Scottish Parliament Region: Mid Scotland and Fife

Case 200501195: Forth Valley NHS Board

Summary of Investigation

Category

Health: Hospital, Gynaecology

Overview

The complainant (Mrs C) raised a number of issues regarding her treatment and care following an operation for a vaginal prolapse.

Specific complaints and conclusions

The complaints which have been investigated are that the Board:

(a) failed to provide full information about the potential side-effects of the operation *(no finding);*

(b) failed to provide adequate post-operative care *(not upheld);*

(c) failed to communicate clearly information to Mrs C about her symptoms *(not upheld);* and

(d) failed to handle properly Mrs C's complaint *(not upheld)*.

Redress and recommendation

The Ombudsman recommends that the Board ensures its health professionals are aware of good practice in obtaining consent.

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

Main Investigation Report

Introduction

1. On 3 August 2005 the Ombudsman received a complaint from a woman referred to in this report as Mrs C that the failures in the treatment and care she received in Falkirk and District Royal Infirmary in 2003 had left her with recurring symptoms and anxiety.

2. Mrs C complained that she had continued to experience problems following an operation for a vaginal prolapse on 30 January 2003. In particular, she has been unable to have intercourse. Despite a number of visits to a consultant gynaecologist, Mrs C did not receive a firm diagnosis or appropriate treatment of her condition. Mrs C first brought her complaint to the attention of the consultant gynaecologist (Consultant 1) on 23 June 2004 by letter. She then saw another consultant (Consultant 2) who said Mrs C had been bleeding from the vaginal adhesions, but had failed to explain Mrs C's other symptoms (stomach bloating, dragging pains and stomach movements). In pursuing her complaint further, she had serious concerns about the way her complaint had been handled by Forth Valley NHS Board (the Board). Mrs C applied for an independent review of her complaint. However, the Convener did not allow her request. Mrs C then complained to the Ombudsman.

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

(a) failed to provide full information about the potential side-effects of the operation;
(b) failed to provide adequate post-operative care;
(c) failed to communicate clearly information to Mrs C about her symptoms; and
(d) failed to handle properly Mrs C's complaint.

Investigation

4. In writing this report I have had access to documents provided by Mrs C, Mrs C's clinical records covering the period of the complaint and the correspondence relating to the complaint from the Board. I have obtained advice from an Independent Professional Adviser to the Ombudsman on the gynaecological aspects of this complaint (the Adviser). I also conducted a telephone interview with Consultant 1. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board have been given an opportunity to comment

on a draft of this report.

(a) The Board failed to provide full information about the potential side-effects of the operation

5. Mrs C complained that she was not informed that the surgery could result in damaged tissues leading to adhesions. This had led to Mrs C being unable to have intercourse.

6. Consultant 1 said the fact that the surgery can result in problems in intercourse should have been discussed with Mrs C before she had the operation but it was not clear from documentation if this had been done.

7. At Mrs C's pre-operative consultation with Consultant 1 on 12 August 2002, Consultant 1 discussed two procedures - vaginal hysterectomy and anterior repair and cervical amputation and anterior repair. The consent form which was completed in the pre-admission clinic on 22 January 2003 was obtained for a vaginal hysterectomy and anterior repair. Mrs C's clinical notes state that although the proposed procedure was for vaginal hysterectomy and anterior repair, the procedure recorded on the admission form dated 29 January 2003 was 'anterior repair plus amputation of cervix'. The Adviser has said Consultant 1's decision to carry out a cervical amputation and anterior vaginal wall repair was well considered and correct. Furthermore, both procedures carried the same risk of difficulty with intercourse. This is because the surgery, anterior repair, which can lead to difficulties with intercourse, is common to both procedures. The likelihood of this is greater for those women, like Mrs C, who have gone through the menopause. The consent form includes a statement to the effect that the procedure (vaginal hysterectomy and anterior repair) and the relevant risks associated with the procedure had been explained to Mrs C by the doctor named on the form, but it does not document what information had been provided.

