Scottish Parliament Region: Glasgow

Case 200502714: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category
Health: NHS Boards; Clinical Treatment

Overview
The complainant (Ms C) raised concerns about her care and treatment by a consultant (Consultant 1), information that was included in a letter and subsequent effect on her medical care as a result.

Specific complaints and conclusions
The complaints which have been investigated are that:

(a) Consultant 1's medical treatment of Ms C was inadequate (*not upheld*);

(b) Consultant 1 wrote a letter to Ms C's GP containing information Ms C had advised was incorrect (*upheld*); and

(c) Consultant 1's comments had a negative influence on other medical practitioners involved with Ms C's case (*not upheld*).

Redress and recommendations
The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 4 January 2006 the Ombudsman received a complaint from Ms C regarding her care and treatment by a Consultant (Consultant 1) at the Rheumatology Department of Glasgow Royal Infirmary (the Hospital). Ms C also complained that Consultant 1 wrote a letter to Ms C's GP containing information that Ms C had told her was not correct and that she believed Consultant 1's comments had a negative impact on Ms C's treatment by other medical practitioners.

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

(a) Consultant 1's medical treatment of Ms C was inadequate;

(b) Consultant 1 wrote a letter to Ms C's GP containing information Ms C had advised was incorrect; and

(c) Consultant 1's comments had a negative influence on other medical practitioners involved with Ms C's case.

Investigation

3. The investigation of these complaints involved obtaining and examining the relevant medical and correspondence files from Greater Glasgow and Clyde NHS Board (the Board) and Ms C's GP practice. I have reviewed the copies of correspondence and comments submitted by Ms C. I have sought the views of a medical adviser to the Ombudsman with specialist knowledge of rheumatology (the Medical Adviser). I have set out my findings of fact and conclusion. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. The terms used to describe other people referred to in the report are noted in Annex 1 and a glossary of the medical terms used is noted in Annex 2. Ms C and the Board were given an opportunity to comment on a draft of this report.

4. In early 2005 Ms C told her GP practice of pain in her neck, shoulders and joints. Investigations were organised including x-rays that showed degenerative changes in her cervical spine. She told her GP that the pain killers she had been prescribed were not effective. Ms C believed that she was suffering from rheumatoid arthritis and that this had been diagnosed in the early 1990s. She asked her GP to refer her to a rheumatologist as her sister, who had been diagnosed with rheumatoid arthritis, had benefited from treatment by the Rheumatology Department at the Hospital.

5. Ms C was referred by her GP practice to Consultant 1 in the Rheumatology Department of the Hospital on 8 June 2005. In his letter to the department her GP pointed out that, as Ms C had only recently joined the practice, he was not sure whether there was convincing evidence that she was suffering from rheumatoid arthritis. Her medical history was lengthy and included conditions of the bowels, oesophagus, bones and lungs as well as anxiety and alcohol abuse. At the time of the referral Ms C was taking a large number of different medications for these various complaints and her GP itemised these in his referral letter.

6. As part of my investigation of the complaint I asked the Medical Adviser whether there was any record in Ms C's medical notes of a diagnosis of rheumatoid arthritis. He told me that he can find no such diagnosis in her record and that he believes the diagnosis of rheumatoid arthritis was introduced into her general practice notes by Ms C herself, possibly inadvertently, when she changed GP practices in 2001.

7. Ms C's appointment with the Rheumatology Department took place on 4 July 2005 when Consultant 1 saw Ms C. Following the appointment Consultant 1 wrote a letter to Ms C's GP practice. Consultant 1 described her clinical findings and noted that she had arranged for an MRI scan. Consultant 1 said that treatment for Ms C's inflammatory arthritis would be reviewed following the results from her appointment with the Neurological Department, but could include the use of the drug Sulphasalzine and local joint injections. Consultant 1 had told Ms C that she could have an injection in her knee at their next consultation if she wished. Consultant 1 also mentioned in the letter that there appeared to be social problems in Ms C's past and that Ms C had not wished to discuss these during the appointment. Consultant 1 speculated that Ms C may have been physically abused in the past which would account for her cervical spine problems.

