SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: North East Scotland

Case 201302928: A Medical Practice in the Tayside NHS Board Area

Summary of Investigation

Category

Health: Family Health Service; General Practice; clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment provided to her by her medical practice (the Practice) since the beginning of 2012. Mrs C believed that the doctor treating her failed to acknowledge or deal with the symptoms she was displaying and that the doctor failed to recognise a general decline in her health. As a result she was not referred timeously for specialist assessment. Mrs C was subsequently diagnosed with bowel cancer and she believes that earlier referral would have avoided the need for the emergency surgery she was required to undergo.

Specific complaints and conclusions

The complaints which have been investigated are that the Practice:

(a) provided inadequate care and treatment (*upheld*); and

(b) unreasonably failed to make the appropriate referrals (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Practice:	*Completion date*
(i) ensure that the doctor responsible for Mrs C's treatment reflects on their practice in relation to these events and discusses any learning points at their next appraisal;	9 December 2014
(ii) review with the doctor involved in Mrs C's care the SIGN guideline 126;	25 November 2014
(iii) review the General Medical Council guidance on record-keeping and evaluate a sample of their case notes to see that they are fulfilling the required standards;	9 January 2015
(iv) apologise in writing for the failures identified in this report.	25 November 2014

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

Main Investigation Report

Introduction

1. Mrs C was 46 years old in 2012. She was known to have anaemia (a deficiency of iron in the blood), which was first recorded in her medical notes in 2009. During 2011 Mrs C attended (the Practice) for a number of complaints including pain in her abdomen and legs. Mrs C was prescribed medication for her anaemia, which was described as mild and underwent other investigations including blood tests and a test of her thyroid activity.

2. In 2012 Mrs C attended the Practice on a number of occasions, with a variety of different symptoms and she was diagnosed with Irritable Bowel Syndrome (IBS) on 3 August 2012. Medication was prescribed to alleviate the symptoms of this condition. Mrs C's IBS was noted to have worsened considerably by 6 November 2012 and alternative medication was prescribed. Mrs C returned to the Practice on 21 November 2012 with worsening rectal pain and frequent bleeding.

3. Mrs C requested a referral to gastroenterology, which was made by her doctor. It was not made as an urgent referral, however, and when Mrs C's symptoms deteriorated the Practice subsequently attempted to expedite this referral. Mrs C was diagnosed with an obstructive tumour in her bowel and admitted for surgery on 21 December 2012. She underwent stenting and was discharged on 25 December 2012. Mrs C was readmitted on 1 January 2013 with increasing abdominal pain, subsequent investigations revealed a perforated bowel. Mrs C underwent an urgent operation on the evening of 3 January 2013 when an ileostomy was performed. She was discharged from the High Dependency Unit on 7 January 2013. The ileostomy was successfully reversed in July 2013.

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

(a) provided inadequate care and treatment; and

(b) unreasonably failed to make appropriate referrals.

Investigation

5. In this investigation all the information provided by Mrs C and by the Practice has been given careful consideration. This included all the complaints correspondence, as well as Mrs C's relevant medical records. An independent

clinical opinion was obtained from a General Practice specialist adviser (the Adviser) and this too was taken into account.

6. 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 Practice provided inadequate care and treatment

7. Mrs C complained to the Practice by letter on 7 May 2013. Mrs C said that she believed symptoms of bowel cancer had been apparent since the beginning of 2012. She felt that the severity of her symptoms had been ignored by the Practice, as had a visible decline in her general state of health. Mrs C said that she had been suffering from severe pain, weight loss, extreme tiredness and rectal bleeding.

8. Mrs C said that despite these symptoms, her concerns were dismissed, and she was told she was suffering from IBS, a relatively minor ailment. Mrs C said that even when the symptomatic treatment she was prescribed failed, she was told that her condition was not serious and that she should not worry. Mrs C said that she was made to feel that her concerns were unfounded and that she was an irritant to the Practice.

