SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Highlands and Islands

Case ref: 201405824, Highland NHS Board
Sector: Health
Subject: Hospitals; clinical treatment; diagnosis

Summary

Mr C complained to the board following treatment he received at Raigmore Hospital. He was admitted for a haemorrhoidectomy (surgery to remove haemorrhoids) and flexible sigmoidoscopy (a procedure to look inside the back passage and lower part of the large bowel). Polyps (small growths on the inner lining of the bowel) were found and removed during the sigmoidoscopy. Mr C was readmitted two days later, after experiencing considerable pain, and it was found that he needed emergency surgery for two holes in his bowel. Mr C said he was told that, if this second operation was not successful, he would need more surgery and a temporary colostomy bag. He said that the procedure caused him further pain, stress and anxiety.

Mr C said that he consented to surgery for haemorrhoids and to a flexible sigmoidoscopy on the understanding that the sigmoidoscopy was investigatory, and that he was not told polyps may be removed if identified. He said that, if he had known of the possibility of damage to his bowel, he may not have had the original procedure done. He was also concerned that, due to annual leave, the surgeon he had seen before his original day surgery did not perform the operation.

In investigating Mr C's complaints, my complaints reviewer obtained independent medical advice from a consultant colorectal surgeon who is experienced in carrying out the surgery Mr C had done.

My adviser noted that the board’s response to Mr C’s complaint said that the risk of bowel perforation from flexible sigmoidoscopy is low but increased with treatment for polyps. My adviser referred to General Medical Council guidance on consent which says that doctors must tell patients if an investigation or treatment could result in a serious adverse outcome. He said that, as the risk of perforation (and, therefore, a hospital admission) is a serious adverse outcome, not having discussed or made a record of such a discussion was unreasonable. He felt the question of whether polyps should have been removed was irrelevant as the consent process was inadequate.

Regarding Mr C's transfer from the care of the surgeon he had seen before his original day surgery to another surgeon, my adviser explained that it was the responsibility of the surgeon in charge of the case on the day to ensure that a procedure's risks had been explained. He said that the second surgeon should have ensured that the first surgeon had properly discussed the procedure with Mr C but the evidence did not show that this was done.

In light of the clear medical advice, I uphold the complaints and have made recommendations to the board.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) apologise to Mr C for the failings identified in this report;	28 October 2015
(ii) consider introducing pre-printed consent forms for common procedures like this to ensure that such rare (but serious) complications are not missed, and report their findings back to the Ombudsman; and	25 November 2015
(iii) consider introducing a review of case notes by the operating surgeon (before the day of surgery) where the patient has been transferred from another surgeon's list, to ensure that the operating surgeon is satisfied the appropriate consent is in place, and report their findings back to the Ombudsman.	25 November 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share

the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mr C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mr C complained to the Ombudsman following treatment he received from Highland NHS Board (the Board). He was unhappy about steps that were taken without his consent during day surgery at Raigmore Hospital (the Hospital) that led to a complication. He then had to be admitted to the Hospital for additional surgery in the coming days.

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

(a) unreasonably failed to obtain Mr C's consent to remove the polyps from his bowel lining *(upheld)*; and

(b) unreasonably failed to advise Mr C of the risk of perforation to his bowel before carrying out this procedure *(upheld)*.

Investigation

3. In order to investigate Mr C's complaint, my complaints reviewer examined all of the information provided by Mr C, his clinical records and the Board's complaint file. They also obtained medical advice from a consultant colorectal surgeon (the Medical Adviser) who is experienced in carrying out the surgery Mr C had done. In this case, we have decided to issue a public report on Mr C's complaint because the failings I found led to a significant personal injustice for Mr C. We also felt the learning from this case should be shared with other health boards.

4. 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.

Background

5. Mr C complained to the Board about his day surgery at the Hospital on 7 October 2014 (a haemorrhoidectomy and flexible sigmoidoscopy). He said his pain in the coming days was such that he was returned to the Hospital by ambulance in the early hours of 9 October 2014. Upon admission, investigations showed that surgery was needed for two holes in his bowel. Mr C explained how upsetting this was for him and that he was told if this operation did not succeed then he would need to have additional surgery and a temporary colostomy bag.

