**Scottish Parliament Region:  Glasgow**

**Case 200802430:  Greater Glasgow and Clyde NHS Board**

## Summary of Investigation

***Category***

Health:  Hospital; gynaecology

***Overview***

The complainant (Ms C), who is an advice caseworker, raised a number of concerns on behalf of her client (Ms A), about the treatment which Ms A had received at the Department of Urogynaecology at the Southern General Hospital, Glasgow (the Department).  Ms A had undergone surgery in 2007 and since then has suffered with incontinence, urinary infections, loss of lower body sensation, vaginal discharge and severe pain.

***Specific complaints and conclusions***

The complaints which have been investigated are that:

(a) proper informed consent was not obtained prior to surgery (*upheld*);

(b) the clinical treatment which was provided was inadequate (*not upheld*); and

(c) following surgery, staff failed to take prompt action to establish the cause of Ms A's concerns (*upheld*).

***Redress and recommendations***

The Ombudsman recommends that Greater Glasgow and Clyde NHS Board (the Board):

(i) review their consent process, to ensure that patients have enough time to digest the information provided by staff and in information leaflets and that sufficient space is available on the consent forms to list what has been discussed;

(ii) share this report with the staff involved and ask them to reflect on the advisers' comments about considering alternative procedures prior to surgery; and

(iii) apologise to Ms A for the failings which have been identified in this report.

The Board have accepted the recommendations and will act on them accordingly.

## Main Investigation Report

### Introduction

1. The complainant (Ms C), who is an advice caseworker, raised a number of concerns on behalf of her client, Ms A, about the treatment which Ms A had received at the Department of Urogynaecology (the Department) at the Southern General Hospital, Glasgow. Ms A had undergone surgery in 2007 and since then has suffered with incontinence, urinary infections, loss of lower body sensation, vaginal discharge and severe pain. Ms A had complained to Greater Glasgow and Clyde NHS Board (the Board) but remained dissatisfied with their responses and subsequently, for health reasons, she asked Ms C to take up her complaints with the Ombudsman.

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

(a) proper informed consent was not obtained prior to surgery;
(b) the clinical treatment which was provided was inadequate; and
(c) following surgery, staff failed to take prompt action to establish the cause of Ms A's concerns.

### Investigation

3. In writing this report I have had access to Ms A's clinical records and the complaints correspondence from the Board. I obtained advice from two of the Ombudsman's professional medical advisers regarding the clinical aspects of the complaint. Adviser 1 is a consultant obstetrician and gynaecologist with a specialist interest in urogynaecology and Adviser 2 is a consultant obstetrician and gynaecologist.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. There are a number of technical terms and procedures referred to in this report. An explanation of the abbreviations used in this report is contained in Annex 1 and a glossary of terms used in this report is contained in Annex 2. Ms C and the Board were given an opportunity to comment on a draft of this report.

**(a) Proper informed consent was not obtained prior to surgery; (b) the clinical treatment which was provided was inadequate; and (c) following surgery, staff failed to take prompt action to establish the cause of Ms A's concerns**

*Clinical background*

5. Adviser 1 reviewed the clinical records and said that Ms A was referred to the Department in late 2006. The referral indication was for stress urinary incontinence and intermittent vaginal discharge. Ms A was seen on 15 November 2006 by a registrar (Registrar 1), when it was noted that Ms A had had the leakage problems for a number of years and that her symptoms were worsened by a chronic cough from her bronchiectasis. It was also recorded that there were recurrent bladder infections, such as urinary tract infections (UTIs) and a sensation of prolapse (descent of pelvic organs). Examination by Registrar 1 confirmed utero-vaginal prolapse. In view of the urinary symptoms, urodynamic investigations were carried out on 28 February 2007, which confirmed that the leakage problem was due to bladder neck weakness. Registrar 1 wrote to Ms A on 8 March 2007 informing her of this and recommending a procedure to improve the symptoms (taping of bladder). He also asked her to return for a follow-up appointment for discussion. His letter referred to an enclosed leaflet giving information about the procedure.

6. Ms A was reviewed on 2 May 2007 by another registrar (Registrar 2) who discussed the symptoms of prolapse further and carried out a further examination confirming the diagnosis. In view of this, it was decided to combine the bladder neck operation for the incontinence (transobturator (TOT) tape) with a prolapse repair operation.

