Scottish Parliament Region: Glasgow

Case 200802296: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mrs C) raised concerns regarding the Orthopaedic treatment she received at the Royal Alexandra Hospital (the Hospital) in the area of Greater Glasgow and Clyde NHS Board (the Board). Mrs C sustained a fall on 16 June 2007 in which she fractured her tibia and fibula and upon admission to the Hospital, she was seen by an orthopaedic consultant who treated the fracture conservatively by placing Mrs C's leg in a cast. Mrs C complained about the fact that she was not treated operatively and about the standard of follow-up care she received in the Fracture Clinic.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the decision to treat Mrs C's fracture conservatively was inappropriate (*not upheld*); and

(b) the standard of follow-up treatment was inappropriate (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mrs C for the failings identified in this report;

(ii) highlight the issues raised in this report to all relevant orthopaedic staff;

(iii) remind clinical staff of the importance of documenting their discussions with consultants; and

(iv) encourage consultants to consider taking a more proactive role in complex cases.

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

Main Investigation Report

Introduction

1. On 16 June 2007, the complainant (Mrs C) suffered a fall and sustained a fracture of her left tibia and fibula. She was subsequently admitted to the Royal Alexandra Hospital (the Hospital) where she was reviewed by a consultant orthopaedic surgeon (Consultant 1). Mrs C was discharged on 18 June 2007 having had her leg placed in a cast and she was provided with crutches and advised not to bear any weight on her leg. The discharge letter noted that treatment options had been discussed with Mrs C and that she had elected for non-operative management. Mrs C was then reviewed regularly at Consultant 1's Fracture Clinic (the Clinic) where it became apparent that her fracture was taking a long time to heal. Mrs C was concerned by this and also by the lack of contact she had with Consultant 1 and she subsequently sought advice from a private consultant (Consultant 2).

2. The complaints from Mrs C which I have investigated are that:
(a) the decision to treat Mrs C's fracture conservatively was inappropriate; and
(b) the standard of follow-up treatment was inappropriate.

Investigation

3. In writing this report I have had access to Mrs C's NHS medical records and the complaints correspondence with Greater Glasgow and Clyde NHS Board (the Board). In addition, I obtained advice from one of the Ombudsman's advisers (the Adviser), who is a consultant orthopaedic surgeon.

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

Background

5. Mrs C wrote to the Board on 27 May 2008 and expressed her concerns with the treatment she had received. She stated that Consultant 1 had decided to treat her conservatively by putting her leg in a cast instead of operating with internal fixation but she stated that her complaint was not with this decision. She advised that she had had no objections to this treatment at the time as she was willing to accept immobilisation for a few weeks with the hope that her leg

would have a complete union in time. However, she expressed dissatisfaction that she was in a cast for nearly five months and that it was eventually removed, not because her leg had healed, but because her ankle had 'broken down' due to the immobilisation. Mrs C complained about the treatment she received at the Clinic following the removal of her cast. She stated that a different doctor reviewed her nearly every time and they provided her with conflicting views. She advised that, due to her concerns with the length of time her leg was taking to heal, she had called Consultant 1's secretary and asked if she could see Consultant 1 in order to clarify the situation. She stated that she required clarification as none of the doctors had been taking responsibility for making a decision, even after six months of non-union, and that they were all happy for her to continue to return, around every six weeks, for regular review.

6. Mrs C said that she obtained an appointment with Consultant 1 for 3 January 2008, however, when she attended she was seen by one of his registrars. He told her that her leg was healing and that she could continue to weight-bear, however, his concern lay with her ankle which 'had broken down' and he advised her to exercise this. She saw the same registrar again on 30 January 2008 and she indicated to him that she was considering contacting a private consultant due to 'the differing opinions, lack of information [and] the length of time [she] was still on crutches and still experiencing pain at the fracture site'.

7. Mrs C confirmed that she subsequently attended a private consultation and, following a computerised tomography (CT) scan, Consultant 2 advised her that there may have been a chance that her leg was healing and that she should leave it another few weeks. She stated that he advised her to attend her next appointment at the Clinic where a difference should be seen in her x-rays. However, at her next appointment at the Clinic on 12 March 2008, she was seen by another doctor who advised that there were no changes to her x-rays and he suggested the exploration of a different treatment option. She said that when she told him that her private CT scan had shown a small amount of healing, he had immediately accepted this and advised her to come back in six weeks.

