Orthopaedic Surgeon, Dr B

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC01580)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary 1
Complaint and investigation 2
Information gathered during investigation 2
Opinion: Dr B — breach 10
Changes made since complaint 16
Recommendations 17
Follow-up actions 17
Appendix A: Independent clinical advice to Commissioner 18
Appendix B: Patient information on knee arthroscopy 23

Executive summary

1. A woman experienced left knee pain from a fall and presented to an orthopaedic surgeon for review. An MRI of the knee showed a tear in the lateral meniscus (a band of cartilage in the outer side of the knee), and the surgeon recommended arthroscopic surgery to remove any damaged tissue.

2. During the surgery, it was discovered that the tear in the lateral meniscus was stable, and therefore no debridement (removal of damaged tissue) was performed. Instead, the surgeon found a small unstable tear present in the medial meniscus (the inner side of the joint), which was debrided. A moderate degree of arthritis was found in the knee but neither the debridement of the medial meniscus nor the finding of arthritis were communicated to the woman by the surgeon after the surgery.

3. The woman presented to the surgeon for a postoperative consultation. She complained that the surgery did not improve her pain and that the surgeon had dismissed her concerns without providing adequate details about the surgery.

Findings

4. The Deputy Commissioner found that during the preoperative consultation, the surgeon did not undertake an adequate physical examination of the woman or obtain a basic medical history from her. The surgeon also failed to consider and discuss the other potential causes of the pain in the woman's knee, including the evolving osteoarthritis as indicated by the MRI report. The Deputy Commissioner concluded that the surgeon failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

5. The Deputy Commissioner found that the woman did not receive all necessary information about the surgery and her condition to enable her to make an informed decision regarding her care. In particular, the Deputy Commissioner was critical that the surgeon did not inform the woman adequately about any conservative treatment options for the small tear in the lateral meniscus, or about the exploratory nature of the arthroscopic surgery and the risks and likelihood of success of the surgery. Accordingly, the Deputy Commissioner found the surgeon in breach of Right 6(1) and Right 7(1) of the Code. The Deputy Commissioner also found the surgeon in breach of Right 6(1)(g) of the Code as he did not inform the woman that the medial meniscus had been debrided instead of the lateral meniscus.

Recommendations

6. The Deputy Commissioner recommended that the surgeon provide a written apology to the woman for the deficiencies in care identified. The Deputy Commissioner also recommended that the surgeon reflect on the deficiencies in communication during both the preoperative and postoperative consultations and undertake an audit of documentation and clinical records to assess whether changes in documentation (recording the discussion with the patient) have been followed.

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Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by an orthopaedic surgeon, Dr B. The following issue was identified for investigation:

- *Whether Dr B provided Ms A with an appropriate standard of care from February 2020 to May 2020 (inclusive).*

8. This report is the opinion of Deputy Commissioner Dr Vanessa Caldwell.

9. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Dr B	Provider/orthopaedic surgeon

10. Further information was received from a private hospital.

11. Independent advice was obtained from orthopaedic surgeon Dr John McKie (Appendix A).

Information gathered during investigation

Introduction

12. This report concerns the orthopaedic care provided to Ms A by orthopaedic surgeon Dr B[1] during the preoperative consultation on 17 February 2020, the surgery performed on 5 May 2020, and the follow-up postoperative consultation on 26 May 2020.

13. During the preoperative consultation with Dr B, it was decided that arthroscopic surgery[2] would be necessary to remove what he understood to be a torn cartilage in Ms A's lateral (outside) meniscus.[3] However, during the surgery, Dr B discovered that Ms A's lateral meniscus did not require surgery. Instead, a small unstable tear to Ms A's medial (inside) meniscus was discovered during surgery, which Dr B debrided.[4]

14. Following the operation, Ms A's knee symptoms and pain did not improve. Ms A raised concerns with Dr B that he had not provided a sufficient explanation as to why the lateral meniscus had not been debrided, as she had understood from him that there was a tear that

[1] Dr B was awarded a general scope of practice and a vocational scope of practice for orthopaedics.
[2] Arthroscopy is a minimally invasive surgical procedure used to examine and treat problems inside a joint.
[3] The meniscus is the soft rubbery bumper cushion that sits between the thigh and leg bones. The knee contains two menisci — a medial (inside) meniscus and a lateral (outside) meniscus. The menisci act as shock absorbers that decrease the stress in the knee. The literature suggests that 90% of the time, the appropriate treatment is arthroscopy to remove the torn fragments, as the meniscus cannot be repaired because of the lack of blood supply.
[4] Removed damaged tissue to allow healing to occur.

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required debridement. Ms A further complained to Dr B that he operated on the medial meniscus without informing her, and she raised concerns that the arthroscopy performed on her was ultimately inappropriate and 'unnecessary'.

15. Dr B told HDC that during the preoperative consultation, there was no explicit intention in describing that the surgery was to debride the lateral meniscus. This was reflected in Dr B's consultation note, which recorded that it was reasonable for Ms A's left knee to be assessed arthroscopically and 'debrided if appropriate'.

Background

16. On 20 September 2019, Ms A (aged in her fifties at the time of events) tripped and fell on her left knee. This caused a hyperextension injury to the knee. Over the following months Ms A's symptoms worsened with increasing pain.[5]

17. On 3 January 2020, Ms A saw her general practitioner (GP), who then ordered an X-ray of her left knee. The X-ray did not identify any fracture or dislocation.

18. On 9 January 2020, Ms A's GP made a referral to an orthopaedic clinic for orthopaedic review, as Ms A had presented with ongoing swelling and pain in her left knee with the feeling that it was unstable. The referral was accepted by Dr B on 3 February 2020.

19. Prior to seeing Ms A, Dr B arranged for an MRI to be taken. Dr B considered this to be appropriate as Ms A's X-ray had been normal and considerable time had elapsed since her knee injury had occurred.

20. The MRI was performed and read by an outpatient radiology service on 11 February 2020. The radiology report noted the following:

- A possible small horizontal tear of the lateral meniscus.
- Moderate cartilage wear and tear on the inside part of the knee.[6]
- Swelling in the Hoffa's fat pad (shock absorber),[7] which may indicate imbalance to the kneecap. However, there was no evidence of bone deformity in her knee.
- Intact ligaments.

February 2020 — preoperative consultation with Dr B

21. On 17 February 2020, Ms A presented to Dr B at the orthopaedic clinic for review of her left knee.

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[5] Her symptoms included a feeling that her fibula head was moving abnormally and tearing. Certain movements caused the fibula head to feel as if it was grinding, dislocating, and locking.

