Scottish Parliament Region: Glasgow

Case 200601008: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; Orthopaedics, Clinical Treatment/Diagnosis

Overview

The complainant (Ms C) was referred to a consultant orthopaedic surgeon (Consultant 1) at the Southern General Hospital in Glasgow for a diagnosis of the knee pain she had been suffering for some time. Because the pain continued, she then saw a private consultant who recommended treatment which proved successful.

Specific complaint and conclusion

The complaint which has been investigated is that Consultant 1 incorrectly diagnosed Ms C's knee condition, leading to damage which could have been prevented if a correct diagnosis had been made earlier *(not upheld)*.

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. The complainant (Ms C) began to suffer knee pain in early 2004. Her GP referred her to a physiotherapist and, as the problem continued, she was later referred to a consultant orthopaedic surgeon (Consultant 1) at the Southern General Hospital in Glasgow (the Hospital) for his opinion. She saw Consultant 1 in February 2005 who diagnosed degenerative changes and recommended some ways of managing her condition. The condition did not improve and she saw a private consultant (Consultant 2) in November 2005 who splinted her leg and set her on a course of physiotherapy. By February 2006, Ms C again saw Consultant 2 who noted improvement in her condition.

2. On 22 May 2006, Ms C complained to Greater Glasgow and Clyde NHS Board (the Board) about Consultant 1's diagnosis, saying that her suffering had been protracted because of his diagnosis and recommended course of action. She also complained that she had incurred costs for private treatment because she had lost confidence in Consultant 1. The Board replied on 6 June 2006 and advised Ms C that they would not investigate her complaint as it fell outside the time limit of six months since becoming aware of a cause for complaint. The Board did not accept Ms C's argument that she only became aware of a cause for complaint when it became clear that the treatment she received from Consultant 2 had been successful.

3. Ms C then referred her complaint to the Ombudsman on 28 June 2006. The Scottish Public Services Ombudsman Act 2002 allows the Ombudsman to consider complaints up to 12 months after the complainant has become aware of a cause for complaint. It was decided to accept Ms C's complaint as being within that time limit on the basis that she considered her diagnosis by Consultant 1 to be incorrect in November 2005, when she sought a referral from her GP to Consultant 2.

4. The complaint from Ms C which I have investigated is that Consultant 1 incorrectly diagnosed Ms C's knee condition, leading to damage which could have been prevented if a correct diagnosis had been made earlier.

Investigation

5. In my investigation of Ms C's complaint, I reviewed her medical records, radiographs and the correspondence relevant to her complaint. I made inquiry of the Board on 23 August 2007 and they replied on 31 August 2007, noting that they had not conducted an investigation of Ms C's complaint for the reasons outlined in paragraph 2. I also sought the opinion of an independent clinical adviser specialising in orthopaedics (the Adviser) who submitted his report on 10 January 2008. It should be noted that the private treatment Ms C received from Consultant 2 cannot be investigated by the Ombudsman.

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board were given an opportunity to comment on a draft of this report.

Complaint: Consultant 1 incorrectly diagnosed Ms C's knee condition, leading to damage which could have been prevented if a correct diagnosis had been made earlier

7. Around March 2004, Ms C went to see her GP because of the pain she was experiencing in her right knee. She was referred for physiotherapy at the Hospital but this did not alleviate her pain. On 17 September 2004, Ms C again visited her GP who referred her to the orthopaedic department of the Hospital. The GP noted that Ms C had been experiencing 'significant pain and swelling of her right knee, which is giving her pain going up and down stairs, waking her from sleep and stopping her walking properly at her work'.

8. Ms C continued to receive physiotherapy privately while she waited for her appointment with an orthopaedic consultant. She saw Consultant 1 on 23 February 2005 and he examined her, took radiographs and recommended measures to minimise her symptoms. His diagnosis was that Ms C's symptoms were due to 'early degenerative change for which there is no surgical solution'. This was based on her radiographs and detailed observations of the affected area around her knee. He noted a greater 'external tibial torsion' (an outward twisting) in the right leg, which is associated with an increased incidence of pain in the patello-femoral joint (where the kneecap joins to the thigh bone). Ms C had asked if there could have been damage caused by her playing 5-a-side football, but Consultant 1 considered tendon damage unlikely, given that she had not suffered a specific injury. In his note to Ms C's GP, Consultant 1 said that Ms C reported a recent reduction in pain as a result of physiotherapy.

9. The measures recommended by Consultant 1 to minimise Ms C's symptoms included exercises to strengthen the muscles around her knee, which he demonstrated, sitting with her knees out straight, wearing shock-absorbing footwear and keeping her body weight to a minimum. He emphasised the importance of continuing the exercises he demonstrated for the foreseeable future. Consultant 1's note concludes by saying that Ms C seemed reassured by the consultation and that no review had been arranged.

