Scottish Parliament Region: Lothian

Case 200600899: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; Orthopaedic

Overview

The complainant (Mr C) raised a number of concerns regarding the treatment he received at the Royal Infirmary of Edinburgh (the Hospital) for an injury to his knee. Mr C also claimed that the consultant treating him (Consultant 1) at the Hospital failed to fully consider all the potential causes for Mr C's problems with his knee.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Consultant 1's assessment of Mr C's symptoms was inadequate and did not go into sufficient detail (*not upheld*); and

(b) Consultant 1's diagnosis was not reasonable and he failed to consider the possibility that Mr C was suffering from Chronic Regional Pain Syndrome (*not upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. The complainant (Mr C) brought his complaint to the Ombudsman's office on 24 October 2006. Mr C was dissatisfied with the treatment he received for an injury to his knee from a Consultant (Consultant 1) while a patient at the Royal Infirmary of Edinburgh (the Hospital).

2. Mr C was aged 24 when he visited the Casualty Department at the Hospital on 10 April 2005. He presented stating that he had twisted his right knee and it had become painful whilst playing football the very same day. The Casualty Officer found that the right knee was very swollen with a positive patella (knee-cap) tap and that he was tender over the medial (middle) joint line with a reduced range of movement. The medial collateral ligament (secondary ligament) was painful on a valgus stress test (test used to examine movement of the knee). However, following further assessment, it was concluded that the ligament was not torn ie there was no gross laxity present (lack of firmness in movement). The notes clearly state that staff were worried about an injury to a meniscus (crescent shaped cartilage in the knee) and a medial collateral ligament sprain. Mr C attended the Fracture Clinic on 11 April 2005 where he was reviewed by another doctor (Doctor 1). During the assessment, Mr C stated that he felt a 'distinct snap when the knee went'. Mr C was, therefore, transferred to the Knee Clinic which he attended on 14 April 2005. At the Knee Clinic a Senior House Officer (SHO) then took a full history including the fact there was no significant previous medical problems in Mr C's history. The SHO noted that the patient was only able to partially weight-bear and in addition to the other findings, he also noted a positive Lachman's test (medical test used for examining the Anterior Cruciate Ligament (ACL) in the knee for patients where there is a suspicion of a torn ACL). X-rays showed an effusion and the patient was reviewed by Consultant 1. Mr C was then to be seen, after physiotherapy, four weeks later for consideration of a reconstruction of the ACL.

3. Mr C was reviewed by a senior specialist registrar (the Registrar) to Consultant 1 on 15 July 2005 who noted: 'On the previous history it does sound as if he has an ACL injury.' The Registrar found that he was tender over the femoral insertion of the medial collateral ligament (ligament in the knee) and agreed that there was not much laxity with regards to the ACL. After consulting another doctor, a decision was made to go for scanning of the knee and a

review in two months time. However, Mr C was brought back to out-patients again on 21 July 2005.

4. Consultant 1 saw Mr C and repeated the history and the examination and decided that he had a locked knee due to a displaced bucket handle tear of his medial meniscus (a flat disc-shaped ligament which stabilises and supports the inner aspect of the knee joint). He also had an ACL tear which was the cause of his instability. He explained to Mr C that he would like to carry out an arthroscopic meniscectomy (a surgical procedure to cut out part or all of the meniscus) and at the same time perform an ACL reconstruction. Consultant 1 explained to Mr C, as evidenced by the notes, the nature of the procedure including the possible risks of draft failure, deep vein thrombosis, deep infection and knee joint stiffness. Mr C agreed to undergo the combined procedure and was listed for admission on 2 August 2005.

5. On 2 August 2005, Mr C underwent the planned operation. Pre-operatively, he was given a detailed information sheet on arthroscopy. This excellent booklet gave details on the front page of contact telephone numbers if there were any problems or further help required, by the patient, from the hospital, post-operatively.

