Case 200800695: Lanarkshire NHS Board

Summary of Investigation

Category
Health: Hospital; orthopaedics

Overview
The complainant (Mr C) raised a number of concerns about the treatment which he had received from clinicians for a finger injury following an assault on 10 June 2007. Mr C said that a consultant orthopaedic surgeon had failed to amputate a sufficient amount of the damaged finger and that this had hampered his ability to continue with his employment as an electrician. In addition, Mr C complained that another consultant orthopaedic surgeon had agreed to further amputate the finger if alternative therapy did not work but then subsequently denied that he had promised this.

Specific complaints and conclusions
The complaints which have been investigated are that:
(a) the clinicians failed to obtain informed consent prior to surgery (*upheld*);
(b) the decision not to provide the level of amputation requested by Mr C was unreasonable (*not upheld*); and
(c) the overall treatment provided by the clinicians was inadequate (*not upheld*).

Redress and recommendations
The Ombudsman recommends that Lanarkshire NHS Board (the Board):
(i) apologise to Mr C for not obtaining informed consent; and
(ii) consider whether procedures require to be amended, so that the surgeon is available at the pre-assessment clinic to discuss the level of amputation which is planned and to take consent.

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

Main Investigation Report

Introduction

1. On 22 September 2008 the Ombudsman received a complaint from Mr C about the treatment which he had received from clinicians for a finger injury following an assault on 10 June 2007. Mr C said that a consultant orthopaedic surgeon (Consultant 1) had failed to amputate a sufficient amount of the damaged finger and that this had hampered his ability to continue with his employment as an electrician. In addition, Mr C complained that another consultant orthopaedic surgeon (Consultant 2) had agreed to further amputate the finger if alternative therapy did not work but then subsequently denied that he had promised this. Mr C complained to Lanarkshire NHS Board (the Board) but remained dissatisfied with their responses and subsequently brought his complaint to the Ombudsman.

2. The complaints from Mr C which I have investigated are that:
(a) the clinicians failed to obtain informed consent prior to surgery;
(b) the decision not to provide the level of amputation requested by Mr C was unreasonable; and
(c) the overall treatment provided by the clinicians was inadequate.

Investigation

3. In writing this report I have had access to Mr C's clinical records and the complaints correspondence from the Board. I obtained advice from one of the Ombudsman's professional medical advisers (the Adviser), who is a consultant orthopaedic surgeon, regarding the clinical aspects of the complaint.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of the medical terms used in the report is contained in Annex 2. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) The clinicians failed to obtain informed consent prior to surgery; (b) the decision not to provide the level of amputation requested by Mr C was unreasonable; and (c) the overall treatment provided by the clinicians was inadequate

5. Mr C sustained an injury to his left index finger following an assault on 10 June 2007. He attended the Accident and Emergency Department at the

hospital that day where the wound was debrided, stitched and a splint was applied by an associate specialist in orthopaedics (the Associate Specialist). Mr C was advised that the finger was unlikely to be viable with limited long-term function. Mr C was known to be a non-insulin dependent diabetic. He was admitted to the hospital overnight and was prescribed intravenous antibiotics and analgesics. The injury was described as a badly comminuted open fracture to the distal and middle phalanx of his non-dominant left index finger. In the early hours of 11 June 2007 Mr C became very distressed with pain and a senior house officer (the SHO) was contacted. He elected to re-dress the wound after putting in a local nerve block at the base of the finger. He found the wound to be tight and removed two of the sutures. Consultant 1 saw Mr C later that day to assess his finger and consider whether amputation was required. He elected not to take him to theatre for amputation of the finger but to keep him on intravenous antibiotics for 36 hours as a ward patient. Mr C was discharged home on 13 June 2007 as his observations were stable.

