Scottish Parliament Region: Highlands and Islands

Case 200600377: Highland NHS Board

Summary of Investigation

Category

Health: Hospital; Surgery

Overview

The complainant (Mr C) raised a number of concerns in respect of the treatment provided to his wife by a consultant surgeon (Consultant 1) prior to her death on 11 April 2005. Additionally, he has stated that both he and his wife were not given a clear picture of her condition and the options for treatment available to her.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Consultant 1 did not fully consider the surgical options, including seeking opinions of specialists where necessary *(not upheld)*; and

(b) the communication from Consultant 1 was unacceptable *(upheld)*.

Redress and recommendations

The Ombudsman recommends that Highland NHS Board (the Board):

(i) apologise to Mr C for the failure to effectively communicate with both him and his wife;

(ii) consider using the events of this complaint to inform practise in communicating with patients, particularly when a number of different specialists are involved in care. This consideration should include both communication with patients and family and the recording of such communication in the clinical records; and

(iii) review their procedures to ensure that all responses provided by them, or on their behalf, to complainants are factually accurate.

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

Main Investigation Report

Introduction

1. On 10 August 2005 a gentleman (Mr C) raised a formal complaint with Highland NHS Board (the Board) about aspects of the clinical care provided to his wife (Mrs C) by a consultant surgeon (Consultant 1) at the Belford Hospital (the Hospital) in Fort William. In an attempt to resolve matters, and after some communication between Mr C and the Board, it was suggested that conciliation should be used to help both parties come to an agreement about the circumstances behind Mr C's complaint. Unfortunately the conciliation was unsuccessful.

2. As a result of the failure of the conciliation, on 8 May 2006, the Scottish Public Services Ombudsman office received a complaint from Mr C in respect of the clinical treatment provided to Mrs C by Consultant 1. Additionally, Mr C was concerned that Consultant 1 had failed to explain the options available in the treatment of Mrs C's condition. After lengthy treatment Mrs C had died on 11 April 2005.

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

(a) Consultant 1 did not fully consider the surgical options, including seeking opinions of specialists where necessary; and

(b) the communication from Consultant 1 was unacceptable.

Investigation

4. I have obtained the clinical records in respect of this case as well as the complaints files held by the Board. I have met with Mr C and his Member of the Scottish Parliament (MSP) to discuss the complaint and to ensure that I was fully aware of his views and concerns. I have also sought clinical advice from our independent clinical adviser (the Adviser). I have set out, for each of the headings of Mr C's complaint, my findings of fact and conclusions.

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

6. (a) Consultant 1 did not fully consider the surgical options, including seeking opinions of specialists where necessary

7. Mrs C had a history of hypertension, hypothyroidism, hypercholesterolaemia and atrial fibrillation. Following further atrial fibrillation and severe brachycardia a permanent pacemaker was fitted in May 2004. During this period Mrs C also presented with signs of recurring abdominal pain, diarrhoea, nausea and weight loss. As a result of this Consultant 1, then consultant surgeon at the Hospital, arranged for Mrs C to undergo a barium enema. This identified that she was suffering from a long tight stricture of the sigmoid colon.

8. It was then decided that a flexible sigmoidoscopy should be carried out. This showed a tight, non-negotiable stricture but no obvious mass. There then followed a CT scan of the abdomen. The findings were suggestive of a probable sigmoid diverticular abscess causing left utereric obstruction. After surgical review Mrs C was discharged home to be followed-up at the surgical out-patient clinic.

9. On 2 August 2004 Consultant 1 saw Mrs C and Mr C at his out-patient clinic. He noted that Mrs C was opening her bowels without difficulty and that her appetite had returned. In his response of 7 April 2006 to the subsequent complaint, Consultant 1 has stated that he advised Mrs C and Mr C at that time that he believed the likely diagnosis was that Mrs C was suffering from a diverticular stricture. He considered that because of the increased risks associated with a patient with a pacemaker, hypothyroidism, hypertension and hypercholesterolaemia, he was not inclined to operate on her. This view is reflected in the clinical records.

10. Mr C's recollection of this consultation is very much at odds with the picture presented by Consultant 1. Mr C considers that he recalls clearly what was discussed at this consultation. He has stated that Consultant 1 told them both clearly that Mrs C did not have cancer, she had diverticulitis. He contends that there was never any mention of Mrs C's other conditions making her an unsuitable candidate for surgery nor was the possibility of an operation even mentioned. Mr C recalls that he left the consultation cheered with the news that Mrs C did not have cancer. He also recalls being told by Consultant 1 that he had just given them great news and yet Mrs C was not smiling. Mr C has stated that his wife replied that she knew she did not have cancer but knew that there was something far wrong.