6. The operation note of 2 August 2005 confirmed the finding of a displaced bucket handle tear of the medial meniscus and that this was removed. Consultant 1 noted that the rest of the knee was normal apart from the completely ruptured (disrupted) ACL. A quadruple hamstring graft was used to replace the ACL and the ends were secured with, on the femoral side, an 'endo-button'. On the tibial side, the notes stated that 'the graft was rather short and was, therefore, secured with a combination of an interference screw but also by tying an ethicon suture round the screw and washer'.

7. Mr C was discharged from the Hospital on the same day he underwent the operation (2 August 2005). He returned to see Consultant 1 on 25 August 2005. Consultant 1 noted during the examination that post-operative progress had been extremely slow. The examination revealed that all the wounds were well healed and the graft itself felt stable. Consultant 1 noted that pre-operatively, the knee was very irritable and there was inflammation of the knee with fixed flexion. There were also concerns about the level of motivation of Mr C, however, Consultant 1 advised him that at this stage no intervention surgically would be required and that Mr C needed to continue with his

physiotherapy. There was a proviso that if the knee continued to remain stiff, Consultant 1 would consider trying to break down any adhesions present by means of keyhole surgery.

8. On 8 September 2005, Mr C returned to the clinic and it was noted that he had made no significant progress. The knee was noted as extremely painful and Consultant 1 recorded that there was also a limited range of movement present. At that time, Mr C had a contracture which meant that he was not able to get the knee straight and could only achieve 20 degrees or 30 degrees of being straight. The flexion range was to 70 degrees, whereas the expectation at that stage would be 90 degrees, or slightly more. Consultant 1 arranged to admit Mr C urgently for manipulation (MUA) of the knee under anaesthetic and under the same anaesthetic he was planning to undertake an arthroscopic arthrolysis (surgical procedure to restore mobility to a joint).

9. On 27 September 2005, Mr C attended day surgery and the above procedure was carried out. The notes showed that the ACL graft was intact and through the use of the arthroscope, all scar tissue at the front of the knee was removed. Consultant 1 noted that despite this, it was not possible to bring the knee into full extension. The notes stated 'It would appear, therefore, that the flexion contracture is extrinsic'. The post-operative plan for Mr C was to have intensive out-patient physiotherapy and be reviewed in the Knee Clinic in three weeks time to then consider whether or not to use serial extension casting. It was noted that there was a physical block to getting the knee out straight during the procedure.

10. On 20 October 2005, Mr C was reviewed by a Senior House Officer who noted that Mr C's quadriceps muscle on the right side was very wasted but he was able to flex further ie to 95 degrees and there was no sign of any instability in the knee indicating that the operative repair of the ACL was working. Mr C was reviewed on 10 November 2005 and at this point he could flex the knee another 20 degrees or 30 degrees, up to 120 degrees in total, but still had a fixed flexion deformity of 10 degrees. This was a significant improvement and although Mr C was reluctant to continue physiotherapy, the importance of it was stressed. He was reviewed on 1 December 2005 by Consultant 1 at which point Mr C stated that he was dissatisfied with his progress and wanted a second opinion. Consultant 1 wrote to Mr C's general practitioner (GP) to expedite that opinion and suggested a colleague of his in Glasgow.

11. Mr C attended a consultation in Glasgow with another consultant (Consultant 2) on 2 February 2006 and it was at this point that the possibility of Mr C suffering from Chronic Regional Pain Syndrome (CRPS) was first raised. I have attached at Annex 3 a detailed chronology of the clinical events, provided by one of the Ombudsman's clinical advisers (Adviser 2), which will aid the understanding of the issues involved in the complaint.

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

(a) Consultant 1's assessment of Mr C's symptoms was inadequate and did not go into sufficient detail; and

(b) Consultant 1's diagnosis was not reasonable and he failed to consider the possibility that Mr C was suffering Chronic Regional Pain Syndrome.

Investigation

13. In conducting my investigation, I obtained evidence from both Mr C and Lothian NHS Board (the Board). I also obtained evidence from Greater Glasgow and Clyde Health Board given that Mr C had attended consultations with Consultant 2, who was based in Glasgow. Furthermore, I also obtained the advice of two of the Ombudsman's clinical advisers (Adviser 1 and Adviser 2), who have significant experience in hospital and orthopaedic related issues, regarding the clinical management of Mr C in this case. The advice provided by Adviser 1 and Adviser 2 was extremely helpful in arriving at my conclusions. Finally, I also examined the NHS Scotland document *The NHS and You: What you can expect from us, What we can expect from you* as the content of this document is particularly relevant to this case.