6. Mr C was seen for follow-up by Consultant 1 at his clinic on 19 June 2007. Consultant 1 found the wound to be healthy and the alignment of the bones to be satisfactory. He advised Mr C that the terminal interphalangeal joint would probably not move and would be stiff but he expected good movement of the rest of the finger. He also arranged further follow-up appointments with Mr C. Consultant 1 saw Mr C again on 26 June 2007 and recommended twice weekly dressings. When he saw him again on 7 August 2007, he recorded that the wound was healed with no signs of infection and that Mr C had full sensation at the tip of the finger. Consultant 1 then saw Mr C on 11 September 2007 and, because of residual pain at the tip of the finger, he discussed amputation of the finger with Mr C and he was placed on the waiting list for surgery. On 29 October 2007 Mr C attended the Accident and Emergency Department and reported that there was pus in the nail fold of the finger. Mr C was prescribed antibiotics.

7. Mr C was admitted for surgery to the left index finger on 3 January 2008 under Consultant 1. The orthopaedic registrar discussed consent with Mr C and the consent form was signed and worded 'amputation left index finger and middle? Proximal phalanx'. Subsequently, the wound healed well but Mr C was unhappy that he had not had a more proximal (nearest the hand) amputation. Mr C subsequently requested a second opinion and was seen by Consultant 2, a consultant orthopaedic surgeon, on 26 March 2008. Consultant 2 reported that there was a good stump with sensation over the tip, good flexion of the

proximal interphalangeal joint, but that Mr C was not using the finger. It was reported that Consultant 2 thought hand therapy may be beneficial and Mr C was subsequently referred for occupational therapy and physiotherapy to his hand. An occupational therapist recorded on 2 April 2008 that the finger was permanently cold but had no hypersensitivity and good sensation at the tip but that the stump was painful on flexing. It was noted that Mr C had said he had banged his finger when he tried to use it and this was very painful. Mr C continued with therapy and on 16 April 2008 he reported that there was redness and swelling around the stump of the finger. He also reported he was still struggling because of a sharp stabbing pain in the finger.

8. Mr C also saw a physiotherapist on 2 April 2008 and 20 May 2008 when he reported pain on the ulnar border of the stump and that any bump of that area caused severe pain which lasted for days. The physiotherapist felt that further conservative therapy was indicated before considering any surgery. Consultant 2 felt that a further consultant opinion was required and an appointment with another consultant orthopaedic surgeon was arranged but Mr C refused to attend.

9. In his letters to the Board, Mr C complained that on 13 June 2007 when the bandages were removed it was obvious to him that, due to the amount of damage done to the finger, if it was not removed then he could not continue in his employment. He asked Consultant 1 to remove the injured part of the finger but he was told to wait a few weeks to allow him time to get used to it. At the out-patient appointment a few weeks later, he again asked Consultant 1 to remove the useless part of his finger but was told that Consultant 1 had a duty to keep the finger if it was at all possible. Mr C was under the impression from Consultant 1 that he would have 75 percent usage of the finger but he said this did not happen and he was left with a finger which was, to all intents and purposes, useless for his work as an electrician. Mr C was then moved to light duties at work and after a few months he noticed that lumps had appeared and were moving around his finger and that it was extremely painful. At a further appointment with Consultant 1, Mr C said he was told that instead of cartilage growing around the bone and becoming stronger it had started to move around and was causing the pain. The options were to leave it for a few more months to see if it settled down or he could have the tip of the finger removed. Mr C agreed that the tip could be removed but with the proviso that all the damaged area would be removed. Mr C assumed this was acceptable as plans were made for the operation to proceed. In November 2007 Mr C suffered an

infection in the finger and was referred to a member of Consultant 1's staff, who said the infection could have moved into the multitude of broken bones in the finger. Mr C said he was told that at the operation they would 'scrape' the remainder of the bones in the finger to remove as much of the infection as possible. Mr C was confused about this as he believed all of the damaged area would be removed at the operation. Mr C said he told the doctor this, who said he would check with Consultant 1.

