Scottish Parliament Region: Glasgow

Case 200502857: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; Oncology

Overview

The complainant, Ms C, raised a number of concerns about the care and treatment provided to her mother, Mrs A, by the Consultant in Clinical Oncology (the Consultant) at the Beatson Oncology Centre (the Centre). Mrs A was subsequently admitted to Stobhill Hospital (the Hospital) then transferred to a hospice but, sadly, died the same night.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the treatment provided by the Consultant was not reasonable (*not upheld*);

(b) the Consultant failed to communicate reasonably with Mrs A and her family about her disease and treatment (*not upheld*); and

(c) the Centre failed to communicate reasonably with the Hospital following Mrs A's admission (*not upheld*).

Redress and recommendation

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. Mrs A was diagnosed with breast cancer in 1994. She underwent a mastectomy and was treated with chemotherapy and radiotherapy, following which she was prescribed Tamoxifen for the following five years. In 2004 Mrs A's cancer was found to have spread to her bones and skin and she had a further course of chemotherapy. A CT scan in January 2005 showed that the disease had not spread further at that stage. On 4 April 2005 Mrs A attended the out-patient endoscopy centre, where she had been referred for nausea and vomiting. It was found that Mrs A's cancer had spread to her duodenum. On 18 April 2005 the results were sent to the Consultant. Ms C's complaints concern the treatment provided by the Consultant to her mother (Mrs A); the Consultant's communication with Mrs A and her family; and the Beatson Oncology Centre (the Centre)'s communication with Stobhill hospital (the Hospital) where Mrs A was subsequently admitted on 20 May 2005, prior to her death on 28 May 2005. NHS Greater Glasgow and Clyde responded to Ms C's complaint but she remained dissatisfied and, on 1 May 2006, she complained to the Ombudsman.

2. The complaints from Ms C which I have investigated are that:

(a) the treatment provided by the Consultant was not reasonable;

(b) the Consultant failed to communicate reasonably with Mrs A and her family about her disease and treatment; and

(c) the Centre failed to communicate reasonably with the Hospital following Mrs A's admission.

Investigation

3. In order to investigate this complaint I have had access to Mrs A's clinical notes from both the Centre and the Hospital and the complaint correspondence. I have obtained advice from an adviser to the Ombudsman who is a Consultant Clinical Oncologist (the Adviser). I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report can be found in Annex 1. A glossary of the medical terms used in this report can be found in Annex 2. Ms C and the Board were given an opportunity to comment on a draft of this report.

(a) The treatment provided by the Consultant was not reasonable

4. Ms C said that she knew that Mrs A had terminal cancer but she had not expected her to die so quickly. Ms C said that Mrs A attended an appointment with the Consultant on 21 April 2005. At that appointment the Consultant explained that her cancer had spread to her duodenum. The Consultant said that he intended to admit Mrs A to the Centre, as he felt she required further chemotherapy and for a CT scan. He recommended that she cancel her appointment on 29 April 2005 for her four weekly Bisphosphonate infusion, as he hoped to admit her by 28 April 2005 and he would give her this infusion after she was admitted. Ms C said that, when she asked the Consultant about this, he said that it would have no bearing on her pain if Mrs A had to wait more than four weeks for this infusion. Ms C said she found this difficult to understand because Mrs A had said she derived great benefit from the infusion which she had every four weeks.

5. In the event, Mrs A was not admitted to the Centre until 11 May 2005, when she had a chemotherapy assessment and staging CT scan (to ascertain the progress of her cancer), following which she was discharged on 13 May 2005. Prior to being admitted, Mrs A had received a Bisphosphonate infusion on 5 May 2005. Ms C complained about the delay in admitting Mrs A following her appointment with the Consultant on 21 April 2005.