7. Consent for the operation was taken on 23 May 2007, which was the day before the planned surgery. The consent form stated 'TOT, pelvic floor repair plus or minus vaginal hysterectomy'. Consent was obtained by Registrar 1. The operation was carried out on 24 May 2007 by Registrar 1 under the supervision of a consultant urogynaecologist (Consultant 1). The operation notes recorded a standard and uncomplicated vaginal hysterectomy and anterior vaginal prolapse (non-mesh) repair, along with insertion of the transobturator tape. Post-operative recovery was straightforward and Ms A was discharged home after three nights. Ms A was seen in the Department as an emergency on 18 June 2007 with a heavy vaginal discharge and having passed

blood. Ms A was given reassurance and it was noted she was on a number of antibiotics which had been prescribed by her GP.

8. Ms A was reviewed at a follow-up appointment on 27 June 2007 by Registrar 1. It was recorded that there was resolution of both prolapse symptoms and stress incontinence. The only complaint was the presenting discharge but examination showed a stitch remnant as a possible cause and this was removed. There was no other abnormality on examination and estrogen vaginal tablets and betadine pessaries were prescribed. Further follow-up was arranged after three months. At this time (12 September 2007) Ms A was seen by Registrar 1. A continuing history of back pain and vaginal discharge was given by Ms A. The pain was episodic and typically followed by an episode of heavy discharge. An ultrasound scan was organised, which showed a possible area of fluid in the pelvis and, in view of the clinical findings, it was felt that the diagnosis was a resolving pelvic abscess. Adviser 1 explained a pelvic abscess is a complication of a hysterectomy whereby a collection of infected material, mainly fluid, gathers in the pelvis adjacent to the vaginal vault. Symptoms are variable but consist of pain, intermittent fever and discharge.

9. Adviser 1 noted that Registrar 1 recommended three weeks of antibiotics, followed by a further scan and review. This review was carried out on 8 October 2007 by another registrar (Registrar 3). The result of the repeat scan showed the fluid collection to be slightly smaller. Ms A reported feeling better on this occasion. Registrar 3 discussed the case with Consultant 1, who recommended continuing conservative management and review after two months. However, Ms A telephoned the Department after the consultation and requested a further review. She was seen by Registrar 1 on 10 October 2007. Adviser 1 said the clinical history recorded was slightly different on this occasion: it was noted that the discharge responded only briefly to antibiotics. A thorough vaginal examination was undertaken and this showed some small polyps of granulation tissue. These were cauterised and arrangements were made for a further review in two weeks.

10. Ms A was reviewed by Consultant 1 on 24 October 2007. He decided to proceed with an exploratory laporotomy with possible ovarian removal and drainage of any residual pelvic collection. Laparotomy was carried out on 25 October 2007 and both ovaries were removed. Post-operative recovery was recorded as being uncomplicated, with good spontaneous bladder function on

removal of the indwelling catheter the following day. Out-patient review was conducted by Consultant 1 on 12 December 2007. It was recorded that Ms A's pain had resolved. Consultant 1 also recorded that there was return of some stress incontinence. He suggested a conservative approach but made clear that, after a few months, if the problem continued then Ms A could contact the Department by telephone to arrange a further review. In February 2008, Ms A contacted the Department as her symptoms had continued but she was told that she would need to go back to her GP (the GP) for a formal referral. The GP duly made the referral and a further appointment was made for 26 March 2008.

11. At that appointment, Ms A described ongoing patternless urinary leakage and loss of bladder sensation, with possible incomplete emptying. No abnormality was seen on examination. Following discussion with another consultant gynaecologist (Consultant 2), voiding studies were arranged. The voiding assessment was carried out on 24 April 2008. The assessment showed some large volumes of urine passed. Residual urine in the bladder was measured and some of the measurements showed significant volumes of urine remaining in the bladder following voiding. It was noted the dribbling of urine during walking was the main complaint and that there was no sensation of feeling the bladder full. The specialist nurse recommended intermittent self-catheterisation (ISC) and this was started immediately. Subsequent telephone review in early May 2008 revealed that there appeared to be some improvement in the symptoms, although the amounts of urine obtained by ISC were moderate and only present at all in the morning and evenings.