9. Mrs C said she wished to know why the Practice had only considered IBS as the cause of her symptoms, without carrying out any other appropriate investigations. She also said that she had been forced to request the appropriate examinations be carried out by the Practice, despite the symptoms of severe pain and bleeding she was experiencing.

The Practice's Comments

10. The Practice responded to the letter of complaint on 30 May 2013. Their letter contained a summarised chronology of Mrs C's appointments with the Practice, beginning with the diagnosis of mild anaemia in 2009. The Practice noted that in 2011 Mrs C attended with complaints of upper abdominal pain and stress, as well as a lump under her arm and pain and cramping in her legs and shoulders. The Practice noted that mild anaemia was again recorded in 2011 and Sytron was prescribed, as well as a lower than normal Vitamin D level, for which Calceos was prescribed. Additionally in September 2011 blood tests returned normal results, and Mrs C was tested for thyroid function and inflammation.

11. The Practice said that in March 2012 Mrs C attended complaining of hair loss and hand pain. She was referred for x-ray of the hand, but this was returned as normal. The Practice said that Mrs C was also tested for thyroid activity at this appointment and was found to be mildly hypothyroid. Mrs C was prescribed the appropriate medication and referred to dermatology for her hair loss.

12. The Practice said the first mention of bowel issues was on 3 August 2012, when IBS was recorded in Mrs C's notes. The Practice said this diagnosis would have been made on a presentation of abdominal cramps an nausea and medication was prescribed to treat both of these symptoms as well as medication to ease discomfort around the back passage. The Practice said there was no specific test for IBS and diagnosis was made on the basis of a clinical assessment of the symptoms present. The Practice said that at this appointment Mrs C's weight was recorded as 59 kilogrammes (when weighed at the rheumatology clinic a few days previously), whereas previously it had been recorded as 53 kilogrammes. The Practice also said she did not report any rectal bleeding at this appointment. This combination of symptoms, combined with her relatively young age, did not suggest a more serious diagnosis.

13. The Practice said at Mrs C's next appointment on 23 August 2012 she had said her symptoms had improved markedly. This suggested the medication provided to counteract the IBS had been effective, supporting their diagnosis. The Practice noted there was no further mention of IBS until 6 November 2012, when it was recorded as 'very bad' in Mrs C's notes. She was given alternative medication to try and referred to a dietician for an assessment of dietary triggers. The Practice said Mrs C returned on 21 November 2012, reporting her abdominal pain had improved, but she had frequent bowel movements and worsening pain, combined with bleeding during the previous week.

14. The Practice said Mrs C had referred to a possible anal fissure at this appointment and she was appropriately examined to establish if this was the cause of the bleeding she was experiencing. The Practice said Mrs C's doctor clearly recalled explaining that as rectal bleeding was not a symptom of IBS a referral to gastroenterology would be appropriate, and this was duly made.

15. The Practice said this was not an urgent referral as a cancer diagnosis was not suspected. The combination of Mrs C's symptoms, coupled with her

consistent weight over the period of her symptoms did not suggest to her doctor that cancer was likely and it was thought Mrs C had internal piles or some form of inflammatory bowel disease. The Practice noted that her initial referral was triaged by a consultant who converted it into request for a routine colonoscopy.

Advice Received

16. The Adviser said he noted Mrs C was known to have anaemia and that in September and November 2012 this had dropped significantly to 10.7 to 10.2 grams per decilitre (g/dl), when a normal level would be about 12.5 g/dl or above. The Adviser said that once the blood count was seen to be dropping and not coming back up, combined with Mrs C's reported abdominal pain and associated symptoms, it would have been reasonable to expect her doctor to consider the possibility that the anaemia was related to problems within her gut.

