Scottish Parliament Region: Mid Scotland and Fife

Case 200502100: A Medical Practice, Forth Valley NHS Board

Summary of Investigation

Category

Health: FHS, GP & GP Practice, Clinical treatment

Overview

The complainant (Mr C) raised concerns about the treatment received by his wife (Mrs C) at their medical practice (the Practice) during February and March 2005.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was a delay in diagnosing that Mrs C was suffering from Cauda Equina Syndrome (CES) *(not upheld)*; and

(b) the clinical records contained inaccurate information *(partially upheld)*.

Redress and recommendations

The Ombudsman recommends that the Practice reminds the GPs concerned about the need to complete clinical records in accordance with guidance from the professional bodies.

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

Main Investigation Report

Introduction

1. On 1 November 2005 the Ombudsman received a complaint from Mr C about the treatment provided to his wife, Mrs C, by doctors at the Practice when she attended in February and March 2005 with back problems.

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

(a) there was a delay in diagnosing that Mrs C was suffering from Cauda Equina Syndrome (CES); and

(b) the clinical records contained inaccurate information.

Investigation

3. In writing this report I have had access to Mrs C's clinical records and correspondence relating to the complaint. I made a written enquiry of the Practice. I sought clinical advice from one of the Ombudsman's professional medical advisers (the Adviser). I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in the report can be found at Annex 1 with a glossary of medical terms at Annex 2. Mr C and the Practice were given an opportunity to comment on a draft of this report.

(a) There was a delay in diagnosing that Mrs C was suffering from CES; and (b) the clinical records contained inaccurate information

4. Mr C said that Mrs C, who has a history of back problems, was referred by her GP for physiotherapy treatment in November 2004. She was discharged from physiotherapy treatment on 9 December 2004 with advice and exercise programmes. The pain continued and Mrs C saw a GP (GP 1), on 21 February 2005 who thought the problem could be a trapped nerve and prescribed painkillers. On 28 February 2005 Mrs C saw another GP (GP 2) who thought the problem could be a hip problem, prescribed medication and arranged an x-ray on 2 March 2005. The pain continued to worsen and also affected Mrs C's ability to walk. On 4 March 2005 the pain from Mrs C's shin area was so bad that a home visit was requested and another GP (GP 3) attended. He examined Mrs C and said she had either sciatica or a possible disc problem and that she should try and walk. GP 3 prescribed medication and planned to review Mrs C in a week if the pain persisted and would consider a MRI scan. On 6 March 2005 Mrs C could not manage to the toilet and was numb in the front and back of her private area. Mrs C telephoned the

Emergency Out-of-Hours Service and another GP (GP 4) arrived. GP 4 listened to Mrs C's history and suggested the problem could be CES and arranged an emergency hospital admission to Stirling Royal Infirmary. Mrs C was then transferred that evening to the Western General Hospital, Edinburgh for a MRI scan where CES was confirmed.

5. Mr C complained to the Practice that due to Mrs C's frequent appointments, doctors should have been alerted to the possibility of CES earlier given her symptoms. Mr and Mrs C attended a meeting at the Practice on 26 August 2005 where they met with GP 5. Mr and Mrs C maintained that GP 3 seemed put out to make a house call and did not investigate Mrs C's symptoms or listen to her history. They also maintained that GP 1 had examined Mrs C's left side despite being told the problems were on the right. GP 5 explained what was behind the doctors' actions and that he too would have diagnosed sciatica because there was no saddle numbness which is red flag warning for CES. GP 5 gave examples of questions that the doctors should have asked and Mr and Mrs C said that none had asked the questions (saddle area numbness, any toileting problems, has the pain changed or moved). Mrs C reviewed her GP records and saw that GP 1 had noted that she had asked Mrs C if she had any bowel/bladder problems. Mrs C denied this was the case. GP 2 had entered that Mrs C could be suffering from a disc prolapse, then mentioned a hip problem and arranged for x-rays to be taken. Mr and Mrs C said GP 2 had not mentioned the disc prolapse to them because they would have considered arranging for a private MRI scan.