14. 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) Consultant 1's assessment of Mr C's symptoms was inadequate and did not go into sufficient detail (b) Consultant 1's diagnosis was not reasonable and he failed to consider the possibility that Mr C was suffering CRPS

15. The two heads of complaint are closely related and in some instances, the issues involved overlap with each other. As a result, I will deal with both heads of complaint together. The overall complaint stems from Mr C's assertion that Consultant 1 failed to adequately assess him and take account of the key issues, including the fact that Mr C was not progressing post-operatively.

16. Mr C has alleged that he failed to progress post-operatively due to the fact that the planned treatment, namely intensive physiotherapy, was too painful to undertake. Adviser 1 and Adviser 2 have commented on the adequacy of the assessments carried out by Consultant 1 and also provided comment in relation to the management of Mr C. Adviser 1's comments are detailed below in paragraphs 17 to 25. Adviser 2 also gave detailed comments regarding the case. To avoid duplication, I have outlined the most important aspects of Adviser 2's comments in paragraphs 26 to 29. The comments should also be read in conjunction with Annex 3 to provide a detailed understanding of the chronology of the overall complaint.

Adviser 1's comments

17. Adviser 1 stated that in large measure, the treatment and assessment provided by Consultant 1 was reasonable. The medical notes, in Adviser 1's opinion, were very good, however, there was some concern as to whether or not there should have been more detail in the notes regarding swelling and redness of the knee.

18. Adviser 1 stated that it should be noted that Mr C did not attend his physiotherapy appointments after the first operation when the ACL was repaired. Adviser 1 commented that physiotherapists do not only treat the knee after the operation in this type of case, but can also help in referring patients back to a consultant if their progress is not as good as it should be. This provides an early warning system and in this case might have been extremely helpful. This meant, in Adviser 1's opinion, that there was every opportunity for stiffness and pain in the knee to get worse without treatment.

19. Adviser 1 noted that Mr C failed to attend routine physiotherapy sessions between April and June 2005. Referral back by Accident and Emergency following repeat injuries to the knee in June meant that physiotherapy was resumed, but again Mr C failed to attend beyond two sessions.

20. The physiotherapy records documented significant swelling in both April and June but, because of failure to attend, the physiotherapists did not discuss the lack of progress with the surgeons. They did, however, communicate the lack of attendance. At a follow-up review in July 2005, the importance of attending physiotherapy was reiterated to Mr C.

21. Mr C's leg gave way again on 17 July precipitating another Accident and Emergency attendance. It is possibly this event that precipitated an earlier appointment and consultant review in July 2005. Following review, surgery was promptly arranged. In surgery, a bucket tear and ligament rupture was dealt with at the beginning of August 2005. The evidence shows that swelling and pain in the lower leg was a symptom from this time onwards.

22. The need for intensive physiotherapy was noted post-operatively, however, there is no evidence to suggest any physiotherapy was undertaken at this time. At review in September 2005 there had been no progress and so MUA was arranged. This, performed at the end of September 2005, suggested that the limited movement was not due to problems with the joint or surgery but due to 'contracture' of the muscles (presumably due to disuse since the injury).

23. Having requested a second opinion, Mr C was reviewed by Consultant 2 in February 2006. As a result, magnetic resonance imaging (MRI) and bone scans were instigated. Physiotherapy treatment was resumed and relatively well attended under Consultant 2's care from May 2006.

24. In July 06, following confirmation by scanning, the probable diagnosis of CRPS was mooted and a pain clinic referral was made. In April 2006 the scenario had been further complicated by Mr C's presentation to Accident and Emergency with symptoms suggestive of circulatory problems in the leg and he was, it seems, admitted for heparin and vascular assessment. Mr C then returned again in April 2006 to Accident and Emergency with more pain. It is not clear from the evidence available how he got referred to neuro-psychiatry in June 2006 as the neurology records have not been provided, but this avenue recommended a cognitive approach to Mr C's pain management.

