

## **Scottish Public Services Ombudsman Act 2002**

### Report by the Scottish Public Services Ombudsman of an investigation into a complaint against

#### Grampian University Hospitals NHS Trust<sup>1</sup>

### **Complaint as put to the Ombudsman**

1. The account of the complaint provided by Mr C (a key to the names used in this report is set out at Appendix 1) is that at the end of the year 2000 he experienced problems with his left shoulder. Following a referral by his General Practitioner (GP), Mr C was seen by a Consultant Orthopaedic Surgeon (Consultant 1) at Fraserburgh Hospital in June 2001. Consultant 1 made an appointment for him to have manipulation under general anaesthetic. This took place towards the end of July. On 25 October 2001 Consultant 1 reviewed Mr C and decided he would benefit from acromioplasty (minor surgery to trim the bones to allow space for them to work). On 10 April 2002 Mr C was admitted for the surgery and was taken to theatre where Consultant 1 told him that he did not think the operation he planned would help. Consultant 1 cancelled the surgery and referred Mr C to another Consultant Orthopaedic Surgeon (Consultant 2). On 26 June 2002 Mr C was examined by Consultant 2 who told him that he had ruptured some tendons in his shoulder and sent him for x-rays which supported the clinical diagnosis. An MRI scan on 30 August 2002 determined the full extent of the damage. Mr C was advised that surgery to repair the tendons was not appropriate after such a long time.

2. The complaint subject to investigation was that Consultant 1's clinical management of Mr C's condition was inadequate, including that he failed

---

<sup>1</sup> Grampian University Hospitals NHS Trust was established by The Grampian University Hospitals National Health Service Trust (Establishment) Order 1998 which came into force on 2 November 1998. The Trust was dissolved under The National Health Service Trusts (Dissolution) (Scotland) Order 2004 which came into force on 1 April 2004. On the same date an Order transferring the liabilities of the Trust to Grampian Health Board came into effect.

to arrange appropriate radiological examination. Furthermore, that Consultant 1 recommended inappropriate treatment, leading to a delayed diagnosis by which time it was too late to consider operative repair of the tendons.

### **Investigation of the complaint**

3. Mr C raised his concerns with the Trust and remained dissatisfied with the Trust's response. He then applied to the Trust's Convener for his complaint to be considered by an independent review panel. The Convener referred the complaint back for further local resolution on the basis that the Trust had not fully addressed Mr C's medical management. The Trust maintained that Mr C had received appropriate care and treatment. Mr C remained dissatisfied and asked again for his complaint to be considered by an independent panel. His request was refused on the basis that all practical steps had been taken to address his complaints and no further benefit would be derived from setting up an independent review panel. Mr C then asked me to consider his complaint. The statement of complaint for my investigation was issued on 8 October 2003. The Trust's comments were obtained and relevant documents, including Mr C's medical records, were examined. Two independent External Professional Assessors – both Consultant Orthopaedic Surgeons – were appointed to advise on the clinical issues in this case. Their report is set out at paragraph 22. Interviews were conducted with Mr C and Consultant 1. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. The medical terms used in this report are explained in Appendix 2.

### **Guidance on record keeping**

4. The General Medical Council produced guidance in May 2001 entitled 'Good Medical Practice' which includes that medical practitioners are expected to 'Keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings ...'.

5. A booklet entitled 'Good Surgical Practice' published in September 2002 by the Royal College of Surgeons of England and endorsed by the Association of Surgeons of Great Britain and Ireland includes that surgeons should 'Ensure that all medical records are legible, complete and contemporaneous ...' and 'Ensure that follow-up notes are sufficiently

detailed to allow another doctor to assess the care of the patient at any time'.

### **Oral evidence of Mr C**

6. Mr C told my Complaints Investigator that he began experiencing problems with his left shoulder and arm towards the end of the year 2000. It was painful when moving and his movement was slightly restricted. He consulted his GP who gave cortisone injections and physiotherapy but that did not work and Mr C's shoulder got worse. Mr C was a bus driver and by April 2001 he was finding it almost impossible to operate the indicators and buttons on the left side of the steering wheel and had to reach across with his right hand. He had to go off work sick. In May 2001 his GP referred him to Consultant 1 who saw him in June. His shoulder was no worse at that time. The problem was that it was not getting any better. Consultant 1 diagnosed a frozen shoulder. He gave Mr C the impression that he thought he was malingering but said that he would arrange for manipulation under general anaesthetic to try to get things moving.