8. After her appointment with the Neurological Department but before a second appointment with Consultant 1, Ms C had a consultation with her GP on 4 August 2005. At this consultation Ms C's GP explained to her that the letter from Consultant 1 said that it was only after the review by Consultant 1 that the drugs could be prescribed and the injections administered. Ms C was shown the letter from Consultant 1 by her GP.

9. Ms C was upset by what she read in the letter, and she telephoned Consultant 1's office and explained this. Later that day Consultant 1 tried to telephone Ms C to apologise for any upset that had been caused and discuss the letter. Consultant 1 was unable to reach Ms C, so she dictated a letter that contained an apology and noted that the matter would be discussed at Ms C's appointment scheduled for 8 August. The letter was sent later on 4 August.

10. Ms C's second consultation with Consultant 1 took place on 8 August 2005. Following the consultation Consultant 1 wrote to Ms C's GP. She noted that the MRI scan of Ms C's cervical spine had shown severe cervical spondylosis. A chest x-ray and blood tests had shown no abnormalities. The letter noted that a neurological assessment would be arranged and Consultant 1 asked the GP to start Ms C on a low dose of the drug Gabapentin and to administer B12 injections. The letter also clarified that Ms C had told Consultant 1 that she had never suffered violence towards her.

11. Ms C visited her GP on 19 August 2005 to receive a B12 injection. While she was there she read Consultant 1's letter of 4 July 2005. Later that day, Ms C called Consultant 1 and spoke to her about the letter and her pain levels. Consultant 1 suggested to Ms C that she should come to the Hospital immediately and be admitted as an inpatient for tests to attempt to control the pain. Ms C declined this offer as she was in the process of selling her home. Consultant 1 told Ms C that she should contact her office immediately that she became available to be admitted.

12. Ms C called Consultant 1's office on 22 August 2005 and said that she was able to be admitted to the Hospital. Consultant 1's office passed this information to the Hospital admission team and a representative from the Hospital called Ms C and told her that there were no beds available and that she would be called when a bed became available.

13. In late August 2005, Ms C wrote to the Patient Liaison Department of the Board, complaining about her care and treatment by Consultant 1.

14. Ms C was eventually admitted to the Hospital on 30 August 2005. Ms C believed that Sulphasalazine would be prescribed to her when she was admitted to hospital. She was unhappy that she was not examined by a consultant until 1 September 2005 and that their diagnosis was of fibromyalgia, rather than rheumatoid arthritis and that the drug Amitriptyline, rather than

Sulphasalazine, was prescribed. Ms C refused to accept the diagnosis or to take Amitriptyline and was asked to sign a form indicating that she had refused treatment. Ms C did not believe that she had refused treatment, but that she had refused a treatment she did not believe would help her. She discharged herself.

15. Coincidentally, shortly after Ms C had discharged herself and left the Hospital, the results of tests undertaken while she was in the Hospital had come back from the laboratory. A ward doctor called Ms C to advise her that Sulphasalazine could now be prescribed and a prescription would be available from her GP.

16. A meeting was held on 20 September 2005 between Ms C, Consultant 1 and the Patient Liaison Department to discuss Ms C's complaints. Ms C raised the issue of the content of the letter of 4 July 2005. Consultant 1 explained her reasons for what was written in the letter, apologised again for any upset that had been caused and pointed out that her subsequent letter to Ms C's GP made clear that Ms C had told her she had not suffered violence towards her at any time.

17. Ms C complained that she had been diagnosed with rheumatoid arthritis and that the drugs she had been prescribed were inadequate. Consultant 1 told Ms C that the blood tests carried out in July 2005 did not confirm a diagnosis of rheumatoid arthritis. Consultant 1 said that during Ms C's stay in hospital it was felt that her neck was the primary problem and her joint pain was secondary. As a result of this a diagnosis of fibromyalgia had been made and the drugs she had been prescribed were suitable for this.

18. Ms C complained that she had been prescribed a drug (Gabapentin) that was primarily prescribed to epileptics and that had side effects that she was not prepared to risk. Consultant 1 accepted that Gabapentin was primarily an anti-epileptic drug but explained that it had also been noted for its effectiveness as a pain relief drug in certain types of nerve root pain. Consultant 1 told Ms C that, for someone in as much pain as Ms C was, the benefits of a drug had to be weighed against possible side effects and that, ultimately, the decision to take a drug or not was Ms C's.

