Scottish Parliament Region: South of Scotland and Lothian

Cases 201000102 & 201001848: Borders NHS Board and Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; surgical

Overview

The complainant (Ms C) raised a number of concerns about the way the relevant medical history of her late partner (Mr A) was initially obtained by Borders NHS Board (Board 1) and provided to Lothian NHS Board (Board 2). She also complained that prior to the decision to operate, Board 2 failed to obtain a full medical history from Mr A and that had they done so, the operation may not have proceeded.

Specific complaint and conclusions

The complaint which has been investigated is that Board 1 and Board 2 failed to ensure all the relevant medical history was obtained prior to the decision to operate on Mr A. There are two elements to this:

(a) Board 1 failed to ensure all relevant medical history was provided to Board 2 (*not upheld*); and

(b) Board 2 failed to ensure a full medical history was obtained during the consultation prior to surgery (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board 1:	*Completion date*
(i) revise their respective policies in relation to existing medical records protocols to ensure that in appropriate cases, all health professionals have direct access to patients' records.	18 June 2011

The Ombudsman recommends that the Board 2:	*Completion date*
(ii) apologise to Ms C for the failures identified;	18 June 2011

(iii)	ensure Consultant 2 reflects on this report so he can review his practice on taking patients' medical history, including when it would be appropriate to request full medical records; and	18 June 2011
(iv)	revise their respective policies in relation to existing medical records protocols to ensure that in appropriate cases, all health professionals have direct access to patients' records.	18 June 2011

The Board 1 and Board 2 have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. In 2005, Mr A had a series of operations, including a colostomy and ileostomy, and suffered from septicaemia as well as a range of other complications. On 5 March 2008, a consultant physician at Board 1 (Consultant 1) referred Mr A to a consultant colorectal surgeon at Board 2 (Consultant 2) to explore reversing his previous colostomy and ileostomy. His medical records were not transferred. Mr A died on 24 March 2009 from sepsis due to aspiration pneumonia following an operation by Consultant 2. Mr A's partner, Ms C, has complained that Board 1 and Board 2 failed to ensure all of Mr A's relevant medical history was obtained prior to Consultant 2's decision to operate on him. Ms C said that Consultant 2 was unaware of Mr A's complicated medical history when he operated: the referral letter (and supporting documents) from Consultant 1 did not contain all the relevant information and Consultant 2 did not ask about Mr A's complicated medical history when he met Mr A and Ms C to discuss the operation. Ms C said that this failure to obtain all the relevant medical history meant they had not been aware of the risks of the operation and had they been, they would have not proceeded with it.

2. Ms C complained to Board 1 on 19 June 2009. On 24 September 2009, Board 1 responded to Ms C's letter of complaint. Ms C raised further issues with Board 1 and received their final response on 29 January 2010. Ms C received Board 2's final response on 21 September 2010. Ms C remained dissatisfied with the Boards' responses and complained to my office.

3. The complaint from Ms C which I have investigated is that Board 1 and Board 2 failed to ensure all the relevant medical history was obtained prior to the decision to operate on Mr A. The specific headings being:

(a) Board 1 failed to ensure all relevant medical history was provided to Board 2; and

(b) Board 2 failed to ensure a full medical history was obtained during the consultation prior to surgery.

Investigation

4. During the course of the investigation into this complaint, my complaints reviewer obtained and examined Mr A's clinical records and the complaint correspondence from the Boards. She obtained advice from two of my

professional advisers, a medical consultant (Adviser 1) and a surgical consultant (Adviser 2). My complaints reviewer also interviewed Ms C and Consultant 2 (by telephone).

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C, Board 1, Board 2 and Consultant 2 were given an opportunity to comment on a draft of this report.

(a) Board 1 failed to ensure all relevant medical history was provided to Board 2; and (b) Board 2 failed to ensure a full medical history was obtained during the consultation prior to surgery

Clinical Background

6. In May 2005, Mr A underwent a stapled haemorrhoidopexy at Borders General Hospital (the Hospital). He had symptoms of rectal pain following the procedure. In June and July 2005, he contracted salmonella enteritis and was subsequently admitted to the Hospital in August 2005 with ulcerated colitis complicated by clostridium difficile enteritis. He received treatment which included steroids, drug therapy and general supportive measures. The colitis failed to respond to medical treatment and a subtotal colectomy with a colostomy was performed on 9 September 2005. At operation, there was a pelvic abscess due to perforation of the colon. He was discharged but readmitted on 30 September 2005 with a fever of unknown origin, which was treated with antibiotics. In November 2005, Mr A was readmitted to the Hospital with a small-bowel obstruction and underwent further surgical treatment. Following this treatment, Mr A developed intra-abdominal sepsis with multiple abscesses and fluid collections requiring drainage and in-patient treatment until late December 2005.