7. The manipulation took place towards the end of July 2001. A physiotherapist saw Mr C in the ward afterwards and gave him stretching and reaching exercises to be performed. Mr C performed the exercises faithfully two times each day for four to six weeks but his shoulder and arm became more and more painful and eventually he was unable to continue with the exercises. While on holiday in August he noticed a golf ball size lump on his shoulder which he had not seen before.

8. Mr C said that a follow-up appointment with Consultant 1 had been arranged for October 2001. When he returned from holiday Mr C asked his GP if it was possible to get an earlier appointment because his arm was so painful. However, this was not possible and he had to wait for his arranged appointment. After the manipulation and at the time when he was reviewed by Consultant 1 in October 2001, Mr C's shoulder was freer and the movement was not as restricted as it had been before the manipulation but it was more painful and the range of movement was still restricted particularly above chest level. Consultant 1 felt that Mr C's condition had improved. Mr C's view was that his arm was moving in a

different way but it certainly was not better. He advised that Consultant 1 had told him he still had a frozen shoulder and that there was a calcium build up in a hole in the shoulder blade through which a tendon runs which was restricting the muscle movement. Mr C told my Complaints Investigator that Consultant 1 had again said that he could not understand why Mr C could not drive buses. Mr C felt Consultant 1 was implying that he was making false claims. Consultant 1 proposed an operation which involved making a hole in the top of his shoulder and removing the calcium.

9. Mr C attended at hospital for the planned surgery on 10 April 2002. He arrived at 9am and he was seen by a junior doctor in the ward. The only x-rays he had had were those arranged by his GP near the beginning of 2001. The doctor seemed to think there should be more recent x-rays. The doctor asked him which shoulder was the problem and made pencil marks on it. He also went over the consent form with Mr C. No-one else came to see Mr C in the ward. Mr C told my Complaints Investigator that at about midday he was taken to the operating theatre where a blood pressure cuff was put on him and a clip on his finger and things on his chest. Soon after that Consultant 1 arrived and asked him which arm was the problem. He also asked Mr C to show him how he could move the arm. Mr C stated that, to do that, he had to sit up and all the things on his chest pinged off. Mr C then demonstrated to Consultant 1 the range of movement he had which he said was the same as it had been back in October 2001. Consultant 1 told him that what he had planned would not help; that he was going to cancel the operation and send him to someone else. Consultant 1 then left. Mr C told my Complaints Investigator that Consultant 1 had seemed to be in a hurry.

10. Mr C said that there was no change in the condition of his shoulder between the cancellation of his operation and his consultation with Consultant 2 in June 2002. As soon as Mr C took his shirt off, Consultant 2 saw that his shoulder had dropped and immediately said to him that he appeared to have ruptured tendons. He explained that if his diagnosis was correct there was only a 3 in 10 chance of successfully repairing the tendons surgically. It was also possible that his condition could be worse after surgery. Consultant 2 explained that he would arrange x-rays and scans to confirm his diagnosis. Ultimately it was

confirmed that Mr C had ruptured tendons and the chances of successful surgery were so low that he decided against it.

11. At interview, Mr C said that now the movement of his arm, when it is hanging down low, is quite free but that he cannot raise his arm above shoulder height and he cannot touch his head with his left hand. He can hold weights down low but the strength in his arm is affected, for instance, if he is digging in the garden he can only use his left hand to guide the spade. Mr C felt that x-rays should have been arranged by Consultant 1 before the manipulation and before deciding to operate on him to ensure that he was being treated for the right condition. Mr C believed that, if that had been done, it was possible the tendons could have been repaired before his condition deteriorated to the extent that they were beyond repair. Mr C also understood that prolonged inflammation of the tendons along with cortisone injections are known to weaken the tendons and he felt that the manipulation, after seven months of treatment including cortisone injections, worsened his condition. He could see no reason why or how a tear could have developed before the manipulation, as he had never taken part in vigorous exercise or sport and the buses he had driven had fully automatic gears and power steering and were very easy to drive. Mr C told my Complaints Investigator that he was amazed at the events that took place in the operating theatre and he was very annoyed. Given that his condition had not changed from October 2001 to the date of his planned operation in April 2002, he felt that Consultant 1 should have recognised in October 2001 that that type of surgery was not appropriate.

12. Mr C also said that during the Trust's investigation of his complaint he had a meeting with Consultant 1 and others. Consultant 1 had not even bothered to have the clinical notes with him and it seemed to Mr C that the meeting was just an inconvenience for them.