12. Ms A was seen by Consultant 2 on 26 June 2008. It was noted that in the morning and evenings there was still urine drained at self-catheterisation. He noted that Ms A's fluid intake was on the high side, in excess of 2000 millilitres per day and advised her to cut this. He suggested that self-catheterisation in the morning and evening should continue. Ms A still complained of a discharge and vaginal examination showed no cause for this. Ms A was discharged from the Department and in a letter to her GP Consultant 2 advised that he felt Ms A was best 'left alone'. Shortly after this, on 4 July 2008, the GP re-referred Ms A asking specifically for a second opinion in view of her lack of satisfaction with the outcome of the treatment she had had so far. After some delay, Ms A received a letter allocating her an appointment once again with Consultant 2 for 22 September 2008, some 11 weeks after the referral. Ms A was not happy with this and the GP wrote again on 19 August 2008 asking if this could be looked into. On 4 September 2008 Consultant 2 wrote directly to Ms A

informing her that he had referred her to a consultant urologist (Consultant 3), who had a special interest in pelvic problems and incontinence. Ms A was seen by Consultant 3 on 6 October 2008 and further investigations, including repeat urodynamics and cystoscopy, took place.

*Ms A's complaint*

13. In her letters of complaint to the Board, Ms A said that that she had had elective surgery on 23 May 2007 for tape of bladder and her womb was removed. Following the surgery, she then suffered a pelvic infection, vaginal bleeding, vaginal discharges and constant pelvic pain, which were treated by antibiotics. This resulted in her attendance at the Department on 23 October 2007, where she was admitted the following day for further surgery. Following the surgery, Ms A began to suffer from incontinence and loss of lower body sensation and was told to wait for a couple of months to see if matters settled down. Ms A attended the Department on 26 March 2008 and an appointment was made for her to attend for a voiding assessment on 28 April 2008. She was led to believe this was a normal appointment but had to remain in the ward all day for a day assessment, where it was suggested that she try self catheterisation but this made no difference. Ms A said she saw Consultant 2 on 26 June 2008 and he used a silver swab to seal a small adhesion. Ms A said she was told by Consultant 2 that she may have to live with the bladder problems for the rest of her life and at that time he discharged her from the Department. Ms A then contacted the GP to ask for a second opinion and investigation into how the surgery had resulted in her incontinence and frequent infections.

14. Ms A continued that her stress incontinence had started to settle but, following surgery on 24 October 2007, the problems occurred more seriously and that the loss of lower body sensation had only happened after the surgery. Ms A also said that staff did not advise her of the risks associated with the procedures and had she known it would have resulted in a change from stress incontinence to fully incontinent she would not have consented. Ms A also complained that it took five months for the investigation into the pelvic pain and discharge (24 May 2007 to 24 October 2007).

*The Board's response to Ms A's complaint*

15. The Board's Director of Women & Children's Directorate (the Director) wrote to Ms A. She said that Ms A inferred that the incontinence had started following surgery in October 2007, whereas it was recorded in November 2006

that she had suffered from chronic stress incontinence for a number of years which was becoming worse, particularly when she had a chronic chest problem. There were also records of recurrent UTIs which required antibiotics, all of which were prior to the surgery complained about. Urodynamics confirmed the presence of stress incontinence and surgery for this and a pelvic floor repair, including vaginal hysterectomy for prolapse, was carried out on 24 May 2007. The Director continued that Registrar 1 had reviewed Ms A on 27 June 2007 but could find no erosion or prolapse. Registrar 1 had reported that the stress incontinence had been cured and the prolapse problems had disappeared. At a review appointment a few months later, Ms A reported some back pain and vaginal discharge. An ultrasound scan revealed a fluid filled cystic lesion in the pelvis which was discharging and was a cause of the symptoms. It was explained that pelvic infections are a recognised complication of pelvic surgery and usually resolve completely without further treatment.

16. The Director said it was Consultant 2's opinion that the conservative approach which was adopted was reasonable. However, when the symptoms failed to resolve, Consultant 1 performed a laparotomy. It was then sensible for Consultant 1 to remove both Ms A's ovaries and free the adhesions in case they were contributing to the pain and continuing discharge. There did not appear to be any sign of pus in the pelvis and Consultant 2 was not aware of why the discharge was occurring. In June 2008, Consultant 2 examined Ms A to see if there was any problem with erosion of the tape which was inserted in the original operation but could not locate any problems apart from a tiny granulation at the top of the vagina, which he treated. The Director continued that, as far as complications of the tape procedure were concerned, staff routinely informed all patients that problems which could be encountered included continuing stress incontinence and difficulties with bladder emptying. A bladder voiding assessment was carried out and an apology was made if Ms A had not been told the procedure would take a full day to complete. The result suggested that Ms A did have a bladder emptying problem and the standard treatment of self catheterising was suggested, which usually cut down on problems with infection.