[6] This was reported as 'moderate chondral loss in the medial tibiofemoral compartment'. Chondral loss is damage or injury to the smooth cartilage of the knee joint. This can lead to osteoarthritis.

[7] The superolateral infrapatellar is also known as the Hoffa's fat pad, which sits behind and just below the kneecap (patella), where it acts as a protective cushion, separating the kneecap from the shin and thigh bones.

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22. Dr B's clinical notes stated: '[T]he MRI reports a horizontal tear of the lateral meniscus.' Dr B then documented that Ms A presented with knee pain and locking, which was consistent with the findings in the MRI. In the clinical examination section, Dr B recorded that Ms A had a limp to her left side[8] and that she had problems flexing her left knee.[9]

23. Given that the MRI report had noted only a 'possible small horizontal tear' in the lateral meniscus, Dr B considered that Ms A's knee needed to be assessed further by arthroscopy, with debridement if appropriate. Dr B's notes recorded:

> '[Ms A] presents with mechanical symptoms and posterolateral knee pain consistent with a lateral meniscus tear. Although the MRI reports only a small tear of the lateral meniscus, it would be reasonable to have this assessed arthroscopically and debrided if appropriate. Given her symptoms have disabled her for more than 3 months [Ms A] has agreed to go ahead with this. She will leave today with standard patient information regarding knee arthroscopy.'

24. Dr B also filed a pre-approval report[10] to ACC for the planned 'arthroscopic debridement' of the knee. It was documented in the ACC application that the expected outcome of the surgery was alleviation of Ms A's ongoing knee problems.

25. Ms A told HDC that she had several problems with Dr B during the initial preoperative consultation. Ms A described the first consultation as being 'very brief, lasting no more than 10 minutes', with Dr B spending the majority of the time speaking into his dictaphone. Ms A asserted that Dr B:

- Did not perform any physical examination.
- Did not enquire about Ms A's history of the injury or pain symptoms. Dr B asked her only one question, which was about whether her knee would become locked.
- Did not consider other probable causes for the pain in her knee.
- Did not discuss other treatment options with her.
- Did not inform her about the probability of a successful/unsuccessful outcome of the surgery. Ms A said that this was discussed with her only when she was waiting outside the operating theatre on the day of surgery.

Discussion of planned treatment

26. Dr B told HDC that during the 17 February 2020 consultation, he discussed with Ms A the findings of the MRI and told her that he recommended 'arthroscopic exploration of her knee with the intention of removing any meniscus tear considered appropriate for surgical debridement'.

[8] Antalgic gait.

[9] The notes stated: '[Ms A] has an antalgic gait with the patient favouring her left side. There is a fixed flexion deformity of 10 degrees, and the patient can flex her knee to 90 degrees.'

[10] Also known as the Assessment Report and Treatment Plan (ARTP), which was signed on 26 February 2020.

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27. Ms A told HDC that Dr B had ‘confidently stated’ that the problem with her knee was a meniscus tear specifically on the lateral side, which would be repaired by surgery. She stated that she would have likely asked more questions and considered alternative options if she had known that the surgery would be ‘exploratory’ in nature.

28. Ms A told HDC that Dr B never discussed the risks of surgery or management of her knee condition at any time during this consultation.

29. Dr B told HDC that following the consultation, he gave Ms A a written information sheet on knee arthroscopy (see Appendix B). Ms A did not comment on whether she received this information sheet. The sheet included information about recovering and the potential complications following the knee arthroscopy procedure.[11] However, the version provided to Ms A did not contain any information about the risks of the surgery itself, nor the likelihood of a successful outcome. Dr B told HDC that the information sheet has since been updated to include this missing information.[12]

30. Dr B acknowledged to HDC that the likelihood of success of the surgery was not discussed with Ms A until the time of the ‘surgical consent process’, which was on the day of surgery.

Consideration of alternative treatment

31. Dr B told HDC that he considered that further ‘conservative’ treatment options would have been unhelpful for Ms A, given that there had been no improvements since she had injured herself over four months previously. Dr B did not explain to Ms A what the ‘conservative’ treatment options may have been.

32. Dr B told HDC:

> ‘[Ms A] could have considered persisting with her symptoms in the hope of spontaneous resolution. Given she had no improvement over more than 4 months after her injury I felt that further conservative measures would be unhelpful.’

5 May 2020 — knee surgery

33. Following the preoperative consultation, Dr B did not see Ms A until the day of surgery.

34. On 5 May 2020, Ms A presented to the private hospital for the planned left knee arthroscopy and debridement. The nursing notes document that Ms A was stable and was made aware to contact ACC for any additional support post-surgery.

35. The consent form for the surgery was signed by Ms A before the surgery began at around 3.15pm. Ms A told HDC that she saw Dr B only once she was by the theatre room door.

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[11] Although uncommon, complications include excessive bleeding from the wounds or soaking of the dressing after the operation, excessive swelling, deep vein thrombosis, infection, and fluid leakage from the incision. The patient is advised to seek nursing staff on the ward or consult their own GP if these complications develop.

[12] See the ‘Outcome’ section in Appendix B. Dr B also told HDC that the terms ‘complications’ and ‘risks’ of surgery are used synonymously, so he considered that the only update required in the patient information handout was a statement regarding the possibility that the surgery may not achieve its intended goal.

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36. Dr B told HDC that the consenting procedure was done by him and then by the anaesthetist. Dr B stated that the standard risks of surgery and likelihood of surgical success were discussed at this point. Ms A feels that the consent process was rushed and that she was not in a position to consider the information or change her mind. Ms A told HDC:

> '[Dr B] did not inform me of the probability of a successful/unsuccessful outcome from surgery until I was on the stretcher waiting outside the operating theatre. I had no time to consider this information before surgery.'

37. Dr B explained to HDC that at the private hospital, there is a designated curtained off preoperative area near the operating theatre where the consent process occurs.[13] Dr B said that this provides context that the consenting process took place in an appropriate environment and was not done on 'a stretcher'.

38. The consent form signed by Ms A included a clause that stated that the patient 'understands that any further treatment/procedure may be carried out should they be found necessary during the course of the operation/treatment'.