8. Following her attendance at the Clinic on 12 March 2008, Mrs C said that she immediately requested an appointment with Consultant 1 in order to seek reassurance and she was advised he would see her at her next appointment in a few weeks. In the meantime, she attended another private appointment with

Consultant 2 and she stated he agreed there was not much happening in the x-rays and he would now consider operating. However, Mrs C paid for another CT scan which, she advised, showed 70 percent more healing than the previous scan. She stated, therefore, that this was not conducive to surgery as Consultant 2 advised he would have had to break approximately 70 percent of the bone which had now healed, although he did not rule out future surgery in the event that the alignment proved to be a problem.

9. Mrs C acknowledged that the outcome of her private consultations was the same as she had been told by the Hospital, however, she expressed disappointment at the length of time it had taken to reach that stage and at the lack of information available throughout. She also expressed disappointment with the attitude of Consultant 1 and she said he 'remained elusive apart from the day after [her] fracture when he decided not to operate'. She stated that 'this may or may not be his fault but certainly he must be responsible for the conflicting views of his registrars and FY2's [Foundation Year 2 – a junior doctor in the second year of postgraduate training] who are consulting in his Clinic'. She advised that she had an extremely active lifestyle prior to her fracture and she did not believe this had been taken into consideration when the original decision not to operate was made. However, she stated that she was more worried by 'the confusion in [her] ongoing care which led to a lengthy recovery with an added problem in [her] ankle'.

Board's response

10. In the Board's response letter of 5 August 2008, Consultant 1 apologised for not having had further contact with Mrs C at the Clinic and he confirmed that he only became aware that he had not seen her personally when he received a copy of her letter of complaint. In his note of 23 June 2008 which informed the Board's response, Consultant 1 explained that it was just a matter of chance that Mrs C had been seen by his registrars each time she attended the Clinic. He said that it was normal practice for patients to be allocated randomly by nursing staff to two doctors, himself and one of his registrars. He advised that, following Mrs C's first call to his secretary, an appointment was arranged for her to be seen by him on 3 January 2008, however, due to personal reasons, he had to go on sudden unplanned leave. He apologised that this was not made clear to her when she arrived for the appointment.

11. Consultant 1 advised that, following Mrs C's second call to his secretary, he had asked that she be informed that he would personally see her at her next

appointment. He stated that he understood there was a time lapse between appointments and he confirmed that this was to ensure there was a sufficient time gap between the two sets of x-rays to make a confident decision regarding the state of union of her tibia fracture. He said he was informed that Mrs C had not attended her next appointment, scheduled for 23 April 2008, as she had decided to seek a further private opinion. He apologised if she had felt that, as a result of the care she had already received, another visit to the Clinic would not have benefited her.

12. Consultant 1 expressed regret that he was not able to provide reassurance to Mrs C personally, however, he noted that she was kept under regular review by his registrars on account of the delayed union of her fracture and the possibility of her requiring further treatment. He stated that he was pleased to note her fracture had now healed with no further intervention, however, he expressed his willingness to meet with her if she had any further concerns.

13. Mrs C wrote to the Board again on 27 August 2008 and expressed her dissatisfaction with their response. She advised that she had requested to see Consultant 1 for some reassurance regarding the delay in her tibia healing and she stated that it was not acceptable that she had to wait until 23 April 2008 for this reassurance and that this was the reason she had made an appointment privately (Mrs C chose not to attend the Clinic appointment on 23 April 2008). With regards to the time lapse between appointments to allow them to make a confident decision regarding x-rays, she stated she had not asked Consultant 1 to x-ray again but that she had wanted his opinion or reassurance regarding her x-ray on 12 March 2008. She said she had explained to Consultant 1's secretary that, due to 'the inconsistencies in his colleagues opinions throughout [her] care' she required help as her appointment on 12 March 2008 had again revealed non-union despite one of the registrars having previously stated that there was a union.

14. Mrs C acknowledged that she had been kept under regular review, however, she said the regularity was not the problem but rather the inconsistency in the information she received from Consultant 1's team and the fact that he had not been aware of her situation as she had not seen him since the day after her accident. She advised that, despite Consultant 1's satisfaction that her fracture had now healed, and despite her best efforts with exercising and private physiotherapy, she still had difficulties with her ankle and had not

been able to return to her active lifestyle. She stated that this was unnecessary as she felt that, had Consultant 1's team been more proactive in her care and reached a decision regarding the non-union of her fracture before her ankle became 'almost completely fused', she may have experienced a much more positive outcome. Mrs C declined the offer to meet with Consultant 1.