10. Mr C continued that he had hoped to see Consultant 1 at the pre-surgery clinic on 19 December 2007 but he was in theatre at the time. Mr C then attended for surgery on 3 January 2008 and was assessed and taken to a pre-op ward, where the doctor advised him about infections and the risks of any surgery. Mr C said he repeatedly told the doctor that he wanted to ensure that Consultant 1 removed all the affected finger and that if that was not the case then he would not go ahead with the operation. He thought the doctor had accepted this. Mr C said that on 9 January 2008 the bandage was removed by his local practice nurse as the bandage had become wet and he could see that despite all his requests, and the assurances he had received, only the tip of the finger had been removed. Mr C was angry that Consultant 1 had ignored his wishes.

11. Mr C said that as he was unhappy with the treatment provided by Consultant 1 he asked for a second opinion. He was referred to Consultant 2, who told him that he should undergo a six week programme of hand physiotherapy and if he still wished the finger amputated then arrangements would be made for it to happen. Mr C completed the course and although the finger was less painful at rest, it worsened whenever he had to use the finger or his hand doing anything strenuous. At the follow-up appointment with Consultant 2, Mr C explained the symptoms were getting worse and that he wanted to proceed to amputation. However, he said Consultant 2 told him that he had changed his mind and that he no longer wanted to amputate the finger and that he wanted him to see another doctor. Mr C said when he questioned this he was told that Consultant 2 wanted another doctor to agree that amputation was appropriate before he would commit to such an operation. As far as Mr C was concerned, Consultant 2 had lied to him by denying he had agreed to amputate the finger. Mr C was concerned that he would have to wait for another opinion and then a further 18 weeks, should Consultant 2 then agree to operate. Mr C said that his GP had told him she had received notification from Consultant 2 which confirmed that, if the hand therapy had

failed, Consultant 2 would be happy to operate and remove the finger without mention of seeking a further opinion. [Note: this refers to a note from Consultant 2 to the GP which stated 'I have asked the hand therapist to see him to start a trial of desensitisation and to get some work done on this and if in the end it doesn't settle, then of course he could have it amputated more proximally but it would be a shame to rush into this as he has had a very neat job done.']

12. In a letter dated 14 February 2008 from a Board general manager (Manager 1) to Mr C, it was explained that the doctor who treated the wound initially on 10 June 2007 assessed the injury and felt the finger was unlikely to be viable with limited long-term functionality. However, following overnight observation it was confirmed that the finger was indeed viable. Mr C was encouraged to persist with splinting and allow the wound to heal. Loss of joint mobility was anticipated but overall the functionality and use of the finger was discussed with Consultant 1 on 19 June 2007. Manager 1 went on to say that the finger fractures had not healed and were unlikely to heal to provide a stable finger. She said it was understood that Mr C had agreed that the finger should be amputated at the level of the unhealed bone. Mr C subsequently complained of pain in the more proximal part of the digit and this information was communicated to Consultant 1 prior to surgery. Consultant 1 did not think it was wise to consider a more proximal amputation on the basis of pain as often pain is not relieved and persists following amputation. Consultant 1 had said that this decision was discussed with Mr C at his follow-up clinic appointment. Manager 1 said that it had been agreed at that meeting that Mr C's case notes would be reviewed by another consultant who would provide a second opinion (see paragraphs 7 and 11).

13. On 13 June 2008 another Board general manager (Manager 2) wrote to Mr C. He explained that Consultant 2 had been asked to review the case and that Mr C had been seen by him on 26 March 2008. On examination it was noted that the stump was nicely healed and the finger was not too swollen, although it was sensitive around the tip as would be expected. Consultant 2 did understand Mr C's wish to have the finger amputated, however, he was concerned that this might simply shift the pain which was being experienced to the new stump at the metacarpal head and would leave Mr C in a worse position. Consultant 2, therefore, referred Mr C to the hand therapist to start a trial of desensitisation. Following the course of therapy, the recommendation was that Mr C would benefit from exhausting all conservative options in an effort to keep the finger, rather than progressing to amputation at that stage. Further

assessment by the Physiotherapy Department for any additional pain relieving measures would also be sought. However, Mr C only attended one appointment and was subsequently discharged from the service. Based on the information provided by the hand therapist on improvements of movement following treatment, Consultant 2 was reluctant at that stage to progress to amputation. Manager 2 advised that amputation, once undertaken, is clearly irreversible and in Consultant 2's professional opinion, based on the review at clinic and the information available to him, he felt that a further opinion should be sought. Consultant 2 had written to a hand surgeon at another Health Board for an opinion and would wait for that opinion to be received. Mr C subsequently refused to attend for a further opinion.