Surgery and unexpected findings

39. During the arthroscopic examination of Ms A's knee joint, Dr B found that contrary to his understanding of the MRI report, the tear of the lateral meniscus did not come into contact with the interior surface of the bone. Dr B told HDC that at this point, he became aware that the tear was only interstitial (situated in-between) and stable. This meant this was 'unlikely to be the cause' of Ms A's pain and knee issues.

40. The arthroscopic examination revealed an unexpected finding that a small unstable tear was present in the medial meniscus. Dr B explained to HDC that the tear was too small to have been detected by the MRI reported earlier in February 2020. Given that only minimal debridement was required, Dr B decided to debride the tear in the medial meniscus during the surgery.

41. Dr B told HDC:

> 'Essentially, arthroscopic examinations of [Ms A's] knee did not concur with findings noted in the MRI report. This kind of discrepancy is not uncommon. Although MRI is the gold standard investigation as far as imaging soft tissues of the knee goes, it still comes with a rate of false results and is not considered more reliable than arthroscopic examination. In my view this is particularly true for assessing meniscus tears.'

[13] According to Dr B, usually patients are sitting in a comfortable chair during the consenting process.

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42. The surgical notes (operation notes) record that the lateral meniscus was normal[14] and that a 'small tear was noted in the body'. The medial compartment of Ms A's left knee was reported as having an Outerbridge Grade 3 finding.[15] Dr B told HDC:

> 'I note that the most significant finding on arthroscopic exploration was the moderate degree of arthritis. The degree of arthritis is reported as Outerbridge Grade [3] on my operative findings.'

43. Ms A told HDC that she had understood that the intent of the surgery was to perform a debridement of the lateral meniscus, as identified in the MRI report, and this did not happen. She stated that the debridement performed on the medial meniscus was not discussed with her following the surgery as she was told by hospital staff that there had been no problems with the surgery.

44. Dr B does not dispute this. The nursing notes documented that the surgery was explained (without any further details written as to what was explained). The debridement of the medial meniscus was not referred to in the discharge summary.

45. Following the surgery, Ms A was transferred to the general ward for further observation and recovery. A physiotherapist was arranged to see her the next day and assess her knee. Pain relief medication was also prescribed.[16]

46. Ms A was discharged from the private hospital the following afternoon (on 6 May 2020) with planned follow-up with Dr B in three weeks' time. It was documented that Ms A was given a copy of the discharge summary and told to attend her nearest White Cross physiotherapy clinic if she had any concerns after the operation. Dr B told HDC that he also gave Ms A a written copy of the postoperative instructions.

26 May 2020 — postoperative consultation with Dr B

47. On 26 May 2020, Ms A presented to Dr B at the orthopaedic clinic for the postoperative consultation.

48. During this presentation, Ms A told Dr B that her knee problems had not improved following the surgery, and she had been experiencing a higher level of pain. Ms A told HDC that she felt that Dr B was dismissive of her concerns, stating that it was 'probably arthritis' and there was unlikely to be anything further he could do, unless she wanted a knee joint replacement. Ms A told HDC:

[14] This is recorded as 'NAD' (no abnormalities detected).

[15] The Outerbridge classification is a grading system for joint cartilage breakdown in the patella and for chondral lesions. Grade 3 generally represents fissuring to the level of subchondral bone in an area with a diameter more than 1.5cm.

[16] This included paracetamol, tramadol, Celebrex and omeprazole.

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> 'This was an unnecessary, unhelpful, arrogant statement that caused me much distress. I was dismissed with a referral to a physiotherapist with no explanation of what the expectations were of this referral. I was just hurriedly fobbed off.'

49. The consultation notes from this appointment record that although the wounds had healed, the arthroscopic debridement had not helped Ms A, as she continued to experience ongoing pain. It was also noted that Ms A would continue with physiotherapy, and that both Ms A and Dr B agreed not to proceed with a knee joint replacement in light of degenerative changes to her knee.

Discussion of surgery findings

50. Ms A told HDC that during the postoperative consultation, Dr B 'did not discuss what actually happened during the surgery'. Ms A stated that she had to raise questions with Dr B before she was informed that the medial meniscus had been debrided instead of the lateral meniscus. The consultation notes do not describe any discussion taking place about the surgery performed, the unexpected findings, or the questions Ms A raised during this consultation.

51. At this consultation Ms A was provided with a copy of the operation notes, which included the surgical findings and a description of the procedures performed. Ms A described the notes as 'vague', containing no further elaboration on why the debridement of the lateral meniscus had not been performed. Ms A was also concerned that the notes did not contain sufficient information about the medial tear that was repaired. The operation notes recorded: 'Medial Meniscus: Small tear noted in the body | Lateral meniscus: NAD.' Ms A noted that none of this information was discussed with her during the consultation.

52. In relation to the postoperative consultation, Dr B told HDC:

> 'I note that I informed her of the degenerative change visualized at the time of surgery. I advised [her] that she may benefit from physiotherapy for which a referral was given. I made no record [of] discussion about whether or not a meniscus tear was noted or debrided. Although [she] left the consult with a copy of my operation note with the surgical findings and procedure performed, it disappoints me that I may not [have] discussed this with her …'

53. Dr B told HDC that he takes 'full responsibility' for any resulting anxiety caused to Ms A.

Events after postoperative consultation

54. Following the postoperative consultation, Dr B referred Ms A for physiotherapy as part of her management plan. Dr B told HDC that this was the last time he saw Ms A, and he did not order any further diagnostic tests, as he understood she had obtained a second opinion from a separate provider.

55. Ms A was not satisfied with the care provided by Dr B and wrote to the orthopaedic clinic on 29 May 2020. She explained that she was experiencing the same significant pain as prior to her surgery and was 'not satisfied with [Dr B's] explanation for this and lack of any further plan to address the matter other than a referral for physiotherapy'.

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56. On 1 July 2020, Ms A sent a further email to Dr B expressing concern that he had not given her any indication that there had been issues with the surgery, and had put her continued pain down to arthritis, which had not been discussed previously. The email from Ms A to Dr B stated:

> 'Immediately following the surgery I was told by hospital staff that all had gone well/no concerns. I returned to see you in 3 weeks later for a post op consultation. I explained that I had the same symptoms and pain as before the surgery. You gave me no indications that there had been any issues with the surgery and put my continued pain and discomfort down to arthritis which had not been previously discussed and referred me to a physio therapist.'

57. Ms A informed Dr B that she had had a further MRI on 15 June 2020, which reported the lateral meniscus tear as remaining the same as prior to the surgery.[17]

58. Ms A told HDC that Dr B responded to her emails on 2 December 2020, following her complaint to this Office. Ms A felt that this response was an apology without any admission of any significant wrongdoing.

