Scottish Parliament Region: Mid Scotland and Fife

Case 200602258: Fife NHS Board

Summary of Investigation

Category

Health: Hospital; Urology

Overview

The complainant (Mr C) raised concerns about the treatment that he received for his urological condition and the fact that he was not appropriately referred for surgery.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Fife NHS Board (the Board) failed to refer Mr C for surgery (*upheld*);

(a) the Board did not provide timely follow-up after Mr C's supra-pubic catheterisation (*not upheld*); and

(b) unnecessary investigations were carried out prior to Mr C's referral to another hospital (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mr C for failing to list him for surgery; and

(ii) take steps to ensure that patients are followed up when required.

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

Main Investigation Report

Introduction

1. On 23 April 2002, the complainant (Mr C) was admitted as an emergency to Queen Margaret Hospital (Hospital 1) with acute retention of urine. He was re-admitted for further examinations over the following months. There elapsed several years during which Mr C was not seen at Hospital 1; he was then admitted again as an emergency on 19 July 2006 with acute retention of urine. Following investigations, he was referred to a hospital within another Health Board (Hospital 2) on 27 September 2006.

1. Mr C made a formal complaint about his treatment on 15 September 2006. Fife NHS Board (the Board) responded to his complaint on 14 December 2006. The Board accepted that Mr C should have been sent for surgery and acknowledged that no arrangements had been made to keep Mr C under review. They explained that, following Mr C's contact in August 2006, urgent investigative procedures had been arranged as the urology surgeon (the Surgeon) required up-to-date results before referring Mr C to Hospital 2.

2. Mr C complained to the Ombudsman on 24 October 2006. I did not investigate this complaint until Mr C had completed the NHS complaints procedure.

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

(a) the Board failed to refer Mr C for surgery;
(b) the Board did not provide timely follow-up after Mr C's supra-pubic catheterisation; and
(c) unnecessary investigations were carried out prior to Mr C's referral to Hospital 2.

Investigation

4. During my investigation of this complaint, I considered background documentation submitted by Mr C and the Board's complaint file on this matter. I obtained Mr C's relevant medical records and obtained advice on the complaints from the Ombudsman's clinical adviser (Adviser 1) and a specialist urology adviser (Adviser 2). Following receipt of comments from the Board on a draft of this report, I also asked for advice from a further clinical adviser (Adviser 3).

5. 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) The Board failed to refer Mr C for surgery

6. Mr C was admitted to Hospital 1 with acute urine retention on 23 April 2002 and was seen there on several occasions over the following months. Investigations showed that he had urethral strictures and a supra-pubic catheter was inserted during this time. A procedure was carried out to divide the strictures with a urethrotomy and Mr C was able to pass urine after this. Further investigations on 29 October 2002 showed that Mr C may have been experiencing a recurrence of the urethral stricture. A cystoscopy was carried out on 15 December 2002 and two strictures were found. A doctor (the Doctor) discussed the long-term management of the situation with Mr C, discussing intermittent self-dilatation or definitive surgery. In a letter to Mr C's General Practitioner (the GP) dated 16 December 2002, the Doctor stated that Mr C would think about these options and that, in the meantime, Mr C would be put on the waiting list for internal urethrotomy. There are no further records of any clinic or admission to Hospital 1 until 2006.

7. Mr C was admitted to Hospital 1 on 19 July 2006 with acute retention of urine. The history of treatment was recorded and he was noted as having had worsening urinary symptoms over the preceding two months culminating in acute retention. A supra-pubic catheter was inserted and a letter to the GP on 26 July 2006 noted that Mr C was to be re-admitted for cystoscopy and possible urethrotomy.

8. Mr C was re-admitted on 6 September 2006 and a urethroscopy was carried out. The Surgeon was unable to find a passage through the stricture and abandoned the procedure.

9. The Surgeon referred Mr C to Hospital 2. Her referral letter, dated 26 September 2006, notes that Mr C was put on a waiting list for urethrotomy for his urethral stricture in 2002, but was never admitted.

10. Judging from the Doctor's operative note of 16 December 2002, he planned to place Mr C on the waiting list for admission for internal urethrotomy. The Doctor's letter to the GP advised 'We will list him for this as soon as is practical'. This never happened and Mr C was never sent for to be admitted for

internal urethrotomy. Adviser 2 stated that this was incompetent and an unacceptable failure of administration. This failure has been acknowledged by the Chief Executive of Hospital 1.