17. The Director continued that matters were complicated, in that Ms A had problems with infections prior to surgery which were unconnected to the surgery. Consultant 2 had arranged a formal assessment of the bladder with a telescope and by a colleague. She stated there was no suggestion that Ms A's bladder had been damaged at surgery but the complications which developed

were well recognised and patients were warned about them beforehand. In summary, she said that Ms A's problems (urinary incontinence; urinary infections; vaginal discharge) were evident prior to surgery. The pattern of discharge and pain were now different and the UTIs required further evaluations should there be continued problems. She confirmed an appointment had been made for Ms A to be reviewed by Consultant 3 (see paragraph 12).

18. The Director wrote again to Ms A on 13 November 2008 advising that Consultant 3 was currently investigating the issues of urine infection, vaginal discharge and stress incontinence with a view to treatment options and, hopefully, this would result in the provision of further answers. Consultant 2 was still unclear as to what Ms A referred to as 'no lower body sensation' but if it referred to reduced awareness of bladder filling then this was a potential complication of any major pelvic surgery such as a hysterectomy. Regarding consent, the Director said it would not be normal practice to tell patients there would be a 100 percent success rate and there was a consent form in Ms A's records which stated that the procedure had been explained by a clinician. She stated that it was routine for staff to inform a patient that bladder emptying problems could arise following surgery.

*Advice received from Adviser 1 and Adviser 2*

19. Adviser 1 said that Ms A's clinical treatment was appropriate, in that she underwent clinical examination and urodynamic studies; the former showing a degree of prolapse and the latter demonstrating urodynamic stress incontinence. This led to the plan for surgical treatment combining prolapse repair and TOT. The surgery was carried out in an entirely standard manner by Registrar 1 under the direct supervision of Consultant 1. Recovery was good and discharge home was within normal expected time. The initial follow-up four weeks later seemed to show things were moving in the right direction, with good improvement in both stress incontinence and prolapse symptoms. The ongoing discharge was noted and Ms A was advised correctly that it should settle spontaneously. A further follow-up was arranged, again correctly, after three months. At this review in September 2007, the discharge continued. Adviser 1 believed this to be much more unusual and resulted in a scan of the pelvis being performed. The scan appeared to show a very small collection in the pelvis, although on a subsequent scan the radiographer reported that it could simply be the fallopian tube. Adviser 1 felt it was reasonable, however, to conclude that the findings suggested a discharging abscess and once again conservative management was correct, with antibiotics and close follow-up.

20. Adviser 1 continued that, as the symptoms failed to settle, a laparotomy was performed on 25 October 2007. This was again perfectly reasonable. No abscess was found. Again, Adviser 1 concluded that it was reasonable to remove the ovaries as they are a recognised cause of post hysterectomy pelvic pain. Recovery from the second operation was rapid and post-operative management (including management of the urinary catheter) was routine. Consultant 1 saw Ms A at six weeks post-operatively and noted that the pain had resolved. At this point it was also noted that stress incontinence had started again. Again, Adviser 1 thought it was reasonable to wait and see if this resolved. He also felt it was reasonable for Ms A to be discharged from the Department with the option for her to arrange a further appointment directly. At review by Consultant 2 in March 2008, continuing incontinence and loss of bladder sensation was reported. At that time there was a low frequency of urinary infections and, as there was a suggestion of incomplete emptying, Adviser 1 felt it was appropriate to consider a voiding assessment. He advised that the voiding assessment suggested a capacious (spacious) bladder with some significant residual urine volumes, resulting in the suggestion that ISC be used. Although some of the residual volumes noted were perhaps high, for such a capacious bladder they were probably not unusual. Adviser 1 felt it was reasonable to try ISC, at least for a time, in an attempt to improve Ms A's symptoms. Adviser 1 noted that, after further contact with the Department in September 2008, a second opinion was offered with an urologist (Consultant 3). He considered this was appropriate, especially with the problem of recurrent UTIs.

