Scottish Parliament Region: South of Scotland

Case 200700599: Borders NHS Board

Summary of Investigation

Category

Health: policy/administration

Overview

The complainant (Mrs C) cancelled her planned hysterectomy at Borders General Hospital (the Hospital). She complained that poor administration by staff of Borders NHS Board (the Board) led to the temporary loss of her clinical records, leaving her with doubts as to the competence of the staff that were caring for her. Mrs C also had a number of concerns over the treatment that she was offered and did not feel that sufficient consideration was given to her family's medical history or her reaction to certain medications.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) administration and staff communication at the Hospital were poor (*upheld*);

(b) staff at the Hospital provided conflicting information about Mrs C's iron levels (*not upheld*);

(c) staff at the Hospital did not acknowledge the severity of Mrs C's gluten intolerance (*not upheld*); and

(d) staff at the Hospital inappropriately recommended a hysterectomy as the best treatment for Mrs C's condition (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board review their record tracking procedures and ensures that all staff are reminded of their responsibilities as far as updating the tracking system whenever records are forwarded to another party.

The Board have accepted the recommendation and will act on it accordingly.

Main Investigation Report

Introduction

1. The complainant (Mrs C) had developed a fibroid on her uterus. After a number of consultations with staff at Borders General Hospital (the Hospital) it was decided that the best course of treatment was for her to undergo a subtotal abdominal hysterectomy. This was scheduled for 19 April 2007. During a consultation on 3 April 2007, Mrs C was advised that her clinical records were unavailable and that Borders NHS Board (the Board)'s record tracking system held no record of their whereabouts. Mrs C had a complex medical history, including an apparent intolerance of gluten which limited the medication that she was able to take. She was concerned about the loss of her records, both in terms of the protection of her personal information and the lack of information being available to consultants making decisions on her treatment.

2. Having extensively researched her condition, Mrs C had concerns over the treatment options that were offered to her. This combined with a number of other factors led her to cancel her scheduled hysterectomy. Mrs C formally complained to the Board on 13 April 2007, outlining her concerns over the loss of her clinical records, and later complained about the management of her condition. Dissatisfied with the response that she received from the Board, she brought her complaint to the Ombudsman's office in May 2007.

3. The complaints from Mrs C which I have investigated are that:

(a) administration and staff communication at the Hospital were poor;

(b) staff at the Hospital provided conflicting information about Mrs C's iron levels;

(c) staff at the Hospital did not acknowledge the severity of Mrs C's gluten intolerance; and

(d) staff at the Hospital inappropriately recommended a hysterectomy as the best treatment for Mrs C's condition.

Investigation

4. In order to investigate this complaint, I have reviewed all of the complaint correspondence between Mrs C and the Board. I have also sought professional medical advice from a professional medical adviser (the Adviser) and reviewed the Board's clinical records for Mrs C.

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

(a) Administration and staff communication at the Hospital were poor

6. Mrs C was referred by her GP to the Hospital due to a mass arising from her pelvis, equivalent in size to a 16-week pregnant uterus. This was diagnosed as a fibroid (a benign tumour on the uterus). She also suffered from erythrocytosis (an increased level of red blood cells, which can lead to thickening of the blood) and an apparent intolerance to gluten.

7. Concerns about Mrs C's red blood cell levels led her GP to refer her to the Hospital in December 2006 for tests to be carried out. From February 2007 she attended regular haematology consultations at the Hospital, where her red blood cell levels were monitored. Where levels are found to be high, a venesection would be performed: this is a procedure to remove blood from the patient to maintain a normal concentration of red blood cells. During Mrs C's second consultation, on 3 April 2007, she was informed by the consultant haematologist (Consultant 1) that her clinical records were not available. The consultation was cut short and, as a precaution in the absence of Mrs C's previous records, Consultant 1 carried out a half unit venesection (taking half the amount of blood that a normal venesection would), leaving Mrs C concerned about her red blood cell levels.

