Scottish Parliament Region: Central Scotland

Case 200600725: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital; General Medical; Clinical treatment/diagnosis

Overview

The complainant (Mr C) raised a number of concerns that his wife (Mrs C) was misdiagnosed during two admissions at Hairmyres Hospital (the Hospital) in 2004, that she was afforded poor clinical and nutritional care at the Hospital during admissions in 2004 and 2005, that record-keeping and communication between staff in relation to Mrs C's care was poor and that Lanarkshire NHS Board (the Board) did not take appropriate action as a result of Mrs C's experiences and Mr C's subsequent complaints.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mrs C was misdiagnosed during two admissions at the Hospital (*not upheld*);

(b) Mrs C was afforded poor clinical and nursing care at the Hospital (*partially upheld* to the extent that Mrs C should have been advised on 6 October 2004 that it was unlikely that the promised visit by the surgical team would be able to be made);

(c) Mrs C was not given appropriate nutritional care at the Hospital (*not upheld*);

(d) the Hospital's record-keeping in relation to Mrs C was poor (*not upheld*);

(e) communication between the Hospital's staff in relation to Mrs C was poor (*partially upheld* to the extent that the prioritisation of Mrs C's endoscopy was not adequate following the observations made during her second admission); and

(f) the Board did not take appropriate action as a result of Mrs C's experience and Mr C's subsequent complaints (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mr C that Mrs C was not advised timeously that it was unlikely that the visit by the surgical team would be able to be made;
(ii) remind staff of the importance of keeping patients informed in these circumstances;
(iii) apologise to Mr C for the insufficient urgency attached to the request for Mrs C's endoscopy; and
(iv) audit their referral process to satisfy themselves that the urgency of a referral is clear at all times.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 5 June 2006 the Ombudsman received a complaint from Mr C, the husband of a woman (Mrs C) who had passed away in April 2005. Mr C complained that Mrs C was misdiagnosed during two admissions at Hairmyres Hospital (the Hospital) in 2004, that she was afforded poor clinical and nutritional care at the Hospital during admissions in 2004 and 2005, that record-keeping and communication between staff in relation to Mrs C's care was poor and that Lanarkshire NHS Board (the Board) did not take appropriate action as a result of Mrs C's experiences and Mr C's subsequent complaints.

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

(a) Mrs C was misdiagnosed during two admissions at the Hospital;
(b) Mrs C was afforded poor clinical and nursing care at the Hospital;
(c) Mrs C was not given appropriate nutritional care at the Hospital;
(d) the Hospital's record-keeping in relation to Mrs C was poor;
(e) communication between the Hospital's staff in relation to Mrs C was poor; and
(f) the Board did not take appropriate action as a result of Mrs C's experience and Mr C's subsequent complaints.

Investigation

3. The investigation of these complaints involved obtaining and examining the relevant medical and nursing records and the complaints file from the Board. This included internal correspondence of the Board during the investigation of Mr C's complaints. I also sought the views of clinical advisers to the Ombudsman (the Hospital Adviser and the Nursing Adviser). I have set out my findings of fact and conclusion. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. The terms used to describe other people referred to in the report are noted in Annex 1 and a glossary of the medical terms used is noted in Annex 2. Mr C and the Board were given an opportunity to comment on a draft of this report.

4. In June 2004 Mrs C's General Practitioner (GP) had referred her to the gastroenterology clinic of the Hospital for an endoscopy. This referral listed Mrs C's symptoms as iron deficiency anaemia, dyspepsia and reduced appetite. This referral was not marked as urgent. A consultant gastroenterologist

(Doctor 1) vetted the letter and requested that Mrs C be put on the list for an endoscopy and colonoscopy. At that time, the maximum waiting time for a non-urgent endoscopy was 36 weeks.