11. Mr C recalls a discussion about self-catheterisation or definitive surgery when he saw the Doctor and is certain that he left the Doctor in no doubt that self-catheterisation was not an option. He states that he was left with the understanding that he would be referred for specialist surgery. However, the Doctor's letter states that, following the discussion of the options for treatment, Mr C would 'go away and think about these various options' the inference being that the Doctor expected Mr C to inform him of his final decision. Adviser 2 stated that, whichever version about the decision concerning long-term management is accurate, the Doctor clearly intended that Mr C be put on the waiting list for internal urethrotomy.

12. Mr C spent most of the next four years with a variably poor urinary stream until he went into retention in July 2006. Mr C lays the blame for this entirely on the failure of Hospital 1 to review his case. However, Mr C should take some responsibility for the fact that he was not treated earlier. Mr C acknowledged that he had been party to a discussion about the management of his urethral stricture during 2002, so in 2002 he knew that he had a recurrent urethral stricture. Between 2002 and 2006, Mr C had a poor urinary stream – sometimes 'very slow' in his own words. That could only have been because Mr C had an untreated urethral stricture, which he knew he had. Mr C must, therefore, bear at least part of the responsibility for the delay in treatment by not asking the advice of the GP or chasing up Hospital 1 for advice – he waited until 2006 before he did this.

13. Adviser 2 concluded that, although Mr C bears some responsibility for the delay in treatment of his recurrent urethral stricture, this does not alter his view that the management of his case by Hospital 1 was not competent. He stated that the Board should have taken the initiative to review the situation and that he would have expected Mr C's name to have been placed on a waiting list for the surgery. An alternative to this would have been for the Doctor to make a further out-patient appointment, allowing Mr C sufficient time to consider the long-term options for treatment, so that a definitive plan for his management could have been made and carried out. I accept this advice.

14. The Board have acknowledged that the letter sent to the GP was very ambiguous and that this is a clinical failing which should be addressed through the normal appraisal route. This has been raised with the Director of Clinical Services.

(a) Conclusion

15. The Doctor's letter of 16 December 2002 stated that he would 'list [Mr C] for [surgery] as soon as [was] practical'. Mr C was not listed for surgery following his appointment with the Doctor. Mr C bears some responsibility for the failure to review the situation as he did not contact Hospital 1 to follow up on the appointment until 2006. Despite this fact, Adviser 2 stated that Hospital 1 should have taken steps to review the situation and should have listed Mr C for surgery. I uphold this complaint.

(a) Recommendation

16. The Ombudsman recommends that the Board apologise to Mr C for failing to list him for surgery. She also recommends that the Board take steps to ensure that patients are followed-up when required.

(b) The Board did not provide timely follow-up after Mr C's supra-pubic catheterisation

17. Mr C had a supra-pubic catheter inserted on 19 July 2006 and was told that he would be seen by the urology consultant approximately ten days later. Mr C complains that he was not seen until 6 September 2006.

18. Mr C's medical records for his admission on 19 July 2006 state 'back for cystoscopy and removal of supra-pubic catheter'. There was no reference to an appointment with the urology consultant ten days later. Mr C was re-admitted on 6 September 2006 for the cystoscopy and removal of the supra-pubic catheter. This was seven weeks after the supra-pubic catheter was inserted.

19. Adviser 2 stated that, due to the history of this case and to the continued recurrence of Mr C's strictures, definitive treatment for these strictures should have been carried out on the next available operating list. He stated that the best thing to do with a patient requiring a supra-pubic catheterisation is to operate as soon as possible and thus dispense with the supra-pubic catheter. Adviser 1 explained that the reasons for this are risk of infection, dislodgement of the supra-pubic catheter and the problems managing the catheter for the patient. He advised that, in his view, Mr C should have been put on the next

available operating list and that this would ensure that surgery would occur within one to two weeks at most. Adviser 2 concluded there was undue delay in operating to allow removal of the supra-pubic catheter and that Mr C should not have been left without supervision for so long.

20. Commenting on a draft of this report, the Board disagreed with Adviser 2's view on management of urethral strictures. They stated that, in their view, it would be extremely unsafe and hazardous to the patient if stricture surgery was to be carried out within two or three weeks after having a supra-pubic catheter inserted following retention. They stated that there would be too much swelling in the region of the bladder neck, making it very difficult to see exactly what was going on and urethrography imaging would be misleading. The Board stated that there is a very low risk of infection from a supra-pubic catheter and that dislodgement of the catheter retained in the bladder with an inflated balloon is generally not an issue. Furthermore, they stated that a young patient would normally be able to manage the catheter for the time it was in place. The Board expressed regret that it was not possible to admit Mr C sooner.