15. The Board responded to Mrs C on 23 September 2008. They acknowledged that there appeared to have been a breakdown in communication in that she had been given conflicting advice by different registrars. They stated that, when Mrs C had asked to see Consultant 1, she was clearly seeking answers to her questions regarding this conflicting advice. Consultant 1, therefore, conveyed his apologies for the misunderstanding over Mrs C's request to see him and for the inconsistent information she received.

16. Consultant 1 advised that it is sometimes very difficult to reach a decision regarding the state of union of a fracture and the only way to decide one way or the other is to take x-rays at reasonable intervals. He stated that, had a hasty decision been taken in Mrs C's case, it may have resulted in the fracture being treated as a non-union when it was actually a delayed union. He said that the fact that her fracture eventually united without the need for further intervention confirmed it had been a delayed union. Finally, Consultant 1 apologised for the fact that Mrs C was still experiencing stiffness in her ankle, however, he stated that this was unfortunately a known complication of tibial fractures which had been treated non-operatively.

(a) The decision to treat Mrs C's fracture conservatively was inappropriate

17. Mrs C complained to the Ombudsman in a letter dated 24 November 2008. She expressed dissatisfaction with the fact that she had not received an explanation regarding Consultant 1's initial decision not to operate. She conveyed her view that her fracture should have been operated on and fixed internally, either at the time of her accident or before her ankle deteriorated to the degree it did. She stated that this would have resulted in a much speedier recovery without the subsequent complication she had experienced. She advised that she was experiencing pain not just in her ankle, but also at the fracture site and in her knee. Mrs C suggested that it was unreasonable for Consultant 1 to have suggested a conservative approach. She stated the decision should have been for Consultant 1 to have made as patients 'cannot

make any sensible decisions regarding their care' due to the effects of the strong pain-killing medication and their limited knowledge of what is involved.

18. I asked the Adviser to review Mrs C's NHS medical notes and NHS x-rays and provide his opinion on her care and treatment. He noted she had sustained a spiral fracture of her left tibia and fibula on 16 June 2007 and that the nursing records indicated that she was placed in plaster that same day. He observed that the medical records suggested treatment options had been explained to her and a note on 17 June 2007 indicated that both operative and non-operative treatment had been discussed and non-operative management had been elected. The following day it was noted that Mrs C was 'to get up with crutches today' and she was to be discharged home and reviewed in the Clinic the following week. The Adviser noted that the discharge letter also confirmed options had been discussed regarding conservative and operative management and Mrs C had elected for non-operative management.

19. The Adviser confirmed that the initial x-rays taken in the plaster showed that there was some displacement of the fracture (the two ends were not lined up perfectly) and a rotational deformity (there was a twisting nature to the fracture which had not been corrected). Therefore, in the Adviser's view, the majority of units would not have treated Mrs C's fracture conservatively.

20. The Adviser informed me that there is no perfect way of treating tibial shaft fractures and there are potential complications of both operative and conservative methods. He advised that the major problems that occur with conservative treatment are of stiffness of adjacent joints (disuse osteoporosis) and loss of position. He said it appeared that both of these complications occurred in Mrs C's case and, whilst he would expect the disuse osteoporosis in Mrs C's ankle to recover, she would not necessarily regain normal movement in her ankle joint.

21. With regards to operative treatment, the Adviser noted that there was a risk of infection. In addition, he noted that a significant proportion of patients who have undergone tibial nailing develop anterior knee pain which does not necessarily resolve and, in fact, infrequently resolves after removal of metal work.

22. On balance, the Adviser concluded that, in his opinion, very few units would have treated Mrs C conservatively and the majority would have advised

and carried out operative treatment. I contacted the Adviser for clarification of whether he considered it appropriate to have treated Mrs C conservatively and he advised that, if there were units which would opt for conservative treatment for a fracture such as that sustained by Mrs C, they would be out of the mainstream of orthopaedics as practised now. However, he stated that, although initial conservative treatment would not have been the normal pattern, it was not entirely unreasonable.