5. However, in the meantime, Mrs C was admitted to the Hospital on 7 August 2004 via the Accident and Emergency Department. The referral from the Accident and Emergency Department gave Mrs C's presenting symptoms as complaints of a two-week history of pain in the fingertips in both hands, shortness of breath and some chest pain. Mr C believed that his wife's presenting symptoms were a long history of complaints with abdominal pain and weight loss that had been investigated over several years, but for which no organic cause had been found.

6. Examination in the medical assessment ward of the Hospital revealed evidence of digital ischaemia in both index fingers and some degree of fluid in the chest, which was confirmed by x-ray. Following investigations to identify the cause of her digital ischaemia, a working diagnosis of autoimmune vasculitis was made and the digital ischaemia was treated by anticoagulation. Mrs C was discharged on 18 August 2004 for follow-up appointments with the rheumatology clinic. Following Mrs C's discharge, however, the results of a blood test taken on 10 August 2004 showed a high concentration of an abnormal antibody commonly found in systemic lupus erythematosus (SLE).

7. Mrs C was re-admitted on 23 August 2004 because of heart palpitations. Her haemoglobin level was found to have fallen since her discharge and investigations showed no evidence of heart disease other than her known high blood pressure. The palpitations were felt to be a consequence of her anaemia and this was treated with blood transfusion followed by iron tablets. Following review by Doctor 1 an endoscopy was arranged and Mrs C was discharged on 1 September 2004.

8. Mrs C's symptoms continued and she was admitted to the Hospital again on 23 September 2004. A blood test revealed a very high level of carcino embryonic antigen (CEA). The measurement of CEA is used as an indicator of the possible presence of certain types of cancer. The discovery of the abnormal levels of CEA led to an abdominal CT scan. The results of the scan suggested a possible diagnosis of cancer of the stomach.

9. Mrs C was scheduled to have an endoscopy on 4 October 2004 at 11:15. She was taken to the appropriate waiting room shortly before 11:15. She remained in the waiting room until 12:40 when she was taken to the appropriate area to undergo the endoscopy. On 5 October 2004, Mrs C was told that the possible diagnosis had been confirmed by the results of the endoscopy and that the surgical team would visit her in the ward the following day.

10. Mr and Mrs C awaited the visit of the surgical team together on 6 October 2004. By 20:30 the team had not visited Mrs C and Mr C raised this with the staff nurse, who could not explain why the visit had not taken place but told Mr and Mrs C that she would ensure the surgical team visited Mrs C the following day. The nurse also commented to Mr and Mrs C that it was noted that Mrs C had had an endoscopy 18 months previously. Mr and Mrs C were puzzled by this because they could not recall Mrs C undergoing an endoscopy at that time.

11. The cancer was not amenable to surgical treatment and Mrs C was treated with chemotherapy. However, Mrs C's condition deteriorated and, sadly, she passed away in April 2005.

(a) Mrs C was misdiagnosed during two admissions at the Hospital

12. Mr C complained that Mrs C was misdiagnosed during her admissions to the Hospital in August and September 2004. He believed that the symptoms of cancer of the stomach should have been noticed and tests carried out that would have resulted in an earlier diagnosis.

13. Regarding Mrs C's first admission, her medical records indicated that her abdominal pain and weight loss were presented as a previous problem and, by implication, non-active. An examination of Mrs C showed evidence of digital ischaemia due to impaired blood supply to the fingers and evidence of fluid in the lungs consistent with a degree of heart failure. This was an ominous phenomenon that can prove fatal and was confirmed by x-ray.

14. In responding to Mr C's complaint the Board said that, following a review of the clinical management of Mrs C, their view was that all appropriate investigations had been undertaken and appropriate actions taken. The Board explained that, in their view, Mrs C's presenting symptoms at her first admission, digital ischaemia, shortness of breath and chest pain, were very

unusual in cases of cancer of the stomach. Subsequent complaints of abdominal discomfort were responded to, but no abnormalities were uncovered.