7. On 5 March 2008, Consultant 1 referred Mr A to Consultant 2 to explore reversing his previous colostomy and ileostomy, at Mr A's request. His medical records were not transferred. Consultant 1 provided a referral letter and supporting documentation to Consultant 2. On 22 April 2008, Consultant 2 met Mr A and Ms C and recommended an operation to remove the rectum and offered to restore gastrointestinal continuity with an ileall pouch anal anastomosis. A trainee, in the presence of Consultant 2, performed this operation on Mr A on 19 March 2009. The procedure was uneventful but Mr A developed sepsis due to aspiration pneumonia in the early post-operative period and died on 24 March 2009.

Boards' response to Ms C's complaint

8. Board 1 said they had liaised with Consultant 1 and Consultant 2 about Ms C's concerns and their response was based on their comments and advice. Board 1 said Consultant 1 had explained it was his usual practice, when referring a patient to a surgeon at another hospital, to write a covering letter detailing the patient's current situation and relevant past history, including copies of relevant letters and reports from the patient's medical records. Board 1 said in his referral letter to Consultant 2 of 5 March 2008, copies of the recent rectal stump assessment along with Mr A's histology from that day, the pathology form from Mr A's colectomy specimen in 2005 and information following Mr A's surgery and subsequent surgical admissions were enclosed. Consultant 1 also told Consultant 2 the reasons for Mr A's initial subtotal colostomy were due to failed medical treatment and clostridium difficile infection. Board 1 said it was not normal practice to send patient medical records with patients when they go to other hospitals to minimise the risk of patient records being mislaid. Consultant 1 believed that full covering letters and photocopies of the relevant information were sufficient to allow good ongoing management of the hospital to which the patient had been referred.

9. Board 1 said Consultant 2 had confirmed that Consultant 1's referral letter was not only fully comprehensive, but exemplary. The referral letter he received from Consultant 1 included Mr A's clinic records, radiology reports, a clinic letter and four pathology reports. He said the only way he could have obtained any more information would have been either from Mr A or Ms C or if he had specifically requested Mr A's medical records from Board 1. Consultant 2 said he took a comprehensive history when he saw Mr A and Mr A did not offer the information that Ms C had provided him with after Mr A's death. Furthermore, Mr A did not inform the preadmission clinic about his previous complicated history when he was admitted to the hospital. Board 1 said even if Consultant 2 had known about the previous problems, he would have proceeded with the surgery and the outcome would have been the same.

10. Ms C expressed concerns to Board 1 about their comments relating to the information provided by Mr A and Ms C about Mr A's complicated medical history to Consultant 2. Board 1 said neither consultant felt that Mr A or Ms C had failed to provide the information about Mr A's medical history. Board 1 repeated that Consultant 2 felt that Consultant 1's referral letter was fully comprehensive and the only way he could have obtained any more information would have been from either specifically requesting Mr A's medical records or

from speaking to Mr A or Ms C. Board 1 went on to say that doctors need to take a full medical history from patients at each visit to see if anything about the condition had changed and that this type of information cannot be obtained by only reading patients' medical records. Medical records are an indication of previous medical interventions and history, but they do not replace a clinical assessment, examination and discussion with the patient or the patient's relative/carer. Consultant 2 felt that Mr A would have gone forward with the operation even if his past medical history had been more thoroughly known.

11. In a further response to Ms C's complaint, Board 2 said Consultant 2 asked patients during the consent process to tell him about their previous surgical history. Patients then explained about their operations and would mention complications, particularly if this had required them to spend time in intensive care which was a very traumatic memory for most patients and their families. Board 2 said that despite receiving a comprehensive referral letter and discussing the procedure fully with Mr A before he obtained his signed consent, Consultant 2 was not made aware of Mr A's previous complicated surgical history prior to carrying out his bowel surgery. Consultant 2 was not aware of the abscesses, septicaemia and the fact that Mr A had spent a long time in intensive care following the original and second operation until after Mr A had died. Board 2 said this was not an accusation against Mr A or a failure on Mr A's part, but it appeared that Mr A had come to a place of acceptance regarding his previous post surgery experience and did not give it the level of importance that others may have, as it was in his past.