6. When Mrs A attended her next appointment at the Centre on 19 May 2005, the Consultant arranged for her to have a chest x-ray, as she was suffering from shortness of breath. The x-ray showed that Mrs A had markings on her lungs. The Consultant arranged for Mrs A to be admitted to Ward G10 for chemotherapy the same day. Mrs A was discharged from the Centre on the afternoon of 20 May 2005 but was admitted to the Hospital that night with breathing difficulties and pain in her left arm. Ms C said that, following Mrs A's admission to the Hospital, she was found to have fluid in her lungs and heart which subsequently led to heart failure. Mrs A was admitted to the Hospital's coronary care unit on 21 May 2005 and was subsequently transferred to the hospice on 28 May 2005 but died the same night. Ms C said that the Cardiologist Specialist Registrar (the Doctor) told the family that Mrs A had lymphangitis. Ms C said that the Doctor had questioned whether Taxol (used in Mrs A's chemotherapy) was appropriate for a patient with lymphangitis. In her complaint, Ms C also suggested that Mrs A may have died from toxicity associated with Taxol and may have lived longer if she had been treated with palliative care rather than chemotherapy.

7. The General Manager of the Centre, in responding to Ms C's complaint on 26 July 2005, said that the Consultant had explained to Mrs A that he would prescribe the Bisphosphonate infusion when Mrs A attended for chemotherapy, to save her attending more often than necessary and she had been happy with this arrangement. The Consultant said he thought chemotherapy should be started in the near future but it was not urgent at that point and should be arranged to coincide with a staging CT scan so that he could monitor the course of the disease. The Consultant had requested a CT scan and admission for assessment for chemotherapy and this request was received in the booking office on 26 April 2005. The situation was that a minimum of two weeks notice was required when booking a scan and that had to be co-ordinated with bed availability. A date was arranged for 11 May 2005. The Consultant said that he did not think that the delay affected the eventual outcome of Mrs A's breast cancer.

8. At a meeting on 17 October 2005 the Consultant explained that, although he would probably not use the term, lymphangitis referred to shadowing on the lung which indicated diffused disease in the lung. The Consultant said that Mrs A had not suffered from lung cancer as suggested by Ms C but suffered from breast cancer which had spread to her lungs. He explained the options he had considered in Mrs A's treatment and had decided on Taxol as the best option and the one least likely to do harm. The Consultant said that the treatment he had prescribed was the best treatment for the spread of breast cancer. The Consultant said that Mrs A had died of breast cancer which chemotherapy had failed to stop. In his opinion, however, Mrs A had received optimum treatment which was best suited to her and nothing could have been done otherwise. In a further response on 24 April 2006, the Consultant said that chemotherapy for breast cancer which has spread to the lungs is, in fact, palliative treatment.

9. I asked the Adviser whether missing a Bisphosphonate infusion on 29 April 2005 would have any effect on the progress of the disease or the pain suffered by Mrs A. The Adviser said that, based on the evidence that is available regarding Bisphosphonate use in metastatic breast cancer, it would not have made any difference to the progress of the disease. There was a small probability that pain control potentially could have been slightly better with regular use of Bisphosphonates but even that was contentious. In the circumstances, the Adviser said that the delay in the infusion of Bisphosphonate

could not be construed as being responsible for the progression of Mrs A's disease or the increase in symptoms suffered by her.

10. The Adviser said that the treatment planned and delivered by the Consultant was standard practice in a case such as Mrs A's. The use of Taxol in metastatic breast cancer in these circumstances was also approved by National Institute for Clinical Excellence (NICE). The dose of Taxol which was given and the weekly schedule which was planned was entirely consistent with standard practice. The Adviser said that Taxol was licensed for use in metastatic breast cancer which included use in patients suffering from lymphangitis. The Adviser had checked the product information for Taxol and there was nothing to suggest that it was not advisable in lymphangitis due to metastatic breast cancer.

(a) Conclusion

11. Ms C complained that the treatment provided by the Consultant was not reasonable. In particular, she was concerned that Mrs A had an increase in her symptoms and that, prior to her death, there was a delay in Mrs A receiving her regular Bisphosphonate infusion. However, I have been advised that this would not have affected the progress of Mrs A's disease or the pain she suffered. The Adviser confirmed that the treatment which Mrs A received was treatment which is standard in patients with Mrs A's condition. The advice I have received is that there is no indication that Taxol is not suitable for patients with lymphangitis. I note that, at the meeting with the Consultant, Ms C said that the Doctor who had raised doubt about this was not an oncology specialist. The Adviser, who is a Consultant Clinical Oncologist, said that Mrs A's cancer had progressed but raised no issues about the treatment which the Consultant provided. The aim of giving Mrs A treatment with Taxol was to try to relieve symptoms caused by the spread of her breast cancer. In all the circumstances, I do not uphold this complaint.