21. Adviser 1 noted that there was no discussion at the first appointment in 2006, and at subsequent visits prior to the initial surgery, of alternatives to surgery. He felt that it would have been appropriate at least to offer Ms A a course of pelvic floor physiotherapy, given her symptoms. He advised that this approach had been shown to be effective for conservative treatment of stress incontinence. It was less effective for prolapse but, again, was worth offering and, indeed, the referral letter from the GP implied that the leakage was the worst symptom. Adviser 1 noted that the letter heading used by the Department listed three physiotherapists who presumably would be specialists at pelvic floor work. Adviser 1 said that it was possible that physiotherapy alone would have led to an adequate improvement in Ms A's symptoms, without incurring the risks of surgery.

22. Adviser 1 saw that in the Board's responses to Ms A's complaint there was mention of the consent process. He felt it was stated, perhaps rather optimistically, that medical staff always explained the risks of surgery as they pertained to the planned operation. Adviser 1 noted that Ms A denied that such pre-operative discussion took place. The discussion was not recorded anywhere in the notes and the consent form simply records the planned procedure without mentioning associated potential complications. Adviser 1 said there was mention of a leaflet about the TOT in a letter from Registrar 1 to Ms A dated 8 March 2007. Although the leaflet was comprehensive and listed the complications of TOT, it did not detail any other surgery that might be performed at the time, ie, vaginal hysterectomy or anterior repair. Adviser 1 continued that there was no evidence to indicate that Ms A was warned about the potential complications of hysterectomy, which include pelvic infection and bladder damage – in other words, there was no evidence that proper informed consent was undertaken for the most major of Ms A's procedures.

23. Adviser 2 also commented on the consent procedure. He said the consent form which was used on 23 May 2007 contained no objective evidence on the depth to which a discussion concerning the complications of pelvic floor repair and vaginal hysterectomy took place. On reviewing the notes, Adviser 2 said it would appear the first time the vaginal hysterectomy was mentioned was at the time of the consent process on 23 May 2007. Although Ms A had signed that she had understood the important risks and appropriate alternatives, there was nothing recorded about what actual discussion took place. Adviser 2 explained that patients' understanding of consent forms can sometimes be impaired and, indeed, the stress of the admission can lead to poor understanding of any discussion offered. Adviser 2 said in Ms A's case this was demonstrated by a statement towards the bottom of the first side of the consent form where Ms A has signed a declaration that was highly unlikely to be accurate. He said this would be a surprising statement given Ms A's medical history. Adviser 2 felt the most likely explanation was failure to understand the form fully and, indeed, a possible failure on the part of the doctor counter-signing to clarify this important point, particularly if a vaginal hysterectomy was considered. Adviser 2 was in agreement with Adviser 1 that the consent processes were flawed in this case.

24. Adviser 2 recommended that the Board review their consent policy. He noted the consent form in place in 2008 appeared to be different to that in use in 2007, in that in the 2008 form there was a box to tick when an information leaflet had been provided. However, he advised there should also be some

space for the patient to confirm that they had read and understood the leaflet and that the leaflet should be issued some time prior to the signing of the consent form. Adviser 2 said, ideally, the information leaflet should be handed out either at the time of consultation or at the pre-assessment visit. This would give the patient time to read the information leaflet and be able to formulate any additional queries which could be clarified at the time of the consenting.

25. Adviser 1 said that it was clearly stated in Consultant 1's discharge letter, and recalled by Ms A herself, that following discharge by him in December 2007 she merely needed to contact the Department by telephone to obtain another appointment. However, when the need arose and Ms A did this, she was told that she needed to seek re-referral from the GP and that was what she then did.

26. Adviser 1 continued that, whilst the voiding studies suggested that ISC may have been helpful, it would seem from Ms A's own account that improvement in her symptoms was marginal at best. In addition, the notes and Ms A's recall make it clear that the UTIs only became a serious problem after ISC was commenced. Consultant 2 suggested that ISC may need to be increased if the UTIs worsened. Adviser 1 felt that it might have been better to try without the ISC for a while, as it was possible that the repeated self-catheterisation was contributing to the worsening UTIs in a person already prone to them. In addition, chronic infections may have been leading, in part, to the urinary leakage. Adviser 1 said it should be pointed out that the repeat urodynamics carried out by Consultant 3 showed no evidence of incomplete voiding. Adviser 1 said that the consultation with Consultant 2 on 26 June 2008 was unsatisfactory in that, despite Consultant 2 advising that Ms A should continue with ISC and would be best 'left alone', there were a number of ongoing problems. Adviser 1 said there may have been no very obvious or immediate clinical answer to the various problems but simply discharging Ms A without any arrangements for follow-up was not a solution. Adviser 1 said there were in fact several possible courses of action at this time. These were: to arrange a follow-up after two to three months to assess the passage of time on Ms A's symptoms; possibly a trial period without ISCs; to offer repeat urodynamics at that stage to see whether further continence surgery was an option; to offer Ms A a second opinion with a suitably specialised colleague; or to offer an appointment at a genito-urinary clinic for further investigation of Ms A's discharge. Adviser 1 noted that most of these options eventually happened but only because of Ms A's complaint.