Ms C's statement

12. Mr A and Ms C attended Consultant 2's clinic on 22 April 2008 to discuss the reversal of Mr A's ileostomy. Ms C said the clinic was very busy and they had only approximately 15 to 20 minutes with Consultant 2. Consultant 2 had talked mainly about the pouch surgery he was going to perform and the problems it would cause. Mr A's previous medical complications did not arise during this consultation. Ms C had brought a list of questions to the consultation, which included questions about Mr A's previous medical complications. She did not raise them with Consultant 2 because he was a professional and she was uncomfortable about instructing him on this.

13. Ms C visited Mr A four days after his operation. He was sitting in a chair looking very ill and could hardly speak. Consultant 2 said Mr A was having a bad post-operative day and Ms C had replied that he had been like that before.

Ms C next saw Consultant 2 on the morning Mr A died. Consultant 2 looked visibly shocked. Consultant 2 said he could not believe Mr A had died given his age (Mr A was 55 when he died) and asked Ms C what she had meant the day before when she said Mr A had been like this before. Ms C explained about the complications following his original surgery.

14. Ms C did not believe the referral letter was exemplary as described because there was so much relevant information missing from it. Also, she did not agree with Board 1's response to her complaint that she and Mr A should have volunteered the information to the doctors, given that they were the professionals and it was their responsibility to ensure they had all the relevant information before they operated.

15. Referring to Board 2's response to her complaint, Ms C said that Consultant 2 did not know Mr A and it was ridiculous for him to say that Mr A had accepted what had happened; he had not accepted it at all because he had nearly died twice, had struggled enormously to recover from his operations and the events had such a big impact on their lives. If they had known about the risks, it would have affected their decision to proceed with the reversal.

Consultant 2's statement

16. During the course of the investigation, Consultant 2 provided a statement to my complaints reviewer, which is summarised below.

17. Consultant 2 said Consultant 1 was a physician (gastroenterologist) and it was not his responsibility or area of expertise to understand the nuances of previous surgical procedures and their impact on future ones. It would be unusual for previous surgical notes to be sent with a referral letter, which Consultant 2 considered to be very comprehensive. Consultant 2 said he was not aware of Mr A's complicated surgical history prior to carrying out the operation in 2009. Had he known, he would have factored it in to his thinking, asked for a more comprehensive summary and following his operation would have had a higher index of suspicion that there may be a greater risk of rare complications. As a gastroenterologist, Consultant 1 would not have been aware of the surgical aspects to Mr A's medical history that he, Consultant 2, needed to know. Consultant 2 said eliciting a medical history is a responsibility shared between himself and the patient whereas Consultant 1's responsibility lay in referral. When Consultant 2 met patients prior to their operations, he would ask them what their history was. Patients would tell him about their

operations and usually mentioned complications such as spending time in intensive care. My complaints reviewer asked Consultant 2 if he asked patients specifically about any complications they had during previous surgical procedures and he replied that he did not. Commenting on the operation he performed on Mr A, Consultant 2 said Mr A required having his rectum removed at some point following his ileostomy and colostomy, but the decision to reconstruct him with a pouch was an additional procedure. If Consultant 2 had been aware of his complex past history he would have counselled Mr A about the risks of the operation differently, but in all probability he believed Mr A would still have proceeded with pouch surgery and the outcome sadly would have been the same.

Advice received

18. Adviser 1 considered the referral letter summarised accurately the situation regarding Mr A's past bowel problems, consequent surgery and complications.

19. My complaints reviewer asked Adviser 2 to consider whether the actions of Consultant 2 in obtaining information about Mr A's medical history before his decision to operate had been reasonable. Adviser 2 said that the clinical diagnosis and appropriate management assessments were based on information collected by the clinician. The usual sources of information were the patient, the case records and correspondence between health care professionals. The principal source of information was the patient themselves and the clinical history was a basic and vital part of the process. The hospital records provide a reliable source of information which supplements clinical history, allows any gaps in the information to be filled and provides evidence of previous clinical events, the significance of which may not be recognised, remembered or understood by the patient. Correspondence between clinicians provides clinical information which is relevant to the current clinical problem, but will not usually provide an exhaustive account of every aspect of the patient's medical care.