17. The Adviser said the Scottish Intercollegiate Guidance Network (SIGN) guideline 126, advises that in patients over the age of 40, bowel problems should be considered as a possible cause of iron deficiency anaemia. The Adviser noted that Mrs C was 46 in 2012 and this guideline should, therefore, have influenced the Practice's treatment of Mrs C. The Adviser said an important reason for iron deficient anaemia is blood loss, as the body's iron stores are used up quickly forming new blood cells, as they are lost (often unknowingly) through the gut. Although there could be many sources of blood loss within the gut, such as a bleeding ulcer, diverticulitis or polyps, the Adviser said bowel cancer should be excluded as a priority.

18. The Adviser also noted that SIGN (126) lists rectal bleeding (including new bleeding) as a strong indicator of bowel cancer. The guidelines also listed other red flag symptoms suggestive of bowel cancer, including a change in bowel habit, such as alternating constipation and diarrhoea. Whilst the Adviser accepted this could have been difficult to quantify in Mrs C's case due to her history of IBS, he felt the collective weight of her symptoms, including severe rectal pain, rectal bleeding, iron deficiency anaemia and an alternating bowel habit should have prompted a concern about bowel cancer.

19. The Adviser said that for the last three years GP's in Scotland have been encouraged to pursue an early diagnosis of cancer. Even in the event that the GP considers it unlikely that the patient will have cancer as a cause for their symptoms, if there are alarm symptoms, over the suggested age (40 in this case), the assumption must be that it is cancer until proven otherwise. The

Adviser said in the circumstances, he had to conclude that Mrs C should have been urgently referred as a possible case of bowel cancer. The Adviser felt that it would have been appropriate for Mrs C to have been referred on 4 September 2012, following a recorded blood count of 10.7g/dl combined with Mrs C informing the practice nurse and her doctor that she had a number of stomach symptoms, which were much worse than previously.

20. The Adviser said while Mrs C's doctor considered her symptoms to be suggestive of IBS from 3 August 2012 onwards, this should have only been considered as a diagnosis of exclusion. The Adviser said it was only safe to assume a patient with these symptoms was suffering from IBS if other more dangerous conditions had been excluded.

(a) Conclusion

21. The advice I have received is that Mrs C's symptoms should have been treated as possible bowel cancer, until proved otherwise. The alarm symptoms of a change in bowel habit, severe rectal pain, rectal bleeding and an iron deficiency anaemia were not responded to in line with the relevant SIGN guidance. This failure led to a delay in the diagnosis of Mrs C's bowel cancer. In view of these failings, I uphold this complaint.

(a) Recommendations

22. I recommend that the Practice:	*Completion date*
(i) ensure that the doctor responsible for Mrs C's treatment reflects on their practice in relation to these events and discuss any learning points at their next appraisal; and	9 December 2014
(ii) review with the doctor involved in Mrs C's care the SIGN guideline 126.	25 November 2014

(b) The Practice unreasonably failed to make the appropriate referrals

23. Mrs C said that the symptomatic treatments she had been prescribed had all failed and she had repeatedly asked to be referred for a specialist opinion. She said she was told that her condition was not serious and that a referral would make no difference as they would reach the same conclusions as the Practice. Mrs C said she was made to feel throughout this process that she was complaining unnecessarily. Mrs C also said that when she was referred, the referral was not made as an urgent one, leading to further delay.

The Practice's Response

24. The Practice said Mrs C was referred to rheumatology in May 2012 after complaining of pain in her foot and that it had not been necessary or appropriate to refer her up to this point. Prior to that referral, Mrs C had been investigated for pain in her hand, but an x-ray had revealed nothing of note, and her blood tests had not indicated inflammation. As she then complained of a second area causing her pain and discomfort, the Practice felt that referral was warranted at this stage. When Mrs C was reviewed in July 2012 the x-ray showed normal results, but an ultrasound suggested some inflammatory changes.

25. The Practice said Mrs C's first presentation with bowel problems had been in August 2012. The Practice set out the chronology of her consultations and said they did not believe Mrs C's symptoms were suggestive of a more serious diagnosis. The Practice said that on 6 November 2012 Mrs C's IBS symptoms were noted to be 'very bad' and she was appropriately referred to a dietician at this point.