### **Extracts from Mr C's clinical records**

13. The following are extracts from Mr C's clinical records:

*GP to the Orthopaedic clinic at Fraserburgh Hospital near the end of May 2001*

'I would appreciate your opinion on further management of this 61 year old bus driver's complaint of increasing stiffness and pain on movement of his left shoulder. This has troubled him increasingly during the past year and though he did derive initial benefit from Depo Medrone [cortisone] injections, these have become progressively less effective. Despite a course of physiotherapy he has again reached the stage where he is frightened he will be unable to drive safely because of the symptoms. X-ray of his shoulder does confirm the presence of calcification in the rotator cuff and beneath the acromion. He also has reversal of the normal cervical lordosis with reduction in disc heights ...'.

*Consultant 1 to the GP on 4 July 2001*

'Thank you for referring this gentleman who has had trouble with his left shoulder for several months. He has now been off work for 8-10 weeks as a bus driver because of this. The pain is becoming less severe but it is certainly extremely stiff.

On examination [on 28 June 2001] he can adduct the shoulder pretty well but only 40° is present on abduction at the glenohumeral joint. All the rest is due to scapula rotation. Similarly flexion is quite good. He has marked restriction of external rotation as well.

He has a classical frozen shoulder and this is best dealt with by manipulation under anaesthesia and installation of steroid and local anaesthetic. I'm putting his name on the waiting list for this and he will be admitted as soon as possible.'

*A Staff Grade Orthopaedic Surgeon to the GP on 14 August 2001*

'This gentleman was an elective admission for [MUA and injection of local anaesthetic and steroid left shoulder under general anaesthetic on 25 July 2001] which was performed uneventfully. At surgery the shoulder could be manipulated through an excellent range of movements with full abduction and limitation of external rotation. He has been advised to mobilise his shoulder very actively and was seen

by the Physiotherapist before he was discharged home. His future follow up will be ... in three months time.'

*Consultant 1 to the GP on 31 October 2001*

'I saw [Mr C] for review [on 25 October 2001]. He has improved range of movement although he feels and has been apparently told that it's not good enough to allow him to return to work.

On examination he still has difficulty with abduction and external rotation. He has in fact a painful arc syndrome.

I think he would be benefited by an acromioplasty and I am putting his name on the waiting list to be done.'

*Consultant 1 to Consultant 2 on 17 April 2002*

'Admitted: 10/4/02 ...

Diagnosis: Left shoulder adhesive capsulitis ...

I would be grateful if you could see this patient who is a bus driver and can't get back to work because he has some residual stiffness in the left shoulder. I first saw him in June last year when he had been off work for about 10 weeks. At that time he had a classic frozen shoulder and I admitted him on 25 July 2001 and carried out an MUA of the shoulder under local anaesthetic with a steroid injection. He had quite a good recovery from this and I saw him for review on 25 October 2001. At that time he had what appeared to be a painful arc syndrome. He was put on the waiting list for an acromioplasty but when he attended today he still had some slight restriction of external rotation and abduction of the shoulder and discomfort in the shoulder.

I don't think I can do anything further myself to help him and I would be grateful if you could see him.'

*Consultant 2 to Consultant 1 on 28 June 2002*

'Thank you for your letter concerning this pleasant 63 year old right handed bus driver who has been off work for over a year. In December 2000 he started experiencing discomfort in his left

shoulder which failed to resolve with physiotherapy and a number of steroid injections.

Over the last year his major problem has been loss of function of the shoulder and on examination there was evidence of wasting of the supraspinatus and infraspinatus muscles and complete loss of power while attempting to externally rotate or abduct his shoulder against resistance. In reality, he has to shrug his shoulder while attempting to move the joint as there is really no gleno-humeral movement of note and this is consistent with complete rupture of the supraspinatus and infraspinatus tendons.

X-rays also demonstrate marked superior migration of the humeral head in relation to the glenoid, confirming the diagnosis.

I think at this stage repairing the muscles will be extremely difficult to achieve and I have arranged for him to have an MR scan of the shoulder to see just how far the tendons have retracted and also to assess the amount of fatty change present within the muscle belly. All being well, it may be possible to reconstruct the rotator cuff muscles although I seriously doubt how strong the repair will be and the chance of a further rupture occurring will be somewhere in the region of 70%.

In all honesty, I do not think this man will be able to go back to work as a driver and he is aware of this. I will be seeing him for review at my clinic with the result of the MR arthrogram.'

*A Specialist Registrar in Orthopaedics to the GP on 20 September 2002*

'I reviewed this man at [Consultant 2's] clinic [on 18 September] following his MRI scan. Presently he does not complain of any pain but he does complain of restriction of range of movement of his left arm ... The MRI scan confirms complete tears of both the supraspinatus and the infraspinatus tendons with a large subcoracoid bursa with marked tendinitis of the long head of the biceps. The x-ray report does not describe the condition of either the supraspinatus or infraspinatus muscles, however, on reviewing the



films there appears to be fatty change of both the supraspinatus and infraspinatus muscles.