8. The loss of her clinical records concerned Mrs C. She was unhappy that important information about the treatment that she had received to date and other conditions that she suffered from were not available to consultants, hindering the treatment process. She was also concerned that detailed personal information about her was unaccounted for.

9. Mrs C made a verbal complaint to the Board about the loss of her clinical records on 13 April 2007. In the meantime, her records were found on 5 April 2007 and a letter was sent to her on 10 April 2007 informing her of this. The records had reportedly been in the possession of one of the consultant gynaecologists' (Consultant 2) secretaries and were found two days after their loss was reported.

10. The written record taken following Mrs C's verbal complaint noted that, at the time of Mrs C's haematology consultation, the Board's clinical records

tracking system, Homer, said that there were 'no notes' for her. I asked the Board what would lead to a patient's records having the status 'no notes'. I was told that this was not a recognised status on Homer and that it was likely that enquiries would have been made by haematology staff at the time, which may have led staff in other departments to state that there were 'no notes' with them. The Board concluded that the verbal complaint note must refer to staff comments rather than the status on the clinical records tracking system.

11. Mrs C told me that on 3 April 2007, when it was established that the notes were missing, she and her husband had suggested that they may be with Consultant 2's secretary. Mrs C said that she was told that the secretary had been asked more than once but had denied having the notes.

12. The letter of 10 April 2007 that was sent to Mrs C by Consultant 1 to confirm that her records had been found was sent to her with her name, as addressee, scored out and '[Consultant 2] for info' written in its place.

13. In a letter to the Board dated 24 May 2007, Mrs C also recounted visiting a subsequent clinic at the Hospital where her clinical records were again misplaced, albeit temporarily. However, she said that there were a number of other patients' records left on shelves and trolleys, easily accessible by passers by.

14. The above incidents combined to leave Mrs C with doubts over the Board's organisational and administrative capabilities.

15. In their correspondence with Mrs C, the Board apologised for the loss of her clinical records but stressed that these had only been missing for two days (between the consultation of 3 April 2007 and their recovery on 5 April 2007). As part of my investigation into this complaint, I asked the Board to provide a history from their Homer system to show the last known whereabouts of the records and their movements around the time of their loss. I was informed that Homer only retains details of the ten most recent moves. By the time of my enquiry, more than ten moves had occurred and information relevant to the complaint was, therefore, lost. I was able to establish from Mrs C, however, that her most recent visit to the Hospital prior to 3 April 2007 was to see the radiologist on 9 March 2007. I understand this to be the last confirmed occasion that Mrs C's records were available prior to 5 April 2007. This is supported by the Board's response to Mrs C's complaint, dated 10 May 2007,

which confirmed that the records were temporarily lost between the Radiology department and Consultant 2's secretary. It was in this letter that the Board stressed that the records were only missing for two days.

(a) Conclusion

16. I was unable to confirm Mrs C's comments about clinical records being left unattended although I do acknowledge her concerns about the security and confidentiality of patient information, given the loss of her own records. Similarly, no explanation has been provided as to why the letter of 10 April 2007 was sent out to her in a form that was evidently intended for an internal staff member. Although neither of these issues directly impacted on Mrs C's treatment, I accept that they would have added to any concerns that she may have harboured over the Board's competence following the loss of her clinical records.

17. The Board have accepted that Mrs C's clinical records were lost. Their investigations into Mrs C's complaint concluded that they went missing temporarily between the Radiology department and Consultant 2's secretary but that they were only lost for two days. Given that the last confirmed reference to the records was 9 March 2007 and their absence was not highlighted until 3 April 2007, it would be more accurate to say that Mrs C's clinical records were unaccounted for between these two dates, rather than the two days that it took to find them having realised on 3 April 2007 that they were not where they should have been. It is impossible to say at this stage where the notes were at any given time or to confirm when they left the Radiology department. However, given the importance of the information contained in patient files and its relevance to ongoing care and maintaining confidentiality, it is imperative that staff at the Hospital know at all times where to access the clinical records. I consider the loss of Mrs C's records, for whatever duration, to be a failure in what is a crucial record-keeping procedure. I, therefore, uphold this complaint.

