SPSO decision report

Case: **201502324, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained that a surgeon failed to properly carry out a laser prostatectomy (surgical removal or resection of the prostate gland) at the Queen Margaret Hospital causing him severe pain, blood loss and the need for further surgery two weeks later.

The board advised Mr C that the surgeon was assisted by a mentor experienced in this type of surgery, and no complications occurred during the procedure. However, they apologised that Mr C had experienced the recognised risk of post-operative bleeding. Mr C remained unhappy that there was a need for more surgery to address his pain and bleeding.

The laser surgery carried out is a relatively new technique which has not be universally adopted by urologists. We took independent advice from a consultant urological surgeon who has undertaken laser prostatectomy. We found evidence of poor record-keeping which fell below a reasonable standard in relation to Mr C being properly informed about all the risks associated with the laser surgery. We were also critical that there was no record of the surgeon's mentor having been present during the operation. Whilst we considered that there was no evidence of damage having been caused, the treatment was inadequate in removing tissue that was causing obstruction. We therefore upheld Mr C's complaint and made a number of recommendations to address the failings we identified.

Recommendations

We recommended that the board:

- apologise to Mr C for the failings identified;
- draw to the surgeon's attention the findings in relation to obtaining informed consent; and
- inform us of the outcome of their review and any action taken in relation to the surgical recording process.