(a) Conclusion

8. Mrs C complains that she was not given sufficient information about the risks of the procedure. If that is the case, Mrs C had not given informed consent to her operation. Certainly Consultant 1 had carried out a different operation to that for which consent had been obtained from Mrs C (although I accept the Adviser's view that this was the right clinical decision to make). However, the procedure common to both operations, and which can lead to difficulty with intercourse, is the anterior vaginal wall repair. Notwithstanding the

fact that both operations carried the same risk, in accordance with guidance issued by the Scottish Executive Health Department on obtaining consent, Mrs C should still have been informed of the risk as well as the possibility that another operation may be carried out after consent was obtained. Whether or not alternative operations and/or specific problems such as the possibility of vaginal fault adhesions had been discussed with Mrs C is impossible to determine given the passage of time since the event and the difficulty in corroborating an oral account by either Mrs C or the doctor named on the form. I am, therefore, unable to make a finding on the complaint.

(a) Recommendation

9. Although I am unable to make a finding, given the lack of information on the consent form for Mrs C, I recommend that the Board ensures that its health professionals are aware of and follow the guidance issued by the Scottish Executive Health Department on good practice on obtaining consent.

(b) The Board failed to provide adequate post-operative care

10. Mrs C set out her complaint in three letters: her letter of 23 June 2004 was addressed to Consultant 1 and her letters of 20 August 2004 and 11 October 2004 to the Board. Consultant 1 responded on 9 July 2004 and the Board responded on 30 September 2004. Mrs C complained that she continued to experience bleeding from her vagina following her operation and pain during intercourse which was as a result of adhesions. Both the Consultant 1 and Consultant 2 failed to provide adequate post-operative care in diagnosing and managing properly the adhesions and managing her pain. She described her symptoms as internal bleeding, swollen stomach, movement inside, a dragging and pulling sensation and that it was painful to lie on her right side. Despite being cauterised several times, Mrs C continued to bleed. The first cauterisation was unsuccessful and on the second, Mrs C experienced a great deal of pain for several weeks after until, in her own words, she felt something separate and collapse and experienced discharge of material and blood. Consultant 1 had failed to diagnose adhesions. Consultant 2 had diagnosed adhesions, which were the cause of the bleeding, but failed to treat the bloating, dragging pains or stomach movement.

11. Specific aspects to Mrs C's complaint concerning Consultant 1 included the fact that on her first post-operation appointment in June 2003, Consultant 1 made a decision about operating that should have been made by an anaesthetist and that she failed to provide a follow-up appointment after

cauterising her. On her second appointment (November 2003), the cautery was extremely painful and several weeks later her insides felt that they had collapsed or separated. On her third appointment (March 2004), Consultant 1 had failed to explain the pain or collapse that Mrs C had experienced or address the gap that had developed. During her fourth appointment (June 2004) Consultant 1 had said she had no idea what was wrong with Mrs C.

12. The Board responded that it can take time to identify the cause of a patient's symptoms before starting on the appropriate treatment. At Mrs C's appointment in June 2003, Consultant 1 found Mrs C's cervix to be regular, but there was no evidence of adhesions at that time. Mrs C had been referred with further bleeding in November 2003 and Consultant 1 cauterised the granulation tissue on Mrs C's cervix. This was re-cauterised on 3 December 2004, but as Mrs C's symptoms had settled, the examination under anaesthetic did not proceed. Mrs C's GP had referred her again because of pain around the umbilicus. On examination on 15 March 2004, Consultant 1 found adhesions present in the vagina and said that the surgery Mrs C had had was unlikely to have caused the symptoms she had been experiencing. On 26 June 2004, Consultant 1 had discussed with Mrs C the possibilities for the bleeding. Consultant 1 had been unable to give a gynaecological cause for the symptoms related to Mrs C's bowels and swallowing that she had described. Mrs C had requested a delay in being admitted for examination under anaesthetic, which made commenting on Mrs C's pelvic pathology more difficult. However, Consultant 1 and Consultant 2 accepted that Mrs C had been experiencing the symptoms described and their diagnosis or management plan did not negate her experiences or views.