11. Mrs C was again reviewed by Consultant 1 on 30 August 2004 when referred by her General Practitioner (GP). This referral was made because the GP had concerns that Mrs C's appetite was becoming poor, she was continuing to lose weight and her bowel movements had decreased.

12. On 18 September 2004 Mrs C was admitted to the Surgical Ward at the Hospital after an emergency referral by the local out-of-hours GP. This doctor also requested that she be sent by emergency ambulance as she was feeling unwell, was in significant pain and had experienced further weight loss. On 24 September 2004 she was transferred to a rehabilitation ward and her condition improved. It was considered that she was well enough for discharge on 21 October 2004.

13. Consultant 1 reviewed Mrs C at his clinic on 6 December 2004. On 21 March 2005 Mrs C had an emergency admission to the Hospital suffering from increased breathlessness and weakness. She was reviewed by both Consultant 1 and another consultant surgeon, Consultant 2, and both were of the opinion that because of her other problems, Mrs C was not a suitable candidate for major surgery. Her condition deteriorated over the following days and sadly, she died on 11 April 2005.

14. On 10 August 2005 Mr C wrote to the Board to raise a formal complaint that he had not been informed of the seriousness of Mrs C's condition until just a few days before her death and also that she had not been given the opportunity of an operation earlier when she was stronger.

15. The Board responded to Mr C's complaint and, as a result of this, there was a period of independent mediation. This mediation was unsuccessful and, as Mr C remained unhappy with the outcome, he raised a complaint with the Ombudsman's office on 8 May 2006.

16. Mr C believes that Consultant 1 never considered operating on Mrs C at an early stage. He believes that had a decision to operate been taken quickly, before Mrs C's condition deteriorated, there would have been a chance of successful surgical intervention. As it was, Mr C believes that Consultant 1 decided incorrectly to treat Mrs C conservatively until a time when Mrs C's condition had deteriorated to such an extent that an operation would not have

been possible. He feels that Mrs C's condition was clearly and significantly deteriorating over the period in question.

17. Mr C considers that this view is supported by information he has obtained since raising a complaint with the Board. Mr C and his MSP have obtained the clinical records and have reviewed correspondence held within the records.

18. The records show that on 2 July 2004 Mrs C was admitted to the Hospital. A diagnosis of stricture of the sigmoid colon had previously been made after a barium enema and at this admission she underwent a flexible sigmoidoscopic examination carried out by Consultant 1. This showed a tight non-negotiable stricture with no obvious mass. The Adviser has pointed out that it was impossible to tell at that time whether or not the stricture and abscess were due to malignancy or due to diverticular disease.

19. During the admission Mrs C was reviewed (in Consultant 1's absence) by another consultant surgeon (Consultant 3). As Mrs C had improved medically during the admission, Consultant 3 recorded in the case notes 'no pains, bowels opening, wishes to go home for the present, ... This lady has a severe sigmoid stricture ? diverticular ?? Ca (cancer) with localised abscess formation ... I feel she needs sigmoid colectomy sooner rather than later ...'

20. It is clear that at that stage the planned treatment was operative. However, when Mrs C was reviewed three weeks later in Consultant 1's clinic on 2 August 2004 Consultant 1 was of the opinion that her medical condition had improved. Consultant 1 wrote in the case notes (typed clinic letter) 'both [Mrs C] and [Mr C] told me that she was opening her bowels without difficulty. She tells me that her appetite is good and she thinks that her weight loss has stopped...' Consultant 1 goes on to explain in the letter that in the light of her improved condition '…it would be my inclination to temporise because surgery on this lady is not without increased risk because of her co-morbidities ...' The decision to treat Mrs C conservatively, therefore, took place at this out-patient consultation.

21. In the opinion of the Adviser this was a reasonable management plan because Consultant 1 made the decision in the full knowledge of the results of Mrs C's investigations and that there was a surgical option possible. If Mrs C had malignant disease it would be highly unlikely that she would improve at all. This made the diagnosis of diverticular disease very likely once she had shown

some improvement as Consultant 1 considered had been the case. Although the stricture in her bowel would not ever go away, she was not, at this consultation, getting symptoms from it (there would have been constipation and abdominal pain). Her abscess could possibly have resolved with time due to the body's own healing mechanisms.

22. Consultant 1 arranged to review Mrs C and, as he considered that she continued to improve over two further reviews on 30 August and 6 December 2004, he felt that the risk of continued medical (conservative) treatment were less than those of surgical intervention (she had hypertension, atrial fibrillation and thyroid problems).