15. I sought the opinion of the Hospital Adviser on this complaint. In relation to Mrs C's first admission he told me that there was nothing in Mrs C's presentation at this admission to suggest the presence of cancer of the stomach, that the most important aspect of her presentation was the digital ischaemia and that the diagnosis reached and the actions undertaken were entirely appropriate. The Hospital Adviser also told me that he could find no reports of autoimmune vasculitis of the kind Mrs C suffered from, accompanying a diagnosis of cancer of the stomach and, as a result, concluded that the two conditions were probably unrelated. He believed it was reasonable that cancer of the stomach was not diagnosed during this admission.

16. Regarding Mrs C's second admission, her medical records showed that Mrs C's presenting symptoms were palpitations and increased shortness of breath. Following examination there were no new physical changes noted, investigations of her heart also proved normal but her anaemia had significantly deteriorated. This deterioration was felt to be the likely cause of her palpitations and was treated by a blood transfusion. A working diagnosis of probable connective tissue disease was reached. There is no record of Mrs C complaining of abdominal pain at the point of admission, although the medical records confirm that Mr C did inform the medical team on 25 August 2004 that Mrs C had been complaining of stomach pain for 'months'.

17. On the same day a discussion took place between Doctor 1 and a Senior House Officer (SHO) when it was agreed that Mrs C would undergo an endoscopy within a week if she remained in hospital and that otherwise an out-patient appointment for an endoscopy would be arranged. Another SHO indicated that it was expected that the endoscopy would take place on 30 August 2004, but this was checked with Doctor 1 who confirmed that Mrs C was not listed as being due to undergo an endoscopy that day. Doctor 1 reviewed Mrs C the following day and decided to perform the endoscopy the following week. However, the clinical team decided to discharge Mrs C on 1 September 2004 and, as a result, Doctor 1 arranged the endoscopy to be performed on Mrs C as an out-patient. A third SHO requested that this out-patient endoscopy be 'expedited to that of an in-patient'.

18. As with the first admission, in responding to Mr C's complaints about Mrs C's second admission, the Board said that, following a review of the clinical management of Mrs C, their view was that all appropriate investigations had been undertaken and appropriate actions taken.

19. In relation to Mrs C's second admission, the Hospital Adviser told me that Mrs C's presenting symptoms were appropriately investigated and her anaemia treated. There were no clinical or biochemical findings that would give reason to change the working diagnosis. However, the Hospital Adviser was concerned that the cause of Mrs C's anaemia was not investigated endoscopically. Given the circumstances, the relative uncertainty of the working diagnosis and the significant fall in haemoglobin within a short space of time in an elderly lady taking anticoagulant medications, he felt that the arrangement of the investigation lacked an appropriate degree of urgency. The Hospital Adviser believed that it was probable that, had an endoscopy been performed during this admission, cancer of the stomach would have been identified as the cause of Mrs C's anaemia. He described it as 'undesirable, but may not be regarded as unreasonable' that logistical pressures meant that the degree of urgency of the need for the endoscopy to be carried out was lost.

(a) Conclusion

20. There is clearly a difference of opinion between the Board and Mr C on what Mrs C's presenting symptoms at her first admission were. However, the medical record is clear that Mrs C's symptoms were digital ischaemia, shortness of breath and chest pain. I agree with the Hospital Adviser's view that Mrs C's presenting symptoms, as recorded, were investigated appropriately and that it was reasonable that no diagnosis of cancer of the stomach was made at her first admission.

21. In regard to Mrs C's second admission, I agree with the Hospital Adviser that her presenting symptoms were appropriately investigated and that there were no findings that would give reason to change the working diagnosis of probable connective tissue disorder. It was also appropriate that it was arranged that Mrs C should undergo an endoscopy, given the deterioration of her anaemia. Given the above, I do not uphold the complaint.

22. However, I also agree with the Hospital Adviser that the arrangement of Mrs C's endoscopy was not sufficiently urgent. This is dealt with in paragraph 59 below, in connection with Mr C's specific complaint on this issue.