(a) Recommendation

18. The Ombudsman recommends that the Board review their record tracking procedures and ensures that all staff are reminded of their responsibilities as far as updating the tracking system whenever records are forwarded to another party.

(b) Staff at the Hospital provided conflicting information about Mrs C's iron levels

19. In her letter to the Board of 24 May 2007, Mrs C included a list of reasons for cancelling her hysterectomy surgery. One of the reasons listed was that she had concerns for her safety should the operation go ahead. She said that Consultant 1 had told her that she was at serious risk of stroke or thrombosis due to iron overload. The threat was increased during and after surgery. Initial diagnosis and investigations into the treatment of Mrs C's fibroid were performed by another consultant gynaecologist at the Hospital (Consultant 3). Consultant 3 reportedly told Mrs C, in August 2006, that high iron levels and red blood cell count are a good thing and that the condition could not be treated. This seemingly conflicting advice unsettled Mrs C and contributed to her decision to cancel her operation.

20. The level of iron in the blood is linked to the level of haemoglobin, an oxygen-carrying agent in red blood cells which contains iron. Patients that suffer from erythrocytosis have an increased number of red blood cells and, therefore, an increased level of haemoglobin.

21. I asked the Adviser to review the clinical records and comment on the advice that was given to Mrs C. The Adviser could find no evidence of advice given by either Consultant 2 or Consultant 3 about the benefits or risks of high haemoglobin levels. Both gynaecologists do, however, acknowledge in correspondence with Mrs C's GP, an association between fibroids and increased red blood cell production and note her concerns on this topic.

22. The clinical records contain evidence that Consultant 1 explained the possible risk of high haemoglobin levels. In a letter to Mrs C's GP dated 4 April 2007, he explained that she was at risk of vascular occlusion (blockage of the blood vessels) in view of her high number of red blood cells.

23. The Adviser further explained that an increased number of red blood cells would not result in any visible symptoms, however, blockage of the blood vessels is a risk if the condition is uncontrolled. Such a blockage could lead to a stroke or heart attack or loss of blood supply to a limb.

(b) Conclusion

24. Although I am unable to comment on the content of verbal discussions that Mrs C would have had with Consultant 2 and Consultant 3, the records that

are available to me do not indicate a contradictory assessment of the risks associated with her haemoglobin levels or that it was suggested that high haemoglobin levels were a good thing. Both consultant gynaecologists noted an association between her fibroid and a potential increase in red blood cell count. Her concerns in this regard were recorded.

25. High iron levels, associated with high haemoglobin levels, did present a risk if uncontrolled. Mrs C's haemoglobin levels were monitored and controlled via regular haematology consultations from February 2007. It is clear that, subsequently, all three consultants involved in Mrs C's care were aware of her potential for increased haemoglobin levels. All evidence that I have seen suggests that this was considered when decisions were being made as to her ongoing treatment. Although I cannot confirm what advice was given to Mrs C verbally, I am satisfied that specialists within the haematology and gynaecology disciplines approached Mrs C's treatment plan with appropriate acknowledgement of her propensity toward raised levels of haemoglobin. With this in mind, I do not uphold this complaint.

(b) Recommendation

26. The Ombudsman has no recommendations to make.

(c) Staff at the Hospital did not acknowledge the severity of Mrs C's gluten intolerance

27. Mrs C had an apparent intolerance to gluten. She was not confident that staff that dealt with her at the Hospital understood the severity of her condition or the effect that medications that included gluten in their ingredients would have on her.

