Scottish Parliament Region: Lothian and South of Scotland

Cases 200801582 & 200801583: Lothian NHS Board and Borders NHS Board

Summary of Investigation

Category

Health: Hospital; maxillofacial/ear, nose and throat; clinical treatment; diagnosis

Overview

In early 2008, Ms A was diagnosed with osteomyelitis of the maxilla, following investigation at a private hospital. This is a condition where the main bone of the upper jaw (maxilla) has become inflamed and damaged by infection. Ms A had suffered from symptoms since at least 2004 and previously attended at both Borders NHS Board (Board 1) and Lothian NHS Board (Board 2) hospitals. She complained that, despite this, she had not been correctly diagnosed by the NHS and that, as a result, she had had to pay for private treatment. Ms A's complaint was brought to the Ombudsman's office by her MSP (Mr C).

Specific complaint and conclusion

The complaint which has been investigated is that Ms A was not investigated properly and that the diagnosis could have been made sooner by the NHS (*upheld*).

Redress and recommendations

The Ombudsman recommends that Board 1

(i) review their procedures for monitoring and auditing the referral process in light of the problems identified;

(ii) remind clinicians involved of the need to consider carefully the information provided as part of the referral process;

(iii) consider the best practice advice made by the Adviser to the Ombudsman; and

(iv) provide him with reassurance that there has been an improvement in the time taken to review CT scans and discuss them with patients. He also asks that Board 1 notify him when the recommendations have been implemented.

The Ombudsman recommends that Board 2:

(i) review their procedures for monitoring and auditing the referral process in light of the problems identified;
(ii) remind clinicians involved of the need to consider carefully the information provided as part of the referral process;
(iii) consider the best practice advice made by the Adviser to the Ombudsman;
(iv) undertake a short, focussed audit of record-keeping in the Ear Nose and Throat clinic and the Dental Institute and put in place an action plan to deal with any problems identified; and
(v) reimburse Ms A for the costs of the private treatment required to identify her condition.

Board 1 have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. Ms A, then aged 67, was referred to the Oral Surgery Department at Borders General Hospital (Hospital 1) by her dentist (Dentist 1) in 2004. She continued to have problems including recurring sinus infections and attended for other referrals. Ms A remained within the overall responsibility of Borders NHS Board (Board 1) through until 2006. In 2007, Ms A attended at both an Ear Nose and Throat (ENT) clinic (the Clinic) and the Dental Institute (the Institute) in the Lauriston Building in Edinburgh (Hospital 2) where she was treated by clinicians within the responsibility of Lothian NHS Board (Board 2). Her last contact with them was in November 2007. Ms A said she was very upset following this final appointment, when she felt that it was being suggested that the pain was psychological rather than physical.

2. In late November 2007 Ms A had a private referral and she subsequently underwent exploratory surgery, following which she was diagnosed with osteomyelitis of the maxilla. This is a condition where chronic infection results in damage to the bone itself – the maxilla is the upper jaw bone. Ms A complained to Board 1 and Board 2 that this had not been diagnosed previously and sought recovery of her private treatment costs, amounting to £2,497, and for the costs of the travel from her home. On 22 April 2008, Board 1 wrote to Ms A and said they considered the treatment had been appropriate and comprehensive. On 15 May 2008, Board 2 said it would not have been appropriate to have undertaken exploratory surgery following the consultation in November 2007 and they did not consider there had been any part of her care which had been substandard.

3. Ms A remained unhappy and concerned about the delay and also considered that she had been compelled to take private treatment as a result. She contacted her MSP (Mr C) and he complained to the Ombudsman on her behalf. The complaint was received by the Ombudsman on 10 September 2008[1].

4. The complaint from Mr C which I have investigated is that Ms A was not investigated properly and that the diagnosis could have been made sooner by the NHS.

[1] Ms A's complaint was supported by her MSP, who represented her throughout.

Investigation

5. In investigating this complaint, I have had access to Ms A's clinical records and the complaint correspondence from Board 1 and Board 2. I obtained advice from a consultant ENT surgeon (the Adviser).

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C, Ms A, Board 1 and Board 2 were given an opportunity to comment on a draft of this report.

