that the blood tests were carried out upon Mrs A's request, whereas, the Practice maintain that they were instigated by GP 1 when she felt it was clinically appropriate. In situations such as this, without the presence of an independent witness, there are no means to corroborate either version of events and it is often impossible to make a judgement, even on the balance of probabilities. It is not a question of whether I believe either account, it is simply that I am unable to find a secure basis upon which to reconcile the differing views. In light of this, I make no finding on this complaint.

(e) The Practice delayed admitting Mrs A to hospital

38. In the meeting of 16 June 2005, Mrs A's family also raised their concerns regarding the delay in admitting Mrs A to hospital and they identified that GP 1, prior to going on holiday, had recorded that Mrs A would merit admission one week later, should there have been no improvement. GP 1 had recorded this on 23 May 2005 and Mrs A met with GP 2 on 30 May 2005 and was given a medical certificate for a further two weeks. The family asked why Mrs A was not admitted in line with GP 1's note and they stated their belief that GP 2 was freeing himself from responsibility in order to revert the problem to GP 1, upon her return from holiday. GP 2 responded by stating that Mrs A was not clinically eligible, upon examination, for hospital admission and he was offended at the implication that he had been 'fobbing [Mrs A] off'.

39. The family then noted that GP 2 had carried out a home visit, at Mrs A's request, on 6 June 2005 and that he still did not suggest admitting her to hospital. He suggested that she could wait for her appointment with the gastroenterology department as it was only a couple of weeks away. The family stated that Mrs A had to be very insistent and that she felt she had to virtually beg to be hospitalised as she could not tolerate the pain any longer. They

asked why GP 1 and GP 2 were so reluctant to admit that they did not know what was going on and that hospital treatment and further expert investigation was required. The Practice advised that they did not feel that Mrs A warranted emergency admission because she was managing to attend her work. Miss C was unhappy with this response and stated that Mrs A had battled through the pain and should not have been penalised for her stoicism.

40. In his correspondence of 7 July 2005, GP 2 stated that he examined Mrs A on 30 May 2005 and was of the impression that there was no need for emergency admission. He noted that the pain had eased somewhat on medication and he issued a medical certificate for two weeks but offered to review Mrs A should further problems develop. He advised that GP 1 had quite correctly spoken to him about her concerns, prior to her holiday, but that his clinical impression on the day was that emergency admission was not required and appropriate follow-up was offered.

41. GP 2's subsequent home visit of 6 June 2005 was arranged following a telephone call from Mrs A stating that her pain was more severe. She advised that it was so severe she could no longer wait for her out-patient appointment and GP 2 advised that he then tried to make arrangements for her admission. He initially spoke to the Senior Registrar within the gastroenterology department but no beds were available there so he arranged to visit Mrs A to assess her clinical situation and determine the best way forward. GP 2 then arranged Mrs A's admission to the on-call surgical ward, having identified acute tenderness in the lower abdomen.

42. In Mr A's response of 17 July 2005, he stated that GP 2's assessment that the pain had eased somewhat on medication did not detract from the fact that Mrs A still felt enough pain to warrant a visit to the surgery and a two week medical certificate to be issued. Finally, Mr A advised that Mrs A had telephoned the surgery on 6 June 2005 as she was virtually bedridden and he stated that the home visit was, therefore, specifically requested by her and not carried out at GP 2's suggestion.

43. The Adviser reviewed the records and stated that he could not see any indication of a requirement to admit Mrs A, prior to late May/early June. He advised that the consultations between 25 February 2005 and 9 May 2005 indicated increasing abdominal pain and nausea, however, he stated that none of these would seem to him to indicate a need for admission to hospital. He

acknowledged that Mrs A had advised that the pain was severe during an out-of-hours visit on 20 May 2005 and, in an entry dated 23 May 2005, GP 1 suggested that she could merit admission should the pain not respond to tramadol (see Annex 2). However, the Adviser noted that GP 2 had indicated, on 30 May 2005, that there had been some relief of the pain using tramadol and thus he did not consider admitting Mrs A to hospital. The Adviser also noted that GP 2 arranged admission to hospital on 6 June 2005 as Mrs A's pain had increased again and in his opinion this course of events was reasonable.

(e) Conclusion

44. The Adviser has confirmed that the Practice's actions were appropriate and that there was no apparent delay in admitting Mrs A to hospital, given the symptoms presented. I accept this advice and, therefore, do not uphold this complaint.

(f) The Practice failed to respond to Mrs A and her family sympathetically and empathetically

45. In Miss C's letter of 21 July 2005, she communicated Mr and Mrs A's belief that the care and treatment that was provided to Mrs A during a very difficult time was not carried out in an empathetic and sympathetic manner.

46. In the complaint form, received by the Ombudsman on 8 September 2005, Mrs A stated that Mr A and Miss A had been treated with disrespect and arrogance during the meeting of 16 June 2005.

47. The Adviser was unable to comment on whether or not the Practice had acted sympathetically and empathetically, beyond confirming that the entries in Mrs A's records for 19 October 2005, 25 October 2005 and 26 October 2005 all seem to be reasonably empathetic.

(f) Conclusion

48. I can find no evidence to suggest that the Practice acted without sympathy or empathy and I, therefore, do not uphold this complaint.

