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: Glasgow

Case ref: 201407899, Greater Glasgow and Clyde NHS Board
Sector: Health
Subject: Hospitals; communication; staff attitude; dignity; confidentiality

Summary
Ms C had been referred to a consultant plastic surgeon then to a consultant general surgeon to undergo a surgical procedure on her buttocks. She has suffered from internal and peri-anal abscesses for a number of years and had previously undergone treatment to drain these on a number of occasions. Ms C said that she had been assured that she would not suffer from any issues with continence following the operation, as this was a significant concern for her prior to undergoing surgery. Following the operation, Ms C found that she was incontinent. As a result she had to undergo a colostomy procedure, which has had a significant impact on her personal life, resulting in her having to give up work.

I took independent advice from a consultant colorectal surgeon, who said that incontinence was a well-recognised side-effect of the procedure Ms C had. Ms C said that she would never have consented to the procedure had she been made aware of this risk. I found Ms C's medical notes documented that this was an area of great concern to her, therefore I consider that it was unreasonable that this was not discussed with her and documented prior to surgery, nor did the consent form that she signed mention this as a possible risk of the surgery.

The board accepted that the forms Ms C signed had not documented incontinence as a risk of the surgery. However, they did dispute whether Ms C was ever given an assurance that there was no risk of this complication from the procedure. I do not accept that this removes the responsibility from the board in this regard. Under General Medical Council guidelines, the medical staff responsible for her care had an obligation to ensure that Ms C was able to give informed consent, particularly as she had identified a particular concern before the operation.

I also found that the board failed to respond appropriately to Ms C's complaint about the cause of her incontinence. Whilst it is possible that the incontinence is a result of a progression of Ms C's on-going condition, it is also possible that it

was a result of a complication of the surgery. Given this, the board's failure to provide adequate information to her before the procedure and later in their complaints responses was unreasonable, so I upheld the complaint.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) review the consent forms used for this type of surgery to ensure they accurately reflect the potential complications;	18 May 2016
(ii) remind staff of the importance of identifying and documenting that issues of importance to patients have been discussed during the consent process; and	4 May 2016
(iii) apologise unreservedly to Ms C for the failings identified in this report.	4 May 2016

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 Ms C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Ms C complained to the Ombudsman about the outcome of surgery to her buttocks at Glasgow Royal Infirmary (the Hospital). Ms C said she had been assured that she would not suffer from any issues with continence following the operation as it was not near her sphincter muscle. Following the surgery Ms C found she was not able to control her sphincter muscle and was incontinent. In order to control these symptoms, Ms C had to undergo a colostomy procedure, which has had a significant impact on her personal life. The complaint from Ms C I have investigated is that Greater Glasgow and Clyde NHS Board (the Board) unreasonably failed to advise Ms C about the risk that her surgery could result in faecal incontinence (*upheld*).

Investigation

2. In order to investigate Ms C's complaint, my complaints reviewer reviewed all the available evidence provided by the Board and by Ms C. They also received advice from a consultant colorectal surgeon (the Adviser) who regularly performs the procedure Ms C has complained about. In this case, because of the significance of the personal injustice experienced by Ms C and the criticisms by the Adviser, I have decided to issue a public report.

3. I have not included in this report every detail investigated but 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.

Complaint: The Board unreasonably failed to advise Ms C about the risk that her surgery could result in faecal incontinence

Concerns raised by Ms C

4. Ms C said the surgery she underwent left her in a worse position than she would have been had it not taken place. Ms C said she had been assured there was no risk of incontinence from the surgery. She would not have agreed to proceed with it otherwise, since this was a very significant concern for her. Ms C said she had subsequently been advised that any peri-anal surgery risked leaving the individual incontinent.

What happened

5. Ms C said she had suffered from internal abscess and peri-anal abscesses for many years. Despite this uncomfortable and debilitating condition, she had managed to remain in employment and raise a family. Ms C

said she had previously undergone surgery on numerous occasions to drain large abscesses.

6. Ms C had been referred to a consultant plastic surgeon (Doctor 1) who had then referred her to a consultant general surgeon (Doctor 2). Ms C said that she was assured on two separate occasions by her doctors that the surgical procedure she was to undergo carried no risk of incontinence.

7. Ms C said she now had a stoma inserted through the wall of her stomach and that she had scarring on her buttocks, which regularly became inflamed and broke, open. Ms C said she continued to suffer from abscesses and she could no longer walk without suffering significant pain. As a consequence she had been forced to stop working and her quality of life had been irreversibly altered.