25. His attendance at the pain clinic resulted in an opinion (in August 06) that he did not suffer from CRPS and although the care team looking after Mr C, as well as the neurologist who had assessed him, all felt that a cognitive or psychology approach to the pain was needed, Mr C was not happy with this idea.

Adviser 2's comments

26. Adviser 2 stated that Mr C had suffered a very debilitating injury to his right knee. Compliance with conservative management (physiotherapy) was not

good and, partly because of this, it was not operated on for four months, despite repeated episodes of instability and an exacerbation of symptoms.

27. Following surgery, negligible progress was made and new symptoms mimicking a Deep Vein Thrombosis became problematic. Lack of progress and on-going symptoms post-operatively are noted throughout August and September 2005. Symptoms documented include pain, immobility and swelling of the limb, which in conjunction with the poor compliance, reported failure of physiotherapy, and general lack of progress since April 2005, should have led to a consideration of the different avenues of investigation and management, which were not actioned until a second opinion was obtained.

28. The evidence confirms that:

- Pre-operatively, assessment and treatment was reasonable. Understanding of progress was hampered by poor attendance at (and hence feedback from) physiotherapy and, although delayed for some months, nevertheless prompt senior review and appropriate surgery was instigated once on-going instability became apparent.
- Post-operatively, Mr C's continued severe symptoms and general failure to progress should have precipitated earlier action by the orthopaedic surgeons. Senior review and reconsideration of diagnosis, earlier referral to a pain clinic and further investigation (for example, MRI and bone scans) would have been appropriate, but these were not forthcoming until a second opinion was sought. However, it is clear that the patient's complex psyche and difficulties in coping with the effects of surgery and the physiotherapy would no doubt have made the management decisions difficult and even with earlier intervention, in all likelihood, the final result may have been the same.
- CRPS was an appropriate diagnosis to consider, as early intervention in such cases is paramount. The fact that this diagnosis was later rejected does not negate the need to consider it early on in the face of debilitating symptoms and poor progress.

29. Adviser 2 stated that she had concerns regarding the time taken to fully investigate Mr C's debilitating symptoms although she noted that the treatment provided by Consultant 1 was appropriate and the outcome was not the result of any error in surgical management.

30. A key issue in the case is that of the delay in fully investigating Mr C's condition. Although Adviser 2 stated that she felt more in-depth investigation should have been conducted earlier, she also recognised that Mr C had contributed to the delay by failing to attend a number of physiotherapy appointments.

31. The NHS Scotland document, *the NHS and You: What you can expect from us, What we can expect from you*, outlines some key principles of the relationship between the NHS and the patient. Essentially, it highlights that individuals have a right to care, however, with that right comes the responsibility of interacting with the staff providing care in a reasonable manner. The document, when outlining what the NHS expects from the patient, stated:
'You can help yourself, other patients and NHS Staff if you do the following;

Keep your appointments

- Be on time for appointments.
- If you know you are going to be late, phone us and let us know.
- If a member of staff is coming to visit you at home (for example, a health visitor or community psychiatric nurse), make sure you are in at the agreed time.
- For hospital appointments we might contact you to arrange an appointment time that suits you. If this happens, let us know what time would suit you best.

Let us know if you have to cancel

- If you cannot keep an appointment, let us know as soon as possible so that we can offer your appointment to someone else.

Follow advice and treatment

- Try to follow any advice or treatment we have agreed with you.
- If you are worried about doing this:
  - discuss it with the person giving you the advice or treatment
  - contact your GP surgery, or
  - speak to someone at your local community pharmacy.

Ask about anything you don't understand

- if there is anything you don't understand about your condition or treatment, let us know and we will explain it to you
- If we use words which you don't understand, let us know and we will explain it to you.'

32. The evidence shows that Mr C, in failing to attend for physiotherapy was, to a degree, undermining the treatment being provided. Furthermore, his actions also denied the team caring for him a number of opportunities to assess his condition and lack of progress.