(b) The Consultant failed to communicate reasonably with Mrs A and her family about her disease and treatment

12. In her complaint Ms C said that, following her endoscopy on 4 April 2005 (see paragraph 1), Mrs A asked her to follow up the results for her. On 18 April 2005 Ms C telephoned and spoke with a Nurse Specialist, who she found to be very helpful and sympathetic. The Nurse Specialist suggested that it might be a good idea if Ms C accompanied Mrs A to her next appointment with the Consultant, which was scheduled for 29 April 2005. Ms C said that Mrs A

became very anxious during the following couple of days and asked her to telephone again, which Ms C did on 21 April 2005. On that occasion the person she spoke to had spoken to the Consultant, who said that he would see Mrs A if she came to the Centre before 13:00 that day. Ms C said that, although Mrs A attended the appointment that day (see paragraph 4), the Consultant had not explained why he said he would see her that day and this had frightened Mrs A.

13. Following this appointment, Ms C said that she made various telephone calls before being told that an arrangement to admit Mrs A on 11 May 2005 had been made. Ms C said that when she spoke to the Consultant on 29 April 2005, he had asked her to stop telephoning his staff as they were very busy and did not have time to talk to her. Ms C said that she took this very personally.

14. In response to the complaint the Consultant said that, following receipt of the result of the endoscopy, he arranged to see Mrs A back at the Centre on 21 April 2005, a week earlier than previously planned. The Consultant was arranging further chemotherapy so suggested that Mrs A did not require to attend for her Bisphosphonate infusion as he could give it to her when she attended for chemotherapy. He indicated that he had explained the reasons for this on numerous occasions to Ms C, as had the breast care nurses. Nevertheless, Ms C was telephoning three or four times per day, asking the same questions again. The Consultant, therefore, spoke with Ms C and suggested that instead of telephoning she should come to the Centre with Mrs A the following week and he could explain it all again in person. Ms C had not attended the appointment, however, and Mrs A attended the Centre with her other daughter. In her letter to Ms C on 26 July 2005, the General Manager said that she was sorry if Ms C was upset when the Consultant suggested she did not make further telephone calls.

15. Ms C later complained that neither Mrs A nor her family had been told that she was suffering from lymphangitis. Ms C said that it was only after Mrs A was admitted to the Hospital that the family were told that she had lymphangitis. On 15 July 2005 the Service Manager wrote to Ms C. She said that it was at Mrs A's 19 May 2005 appointment that she had complained of shortness of breath. The Consultant had arranged a chest x-ray, which showed increased markings in the lungs. Mrs A had been accompanied on this visit by her other daughter. The Consultant said he had told them that there was shadowing on the lungs and had explained to them that this was why Mrs A was short of

breath. At the meeting on 17 October 2005, the Consultant confirmed that lymphangitis was the same thing as shadowing on the lung.

16. In Mrs A's clinical notes there is a copy of the letter to the Consultant giving the results of Mrs A's endoscopy. The letter is dated 18 April 2005. When Ms C telephoned the same day because Mrs A was anxious that she did not have the results, the Consultant did not have them either.

(b) Conclusion

17. Ms C complained that the Consultant failed to communicate reasonably about Mrs A's disease and treatment. When Ms C telephoned on 18 April 2005 and spoke to the Nurse Specialist, however, the Consultant did not have the results. The advice to attend the pre-arranged appointment on 29 April 2005 was, therefore, reasonable. Ms C telephoned again on 21 April 2005 because she said Mrs A had become very anxious. By this time, the Consultant had the results and agreed to see Mrs A that day. Ms C said that the fact that the Consultant agreed to see her so quickly caused Mrs A to be more distressed. That is a pity because it is clear that the Consultant could have waited until 29 April 2005 to see Mrs A but offered to see her early because Ms C said she was so anxious.