28. In Consultant 1's letter to Mrs C of 10 April 2007, he commented that he did not believe her gluten allergy had been fully documented and asked whether she could bring all of her current medications to their next clinic so that he could take a look at them. Mrs C said that she was surprised to learn that her condition was not fully documented as she had undergone a number of tests in the past to assess the impact that gluten had on her. She explained that thorough tests had been carried out in Durham in 2000 and that the results, which suggested gluten sensitivity, should be contained in her clinical records. As the tests in Durham were carried out privately, no notes were held in the Board's records.

29. Mrs C wrote to Consultant 1 on 18 April 2007 expressing her concern that her gluten intolerance had not been documented. In her letter she explained the effect that gluten had on her, providing witness accounts relating to one episode during treatment at another hospital in 2002. Mrs C had no recollection of the event, however, her children recounted that she began to shake to the point of fitting. Her skin became red and itchy and her mood alternated between aggression and depression over a period of around 45 minutes.

30. A 'gluten challenge' was performed on Mrs C by the Hospital. This six-week test reportedly had to be abandoned after only six hours as she became too unwell to continue. Mrs C told Consultant 1 that she was reluctant to undergo any further tests involving gluten in case she experienced a similar reaction.

31. Mrs C explained to Consultant 1 in her letter of 18 April 2007, that she did not wish to pursue a diagnosis for her gluten allergy, but sought reassurance that staff at the Hospital recognised the consequences of giving her medication containing gluten. She was concerned that the Hospital staff may not be aware of which medication contained gluten. She reminded Consultant 1 that she had been admitted to the Hospital in January 2007 as an emergency patient and had been prescribed medication containing gluten, despite having told staff of her intolerance upon arrival. On that occasion, she reportedly refused to take the medication. Mrs C also commented that even basic medication such as paracetamol used at the Hospital contained gluten. She said that she had to ask the Hospital staff for a list of ingredients in any medication to be used, as she did not feel that the staff knew how to check for gluten.

32. It is clear from the correspondence between Mrs C and consultants at the Hospital that she had researched gluten intolerance extensively and consistently raised the subject with the Hospital staff.

33. Coeliac disease is the medical condition caused by gluten intolerance. Mrs C's clinical records contain a report that she wrote dated 6 May 2003 in which she states that she underwent blood tests in February 2002 which proved negative for coeliac disease. Her GP noted in correspondence with staff at the Hospital that Mrs C adhered to a gluten-free diet on the advice of a chiropractor GP that she had visited. Whilst acknowledging this, he was unsure whether or not she had been formally diagnosed with coeliac disease. Another GP at Mrs C's local practice noted, in a letter to Consultant 1, that she had had two

coeliac disease screens performed, one in 2004 and one in December 2006, both of which were negative. Consultant 1 noted in correspondence with the GP that these screens were performed at a time when Mrs C was on a self-imposed non-gluten diet and that negative results do not exclude coeliac disease under these circumstances. There are a number of references to Mrs C's gluten sensitivity in the clinical records. The consistent opinion of consultants that examined her was that she may have a gluten or general food intolerance, and that coeliac disease could not be ruled out.

34. When investigating this complaint I wanted to establish whether Consultant 1 and Consultant 2 were both aware of Mrs C's apparent gluten intolerance, as these two consultants were responsible for the overall management of her erythrocytosis and fibroid respectively. Discussions and correspondence between Consultant 1 and Mrs C are documented in the clinical records. Notes taken following her haematology consultation of 3 April 2007 acknowledge that gluten-free tablets were to be obtained and in his subsequent letter to Mrs C's GP, Consultant 1 stated that he believed that Mrs C had coeliac disease. Subsequent enquiries made by Consultant 1 into medication for Mrs C specifically asked the Hospital's Pharmacy department to check for gluten before providing the requested medication.

35. By cancelling her hysterectomy operation, Mrs C did not require treatment from Consultant 2 that required medication. However, a meeting with a dietician was planned to take place during the week prior to the operation. Mrs C said that the planned meeting was discussed on a number of occasions but a date was never confirmed. She said that this contributed to her decision to cancel her surgery.