8. Ms C had complained to the Board on 30 August 2014 in writing. She said she had agreed to the operation after much discussion with Doctor 1 and Doctor 2. She said they had provided repeated assurances to her about the risk of incontinence, as her main concern was to avoid continence issues or being required to have a colostomy after the procedure.

9. Ms C told the Board that after her recovery period was complete, she realised that she was experiencing serious problems. She said she had no bowel control at all and that when walking she felt an extremely painful swelling inside her left buttock. Ms C informed Doctor 1 and Doctor 2 about these problems when she met them after the operation.

10. Ms C said she was assured that the incontinence could not be related to her surgery, as the procedure had not involved her sphincter. Ms C noted she had never suffered any continence issues prior to the operation and the change in her condition was severe. Ms C said she was told that the lump she felt was probably excess skin following the operation.

11. Ms C said she believed this skin had been infected and should have been removed and that she was not provided with an adequate explanation for the failure to do so. Ms C noted she suffered from a painful skin condition, which caused abscesses and scarring on her skin and there was a particular risk of infection.

12. Ms C said she was subsequently tested in an effort to establish the cause of her incontinence. The tests revealed she had developed diverticulitis, but this was not the cause of her continence issues. Ms C believed the only rational explanation was that she was incontinent because her sphincter control had been affected by her operation. As a result she had to undergo a colostomy operation on 3 July 2014. Although the colostomy was reversible, Ms C said this was irrelevant, since she would never regain control of her sphincter. Additionally, she had continuing problems with abscesses and boils at the wound site and walking caused her extreme discomfort and irritated the skin at the wound site.

The Board's response of 13 October 2014

13. The Board's initial response to Ms C's complaint stated she had previously undergone multiple procedures for chronic perianal discharge related to fistula. The Board said the risk of incontinence was not directly mentioned to Ms C, because it was not an expected complication of her surgery. The Board accepted that the consent forms Ms C had signed had not documented it as a risk of the surgery. The Board added that there was, however, no written record that Ms C had been provided with assurances her surgery carried any risk of incontinence.

14. The Board said that following a review of Ms C's complaint, they were of the view it was not clear whether the incontinence was a consequence of the surgery, or if it was related to a progression of Ms C's medical condition. The Board said Ms C had been advised of the possible persistence of her condition including the risk of scarring and reoccurrence following surgery. These discussions were clearly recorded in Ms C's medical records.

15. The Board said that Ms C had not been left with any infected skin following the operation. The flap of skin referred to in her meeting with Doctor 1 and Doctor 2 had been used in accordance with a recognised surgical procedure. The Board said the doctors involved wished to assure Ms C they had always acted with her best interests in mind.

Ms C's response of 3 November 2014

16. Ms C wrote again to the Board, as she did not believe they had explained why she had been left incontinent following her surgery. Additionally, she said she had asked on two separate occasions if this was a risk of the surgery. Both occasions had been in front of witnesses, including her husband. Ms C said

she had asked for a formal note to be taken of the assurances she had been given and considered it unreasonable that this had not been done. Ms C said she had a copy of the questions she had asked prior to surgery in order to allay her fears.

17. Ms C said she would not have undertaken the surgery if she had been aware there was any risk of faecal incontinence resulting from it. She added that as it was not mentioned on the consent form, this, coupled with her conversations with Doctor 1 and Doctor 2 had led to her believe it was not a risk.

18. Ms C said it was not reasonable to suggest her condition had contributed to her incontinence. She said she had suffered abscesses and perianal abscesses for years, but even at its worst, she had never experienced any continence issues. Ms C emphasised that she had only developed problems following the surgery.

19. Ms C said that she had been left with a colostomy, which she had been desperate to avoid. She was unable to walk without pain or return to work. Ms C said she disputed that her best interests had been served by having the surgery performed.

The Board's Response

20. The Board did not respond in detail in writing, but did offer Ms C a meeting with a senior member of medical staff. Ms C did not wish to meet and no further response was provided by the Board.

Medical advice

21. The Adviser said the appropriate guidance was the General Medical Council (GMC) general consent guidance in this instance, rather than specific government guidelines. The Adviser said that incontinence was a well-recognised complication of the surgery that Ms C underwent. They said, however, that it was not possible at this stage to determine whether it was the surgery or the on-going progression of her disease that had caused Ms C's incontinence.

22. The Adviser said the risks of the surgery to be performed on Ms C were not properly explained. It was clear from the available evidence that the risks of

incontinence were not explained in the discussions Ms C had with medical staff or in the consent documents she was asked to sign.