Further information received

Ms A

59. Ms A told HDC that following the arthroscopy surgery she was unable to walk any distance and could not sit or stand for any period of time without feeling pain. She was unable to sleep because of the pain and distress. Ms A stated:

> 'I have developed depression and anxiety along with a mistrust of the medical profession. The result of [Dr B's] actions have impacted on me physically, socially and mentally.'

60. In an undated letter to Dr B written after the postoperative consultation, Ms A also stated:

> 'I expressed my concern to you that the pain in my knee was the same, if not worse than before the surgery and I had felt no benefit from the surgery. You were dismissive of my concerns and distress. Stating it was probably arthritis and there was nothing more you could do for me unless I wanted a knee replacement … The intent of the surgery was to perform a debridement of the lateral meniscus because of the tear noted on the MRI report which you had identified as the cause of my knee pain. This did not happen. Instead you claim you performed a debridement of the medial meniscus but never divulged this to me until I raised questions.'

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[17] The MRI reported: 'No change in the abnormal T2 hyperintensity of the meniscal body extending to the inferior articular surface. Remainder of the meniscus is intact. No through-and-through tear. No para meniscal tear.' The report concluded that there was 'no change in the partial tear of the lateral meniscus'.

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Dr B

61. Dr B told HDC that he was not aware of the misunderstandings about the surgery, and Ms A's concern about the discrepancy between the MRI report taken on 11 February 2020 and the arthroscopic findings, until he read Ms A's email of 1 July 2020.

62. Dr B asked whether Ms A would like to see him again but said that he understood that she had sought a further opinion on her knee from another provider.

Responses to provisional opinion

Ms A

63. Ms A was provided with an opportunity to comment on the 'information gathered during investigation' section of the provisional opinion. Ms A was unable to be reached for comment.

64. Ms A had indicated to HDC during the process that she wished only to receive a copy of this report from HDC. A copy of the report has been sent to her via email.

Dr B

65. Dr B was provided with an opportunity to comment on the provisional opinion. He agreed with the finding that his care of Ms A was 'below acceptable standard and in breach of the Code of Health and Disability Services Consumers' Rights'. Dr B submitted several points of clarification, and these have been incorporated into this report where relevant.

66. Dr B told HDC that he does not agree with the implication that surgery 'would be a necessity' or that he explicitly told Ms A that the intention of the surgery was to debride the lateral meniscus. Dr B submitted that his preoperative consultation note (see paragraph 23) stated that it was reasonable to have Ms A's knee assessed arthroscopically and debrided if appropriate. He said that this did not imply to Ms A that the procedures came with 'the guarantee of successfully alleviating her presenting symptoms'.

Opinion: Dr B — breach

Introduction

67. This opinion concerns the care provided to Ms A by Dr B. I have considered all the evidence collected during the course of this investigation, including information provided by Dr B and Ms A. To assist in determining whether the care provided was of an appropriate standard, I obtained independent advice from an orthopaedic surgeon, Dr John McKie (see Appendix A).

Preoperative consultation

Inadequate physical examination

68. Ms A told HDC that during the preoperative consultation on 17 February 2020, Dr B did not examine her physically. Although the clinical notes taken by Dr B recorded that Ms A had a

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limp to her left side and had problems flexing her left knee, they do not document any further physical examination taken.

69. Dr McKie advised HDC that an orthopaedic surgeon would normally be expected to 'physically examine the patient and look for localised signs of joint margin tenderness, effusion in the joint and tests of meniscal irritability'. This was particularly important given the context of Ms A's age and knee pain that was present following a fall.

70. I note that there is no documentation to suggest that Ms A's knee was examined for any of these signs. Dr B told HDC that he cannot recall the examination with Ms A but acknowledged that his clinical notes describe only the observation of her gait and the limited range of knee motion. Dr B stated:

> 'I agree with Dr McKie that a clinical examination limited to that which I have documented is inadequate. I acknowledge this as a key shortcoming in my initial consultation with [Ms A] that I have no explanation for.'

71. Based on the evidence available to me, I consider that a physical examination was not done to the accepted standard for an orthopaedic surgeon. I accept Dr McKie's advice regarding the normal physical examination expected of an orthopaedic surgeon, and I am critical that there is no evidence that this occurred.

Failure to obtain basic medical history and to consider other potential causes of pain

72. Ms A told HDC that during the preoperative consultation, Dr B did not ask her about the basic medical history of her pain and symptoms, and only queried whether her knee would become locked. Ms A stated that no consideration was given to other probable causes of her knee pain, including osteoarthritis.

73. On the other hand, Dr B told HDC that the preoperative consultation note did record the mechanism of injury to Ms A's left knee, the date of her injury, the site of her knee pain, the presence of locking and that her symptoms were disabling to her.

74. Dr B's contemporaneous preoperative notes describe Ms A's gait and a record of her range of knee motion. The clinical notes document 'postero-lateral knee pain consistent with a lateral meniscus tear', with no other discussion recorded about Ms A's basic medical history or other probable causes of the pain in her knee.

75. Dr McKie noted that the MRI scan[18] performed in February 2020, on which Dr B based his decision to offer the knee arthroscopy, showed abnormal high signals (bright areas in the MRI) but did not necessarily show a discreet tear in the meniscal cartilage. Dr McKie considered that the MRI also showed moderate chondral thinning to Ms A's knee, which he

[18] An MRI scan is often used to diagnose meniscal injuries. The meniscus shows up as black on the MRI. The MRI diagnosis is based on the presence of linear signal changes (brightness of an area) that come in contact with the meniscal surfaces.

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said would be consistent with 'early, potentially hitherto asymptomatic evolving osteoarthritis in the knee joint'.

76. Dr McKie told HDC that this should have been raised with Ms A as a possible alternative cause of her knee pain, ahead of the surgery. He stated:

> 'I would expect most surgeons to inform the patient that their symptoms may in fact be due to previously asymptomatic articular chondral change rather than any mechanical derangement of the menisci.'

77. There is no evidence that this occurred. I consider that during the preoperative consultation, there was no consideration given to the other potential causes of Ms A's knee pain (such as osteoarthritis) before making the decision to proceed to surgery. In my view, this was particularly important given that MRI comes with a rate of false results, as Dr B acknowledges.

