Scottish Parliament Region: Glasgow

Case 200500228: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; Neuroradiology

Overview

The complainant (Mr C) had an AVF (arteriovenous fistula) in his spine. When the Consultant Neuroradiologist clotted the blood vessels, some glue (embolic fluid) escaped into the central draining vein of the spinal cord which became blocked. Mr C complained that his symptoms were worse after the procedure.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr C was given insufficient information to allow him to make an informed choice of treatment; *(upheld)* and

(b) the procedure was not adequately explained and he was not appropriately warned about possible complications *(upheld).*

Redress and recommendations

The Ombudsman recommends that the Board:

(i) review their current protocols for consent and recording of consent in line with 'A Good Practice Guide on Consent for Health Professionals in NHS Scotland' issued by the Scottish Executive on 16 June 2006 especially for neurosurgical and radiological interventions;

(ii) include details of procedures, alternatives and possible complications in leaflets and that they are given to patients as soon as the diagnosis is made;

(iii) develop standard letters to be used until the leaflets are available;

(iv) ensure that the fact that the relevant leaflet has been given to the patient is recorded in the patient's notes;

(v) include information about embolisation and the possibility of complication occurring in the appropriate leaflet;

(vi) ensure that Handbooks for Doctors and protocols on consent include detail on when, where and how to obtain informed consent; and

(vii) apologise to Mr C for the failings in giving him information.

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

Main Investigation Report

Introduction

1. Mr C was admitted to the Southern General Hospital, Glasgow (the Hospital) on 3 October 2003 for investigation. A mid-thoracic spinal dural AVF was diagnosed. He was subsequently re-admitted in November under the care of a Consultant Neurosurgeon (Consultant 1). On 20 November 2003, a Consultant Neuroradiologist (Consultant 2) performed spinal angiography and embolisation. The AVF was successfully occluded but some embolic fluid escaped and blocked the central draining vein of the spinal cord. Mr C's symptoms became worse following the procedure and he made a complaint.

2. Following correspondence with Consultant 2, Consultant 1 and attempted local resolution of his complaints, Mr C asked for an Independent Review on 21 October 2004.[1] The Convener initially referred the complaint back for further local resolution to allow the Chief Executive to respond to Mr C's outstanding concerns. Mr C remained dissatisfied and on 21 March 2005 again requested Independent Review, but the Convener declined on the grounds that Mr C had exceeded the time limit to apply. The Convener said that he did not intend to exercise his discretion to consider Independent Review.

3. Mr C complained to the Ombudsman on 19 April 2005.

4. The complaints from Mr C which I have investigated are that:

(a) Mr C was given insufficient information to allow him to make an informed choice of treatment; and

(b) the procedure was not adequately explained and he was not appropriately warned about possible complications.

Investigation

5. In order to investigate this complaint I have had access to Mr C's clinical records from the Hospital and the NHS complaints correspondence. I have identified relevant guidelines and protocols and have corresponded with Mr C and Greater Glasgow and Clyde NHS Board (the Board). I have obtained

[1] Independent Review was part of the NHS complaints procedure at that time. A Convener, usually a non-executive director of the NHS Board concerned dealt with requests for Independent Review. The procedure changed in April 2005 and Independent Reviews are no longer held.

clinical advice from an adviser to the Ombudsman (the Adviser). My report is based on the available evidence and the advice I have received.

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 and the Board were given an opportunity to comment on a draft of this report.

(a) Mr C was given insufficient information to allow him to make an informed choice of treatment

7. Mr C was admitted for investigation on 1 October 2003. He was discharged on 4 October 2003. On 14 October 2003, the Specialist Neurosurgical Registrar wrote to Mr C's GP. He explained the investigative procedures which had been used and the diagnosis. He said that Consultant 1 had discussed the findings with Consultant 2 and they had come up with a plan of management. Mr C was to be re-admitted in a few weeks for a spinal angiogram with possible glue embolisation during the same procedure. The Registrar said that Mr C would be notified by post of the admission date. Consultant 1's secretary wrote to Mr C on 5 November 2003. In her letter, she simply told Mr C that a bed had been reserved for him on 18 November 2003.

8. Mr C's procedure was carried out on 20 November 2003. In Mr C's clinical notes there is an entry on that day that Consultant 2 had telephoned the ward. He said that he would come to the ward to obtain Mr C's consent that morning. Mr C said that the Consultant 2 did not come to the ward to talk to him. Instead, he met him on his way to the theatre. In correspondence, Consultant 2 has not disputed this. On 12 September 2004, he wrote to Mr C to say that he was very sorry that he had not been able to see Mr C the night before the procedure.

9. On 29 March 2004, while Mr C's complaint was being investigated, Consultant 2 wrote to Mr C that there were two options for treatment of his condition - embolisation or surgery. He said that both are normally effective but there had been a progressive move away from invasive treatments like surgery. Surgery usually has a longer recovery period. There is no evidence that Mr C was given this information prior to his procedure.

10. In response to my enquiries, the Board said that a hospital patient information leaflet for Mr C's condition was not available and, therefore, could not be given to Mr C. Consultant 2 said that he recommended information available on three websites to patients, if they wished further information.

11. The relevant guidance[2] states that:

'Patients are entitled to receive sufficient information in a way that they can understand about the proposed procedure, the possible alternatives and any substantial risks so that they can make a balanced judgement.'