(c) Conclusion

36. Whilst Mrs C raised concerns about staff at the Hospital's general competence when prescribing medication, I have only considered the approach of the two consultants that managed her treatment during the time period relevant to this complaint; Consultant 1, her haematologist, and Consultant 2, her gynaecologist. The question of whether Mrs C's apparent gluten intolerance was taken seriously by clinical staff is only relevant to Consultant 1, as he was the only consultant to prescribe medication during this time. I acknowledge, however, that Mrs C was generally anxious about the Hospital's understanding of her condition and that this may have contributed to her decision to cancel her surgery.

37. There are a number of notes in Mrs C's clinical records which record her, and her husband's, concerns regarding gluten intolerance. Consultant 1 also received a number of letters on the subject from Mrs C's GP practice and other consultants that had examined her. Although no clear diagnosis of coeliac disease had been made for Mrs C, there is evidence to show that Consultant 1 was aware of her concerns and that he accepted that she probably did have coeliac disease and proceeded on that basis. Correspondence between Consultant 1 and the Hospital's Pharmacy department confirms that he specifically requested that any medication was checked for gluten before being prescribed to Mrs C.

38. I am satisfied that there was sufficient information available in the clinical records to make staff at the Hospital aware of Mrs C's sensitivity to gluten. Furthermore, there is evidence to show that her concerns were taken seriously and that Consultant 1 sought to use medication that did not contain gluten. With this in mind, I do not uphold this complaint.

(c) Recommendation

39. The Ombudsman has no recommendations to make.

(d) Staff at the Hospital inappropriately recommended a hysterectomy as the best treatment for Mrs C's condition

40. In her complaint to the Board, Mrs C said that she was reluctant to undergo a hysterectomy operation, as there was a poor history of this procedure in her family. Two of her female relatives had died of surgical complications during, or shortly after, hysterectomy and two more had been left doubly incontinent. Mrs C felt particularly vulnerable to complications given her erythrocytosis and a history of high blood pressure.

41. In her letter to the Board of 24 May 2007, Mrs C explained that, at the time of agreeing to the hysterectomy, she had tried to discuss her concerns with Consultant 2, but had been too upset to be totally coherent so Consultant 2 had gone ahead and booked the surgery. After cancelling her operation, Mrs C sought treatment at the Royal Victoria Infirmary in Newcastle upon Tyne. She said that the consultant there was surprised to learn that a hysterectomy had been offered as the best course of treatment for her fibroid, as other, more appropriate options were available that could have been used alongside a more holistic approach to treatment.

42. Fibroids affect individuals differently. Some will experience no symptoms, while others may be affected by abdominal pain, heavy periods, incontinence or infertility. Mrs C said that her quality of life was significantly affected by heavy periods and constant abdominal pain.

43. Initial diagnosis and investigations into the treatment of Mrs C's fibroid were performed by Consultant 3. The clinic letter written by Consultant 3 following Mrs C's first consultation on 8 June 2006 stated that Mrs C was 'not keen on surgery and I would agree with her because of her underlying medical risks'. The letter recorded that Consultant 3 had suggested that the best option would be to monitor the fibroid by ultrasound every six months to make sure that it was not causing any further problems and to assess its size. Should Mrs C's heavy, painful periods continue, she could be administered Depo-provera injections (a progesterone injection used as a contraceptive). This would stop her periods until she passed the menopause, after which the fibroid would shrink naturally. An alternative suggestion of uterine artery embolisation (a procedure carried out under x-ray control which involves the insertion of small coils to block the arteries that supply the fibroid) was also made. This treatment was not available at the Hospital, but it was noted in the letter that it could be carried out at the Royal Infirmary of Edinburgh.