23. The Adviser noted the GMC guidance was clear that a patient's views and preferences should be ascertained in advance of any proposed investigation or treatment. The guidance specifically required doctors to make an effort to understand which adverse outcome the patient was most concerned about, prior to commencing treatment. It was important that assumptions were not made about the patient's level of understanding, or about the importance they might attach to different outcomes. All issues should then be discussed with the patient. Additionally the guidance required that a patient should be told of any possible adverse outcomes, even if the likelihood was very small.

24. The Adviser said the consent form signed by Ms C was inaccurate. The form documented a laparotomy (exploratory opening of the abdomen). This was never planned, and did not, in fact take place. The other parts of the operation, excision of two rectal sinuses, which were carried out were recorded. Some of the risks associated with this procedure were listed, but significantly, faecal incontinence was not one of them.

25. The Adviser said it was clear Ms C was most concerned about incontinence and that she would consider it a serious adverse outcome. This was not discussed with Ms C and consequently the Adviser considered she could not have been considered to be in a position to give an informed decision about surgery. It was not possible state whether or not she would have consented to surgery at the time had she been given adequate information, however, they noted Ms C was now adamant that she would not have done so. The Adviser said that the failure to provide adequate information or to address Ms C's most significant concern was unreasonable.

Decision

26. Ms C complained that she was given assurances there was no risk of incontinence from undergoing surgery. She gave her consent for the procedure to be carried out, but subsequently developed faecal incontinence, which she attributed to a complication from the surgery. Ms C said this had severely impacted her professional and personal life and that she would not have agreed to surgery had she been aware this was a risk of the procedure. Ms C said that she was unable to work, having previously been in full time employment and having raised a family.

27. The Board have acknowledged the consent form signed by Ms C did not mention faecal incontinence as a possible complication. They have disputed whether Ms C was ever given an explicit assurance that there was no risk of this complication from her surgical procedure.

28. The advice I have received is that incontinence is a recognised complication from this type of surgery. The advice notes that it was clear Ms C was extremely concerned about this possibility. The advice also notes the medical staff responsible for her care had an obligation under GMC guidance to ensure that they had identified issues of importance to Ms C and discussed them with her as part of the process for obtaining her consent for the surgery. The advice concludes that Ms C was denied the opportunity to make an informed decision about the surgery she was to undergo.

29. In view of the advice I have received, I consider it was unreasonable that the issue of greatest importance to Ms C, her possible incontinence, was not discussed with her prior to her surgery. I do not accept the Board's position that the absence of any written evidence that assurances were given to her that there was not a risk of incontinence mitigates this issue. The responsibility for ensuring Ms C was able to give informed consent lay with her clinicians, especially as she had clearly articulated the issues around the surgery that concerned her.

30. I am also critical of the failure by the Board to fully answer Ms C's question regarding the cause of her incontinence over two letters of complaint. It is possible as the Board suggest that the cause is the on-going progression of her condition. It is also possible, however, that the condition has resulted from a well-recognised complication following her surgery and the failure by the Board to recognise or apologise for this is unreasonable.

31. I uphold the complaint and make the following recommendations.

Recommendations

32. I recommend that the Board:	*Completion date*
(i) review the consent forms used for this type of surgery to ensure they accurately reflect the potential complications;	18 May 2016

(ii)	remind staff of the importance of identifying and documenting that issues of importance to patients have been discussed during the consent process; and	4 May 2016
(iii)	apologise unreservedly to Ms C for the failings identified in this report.	4 May 2016

33. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date 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

Ms C	the complainant
the Hospital	Glasgow Royal Infirmary
the Board	Greater Glasgow and Clyde NHS Board
the Adviser	a consultant colorectal surgeon who provided advice on the care and treatment provided to Ms C
Doctor 1	a consultant plastic surgeon
Doctor 2	a consultant general surgeon
GMC	General Medical Council which registers all practising doctors in the United Kingdom

Annex 2

Glossary of terms

abscess	a swollen area of tissue within the body, containing an accumulation of pus
colorectal surgeon	a surgeon who operates on the colon, rectum, anus and pelvic floor.
colostomy	surgical procedure, which draws part of the intestine or colon through the abdominal wall and stitches it into place
diverticulitis	an inflammatory disease of the intestine
faecal incontinence	an inability to control bowel movements resulting in involuntary soiling
fistula	a small channel that develops between the end of the bowel and the skin near the anus.
peri-anal	situated in or affecting the areas around the anus
rectal sinus	a chronic condition which develops from an abscess, leaving a fissure prone to discharge
sphincter	circular muscle that controls a body passage or orifice
stoma	an opening in the skin of the abdomen, used to divert either faeces or urine to a bag on the outside of the body.

Annex 3

List of legislation and policies considered

General Medical Council. Consent: patients and doctors making decisions together