18. Ms C said that she considered that Mrs A required urgent chemotherapy but the Consultant said he explained to Ms C that, although he thought Mrs A should re-commence chemotherapy as soon as possible, it was not urgent and a CT scan should be arranged at the same time so that he could check progress. There were no notes on the file indicating each time Ms C telephoned following the 21 April 2005 appointment. The Consultant said that she telephoned up to four times a day. Ms C said that she made various calls. The Consultant said that he suggested that instead of calling Ms C should accompany Mrs A to her next appointment and he would explain the situation in person. Ms C was, therefore, given the opportunity to discuss matters with the Consultant face-to-face. I do not consider that this was unreasonable. I am also satisfied that the Consultant explained the findings of the x-ray to Mrs A and her other daughter, as there is evidence for that in the notes. He described the result as shadowing on the lung, which he explained at the meeting meant the same thing as lymphangitis. I consider that the explanation given to Mrs A and her other daughter was reasonable. As I have not found the Consultant's communication to be unreasonable, I do not uphold this complaint.

(c) The Centre failed to communicate reasonably with the Hospital following Mrs A's admission

19. Ms C said that, following Mrs A's admission to the Hospital, the Hospital required information from the Centre in the early hours of the morning on 21 May 2005. The information provided was inadequate and had delayed the start of Mrs A's treatment.

20. In the clinical notes following Mrs A's admission to the Hospital there was a note written by the Doctor who was treating Mrs A. He took a careful history and noted her condition. The Doctor said that there appeared to be pressure on Mrs A's heart, which he thought could have been caused by tamponade (pressure on the heart caused by fluid in the space between the heart muscle and the outer covering of the heart, which results in the heart not being able to pump properly). He did not understand what was causing Mrs A's oedema (swelling caused by fluid). There was also a note of the full findings of the CT scan which Mrs A had on 11 May 2005 and which the Doctor had obtained. The Doctor noted that, prior to obtaining the CT scan results, the clinical picture in relation to Mrs A did not hold together. When he obtained the results of the scan, however, he noted that it said Mrs A was suffering from lymphangitis as a result of her cancer and also that a pericardial effusion had been noted. The Doctor wrote that the emphasis would be on symptom relief. The Doctor said that he explained the position to Mrs A's son and daughter (Ms C's sister) and the reason for the discrepancy between 'fluid on the lungs' and 'fluid around the heart' was the finding of lymphangitis which, sadly, meant that Mrs A was likely to die given the poor state she was in that night. In the event, Mrs A did not die that night but remained in the cardiac care unit until she was transferred to the hospice on 28 May 2005 although she died very soon after that.

21. The Adviser has reviewed the clinical notes and has advised me that she has no concerns about the communication with the Centre on this matter.

(c) Conclusion

22. It is clear from the clinical records that Mrs A's condition deteriorated rapidly and it must have been confusing for her family but the advice I have received is that the information provided by the Centre was correct and that was well documented in the clinical notes. I, therefore, do not uphold this complaint.

Annex 1

Explanation of abbreviations used

Mrs A	Ms C's mother
The Consultant	The Consultant in Clinical Oncology (a specialist in the treatment of cancer)
Ms C	The complainant
The Centre	The Beatson Oncology Centre
The Hospital	Stobhill Hospital
The Adviser	Adviser to the Ombudsman who is a Consultant Clinical Oncologist
The Doctor	The Cardiologist Specialist Registrar

Annex 2

Glossary of terms

Bisphosphonates	Drugs which, in certain situations, can help to protect bones against some of the effects of cancer, such as pain and weakness
Chemotherapy	A treatment used for some types of cancer
Computerised Tomography scan (CT Scan)	A scan which takes pictures from all around the body and uses a computer to put them together
Duodenum	The first section of the small intestine
Endoscopy	A test to look inside the body through a flexible tube
Hospice	Hospital caring for terminally ill patients
Lymphangitis	Spread of cancer in the lymph vessels of the lung resulting in fine lace-like shadowing
Mastectomy	Removal of the breast
Metastatic	Spread of cancer to other parts of the body
NICE	
Oedema	Swelling caused by fluid in the body
Radiotherapy	A treatment for some types of cancer

Tamponade	Pressure on the heart, caused by fluid in the space between the heart muscle and the outer covering of the heart, which results in the heart not being able to pump properly
Tamoxifen	Hormone therapy used to treat breast cancer
Taxol	A chemotherapy drug