# SPSO decision report

**Case:** **201601102, Greater Glasgow and Clyde NHS Board - Acute Services Division**
**Sector:** health
**Subject:** clinical treatment / diagnosis
**Outcome:** some upheld, recommendations


## Summary

Mrs C complained about the care and treatment given to her father (Mr A) after his referral to Glasgow Royal Infirmary. Mr A underwent a colonoscopy (his bowel was examined with a camera on a flexible tube), a number of polyps were removed and a likely cancer of the rectum was biopsied. He was discharged home but began to feel unwell and was later admitted to hospital as an emergency. He had a perforated bowel which required repair.

Mrs C complained that Mr A was not given appropriate advice about the risks of his initial surgery or about what to do if his health deteriorated after being discharged. She further complained that Mr A had not been fully advised of his state of health by the clinician who was treating him. In particular, she complained that he had not been told that his cancer had returned, for which he would be given no treatment as agreed by a multi-disciplinary team who discussed his case. Mrs C said that as a result, the family was not prepared when Mr C died, seven months after his initial referral to the hospital.

We took independent advice from a consultant general and colorectal surgeon. We found that before his operation, Mr C had been given clear information about the possible risks, including of the possibility of a perforation. Although Mr C became unwell following the procedure, we found that he had been given written advice about what to do in such circumstances. We therefore did not uphold this aspect of Mrs C's complaint.

We found that while Mr C had been told that his cancer had been removed and that, unlike most colorectal cancers, showed no further involvement in his liver, lungs or abdomen, he had not been told that, unusually, it had spread to his bones. In their reponse to Mrs C's complaint, the board said it was difficult to achieve the right balance in terms of how much information to give to patients and their families. In this case, Mr A had already undergone multiple surgeries and the multi-disciplinary team decided not to provide Mr A with chemotherapy because of his very weak and frail condition. However, we established that he and his family should have been told that the cancer had spread. This would have been in line with the General Medical Council guidance on effective communication. We therefore upheld this aspect of Mrs C's complaint.


## Recommendations

We recommended that the board:

- make the relevant staff aware of the outcome of this investigation;
- apologise for the failure to inform Mr C and his family of a multi-disciplinary team meeting and the decision it reached; and
- remind the clinician concerned of the relevant General Medical Council guidance.