10. In reviewing Consultant 1's records and the radiographs he took on 23 February 2005, the Adviser confirmed that Consultant 1's conclusions about the external tibial torsion were correct and that the associated pain was 'normally felt to be owing to changed mechanics in the patello-femoral joint leading to mal-tracking of the patella on the underlying femur'. He also found a 'minor degenerative change' in the radiographs of the patello-femoral joint.

11. Ms C continued to experience pain and sought the advice of her private physiotherapist, who considered that her pain was more likely to have been caused by tendon damage than the 'wear and tear' diagnosed by Consultant 1. She did not contact the Hospital but asked her GP for a further referral. She was told that this may take up to a year so decided to seek private treatment.

12. On 15 November 2005, Ms C was referred to and examined by Consultant 2. Consultant 2's note of this consultation records Ms C's suggestion that the pain may have been associated with playing 5-a-side football. The note also records Ms C's view that her pain had increased following physiotherapy. This contrasts with Consultant 1's record from February 2005 (see paragraph 8).

13. Consultant 2's note does not refer to a diagnosis, but Ms C recalls that he recommended treatment for tendon damage. That treatment involved splinting her leg and physiotherapy. At further appointments on 10 January 2006 and 7 February 2006, Consultant 2 noted improvements to Ms C's knee pain. He discharged her on 7 February 2006. Ms C said that an MRI scan in April or May 2006 confirmed that there had been tendon damage and that it was this confirmation that prompted her to complain about Consultant 1's diagnosis. It has not been possible to find a record of this scan.

14. In considering the treatment offered by Consultant 2, the Adviser noted that a splint and physiotherapy is a course of action that can be applied

successfully to pain resulting from patello-femoral degenerative change or to tendonitis. Although there is no record of a specific diagnosis of tendonitis, the Adviser considered that it was possible that Ms C had a patellar tendonitis in addition to the degenerative change he found in the radiographs taken by Consultant 1.

Conclusion

15. Ms C has suffered considerable pain in her knee which has now been eliminated, although she continues to experience minor mobility problems. She believes that Consultant 1 made an incorrect diagnosis, which led to the protraction of her pain and may have caused permanent damage. The Adviser's opinion is that Consultant 1 was correct in identifying a degenerative change which could reasonably account for her pain. He considers that Consultant 1 conducted an 'excellent' examination and undertook the appropriate special tests leading to an 'appropriate' diagnosis. Furthermore, he considers that the advice Consultant 1 gave to Ms C to minimise her symptoms was sensible and 'may have been tempered by being told that physiotherapy had helped'.

16. In the Adviser's view, the treatment given by Consultant 2 could also have been an appropriate course of action in response to the diagnosis made by Consultant 1. He considers that, while the earlier use of this more interventionist approach may have brought an earlier improvement to her symptoms, there has been no permanent damage as a result of the approach taken by Consultant 1. The advice he gave Ms C was appropriate at the time, bearing in mind the information he had before him. In general, it would be appropriate to make a lesser intervention to address a condition in the first instance if there is a reasonable expectation that this will be successful. It is also reasonable to assume that Consultant 2's decision to adopt a more interventionist approach was taken in the light of the progression of the condition almost nine months after Consultant 1's recommendations.

17. In commenting on a draft of this report, Consultant 1 noted that opinion is divided over the efficacy of the treatment recommended by Consultant 2. Similarly, he considered that there are also diverging views about the correlation between symptoms such as those suffered by Ms C and changes found normally in the population as part of the degenerative process.

18. The Adviser noted that there is no evidence that Consultant 1 offered Ms C the opportunity to come back to him if her symptoms did not improve. Such an offer may have encouraged Ms C to return to him for further attention. However, it was not unreasonable for him to expect that her condition would improve in the light of his understanding that physiotherapy was having a positive effect.

19. With all of this in mind, I conclude that the diagnosis and recommendations made by Consultant 1 on 23 February 2005 were reasonable and I do not, therefore, uphold this complaint.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Consultant 1	An orthopaedic consultant in the Hospital
The Hospital	The Southern General Hospital in Glasgow
Consultant 2	An orthopaedic consultant who treated Ms C privately
The Board	NHS Greater Glasgow and Clyde
The Adviser	An independent adviser specialising in orthopaedics

Annex 2

Glossary of terms

External tibial torsion	A twisting of the lower leg which occurs normally. If the angle of torsion is greater than a certain tolerance, this may be indicative of certain conditions
Patello-femoral joint	The joint between the kneecap (patella) and the thigh bone (femur)
Tendonitis	A painful inflammation of a tendon. Patellar tendonitis is also known as 'jumpers' knee'