
Orthopaedic Surgeon

Report on Opinion - Case 99HDC02569

Complaint

The Medical Council of New Zealand forwarded a complaint to the Commissioner about services the complainant's wife received from an orthopaedic surgeon. The complaint is that:

- *In mid-December 1998 the consumer had a second consultation with an orthopaedic surgeon. Because of the provider's comments and his manner towards the consumer on her first consultation, the consumer attended the second consultation with the support of her husband.*
 - *The consumer's husband says the provider's manner, presentation and delivery during the consultation was soul destroying. The provider did not look at the consumer's x-rays until the consumer's husband asked him to. The provider made comments about the consumer being an invalid.*
 - *The provider did not listen to the consumer's concerns about daily swelling of her knee, leg and foot. Two days later the consumer was diagnosed at a public hospital with thrombosis.*
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Investigation Process

The Commissioner received the complaint on 1 March 1999 and commenced an investigation on 23 July 1999. Information was obtained from:

The consumer
The consumer's husband
The provider / orthopaedic surgeon

The consumer's medical records were obtained and the Commissioner sought advice from an independent orthopaedic surgeon.

Information Gathered During Investigation

In late August 1998, while travelling in an aeroplane to Ireland, the consumer twisted and locked her left knee. After arriving in Ireland, the consumer consulted an orthopaedic surgeon. A few weeks later the consumer travelled to England and near the beginning of October 1998 she consulted an orthopaedic surgeon there. In early October 1998, this surgeon diagnosed a meniscal (cartilage) tear on the surface of the consumer's tibia (shin bone). The surgeon inserted an arthroscope into the consumer's knee to inspect the torn cartilage. The surgeon then removed the torn cartilage. He noted a degenerative osteoarthritic change in the medial (central part) of the consumer's left knee.

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**Information
Gathered
During
Investigation
*continued***

Following her return to New Zealand, the consumer experienced increasing pain, swelling, clicking and locking of her damaged left knee. The consumer had difficulty moving around and was mobilising on crutches. The consumer consulted a general practitioner in mid-November 1998 about her painful knee. The general practitioner had received the consumer's records from the surgeon. The surgeon suggested in the records that the consumer required further consultation with an orthopaedic surgeon. Accordingly, the general practitioner wrote a referral letter to an orthopaedic surgeon ("the provider") outlining the consumer's knee history.

The consumer attended an initial consultation with the provider in late November 1998. The consumer's husband accompanied the consumer to the consultation appointment, where he remained in the waiting room.

The consumer told the Commissioner that during the consultation the provider spoke to her harshly and his manner was "*off-putting*". The consumer stated that the provider told her to throw away her crutch. The consumer advised the Commissioner that she told the provider that her left knee was swollen and painful. She was afraid of falling and could not move around freely without the crutch. The consumer stated that the provider told her to stop being an invalid and to get on with her life. The consumer advised the Commissioner that she was devastated by the provider's judgement of her and left the consultation feeling terrible. The consumer stated that she could not understand how someone she had never met before could make such an assumption about her without knowing her or what she was like.

The consumer's husband advised the Commissioner that on the day of his wife's initial consultation with the provider she was enthusiastic about the consultation because she was going to get some help for her sore leg. The consumer's husband stated that when his wife came out of the consultation room after seeing the provider, in his opinion she looked totally destroyed.

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**Information
Gathered
During
Investigation
*continued***

The provider advised the Commissioner that he spent a long time with the consumer at this first consultation. He examined the consumer's leg and recommended an erythrocyte sedimentation rate reading (ESR), C-reactive protein and blood screen and also suggested a MRI scan. The provider stated the following:

"I believe in my attempts to analyse her problem and help her with it I spent well over an hour with her. ... It was my opinion ... that this woman was suffering from an Atypical Pain Syndrome (reflex sympathetic dystrophy). ... I tried to explain to this woman as best I could the nature of the condition. I also tried to point out to her that in order for the condition to improve I felt it was most important for her to try and use the limb in a normal manner. I did try and emphasise to her that I felt it was inappropriate for her to rest the limb in the hope or the belief that it would get better."

The consumer visited the provider for a follow up appointment in mid-December 1998. On this occasion the consumer's husband accompanied her into the consultation room.