Adequacy of information provided about arthroscopic surgery

78. Ms A also raised concerns about the adequacy of the information provided to her about the surgical procedure itself. Ms A told HDC that during the preoperative consultation she was not made aware that the procedure was exploratory in nature and that it might involve debridement of the medial meniscus (as opposed to the lateral meniscus).

79. Dr McKie advised that normally, a surgeon would not need to inform a patient that the knee arthroscopy and debridement was intended only for the lateral meniscus. A surgeon was also unlikely to specifically state all the technical components of any potential surgery in different parts of the knee.

80. However, Dr McKie noted that for patients with known abnormalities in the knee, as in Ms A's case, Dr B would have been expected to include a clear explanation on the expectation that any other clinically important abnormalities identified during surgery would be managed appropriately.

81. Dr McKie said that most surgical consent forms include a clause acknowledging that 'sufficient explanation' has been given to the patient and/or allowing any further surgery that may be deemed necessary and appropriate at the time. I note that a similar clause was present in the consent form signed by Ms A, which stated that the patient 'understands that any further treatment/procedure may be carried out should they be found necessary during the course of the operation/treatment'.

82. However, Ms A told HDC that she was told that the surgery was specifically intended only for her lateral meniscus, with no further discussion about any other uncertainties or the possibility of any additional surgery.

83. I also note that although the MRI report from 11 February 2020 suggested that the lateral meniscus tear was only a 'possibility', Dr B did not communicate this to Ms A, nor did he inform her of the possibility of a false result from the MRI.

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84. In summary, I consider that the information Dr B provided to Ms A about the procedure was inadequate. If the surgery was exploratory in nature and there was any degree of uncertainty about what might be causing Ms A's pain and what might need to be done during the surgery, this should have been communicated to her. I am critical that this did not happen.

Discussion of alternative treatments

85. Ms A told HDC that during the preoperative consultation, Dr B did not discuss any alternative treatment options with her. Dr B told HDC that Ms A could have considered persisting with her symptoms in the hope of 'spontaneous resolution'. However, he considered that 'conservative' measures would not have been helpful for Ms A, given that she had had no improvement over a period of four months.

86. Dr B did not explain further to HDC what he meant by 'conservative' measures. However, I note that when the surgery did not alleviate Ms A's ongoing symptoms, he advised that she should continue with physiotherapy. I consider that this was a possible 'conservative' measure that could have been recommended prior to surgical intervention.

87. It is a reasonable expectation for a patient in Ms A's circumstances that a specialist will discuss different treatment options (including, if appropriate, conservative management). This allows the patient time to ask further questions, consider the options, and make an informed choice. Whilst Dr B may have considered that conservative treatment would not be beneficial to Ms A, I make a finding that this was not communicated to her.

Discussion of risks of surgery and likelihood of success

88. Ms A told HDC that during the preoperative consultation, Dr B did not advise her on the likelihood of the surgery being successful, the possibility that it might not relieve her ongoing pain, and the risks of the surgery. Ms A said that as a result, she did not ask any further questions and accepted that the surgery would be successful.

89. Dr B told HDC that following the preoperative consultation, Ms A was provided with a patient information sheet with further information about the knee arthroscopy. However, Dr B confirmed that the information sheet provided to Ms A at the time of events did not include details of the risks of the surgery, and the likelihood of success. Dr B told HDC that these details have now been added to the document (see Appendix B).

90. Dr B told HDC that the likelihood of the surgery being successful was discussed with Ms A verbally on the day of surgery. Ms A told HDC that this happened when she was outside the theatre, and at this point she did not have sufficient time to consider the information, and she felt rushed.

91. Dr McKie advised that normally there would be some discussion of the likelihood of success, both during the preoperative consultation and on the day of the surgery. He said that he would expect the discussion on the day of the surgery to be 'in general terms only'.

92. In previous decisions I have stressed the importance of a patient having all the relevant information available to them in sufficient time, so that they can reasonably consider that

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information and make an informed choice. In this case, it appears that Ms A was not informed about the likelihood of success of the surgery until the day of the surgery. I am critical of this and note that Dr B has acknowledged and apologised for this oversight.

Postoperative consultation 26 May 2020

93. Following the surgery on 5 May 2022, Dr B saw Ms A for a postoperative consultation on 26 May 2020. During this presentation, Ms A told Dr B that the pain in her knee had not improved. Ms A said she felt that Dr B dismissed her concerns by referring her for physiotherapy without further explanation.

94. Ms A raised concerns that Dr B withheld information from her about the unexpected findings during the surgery, ie, that Dr B did not perform debridement of the lateral meniscus as intended and had instead debrided the medial meniscus without her knowing. Ms A described the surgical notes she received during the postoperative consultation as 'vague'. The notes stated that there were no abnormalities in the lateral meniscus.

95. Dr B acknowledged to HDC that his notes from the postoperative consultation do not record any discussion with Ms A about whether or not 'a meniscus tear was noted or debrided'. He also acknowledged that he may not have discussed the findings of the surgery with Ms A in any detail during this consultation. I note that the notes from this consultation simply refer to Ms A's presentation of ongoing pain and possible treatment options (ie, physiotherapy and knee joint replacement).

96. Dr McKie advised:

> 'It would normally be expected where findings, interventions or outcomes are at variance with what is expected preoperatively, that a record of the discussion and explanation with the patient would be made to protect the surgeon about any criticism further down the track when the nature of such conversations may not be able to be accurately recalled.'

97. Dr McKie told HDC that this was important in this case and Dr B should have explained the surgical findings and arthritic change in greater detail for Ms A.

98. I note, however, that Dr McKie stated in his further advice dated 19 June 2022 (Appendix A) that '[he] does not believe that there [has] been any departure from the accepted standard of care at the post operative visit'. Whilst I acknowledge my independent advisor's view that there was no departure in care, I respectfully disagree.

99. In my view, it was Dr B's responsibility to communicate the actual results of the surgery to Ms A, including the fact that the medial meniscus had been debrided rather than the lateral meniscus. It was important that Dr B explained to Ms A that her symptoms and pain were more likely related to the arthritic changes in her knees. This should have been communicated in a manner that enabled Ms A to understand, process, and retain this new information. Based on Ms A's description of the events, it is clear to me that this did not happen.