20. In relation to the referral letter, Adviser 2 said that the referral letter sent by Consultant 1 was thorough and provided a comprehensive overview of Mr A's clinical situation. However, the referral letter did not contain certain aspects of Mr A's previous surgical history, such as the intra-abdominal sepsis Mr A had developed following his small-bowel obstruction in November 2005. Nonetheless, Adviser 2 said it was not reasonable to expect Consultant 1, a

medical gastroenterologist, to include every detail of Mr A's past surgical history in his referral letter.

21. Referring to Consultant 2's consultation with Mr A on 24 April 2008, Adviser 2 said Mr A's past medical history should have been discussed. The precise details of the consultation have not been documented in Mr A's medical records. It appeared that Consultant 2 was satisfied he had acquired the information he needed to recommend that Mr A undergo removal of his rectum. However, Adviser 2 said it later became apparent that Consultant 2 was not aware of certain aspects of Mr A's previous surgical history. This additional information could have been obtained from Mr A himself and from his clinical records, but not the referral letter. Adviser 2 said that after Mr A's second abdominal operation in 2005, he developed severe intra-abdominal sepsis which necessitated intensive and invasive intervention. Intra-abdominal sepsis is a recognised, but uncommon complication of abdominal surgery and bowel resection. In his view, neither a past history of post-operative infection or a low white cell count seen during an episode of sepsis indicated a pre-existing immunodeficiency or susceptibility to infection.

22. Adviser 2 stated that it is the responsibility of the surgeon to ensure they are familiar with all aspects of the clinical history which may influence the decision to operate and the operation to be performed. Taking a patient's clinical history is a basic and vital part of the information gathering process. Adviser 2 said Consultant 2 should have been aware of Mr A's past surgical history and should have had access to his medical records. However, Adviser 2 also said Consultant 2's decision to proceed to surgery was reasonable and the outcome could not have been predicted.

(a) Conclusion

23. Ms C's complaint to this office was that the Boards failed to ensure all of Mr A's relevant medical history was obtained prior to the decision to operate on him. That Consultant 2 was unaware of Mr A's complicated medical history before he operated is not in doubt; the question I have to ask is why he was unaware. There are two elements to this: firstly, whether the referral letter sent by Consultant 1 to Consultant 2 was reasonable in the circumstances; and secondly, whether Consultant 2 made reasonable efforts to obtain information about Mr A's relevant medical history that he needed before making a decision to operate.

24. Turning first to the referral letter, the advice which I have received and accept is that some surgical aspects to Mr A's complicated medical history was not contained in the referral letter (see paragraph 20) but that it was not reasonable to expect Consultant 1 to have included this information because it was outwith his speciality. I therefore do not uphold this head of complaint against Board 1.

(a) Recommendation

25. I recommend that Board 1:	*Completion date*
(i) revise their respective policies in relation to existing medical records protocols to ensure that in appropriate cases, all health professionals have direct access to patients' records.	18 June 2011

(b) Conclusion

26. Turning now to the second head of complaint, I have decided there were failings by Consultant 2 in his actions relating to obtaining all of Mr A's relevant medical history. In reaching my decision, I have taken into account Consultant 2's comments that taking a patient's medical history is a shared responsibility between the clinician and the patient. However, the advice that I have accepted is that it is the responsibility of the operating surgeon to ensure they are familiar with all aspects of a patient's clinical history, which may influence the decision to operate and the operation to be performed, and that Consultant 2 should have been aware of Mr A's surgical history.

27. Consultant 2 met Mr A and Ms C on 22 April 2008 to take a medical history and discuss the proposed operation but I have concluded that Consultant 2 failed to take a full medical history. There is no record of that consultation in Mr A's medical records, but Ms C has provided convincing evidence about it, which is corroborated by Consultant 2's statement that he does not as a matter of course ask patients about any complications they may have had and that he relies on them to volunteer the information. This is a serious failing; patients cannot be expected to know the significance of previous clinical events or even to remember them all. I do not accept Board 2's statement that Mr A did not provide this information because he did not deem it important; Mr A did not provide this information because he was not asked. Furthermore, it is disturbing to note that Consultant 2 seemed to be unaware of aspects of Mr A's medical history that were contained within the referral letter. There was sufficient information in the referral letter to alert Consultant 2 that

Mr A's medical history was not straight forward and should have prompted a full and proper history taking by Consultant 2 during the consultation of 22 April 2008.