27. Adviser 1 said that, in the event, the GP wrote a referral shortly after that consultation requesting a second opinion. In spite of this very clear request, there was no response for a month and when the GP made contact with the hospital to find out what was happening, she was told that there was no other doctor who would be able to give such an opinion and Ms A would have to wait for a routine appointment with Consultant 2 again. Adviser 1 did not think this was acceptable. He explained that it was every patient's right to seek a second doctor's opinion if desired and any such request should have been dealt with promptly and sympathetically. Adviser 1 said that if there was no other urogynaecologist in the Department (six were listed in the letterhead), then efforts should have been made for Ms A to see an urogynaecologist at another hospital, or to do what eventually happened, ask an urologist to see her. An appointment was eventually arranged with Consultant 2 for 22 September 2008, some 11 weeks after the referral, but Adviser 1 felt that the circumstances had merited a far quicker appointment with another suitably specialised consultant.

28. In summary, Adviser 1 concluded that the majority of the clinical care provided to Ms A was reasonable and some of her ongoing symptoms were quite difficult to explain. However, Adviser 1 had some concerns with administration matters such as the consent processes; arranging of follow-up appointments; and conduct of appointments in general. There should have been an offer of a conservative option to surgery and the Board's response to Ms A's first complaint did little to address the actual concerns she had (other than confirm the second opinion, which should already have been offered) and concentrated mainly on telling her she had most of her symptoms prior to attending the Department in the first place.

*(a) Conclusion*

29. Ms A is of the opinion that her condition deteriorated following the surgery; that staff had not advised her of the risks of surgery; and that had they done so she would not have given consent for the surgery to go ahead. On the other hand, the Board maintain that Ms A's problems existed prior to the surgery; that when she had signed a consent form the procedure had been explained by a clinician and that it would be routine for staff to inform patients that bladder emptying problems could arise following surgery. Notwithstanding this, Adviser 1 and Adviser 2 have concerns as to whether proper informed consent was obtained from Ms A, in that nowhere is it recorded exactly what was discussed with Ms A and whether she was told about the potential complications of hysterectomy which would include possible pelvic infection and

bladder damage. Indeed, from the notes it appears that the first mention of the vaginal hysterectomy was at the time the consent form was signed on 23 May 2007. It has been pointed out by Adviser 1 and Adviser 2 that the consent form was not properly completed, as there was reference to a matter which was unlikely to be accurate. It is not clear whether this part of the form was completed by Ms A or Registrar 1 but, nevertheless, it does indicate that the form has not been read correctly.

30. Taking the above information into account, I have decided that there is some doubt that Ms A was fully informed about the risks associated with her surgery and, as such, was not in a position to give informed consent. I appreciate that it would be impractical for staff to record word for word what was discussed with a patient, however, there should be a mechanism for recording the main issues so as to prevent similar complaints arising in future. As a result, I uphold this complaint.

*(a) Recommendation*

31. The Ombudsman recommends that the Board review their consent process, to ensure that patients have enough time to digest the information provided by staff and in information leaflets and that sufficient space is available on the consent forms to list what has been discussed.

*(b) Conclusion*

32. The advice which I have received, and accept, is that the clinicians involved in Ms A's treatment carried out appropriate clinical examinations and studies in an effort to resolve Ms A's problems. The decisions to undertake prolapse repair, TOT, hysterectomy, voiding assessment and ISC were entirely reasonable and there is no evidence to suggest the procedures were carried out in anything other than a standard manner. The fact that Ms A has continued to suffer problems following the procedures cannot be attributed to failings in the way they were carried out. That said, I note that Adviser 1 has mentioned that there was no indication that staff considered or indeed discussed with Ms A whether there were any alternatives to surgery, such as pelvic floor physiotherapy, which if carried out successfully may have negated the need for surgery. However, the outcome could still have been that surgery was required and, as I have mentioned above, I have no criticism of the procedures which were carried out and, as such, I do not uphold this complaint.

