SPSO decision report

Case: **201700981, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: not upheld, no recommendations

Summary

Mr C complained that the board unreasonably failed to provide him with appropriate care and treatment for his prostate cancer. He said that a consultant urologist (a doctor who specialises in medicine focusing on diseases of the urinary tract and the male reproductive organs) at Hairmyres Hospital advised him that his cancer was confined to his prostate, that it was T3 (had grown through the prostate capsule, outwith the prostate and was just outside the prostate) and that a laparoscopic radical prostatectomy (removal of the prostate via a small incision using robotic surgery) was an appropriate treatment. The consultant referred Mr C to a second consultant urologist at another board. Mr C said that when he was seen by the second consultant, he was told that the surgery proposed was not appropriate.

We took independent advice from a consultant urologist. We found that the first consultant referring Mr C for consideration of laparoscopic radical prostatectomy was appropriate and was in keeping with the West of Scotland Management Guidelines for prostate cancer. We found that, ideally, the first consultant should have pointed out that in their opinion Mr C's disease was suitable for radical prostatectomy, but that the final decision on suitability for surgery lay with the surgeon performing the surgery. The adviser explained that the main issue was one of a difference in clinical opinion between surgeons, and not a change in the extent of Mr C's cancer during the time between his appointments. On balance, we did not consider that the board unreasonably failed to provide Mr C with approprite care and treatment for his prostate cancer, and we did not uphold this aspect of the complaint.

Mr C also complained that the board unreasonably failed to arrange his referral for prostate surgery within a reasonable time and that they did not take the issue of the delay in arranging the referral appointment seriously. We found that the board had failed to respond to Mr C's phone calls about his referral and to take the issue of the delay seriously. We upheld this aspect of the complaint. We noted that the board had already apologised for this, and had taken steps to avoid this happening again in the future. We asked them to provide us with evidence of the action they had taken, however we made no further recommendations.