I have reiterated to him that there would only be a 20%-30% chance of success of repair of the rotator cuff muscles and considering the extent of the tear, now confirmed on the MRI scan, and the fatty change in his muscle, it is unlikely that even with a successful repair that he would have significant restoration of function. He is happy with the outcome of this and accepting that he will have to persist with a limited range of movement to his left shoulder... He has been discharged from the clinic.'

### **Trust's reply to the statement of complaint**

14. In his formal reply to my statement of complaint the Chief Executive of the Trust wrote:

'... the Trust endeavoured to deal with the issues that were raised by Mr [C], including a meeting with [Consultant 1] and the Clinical Group Co-ordinator of the Orthopaedic Service.

... we believe that Mr [C] has had appropriate treatment for his shoulder condition under the circumstances as they were presented to [Consultant 1].'

### **Written evidence of Consultant 1**

15. In a statement obtained during the Trust's investigation of the complaint, Consultant 1 wrote:

*Statement provided on 21 November 2002*

'I first saw this gentleman ... in June 2001 with a several month history of a painful left shoulder. He had a classical frozen shoulder at that point in time. The best treatment for that is manipulation under anaesthesia and injection of steroid. This was arranged as a matter of relative urgency. In the past we regularly carried out x-rays in this situation but they are virtually always normal and I would now probably only do one in the first instance if there is a suggestion of sinister pathology ie history of tumour, infection or something of that sort.

... this man almost certainly had an acute rupture of the supraspinatus and infraspinatus tendons early in 2001. However the evolutionary process of this is that they often go ahead to develop a frozen shoulder and certainly by the time I saw him in June [2001] an x-ray taken at that time would not necessarily have suggested the condition. Even if it did, surgical repair would not have been a possibility and I would have carried out exactly the same treatment. ...'.

### **Oral evidence of Consultant 1**

16. Consultant 1 told my Complaints Investigator and one of the Professional Assessors that the GP referral letter asked for an urgent appointment for Mr C. He was slotted in as an urgent appointment, however it was important to note that this type of case would not normally be considered urgent. From the date of the GP referral letter (received 31 May 2001) to the date of the first consultation (28 June 2001) Mr C's condition had changed. In his referral letter, the GP described Mr C's complaint of increasing stiffness and pain on movement of his left shoulder which had troubled him increasingly over the past year. Consultant 1 found that the pain had become less severe but the stiffness had increased and the joint was almost completely immobile. He said that acute calcification had passed to frozen shoulder. An x-ray had been arranged by the GP and the GP said in his referral letter that 'x-ray of his shoulder does confirm the presence of calcification of the rotator cuff and beneath the acromion'. Consultant 1 could not say whether or not he had seen the x-ray. If it was with the records when he saw Mr C then he would have looked at it but they were not always there. If he did not see the x-ray, he would have relied on the GP letter which provided a clear report on the x-ray. It confirmed the presence of calcification. Consultant 1 explained that calcification occurs in a tear in the tendon which is very painful. There was no mention of any other abnormality on the x-ray.

17. Consultant 1 confirmed that the main reason for arranging an x-ray before manipulation would be if there was evidence of sinister pathology. He explained that an x-ray was no help with a frozen shoulder and only an MRI scan would reveal a torn rotator cuff. At that time there would

have been general wasting of the muscles because of Mr C's inability to move his arm but there was no sign of localised wasting which would have indicated a torn rotator cuff. The standard treatment for a frozen shoulder is manipulation under general anaesthetic with a local injection of steroid followed by physiotherapy. He put Mr C on a waiting list to undergo manipulation which took place on 25 July 2001.

18. Consultant 1 said that when he reviewed Mr C on 25 October 2001 he found that Mr C had recovered quite a good bit of mobility in his shoulder. He had an improved range of movement but difficulty with abduction. At that time Mr C had a painful arc syndrome. Consultant 1 said he would have looked for wasting of the muscles and tested external rotation and abduction but there was no sign of localised wasting at that time. He stated that Mr C had active abduction. He was sure that Mr C did not have the clinical signs that Consultant 2 saw in June 2002 because he had abduction quite high up and could hold it. He arranged for Mr C to go on the waiting list for acromioplasty.