The provider's consultation notes for this visit recorded that the consumer's blood tests, taken at the first consultation, were normal. The provider's notes also recorded the range of movement in the consumer's left knee and that her left knee was not hot. The provider did not note any swelling below the consumer's left knee. There was no record in the consultation notes that the consumer's leg was swollen. The provider advised the Commissioner that if there had been swelling he would have seen it and recorded it in the notes. The provider discussed atypical pain syndrome with the consumer and suggested that she mobilise more vigorously. The provider suggested a referral to the pain services team at a public hospital.

The consumer stated that she explained to the provider during the second consultation appointment that she was not resting the limb, it was swollen and hurt and she had come to him for professional help. The consumer stated to the Commissioner that she felt the provider "*saw her as an invalid*". The consumer advised the Commissioner that she felt something fairly obvious was going on with her foot because it was so swollen, but that when she showed her swollen foot to the provider, he reacted with annoyance.

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**Information
Gathered
During
Investigation
*continued***

On arrival at the second consultation in mid-December 1998, the consumer and her husband gave the provider two sets of film from the MRI scans that the orthopaedic surgeon in England took in October 1998. The scan films showed the status of the operation on consumer's left knee before and after the operation. The consumer's husband stated that the provider did not look at the films until they requested him to do so.

The consumer's husband advised the Commissioner that he had witnessed the swollen appearance of his wife's left leg, knee and foot, prior to her second consultation with the provider.

The consumer stated that following her consultations with the provider she felt "*like dirt and was devastated*" because of the manner in which he spoke to her. She advised the Commissioner that it took her a considerable amount of time to overcome the effect that the provider had on her, and she stated that she had no desire to ever speak to or meet with him again. The consumer declined to participate in resolution of her complaint through the advocacy process.

The consumer's husband advised the provider in a letter dated late December 1998: "*... do you realise your manner, presentation and delivery can be soul destroying?*"

In his letter of late July 1999, the provider advised the Commissioner:

"Again on the occasion of the following visit I explained the nature of the condition to both [the consumer and the consumer's husband]. I believed the history and findings were characteristic of an atypical pain syndrome. There were no physical findings suggestive of a significant deep vein thrombosis when I saw this woman at the initial or follow up consultation. I spent a long time at both the initial and follow up consultations explaining to her (and at the time of the follow up to her husband) the nature of the condition. I did try to emphasise to her that I thought it was inappropriate for her to rest the limb and to hope that it would improve if she rested it and used crutches to walk."

Two days after her consultation with the provider, the consumer presented to the public hospital emergency department in mid-December 1998. The examining doctor diagnosed a DVT (deep vein thrombosis), which was confirmed by an ultrasound.

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**Independent
Advice to
Commissioner**

The Commissioner obtained advice from an independent orthopaedic surgeon, who advised the following:

“Following returning to New Zealand she [the consumer] developed a swollen, painful [left] knee which she was having difficulty mobilising with. The sequence of events is reasonably predictable when one considers the patient had undergone arthroscopic surgery followed by a prolonged aeroplane flight from [England] to New Zealand, usually taking around 30 hours. An atypical pain syndrome or a sympathetic dystrophy is an unusual diagnosis following arthroscopic surgery though occasionally encountered and would not be surprising when one considers the sequence of events here. One would also have had to be suspicious about the possibility of a deep vein thrombosis following a prolonged aeroplane flight soon after undergoing arthroscopic surgery.

It is therefore disappointing that [the provider] did not recognise the possibility of a deep vein thrombosis on his initial clinical examination. Deep vein thrombosis in itself is not an unusual problem following both surgery and or prolonged aeroplane flights and does not usually cause patients significant disability and frequently does not require treatment. It could almost be anticipated that if an ultrasound was performed on a patient's leg following this sequence of events a DVT would be found.

I feel [the provider's] approach to this patient's problem in that he investigated her for infection and was pursuing MRI was a satisfactory outcome from the initial consultation. Possibly a DVT should have been considered though I do note that [the provider] had inspected [the consumer's] lower limb and tested her pulses. ...”

The Commissioner's advisor formed the opinion that:

“... from the competency point of view [the provider] has maintained his standards and performed as one would hope a well qualified specialist would. ...

In summary therefore I feel [the provider's] dealing with the consumer is adequate. ...”

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**Code of Health
and Disability
Services
Consumers'
Rights**

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint as follows:

RIGHT 1

Right to be Treated with Respect

- 1) *Every consumer has the right to be treated with respect.*

RIGHT 4

Right to Services of an Appropriate Standard

- 2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

RIGHT 5

Right to Effective Communication

- 2) *Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.*
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**Opinion:
No Breach**

In my opinion the provider did not breach Right 1(1) or Right 4(2) of the Code.