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Conclusion

100. Whilst I am satisfied that the surgery itself was technically of an acceptable standard, Dr McKie made the following comment about the overall standard of care Dr B provided to Ms A, which I accept:

> 'While [Dr B's] decision to arthroscopically evaluate [Ms A's] knee may well have been motivated out of her best interests and care, in retrospect I think the decision was probably ill advised. The lack of adequate clinical examination, correlation of the clinical and imaging findings, adequate discussion and interaction with the patient along with some deficiencies in record keeping would suggest that the care he offered did fall below that expected of a Consultant Orthopaedic Surgeon.'

101. I consider that during the preoperative consultation on 17 February 2020 and before making the decision to proceed with the arthroscopy, Dr B failed to provide services to Ms A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), by:[19]

a) Failing to undertake an adequate physical examination of Ms A, including her knee joint; and

b) Failing to obtain a basic medical history from Ms A and to consider and discuss the other potential causes of the pain in her knee, including the evolving osteoarthritis as indicated by the MRI report (and noted by Dr McKie).

102. I consider that Dr B also failed to provide Ms A with the information that a reasonable consumer, in Ms A's circumstances, would have expected to receive about the procedure during the preoperative consultation, and therefore breached Right 6(1) of the Code, in the following ways:[20]

a) Dr B did not inform Ms A adequately that the small tear in the lateral meniscus was noted only as 'possible' on the MRI report, and that MRI comes with a rate of false results;

b) Dr B did not inform Ms A adequately of any conservative treatment options, what this may have entailed, and the appropriateness of these options;

c) Dr B did not provide Ms A with adequate information about the arthroscopic surgery itself, including that it was exploratory in nature; and

d) During the preoperative consultation, Dr B did not discuss the risks of the surgery and the likelihood of success, including the risk that it might not alleviate her ongoing symptoms, and instead informed Ms A of this only on the day of the surgery.

---

[19] Right 4(1) of the Code states: 'Every consumer has the right to have services provided with reasonable care and skill.'

[20] Right 6(1) of the Code states: 'Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive.'

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103. I consider that without the information outlined above, Ms A was unable to make an informed choice, and did not give informed consent to the procedure. Accordingly, I consider that Dr B also breached Right 7(1) of the Code.[21]

104. In addition, I consider that following the surgery, Dr B did not communicate the results of the procedure to Ms A adequately. This included that the medial meniscus had been debrided rather than the lateral meniscus, and that Dr B now thought that Ms A's symptoms and pain were more likely related to evolving arthritic change in the knee. As such, I consider that Dr B also breached Right 6(1)(g) of the Code.[22]

Changes made since complaint

105. Dr B told HDC that he has made the following changes to his practice in light of Ms A's complaint:

a) While discussing treatment options at the time of a clinic consultation, he ensures that the patient understands that the intended goal of the surgical treatment is not always achieved. He also highlights the possibility that findings at the time of surgery may in some instances differ from the MRI report.

b) He has amended the patient information handout for knee arthroscopy to include a section on the expected outcome following the procedure. The new section describes the possibility of persisting knee pain following the surgery, and that full recovery may not be possible if the articular cartilage has evidence of wear (see Appendix B).

c) At the time of obtaining surgical consent for patients for knee arthroscopy, he informs the patient that the outcome of the surgery is dependent on the operative findings and what can be done to treat the noted pathology.

d) During the postoperative follow-up, he goes over the findings with the patient. If the symptoms persist, he takes extra care to discuss why this may be, based on the operative findings, and explains the surgery that was undertaken. He then discusses further management options should the patient's symptoms persist.

[21] Right 7(1) of the Code states: 'Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Codes provides otherwise.'

[22] Right 6(1)(g) of the Code states: 'Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including the results of procedures.'

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Recommendations

106. In considering the changes already made, I recommend that Dr B:

a) Provide a written apology to Ms A for the breaches of the Code and deficiencies in care identified in this report. The apology should include the changes he has made in response to Ms A's complaint. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

b) Reflect on his failings in this case, in particular the deficiencies in communication during both the preoperative and postoperative consultations, and provide a written outline of his reflections and the changes he has made to his practice as a result of this case. This is to be sent to HDC within three months of the date of this report.

c) Undertake an audit of documentation and clinical records for a selection of 10 orthopaedic cases since 30 June 2022, to assess whether the changes made in documentation have been followed and, if not, what further action will be taken to address this. The results of the audit are to be sent to HDC within three months of the date of this report.

Follow-up actions

107. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name.

108. A copy of this report with details identifying the parties removed, except the advisor on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from orthopaedic consultant Dr John McKie:

> 'Thanks for asking me to provide independent expert advice to the Commissioner in the complaint of [Ms A] against [Dr B], Orthopaedic Surgeon.
>
> I have taken time to review all the documentation that has been sent to me and have also sourced the radiography imaging and independently reviewed these.
>
> You have asked me to review this documentation and advise whether I consider the care provided to [Ms A] by [Dr B] was reasonable in the circumstances, with particular emphasis on
>
> a) the preoperative consultation on the 17th of February 2020 and
>
> b) the post-operative consultation on the 26th of August 2020.
>
> Regarding the initial consultation, the complainant asserts that this interaction took approximately 10 minutes and at no stage did [Dr B] actually physically examine her. Neither of these accusations are discussed or refuted by [Dr B] in his response, leading me to assume that this is an uncontested and accurate summary of the clinical consultation.
>
> [Dr B] notes in his response that following triage of the general practitioner's referral letter, he arranged for the patient to have an MR scan done of her knee prior to the consultation. This is an entirely reasonable action, particularly for a patient with noted symptoms following a fall who lived remote from the centre where care was to be provided.
>
> It would be expected that a surgeon would physically examine the patient, in particular looking for localised signs of joint margin tenderness, effusion in the joint and tests of meniscal irritability in a lady [in her fifties] presenting with knee pain following a fall.
>
> The MR scan from the 11th of February 2020 on which [Dr B] made his decision to offer arthroscopic evaluation and debridement did show high signal change in 2 slices of the lateral meniscus, but also clearly showed "moderate chondral thinning over the medial femoral condyle". These reported findings would be consistent with early, potentially hitherto asymptomatic evolving osteoarthritis in the knee joint.
>
> Without clinical examination, assessment to endeavour to localise tenderness and symptoms within the knee in the presence of an MR scan only showing subtle change in the lateral meniscus in 2 slices, while clearly showing chondral changes on the articular cartilage in the medial side of the knee might be considered bold. The findings described on the scan and subsequently confirmed with arthroscopic evaluation would be unlikely to cause mechanical locking of the knee and with the obvious presence of chondral change in the medial compartment, I would expect most surgeons to inform

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the patient that their symptoms may in fact be due to the previously asymptomatic articular chondral change rather than any mechanical derangement of the menisci.

