Scottish Parliament Region: Glasgow

Case 201101691: A Medical Practice in the Greater Glasgow and Clyde NHS Board area

Summary of Investigation

Category

Health: General Practice; clinical treatment; diagnosis

Overview

The complainant (Mr C) raised concerns about the failure by the medical practice (the Practice) to diagnose that he had Crohn's disease. He said that the Practice failed to carry out appropriate investigations, despite his regular visits complaining about stomach problems.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) over a five-year period from April 2005, the Practice unreasonably failed to diagnose that Mr C had Crohn's disease (*upheld*); and

(b) the Practice failed to respond properly to Mr C's letter of complaint (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Practice:	*Completion date*
(i) issue a written apology to Mr C for the failure to carry out further investigations and/or make a referral when he attended with ongoing bowel symptoms in March and April 2009;	1 August 2012
(ii) apologise to Mr C for the failure to take steps to try to obtain his full medical records in order that they could respond to his complaint in full; and	1 August 2012
(iii) make relevant staff aware of our finding on this matter.	1 August 2012

Main Investigation Report

Introduction

1. The complainant (Mr C) raised concerns about the failure by the medical practice (the Practice) to diagnose that he had Crohn's disease. He said that he attended the Practice about his stomach problems between 2005 and 2009 and was diagnosed with irritable bowel syndrome. He then registered with another medical practice in late 2009. They referred him for tests and Crohn's Disease was diagnosed. Mr C said that the consultant who made the diagnosis told him that it should have been diagnosed much earlier. He said that the Practice failed to carry out appropriate investigations, despite his regular visits complaining about stomach problems.

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

(a) over a five-year period from April 2005, the Practice unreasonably failed to diagnose that Mr C had Crohn's disease; and

(b) the Practice failed to respond properly to Mr C's letter of complaint.

3. Mr C said that:

- the Practice failed to investigate anything further than one endoscopy, despite his regular visits complaining about stomach problems;
- all GPs at the Practice misdiagnosed him on many occasions by not ruling out other conditions prior to making a diagnosis; and
- the GPs at the Practice wrote many sick lines for him and still failed to act.

Investigation

4. Investigation of the complaint involved reviewing the Practice's medical records for Mr C. My complaints reviewer also obtained advice from a medical adviser (the Adviser).

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of terms used in this report can be found at Annex 2. Mr C and the Practice were given an opportunity to comment on a draft of this report.

(a) Over a five-year period from April 2005, the Practice unreasonably failed to diagnose that Mr C had Crohn's disease

Background

6. Mr C joined the Practice in April 2005. He had an endoscopy at Glasgow Royal Infirmary on 8 April 2005 and was diagnosed with minor reflux oesophagitis, gastritis and duodenitis. The endoscopy had been arranged before he joined the Practice.

7. Mr C was seen by a GP from the Practice on 9 May 2005. The medical records show that he complained of upper abdominal pain, although Mr C has told us that he did not state that the pain was isolated to the upper abdominal area. He attended the Practice again on 29 August 2005 and it was recorded that he still had epigastric pain and had vomited some blood. An ultrasound of his abdomen was performed to see if gallstones were present and this diagnosis was excluded. He attended on 2 September 2005 and further tests were carried out. He made further visits to the Practice on 12 September 2005 and 27 September 2005.

8. A locum GP from the Practice referred Mr C to gastroenterology at Glasgow Royal Infirmary on 28 September 2005 for further investigations. In the referral letter, she said that she wondered if Mr C needed investigation to exclude a diagnosis such as inflammatory bowel disease. The term inflammatory bowel disease is used mainly to describe two diseases: Crohn’s disease and ulcerative colitis. Both Crohn’s disease and ulcerative colitis are chronic long-term diseases that involve inflammation of the gastrointestinal tract.

9. Mr C subsequently attended a private hospital on 5 October 2005. The consultant he saw there wrote to the Practice on the same day and said that he considered Mr C had functional dyspepsia. Mr C then attended a gastroenterology clinic at Glasgow Royal Infirmary on 14 February 2006. He was diagnosed with mild gastro-oesophageal reflux disease.

10. Mr C has stated that he continued to attend the Practice over the next few years due to the continuing pain in his stomach. He said that he told the Practice that the medication he had been prescribed was not working. He told us that he started to feel that he was wasting his time. He said that the only suggested diagnosis was irritable bowel syndrome. There is little evidence in relation to this in the medical records.

