Scottish Parliament Region: Central Scotland

Case 201002075: A Medical Practice, Forth Valley NHS Board

Summary of Investigation

Category

Health: General Practice; care and treatment, complaint handling

Overview

The complainant (Mrs C) raised a number of concerns about delays and failures in the care and treatment provided to her mother (Mrs A) by a medical practice (the Practice) between November 2009 and August 2010. Mrs C was also dissatisfied with aspects of the Practice response to her complaints.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the care and treatment which the Practice provided to Mrs A between late 2009 and August 2010 was inadequate (*upheld*);

(b) the Practice did not take reasonable action in response to information provided about planned investigations of Mrs A's health (*not upheld*); and

(c) the Practice response to Mrs C's complaints was inadequate (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Practice:	*Completion date*
(i) apologise to Mrs A for their failure to reasonably assess and oversee her care and treatment in 2009 and 2010;	17 February 2012
(ii) ensure that their GP records accurately reflect and define patients' symptoms and consultants' findings as part of the on-going diagnostic process; and	17 February 2012
(iii) apologise to Mrs A and Mrs C for the failure to adequately address the complaint.	17 February 2012

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

Main Investigation Report

Introduction

1. Mrs C's mother (Mrs A) attended a medical practice (the Practice) on 28 November 2009 complaining of tingling and numbness in her hands. She attended the Practice several more times in December 2009 with the same symptoms. There were also several telephone consultations made. Symptoms were noted to be no better by the end of December 2009. In January 2010, Mrs A was referred to a hospital within NHS Lothian by the Practice and further investigations were made by an acute medicine specialist (the Doctor). A possible diagnosis of Polymyalgia Rheumatica (PMR) was suggested and a one week course of steroids was given. This treatment did not improve Mrs A's condition and after one week the steroids were discontinued. Mrs A was referred to a neurology clinic by the Doctor and a neck MRI scan was arranged to provide further information to help diagnosis. The neck MRI scan was done on 15 February 2010 and reported on 22 February 2010. The Doctor wrote to the Practice on 3 March 2010 and advised that a further MRI and/or other neck imaging and a referral to neurology were needed and she was in the process of making arrangements for these to be carried out. Mrs A continued to attend appointments at the Practice and seek further help for her ongoing pain and numbness throughout this period.

2. The Doctor spoke with a senior member of neurology staff by telephone in mid-March 2010. The advice she received was that the changes on the MRI scan were mild and it would be sufficient to see Mrs A as an out-patient, as a further neck MRI and/or other neck imaging would not be necessary. The Doctor made this out-patient referral and Mrs A was seen by a neurosurgeon (the Neurosurgeon) on 28 April 2010. The Neurosurgeon diagnosed carpal tunnel syndrome and contacted the Doctor and the Practice on 28 April 2010 notifying them of his suggested diagnosis and his intention to carry out further tests. These tests were carried out on 8 June 2010. The Neurosurgeon wrote to the Practice on 23 June 2010 and advised that the results showed carpal tunnel syndrome in Mrs A's right arm and that her left arm was normal. The plan was to operate on Mrs A's right arm as soon as possible. Again, Mrs A had continued to seek help from the Practice at appointments and via telephone consultations during this time (see paragraph 3).

3. Mrs A had a number of falls at home, had to call NHS 24 services on a number of occasions for help and was reviewed in the hospital emergency

department. Mrs A also attended an orthopaedic appointment in April 2010 and was due to have a hip replacement operation in May 2010. This was cancelled, in part because of concerns about her possible neurological problems. The orthopaedic surgeon wrote to the Practice on 24 May 2010 and advised that he felt Mrs A required a neurological review and asked the Practice to arrange this (the orthopaedic surgeon noted he was aware of the diagnosis made by the Neurosurgeon).

4. Around this time there was confusion about a neurology appointment which Mrs A cancelled as she was being seen by the Neurosurgeon. In fact the neurosurgery and neurology referrals were separate issues and there were two distinct referrals made for her, however, this was not explained to Mrs A at any time. The Practice re-referred Mrs A on 7 July 2010 for a routine neurology appointment.