Complaint: Ms A was not investigated properly and that the diagnosis could have been made sooner by the NHS

Clinical background

7. Dentist 1 referred Ms A to the Oral Surgery Department at Hospital 1 on 3 June 2004[2]. He said Ms A was suffering from pain and swelling around the upper right jaw. He said it was possible it could be a sinus problem and it was noted Ms A was also suffering from a feeling of pressure in the sinus and a continuous discharge. Ms A attended at Hospital 1 on 16 June 2004, where she saw an associate dental specialist (Dentist 2). Dentist 2 wrote to Ms A's GP (the GP) on 18 June 2004. He noted that Ms A had had a cyst drained in the right sinus area about 40 years previously and had had extensive dental treatment. He said that, from x-rays he had taken, there appeared to be fluid in the right sinus and, with Ms A's history, this was suggestive of a chronic sinus problem and he was referring her to the GP. Dentist 2 also told Ms A to make an appointment with the GP about her sinuses. Dentist 2 thought Ms A's molars might need treatment and had a review appointment scheduled.

8. On 29 July 2004, Dentist 2 wrote to Dentist 1 to say that Ms A had been prescribed antibiotics and a decongestant by the GP which had helped but some pain remained. Dentist 2 remained concerned about the molar and proposed apical surgery (surgery to the root of the tooth). Dentist 2 undertook this surgery on 11 August 2004. On 13 August Dentist 2 reported to Dentist 1 that granulation tissue had been found and removed and the bottom of the tooth was sealed. Dentist 2 made an appointment to review Ms A again in a further month. Prior to this appointment, Ms A called to say that there had been no improvement in her condition. Dentist 2 decided that, given this, it was likely her problem was sinus related and suggested she ask the GP to refer her to an

[2] The Dentist referred to an earlier referral in January which appeared to have been lost.

ENT consultant[3]. On 6 September 2004, the GP wrote to Dentist 2 and asked if Dentist 2 could refer Ms A direct to ENT because of problems with extensive waiting times. He said it seemed unfair for Ms A to have to go through the full waiting list again. Ms A attended at Hospital 1 to see Dentist 2 on 7 September 2004 and, following this, Dentist 2 made a referral to an ENT consultant (Consultant 1). In the referral, he said that Ms A had expressed her willingness to see Consultant 1 privately given the pain she was experiencing and asked if this could be arranged as soon as possible. A later letter from Ms A's GP said she had decided to go private because of the times of the waiting list.

9. Consultant 1 saw Ms A on 13 October 2004 at a private appointment and arranged for a CT scan of her sinuses to be carried out on 29 October[4] and Ms A seen again by Consultant 1 on 30 November 2004.

10. On 2 December 2004, Consultant 1 wrote to the GP to say the CT scan had come back as normal. He said the granulation discovered during the apical surgery suggested a dental origin but Dentist 2 was satisfied there was no longer any infection. Having also ruled out a sinus problem, Consultant 1 suggested a diagnosis of neuropathic atypical facial pain. Atypical neuropathic pain is pain which is chronic and often difficult to diagnosis. This may be caused by soft tissue damage and, in some cases, a psychological problem can be a partial cause. Dentist 2 suggested that the GP refer Ms A for a neurological opinion and, in the meantime, try a range of pain medication to see what was most effective. However, Ms A's symptoms improved and she cancelled this appointment. (This followed her decision to have the tooth that had been operated on removed fully.)

11. On 11 August 2005, the GP wrote again to Consultant 1. The GP said that, despite the initial improvement, Ms A was having recurring episodes of pain usually associated with a nasal discharge. He had had tests done and infection had been present. Despite treatment with antibiotics, the infection was recurring. He asked for advice on how to prevent this recurrent infection and whether Ms A should be re-assessed. Although he had written to Consultant 1, it appears the referral was sent to Oral Surgery and the Oral Medicine

[3] This is based on the information in the subsequent letter by the GP. I have been unable to find any notes of this by Dentist 2.

[4] From this date, Ms A was back within NHS treatment.

Consultant wrote to the GP on 6 October 2005 to say he recommended a re-referral to the ENT surgeons. An appointment was made for 15 November 2005 when Ms A was seen by Consultant 1.

12. On 16 November 2005, Consultant 1 wrote to the GP. He said that he did not think the problem was sinus related but he would arrange for a CT scan. The CT scan was undertaken in December 2005 but not discussed with Ms A by Consultant 1 until April 2006. Consultant 1 said the CT scan did not explain her symptoms. However, he noted the surgery she had had to drain the cyst some years ago. He said it was possible that there was some recycling of mucus and suggested surgery could be undertaken which would prevent this. This was performed on 15 May 2006.

13. On 28 June 2006, the GP wrote to Consultant 1 in advance of a scheduled appointment to review the surgery. The GP gave details of continuing symptoms – localised facial pain and discharge. The GP asked whether this could be osteomyelitis of the maxilla. After the appointment, Consultant 1 wrote to the GP and said he had examined the surgery and the system for draining mucus, which was clear and working well. He said that the pain was clearly not coming from her sinuses. He said that the symptoms would best be categorised as atypical mid-third facial pains and he referred her again for neurological opinion. Consultant 1 ended by saying he was sorry he could not help further. No comment was made about the GP's suggested diagnosis. This ended Ms A's involvement with Board 1.