With respect to whether it was reasonable for [Dr B] to inform [Ms A] that arthroscopic surgery and debridement was only intended for the lateral meniscus, this would not be a normal expected discussion pre-surgery. It would be expected that a surgeon, having made a clinical diagnosis with radiological confirmation and support, would embark on arthroscopic evaluation and surgery with the intent of dealing with the preoperatively known abnormalities in the knee. This would normally be discussed with the patient in the preoperative planning and consenting for the surgery with the clear expectation that any other clinically important abnormalities that were identified at surgery would be managed appropriately.

Most consent forms, including the one that [Ms A] signed prior to her surgery, include a clause acknowledging sufficient explanation has been given and/or allowing further and additional surgery which may be deemed necessary and appropriate at the time.

I would consider a patient would have a just complaint if a surgeon went to, for example, excise a known tear of the medial meniscus, discovered a lateral meniscal tear which hadn't been previously identified or discussed and then didn't deal with it at the time under the same anaesthetic. This situation would lead to the patient having to have ongoing morbidity and further anaesthesia and surgery when the problem could have been easily attended to in the index procedure.

With respect to the question whether it was reasonable to discuss the likelihood of a successful outcome of the surgery preoperatively, the answer to this is clearly yes and I note in the documentation provided that [Dr B] has amended the formal information he gives patients to cover this fact going forward.

As noted above, with respect to the management of unexpected findings, most surgeons are likely to discuss preoperatively, albeit in general terms, that they will deal with the problems or abnormalities as appropriate, but wouldn't be expected to specifically specify all the technical components of potential surgery in different parts of the knee.

With respect to the adequacy of [Dr B's] clinical notes to be an accurate reflection of the interaction, as noted above the patient claims that she wasn't physically examined and [Dr B's] examination findings are very limited and presumably only relate to observation of her gait into the room and sitting in a chair.

The notes also only annotate changes in the knee specific to the lateral meniscus from the imaging that had taken place.

One would normally expect a fuller record of examination findings, however, if no such significant examination occurred, the notes are then in fact an accurate record of the interaction.

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With respect to the post-operative consultation on the 26th of August 2020, [Dr B] acknowledges that he didn't formally discuss in detail the findings and what had actually occurred at surgery and acknowledges this was deficient and inappropriate on his behalf.

[Dr B] acknowledges that he made no record of any discussion regarding meniscal tears and the debridement that took place. He acknowledges that this was an omission on his behalf.

It would normally be expected where findings, interventions or outcomes are at variance with what is expected preoperatively, that a record of the discussion and explanation with the patient would be made to protect the surgeon against any criticism further down the track when the nature of such conversations may not be able to be accurately recalled. This would be especially important in this case where the lateral meniscus, which was thought to be the cause of her problems on the preoperative assessment and scan, was in fact noted to be stable and not grossly torn or overtly damaged at arthroscopy.

Given that [Dr B] now felt that the patient's symptoms were more likely to in fact be due to evolving arthritic change in her knee, he might reasonably have been expected to expand on this in more detail and discuss what the role and objectives of the suggested physiotherapy were to help with these symptoms.

Item 3, other issues.

a) Was the surgery performed by [Dr B] reasonable in the circumstances of [Ms A's] presenting symptoms?

The clear vision of hindsight would suggest that surgery was probably not helpful to the patient. However, if [Dr B] firmly believed the abnormalities noted in the lateral meniscus on the MR scan were indeed the cause of her problems, proceeding to surgery could be justified. The fact that the meniscus was in fact intact and not unstable at surgery and that there is no clear documented evidence of any formal examination preoperatively does tend to weaken indication and argument in favour of a surgical procedure.

b) [Ms A] states that she was advised after surgery that moderate arthritis was the cause of her ongoing knee pain. Should this have been raised with [Ms A] as an alternative cause of the pain ahead of surgery?

The answer to this question is yes particularly, as noted above, when the potential mechanical abnormalities due to a tear or derangement of the meniscus were small and there was obvious noted chondral change in the medial compartment which was reported on the MRI scan report.

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a) Was the surgery performed by [Dr B] of a reasonable standard?

While I don't have any arthroscopic imaging, there is nothing to suggest that the surgery was not reasonable or efficiently carried out technically.

[Dr B's] note in his response that trimming of a minor tear in the meniscus didn't result in any noted change on the subsequent MR scan is entirely plausible and believable.

While I am sure [Dr B] has reflected on this case significantly, and I dare say given the same circumstances again may not have proceeded to surgery so rapidly, there is no suggestion that his actions have worsened or done any further damage to [Ms A's] knee.

Her statements that she is enduring disabling pain and can't sit or stand do not tally with the objective findings in her knee either on the basis of the arthroscopic evaluation, the subsequent MRI, or from the clinical assessment of [an orthopaedic surgeon] subsequent to this case.

While [Dr B's] decision to arthroscopically evaluate [Ms A's] knee may well have been motivated out of her best interests and care, in retrospect I think the decision was probably ill advised. The lack of apparent adequate clinical examination, correlation of the clinical and imaging findings, adequate discussion and interaction with the patient along with some deficiencies in record keeping would suggest that the care he offered did fall below that expected of a Consultant Orthopaedic Surgeon.

While there is no suggestion that her surgery has caused any further damage or deterioration to her knee, it may well have amplified or exaggerated her current pain response.

The patient has made claims regarding [Dr B] indulging in fraudulent behaviour. On this case alone there is no evidence to support this claim and even if his decision in hindsight was inappropriate, it was most likely made with the patient's well-being and relief of symptoms in mind.