(a) Conclusion

23. It is documented that both conservative and operative treatment options were discussed with Mrs C and she elected for conservative treatment. I note that she had no concerns about this treatment choice at the time and when she first complained to the Board, Mrs C stated that her complaint was not with the original decision. Although she later expressed concern with the choice of treatment, this was as a result of subsequent difficulties she encountered in her recovery and was, therefore, largely informed by hindsight. I cannot judge a complaint based on hindsight and the question is whether the initial decision to treat the fracture conservatively was appropriate, based on the information available to the medical staff at that time. Whilst the Adviser has indicated that, in his view, most orthopaedic units would have treated Mrs C's fracture operatively, he stated that initial conservative treatment was not entirely unreasonable. Therefore, in the circumstances, I do not uphold this complaint.

(b) The standard of follow-up treatment was inappropriate

24. Whilst the Adviser has indicated that the initial decision to treat Mrs C's fracture conservatively was not unreasonable, he stated that, with the failure of that treatment, early consideration should have been given to operating and that operative treatment should have subsequently been carried out. Following the initial consideration of both treatment options, he noted that there was no evidence of further consideration of surgical intervention until Mrs C was reviewed on 12 March 2008.

25. I asked the Adviser whether he considered the level of input into Mrs C's treatment from Consultant 1 to have been appropriate. He advised that Mrs C's union of fracture was obviously progressing slowly and he would have thought that it would have been best practice for the registrars to have at least discussed this, and to have documented their discussion, with Consultant 1 regarding the failure to progress. I subsequently discussed this issue further with the Adviser and he indicated that, in a complex case such as this, it would

have been appropriate, in his view, for Mrs C to have had regular consultant review, perhaps on every second or third visit.

26. I also asked the Adviser whether it would have been appropriate for the Clinic to have organised a CT scan to be carried out. He advised that, when Mrs C's plaster was removed in November 2007, she was allowed to commence weight-bearing and he stated that this indicated that the doctors had felt that there was some degree of union. However, he said there may have been more confidence in their advice to weight-bear if further and alternative imaging in terms of a CT scan had been obtained. Notwithstanding this, however, the Adviser stated that Mrs C's union was assessed on clinical grounds and he was entirely in agreement with this.

27. Finally, with regards to the consistency of information provided to Mrs C at the Clinic, the Adviser noted that there was no documentary evidence to indicate that Mrs C was given conflicting views.

(b) Conclusion

28. The advice I have received indicates that there is no evidence in the records to suggest that Mrs C was provided with conflicting information and, in any case, I note the Board have acknowledged that conflicting information may have been provided and they have already apologised for this. There is, therefore, nothing further I can add in respect of this aspect of Mrs C's follow-up treatment.

29. However, the Adviser has indicated that the failure of conservative treatment should have given cause for the early consideration, and carrying out, of surgical intervention. In addition, he has raised some concerns regarding the level of consultant input into Mrs C's case. Whilst I note that Consultant 1 has offered an explanation and an apology for this, the Adviser stated that, due to the complexity of Mrs C's case, regular review by Consultant 1 would have been appropriate and, at the very least, his registrars should have discussed the case with him and documented their discussions accordingly. In the circumstances, I uphold this complaint.

(b) Recommendations

30. I recommend that the Board should:

(i) apologise to Mrs C for the failings identified in this head of complaint;

(ii) highlight the issues raised in this report to all relevant orthopaedic staff;

(iii) remind clinical staff of the importance of documenting their discussions with consultants; and
(iv) encourage consultants to consider taking a more proactive role in complex cases.

31. 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

Mrs C	The complainant
The Hospital	The Royal Alexandra Hospital
Consultant 1	The consultant orthopaedic surgeon who treated Mrs C
The Clinic	Consultant 1's Fracture Clinic
Consultant 2	The private orthopaedic consultant from whom Mrs C sought an opinion
The Board	Greater Glasgow and Clyde NHS Board
The Adviser	The orthopaedic adviser to the Ombudsman
CT scan	Computerised tomography scan (a detailed x-ray imaging technique)

Annex 2

Glossary of terms

Tibia	The shin bone (the inner and larger of the two leg bones below the knee)
Fibula	The calf bone (the outer and smaller of the two leg bones below the knee)
Spiral Fracture	A fracture where the bone has been twisted apart
Osteoporosis	A condition that affects the bones, causing them to become thin and week. Disuse osteoporosis commonly occurs in patients with immobilised limbs secondary to fracture