(b) Mrs C was afforded poor clinical and nursing care at the Hospital

23. Mr C complained that Mrs C had been left to wait for almost one and a half hours before having an endoscopy on 4 October 2004 (see paragraph 9), that a promised visit from the surgical team was not made on 6 October 2004 and no reasonable explanation was given (see paragraph 10), that neither he nor his wife had been advised that Mrs C was suffering from Methicillin-resistant staphylococcus aureus (MRSA) during her time in the Hospital and that no test for blood was carried out on Mrs C's stools.

24. In response to Mr C's complaints about the time Mrs C had to wait away from the ward for an endoscopy, the Board explained that complications can occur in the course of a series of endoscopies being carried out and, as a result can cause delays for patients scheduled for later in any given day. The Board apologised that this had happened in Mrs C's case.

25. Mr C mentioned the issue of the promised visit from the surgical team not being made on 6 October 2004 in his initial letter of complaint to the Board, however, it was not stated as a clear and unambiguous complaint. The Board did not refer to it in their response of 6 January 2005. The issue is not referred to in the Board's minute of a meeting between Mrs C's family and clinicians held on 12 August 2005, nor in the family's subsequent letter that outlined issues discussed at the meeting.

26. I asked the Board why the promised visit had not been made. They told me that this was most likely to have been due to other clinical commitments. The Board also advised me that, in these circumstances, making surgical review visits or ensuring patients are aware that these are unlikely to be made is afforded a lower priority than the clinical referrals made to a surgical team.

27. Mr C discovered that his wife was suffering from MRSA when he noticed that her antibiotic treatment had been altered. He asked a nurse why this change had occurred and she told him it was to combat MRSA. Neither he, nor his wife, were aware that she had been suffering from MRSA.

28. In response to Mr C's complaint about this issue, the Board apologised that this had not been directly discussed with Mr C and advised him that nursing record templates had been altered to ensure that communication with relatives

of patients was highlighted and recorded. The Board provided me with a copy of the revised nursing record template.

29. Mr C was concerned that a test on Mrs C's stools had not been carried out, even though she had informed staff that they were black. This is recorded in her medical records on 16 August 2004. Mr C felt that a test for blood in Mrs C's stools would have led to an earlier referral for endoscopy.

30. In response to Mr C's complaint about this issue, the Board acknowledged his concerns and explained that, had a positive stool test been carried out, this would not have altered the timing of her referral for endoscopy. The Board further explained to me that no test was carried out as Mrs C was already scheduled to undergo an endoscopy and a positive test would not have increased the urgency of that referral.

31. I sought the opinion of the Hospital Adviser on the issue of the blood test. He told me that the value of such tests in the specific clinical circumstances would have been extremely limited due to Mrs C's anticoagulant treatment. He concluded that the Board's actions and response had been reasonable.

(b) Conclusion

32. The Board have appropriately explained and apologised for the length of time that Mrs C had to wait in the waiting area before undergoing an endoscopy. The Board have also appropriately apologised for the fact that Mrs C's suffering from MRSA had not been discussed with Mr or Mrs C and taken action to ensure this should not happen again in the future. The Board explained why a positive stool test would not have increased the urgency of Mrs C's referral for an endoscopy and, as the Hospital Adviser pointed out, the value of such tests would have been limited due to the other treatment Mrs C was undergoing. I consider that the Board's actions in relation to this issue were also reasonable.

33. Mrs C was advised that a surgical team would visit her the day after she had been told that the diagnosis of cancer of the stomach had been confirmed. This would have been an extremely stressful time for Mrs C and Mr C, and I do not consider it acceptable that Mrs C was not either visited by the surgical team as advised, or updated that the surgical team would not be able to visit her that day. The nurse who Mr C approached in the evening of 6 October 2004 should have been able to advise Mrs C that no visit was likely be made that night and

the reasons why. Given this, I partially uphold Mr C's complaint to the extent that Mrs C should have been advised on 6 October 2004 that it was unlikely that the promised visit would be able to be made.