19. Consultant 1 said that clinicians are pressurised not to take x-rays unless absolutely necessary because there are significant budget constraints. Also x-rays do not show torn tendons. The x-ray arranged later by Consultant 2 confirmed complete rupture of the tendons because the joints were separated but they would not have been like that when he reviewed Mr C in October 2001 because active abduction is not possible when the tendons are torn. Consultant 1 said that if it is decided that an MRI scan is to be carried out it has to be done early on. MRI scans are not undertaken unless it is clear that abduction of the shoulder is not possible. Consultant 1 felt that in this case the ruptured tendons were probably the result of a small tear which slowly extended to a complete tear. He said that frozen shoulder complicates the whole picture. However, even if a small tear existed before the manipulation, the manipulation could not have caused the complete rupture of the rotator cuff because the opposite side is stretched and the tendons are not stretched.

20. On 10 April 2002 Mr C was admitted as a day case for acromioplasty. Consultant 1 said that he had a normal operating list that day and therefore could not see day patients on the ward. Patients were seen by

a junior doctor on the ward and examined by Consultant 1 in theatre. Procedures have changed since then and patients are now asked to attend for an assessment before their admission. He did not see patients at the pre-admission assessment unless the junior doctor thought that the patient's condition had changed. Consultant 1 said that when he saw Mr C in theatre, Mr C did not have a painful arc and so the planned surgery was inappropriate. He did not record his findings on examination that day and could not remember clearly what he found. Mr C did not have good abduction and Consultant 1 thought that he probably found much the same as Consultant 2 did when he saw Mr C in June 2002. He referred Mr C to Consultant 2 because Consultant 2 had a special interest in shoulders.

21. Consultant 1 told my Complaints Investigator that he has always tried to do the best for all his patients and he was sorry that Mr C felt that he had not done the right thing for him. However, even in hindsight he felt that he provided appropriate care and treatment for Mr C. He would have preferred to have seen Mr C in the ward rather than cancelling his operation in the operating theatre but that was not possible at that time.

### **Assessors' Report**

22. I reproduce next, in its entirety, the report prepared by the Assessors who were appointed to give advice on the complaint.

#### ***Matters considered***

*i. Whether Consultant 1's management of Mr C's condition was inadequate, leading to a delayed diagnosis, by which time it was too late to consider operative repair of the ruptured shoulder tendons.*

#### ***Basis of the report***

*ii. This report is based on the documents provided including Mr C's statement of complaint, the reports of interviews with Mr C and Consultant 1, review of the General Practice records, review of the hospital records and review of correspondence during the NHS Complaints Procedure.*

### ***Interview with Mr C***

*iii. At interview, Mr C outlined the various stages of his clinical management by Consultant 1, the subsequent consultation with Consultant 2 and his present condition. Following an initial diagnosis of frozen left shoulder by Consultant 1, manipulation under anaesthesia combined with an injection of local steroid to the shoulder joint, was carried out in late July 2001. A post-operative exercise programme was advised and Mr C reported that he noticed a golf-ball sized lump at the left shoulder while on holiday in August 2001. When Consultant 1 reviewed the problem in October 2001, some improvement was apparently noted but surgery in the form of an acromioplasty was advised and his name placed on the waiting list. When he attended for his operation in April 2002, the surgery was cancelled in the Operating Theatre after Consultant 1 carried out a further clinical review. Mr C was upset at this late cancellation and felt that his shoulder function was no different than at the consultation the previous October. When he attended Consultant 2 in June 2002, the correct diagnosis was immediately evident on clinical examination, suggested by x-ray and confirmed by MR scan. His present condition was that he was unable to raise his left arm above shoulder height and the general function of the left upper limb remained curtailed. Mr C concluded that his problem had been misdiagnosed by Consultant 1 and that a surgical repair might have been possible if the diagnosis had been correctly made earlier.*

### ***Interview with Consultant 1***

*iv. The initial presentation was outlined indicating that the movement range at the left shoulder had been almost completely lost by the time of the initial consultation in June 2001. Consultant 1 could not recall whether the x-rays arranged by the GP had been viewed but was reasonably certain that the x-ray changes noted by Consultant 2 a year later would not have been present. A further update x-ray did not seem justified as there was no clinical evidence of sinister pathology. A frozen shoulder was diagnosed and a manipulation under general anaesthetic with a local injection of steroid and some physiotherapy was arranged for July 2001. At subsequent review in October 2001 an improved movement range at the left shoulder was noted but ongoing difficulty with abduction*

remained leading to a diagnosis of painful arc syndrome. From his recollection, he was confident that Mr C was able to elevate the left arm above shoulder height and that there were no clinical signs of muscle wasting around the left shoulder. Surgical acromioplasty was recommended. Neither update x-rays nor an MRI scan was deemed necessary. On the day of the planned operation in April 2002, Mr C had been examined by a junior doctor but Consultant 1 did not see Mr C until he reached the Operating Theatre. At that point, the clinical picture appears to have changed but the findings were not documented. A referral to Consultant 2 was arranged because of his special interest in shoulder problems. Consultant 1 believed that his clinical findings on the day of surgery were similar to those found by Consultant 2 two months later. In retrospect, Consultant 1 believed that a small tear of the rotator cuff which had caused the initial frozen shoulder had slowly extended in early 2002, leading to the change in the clinical picture. He believed that, even with hindsight, his management of Mr C's problem was appropriate, although he regretted his failure to review the patient prior to his arrival at the Operating Theatre.