14. On 22 February 2007, Ms A was seen at the Clinic, in Board 2's area, following a referral from the GP. A registrar (the Registrar) wrote on the 13 March 2007 to Consultant 1 for a copy of Board 1's notes. These were provided, although it appears this did not include the letter from the GP which suggested osteomyelitis.[5]

[5] This was not in the copies of the notes held by Board 2, although they did hold copies of other letters. They also confirmed in response to a direct question that they had checked all notes held in relation to Ms A and did not have this letter on file.

15. At the end of April 2007, the Registrar concluded that the problem was not sinusitis and a further operation was not required. He wrote in these terms to the GP. It was not clear when this letter was sent[6].

16. On 21 March 2007, Dentist 1 referred Ms A to the Institute because of the recurring pain she was experiencing. Ms A has said she attended at the Institute twice but there was no note of this in the records. Ms A was then referred to a consultant in Oral and Maxillofacial surgery (Consultant 2). Ms A was seen on 4 September and then on 28 September 2007 at St John's Hospital (Hospital 3) and a CT scan scheduled and carried out on 18 October 2007. Medication was prescribed but did not prove helpful. Consultant 2, in a letter of 9 November 2007, to Dentist 1, said that Ms A had been reviewed again on 2 November 2007. He said the CT scan had shown there was thickening in the sinus lining and a hypo-plastic (underdeveloped) maxilla. He said that he felt there were two elements to Ms A's condition: chronic, atypical facial pain; and low grade sinusitis. He added:

> 'She demonstrates another feature of what the psychologists would call 'confirmational bias' where she has decided that this is due to 'bone cavitation' and to some extent tries to make her symptomatology fit this.'

17. In conclusion, Consultant 2 said he would be very reluctant to carry out an operation for her current symptoms but felt that she should possibly have her sinuses visualised. He said Ms A would let them know how she wished to proceed.

18. In her complaint to Board 2, Ms A said she had been told by Consultant 2 that it was all in her mind and he had recommended an anti-depressant. In responding to her complaint to internal Board 2 staff[7], Consultant 2 disagreed with Ms A's statement on this point and said he had been mindful of the length of time she had been experiencing symptoms. He said that he had been reluctant to undertake surgery, particularly given the recurring infection, but Ms A had been of the view that surgery was the only way forward. Consultant 2 also said that it was common to prescribe both anti-depressants and anti-

[6] The letter was dated 27 April 2007 below the signature but the date on the top of the letter was that of the day the documents were copied for release to this office in late 2008. It is not clear if there was any delay between the date this was completed by the Registrar (27 April 2007) and the date sent to the GP.

[7] The letter of response was based, in part, on a summary of this correspondence.

epileptic medication to modulate pain perception as part of the diagnostic process. The drug he had prescribed was an anti-epileptic drug. Consultant 2 said that he had sympathy with the problems experienced by patients with ongoing symptoms being referred first to one specialty and then to another within a hospital when little priority was given to the subsequent referrals. He said this meant some patients with complex problems could spend significant lengths of time on waiting lists.

19. On reviewing the notes, it was clear that the anti-epileptic drug prescribed by Consultant 2 had been prescribed previously. A referral letter from the GP, initially to Hospital 1 and written in 2005, referred specifically to the use of this drug and said it had provided Ms A with some benefit initially but that the pain had returned. This letter was within Board 2's notes. The same letter described Ms A as an 'extremely active and uncomplaining patient'. The notes from Board 2 were in general not of a very good quality and consisted mostly of referral letters or letters from staff. There were no notes or any information about her previous attendance at the Institute prior to 4 September 2007. There were letters referring to her attendance at the Clinic in February 2007 but there was no clinical note of this attendance or copy of the referral letter which led to this attendance.

20. Following the November 2007 meeting with Consultant 2, Ms A was referred for private care by the GP. Following initial consultation, an MRI scan was carried out. This showed what appeared to be a foreign body at the base of the right upper jaw bone. Exploratory surgery was undertaken on 29 February 2008 and Ms A was subsequently told she had osteomyelitis. There were limited treatment options but Ms A was given hyperbaric oxygen and this aided her symptoms. This treatment increases the amount of oxygen in tissue by administering oxygen while in a compression chamber. It can be used to treat infections.