(b) Recommendations

34. The Ombudsman recommends that the Board apologise to Mr C that Mrs C was not advised timeously that it was unlikely that the visit by the surgical team would be able to be made and that staff are reminded of the importance of keeping patients informed in these circumstances.

(c) Mrs C was not given appropriate nutritional care at the Hospital

35. Mr C complained that the Hospital had not properly monitored and responded to Mrs C's food intake and weight, that Mrs C was served unpalatable food and that foods prescribed for Mrs C were not supplied appropriately.

36. Mr C was concerned that Mrs C's food intake and weight were not monitored during her stay in the Hospital, as he felt she ate very little and lost weight during her admission.

37. In responding to this complaint, the Board accepted that Mrs C had not been weighed in accordance with policy on every admission to the Hospital. Mr C was given an apology for these errors and was told that the need for proper monitoring of a patient's weight had been reinforced to staff at the Hospital. The Board explained that a nutritional screening tool had subsequently been introduced that required a patient's weight be recorded. The Board provided me with a copy of this tool.

38. I sought the opinion of the Nursing Adviser on this issue. She told me that Mrs C's nutritional management had been poor, as the Board had acknowledged, but that their actions following Mr C's complaint had reflected national best practice standards and that the Board had undoubtedly made efforts to effect positive change.

39. During Mrs C's stay in hospital, she was unhappy with the quality of the food she was served. Mr C approached the dietician responsible for the ward Mrs C was staying in to discuss this. Mr C told me that the dietician examined the food Mrs C was being served and agreed that it was not up to standard and that some was unpalatable. The dietician attempted to resolve the issue, but it

continued. The dietician suggested to Mr C that he raise the issue formally with the General Manager of the Hospital or the Complaints Manager. After Mr C did this a meeting was arranged with an Assistant Catering Manager and some improvement took place, but Mr and Mrs C were still unhappy with the quality of food that was served to Mrs C.

40. Mr C raised this issue with his Member of the Scottish Parliament (MSP), who raised it with the Board on Mr C's behalf. The Board explained that the requirement for Mrs C to receive soft or finely-mashed foods meant that it was likely that there would have been a certain amount of repetition of meals; that some of the food Mr C had complained about had not come from the kitchens that prepared food for patients because, as a long-term care patient, Mrs C occasionally had the option of receiving meals from the Hospital's staff and public canteen and that some comments from the dietician may have referred to the fact that the natural flavours of some of the food being served to Mrs C were quite bland, and this was unfortunate at a time when their aim was to encourage Mrs C to eat, rather than a comment on the quality of that food. The Board also explained that a working group had been created to review these issues throughout the Hospital. The group had taken various actions related to the issues raised by the complaint including auditing patient nutrition and increasing the ease of identifying those patients with special dietary requirements.

41. On 18 March 2005 Mrs C was prescribed 'Yakult', a commercially-available probiotic yoghurt-like drink. These were not supplied via the Hospital until the end of March 2005 and in the meantime Mr C purchased 'Yakult' himself and supplied them to his wife.

42. Mr C also raised this complaint via his MSP (see paragraph 40). In response to this complaint, the Board explained that the supply of 'Yakult' could not be met by any of the Hospital's regular suppliers and, consequently, it took longer to receive this product than would normally be the case. The Board offered an apology to Mr C for this delay and explained that a list of contingency suppliers had been set up to ensure that there would be no further similar occurrences.