### **Review of GP records**

v. These show that Mr C developed pain and stiffness of the left shoulder in late 2000. X-rays in February 2001 confirmed calcification in the rotator cuff tendon, indicating a degenerative, age-related disorder. The GP administered a series of three steroid injections with only short term benefit. In the late spring of 2001, pain and stiffness increased in severity, leading to Mr C going on sick leave because he felt it unsafe to drive his bus. A request for an out-patient consultation appears to have been submitted and, after a telephone request for urgency, Mr C was seen by Consultant 1 in June 2001, when a frozen left shoulder was diagnosed and arrangements made for day case management. In late July 2001 Mr C attended as a day case and a manipulation of the left shoulder under anaesthesia was carried out, combined with a further injection of local steroid. Post-operative physiotherapy was arranged. On his return from holiday in August 2001, Mr C seems to have reported noticing a golf-ball sized lump on the top of the left shoulder. The GP's entry on 27 August 2001 indicated that examination revealed no

*major change in the function of the left shoulder. Following hospital review, the GP received a letter in October 2001 stating that shoulder function had improved but that a painful arc of movement persisted. Accordingly, Mr C's name was placed on the waiting list for surgical decompression of the rotator cuff tendon.*

### **Review of hospital records**

*vi. These confirm that Mr C's initial consultation by Consultant 1 in June 2001 was an extra slot at the end of a Clinic at the specific request of the GP. The examination findings have not been recorded by Consultant 1 in the clinical notes although he did include them in a dictated letter to Mr C's GP. He diagnosed a frozen left shoulder and recommended day case surgery in the form of manipulation under general anaesthesia combined with an injection of a local steroid. The procedure appears to have been carried out by an intermediate grade member of staff and follow-up physiotherapy was arranged. The physiotherapy records indicate poor progress. At the review in October 2001, examination findings were recorded only in a letter to the GP. Consultant 1 diagnosed a painful arc syndrome. X-rays of the shoulder do not appear to have been taken at any of these out-patient consultations. A rotator cuff decompression was advised and Mr C's name was placed on the waiting list. The records of the pre-admission Clinic in April 2002 indicate that Mr C was seen by a junior doctor who did not record examination findings. The consent form appears to have been signed by this member of staff and Mr C. The clinical findings by Consultant 1 on the day of surgery were not recorded so the reason for cancellation of surgery is not clear. In his referral letter to Consultant 2, there is reference to some difficulty in abduction and external rotation. Muscle wasting is not mentioned. Consultant 2 recorded his clinical findings noting established muscle wasting around the shoulder, poor function and upward migration of the humeral head – all indicating a total rupture of the rotator cuff tendon. This was confirmed by MR scan. It was considered that the prospects of considerable benefit from reparative surgery were poor.*

### **Comments**

*vii. Mr C's left shoulder problem was initially diagnosed as a calcific frozen shoulder in June 2001, a calcific painful arc syndrome in*

*October 2001 and subsequently, by Consultant 2, as an established complete rupture of rotator cuff tendons. The x-ray report in 2001 revealed calcification of the left shoulder but no upward migration of the head of the humerus to indicate rotator cuff rupture. This strongly supports an initial diagnosis of frozen left shoulder. Following the manipulation under anaesthesia in July, the Physiotherapist did not report a major deterioration in function as would be expected if the tendon ruptures had occurred during the procedure. Following the incident on holiday in August 2001 when Mr C noticed a swelling on the top of the left shoulder, the GP again did not seem to notice a major change in function. At the time of the October review by Consultant 1, repeat x-rays of the left shoulder were not taken and the clinical findings not recorded but painful arc syndrome was diagnosed, indicating improved function. If an x-ray had been taken at this stage and had shown no major change in the appearance of the humeral head compared to the February films, this would have offered major evidence that the rotator cuff was at this stage still intact. By the time of the April operation, the reason for cancelling surgery is not evident as muscle wasting is not mentioned either at the pre-admission clinic or in Consultant 1's letter to Consultant 2. Both the hand-written notes by Consultant 2 and his subsequent letter indicate that by June 2002 clinical and x-ray findings were virtually diagnostic of total rupture of the rotator cuff tendons.*