44. Mrs C wrote to Consultant 3 on 5 July 2006. She stated that she found the proposed 'watchful waiting' approach, with regular screening to be appropriate at that time. However, she suggested that the screening take place more frequently than the six-month intervals proposed by Consultant 3. This was due to concerns that she had over her haemoglobin levels. Although tests had shown that her haemoglobin levels were at the top end of normal levels, Mrs C had researched her condition and established that high haemoglobin levels are not unknown in women with fibroids. Having doubts over the validity of the haemoglobin information, Mrs C suggested that blood tests be taken more frequently than the proposed six months. Mrs C expressed her reluctance to go with the Depo-provera option given adverse reactions that she had had to 'safe' medications in the past and specifically to contraceptives containing progesterone.

45. Mrs C also obtained the patient information leaflet for Depo-provera injections, which listed a number of health considerations that should be taken into account before proceeding with the treatment. Mrs C had a personal and

family history of a number of the conditions listed. She said that, after raising this with Consultant 3, he maintained that Depo-provera was a safe option for her. Her concerns over the potential side effects of Depo-provera added to her reluctance to follow this treatment path.

46. Consultant 3 responded to Mrs C's comments in a letter dated 17 July 2006. He explained that he was aware of the association between fibroids and haemoglobin levels. He also acknowledged Mrs C's concerns over Depo-provera. Whilst his letter sought to reassure Mrs C that Depo-provera was a suitable treatment for the management of her periods until such time as her fibroid began to shrink, he did recognize that she was unwilling to consider this option and invited her to make an appointment to discuss her other options.

47. Mrs C met with Consultant 3 on 14 August 2006 to talk through her options. In the clinic letter following this consultation, Consultant 3 noted that he had found Mrs C difficult to deal with, as it was obvious that she had extensively researched her condition and was reluctant to consider any medication or surgery without asking many questions. As well as those treatments already discussed during the consultation of 8 June 2006, microwave endometrial ablation (destruction of the wall of the uterus by heating it with microwaves), a contraceptive coil and hysterectomy were all suggested as possible treatments. It is noted that Mrs C's preferred option was the microwave endometrial ablation, however, she still had concerns over the anaesthetic that would be used for this operation. Consultant 3 suggested that she be admitted the day before the operation to go through all of the medications that would be used with the anaesthetist. This would give her the opportunity to raise any concerns that she may have. Consultant 3's clinic letter stated that Mrs C was offered a date for surgery in September 2006 but that she did not feel well enough to undergo the procedure at that time, and it was, therefore, left to her to book an appointment at a time that suited her. Mrs C told me that this was not the case. She said that, during the consultation, Consultant 3 told her that microwave endometrial ablation was a simple procedure that required no preparation and only a short visit to the hospital. A telephone number was provided to Mrs C for her to call and book an appointment. Upon calling to make an appointment, Mrs C was told that a minimum of six months' hormonal treatment was required before the procedure could be carried out. Mrs C decided not to proceed with the treatment, being reluctant to undergo the hormonal treatment due to the effect that a hormonal disturbance could have on her blood pressure.

48. In February 2007, Mrs C requested a second opinion on her treatment options. Although records concerning this are limited, I understand from talking to Mrs C that this was largely due to her reluctance to continue treatment with Consultant 3. She said that she had found his attitude to be aggressive and was upset when he discussed her condition in a public corridor.

49. Mrs C was examined by Consultant 2 on 21 February 2007. In a letter sent to Mrs C's GP following the consultation, Consultant 2 noted that Mrs C had complained of worsening symptoms and a poor quality of life as a result of her fibroid. Again, the clinical records indicate that the various treatment options were discussed. Mrs C was said to be reluctant to undergo any hormonal therapy and she was concerned that microwave endometrial ablation and uterine artery embolisation could both leave her with pain following the procedure. It was recorded that, although Mrs C had substantial concerns over undergoing a hysterectomy due to her family history, her quality of life at that time meant that the benefits of a hysterectomy outweighed the risks. With this in mind, she and her husband agreed that this was the best course of action. Following this consultation, an appointment was made for surgery on 19 April 2007. Mrs C disagreed with the recorded description of the consultation and told me that a hysterectomy was the only suggested option.