5. Mrs A was admitted for surgery on 30 July 2010 but this was cancelled by the Neurosurgeon due to the lack of mobility in Mrs A's right arm. The Neurosurgeon wrote to the Practice on 5 August 2010 and advised that there was clearly another problem beyond carpal tunnel syndrome and asked the Practice to make a neurology referral to investigate possible causes. Mrs C contacted the Practice on 2 August 2010 and requested a home visit, as she was extremely anxious about Mrs A's deteriorating health and mobility. Mrs C spoke with the Practice again on 3 August 2010 and advised them of the most recent issues and of Mrs A's declining health. During this discussion Mrs C expressed her dismay that the neurology referral made in July 2010 had only been a routine one and, following discussion of possible options, the Practice arranged to have Mrs A admitted to hospital for immediate investigations. On 11 August 2010 Mrs A was transferred to a specialist neurology unit and was diagnosed with cervical myelopathy and an operation was carried out to relieve the symptoms on 17 August 2010. Mrs A was also re-referred to the Neurosurgeon for carpal tunnel surgery on her right arm in February 2010 and this was undertaken in March 2010.

6. Mrs C complained to the Practice on 9 August 2010. She complained that there had been a lengthy delay in diagnosing and treating Mrs A's condition and stated that she felt this was due to inaction on the part of doctors in the Practice who had ignored Mrs A's requests for help; failed to follow up on test results and planned tests; and failed to react to the obvious severe deterioration in Mrs A's health. The Practice responded on 9 September 2010. Mrs C was not satisfied

with the response, as she felt the Practice were avoiding any responsibility for Mrs A's health care and had been inaccurate in a number of the responses they had made to her complaint.

7. The complaints from Mrs C which I have investigated are that:

(a) the care and treatment which the Practice provided to Mrs A between late 2009 and August 2010 was inadequate;

(b) the Practice did not take reasonable action in response to information provided about planned investigations of Mrs A's health; and

(c) the Practice response to Mrs C's complaints was inadequate.

Investigation

8. In her investigation into this complaint, my complaints reviewer obtained and examined Mrs A's clinical records relevant to this complaint (the Records) and the complaint correspondence from the Practice. My complaints reviewer sought advice from one of my professional advisers, a General Practitioner (the Adviser). My complaints reviewer also discussed the case with the Adviser and spoke with Mrs C and Mrs A by telephone on a number of occasions.

9. The investigation of this complaint also required my complaints reviewer to consider responses to complaints about the hospital care and treatment provided to Mrs A by the Doctor and a Neurosurgeon. These complaints were facilitated by the Practice on behalf of Mrs A and were responded to by the Doctor and NHS Lothian respectively. This report does not include any investigation of those complaints by my staff. However, reference is made to these responses, as they held information relevant to aspects of some of the issues addressed in this report.

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

(a) The care and treatment which the Practice provided to Mrs A between late 2009 and August 2010 was inadequate

11. Mrs C complained about a number of aspects of the care and treatment provided to Mrs A by the Practice. Mrs C stated that, on a number of occasions, the Practice had failed to respond appropriately to the ongoing rapid deterioration of Mrs A's medical condition and failed to make home visits when Mrs A was unable to attend surgery because of her condition. In particular,

Mrs C stated that the Practice sent Mrs C for an unnecessary chest x-ray in January 2010; failed to follow up on a referral to Occupational Therapy; failed to make a timely referral to neurology on more than one occasion; and that Mrs A's GP records did not contain sufficient detail.