Initial advice received

21. The Adviser reviewed the clinical notes and scans held by Board 1 and Board 2 and the private hospital. He said that this was a very rare disease, particularly given Ms A's age. He described the process of the disease and said that this would have been caused by the dental disease which triggered the inflammation but once the disease had progressed, it would have required surgery. He said that this disease followed a slow process and had 'fooled good practitioners over a number of years'. He was, therefore, not overly critical

of the general failure to diagnose this condition. However, he said that in November 2007, given the continuing chronic pain plus 'smelly nasal discharge', further exploration should have been undertaken. Consultant 2 should have queried why the maxilla was hypo-plastic. The Adviser also said he was concerned about the overall management of the referrals and the waiting lists.

22. I asked Board 1 and Board 2 to comment on Ms A's treatment and aspects of the Adviser's comments.

Boards' comments

23. Board 1 set out a timeline of events and explained that in 2004 and 2005 the waiting list time for an ENT appointment was six months. It was currently 12 weeks. On the delay to report the results of the CT scan, they set out the timescale as follows: this was requested on 17 November 2005 and completed on 22 December 2005; the results were reported on 28 December and available for review in January 2006. These showed minimal disease and were discussed with Ms A at a review appointment in April 2006.

24. Board 2 arranged for the file and my questions to be reviewed by their relevant Clinical Director (the Director). The Director said that this was a rare condition and he had not seen this in his own professional career. He also said that chronic pain diagnosis was a challenging and difficult diagnostic area. He reviewed in detail the actions by Consultant 2.

25. The Director said that, in his view, Consultant 2 had taken the correct approach and the working diagnosis and medication were appropriate. He said that it appeared there had been a breakdown at the end of the consultation with Consultant 2, when an operation was not offered to Ms A. However, Ms A had been offered further treatment and it was not possible to say what would have happened if she had attended again. Ms A had not been discharged from treatment.

Further advice received

26. I asked the Adviser to respond to the further comments. The Adviser noted Board 1 and Board 2 were trying to improve their referral pattern. He suggested an audit may be appropriate to see if this was generating real improvement. I asked the Adviser whether the comments by the Director from Board 2 indicated that the difference between the actions the Adviser would have recommended and those taken by Consultant 2 amounted to a reasonable

difference of clinical approach or whether he remained concerned about the actions taken. The Adviser said that, given the presence of the nasal discharge, action should have been taken. In particular, he said that one of basic principles of surgical training was that where you found pus it had to come out and be surgically drained. He did not think two clinicians should differ on this basic principle and the right maxillary sinus should have been explored in November 2007[8].

27. I also asked the Adviser if there was any advice on best practice he thought it would be helpful to share with the Board. He said that it was important to give patients and colleagues credibility and empathy. He also said that he would recommend, if this were not already happening, a monthly meeting with radiologists to discuss cases where clinical symptoms did not correspond with radiological findings.

Conclusion

28. Reading through Ms A's clinical notes, it is clear that she suffered with pain for a number of years. The GP and Dentist 1 indicate in their letters that Ms A is not the type to make such claims or to draw on assistance lightly. Having spoken to her, it is clear that independence is important to her and that she was upset by the suggestion that the pain may have had, even in part, a psychological basis.

29. However, the decision I have to make is not whether Ms A has had a very unpleasant time. It is clear and undisputed that she did. It is whether the care and treatment provided by the NHS was reasonable. In this context, reasonable means reasonable in the light of the circumstances at the time. This means it is important to be careful not to let the knowledge of the final diagnosis affect unduly my view of the actions of clinicians who saw Ms A from 2004 to 2007. The Adviser has explained this was a rare condition and difficult to diagnose.

30. Taking this into account, however, I still have concerns about two aspects of Ms A's care: the management of the referral process by Board 1 and Board 2; and the decision made by Consultant 2 in November 2007.

[8] ie, exploratory surgery

31. Ms A was referred a number of times to Board 1 and Board 2 and through different routes. I did note the significant improvement in waiting times between 2004 and 2005 for the initial appointments and re-referrals by Board 1. The delay to April 2006 for the further review with Ms A of the CT scan taken in December 2005 was overlong and the Ombudsman has asked for reassurance on this point but, equally, I have borne in mind that the CT scan did not show a critical finding which would have required urgent action.

32. It has been difficult to assess or fully understand the referral process at Board 2. The clinical notes are incomplete and the initial referral letter from the GP to the Clinic is missing. There is no information about at least two appointments, so it is not clear why the decision was made to ask Consultant 2 to review this case. It is not clear that the two lines of referral to the Board were brought together (see paragraphs 14 to 16).