*(b) Recommendation*

33. The Ombudsman recommends that the Board share this report with the staff involved and ask them to reflect on the Adviser's comments about considering alternative procedures prior to surgery.

*(c) Conclusion*

34. Ms A has continued to suffer from problems following her surgery. I have concluded above that the actual treatment which was carried out was reasonable. However, the advice which I have received is that, when it became clear that Ms A's problems were not resolving, the clinicians involved in her follow-up treatment did not take timely action in an effort to demonstrate that her concerns were being taken seriously. While in the initial stages it was appropriate to take a conservative approach, when it became clear there were still problems more robust action should have been taken. It was a good idea in December 2007 that Ms A was told to contact the Department directly should she continue to have problems but when she did so she was then told to make contact through her GP and this resulted in an appointment some three months later. Following voiding studies in April 2008 and contact with a specialist nurse, Ms A was subsequently seen by Consultant 2 at the end of June 2008 and her problems still continued. Consultant 2 decided that Ms A should be best 'left alone' and to continue with ISC. This left Ms A with no alternative but to contact her GP again and ask for a second opinion and this resulted in her receiving notification of a further appointment with Consultant 2 on 22 September 2008. Ms A again contacted her GP, who made further representations, and on 4 September 2008 Consultant 2 advised Ms A that an appointment had been made with Consultant 3 on 6 October 2008, who arranged for further investigations to take place.

35. I am of the opinion that, following Ms A's appointment with Consultant 2 on 26 June 2008, more robust action should have been taken in an effort to establish the cause of her continuing problems rather than she should be 'left alone'. This could have included: arranging a follow-up appointment to see if the problem had resolved or was still occurring; suspending the use of ISC for a period; carrying out repeat urodynamics; or offering a second opinion. The decision to discharge Ms A without further follow-up was an omission and led to a delay in her receiving further treatment in an effort to alleviate her symptoms. As a result, I uphold this aspect of the complaint.

*(c) Recommendation*

36. The Ombudsman recommends that the Board apologise to Ms A for the failings which have been identified in this report.

37. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

**Annex 1**

## Explanation of abbreviations used

| | |
|---|---|
| Ms C | The complainant |
| Ms A | The aggrieved |
| The Department | Department of Urogynaecology at the Southern General Hospital, Glasgow |
| The Board | Greater Glasgow and Clyde NHS Board |
| Adviser 1 | The Ombudsman's professional medical adviser |
| Adviser 2 | The Ombudsman's second professional medical adviser |
| UTI | Urinary tract infection |
| Registrar 1 | Registrar who saw Ms A on 15 November 2006 |
| Registrar 2 | Registrar who saw Ms A on 2 May 2007 |
| Consultant 1 | Consultant urogynaecologist who supervised surgery on 24 May 2007 |
| Registrar 3 | Registrar who saw Ms A on 8 October 2007 |
| The GP | Ms A's General Practitioner |
| Consultant 2 | Consultant urogynaecologist who was contacted on 26 March 2008 |
| Consultant 3 | Consultant urologist who saw Ms A on 6 October 2008 |
| The Director | The Board's Director of Women & Children's Directorate |

**Annex 2**

**Glossary of terms**

| | |
|---|---|
| Betadine pessaries | Medication to treat vaginal infections |
| Bronchiectasis | Chronic respiratory infection |
| Cystoscopy | Telescopic investigation of the inside of the bladder |
| Estrogen vaginal tablets | Medication to help combat UTIs and for HRT |
| Hormone replacement therapy (HRT) | Post menopausal medication |
| Intermittent self catheterisation (ISC) | Passage of a catheter by the patient to ensure bladder stays empty |
| Laporotomy | Open abdominal operation |
| Pelvic floor repair | Procedure to strengthen vaginal walls |
| Stress urinary incontinence | Involuntary leakage of urine during activity such as coughing or laughing |
| Transobturator tape (TOT) | Procedure to provide support to the bladder neck |
| Urodynamic investigations | Test of bladder function |
| Utero-vaginal prolapse | Descent of pelvic organs, which can affect bowel or bladder function |
| Vaginal hysterectomy | Removal of the uterus |
| Voiding studies | Measurements to check volume of urine passed, urine flow rates, completeness of bladder emptying |