6. Mr C was discharged from the Hospital on 20 October 2014 following his second operation. He was concerned that, due to annual leave, the surgeon he

had seen in advance of his original day surgery (Doctor 1) did not in fact do the operation on 7 October 2014. Rather, it was done by a second surgeon (Doctor 2).

7. Mr C said the emergency procedure that followed caused considerable pain, stress and anxiety which he felt could have been avoided at the time he consented to the original procedure. Mr C said the consent he signed for his day surgery was to have been under Doctor 1's care and the possibility of damage to his bowel was not explained. He said if he had known all of the risks he may have reconsidered having the procedure done and that Doctor 1 and Doctor 2 subsequently apologised to him for what happened. They had said this was a rare complication, but Mr C was concerned that the risks had not been fully discussed with him in advance.

8. The Board's response said that Doctor 1 discussed surgery with Mr C on 25 April 2014 which, in the circumstances, included a flexible sigmoidoscopy. They said Mr C's name was transferred from Doctor 1's surgical list to Doctor 2's surgical list - possibly to ensure surgical timescales were met – and they confirmed that Doctor 2 supervised the original operation directly. The Board explained that Mr C was transferred to Doctor 2's surgical list without any discussion between Doctor 1 and Doctor 2; this was contrary to normal practice and had been raised with secretarial staff to ensure nobody was transferred between lists without such clinical discussion and notification to patients. The Board said Doctor 2 had understood that Mr C previously discussed surgery with Doctor 1 and, despite this omission, Doctor 2 was entirely capable of carrying out the procedure. There had been nothing to indicate a complication post-operatively (so rare was Mr C's complication that it was the first time Doctor 2 – who was very experienced - had encountered it).

9. They explained that the surgeon who carried out the emergency procedure upon Mr C's readmission contacted Doctor 1 to discuss how to manage his condition. The Board said Doctor 1 met Mr C to explain that this was a recognised but rare complication of a flexible sigmoidoscopy and could happen to any surgeon; having spoken with Doctor 2, Doctor 1 did not think any mistakes had been made. Doctor 1 said he explained to Mr C that his usual practice was to explain the risk of perforation but he had not documented this and could not confirm whether he had done so. The Board explained the process for removing polyps and said there was a number of possible reasons

for Mr C's bowel perforation; Doctor 1 said he would ensure he recorded all discussions in the notes going forward.

10. Mr C's complaint to my office said he consented to surgery for haemorrhoids and to a flexible sigmoidoscopy; he had understood the sigmoidoscopy was investigatory and was not told polyps may be removed if identified. Mr C said he had not consented to that and he was not told of the possibility of bowel perforation, which he felt caused him unnecessary pain and suffering.

11. The Board told my office that Doctor 1 acknowledged not having noted discussions about the risk of perforation with Mr C (although he usually discussed this low risk he could not, in the absence of a record, dispute Mr C's claim). They said their internal guidance indicated that, although there was no hard and fast rule, risks below 2 per cent (as here) were not expected to be routinely mention unless the doctor felt they would result in a serious adverse outcome for the patient. The Board also pointed to an academic article which said that the decision over the complications to mention was ultimately the surgeon's to make, depending on the relative level of risk and possible outcome. The Board pointed to a document by the British Society of Gastroenterology which outlined the rarity of Mr C's complication (beneath the level detailed in either the journal article or their internal guidance that would normally require discussion).

(a) The Board unreasonably failed to obtain Mr C's consent to remove the polyps from his bowel lining

Medical advice

12. The Adviser referred to General Medical Council guidance which says a doctor 'must tell patients if an investigation or treatment might result in a serious adverse outcome'.[1] He confirmed this would apply to Mr C's complication because the guidance detailed an outcome resulting in a hospital admission as a serious adverse outcome.