23. The Adviser has also reviewed the comments made in a letter to the Assistant General Manager of the Mid Highland Community Health Partnership by Consultant 2, a consultant surgeon and colleague of Consultant 1's, who reviewed the complaints correspondence. In this letter dated 10 October 2005 Consultant 2 suggested that it would have been sensible for Consultant 1 to obtain an anaesthetic and/or colorectal opinion 'as [Mrs C's] condition was gradually deteriorating over the year following this decision'. He also detailed, however, that he understood Consultant 1's reluctance to operate on Mrs C. Consultant 2 had reviewed Mrs C's case in person along with Consultant 1 in March 2005 after her emergency admission by which time it was very clear that operating was not an option. The Adviser has pointed out that the records indicate that on the three occasions that Consultant 1 reviewed Mrs C, her condition is recorded as not gradually deteriorating but in fact stable or improving. Consultant 1 made his decision based on prior investigation and personal review.

24. The Adviser considers that Consultant 1 made a reasonable decision; the one which he felt carried the lowest risk for Mrs C. With hindsight it can be criticised, but at the time it was a reasonable decision to make. The Adviser further suggests that it would have been impossible to hypothesise which management plan would have ultimately resulted in a greater length and/or quality of her life as she may have either recovered from surgery or indeed developed severe complications from a major surgical intervention.

25. Mr C has justifiably raised concerns about the seemingly conflicting views of Consultant 2, as detailed in his letter of 10 October 2005, and those of the Adviser, in respect of Consultant 1's decision to treat Mrs C conservatively. As

a result of these concerns I contacted Consultant 2 by telephone to seek his opinion directly.

26. Consultant 2 confirmed his view, as detailed in his letter of 10 October 2005, that had he been in Consultant 1's position, he would have sought the opinion of an anaesthetist and a colorectal specialist before deciding on Mrs C's treatment plan. However, as has been identified in a number of previous reports from this office, the fact that, in the same circumstances, one doctor might do one thing and another doctor might do something different does not necessarily mean that either is wrong – or even that one is better than the other. Both actions might be considered to fall within this range of reasonable practice.

27. In light of this, I asked Consultant 2 to advise me whether he thought that Consultant 1's decisions on treatment options fell within this range of reasonable practice. Consultant 2 confirmed to me that he was of the view that Consultant 1's action fell within this range. He made clear that it was not the action he would have taken but it was reasonable although, perhaps, towards the limit of what he himself would consider as reasonable practice.

(a) Conclusion

28. There are clear differences of opinion over the state of Mrs C's health on the days she was reviewed by Consultant 1 and in particular, on 2 August 2004. Mr C believes that Consultant 1 seriously underestimated the speed and extent of Mrs C's deteriorating health.

29. Mr C also believes that at no stage during the 2 August 2004 consultation was the possibility of an operation mentioned.

30. However, on the basis of the advice I have received, correspondence from clinicians and the information held in the clinical records, I consider that, on balance, Consultant 1 did consider the surgical options (although he clearly failed to communicate these options) and his decision not to obtain further specialist advice was reasonable in light of her general health problems and regular review by Consultant 1. For this reason, I do not uphold this aspect of the complaint.

(a) Recommendation

31. The Ombudsman makes no recommendations on this point.

(b) The communication from Consultant 1 was unacceptable

32. There are two central issues which arise in this aspect of Mr C's complaint. The communication in respect of Mrs C's likely prognosis and the communication in relation to the treatment options and planning between Consultant 1 and the family.

33. In his original complaint to the Board, Mr C advised that despite the seriousness of Mrs C's condition, it was only a few days before her death that he was told that she was unlikely to survive.

34. On 4 April 2005 Mr C was told that Mrs C was likely to die and that they could not operate on her because of her poor health. Mr C was very surprised and upset at this news. Until a short time before he had been advised by the locum consultant physician (Consultant 4) that there was every chance that Mrs C would make a recovery. Consultant 4 subsequently advised that he had been optimistic about the possibility of Mrs C's condition improving but has apologised to Mr C for any poor communication for which he had been responsible. Mr C made clear that he had no complaint about the way Consultant 4 treated Mrs C.

35. Mr C's central concerns about communication relate to his view that Consultant 1 failed to fully inform the family of what he considered was wrong with Mrs C, what treatment he had planned for her and how he intended to monitor her progress and perhaps most importantly, whether there were treatment options available and what risks were associated with them.

36. There is no documentary evidence in the medical records that Consultant 1 explained any of his reasoning for the treatment given to Mrs C. It is the Adviser's opinion that he has a duty to make this explanation given the fact that a decision to treat conservatively, and withhold surgical intervention, was one which reversed an earlier consultant surgical opinion. The Adviser has made clear that whatever course of treatment was embarked on would have carried serious risks but that Mr C and Mrs C had a right to know of both the options and the risks and an explanation as to why the management plan had changed. If there were surgical options available, Consultant 1 had the responsibility to advise Mr C and Mrs C of these and the associated risks. He should also document these discussions.