50. Mrs C cancelled her hysterectomy operation on 28 March 2007 and provided a list of reasons why in her letter to the Board of 24 May 2007. In addition to the reasons mentioned earlier in this report, she felt that insufficient information had been made available to her regarding the surgery and how it would affect her in the following weeks. A case conference was to be arranged prior to the operation to discuss her concerns over medication and diet, however, she said that this had not been organised.

51. Following cancellation of her operation, Mrs C was referred by her GP to the Royal Victoria Infirmary in Newcastle upon Tyne. She told me that she was unhappy with the gynaecology staff at the Hospital as, having spoken to staff at the Royal Victoria Infirmary, she understood that a more holistic treatment plan alongside uterine artery embolisation would have been a more effective means of addressing the symptoms caused by her fibroid. She felt that she should have been made aware of these options by the Hospital in light of her concerns over undergoing a hysterectomy.

(d) Conclusion

52. Mrs C felt she had been pressurised by the Hospital's consultant gynaecologists into agreeing to a hysterectomy operation and that she was not made aware of the other, non-surgical, options available to her. She felt that this was particularly inappropriate considering the concerns that she had over medication of any kind and of undergoing surgery.

53. It is clear from the clinical records that a number of different treatments were discussed with Mrs C. It would also appear that she had a good knowledge of the various options available to her and their potential side effects, having carried out her own research. Consultant 3 did propose one non-surgical option; leaving the fibroid but monitoring it every six months, on the assumption that it would eventually shrink naturally.

54. In reviewing this complaint, I have considered whether the suggestions that were made by Consultant 2 and Consultant 3 were reasonable or whether, given Mrs C's sensitivity to medication and reluctance to undergo surgery, homeopathic or other non-surgical treatments should have been included as options.

55. The Adviser reviewed the complaint file and the clinical records and commented on the treatment options proposed by Consultant 2 and Consultant 3. He said that he considered the range of treatments offered to be appropriate, given Mrs C's presenting symptoms and history. He also considered that the comments made in clinical letters in the file indicated that Consultant 2 and Consultant 3 had gone to great lengths to help Mrs C understand her condition and the available treatment options.

56. Mrs C presented with advanced symptoms and a complex history of other conditions that could affect the treatment of her fibroid. Although no formal diagnosis of an allergy to progesterone appears to have been made for Mrs C, her account of previous problems with this medication was accepted and a course of Depo-provera injections was ruled out. The other options discussed with Mrs C are all recognised and appropriate treatments for fibroids. Despite her concerns, there was no evidence from Mrs C's past medical history to suggest that she would not react well to any of these treatments and full discussions were held with her to ensure that she was aware of the procedures involved. Ultimately the decision to undergo a hysterectomy appears to have

been made by Mrs C and her husband with all relevant information being available to them.

57. I am aware that there are a number of non-surgical options for treating the symptoms caused by fibroids. However, I accept the opinions of Consultant 2 and Consultant 3, given that they were able to carry out a full assessment of Mrs C's presenting symptoms. Although I cannot comment as to any information that Mrs C may have been provided with verbally, the evidence that I have seen suggests that she was made aware of a number of options that I find reasonable for the treatment of her symptoms. I have seen no evidence to suggest that hysterectomy was favoured by Consultant 2 and Consultant 3 or that the decision to undertake this procedure was made without her involvement. As such, I do not uphold this complaint.

(d) Recommendation

58. The Ombudsman has no recommendations to make.

59. The Board have accepted the recommendation and will act on it accordingly. The Ombudsman asks that the Board notify her when the recommendation has been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Hospital	Borders General Hospital
The Board	Borders NHS Board
The Adviser	Professional medical adviser
Consultant 1	A consultant haematologist at the Hospital
Consultant 2	A consultant gynaecologist at the Hospital
Consultant 3	A consultant gynaecologist at the Hospital