13. The Adviser noted that the Board's response outlined Doctor 1's view that the risk of bowel perforation from flexible sigmoidoscopy is low but increased

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[1]General Medical Council, 'Consent guidance: Discussing side effects, complications and other risks' (available online at: http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_discussing_side_effects_and_complications.asp)

with treatment for polyps. He said the risk of perforation should have been discussed with Mr C regardless of whether treatment of polyps had been included as a possibility and, as that risk was a possible serious adverse outcome, not having discussed or documented such a discussion was unreasonable. The Adviser felt the question of whether polyps should have been removed upon discovery was irrelevant due to the inadequacy of the consent process; the alternative in this case, upon discovery that consent had not been given to the risk of bowel perforation, was not to have done the flexible sigmoidoscopy at all. He explained that the procedure should have been cancelled or, alternatively, the consent process could have been undergone again.

(a) Decision

14. The medical advice I received was clear both generally that a doctor must tell a patient about a possible adverse outcome and specifically that it should have happened here. The Adviser explained that the question of whether Mr C's polyps should have been removed was rendered irrelevant by the fact that the procedure should not have gone ahead without his consent about the risk of bowel perforation having been obtained.

15. That being the case, I consider it clear that the Board should not have been in a position where the question of whether to remove Mr C's polyps could have even arisen, given the inadequacy of the underlying consent (discussed in more detail below). In light of the clear advice I have received I uphold this complaint and make the recommendations below.

(a) Recommendations

17. I recommend that the Board:	*Completion date*
(i) apologise to Mr C for the failings identified in this report; and	28 October 2015
(ii) consider introducing pre-printed consent forms for common procedures like this to ensure that such rare (but serious) complications are not missed and report their findings back to the Ombudsman.	25 November 2015

(b) The Board unreasonably failed to advise Mr C of the risk of perforation to his bowel before carrying out this procedure

Medical advice

16. The Adviser agreed that bowel perforation was a rare complication of a flexible sigmoidoscopy and was not something caused simply by Mr C being transferred from Doctor 1's surgical list to Doctor 2's list.

17. The Adviser said it was for the operating surgeon to ensure that a patient was given adequate information to give consent before a procedure was undertaken. He explained that it did not matter who was originally going to carry out the operation, who originally obtained consent or from which surgical list the patient came: ensuring that a procedure's risks have been explained was the responsibility of the surgeon in charge of the case on the day. In this case, that was Doctor 2 and the Adviser said it was for him to have ensured that that he was happy that Doctor 1 had discussed the procedure adequately with Mr C. In the Adviser's view, the Board unreasonably failed to advise Mr C of the risk of bowel perforation.

(b) Decision

18. Despite the Board's indication that the risk of Mr C's complication was low (beneath the level detailed in their internal guidance), their response to Mr C's complaint explained that Doctor 1 would normally have discussed this risk.

19. The Board's response also said Doctor 2 had understood Mr C had previously discussed surgery with Doctor 1. While it is clear from the records that surgery was indeed discussed on 25 April 2014, Doctor 1 acknowledged not having documented his usual discussions about the risk of Mr C's complication. In addition, the Board said there was no discussion between Doctor 1 and Doctor 2 prior to Mr C's transfer between their lists.

20. Mr C's complaint outlined how significantly this matter had affected him and, although I consider it clear that he suffered from a rare complication, the advice I received was equally clear that Doctor 2 should have ensured that the procedure had been discussed adequately. I do not consider the evidence indicates that this was done in Mr C's case and I uphold this complaint.

(b) Recommendation

21. I recommend that the Board: *Completion date*

	Recommendation	Date
(i)	consider introducing a review of case notes by the operating surgeon (before the day of surgery) where the patient has been transferred from another surgeon's list, to ensure that the operating surgeon is satisfied the appropriate consent is in place, and report their findings back to the Ombudsman.	25 November 2015

22. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations and the Board are asked to inform us of the steps that have been taken to implement them by the dates specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	the complainant
the Board	Highland NHS Board
the Hospital	Raigmore Hospital
the Medical Adviser	a consultant colorectal surgeon
Doctor 1	a surgeon at the Hospital
Doctor 2	a surgeon at the Hospital

Annex 2

Glossary of terms

bowel perforation	a hole in the lining of the bowel
flexible sigmoidoscopy	a procedure to look inside the back passage and lower part of the large bowel
haemorrhoidectomy	a surgical procedure for the removal of haemorrhoids
polyps	small growths on the inner lining of the bowel