(c) Conclusion

43. In responding to Mr C's complaints, the Board accepted that Mrs C had not been weighed and monitored in accordance with their policy. They appropriately apologised to Mr C for this and explained that steps had been

taken to address this issue. I consider this to have been a reasonable response to the issue. The Board explained that their regular suppliers could not provide 'Yakults', as prescribed to Mrs C, immediately and apologised for this: they also explained the actions that had been taken to ensure that no similar instances occurred in the future. Again, my view is that this was a reasonable response to the issue. The concerns Mr C raised regarding the quality of the food Mrs C was served in the Hospital is a difficult issue to reach a conclusion on. However, the Board have taken action, a result of Mr C's complaints, to ensure that patients with special dietary needs are clearly identified and that various aspects of patient nutrition are monitored. On the balance of the evidence presented, I have concluded that this was also a reasonable response to the issues raised. Given all of the above, I do not uphold the complaint.

(d) The Hospital's record-keeping in relation to Mrs C was poor

44. Mr C developed concerns about the Hospital's record-keeping because a nurse who consulted Mrs C's records told him that they stated Mrs C had undergone an endoscopy approximately 18 months before October 2004 (see paragraph 10) and because he felt that Mrs C's stomach pains were not appropriately noted in her medical records.

45. As with the issue of the visit from the surgical team (see paragraph 25), Mr C noted his disagreement with the information the nurse had given him and his wife in his initial complaint letter to the Board but it was not clearly stated as a complaint, nor referred to in the Board's response or in Mr C's subsequent letters or record of discussions with the Board.

46. I asked the Board for their response to this issue. They told me that there is no record of Mrs C having had an endoscopy in the time period specified, nor any mention of any member of staff communicating this to her or Mr C. They explained that the passage of time since the alleged incident meant it was difficult for them to investigate or comment further, but they assured me that staff are routinely reminded of the need for accuracy in documentation and communication and offered apologies to Mr C for any additional distress caused.

47. Following a meeting with the Board, Mr C complained that his wife's stomach pain was not appropriately recorded or taken into account on her first admission to hospital.

48. The Board told Mr C that Mrs C's stomach pain had been recorded several times in her medical notes and, in their opinion, responded to appropriately.

49. Mr C was unhappy with this response and advised the Board of this. The Board acknowledged that their first reply had not given details of all the recorded instances of Mrs C's complaints of stomach pain, but maintained that their responses had been appropriate.

50. I sought the opinion of the Hospital Adviser as to whether he felt the Board's response to Mr C's complaints about the recording of his wife's stomach pain was reasonable. He told me that there were records of stomach pain in Mrs C's medical records, but that there is only one instance where this was a spontaneous complaint from Mrs C herself. From his review of the medical record he concluded the Board's response was reasonable.

(d) Conclusion

51. In regard to Mr C's concerns about the nurse's comments about Mrs C having undergone an endoscopy approximately 18 months previous to October 2004, there is no objective record of this conversation, but it is clear that there is no record of such an endoscopy in Mrs C's medical record. With regard to the recording of Mrs C's stomach pain, I agree with the Hospital Adviser that, based on the information in the medical record, the Board's response was reasonable. Given this, I do not uphold the complaint.

(e) Communication between the Hospital's staff in relation to Mrs C was poor

52. Mr C complained that Mrs C's discharge papers of 1 September 2004 were not appropriately sent to Doctor 1 (Mrs C's Consultant Gastroenterologist) and that appropriate arrangements were not made for an endoscopy, despite three doctors recommending it.

53. As noted in paragraph 7, Mrs C was discharged from her second admission on 1 September 2004. On 7 September 2004 Mr C contacted Doctor 1's office who told him that no discharge papers had been received from Mrs C's Consultant Physician and Cardiologist (Doctor 2). Mr C contacted Doctor 2's office who confirmed that no discharge papers had been sent and assured him that these would be sent later that day. Mr C considered that it was not reasonable that Mrs C's discharge papers had not been sent in this time and indicated his concern in his initial complaint to the Board. The Board

did not respond to this concern in their initial response and discussion of it was not noted in the minutes of the meetings Mr C had with the Board or the clarifying letters following this.