37. The lack of evidence of discussions in the medical record is a significant concern and is inadequate. The record-keeping does not demonstrate compliance with the General Medical Council (GMC) guidance on Good Medical Practice 2006 (paragraph 3). However, of greater concern is the failure to provide information to Mr C and Mrs C which meets the standard set out in the guidance (paragraph 22).

38. As part of the Board's handling of the complaint Consultant 1 wrote to Mr C on 7 April 2006. In his letter Consultant 1 states 'I was on holiday at the time of your wife's admission and Consultant 4 asked one of my colleagues, Consultant 3 to review your wife. It was his opinion that as Mrs C's condition was stable and she was opening her bowels every day she was not a candidate for elective surgery.'

39. This is not true and is directly contradicted by the clinical records. As stated in paragraph 17 of this report, Consultant 3 actually recorded in the records that: 'I feel she needs a sigmoid colectomy sooner rather than later as she is very likely to run into further bowel problems soon.' I have asked the Board whether Consultant 1 had access to Mrs's C's clinical records when providing this response and they have confirmed that these were sent to him to enable him to write this letter. In addition the Board accept that Consultant 1's letter is clearly contradicted by the clinical records.

(b) Conclusion

40. Either Mr C and Mrs C were not provided with the information and/or it was not provided in a way which enabled them to properly consider the implications of Mrs C's illness and the options for managing this illness. The decision to treat conservatively appears to have been taken without any discussion with Mr C and Mrs C about any other options or possible implications of these options.

41. Mr C has complained that had the family been aware of the poor prognosis much earlier then both he and Mrs C would have been able to make the most of her finals months. From the records, however, it is clear that until comparatively late, clinicians hoped that Mrs C would survive. She had a number of very serous illness which meant that the long term prognosis was not good but clinicians did not believe that her condition would decline so quickly.

42. In his response to Mr C's complaint, Consultant 4 advised that after Mrs C's admission on 21 March 2005 he was optimistic that her condition would improve. He has advised that by 5 April 2005, when Mr C met with Consultant 4's specialist registrar, it was clear that this was unlikely to happen. Consultant 4 has acknowledged that he may have failed to keep Mr C and Mrs C fully informed of the progress of Mrs C's illness and he has apologised for this. He also met with Mr C to discuss his on-going concerns.

43. Consultant 1's letter to Mr C of 7 April 2006 contained information which directly contradicted the evidence held in the clinical records. When Mr C obtained his wife's clinical records this contradiction became apparent. This clearly had a significant impact on Mr C's view of the accuracy of any information provided to him and Mrs C by Consultant 1.

44. It is in the communication between Consultant 1 and Mr C and Mrs C that my greatest concerns remain. There is no evidence to indicate that appropriate discussions took place between Consultant 1, Mrs C and her family about the diagnosis, treatment planning and options and the risks associated with these options and this is unacceptable. In addition, Consultant 1's letter to Mr C of 7 April 2006 contained information which was untrue and directly contradicted the clinical records. As a result of this, I uphold this aspect of the complaint.

(b) Recommendations

45. The Ombudsman recommends that the Board apologise to Mr C for the failure to effectively communicate with both him and Mrs C. The Ombudsman further recommends that the Board consider using the events of this complaint to inform practise in communicating with patients, particularly when a number of different specialists are involved in care. This consideration should include both communication with patients and family and the recording of such communication in the clinical records.

46. The Ombudsman also recommends that the Board carry out a review of their procedures to ensure that all responses provided by them, or on their behalf, to complainants are factually accurate.

47. 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
The Board	NHS Highland
Mrs C	Mr C's wife
Consultant 1	Mrs C's Consultant Surgeon
The Hospital	The Belford Hospital
MSP	Member of the Scottish Parliament
The Adviser	The Ombudsman's independent clinical adviser
Consultant 2	Consultant Surgeon
Consultant 3	Consultant Surgeon
Consultant 4	Locum Consultant Physician
GMC	General Medical Council

Annex 2

Glossary of terms

Atrial Fibrillation	Fast and Irregular contractions of the of the Atria (upper chambers of the heart)
Barium Enema	X-ray procedure to examine the large bowel
Brachycardia	Slow Heart Beat
Colectomy	The Surgical Removal of the Colon or Part of the Colon
Co-morbidities	Overall Medical Conditions
CT Scan	A series of x-rays which produce a cross section of the area being scanned
Diverticular	Relating to the Diverticulum (ie. small sac like structure which sometimes forms on the walls of the intestines)
Endoscopy	Examination by Endoscope (flexible viewing equipment)
Hypercholesterolaemia	High cholesterol levels
Hypertension	High Blood Pressure
Hypothyroidism	Underactive thyroid
Malignancy	A Cancer
Sigmoid Colon	Lowest Part of the Colon
Sigmoidoscopy	Examination of the Sigmoid Colon by Endoscopy

Stricture	A Narrowing
Utereric Obstruction	Obstrcution of the Uterus