6. GP 5 wrote to Mr and Mrs C on 18 October 2005 to summarise what was discussed at the meeting. GP 5 explained that it would not be possible for a GP to have diagnosed that Mrs C was suffering from CES earlier as she was not displaying symptoms of saddle anaesthesia and bladder problems. He also said that earlier MRI scanning would have picked up the central disc prolapse but the guidelines on MRI scanning would not have been met as normally GPs are expected to give sciatica up to 6 weeks to recover before considering MRI scanning. Comments would be sought from GP 1 as to whether she had asked Mrs C about bladder problems because she was no longer employed at the Practice. The Practice would also carry out its own Critical Event Analysis of Mrs C's care. This is a mechanism which allows them to review cases and learn from the experience.

7. In response to my enquiry, GP 1 said that she asked whether Mrs C had

any disruption in urinary or bowel function and about paraesthesia. She had documented this and could see no reason why she would not have asked the questions. GP 1 said that she had recorded Mrs C was complaining of pain in the left SI joint and it was possible that she could have mistakenly transposed left for right. If she had made a mistake by transposition and had caused Mrs C distress then she unreservedly apologised for this. GP 2 said that he was unable to clarify whether the entry in the clinical records '?disc prolapse' related to a letter from the physiotherapy department or a comment from Mrs C. GP 3 said that she had to agree that the standard of record-keeping was not of the highest standard on 4 March 2005. GP 3 said he would normally record when a patient provided a negative answer to his questions. GP 3 made an unreserved apology and explained that work pressures and time restraints had an effect on the ability to provide a full and accurate description of the consultation which took place and secondly that no-one had been harmed by poor record-keeping in this instance as no-one has had to rely on his record-keeping from that consultation to make any kind of decision regarding Mrs C's medical care.

8. The Adviser reviewed Mrs C's clinical records and explained that CES is a medical emergency. It relates to pressure on the spinal cord often, and in Mrs C's case, due to a prolapsed intervertebral disc. The symptoms that stand out, and are referred to as red flags since action needs to be taken immediately, are numbness of the perineum and of bowel or bladder disturbance. Low back pain is common and difficult to treat. It can be described as having four levels:

(1) Simple: no referral to specialist needed: patient aged between 20 and 55, generally well, suffering with mechanical pain in the lower back, buttocks or thighs.

(2) Nerve root pain: referral not indicated for about four weeks – provided there is evidence of some resolution. The pain from the low back may radiate as far as the foot, the leg pain is usually worse than the back pain, and numbness is in the same distribution as the pain. Examination (straight leg raising (SLR)) reproduces the pain, and there may be absent knee or ankle jerks in the limb.

(3) Possible serious: under 20 years, or over 55, the presence of thoracic pain, history of cancer, taking of steroid medication, weight loss. X-rays should be arranged, and referral to a specialist.

(4) CES: immediate referral is indicated.

9. The Adviser considered Mrs C would come in the second category at the initiation of this series of consultations, in that there is evidence she was

worsening as regards pain level, the pain radiated down the leg, and SLR reproduced the pain. Mrs C entered the fourth category on 6 March 2005 when she had symptoms of saddle anaesthesia (numbness of the private parts).

10. The Adviser felt the consultation of 21 February 2005 was reasonable although he cannot be certain as to the care given by GP 1 due to the uncertainty as to whether she was told the pain was on the left, and thus examined the correct side, or whether she examined the left side although told the right side was the problem side. As Mrs C consistently states the pain was on the right, and as GP 2 came to a diagnosis of a problem on the right, the Adviser felt that it is possible that GP 1 did examine the wrong side. She did, however, arrange appropriate follow-up. The Adviser felt that an appropriate history was taken at this consultation with Mrs C. It is recorded in the notes that GP 1 asked questions concerning bowel and/or urinary symptoms. As this is in the contemporaneous notes the Adviser would accept GP 1 did ask the questions.