54. I asked the Board what their procedure was for the supply of discharge papers to other medical staff currently or previously involved in a patient's care. The Board told me that patients are routinely given an interim discharge letter to be passed to their GP: this is followed up by a formal discharge letter sent to the GP within ten days of the date of discharge. At the same time as this is sent to the GP, copies are sent to other medical staff currently or previously involved in the patient's care.

55. At the time of her first admission, Mrs C had been awaiting an appointment for an endoscopy following a referral from her GP (see paragraph 4). This referral had been vetted by Doctor 1. During Mrs C's second admission, a locum Consultant Physician (Doctor 3) reviewed Mrs C's condition. Mr C believed that Doctor 3 told Mrs C and himself that she would undergo an endoscopy on 25 August 2004, and that a Senior House Officer (Doctor 4) concurred with this. When he raised this with the Board, Doctor 1 advised Mr C that there was no evidence of this in Mrs C's medical record and that Doctor 3 had not been authorised to give a definitive date for such a procedure.

56. Mr C was concerned that Mrs C had not been referred for an endoscopy with sufficient urgency given that three physicians (her GP and Doctors 3 and 4) had recommended that she undergo this procedure.

57. In responding to Mr C's complaint, the Board acknowledged his concerns and explained the events from their point of view. They concluded that there had been little clinical evidence to point to the gastro-intestinal tract as the source of Mrs C's presenting symptoms. Following a review of Mrs C's clinical management the Board concluded that the actions taken in relation to endoscopy had been appropriate.

58. I sought the opinion of the Hospital Adviser as to whether the Board's response had been accurate and reasonable in terms of Mrs C's medical records. He told me that the accuracy of the Board's response was supported by the medical records and that the decisions taken had been reasonable at the

time but, as noted in paragraph 19 above, had, in his opinion, lacked a degree of urgency during her second admission.

(e) Conclusion

59. The Board's policy for the submission of discharge letters to other medical staff was met in regards to passing Mrs C's discharge papers to Doctor 1, therefore, I consider the Board's actions in this regard to be reasonable. Mrs C was already awaiting an appointment for an endoscopy following referral from her GP, and this was appropriately prioritised given the details of that referral. However, I do share the Hospital Adviser's view that the prioritisation of Mrs C's endoscopy following the observations made during her second admission was not adequate, although I accept that an earlier endoscopy was very unlikely to have altered the ultimate outcome in Mrs C's case. Therefore, I partially uphold the complaint to the extent that the prioritisation of Mrs C's endoscopy was not adequate following the observations made during her second admission.

(e) Recommendation

60. The Ombudsman recommends that the Board apologise to Mr C for the insufficient urgency attached to the request for Mrs C's endoscopy and audit their referral process to satisfy themselves that the urgency of a referral is clear at all times.

(f) The Board did not take appropriate action as a result of Mrs C's experience and Mr C's subsequent complaints

61. Mr C was concerned that, during the Board's investigation of his complaints, Doctor 2 asserted that if another patient presented with the symptoms Mrs C had displayed on her first admission, he would respond in the same way. Mr C believed that this meant the Board had not taken appropriate action as a result of his wife's experience or his complaints. Mr C felt that, as a result of Mrs C's experiences, a wider range of investigative tests should be carried out.

62. As part of the Board's response to Mr C's complaints, a meeting between Mr C, a close relative of his and the Board, represented by Doctor 2 and the General Manager of the Hospital, was held on 12 August 2005. It was during this meeting that Doctor 2 told Mr C that if another patient presented with the symptoms Mrs C had displayed on her first admission, he would respond in the same way. Following the meeting, the Board clarified some points raised at the

meeting, and other points raised in a letter on behalf of Mr C, and responded on 13 October 2005.

63. Further clarification was sought on behalf of Mr C, with emphasis on Doctor 2's comments that if a patient presented with the symptoms Mrs C had displayed on her first admission, he would respond in the same way.

64. The Board responded on 10 January 2006. They explained Doctor 2's view that Mrs C's presentation was very unusual and that, though lessons had been learned from Mrs C's experience, he still felt it was important that logical systematic investigations should be undertaken appropriately to avoid patients being subject to potentially intrusive and unnecessary investigations.