21. Due to the differing views on this situation, I asked Adviser 3 to review this complaint and provide informal advice. He advised that both Adviser 2's and the Board's position were within the bounds of what was considered reasonable practice.

(b) Conclusion

22. There is no evidence in the medical records that Mr C was told that he would be seen by the urology consultant ten days after the insertion of the supra-pubic catheter.

23. Adviser 2 stated that Mr C should have been put on the next available operating list and had surgery sooner so he could dispense with the supra-pubic catheter. The Board stated that they did not consider surgery should be performed until at least approximately three weeks after a supra-pubic catheter is inserted following retention. In the event, Mr C was not seen for another seven weeks. The Board expressed regret that it was not possible for Mr C to be seen earlier.

24. It is clear that there are differing clinical views about the treatment Mr C received. The Board had to consider complex issues and whatever course of treatment was undertaken there were risks. Adviser 3 sought the views of

urologists and advised me that both the Board's and Adviser 2's positions can be regarded as falling within the bounds of reasonable practice.

25. I have considered all the evidence and the advice I have received and I have concluded that it is possible for reasonable clinicians to disagree about the treatment which should have been given. In these circumstances I do not uphold the complaint.

(c) Unnecessary investigations were carried out prior to Mr C's referral to Hospital 2

26. Mr C was aggrieved that certain investigations were carried out at Hospital 1 prior to his referral to Hospital 2; but that he was told by the urology consultant at Hospital 2 (the Consultant) that the results of the investigations were not useful and that further investigations would have to be carried out.

27. Mr C's medical records indicate that a urethrogram was carried out in Hospital 1 before he was referred to Hospital 2. Mr C was seen at Hospital 2 on 17 October 2006 and the Consultant arranged to admit Mr C to carry out a cystoscopy and decide how to treat his stricture.

28. The advisers stated that the referral letter from Hospital 1 is of adequate standard and information. They explained that there is no reason why a referring doctor should not request the investigations in question in the hope that sufficient information would be available and helpful for the next doctor who sees the patient. As it turned out, this was not the case in this instance, because Mr C's stricture was so severe that the x-ray contrast material used to outline the urethra and the narrowed area failed to get through. It was, therefore, necessary for the Consultant to use a different procedure, a cystoscopy. The combination of these two procedures would enable the operator to determine the length of the stricture. This information was considered necessary prior to the possible urethroplasty operation.

29. Such procedures are invasive and uncomfortable but, in this case, were medically necessary in order to offer Mr C the best surgical outcome.

(c) Conclusion

30. The results of the procedures carried out at Hospital 1 prior to Mr C's referral were unhelpful to the Consultant, however, no fault can be attributed to the Consultant for this fact. The procedure was not efficient because of the

severity of Mr C's stricture. Furthermore, it is normal for a referring doctor to perform investigations prior to referring a patient. In these circumstances, I do not uphold this complaint.

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

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Hospital 1	Queen Margaret Hospital
Hospital 2	A hospital within another Health Board
The Board	Fife NHS Board
The Surgeon	A urology surgeon at Hospital 1
Adviser 1	One of the Ombudsman's clinical advisers
Adviser 2	A specialist urology adviser
Adviser 3	One of the Ombudsman's clinical advisers
The Doctor	A doctor at Hospital 1
The GP	Mr C's General Practitioner
The Consultant	A urology consultant at Hospital 2

Annex 2

Glossary of terms

Catheterisation	Insertion of a plastic tube through the patient's urethra to their bladder to allow drainage of urine
Cystoscopy	A diagnostic procedure in which a device called a cystoscope is inserted into the urethra to examine the inside of the bladder
Self-dilatation	Procedure for widening the urethra by passing a special catheter down it and immediately removing it again. The size of catheter used is gradually increased.
Supra-pubic catheter	A supra-pubic catheter is a hollow flexible tube that is used to drain urine from the bladder. It is inserted into the bladder through a hole in the abdomen
Urethra	The canal through which urine is discharged from the bladder
Urethral stricture	Narrowing of the urethra
Urethrogram	An x-ray test to take pictures of the urethra whereby a small catheter is placed into the opening of the urethra at the end of the penis, x-ray dye is injected to fill the urethra and images are taken
Urethroplasty	A surgical procedure for urethral reconstruction to treat urethral stricture

Urethroscopy	A diagnostic procedure in which a device call a urethroscope is inserted to examine the urethra
Urethrotomy	An operation performed for a stricture whereby a small cut is made in the narrowed area of the urethra in order to widen it
Urinary Retention	The inability to urinate