### **Conclusion**

*viii. We believe it highly unlikely that Mr C had a rupture of the rotator cuff tendon at the time of the initial consultation in June 2001. This view is based on the description of the examination findings by the GP and the x-ray report of February 2001, when the humeral head had clearly not migrated upwards. On the other hand, by June 2002 muscle wasting was well established and the diagnosis was evident to Consultant 2. This level of muscle wasting takes at least six months to evolve and suggests that the rupture probably developed during the late summer and autumn of 2001. Manipulation under anaesthesia and an injection of local steroid to the shoulder are common day case procedures around the country and the incidence of rotator cuff rupture associated with the*



*procedure is extremely low. In this instance, the Physiotherapist did not notice a major deterioration in function. After Mr C noticed the golf-ball sized swelling on the shoulder whilst on holiday, neither the GP nor Consultant 1 noticed major deterioration in function at their consultation, although examination findings were not clearly recorded. By June 2002, clinical wasting at the left shoulder was clearly evident indicating rotator cuff rupture.*

*ix. The absence of well-recorded examination findings makes it extremely difficult to identify the approximate date on which the rotator cuff rupture occurred. As neither Mr C himself, the GP nor Consultant 1 noted a deterioration in function, it seems probable that a sub-total rupture occurred while Mr C was on holiday in August 2001 and gradually became complete thereafter in late October 2001. A repeat x-ray at the time of the October review by Consultant 1 might well have offered evidence that the rotator cuff was intact before surgery was advised. If the x-ray appearance had not changed significantly since the February film, the recommendation for surgery was entirely appropriate. On the other hand, if the head of the humerus had migrated proximally within its socket, a decompression operation would not have been appropriate. Similarly, the absence of a consultant based pre-assessment system prior to surgery in April 2002 seems to have resulted in the evolving clinical signs being undetected. We feel unable to agree with Consultant 1's view that the tendon rupture occurred gradually in early 2002, as the muscle wasting would not have had time to evolve by the time of the decision to defer the operation in April and the time of the definitive diagnosis in June.*

*x. The incidence of post-operative re-rupture after surgical repair of a degenerative tear of the rotator cuff is high. Accordingly, we feel that surgical repair would not have been advisable, even if the tear had been diagnosed in October 2001.*

*xi. In summary, we conclude the following:*

- *The recommendation for manipulation under anaesthesia combined with a fourth cortisone injection was entirely reasonable as an initial treatment.*
- *An x-ray at the initial consultation in June 2001 was optional, as the GP had arranged x-rays only four months earlier.*
- *It is highly unlikely that the manipulation resulted in the rupture of the rotator cuff.*
- *A repeat x-ray of the left shoulder should have been taken prior to the recommendation of acromioplasty in October 2001.*
- *The absence of a Consultant based pre-operative assessment system indicated sub-standard practice in the modern NHS.*
- *Recent improvements in Consultant 1's Orthopaedic Unit have apparently included the introduction of pre-assessment prior to surgery but we are unclear whether this system is Consultant based. We consider that good practice requires a Consultant to be present during a pre-assessment clinic.*

## **Findings**

23. Mr C complained that Consultant 1's clinical management of his condition was inadequate, including that he failed to arrange appropriate radiological examination. Mr C further complained that Consultant 1 had recommended inappropriate treatment, leading to a delayed diagnosis by which time it was too late to consider operative repair of the tendons. In particular, Mr C felt that x-rays should have been arranged before the manipulation took place in July 2001 and before deciding to operate on him to ensure that he was being treated for the right condition.

24. Consultant 1 said in a statement given during the Trust's investigation that Mr C almost certainly had an acute rupture of the supraspinatus and infraspinatus tendons in early 2001. When interviewed

during my investigation of the complaint he said that he felt that the ruptured tendons were the result of a small tear which slowly extended to a complete tear. When he first saw Mr C on 28 June 2001 there was no sign of localised wasting which would have indicated a torn rotator cuff. When he reviewed Mr C on 25 October 2001, Mr C had a painful arc syndrome but again there was no sign of localised wasting. Consultant 1 considered that, on the day of the planned acromioplasty, he thought Mr C presented in much the same condition as he was when seen by Consultant 2 two months later although that is not reflected in his letter to Consultant 2 on 17 April 2002 (see paragraph 13, page 7 of this report). Consultant 1 did not document his findings on the day of the planned acromioplasty. He did not arrange x-rays at any stage because he would normally only x-ray before manipulation if there was evidence of sinister pathology and he said there was no clinical reason to request an MRI scan. Clinicians were pressurised not to take x-rays unless absolutely necessary due to budgetary constraints.