12. The Adviser reviewed the Records and made a number of comments in relation to the care and treatment provided by the Practice. He stated that the referral for a chest x-ray in January 2010 was reasonable, as Mrs A was noted to be a cigarette smoker and her symptoms could have indicated possible lung cancer that was not unreasonable to seek to exclude. However, the Adviser noted that after the initial decision to refer to neurology had been taken by the Doctor in January 2010, there were a number of requests to the Practice to ensure neurological follow-up dating back to March 2010 which were not acted upon until July 2010, creating a significant delay. There was also a further indication in March 2010 from the out-of-hours service and from orthopaedics in May 2010 that such a review was still needed and both of these should have prompted the Practice to take immediate steps to follow up. The Adviser stated that although the Practice was aware of Mrs A's deteriorating condition on 30 June 2010 (it was noted in the Records she had a shuffling gait, was dragging her feet and tipping forward), it took seven days for them to make a non-urgent referral to neurology on 6 July 2010. Similarly the Adviser commented that no consideration was given to admitting Mrs A to hospital following a home visit on 14 July 2010, when a clear and further deterioration was noted (Mrs A had fallen the previous night). The Adviser was critical of the level of examination recorded for this visit and throughout Mrs A's GP appointments. For example, there was no apparent assessment of her neurological symptoms, the power in her limbs or reflex patterns – all of which the Adviser considered would have been good practice, in view of Mrs A's symptoms.

13. The Adviser recognised the role of the Doctor and the Neurosurgeon in making diagnoses which clouded the overall picture of Mrs A's condition. However, the Adviser concluded that in his view the Practice had failed to recognise the link between Mrs A's neck MRI result and her progressive symptoms and delayed in acting on the concerns raised by several specialists. The Adviser stated that this made the Practice's clinical conclusions and actions deficient.

14. According to the Adviser, the Records were incomplete in a number of respects: for example, Mrs A's neurological symptoms were not clearly defined and the progression of symptoms was sometimes unclear; no scoring systems were used to measure power in limbs; and key examination findings such as reflex patterns were absent. This contrasted with the assessments made by the Doctor where, at an early stage, weakness of the deltoid muscles on both sides was noted. This finding was not noted by the Practice nor was there evidence that this clinical sign was sought in the GP assessments. This is important, as such a finding would not be consistent with CTS.

15. The Adviser also stated that on 10 March 2010 the Records indicated that a referral to Occupational Therapy was needed and later noted as to be chased up, however, the Records contained no actual referral or reference to any subsequent chase-up.

(a) Conclusion

16. The Adviser stated that there was a failure to undertake timely follow-up on planned interventions; a failure to draw together and reflect on all the concerns and evidence being presented in Mrs A's case; and a failure to adequately recognise and assess Mrs A's progressive symptoms. The Records also suggested that there were delays in acting on an overall deteriorating clinical picture. Taking all these factors into account, I conclude that the care and treatment provided by the Practice was inadequate and I uphold this aspect of the complaint.

(a) Recommendations

17. I recommend that the Practice:	*Completion date*
(i) apologise to Mrs A for their failure to reasonably assess and oversee her care and treatment in 2009 and 2010; and	17 February 2012
(ii) ensure that their GP records accurately reflect and define patients' symptoms and consultants' findings as part of their on-going diagnostic process.	17 February 2012

(b) The Practice did not take reasonable action in response to information provided about planned investigations of Mrs A's health

18. Mrs C complained that the Practice failed to take reasonable action following the report of Mrs A's MRI, which they received in February 2010, and

failed to follow up on the action planned by the Doctor to arrange further imaging (see paragraph 1).

19. The Adviser noted that with hindsight that the results of the neck MRI performed in February 2010 showed evidence of the compression of the spinal cord which was causing some of Mrs A's pain and movement difficulties. However, the Adviser noted that it was reasonable for the Practice to accept the views of the Doctor and the Neurosurgeon Mrs A consulted at the hospital, as to the significance of these results and how this should be progressed. The Practice would have had very little input into this process of review and once the Doctor had referred Mrs A on to Neurosurgery (as specialists in this field), it was appropriate for the Practice to follow their joint plan. The Adviser stated that the Practice was not responsible for the immediate investigation after the scan in February 2010. However, the Adviser repeated his concerns expressed in complaint (a) that the Practice had not acted on the results of the scan at a later date when Mrs A's condition continued to deteriorate (see paragraphs 12 and 16).