11. Mr C attended a medical practice in another area on 9 January 2009 with abdominal pains. He then attended the Practice regarding his abdominal pain on 26 March 2009, 31 March 2009 and 17 April 2009. The Practice reviewed his medication.

12. Mr C left the Practice in November 2009, as he had moved out of the area. He registered with the medical practice he had attended in January 2009. The new practice referred him to Crosshouse Hospital on 15 December 2009. The hospital carried out an endoscopy on 26 February 2010. A barium enema was then carried out in April 2010. Mr C also had a colonoscopy and biopsies were taken. He was then referred to a consultant gastroenterologist and was subsequently diagnosed with Crohn's disease of the small bowel. He had part of his small bowel and part of his large bowel removed and a stoma bag fitted in November 2010.

Advice obtained

13. I asked the Adviser for his comments on the matter. In his response, he said that the initial consultations with Mr C at the Practice for 12 May 2005, 29 August 2005 and 2 September 2005 had scant notes, poor recording of history and minimal examination findings. He also said that the locum GP who saw Mr C on 12 September 2005 had clearly suspected inflammatory bowel disease and this was expressed in her referral letter of 28 September 2005. He said that the locum GP's referral to gastroenterology was detailed, clear and contained positive and negative results of relevant investigations.

14. The Adviser also commented that it was likely that Mr C's symptoms in 2005 were due to Crohn's disease. He said that the symptoms described in latter years were consistent with a stricture of the small bowel caused by Crohn's disease. He said that it was clear that the working diagnoses by the Practice was of dyspepsia and/or irritable bowel syndrome.

15. Mr C returned to the Practice with ongoing abdominal problems in March 2009. The Adviser commented that the major failing was that, despite the persistence of symptoms and the fact that inflammatory bowel disease had been raised by the locum GP in 2005, there was no attempt to review the case. He said that inflammatory bowel disease had not been excluded by tests and that imaging or investigation of the lower gastrointestinal tract was warranted. He also said that investigation by barium enema, colonoscopy or both would

have been reasonable and indeed this was the path chosen by the new practice later in 2009. The Adviser said that there was no evidence that the Practice reconsidered the previous diagnosis. He also commented that many patients settle rapidly on treatment for dyspepsia and Mr C's failure to respond should have placed the diagnosis in question.

16. The Adviser stated that there was a failure to further investigate and failure to refer the symptoms Mr C presented with in 2009. The Adviser said that these symptoms were rapidly investigated and a further referral made when Mr C moved to another practice.

The Practice's response

17. In line with our normal process, we sent both Mr C and the Practice a copy of the draft report on the complaint and offered them the opportunity to provide comments. In their response, the Practice said that Mr C had attended the Practice in 2005 and was referred to gastroenterology. They stated that a functional bowel disorder was subsequently confirmed.

18. The Practice commented that four years later, Mr C attended the Practice over a three-week period with gastrointestinal symptoms. They stated that on the second attendance at the Practice, Mr C was given a sick line for one week and a review was recommenced thereafter. They stated that Mr C attended again having failed to tolerate the prescribed therapy. They said that he subsequently left the Practice before further review and before any investigations could be organised. The Practice said that Mr C's gastrointestinal symptoms would have been investigated if he had continued to attend the Practice.

Mr C's response

19. In his response to the draft report, Mr C said that he had continued to discuss his ongoing stomach problems and the fact that his medication was not working with the Practice during the period 2006 to 2009. He stated that he remembered discussing this with individual doctors. He said that this was not recorded because of the Practice's poor record-keeping and their lack of interest.

(a) Conclusion

20. I agree with the Adviser that the case records for Mr C's initial visits to the Practice in 2005 are generally poor. However, on 28 September 2005, the

locum GP made a referral to gastroenterology at Glasgow Royal Infirmary for further investigations. In the referral letter, she said that she wondered if Mr C needed investigation to exclude a diagnosis such as inflammatory bowel disease. I am satisfied, therefore, that the Practice did make a referral for Mr C's bowel problems to be investigated at that time. I consider that this was an appropriate course of action. I also agree with the Adviser that the referral letter was detailed, clear and contained positive and negative results of relevant investigations. Mr C was seen at a gastroenterology clinic at Glasgow Royal Infirmary on 14 February 2006 and was diagnosed with mild gastro-oesophageal reflux disease. Although the medical advice I have received is that it was likely that Mr C's symptoms in 2005 were due to Crohn's disease, I consider that the Practice's actions at that time in making a gastroenterology referral were reasonable.