13. In response to Mrs C's specific complaints, Consultant 1 said that she had been stating honestly that she had been unable to explain Mrs C's symptoms medically. The bleeding Mrs C had experienced after surgery was due to granulated tissue which she had described as the gap around where Mrs C's new cervix is. The gap had been healed with the cauterisation, which Consultant had been unaware had caused pain. On the decision on whether or not to operate, Consultant 1 said it rested with her as the surgeon, and that she had to take Mrs C's medical condition into account in making that decision, but that surgeons were always guided by anaesthetists. She had asked Mrs C to come into hospital not to operate but to examine her to determine the source of the bleeding and reason for other symptoms.

14. The Adviser has said the management of Mrs C's post-operative care throughout has been reasonable and appropriate in all respects. Mrs C had extensive contact with Consultant 1 who had carried out the operation. The clinical notes indicate that Consultant 1 had identified the initial source of bleeding as the granulation tissue at the cervix which had been appropriately treated by chemical cauterisation. A transvaginal ultrasound scan had excluded other causes of bleeding. Consultant 2 had identified vaginal adhesions in the vagina secondary to the surgery which are common following the surgery Mrs C had had. This can lead to vaginal bleeding following intercourse for which Mrs C has been treated with oestrogen cream. It is the Adviser's view that the adhesions, pain and difficulty with intercourse that Mrs C experienced is because of a lack of oestrogen and it is reasonable for oestrogen cream to be used on a long-term basis with medical supervision to attempt to prevent further adhesions formation. Mrs C has had two senior review appointments and examinations as well as an independent review of the records by another consultant. Mrs C had also been investigated in the gastroenterology clinic for abdominal discomfort and difficulty in swallowing for which an upper GI endoscopy had been performed.

(b) Conclusion

15. It is the Adviser's view that Consultant 1 and Consultant 2 acted appropriately and applied sound clinical principles in their diagnosis and treatment of Mrs C. Based on the advice I have received, I am, therefore, satisfied that the post-operative care provided to Mrs C was adequate. The treatment provided to Mrs C for her adhesions was clinically appropriate. I do not uphold the complaint.

(c) The Board failed to communicate clearly information to Mrs C about her symptoms

16. Mrs C had experienced a number of painful symptoms following her operation (see paragraph 11 above). She complained that Consultant 1 had failed to explain the pain, collapse or other information about her symptoms and did not mention adhesions. Consultant 2 had referred to adhesions, which were the cause of the bleeding, but failed to explain the bloating, dragging pains or stomach movement. In her complaint to the Board of 20 August 2004, Mrs C said she wanted answers as to why she had suffered pain.

17. In the Board's response, they apologised for any perceived lack of thought or insight regarding Mrs C's needs. Staff had not knowingly disregarded or

failed to respond to Mrs C's concerns and believed that the meetings and letters had provided the explanations required. Following an examination and ultrasound scanning, Mrs C had been told that there was no abnormality found to explain her symptoms. On 15 March 2004, Consultant 1 said that the surgery Mrs C had had was unlikely to have caused the symptoms she had been experiencing. The Board said the consultants involved believed that the meetings they had with Mrs C and the letters they had shared with her and her GP had provided the detailed explanation required.

18. Having carefully considered the Board's complaint file and Mrs C's medical records, it is clear to me that Mrs C was provided with information about her condition through numerous meetings with the relevant health professionals and letters. In a telephone interview, Consultant 1 said she had not been aware there had been communication difficulties with Mrs C as she had seemed at the time to have taken on board what Consultant 1 had said at each consultation. Consultant 1 had, therefore, been disappointed that Mrs C had felt she had not communicated well with her. However, it was apparent from Mrs C's body language during her last consultation with her that she was unhappy but Consultant 1 had been unable to draw out Mrs C's concerns. Instead, Mrs C had written her letter of complaint after the consultation. Consultant 1 had referred to communication failures in her letter of 5 July 2004 to Mrs C. During the telephone interview, she said this meant the misunderstanding that Mrs C had had abdominal surgery. This misunderstanding had been exacerbated by doctors outwith the Gynaecological Department who had referred to such surgery in their correspondence.