26. The Practice said Mrs C was next seen on 21 November 2012 and reported a worsening of her symptoms, which now included rectal bleeding. The Practice said the doctor's recollection was that they told Mrs C this was not a normal symptom of IBS and that they would, therefore, refer her to gastroenterology, which was done. The doctor had not made an urgent referral, as they did not consider Mrs C's combination of symptoms warranted it.

27. The Practice said Mrs C's referral was subsequently triaged by a consultant who converted it into a request for a routine colonoscopy. The Practice had then contacted Tayside NHS Board on Mrs C's behalf in order to expedite this referral process when her symptoms deteriorated.

Advice Received

28. The Adviser said in his view an urgent referral for closer examination of Mrs C's bowel problems could reasonably have been made in September 2012. Mrs C's blood count had dropped significantly and she had told a practice nurse and the doctor that she was experiencing a significant number of stomach symptoms which were worse than before.

29. The Adviser said it was not possible to ascertain if Mrs C had requested a referral. He said that the overall quality of the clinical records were poor and

they had to be considered an unreliable source, however, it was not possible to rely solely on the letters provided by Mrs C, as they could not be considered a contemporaneous record of her consultations. The Adviser said that the medical record lacked detail and did not include the doctor's clinical findings. In his view they did not comply with General Medical Council (GMC) guidance on medical records.

(b) Conclusion

30. The advice I have received is that an urgent referral should have been made in September 2012. The Practice record shows that Mrs C was not referred until November 2012 and that the referral that was then made was not urgent. I have also noted the Adviser's comments on the inadequacy of the notes.

31. I uphold this complaint

(b) Recommendations

32. I recommend that the Practice:	*Completion date*
(i) review the GMC Guidance on record-keeping and evaluate a sample of their case notes to see that they are fulfilling the required standards; and	29 January 2015
(ii) apologise in writing for the failures identified in this report.	25 November 2014

33. 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
the Practice	A Medical Practice in the Tayside NHS Area
IBS	Irritable Bowel Syndrome
the Adviser	a specialist adviser on General Practice Medicine
SIGN	Scottish Intercollegiate Guidance Network
g/dl	grams per decilitre
GMC	General Medical Council

Annex 2

Glossary of terms

abdomen	stomach, includes the entire area between the chest and pelvis
anaemia	a lowered amount of red blood cells, reducing the ability of the blood to carry oxygen
calceos	a calcium and vitamin D supplement
colonoscopy	examination of the bowel with a camera on a flexible tube
diverticulitis	inflammation of the lining of the intestine
gastroenterology	medical specialism focussed on the digestive system
General Medical Council (GMC)	the regulatory body for doctors and registrar for doctor's practices
g/dl	grams per decilitre, a measurement of red blood cells
hypothyroid	a medical condition in which the thyroid gland is underactive, causing tiredness, constipation, aches and weight gain
ileostomy	a surgical opening in the skin, which brings a loop of the small intestine, allowing waste to be passed to an external artificial pouch adhered to the skin
Irritable Bowel Syndrome	a functional disorder of the bowel, diagnosed by symptoms

obstructive tumour	abnormal growth of tissue, blocking the function of an internal organ
polyps	small growths on the lining of the intestine
rectum	the final straight portion of the large intestine, which terminates in the anus
theumatology	medical specialism relating to arthritis and other problems relating to joints, soft tissues and connective tissue disorders
stenting	insertion of a mesh tube into a natural passage within the body, to prevent its blockage or constriction through disease
sytron	a medicated form of iron, used to treat anaemia
thyroid	gland that controls the body's use of energy and sensitivity to hormones
x-ray	medical imaging technique using radiation to view the internal structure of the human body

Annex 3

List of legislation and policies considered

http://www.gmc-uk.org/guidance/good_medical_practice/record_work.asp

http://www.sign.ac.uk/pdf/sign126.pdf

http://www.scotland.gov.uk/News/Releases/2011/02/detectcancerearly