(b) Conclusion

20. I have taken account of the Adviser's considerations and I am satisfied that the Practice acted reasonably in accepting the review and planned course of action set out by the Doctor and the Neurosurgeon.

21. The Adviser has explained that interpretation of scans is a specialist field and a GP would not be expected to undertake this work or question the planned course of action following this scan when it had been reviewed by the Doctor and neurosurgical specialists at the hospital (see paragraph 19). For all these reasons, I do not uphold this aspect of the complaint.

(c) The Practice response to Mrs C's complaints was inadequate

22. Mrs C complained that the response provided to her by the Practice was inadequate. She stated that the response avoided answering a number of her concerns and answered others inaccurately. Mrs C was also concerned that the Practice appeared to hold the view that they had no responsibility for Mrs A's ongoing diagnosis and treatment once she was being seen by consultants at the hospital. Mrs C felt that the Practice was responsible for Mrs A's overall care and treatment and, in particular, for ensuring that planned investigations and other referrals went ahead.

23. The Adviser reviewed the Practice response for technical accuracy. He noted that on most occasions the comments in the Practice response were consistent with the Records, however this was not always the case. The Adviser also stated his concern about the quality of the record-keeping in Mrs A's medical records, as this did not always contain sufficient detail to make any useful comment possible (see complaint (a)). The Adviser was particularly critical of the view expressed by the Practice in their response that 'once you [Mrs A] were referred to a consultant at the hospital it is their responsibility for your treatment', which the Adviser considered was inaccurate. The Adviser stated that, while it subsequently transpired that specialist opinions had led to an erroneous diagnosis being made, this did not absolve the Practice from its duty of care to act on behalf of Mrs A as her advocate and ensure continuity of care. He said that if questions arise, it is the GP's function to question on behalf of the patient. While a GP will usually defer to specialist opinion, this does not mean a GP should suspend their own clinical view, especially in the face of progressive symptoms, or where the clinical picture is at odds with the known facts.

24. The Practice response also outlined that they did not seek to excuse how Mrs A felt about her experience with the Practice and noted that her complaint would be used as a learning point for the Practice in considering how it can be that patients are the last to know the details of their own care.

(c) Conclusion

25. The Adviser has told me that the Practice response did not contain sufficient levels of detail and accuracy, at least in part because of the quality of the Records. The Adviser has also expressed the view that the response sought to transfer too much responsibility elsewhere - to the process of consultant referral. For these reasons, I uphold this aspect of the complaint.

26. I note that the Practice have reflected already on the impact of Mrs A's care pathway and the broader learning from this complaint for other patients. However, I believe that further reflection by the Practice would be useful in light of the Adviser's comments outlined above.

(c) Recommendation

27. I recommend that the Practice:	*Completion date*
(i) apologise to Mrs A and Mrs C for the failure to	17 February 2012

adequately address the complaint.

28. The Practice have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Practice notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mrs A	The aggrieved, Mrs C's mother
The Practice	Mrs A's GP Practice in Central Scotland until August 2010
The Doctor	The acute medicine specialist doctor within an NHS Lothian hospital
The Neurosurgeon	The neurosurgeon within an NHS Lothian hospital who reviewed Mrs A between April 2010 and July 2010
The Records	Mrs A's clinical records
The Adviser	The professional medical adviser to the Ombudsman

Glossary of terms

Term	Definition
Carpal Tunnel Syndrome	Pressure on the nerves of the wrist which leads to numbness, tingling, weakness, or muscle damage in the hand and fingers
Cervical Myelopathy	Pressure on an area of the lower spinal cord which causes loss of function in the arms and legs
Deltoid muscle	The muscle forming the rounded contour of the shoulder
Magnetic resonance imaging (MRI) scan	Provides detailed internal pictures of body organs and structures
Polymyalgia Rheumatica (PMR)	An inflammation of the muscles which causes severe pain in the affected area