Scottish Parliament Region: North East Scotland

Case 200500717: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital; Clinical Diagnosis and quality of records.

Overview

The complainant (Mr C) raised two specific complaints regarding a Clinician (Clinician 1)'s diagnosis of his condition and the quality of the records taken by Clinician 1 during a consultation.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Clinician 1's diagnosis did not take into account all of the complainant's conditions and symptoms *(upheld)*; and

(b) the notes taken at a consultation were inaccurate and of poor quality *(not upheld)*.

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. I shall refer to the complainant as Mr C. On 10 June 2005, Mr C lodged a complaint with the Ombudsman's Office regarding the diagnosis of his condition following an assessment carried out by a doctor (Clinician 1). Mr C felt that Clinician 1 had not accurately diagnosed a spinal condition. Mr C also complained that the quality of notes taken at a consultation with Clinician 1 were not adequate and did not record all relevant information. The complaint had been lodged formally with Tayside NHS Board (the Board) and had completed the Board's complaints procedure. The complaint was, therefore, eligible to be examined by the Ombudsman. Mr C claimed that Clinician 1's diagnosis led to a false, misleading record within his medical records.

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

(a) Clinician 1's diagnosis did not take into account all of the complainant's conditions and symptoms; and

(b) the notes taken at a consultation were inaccurate and of a poor quality.

Investigation

3. The evidence gathering for this complaint was carried out via written and verbal requests for information from the Board. Mr C submitted evidence for consideration and I also examined Mr C's medical records. The investigation was also aided by one of the Ombudsman's clinical advisers (the Adviser) who provided a detailed assessment of the complaint by reviewing all the relevant documentation and medical records, including x-rays. The Adviser's area of expertise is hospital-related clinical issues.

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.

5. The Board, when commenting on the draft, stressed that they felt it should be acknowledged that Mr C was seen by two separate clinicians within NHS Tayside and that he had a detailed assessment. The Board also stated that it is clear from the evidence that the clinicians made every effort to speak to Mr C to try to assess what was occurring in what was a complex case.

(a) Clinician 1's diagnosis did not take into account all of the complainant's conditions and symptoms

6. Records show that Mr C has a history of cervical, thoracic and lumbar back pain (cervical relating to the neck area, thoracic relating to the mid-back area and lumbar relating to the lower back area) which has spanned over 20 years. Mr C has been assessed by numerous medical staff over this period. Mr C was assessed by Clinician 1 following a GP referral which was made due to Mr C's ongoing back pain.

7. On 17 November 2004, Clinician 1 issued a letter to Mr C's GP following his assessment. It is this letter that led to Mr C raising his first point of complaint. The letter contained a number of statements which Mr C disagreed with and felt that the letter portrayed a false impression of his conditions. The letter used the phrase 'completely normal' when referring to Mr C's spinal x-rays. The Adviser has noted that this term does not accurately reflect Mr C's spinal condition. Furthermore, the inclusion of this terminology led Mr C to believe that Clinician 1's overall diagnosis was inaccurate and that Clinician 1 had not taken into account all relevant factors of Mr C's condition.

8. Clinician 1's diagnosis was scrutinised by the Adviser to ascertain whether or not it was a reasonable assessment of Mr C's condition, based on the evidence available in Mr C's medical records. The Adviser has produced a report on his assessment of the complaint and his comments are summarised below:

> 'The history which [Clinician 1] took is satisfactory as is the examination which was recorded. There is concern with regards to [Clinician 1]'s interpretation of the X-rays as being completely normal as they do not appear to be normal. However, the evidence does not indicate that anything very serious has gone wrong and apart from some areas of slight concern, there is no practice that was less than reasonable in terms of the consultation provided by [Clinician 1].'

(a) Conclusion

9. Although the Adviser considered there were no significant points of concern in terms of the consultation, the fact remains that there were concerns regarding Clinician 1's assessment. I accept the Adviser's view and, therefore, this point of complaint is upheld. However, I am pleased to record here that Clinician 1 has since issued a revised letter clarifying his assessment of Mr C's condition following my suggestion which I put to the Board during the conduct of

my investigation. As appropriate action was taken to redress and remedy this point of complaint during the investigation, I have no further recommendations to make.

(b) The notes taken at a consultation were inaccurate and of poor quality

10. Mr C complained that Clinician 1 had failed to make full and comprehensive notes of Mr C's symptoms and suffering. In order to reach a conclusion on this aspect of the complaint, I requested a copy of the relevant medical notes from the Board and sought the Adviser's opinion on this matter. I also made an additional request for further information from the Board regarding the notes that were taken at the consultation.

11. It was Mr C's opinion that Clinician 1 failed to make comprehensive notes of his condition at the consultation. I have obtained and reviewed a copy of the handwritten notes that were recorded by Clinician 1.

(b) Conclusion

12. Having reviewed the relevant documents, the Adviser's view, which I accept, is that the records are of an acceptable standard, detailing the main points which Clinician 1, in his professional opinion, felt relevant to note. I am also conscious of the fact that Clinician 1 would have had the option of assessing any relevant medical history notes to assist him in reviewing Mr C's condition.

13. I am aware that it is Mr C's strong opinion that the notes were not of a suitable standard. It appears to me that Mr C expected that the notes would be more comprehensive and note his conditions in a greater level of detail. I can fully appreciate that Mr C may feel frustrated, having suffered from his conditions for a prolonged period of time, particularly when he was communicating his symptoms and conditions to medical staff. However, I am satisfied that the evidence demonstrates that the notes taken were of an acceptable standard.

14. To conclude, I am satisfied that the notes taken were of a reasonable standard and, therefore, I do not uphold this aspect of complaint.

22 August 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Clinician 1	The doctor who carried out the assessment of Mr C
The Board	Tayside NHS Board
The Adviser	One of the Ombudsman's clinical advisers