(c) Conclusion

19. Mrs C has had full and clear explanations about her gynaecological problems. However, Mrs C has related directly her abdominal symptoms with her gynaecological ones. Despite investigation, no cause has been found to explain her abdominal symptoms. While I can understand Mrs C's frustration and distress with this, this does not mean that staff failed to communicate clearly with her but that only the information that had been available to them about her symptoms could be communicated. I do not uphold the complaint and the Ombudsman has no recommendation to make.

(d) The Board failed to handle properly Mrs C's complaint

20. Mrs C complained about the way the Board handled her complaint. Mrs C complained that the Convener rescinded an offer of a meeting with the

clinicians involved in which the Chairman and the Convener would attend because she had believed wrongly that Mrs C had described the Convener and Consultant 2 as 'nasty'. On 11 April 2005, the Convener refused Mrs C's request for an independent review of her complaint. Mrs C complained that the Convener should not have made the decision because of her alleged partiality. She also complained that the Patients Relations Officer should not have revealed details of their discussion to the Convener.

21. The Patient Relations Officer responded that her role was to provide administrative support and act as a post-box for the Convener and that she had made the Convener aware of Mrs C's comments because she was concerned by them. The Convener offered to stand down from Mrs C's case but only if another Convener could be found.

22. In the Board's complaint file, there is a copy of an email from the Patient Relations Officer to the Convener saying that Mrs C had described both Consultant 2 and the Convener as 'nasty' during a telephone conversation on 9 March 2005. There is also a letter from Mrs C to the Patient Relations Officer denying this. Other documents showed the process leading to the Convener's decision not to grant Mrs C's request and that the Convener had obtained independent clinical advice saying that the care and treatment provided to Mrs C had been appropriate. In response to enquiries about Mrs C's request for another Convener, the Board said that Mrs C's request had been given due consideration but that the Board's other Convener had retired.

(d) Conclusion

23. I did not attempt to find out whether Mrs C had made the alleged comment. Firstly, as I said in paragraph 8 it is difficult to corroborate what is said between two parties during a conversation especially when some time has passed since it took place. Secondly, and more importantly, even if Mrs C had made the comment, the critical issue is whether the Convener showed any partiality in her handling of Mrs C's request for an independent review. I am satisfied there is no evidence to suggest she showed partiality in her decision-making. The only criticism I have to make on the way Mrs C's complaint had been handled is that the Board failed to inform Mrs C that it was not possible to agree to her request for another Convener because they did not have a replacement. However, my finding on the main issue is that I do not uphold the complaint.

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

27 March 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Consultant 1	Consultant Gynaecologist at Falkirk and District Royal Infirmary
Consultant 2	Consultant Gynaecologist at Falkirk and District Royal Infirmary
The Board	Forth Valley NHS Board
The Convener	Forth Valley Health Board's Convener
The Adviser	Ombudsman's medical adviser
The Chairman	Forth Valley Health Board's Independent Lay Chairman

Annex 2

Glossary of terms

Adhesions	Response of tissue anywhere in the body to scarring, bleeding, infection or inflammatory changes in the surface tissue concerned
Anterior vaginal wall repair	Surgical correlation of anterior vaginal wall prolapse (bulging of front wall of vagina due to pressure on muscles and fascial tissue from beneath vaginal wall by bladder and urethra). It involves vertical vaginal wall incision and tightening of stretched tissues, excision of vaginal wall skin and restructuring
Cauterisation	Destruction of excess tissue usually in suture line by chemical or thermal means
Granulated tissue	Scar tissue formed around the site of an operation
Vaginal adhesions	Bands of tissue between two raw bleeding or inflamed surfaces. These may form in response to the lack of oestrogen post-menopause which can lead to a thin inflamed sore vaginal skin and the "sticking" of the anterior and posterior vaginal walls. This fusion may be followed by true adhesion formation which is like bands of tissue joining up the two surfaces.