65. I asked the Board to clarify that the view put forward by Doctor 2 at the meeting on 12 August 2005 was an accurate representation of the Board's view on the matter. The Board told me that Doctor 2 had advised them that he had learned from Mrs C's experience but remained of the view that patients who present with a digital ischaemia should be investigated for the usual causes of arteritis. He had been aware that cancers can cause signs not directly related to the individual tumour, and accepted that Mrs C's unusual case had heightened his awareness of this. However, he believed that each case should be considered on its presentation and that it would be inappropriate to make a diagnosis, or suggested diagnosis, of cancer when this was not likely.

66. I sought the opinion of the Hospital Adviser on whether the Board's position as outlined to me was reasonable. He explained that diagnoses are made by pattern recognition of symptoms, supported by physical signs on examination, followed by specific diagnostic tests that are designed to confirm the clinical diagnosis. The symptom complex initially presented by Mrs C was in keeping with arteritis associated with connective tissue disease, and this appeared to be confirmed by the tests undertaken. It was not until the rapid fall in Mrs C's haemoglobin that the probability of gastrointestinal bleeding was raised, and this represented the first suggestion of cancer of the stomach. The Hospital Adviser told me that he knew of no recognised association between digital ischaemia, vasculitis and cancer of the stomach. As a result of these factors he concluded that the diagnostic pathway followed by Doctor 2 was in line with good practice and the Board's position was entirely reasonable.

(f) Conclusion

67. The final few months of Mrs C's life were, understandably, a difficult and distressing time for Mr C and I can understand the depth of his desire that his wife's care should be of the highest quality that it could have been, and also his desire that no other partner be given cause for the same concerns as he was. However, I agree with the Hospital Adviser that Mrs C's presenting symptoms did not suggest cancer of the stomach and that the Board's actions in responding to them was consistent with good practice and were entirely reasonable. As a result, I do not uphold the complaint.

68. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	Mr C's wife
The Hospital	Hairmyres Hospital
The Board	Lanarkshire NHS Board
The Hospital Adviser	A clinical adviser to the Ombudsman
The Nursing Adviser	A clinical adviser to the Ombudsman
GP	General Practitioner
Doctor 1	A consultant gastroenterologist
SLE	Systemic lupus erythematosus
CEA	Carcino embryonic antigen
CT scan	Computerised Tomography scan
SHO	Senior House Officer
MRSA	Methicillin-resistant staphylococcus aureus
MSP	Member of The Scottish Parliament
Doctor 2	A consultant physician and cardiologist
Doctor 3	A locum consultant physician
Doctor 4	A senior house officer

Annex 2

Glossary of terms

Anaemia	A qualitative or quantitative deficiency of haemoglobin
Anticoagulant	A substance that prevents blood from clotting
Arteritis	Inflammation of the walls of the arteries
Autoimmune vasculitis	Inflammation of the arteries caused by an autoimmune disease connective tissue disease
Carcino embryonic antigen (CEA)	A protein involved in cell adhesion
Computerised Tomography scan (CT scan)	A medical imaging method
Connective tissue disease	A disease that has the connective tissue of the body as a target of the pathology
Digital ischaemia	Lack of blood supply to the fingers
Dyspepsia	Chronic or recurrent pain centred in the upper abdomen
Endoscopy	Looking inside the body for medical reasons using an instrument called an endoscope
Haemoglobin	A molecule found in red blood cells
Iron deficiency anaemia	The most common form of anaemia, occurring when iron intake is insufficient and, consequently, haemoglobin cannot be formed

Methicillin-resistant staphylococcus aureus (MRSA)	A bacterium responsible for difficult to treat infections
Systemic lupus erythematosus (SLE)	A chronic auto-immune disease that can be fatal
Yakult	A commercially-available probiotic yoghurt-like drink