14. The Adviser said that a crush injury to a finger causes damage to bone, joint tendon, nerves and arteries. All these elements of the injury need to be considered at the time of the first presentation of the patient. Mr C was a non-insulin dependent diabetic and, therefore, the risk of infection was higher than in the general population. The Adviser continued that the treatment by intravenous antibiotics in the ward was correct and further consultations with Consultant 1 appeared satisfactory. Mr C was requesting amputation and Consultant 1 was conservative in discussing amputation at the level he felt would give adequate finger function without residual pain. At the time of the initial injury, the Associate Specialist told Mr C that the finger was severely injured and may not function well again. This was good advice and the Adviser felt the management by Consultant 1 was good until the finger had healed fully and final function could be assessed. This period in question was up to five months from the time of the injury and it would then be acceptable to proceed with surgery if indicated.

15. The Adviser felt that the surgical procedure, completed by Consultant 1, with the definitive amputation was completed at the correct level on clinical grounds. It would have been difficult for the patient to appreciate the eventual function of his finger at that moment in time and the Adviser stated that, generally, good surgical practice is to maintain finger length, provided the stump has good sensation and is not painful. It is, however, essential that the patient agrees with the surgeon, prior to surgery, on the exact level of amputation during the surgical procedure. It would be considered good practice for the surgeon to take the consent for amputations himself to ensure there is no

confusion on the level.[1] The Adviser told me that the consent obtained and signed by Mr C left it open for Consultant 1 to amputate at the level of his own choice based on his clinical assessment. However, it appeared from the notes that Mr C was concerned that the level of amputation was not going to be what he wanted and both the surgeon and the patient should have discussed this further prior to surgery. This suggested to the Adviser that the informed consent was not adequate. The Adviser felt it was difficult for him to comment on the discussions between Mr C and clinical staff from the clinical notes. He could appreciate that if there was some residual pain in the finger then Mr C would find it problematic in his work. In the long term if the pain was persistent it would not be unreasonable to amputate the finger further. Hand injuries generally interfere with a patient's work for much longer than the patient could anticipate and, therefore, their frustration at not being able to return to work is aggravated.

16. Insofar as the decisions of Consultant 1 and Consultant 2 not to proceed with the level of amputation requested by Mr C, the Adviser mentioned that the level of amputation performed by Consultant 1 was correct on clinical grounds. The request by the patient to make a further, more extensive, amputation had to be considered in the light of the time elapsed since the injury and the request so that enough time had passed for the injury to heal adequately for final function to be assessed. The second point was whether there were any grounds, apart from clinical grounds, for the patient to request this further amputation. In Mr C's case he felt that it interfered with his work and was putting his hand at risk of injury. This discussion took place between Mr C and Consultant 2 in March 2008 (over nine months had passed since the injury) and Mr C was well placed to assess whether this was interfering with his work or not. The Adviser said that either Consultant 1 or Consultant 2 could have made this decision once the original injury had healed fully and they could perhaps have requested a report from an occupational therapist to assess how it was interfering with Mr C's function at work, if they had any doubts. The Adviser said that Consultant 2 was correct in requesting a further opinion if he had any doubts as to the need for further amputation but he should perhaps have listened to Mr C's request in more detail.

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[1] Note: in providing comments for the Board response, Consultant 1 said that it was disappointing that Mr C was not seen at the pre-assessment stage by himself or his colleague. Recent policies involving pre-assessment of day cases had meant that this was likely to happen on a repeated basis.