19. Ms C complained that she had been prescribed Amitriptyline in the past and it had not proved effective in relieving her pain. Consultant 1 told Ms C that

in light of this she was unsure how to treat Ms C's symptoms but would continue to consider all options. Consultant 1 hoped that her referral of Ms C for a neurosurgical opinion would result in action to relieve some of the pain Ms C was suffering.

20. Ms C complained that Consultant 1 had offered to inject Ms C's knee during her consultation in July, but had not mentioned it during their August consultation. Consultant 1 explained that she had not initiated discussion about an injection at the second consultation as she wanted to ensure that Ms C had considered that injection could be painful or unsuccessful and definitely wanted to go ahead with it.

21. At the conclusion of the meeting Ms C agreed that the issues she had complained about had been addressed at the meeting and that she wanted to continue as a patient of Consultant 1 and would attend a further consultation on 28 September 2005.

22. Ms C attended the consultation of 28 September 2005 when she was seen by Consultant 1's partner in the Rheumatology Clinic, Consultant 2. Consultant 2 wrote to Ms C's GP following this appointment and noted that Ms C was still awaiting an appointment with the Neurological Department and that, although Ms C had not perceived any major benefit from its prescription, her treatment with Sulphasalazine should continue.

23. In October 2005 Ms C changed GP practices. On 25 November 2005 Ms C called Consultant 1's office and detailed the pain she was experiencing. She asked for an appointment for an injection, Ms C was told she would be called back. Still in pain, Ms C went to her new GP practice where she asked for an injection. Ms C believes that her GP was prepared to give her an injection until he consulted her notes, after which he changed his mind and told Ms C she should discuss the injection with Consultant 1. Ms C called the Patient Liaison Department and complained about this. The Patient Liaison Department tried to contact Consultant 1 but found that the Consultant and her secretary were both on leave until 4 December 2005, the representative from the Patient Liaison Department also found an appointment for Ms C noted in Consultant 1's diary for 15 December 2005.

24. Ms C believes that information that Consultant 1 introduced to her medical records has meant that various GP's and practice staff have not given her

proper medical care and treatment, and she cites delays in obtaining prescriptions and occasions when she felt that the administration of medication was not properly explained to her as results of this.

25. On 4 January 2006, Ms C brought her complaint to the Ombudsman.

(a) Consultant 1's medical treatment of Ms C was inadequate

26. Ms C complained that Consultant 1 had not adequately responded to Ms C's medical problems because Consultant 1 did not give her injections in her knee that she believed had been promised during the appointment in July 2005 and had not prescribed Sulphasalzine to her in an appropriate time.

27. I asked Consultant 1 for her recollection of what had been discussed with Ms C regarding injections. Consultant 1 told me that the benefits of local injections were discussed with Ms C and that Ms C had been advised that this would only be a temporary solution that could be carried out no more than twice a year if it was found to be of benefit. As noted in paragraph 20 above, Consultant 1 did not initiate further discussion at the subsequent appointment because she wanted to be sure that Ms C had understood that this could be painful and unsuccessful. Consultant 1 made clear to me that at any particular consultation Ms C's clinical condition would have been taken into consideration before it was decided to administer an injection.

28. I sought the opinion of the Medical Adviser on this complaint. The Medical Adviser told me that Consultant 1's opinion was given promptly, that there was evidence in Ms C's medical notes of a full and extensive examination having been undertaken, an appropriate diagnosis being arrived at and a suitable treatment plan devised and discussed with Ms C. His opinion was that the consultation was conducted to the highest clinical standards and that Ms C had received the highest quality of medical and rheumatological care throughout the period she had complained of.

(a) Conclusion

29. Ms C was dissatisfied that Consultant 1, having suggested that injections could be administered, did not then bring the subject up again and that drugs had not been prescribed properly or timeously. Consultant 1 reasonably explained during the meeting on 20 September 2005 why she had waited for Ms C to raise the issue of injections. It is clear from examination of Ms C's medical records that Consultant 1 acted appropriately in terms of diagnosis and

treatment for the symptoms Ms C displayed, including the prescription of drugs. I concur with the Medical Adviser's opinion and, therefore, I do not uphold the complaint.