(a) Conclusion

33. Taking the first head of complaint, I am satisfied, having reviewed the evidence and taken account of Adviser 1's and Adviser 2's comments, that the assessments carried out by Consultant 1 were adequate and reasonable. As a result, I do not uphold head of complaint (a).

(b) Conclusion

34. Turning to the second head of complaint, having reviewed the evidence and taken account of Adviser 1's and Adviser 2's opinions, it is clear to me that this aspect of complaint is finely balanced as to whether or not to uphold the complaint. The key issues are that the time taken to fully investigate Mr C's condition was, in normal circumstances, too long. However, this must be offset against the fact that Mr C contributed to this delay by his own actions and non-compliance with the care being provided.

35. I fully appreciate how difficult Mr C's condition was and that the recovery process would undoubtedly have caused pain and discomfort. Had Mr C attended the planned physiotherapy sessions which he failed to attend and the circumstances of his complaint, namely delay to fully investigate his condition, remained the same, I would have upheld this aspect of complaint. However, each individual has a responsibility to engage, as much as possible, with the care being provided. I have seen no reason which satisfies me as to why Mr C failed to attend his physiotherapy sessions, particularly when it is shown in Annex 3 that he was capable of attending at other times.

36. Furthermore, Mr C's actions denied the team caring for him the opportunity to carry out regular reviews and obtain feedback on his progress (or lack of) which those physiotherapy sessions may have given. This undoubtedly impacted on the time taken to fully investigate Mr C's condition. The extent to which the delay to fully investigate Mr C's condition can be attributed to his failure to attend physiotherapy sessions is very difficult to define. Essentially, given the absence of evidence as a result of Mr C's non-attendance, I am led not to uphold the complaint.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Board	Lothian NHS Board
The Hospital	Royal Infirmary of Edinburgh
Consultant 1	The Consultant who was responsible for Mr C's care at the Hospital
Consultant 2	The Consultant who was responsible for Mr C's care while receiving care in Glasgow
Doctor 1	Member of staff at the Knee Clinic who assessed Mr C
SHO	A Senior House Officer who saw Mr C at the Knee Clinic on 14 April 2005
ACL	Anterior Cruciate Ligament
The Registrar	Member of staff who assessed Mr C
MUA	Manipulation under anaesthetic
GP	Mr C's general practitioner
CRPS	Chronic Regional Pain Syndrome
Adviser 1	One of the Ombudsman's clinical advisers with experience in hospital and orthopaedic matters

Adviser 2	One of the Ombudsman's clinical advisers with experience in hospital and orthopaedic matters

Annex 2

Glossary of terms

Anterior cruciate ligament	Ligament in the knee
Arthroscopic arthrolysis	A surgical procedure to restore mobility to a joint
Arthroscopic Menisectomey	A surgical procedure to cut out part or all of the knee meniscus
Gross laxity	A term used to describe complete looseness of a joint
Lachman's test	A method used to examine the knee
Medial collateral ligament	Ligament in the knee
Medial meniscus	The mid-section of the meniscus
Meniscus	Crescent shaped cartilage in the knee
Patella tap	A method used to examine the knee cap
Valgus stress test	A method used, in this case, to examine the knee
MRI scan	An MRI (or magnetic resonance imaging) scan is a radiology technique that uses magnetism, radio waves and a computer to produce images of body structures

Annex 3

Clinical Chronology of Events

Date	Event
10 April 2005	Accident and Emergency attendance: injury to right knee
11 April 2005	Fracture clinic review. For review in Knee Clinic
14 April 2005	Knee clinic review. See again after four weeks
19 April 2005	First physiotherapy treatment
29 April 2005	Two sessions documented then Mr C did not attend (DNA). Marked swelling noted. Swelling not reduced by treatments. Discharged due to DNA
12 May 2005	Orthopaedic clinic (OPD). Noted DNA at physiotherapy, therefore, referred back by physiotherapy. Re-stressed need for physiotherapy
20 June 2005	Mr C attended Accident and Emergency - leg gave way. Re-referred to physiotherapy
21 and 27 June 2005	Reviewed in physiotherapy following above. Moderate effusion noted but swelling reduced by 27th. Then DNA. Discharged again because of DNA
14 July 2005	OPD - Further injury on 20 June noted. Encourage to exercise
21 July 2005	Returned to OPD. Admitted for artroscopic menisectomy and ACL reconstruction