33. It also appears that the views of the referring clinician were not given appropriate consideration by either Board. Ms A had a difficult to diagnose, rare condition. Clinicians who saw her were reasonable to explore the more obvious causes first. However, from mid-2006, Ms A and the GP raised the possibility of the rarer diagnosis. Consultant 1, who was asked this point directly, did not explain why he had rejected this diagnosis. In the referral to Board 2, Dentist 1 made it clear that he regarded Ms A as generally uncomplaining, yet Consultant 2 suggested confirmational bias (see paragraph 16). The referral letter from the GP of 2005 was in Board 2's file (see paragraph 19) but no reference was made to the fact that Consultant 2 was recommending a medication which had already been tried.

34. While clinicians do need to come to their own view on the basis of clinical signs, information supplied with the referral should always be regarded as significant. In this case, these were the pointers to the correct diagnosis. I have asked the clinicians to reflect on this. However, the rarity of Ms A's condition and the advice I have received leads me to conclude that, on their own, the general failure prior to November 2007 to spot these signs would not have led me to fully uphold this complaint.

35. This leads me to my second concern, the appointment in November 2007. It is not clear what was said and I have seen no clinical note of the appointment. However, the tone of the letter by Consultant 2 to Dentist 1 which included a psychological diagnosis, which was outside Consultant 2's own speciality, does

support the view that this was not a successful meeting. Consultant 2 has said Ms A was given the opportunity to have a further review. It is also clear that they had not been able to come to an agreement on the management of her condition. Ms A had attended previously at the Clinic and the Institute. There are no notes of at least two of these meetings, so it is not known what she was told. However, I do not think it was unreasonable that she sought advice elsewhere. The advice I have received has criticised the decision made not to explore further at that time. On this basis, I uphold the complaint.

36. Given that I uphold the complaint, I turn now to redress. It is unusual for this office to make a monetary finding. However, at times, recommendations have been made to refund private treatment which should have been offered on the NHS. Given the advice I have received, that the right maxillary sinus should have been explored in November 2007, the Ombudsman makes the following recommendations.

Recommendations

37. The Ombudsman recommends that Board 1:

(i) review their procedures for monitoring and auditing the referral process in light of the problems identified;

(ii) remind clinicians involved of the need to consider carefully the information provided as part of the referral process;

(iii) consider the best practice advice made by the Adviser to the Ombudsman; and

(iv) provide him with reassurance that there has been an improvement in the time taken to review CT scans and discuss them with patients.

38. The Ombudsman recommends that Board 2:

(i) review their procedures for monitoring and auditing the referral process in light of the problems identified;

(ii) remind clinicians involved of the need to consider carefully the information provided as part of the referral process;

(iii) consider the best practice advice made by the Adviser to the Ombudsman.

(iv) undertake a short, focussed audit of record-keeping in the Clinic and the Institute and put in place an action plan to deal with any problems identified; and

(v) reimburse Ms A for the costs of the private treatment required to identify her condition.

39. Board 1 has accepted the recommendations and will act on them accordingly. The Ombudsman asks that Board 1 and Board 2 notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms A	The aggrieved
Hospital 1	Borders General Hospital
Dentist 1	Ms A's dentist
Board 1	Borders NHS Board
ENT	Ear, nose and throat
The Clinic	An ENT clinic based in Hospital 2
The Institute	The Dental Institute based in Hospital 2
Hospital 2	The Lauriston Building, Edinburgh
Board 2	Lothian NHS Board
Mr C	The complainant
The Adviser	Consultant ENT surgeon and independent adviser to the Ombudsman
Dentist 2	The associate specialist who saw Ms A at Borders General Hospital
The GP	Ms A's GP
Consultant 1	The ENT consultant who saw Ms A at Borders General Hospital
The Registrar	An ENT registrar based at the Lauriston Building

Consultant 2	An oral surgeon who saw Ms A at the Lauriston Building and St John's Hospital, Edinburgh
Hospital 3	St John's Hospital, Edinburgh
The Director	Board 2's clinical director

Annex 2

Glossary of terms

Apical	The root of the tooth
Atypical neuropathic pain	Pain which is chronic and the cause is difficult to define
Computerised tomography scan (CT scan)	A scan which allows x-rays to be linked to form a 3-D picture
Hyperbaric oxygen	Oxygen that is delivered under compression
Hypo-plastic	Underdeveloped
Maxilla	The upper jaw bone
Maxillofacial	Relating to the face and jaw structures
Magnetic resonance imaging (MRI) scan	A technology which allows for very detailed imaging and includes soft tissue
Osteomyelitis	Inflammation of the bone due to infection. It is a chronic, relentless, destructive bone inflammation
Sinus	Cavities in the skull: they are lined with mucus secreting cells and it is important they are clear to allow for drainage