11. The Adviser thought that GP 2 appeared to have appropriately listened to and examined Mrs C on 28 February 2005. The statement in the records (presumably from the physiotherapist report) that there was consideration by them of a possible disc prolapse is one for her to consider in her history taking, examination and conclusion, but not necessarily to discuss with the patient. The arrangement of x-rays is appropriate as Mrs C was not improving. The recording of the power, tone and normal reflexes are indicative the CES had not yet occurred. GP 2 would seem to have taken an appropriate history, examined appropriately and arranged appropriate second line tests. She also arranged appropriate follow-up.

12. The Adviser said that GP3's record of the consultation on 4 March 2005 was minimal – in that there is recorded the history of the present complaint (back pain worse) and a partial diagnosis that PID (prolapsed intervertebral disc) seems likely – but there is no indication of any examination for the Adviser to adduce as to how he came to that conclusion. This is poor practice – either the not examining or the not recording of the examination. The Adviser noted that in the letter of complaint Mr C does intimate that GP 3 performed straight leg raising and, therefore, might or might not have performed other examinations. Nonetheless the Adviser could not see from the evidence that the red flag signs of bladder problem/saddle (perineal) numbness occurred prior to 6 March 2005 when GP 4 saw Mrs C and admitted her to hospital.

13. The Adviser noted the comments from GP 3 to my enquiry. He said that it is the view of the GMC and the RCGP, that record-keeping should include negative answers to queries as well as positive answers. This is because both are important in assessing the development of an illness, as time passes. It is indeed a requirement of the current GMC good medical practice to keep appropriate (good) medical records. The Adviser agreed with GP 3's comments that Mrs C did not suffer from the poor record-keeping, as the next consultation – on 6 March 2005 resulted in Mrs C being admitted to hospital.

(a) Conclusion

14. The advice which I have received and accept is that Mrs C was not showing evidence of CES symptoms until she was examined by GP 4 on 6 March 2005. Prior to this the GPs had followed recognised procedures in an effort to diagnose Mrs C's condition and accordingly I do not uphold this complaint.

(b) Conclusion

15. I will deal firstly with Mrs C's concerns that GP 1 examined her left side and did not mention whether she suffered from bowel or bladder problems. On the evidence provided I believe that GP 1 probably examined the left side but did ask the questions about bowel/bladder problems. Similarly, it is possible that GP 2's entry in the clinical records about '?disc prolapse' could have been as a result of the physiotherapist's letter and as such she did not mention it to Mrs C. I am, however, concerned about GP 3's recording of the consultation with Mrs C on 4 March 2005. On this occasion the patient's care was not compromised but it could easily happen in another case. On the balance of probabilities I am minded to partially uphold this aspect of the complaint to the extent that there were deficiencies in the standard of record-keeping.

(b) Recommendation

16. The Ombudsman recommends that the Practice take note of the Adviser's concerns about the standard of record-keeping and remind the GPs involved of their obligations to act in accordance with the guidance from the professional bodies.

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

27 March 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	The complainant's wife
The Practice	The medical practice which Mrs C attended
GP 1	GP who saw Mrs c on 21 February 2005
GP 2	GP who saw Mrs C on 28 February 2005
GP 3	GP who saw Mrs C on 4 March 2005
GP 4	Out of Hours GP who saw Mrs C on 6 March 2005
GP 5	GP who met with Mr and Mrs c on 26 August 2005
GMC	General Medical Council
RCGP	Royal College of General Practitioners

Annex 2

Glossary of terms

Cauda Equina Syndrome (CES)	Damaged spinal root nerves
MRI Scan	Magnetic Resonance Imaging – A diagnostic technique that provides cross sectional images of organs within the body
SLR	Straight Leg Raising