(g) The Practice caused distress by asking Mrs A why she needed a medical certificate

49. Mr A sent a letter to Miss C dated 3 November 2005 in which he stated that Mrs A had telephoned the receptionist at the Practice to request another medical certificate and she had explained that she had just finished her

chemotherapy. A GP (GP 3) returned the call and left a message asking Mrs A to call the surgery to confirm why she needed the certificate. Mr A advised that Mrs A did so, however, she found it very distressing to both herself and her family who were trying to come to terms with her prognosis.

50. GP 3 responded to this issue in a letter dated 9 February 2007 and he stated that he had no recollection of the incident and he could only report on the written notes. The notes advised that the telephone call in question was made on 25 July 2005 and they stated that a sick line had been requested, Mrs A was due chemotherapy in two days time, tests were to be taken at home that day and she was still feeling very nauseous.

51. The Adviser had no comment to make regarding the issuing of medical certificates. He merely noted that there are entries indicating the issuing of such, dated 23 May 2005 (until 31 May 2005), 27 June 2005 (for four weeks) and 25 July 2005 (for 13 weeks), and he stated that this would seem reasonable.

(g) Conclusion

52. As GP 3 has no recollection of the telephone call in question and the Adviser has no comments to make, I can make no finding on this complaint. I would, however, remind the Practice of the need for added sensitivity and diligence when dealing with requests from terminally ill patients.

(h) The Practice dealt inefficiently with a request for a repeat prescription

53. In his letter of 3 November 2005, Mr A also advised that Mrs A ordered a repeat prescription from the Practice on 21 October 2005 and went to collect her medication from a pharmacy on 25 October 2005. The pharmacy had no record of the repeat prescription and Mr A telephoned the surgery and was advised by the receptionist that no prescription had been ordered and she would get a doctor to call him back. He received a call back shortly thereafter from a GP (GP 4) who confirmed that no prescription had been ordered. Mr A stated that he advised GP 4 that this was the third such instance of this and GP 4 responded by stating that it was sloppy and unacceptable. Mr A further stated that this error resulted in him going to the surgery to pick up the prescription and take it to the pharmacy, to which he had to return the following day in order to collect the medication.

54. In a response letter to the Practice Manager dated 9 August 2006 and forwarded to the Ombudsman on 14 August 2006, a GP (GP 5) advised that he saw Mrs A at home on the 24 October 2005 for a follow-up visit. He stated that he unfortunately did not have her notes with him and he advised that Mrs A did not request any treatment as she thought that Mr A had requested all necessary treatment through their repeat prescription service. He advised, however, that the GP who was dealing with prescription requests on that day did not issue Mrs A's prescription as he thought this would have been issued during the home visit. GP 5 apologised for this misunderstanding.

55. In a telephone call to the Ombudsman's office on 20 September 2006, Mr A stated that he thought it would have been common practice to have the notes when making a home visit. He advised that he was not informed that the notes had not been available when he called the surgery the next day and he said that he felt the episode showed inefficiency and he remained dissatisfied.

56. The Adviser noted that the entry dated 27 September 2005 indicated that the GP was unsure as to the frequency morphine had to be taken, however, he advised that this is a common problem with terminally ill patients where the Macmillan nurses are regularly altering treatment for the benefit of the patient. The Adviser also noted the entry dated 25 October 2005 which advised that Mrs A's prescription for further opiates was not at the pharmacy. The Adviser noted and accepted the GP's apology for 'sloppy administration' and, whilst not condoning the absence of a particular prescription which was needed for a very ill patient, he again mentioned the varying and possibly increasing use of medications by Mrs A as a possible explanation. He also advised that further explanation was provided by the GP in an entry dated 26 October 2005 which intimated that Mrs A had had several differing contacts with differing personnel and thus her notes were not easily available. He commented that this was understandable, and whilst it did not obviate the need for an appropriate prescription to have been appropriately available for Mrs A, he again noted the Practice's apology.

(h) Conclusion

57. As mentioned in paragraph 52, I would remind the Practice of the need for added sensitivity and diligence when dealing with requests from terminally ill patients, however, I note and accept the Adviser's comments regarding the complexities involved in treating terminally ill patients and I also note the Practice's apology for the misunderstanding regarding the prescription. I have

deemed this apology to be appropriate and I, therefore, do not uphold this complaint.

58. The Practice have accepted the recommendation and will act on it accordingly. The Ombudsman asks that the Practice notify her when the recommendation has been implemented.

Annex 1

Explanation of abbreviations used

Miss C	The complainant – an advocacy worker representing the aggrieved
Mr A	The aggrieved
Mrs A	Late wife of the aggrieved
The Practice	The GP Surgery Mrs A attended
The Adviser	The GP adviser to the Ombudsman
GP 1	The GP who primarily treated Mrs A
GP 2	The GP who treated Mrs A in GP 1's absence
Miss A	Daughter of the aggrieved
The Board	Grampian NHS Board
GP 3	The GP who returned Mrs A's call to request a medical certificate
GP 4	The GP who called Mr A on 25 October 2005 when Mrs A's prescription had been unavailable at the pharmacy
GP 5	The GP who visited Mrs A at home on 24 October 2005

Annex 2

Glossary of terms

Gastroenterology	Branch of medicine where the digestive system and its disorders are studied
Omentum	The sheet of fatty tissue lying within the abdominal cavity
Tramadol	Analgesic medication used to treat moderate to severe pain