28. Adviser 2 has also stated that Consultant 2 should have had access to Mr A's records because these provided a reliable source of information which complemented the clinical history. I note Board 1's position that they do not transfer patients' medical records when patients are referred because of the risk of the medical records being lost. However, given that Mr A was being referred from another Board, and more importantly another speciality, and that his medical history was complex, Consultant 2 should have had access to his records. I am concerned that, in the circumstances, Consultant 1 did not consider sending the records and that the convention of not sending patients' medical records had an adverse impact on the standard of care Mr A received. This convention may also impact adversely on other patients in similar situations. In this case, the onus was on Consultant 2 as the operating surgeon to ensure he was aware of all aspects of Mr A's clinical history before he operated and he should have requested Mr A's records.

29. Adviser 2 has said that even if Consultant 2 had been aware of all of Mr A's past medical history, including the intra-abdominal sepsis, the decision to proceed to surgery was reasonable and there was no way the outcome could have been predicted. However, Consultant 2 has confirmed that had he known, he would have: factored it into his thinking; asked for a more comprehensive summary from Consultant 1; had a higher index of suspicion that there may be a greater risk of rare complications following the surgery; and he would have counselled Mr A differently about the risks of the operation. Consultant 2 has stated that it was likely Mr A would have proceeded with the operation even if he had counselled Mr A differently about the risks. That is speculative; what is certain is that Mr A was denied an opportunity to consider the risks and make an informed decision on whether to proceed with the surgery.

30. In view of all the circumstances, I uphold the complaint against Board 2 and I make the following recommendations.

(b) Recommendations

31. I recommend that Board 2:	*Completion date*
(i) apologise to Ms C for the failures identified;	18 June 2011

(ii)	ensure Consultant 2 reflects on this report so he can review his practice on taking patients' medical history, including when it would be appropriate to request full medical records; and	18 June 2011
(iii)	revise their respective policies in relation to existing medical records protocols to ensure that in appropriate cases, all health professionals have direct access to patients' records.	18 June 2011

32. Board 1 and Board 2 have accepted the recommendations and will act on them accordingly. The Ombudsman asks that Board 1 and Board 2 notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mr A	The complainant's late partner
Board 1	Borders NHS Board
Board 2	Lothian NHS Board
Consultant 1	A consultant physician at Borders NHS Board
Consultant 2	A consultant colorectal surgeon at Lothian NHS Board
The Hospital	Borders General Hospital
Adviser 1	A consultant physician, one of the Ombudsman's professional advisers
Adviser 2	A consultant general colorectal surgeon, one of the Ombudsman's professional advisers

Annex 2

Glossary of terms

Adhesions	Fibrous bands which form between tissues and organs; post surgical adhesions can cause small bowel obstruction
Clostridum difficle enteritis	Inflammation of the small bowel caused by a bacterium
Colostomy	An operation where a section of the large intestine is diverted and attached to an opening in the abdominal wall
Haemorrhoidopexy	Surgical treatment for symptomatic haemorrhoids
Ileal pouch-anal anastomosis	An internal reservoir; usually situated where the rectum would normally be. It is formed by folding loops of small intestine back on themselves and stitching or stapling them together. The internal walls are then removed thus forming a reservoir. The reservoir is then stitched or stapled into the perineum where the rectum was
Ileostomy	A surgical opening constructed by bringing the end or loop of small intestine out onto the surface of the skin. Intestinal waste passes out of the ileostomy and is collected in an external pouching system stuck to the skin
Intra-abdominal sepsis	Inflammation of the membrane which lines the abdominal and pelvic cavities
Salmonella enteritis	An infection caused by the bacteria salmonella enterica

Sepsis due to aspiration pneumonia	A severe infection of the blood from the spread of infection from the lungs
Subtotal colectomy	Resection of part of the colon
Ulcerated colitis	A type of inflammatory bowel disease which affects the large intestine and rectum