25. The Assessors' advice, which I accept, is that it seems probable that a sub-total rupture of the tendons occurred when Mr C was on holiday in August 2001 and gradually became complete by late October 2001. The Assessors say that an x-ray should have been taken before recommending acromioplasty to determine whether that type of surgery was appropriate. An x-ray in October 2001 also might well have led to a diagnosis and earlier referral to Consultant 2. I would have expected Consultant 1 to make a decision based on his clinical judgement rather than budgetary constraints in considering whether an x-ray was necessary in these circumstances. I consider that he made an error of judgement and I criticise Consultant 1 for that. However, I hope that Mr C will take some comfort from the Assessors' opinion that, even if the diagnosis had been made earlier, the outcome would most likely not have been different, in that surgical repair of the rotator cuff tendons would not have been advisable. I uphold the complaint to the extent described above.

26. The Assessors also comment that absence of well recorded examination findings made it extremely difficult to identify when the rotator cuff rupture occurred. They also commented on the pre-admission assessment arrangements that are now in place and consider

that good practice requires a Consultant to be present during pre-assessment clinics.

### **Recommendations**

27. I recommend that the Board's Chief Executive (a) draws the guidelines referred to in paragraphs 4 and 5 of this report and the comments of the Assessors in relation to record keeping and the pre-assessment clinic to the attention of Consultant 1, and (b) apologises to Mr C on behalf of the Board and Consultant 1, for the shortcomings I have identified.

Professor Alice Brown  
Scottish Public Services Ombudsman

6 May 2005

**Key to names used**

Mr C	The Complainant
Consultant 1	The Consultant Orthopaedic Surgeon in charge of Mr C's care from June 2001 to April 2002
Consultant 2	The Consultant Orthopaedic Surgeon who saw Mr C on 26 June 2002

**Glossary of medical terms**

<b>Term</b>	<b>Definition</b>
Abduction	The movement of a limb away from the midline of the body; the opposite of adduction
Acromion	The projection of the shoulder blade that forms the point of the shoulder
Acromioplasty	Minor surgery to trim the bones to allow space for them to work
Adduction	Movement of a limb toward the midline of the body; the opposite of abduction
Adhesive capsulitis	Frozen shoulder (see below)
Calcification	Deposition of calcium in body tissues often following inflammation or injury
Cortisone injection	Medication to reduce inflammation
External rotation	The movement of a limb outward and away from the middle of the body
Flexion	The act of bending at a joint
Frozen shoulder	A shoulder joint with significant loss of its range of motion in all directions; the range of motion is limited not only when the patient attempts motion, but also when the doctor attempts to move the joint fully while the patient relaxes
Gleno-humeral joint	The joint between the shoulder-blade (scapula) and the bone of the upper arm (humerus)

Infraspinatus muscle	A muscle that assists the lifting of the arm while turning the arm outward (external rotation)
Infraspinatus tendon	The tendon of the infraspinatus muscle is one of four tendons that stabilise the shoulder joint and constitute the rotator cuff. Each of the four tendons that make up the rotator cuff links to a muscle that moves the shoulder in a specific direction.
MR arthrogram	MRI scan of a joint taken after the injection of radio-opaque substance
MR/MRI scan	Magnetic resonance imaging – a scan using radio waves and used for a number of purposes including giving accurate information about the structure of the joints, soft tissues and bones of the body
MUA	Manipulation under anaesthetic
Painful arc syndrome	An inflammatory disorder of a tendon or bursa around the shoulder joint which causes pain when the arm is lifted away from the body and upwards
Reversal of normal cervical lordosis with reduction in disc heights	Straightening of the neck with severe loss of height of the fibro-cartilage discs which separate the neck bones (vertebrae)
Rotator cuff	Four muscles whose tendons form the rotator cuff (see supraspinatus and infraspinatus tendons)

Subcoracoid bursa	The bursa (a small fibrous sac which acts as a cushion between some tendons and bones) which lies below the coracoid process, part of the upper border of the shoulder blade
Superior migration of the humeral head in relation to the glenoid	The head of the upper arm bone (humerus) rises higher than the glenoid cavity of the shoulder bone into which it normally fits
Supraspinatus muscle	A muscle that is responsible for elevating the arm and moving it away from the body
Supraspinatus tendon	The tendon of the supraspinatus muscle is one of the four tendons that stabilise the shoulder joint and constitute the rotator cuff
Tendonitis of the long head of the biceps	Inflammation of the tendon of a muscle on the front of the upper arm