Yours sincerely

JOHN MCKIE, MB ChB, FRACS
Orthopaedic Surgeon
Med Council No: 13530'

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Further clarification was obtained from Dr McKie on 19 June 2022:

> 'Thanks for your email requesting further clarification.
>
> Clinical medicine is founded on the principle of making a diagnosis, understanding the natural history of the condition and intervening to alter the natural history when and where it is prudent and possible to do so. Making a diagnosis involves a combination of obtaining a history of the presenting complaint, performing an appropriate, relevant clinical examination and using additional adjunctive investigations.
>
> As investigations often play a major part in surgical decision making, it is easy to focus unduly on them at the expense of the basic history and examination.
>
> This is what has been asserted by the patient and has not been refuted by [Dr B]. As noted previously, there is no evidence to support the claim that this was in any way malicious in intent, however it has resulted in the patient having a surgical procedure that would have better been avoided.
>
> As a consequence of this, and in the light of the significant issues that the patient has subsequently experienced, my view is that this is a moderate breach of the expected standard.
>
> Regarding the post-operative visit, there is a clear variance between what has been recorded in the contemporaneous record and what the patient has "heard". This is not an uncommon situation especially if the news is unexpected or disappointing. Both parties have acknowledged discussion of the status of the knee, the role for physiotherapy and the possible future role of joint replacement surgery.
>
> Having further reviewed the records, I don't believe that there has been any departure from the accepted standard of care at the post-operative visit. The patient was clearly very disappointed in the outcome of her surgery. The seeds of this disappointment were sown at the initial consultation where the assessment left her with an inappropriate expectation of the potential outcomes of surgery to her knee.'

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Appendix B: Patient information on knee arthroscopy

The following information sheet about knee arthroscopy was provided by Dr B on 1 December 2020:

‘***[Dr B] FRACS***

— Orthopaedic Surgeon —

Patient Information
Knee Arthroscopy

During an arthroscopy, a camera is inserted into the knee through two or three small puncture wounds. It allows the surgeon to look at the joint surfaces, cartilage and the main ligaments of the knee. The operation is usually carried out under a general anaesthetic.

Why it is done?

As well as allowing the surgeon to see the problem, some procedures can be performed.

- Repair or removal of torn cartilages. These are shock absorbers of the knee and are commonly damaged as a result of sports injury or simply “wearing out”.
- Damage to the knee cap and the joint surfaces can be trimmed or shaved.
- Small holes (micro-fractures) can be made in the bone to stimulate new cartilage growth.
- Removal of loose bodies such as bone, cartilage or debris from the joint.
- If inflammation is present, samples from the lining of the joint can be taken.

What happens before I come into hospital?

This information will help you prepare for admission to hospital. Treatment is always planned on an individual basis so your experience may differ slightly from the information given.

[Dr B] operates at both [the private hospital] and [the orthopaedic clinic]. If you do not go home on the day of your surgery, it will be done at [the private hospital].

All our staff are friendly and available to help answer any questions that you may have at any stage of your treatment.

Pre-assessment

If there are concerns around your fitness for an anaesthetic you may be asked to attend a pre-assessment. This is a medical examination made by the anaesthetist who works with [Dr B] to make sure you are well enough for surgery.

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Transport

Patients are responsible for their own transport to and from the hospital. You will be informed of your admission and discharge date in advance so that you can arrange for a relative, friend or taxi to transport you.

What happens on the day of surgery?

On the morning of your surgery you will be greeted by the staff at the hospital reception on your arrival. Before being taken to the theatre suite you will be greeted by the nursing staff who will be looking after you and ask you to change into a hospital gown to get you prepared for theatre. You will be assessed by [Dr B] and the anaesthetist to perform a final check that you are fit for surgery and answer any questions you may have. You will be asked to sign a form giving your consent to the operation. You will then go to theatre, accompanied by a nurse where your personal details and the operation will be confirmed.

How is it performed?

The skin around the knee is cleaned and sterilised. Two cuts are made at the front of the knee; one for inserting the camera and the others for instruments. Sometimes additional incisions are necessary. Fluid is inserted into the knee to allow the surgeon to see inside the joint and surgery carried out. The incisions are then closed with small sticky dressings (steristrips) and the knee is padded and bandaged.

Once you have recovered from the anaesthetic, you will be able to get up and a nurse will check you are walking safely before discharge.

Dressings

You can remove the outer-crepe bandage and cotton wool yourself at home 24 hours after surgery. After 14 days remove the remaining waterproof dressings and the steristrips.

If you are at all worried, concerned or unhappy with doing dressing care yourself please make an appointment with your practice nurse at your GP surgery.

After the operation

The knee may ache and swell following surgery and you will probably need to take some painkillers until this settles. Recovery from the operation is extremely variable and depends on many factors. Although your hospital stay is short, your recovery takes time. Although the incisions are small, the work done inside the knee itself may be complex and prolonged, causing inflammation and swelling.

There is often a leakage of clear fluid from the knee through the incisions in the first few days until the wound is healed. This can take several days to settle.

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In most cases you will be able to walk without crutches. Ice packs such as a bag of frozen peas wrapped in a tea towel will help to reduce swelling and can be applied, if needed, every hour for 15–20 minutes.

Work

The majority of patients should be walking without too much pain and able to do normal daily activities and sedentary (office-type) work within one to two weeks. If your job is more physical and involves climbing, squatting or lots of stairs, you will probably need two to three weeks off to recover. The small incisions may well be tender and lumpy and your knee may swell after activity for up to three months. You will be issued with an off-work certificate for 21 days before you leave hospital.

Driving

Driving is possible after five to seven days when your knee is feeling comfortable. Make sure you can bend and straighten your knee without excessive pain. Check that you can perform an emergency stop safely.

Sport

Strenuous physical activity can be resumed when your knee is feeling strong and comfortable and no longer swollen. This is usually after two or three weeks. It is advisable to gradually increase your level of activity to see how your knee copes. It will usually take six weeks before returning to competitive sport such as running, skiing, racquet and contact sports. Make sure you can hop, squat and sprint with changes of direction and make sudden stops and starts without pain.

Complications

Although uncommon, complications can occur following your surgery. These include:

- excessive bleeding from the wounds or soaking the dressing after the operation
- excessive swelling
- deep vein thrombosis (a clot in the lower leg veins)
- infection
- fluid leakage from the incisions after seven days.

If you are concerned in any way, please contact the nursing staff on the ward or your own GP for advice. If you develop a fever, severe pain or significant wound problems, you will need to see someone as soon as possible.'

On 5 July 2023, [Dr B] provided HDC with the current patient information sheet for knee arthroscopy, which now includes an 'Outcome' section as a result of the changes made:

'**Outcome**

The outcome of your surgery depends entirely upon what was found and what was done at the time of surgery. It is important to note that arthroscopic findings at the time

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of your surgery may not be entirely in keeping with what is reported on your MRI scan. For example, if the articular cartilage in your knee has evidence of wear, then full recovery may not be possible. In fact, in this scenario it is possible the procedure may provide no improvement in your pain. If a torn meniscus was found and removed, then you can usually return to your previous athletic activity.’

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