Scottish Parliament Region: Highlands and Islands

Case 200502537: Grampian NHS Board

Summary of Investigation

Category

Health: Clinical treatment

Overview

The complainant raised a number of concerns about the care she received from psychiatric services in Aberdeen and Elgin.

Specific complaints and conclusions

The complaints from Ms C which have been investigated are that:

(a) her condition was originally misdiagnosed in 1999 and continues to be so *(not upheld);*

(b) she received incorrect medication which has worsened her condition *(not upheld)*; and

(c) the clinical judgement exercised by those involved was questionable as no regard was placed on her evolving medical history (*not upheld).*

Redress and Recommendation

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 25 November 2005 the Ombudsman received a complaint from Ms C, who was concerned about the care she received from psychiatric services in Aberdeen and Elgin. She maintained that she suffers from a form of bipolar affective disorder but that this was not properly diagnosed. She said that, because of this, she received incorrect medication which worsened her condition. She alleged that the clinical judgement exercised by those involved was questionable and that no regard had been placed on her evolving medical history.

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

(a) her condition was originally misdiagnosed in 1999 and continues to be so;

(b) she received incorrect medication which has worsened her condition; and

(c) the clinical judgement exercised by those involved was questionable as no regard was placed on her evolving medical history.

Investigation

3. The investigation of this complaint involved obtaining and reading all the relevant documentation, including correspondence between Ms C and Grampian NHS Board (the Board). I have also had sight of GP records which included psychiatric records. On 7 June 2006 I advised the Board of my decision to investigate and requested their comments. Their reply, dated 13 July 2006, indicated that, at that time, they had nothing further to add. Finally, independent psychiatric advice has been obtained on the treatment given to Ms C.

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

(a) Her condition was originally misdiagnosed in 1999 and continues to be so

5. Ms C said that she first sought help for her problems when she was at university. At that time, she was described in her medical notes as being 'depressed' and on 1 November 1999 she was prescribed paroxetine. As she said that her condition continued to deteriorate, she was prescribed fluoxetine on

21 April 2000. Ms C took an overdose on 3 June 2000 and was seen by a liaison psychiatric nurse in Aberdeen Royal Infirmary, when she was referred to outpatients for further assessment. Later that year, she was seen by two consultant psychiatrists, in Elgin and in Aberdeen, who referred to her anxiety symptoms and low self esteem.

6. Then, on 18 January 2001, Ms C was seen in Accident and Emergency with self-inflicted superficial cuts and, from then until September 2002, she saw two clinical psychologists and attended a psychiatric clinic in Elgin. She also saw Dr A, a locum consultant who suggested replacing her current medication with another and who, she said, dismissed any suggestions that she had bipolar disorder. Meanwhile, about this time, Ms C referred to an American website and concluded that she had a bipolar disorder and that previously the professionals she had seen had not diagnosed her correctly. She believed that the treatments she had been given were 'contraindicative for her illness'. She claimed that they had worsened her condition. She then began to complain to the Board about the treatment she received, and in particular against Dr A, who did not consider that she had a bipolar disorder and who had referred to her as 'plump'. From then on, Ms C disputed her care and, on 24 January 2005, she made a formal complaint to the Board. In the meantime, from February 2003 her care was taken over by Dr B who, Ms C said, treated her symptoms as they appeared and evolved. Ms C's mother has also corresponded with Dr B about Ms C's condition (June 2004). She also attended with Ms C at her appointment on 28 September 2004.

7. I have sought independent professional advice from a psychiatric adviser to the Ombudsman (the Adviser) on all the treatment received by Ms C (see paragraph 3) and the Adviser has made separate comment on each aspect of that treatment. Overall, he said that Ms C had always been given a reasonable assessment and clear formulation. In particular with regard to Dr A, he commented that his letter to the GP was reasonably detailed and had carefully considered Ms C's reported mood swings in some detail. Dr A had concluded that:

> 'I did not get any evidence of sustained depression and certainly did not feel that the mood swings were in any way manic at the time.'