Date	Event
2 August 2005	Admission for ACL reconstruction and partial medial menisectomy right knee. Operation note – displaced bucket handle tear and completely disrupted ACL
22 August 2005	Accident and Emergency attendance: pain and swelling in ankle and tightness in calf
25 August 2005	OPD slow progress. Noted that DVT was excluded as possible condition. Very irritable and inflamed knee with fixed flexion. Need for intense physiotherapy
8 September 2005	OPD - absolutely no progress. Poor compliance. Identified for manipulation under anaesthetic (MUA)
27 September 2005	Admission for MUA. Scar tissue excised but still not achieving full extension due to extrinsic contractures, therefore, Mr C needed intensive physiotherapy. To be seen again in three weeks
20 October 2005	OPD: physiotherapy is on-going but the knee remains stiff and sore and Mr C complained of marked swelling. Continued physiotherapy and night splint. To be seen in three weeks
10 November 2005	OPD: no better. Knee painful and swollen after physiotherapy. Not using splint because of pain. More physiotherapy
1 December 2005	OPD: effusion now settled. Still stiff but improved. Mr was dissatisfied with lack of progress. Request for second opinion made and discharged

Date	Event
1 December 2005	Letter to GP from Consultant 1 suggesting a suitable second opinion
11 December 2005	Accident and Emergency attendance. Tight calf
16 December 2005	Accident and Emergency attendance swollen calf
20 & 21 December 2005	Accident and Emergency attendance with head injury
27 January 2006	Accident and Emergency attendance groin pain
2 February 2006	Accident and Emergency attendance with back pain
2 February 2006	Mr C visited Consultant 2 for second opinion, who then wrote to GP: possible CRPS for investigation with MRI and possibly bone scan
9 April 2006	Accident and Emergency attendance burning sensation in his left foot
11 April 2006	Accident and Emergency attendance with more pain
20 April 2006	Referral to physiotherapy for quads exercises. Seen at OPD. Awaiting MRI and needed physiotherapy
5 May 2006	MRI scan of the knee showed undisplaced lateral meniscal tear but no obvious cause of his knee immobility
24 May 2006	Physiotherapy

Date	Event
1 June 2006	Bone scan, non-specific changes and the possibility that there is an infection present in the knee was raised
2 June 2006	Physiotherapy
12 June 2006	Radiology white cell scan – no evidence of infection
21 June 2006	Letter from neurosciences (referred to them following admission under neurosurgeons – no notes available for this). Opinion is that functional neurological disorder complicates picture – referred to neuropsychiatry
6 July 2006	OPD. Note that leucocyte scan normal (no infection). Probable diagnosis CRPS. Noted to be awaiting neuro-psychologist appointment. Referred to pain clinic in Edinburgh
22 July 2006	Accident and Emergency attendance - TV bracket fell on knee
29 June 2006-23 August 2006	Eight attendances in Accident and Emergency with assorted conditions not related to knee
4 August 2006	Physiotherapy
17 August 2006	Following assessment, current diagnosis is that it is not CRPS at the moment. Needs psychology/ physiotherapy
18 August 2006	Physiotherapy
22 August 2006	Physiotherapy

Date	Event
31 August 2006	Physiotherapy
12 September 2006	Physiotherapy
14 September 2006	Physiotherapy
28 September 2006 3, 9 and 11 October 2006	Physiotherapy (note – told by pain clinic not CRPS). UTA physiotherapy
31 October 2006	Accident and Emergency attendance with knee giving way – injured back
20 October 2006 (letter 2 November 2006)	Reviewed at pain clinic - need for cognitive therapy repeated. No follow-up
9 November 2006	Review at pain clinic. Cognitive approach suggested again (not happy)
5 February 2007	Physiotherapy. No further attendances. Discharged 23 May 2007 for non-attendance