21. Mr C has stated that he continued to attend the Practice over the next few years due to continuing pain in his stomach. I have seen that he attended the Practice on several occasions between February 2006 and March 2009. I have considered Mr C's comments in response to the draft report that he did discuss his stomach problems with the Practice during this period. He said that this was not recorded because of the Practice's poor record-keeping and their lack of interest. However, the medical records state that his visits to the Practice were in relation to other medical problems and not his bowel problems. There is no clear and objective evidence in the contemporaneous medical records that Mr C discussed the continuing pain in his stomach with the Practice during this period.

22. Mr C returned to the Practice with abdominal pain in 26 March 2009. He was seen again on 31 March 2009 and on 17 April 2009 and his medication was reviewed. Although I do not consider that the Practice unreasonably failed to diagnose that Mr C had Crohn's disease over a five-year period from April 2005, I consider that they should have been more proactive when Mr C attended with ongoing bowel symptoms in March and April 2009. The Practice should have reconsidered the previous diagnosis of dyspepsia / irritable bowel syndrome and should have made further investigations and / or a further referral at that time.

23. For this reason, I uphold the complaint.

(a) Recommendation

24. I recommend that the Practice:	*Completion date*
(i) issue a written apology to Mr C for the failure to carry out further investigations and/or make a referral when he attended with ongoing bowel symptoms in March and April 2009.	1 August 2012

(b) The Practice failed to respond properly to Mr C's letter of complaint

25. Mr C said that the Practice failed to respond with the detail the complaints merited and failed to answer the questions asked.

26. Mr C sent a lengthy letter of complaint to the Practice on 26 January 2011. The Practice acknowledged receipt of the complaint on 28 January 2011. They then responded on 9 February 2011. They said that they did not hold a full set of his medical records and only held the electronic records from 2008, when they became a paper-light practice. They said that Mr C had transferred to the Practice in 2005, when they had been asked to take patients from another practice. They said that they could only see three consultations relating to his stomach problems and referred to the three consultations at the Practice in 2009. They also said that from the limited information they held, it was not possible to answer Mr C's questions. They said that all of his clinical contacts were contained within his medical records held by his current GP.

(b) Conclusion

27. I consider that, at the very least, the Practice should have offered to obtain a copy of Mr C's records from his current practice in order that they could respond to his complaint and answer his questions. They would have required Mr C's permission to obtain the records. The fact that they could only view the electronic records meant that they could not respond to Mr C's complaint in full or answer his questions. In view of this, I uphold the complaint.

(b) Recommendations

28. I recommend that the Practice:	*Completion date*
(i) apologise to Mr C for the failure to take steps to try to obtain his full medical records in order that they could respond to his complaint in full; and	1 August 2012
(ii) make relevant staff aware of our finding on this matter.	1 August 2012

29. The Ombudsman asks that the Practice notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Practice	The medical practice Mr C has complained about
The Adviser	The Ombudsman's GP Adviser

Annex 2

Glossary of terms

Barium enema	An injection of liquid into the rectum to enable x-rays to be taken
Colonoscopy	Inspection of the interior surface of the colon with a flexible endoscope
Crohn's disease	Inflammation, thickening, and ulceration of any of various parts of the intestine
Duodenitis	Inflammation of the first part of the small intestine
Dyspepsia	Difficulty in digesting food or indigestion
Endoscopy	A visual examination of the interior of a hollow body organ by use of an endoscope
Epigastric	Of or relating to the anterior walls of the abdomen
Gastritis	An inflammation of the stomach lining
Inflammatory bowel disease	Used mainly to describe two diseases: Crohn's disease and ulcerative colitis
Irritable bowel syndrome	A common intestinal condition characterized by abnormalities of the small and large intestines, causing variable symptoms including cramping, abdominal pain, constipation, and diarrhoea
Gastrointestinal tract	The tubular passage from mouth to anus
Oesophageal reflux disease	Abnormal backward flow of body fluids causing heartburn and acid indigestion