17. The Adviser concluded that the overall treatment by Consultant 1 was satisfactory but it appeared that he did not discuss the level of the amputation of the finger clearly with Mr C prior to the surgical procedure and he should have taken the consent himself. The Adviser felt that the overall treatment provided by Consultant 2 was good, with the exception that there was some misunderstanding between him and Mr C as to Mr C's expectations following therapy.

(a) Conclusion

18. Mr C complained that he constantly told medical staff that his wish was for all the damaged tissue to be removed from the finger and that he was surprised to find out after the operation on 3 January 2008 that only the tip had been amputated. Consultant 1 had been aware, prior to surgery, of Mr C's request to have a more proximal amputation of the finger on the basis of pain. However, Consultant 1 did not feel it would be wise to agree the request, as often the pain is not relieved and the pain persists following amputation. It is clear that there has been a breakdown in communication in this case, as both Mr C and Consultant 1 had differing views as to the level of amputation which was required and this difference of views should have been addressed prior to surgery, so that Mr C was aware what he was consenting to at the appropriate time. I fully agree with the Adviser's comments that it would have been good practice for Consultant 1 to take the consent on the amputations himself, as this may have cleared up any doubt as to the level of amputation which was planned to take place. I am also aware that Consultant 1, in commenting on the complaint, acknowledged that this could be an issue in some cases. Accordingly, I have decided that the clinicians involved did not obtain informed consent and I uphold this complaint.

(a) Recommendations

19. The Ombudsman recommends that the Board:

(iii) apologise to Mr C for not obtaining informed consent; and

(iv) consider if procedures require to be amended, so that the surgeon is available at the pre-assessment clinic to discuss the level of amputation which is planned and to take the consent.

(b) Conclusion

20. I turn now to the question as to whether the decision not to provide the level of amputation requested by Mr C was unreasonable. The advice which I

have received and accept is that the decisions by Consultant 1 and Consultant 2 were correct on clinical grounds. It is important that sufficient time has elapsed since the injury to allow for the healing process to take place and that final function can be assessed. It is also important that the views of the patient are taken into account and that if the surgeon has any doubts about amputation then a further opinion should be sought. It would also be good practice to consider whether the input of other health professionals, such as physiotherapists or occupational therapists, would be of value before reaching a decision on amputation. In this case, I am satisfied that the clinicians involved made appropriate decisions on the level of amputation required and I do not uphold this complaint.

(b) Recommendation

21. The Ombudsman has no recommendations in this regard.

(c) Conclusion

22. I now have to consider whether the overall treatment provided by the clinicians was inadequate. Mr C is a non-insulin dependent diabetic, which meant that the risk that he could suffer an infection was higher than in the general population. I accept that it was appropriate for the Associate Specialist to perform the initial debridement in the Accident and Emergency Department and that Mr C was reviewed by Consultant 1 the following day. I have also been advised that the treatment provided to Mr C, including follow-up appointments with the Consultants, was satisfactory. As a result, I have decided that the overall treatment received by Mr C was adequate and as a result I do not uphold this complaint.

(c) Recommendation

23. The Ombudsman has no recommendations to make.

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

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Consultant 1	Consultant orthopaedic surgeon who treated Mr C initially
Consultant 2	Consultant orthopaedic surgeon who provided a second opinion
The Board	Lanarkshire NHS Board
The Adviser	Ombudsman's professional medical adviser
The Associate Specialist	Associate Specialist in Orthopaedics who attended Mr C on 10 June 2007
SHO	Senior House Officer who attended Mr C on 11 June 2008
Manager 1	Board General Manager who wrote to Mr C on 14 February 2008
Manager 2	Board General Manager who wrote to Mr C on 13 June 2008

Annex 2

Glossary of terms

Comminuted	Fractured in many places
Debrided	Removal of dead tissue
Distal/middle phalanx	Distal/middle finger bone
Hypersensitivity	Body reaction after injury where sensations are abnormal, exaggerated and painful
Local nerve block	Injection given to block a nerve
Metacarpal head	Bone in finger
Proximal	Nearest to the hand
Terminal interphalangeal joint	Fingertip joint
Ulner border	Outside edge of the finger