12. In his letter of 12 September 2004 Consultant 2 said that, on the morning of the procedure (which was the first time Mr C and the Consultant had met) he had explained the nature of spinal angiography to Mr C. He said he was truly sorry that it had not been a longer discussion.

13. Mr C said that he had not been informed about or offered any alternative treatment. He was not referred to any websites.

14. The Adviser said that Mr C was not given enough information before the procedure.

(a) Conclusion

15. Consultant 2 said that the recommendation for the course of treatment would have been unaltered by further discussion and they had never had a patient who had not accepted their professional advice. That misses the point, however, that Mr C was entitled to receive information about the alternatives available to him and to make an informed choice if he wished to do so. I do not consider it likely that, on the threshold of the theatre where Consultant 2 was about to proceed to embolisation, he told Mr C that he could have surgery instead. There is no evidence of any discussion about alternative treatment. I am satisfied, on a balance of probabilities, that Mr C was not informed about alternative treatments prior to his procedure. I uphold this complaint.

(a) Recommendation

16. I am concerned that Mr C was not informed about alternative treatment prior to his procedure taking place. I am also concerned about the timing. Mr C was not treated as an emergency. There were several weeks between his diagnosis and treatment, which he could have used to consider alternatives if they had been drawn to his attention. I note that, this year, the Neuroradiology Department intends to produce dedicated patient information leaflets to cover

[2] 'A guide to consent to examination, investigation, treatment or operation' published by the Scottish Health Department in 1992.

the rare conditions such as Mr C's which it treats. The Ombudsman recommends that the Board:

(i) review their current protocols for consent and recording of consent in line with 'A Good Practice Guide on Consent for Health Professionals in NHS Scotland' (issued by the Scottish Executive on 16 June 2006) especially for neurosurgical and radiological interventions;

(ii) include details of procedures, alternatives and possible complications in leaflets and that these are given to patients as soon as the diagnosis is made;

(iii) develop standard letters to be used until the leaflets are available; and

(iv) ensure that the fact that the relevant leaflet has been given to the patient is recorded in the patient's notes.

(b) The procedure was not adequately explained and Mr C was not appropriately warned about possible complications

17. Mr C said that he thought that he was going to have an angiogram. He said that he had not been informed about possible embolisation nor had he been warned of possible complications.

18. Consultant 2 said that on the morning of the procedure he explained the procedure and the risks to Mr C, who had appeared happy with the explanation although he was nervous. On 26 May 2004, Consultant 2 wrote to Mr C that passage of glue through an AV fistula into a draining vein, leading to worsening of symptoms, is rare. Consultant 2 said that he was aware of this complication happening in the brain but not in the spine. That is why he had not specifically referred to that possibility.

19. The relevant guidelines (see Footnote 2) state:

'A health professional has a duty to warn patients of substantial or unusual risk.' and

'Consent for one procedure does not give any automatic right to undertake any other procedure.'

20. The Adviser said that in his opinion there was a breakdown in communication and documentation around the whole process of giving information to a patient before an invasive procedure. He said that Mr C should have been given much more comprehensive information about the procedure and it should have been documented in the notes. The risk of the glue ending

up in the wrong place is a rare but known complication and, whilst it might not have happened in Consultant 2's experience, it is conceivable that it could happen, Mr C should, therefore, have been told of the risk. The Adviser also said that the consent form was inadequate for the purpose. It did not have space for explanations to be recorded as given. Mr C said that his reading glasses had been left behind on the ward and so he was unable to read the consent form.

21. In response to my further enquiries, the Board produced a copy of the consent form currently in use which has a space to record the procedure, risks and alternatives.

(b) Conclusion

22. I am satisfied from the evidence that Consultant 2 was clear about what the plan of management was and that he believed that embolising Mr C's AVF would be a straightforward procedure. He said that he told Mr C what he planned to do and I have no reason to doubt that. However, it was not appropriate to leave doing so until Mr C was about to enter the theatre. Mr C was wearing only a surgical gown, lying on a trolley at the theatre door and understandably nervous. He was not, therefore, in the best position to receive such information and he clearly did not take it in. Consultant 2 should have taken Mr C's situation into account and made sure that he understood what he was telling him. He should also have documented in the notes what he said to Mr C. The Adviser said that Mr C should have been told of the possibility of this particular complication but he was not. I uphold this complaint.

(b) Recommendation

23. Where and when important information was conveyed to Mr C were also factors in this aspect of his complaint. The Ombudsman recommends that the Board:

(i) include in the appropriate leaflet information about embolisation and the possibility of complication occurring (see paragraph 10);
(ii) ensure that Handbooks for Doctors and protocols on consent include detail on when, where and how to obtain informed consent;
(iii) apologise to Mr C for the failings in giving him information.

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

20 June 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Consultant 1	The Consultant Neurosurgeon
Consultant 2	The Consultant Neuroradiologist
The Board	Greater Glasgow and Clyde NHS Board
The Hospital	Southern General Hospital

Annex 2

Glossary of terms

AVF (arteriovenous fistula)	A short circuit in circulation where a link develops between an artery which supplies blood and a vein which drains blood
Dural	Relating to the dura or membrane surrounding the spinal cord
Mid-thoracic	Half way down the chest
Spinal angiography	A radiographic technique where a radio-opaque (shows up on x-ray) contrast material is injected into a blood vessel for the purpose of identifying its anatomy on x-ray
Embolisation	The process by which a vessel is closed by clotting blood