(b) Consultant 1 wrote a letter to Ms C's GP containing information Ms C had advised was incorrect

30. Ms C complained that during her appointment with Consultant 1 she made clear that she had not suffered any physical abuse at any time, but that Consultant 1 did not make Ms C's denial of this clear in a letter to Ms C's GP (see paragraph 7).

31. Consultant 1 told me that she had included the information in the letter because she was concerned that Ms C was potentially in danger. When she was informed that Ms C had seen the letter and had been upset, Consultant 1 contacted her to apologise for the upset (see paragraph 9) and made clear in a subsequent letter to Ms C's GP that Ms C had told Consultant 1 that she had never suffered any physical abuse (see paragraph 10). Consultant 1 repeated her apology personally during the meeting of 20 September 2005 (see paragraph 16).

32. I sought the opinion of the Medical Adviser on this point. He told me that, in his opinion, it was reasonable for Consultant 1 to have included in the letter the information that there may have been problems in Ms C's past and that she did not wish to discuss these but that it was unreasonable for Consultant 1 to speculate as to what those problems might have been. He was confident, however, that Consultant 1 did not include the information maliciously or with intent to upset Ms C.

(b) Conclusion

33. I concur with the Medical Adviser that Consultant 1 did not include the information relating to Ms C's past maliciously and that it was reasonable to include her belief that there may have been problems in Ms C's past. There is no record of the conversation that took place between Ms C and Consultant 1 but, regardless of this, I believe that it was unreasonable for Consultant 1 to speculate on what those problems may have been and, therefore, I uphold the complaint.

(b) Recommendation

34. As noted in paragraph 9, when Consultant 1 was made aware that Ms C had been upset by the wording of her letter, she apologised to her. This apology was repeated at the meeting of 20 September 2005. In her second letter to Ms C's GP, Consultant 1 clarified the information she had included in her first letter and made clear that Ms C had told her she had never suffered any physical abuse. The Ombudsman commends Consultant 1 for this action and, in light of this appropriate action having already been taken, has no recommendations to make.

(c) Consultant 1's comments had a negative influence on other medical practitioners involved with Ms C's case

35. Ms C believed that her complaints led Consultant 1 to add comments to her medical records which, along with the comments in her letter, influenced various medical practitioners in their care and treatment of Ms C.

36. I have had sight of Ms C's medical records and can see no comments from Consultant 1 that would have this effect. I sought the opinion of the Medical Adviser who told me that he believed that the letter Consultant 1 wrote to Ms C's GP would not have influenced medical practitioners in any way. As noted in paragraph 28 his opinion was that Ms C had received the highest quality of medical and rheumatological care throughout the period she had complained of.

(c) Conclusion

37. I concur with the Medical Adviser's opinion that Consultant 1's letter to Ms C's GP did not influence any other medical practitioners and there is no evidence that Consultant 1 made any further comments on Ms C's medical records. Accordingly, I do not uphold the complaint.

24 October 2007

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Consultant 1	A Consultant Rheumatologist at Glasgow Royal Infirmary
The Hospital	Glasgow Royal Infirmary
GP	General Practitioner
The Board	NHS Greater Glasgow and Clyde
The Medical Adviser	A medical adviser to the Ombudsman with specialist knowledge of rheumatology
Consultant 2	A Consultant Rheumatologist at Glasgow Royal Infirmary

Annex 2

Glossary of terms

Amitriptyline	A drug prescribed to combat depression
B12	A vitamin, deficiency of Vitamin B12 can be supplemented by injection
Cervical spine	That part of the spine immediately behind the skull
Cervical spondylosis	A degenerative osteoarthritis affecting the bones in the neck
Fibromyalgia	A collection of symptoms, rather than a specific disease, defined as widespread pain for at least three months which is experienced in at least 11 specified points in the body
Gabapentin	A drug initially developed to aid suffers of epilepsy, now also used as a pain reliever for sufferers of other conditions
MRI scan	A scan used in the investigation of neurological problems
Rheumatoid arthritis	A disease of the autoimmune system in which inflammation causes the destruction of joints around the body
Sulphasalazine	A drug prescribed to arthritis sufferers to reduce inflammation in the joints