Right 4(2)

The consumer's husband was concerned that the provider failed to diagnose the consumer's DVT at the second consultation visit in mid-December 1998.

At the first consultation visit in late November 1998, the provider examined the consumer's leg and recommended an erythrocyte sedimentation rate reading (ESR), C-reactive protein and blood screen and also suggested an MRI scan.

The independent advisor stated that in his opinion the provider's approach to the consumer's problem was satisfactory from the competency point of view, in that he investigated the consumer for infection and was pursuing a MRI scan.

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Opinion:
No Breach
continued

At the second consultation visit in mid-December 1998, the provider recorded in the notes that the consumer's blood tests, taken at the first consultation visit in late November 1998, were normal. The provider's notes also recorded the range of movement in the consumer's left knee and that her left knee was not hot. The independent advisor stated that possibly a DVT should have been considered, however the provider did inspect the consumer's lower limb and tested her pulses and did not note any swelling below the consumer's left knee. Although the consumer's husband noted the swollen appearance of his wife's left leg, knee and foot, prior to her second consultation with the provider, there was no record in the consultation notes that the consumer's leg was swollen. The provider advised that if there had been swelling he would have seen it and recorded it in the notes.

The independent advisor stated that the provider maintained his standards and performed as one would hope a well-qualified specialist would. The provider advised that he did not find any physical findings suggestive of a significant deep vein thrombosis at either the initial or follow-up consultation with the consumer.

Accordingly, in all the circumstances, my opinion is that the provider did not breach Right 4(2) of the Code.

Right 1(1)

In my opinion the provider did not breach Right 1(1). The consumer reports feelings of devastation and the effect on her self-esteem following her consultations with the provider. Under the Code every consumer has the right to be treated with respect. The provider spent a long time at both consultations attempting to explain the consumer's condition. The consumer's husband described the provider's presentation and delivery to be "soul destroying". In my opinion the feelings the consumer experienced, both during and following her consultations with the provider, resulted from ineffective communication and not as a result of any disrespect. The provider gave his advice based on his medical judgement. Comments were made to convey what he believed would alleviate her symptoms.

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**Opinion:
Breach**

In my opinion the provider breached Right 5(2) of the Code.

Right 5(2)

The consumer's complaint was about the provider's manner and attitude towards her during the consultation visits.

In late November 1998, the consumer felt that the provider spoke to her harshly and she found his manner "*off-putting*". The consumer felt devastated by the provider's judgement of her and left the consultation feeling terrible. The consumer could not understand how a person she had never met before could make such an assumption about her when he did not know her or what she was like.

The consumer's husband stated that when his wife came out of the consultation room after seeing the provider, in his opinion she looked totally destroyed.

During the second consultation appointment the consumer stated that she felt the provider "*saw her as an invalid*". The consumer advised that she felt something fairly obvious was going on with her foot because it was so swollen, but that when she showed her swollen foot to the provider he reacted with annoyance.

The consumer stated that following her consultations with the provider she felt "*like dirt and was devastated*" because of the manner in which the provider spoke to her. The consumer advised that it took her a considerable amount of time to overcome the effect that the provider had on her, and that she had no desire to ever speak to or meet with him again.

The consumer's husband advised the provider in a letter dated late December 1998: "*... do you realise your manner, presentation and delivery can be soul destroying?*".

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**Opinion:
Breach
*continued***

The provider stated that he tried to explain as best he could the nature of the consumer's condition. In my opinion, had the provider's communication been effective, the consumer would not have left the provider's rooms feeling as she did. The subsequent diagnosis of deep vein thrombosis confirms that the consumer's concerns were genuine, however at the time of both consultations with the provider, the consumer's concerns were either dismissed or she was not listened to. In my opinion, the provider did not create an environment that enabled both consumer and provider to communicate effectively and therefore breached Right 5(2) of the Code.

Actions

I recommend the provider takes the following actions:

- Apologises in writing to the consumer for not communicating effectively. This letter is to be sent to the Commissioner's office and it will be forwarded to the consumer.
 - Reviews his manner of communication with patients.
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Other Actions

A copy of this opinion will be sent to the Medical Council of New Zealand. A non-identifying copy will be sent to the Royal Australasian College of Surgeons for educational purposes.