The Adviser considered this to be a reasonable assessment. Dr A said that when he saw her a month later, Ms C reported feeling better and expressed a desire to

see a Community Psychiatric Nurse to talk about her problems. It was about this time that Ms C concluded that she had a disorder in the 'bipolar spectrum' and began raising her complaint about her treatment.

8. Generally, the Adviser has made the point that psychiatric diagnosis is often tentative and that diagnostic concepts change over time. He said:

> 'There is no doubt that there are personality problems, and descriptively Ms C had symptoms of unstable mood, mild or moderate depression, irritability and tension. She has not had any prolonged periods of abnormally elated mood. Dysthymia is a reasonable diagnosis. She does not have a classical manic depressive illness, now called bipolar affective disorder, although it is not impossible that she will eventually develop it. It is at least debateable whether she has bipolar II disorder, which she herself strongly supports. This is a fairly new concept, as is borderline personality disorder, which again would be a reasonable diagnosis.'

(a) Conclusion

9. Given this independent advice, I cannot agree with Ms C that she has been misdiagnosed or that this continues to be the case. Accordingly, I do not uphold this aspect of the complaint. Although Ms C was unhappy that Dr A had referred to her as 'plump', which she considered to be unprofessional, I am aware from the correspondence available to me that the Board's Chief Operating Officer had written to her on 22 February 2005, apologising and saying that there had been no intention to be judgemental. In a further letter of 6 May 2005, acknowledgement was made that this was not a medically descriptive term and once again the Board apologised for its use. Taking this into account, I think there is little to be added on this point and, accordingly, there would be no value in pursing it further.

(b) She received incorrect medication which has worsened her condition

10. In his letter to me of 22 August 2006, the Adviser commented that treatment in psychiatry is less accurately tied to diagnosis than in most branches of medicine and the specific indications and complications cited by Ms C are not well established. He went on to say:

> 'It is generally accepted that the use of anti-depressants can provoke manic attacks in predisposed patients who may develop bipolar II disorder, or rapid

cycling disorder, but there is little evidence in favour of this diagnosis recorded.'

While he suspected that Ms C would say that it was because it had not been asked for, he agreed that it would have been better if one of the psychiatrists involved had asked Ms C if her mother would come along to give her account. However, he said that the various psychiatrists who saw Ms C reported mood swings in proper detail and reached reasonable conclusions. He said that, given the other evidence about her life, he doubted if her mother's evidence would have altered the diagnosis significantly.

(b) Conclusion

11. As described above (see paragraphs 7, 8 and 10), the Adviser takes the view that Ms C's treatment has been satisfactory. Similarly, that, in the circumstances, the medication she was prescribed was appropriate. This being so, I do not uphold this aspect of the complaint.

(c) The clinical judgement exercised by those involved was questionable as no regard was placed on her evolving medical history

12. The Adviser said that it may have been preferable for Ms C's mother to have been asked to attend with her at some point, in order to provide further background information. However, it is clear that to some extent Ms C's mother was involved (see paragraph 6), although this appeared to have been on her own initiative. Dr B's notes, however, recognised Ms C's mother's input. Nevertheless, the Adviser said (see paragraph 10) that in his view, her evidence was unlikely to have changed the diagnosis significantly, as indeed it had not with Dr B.

(c) Conclusion

13. I must be guided by the professional advice given and, in the circumstances as described above (see paragraph 12), I see no grounds to uphold this part of the complaint. Overall, the Adviser has said that he considers that Ms C has received a reasonable standard of care, 'in fact a good one in several respects, including the availability of psychological treatment'. The fact that Ms C disagrees with the diagnosis does not mean that her care was poor or that the psychiatrists were wrong. I, therefore, do not uphold the complaint.

28 November 2006

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Dr A	Psychiatrist 1
Dr B	Psychiatrist 2
The Adviser	Independent psychiatric adviser to the Ombudsman

Annex 2

Glossary of terms

Bipolar disorder	An illness characterised by prolonged episodes of major depression and of severely abnormal elation (mania)
Bipolar II disorder	Similar to above, but with less severe elation (hypomania). Both varieties may be 'rapid cycling'
Dsythymia	Chronic depression, usually variable in severity, but without the distinct episodes seen in recurrent depression and bipolar disorder