SPSO decision report

Case: **201704393, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained about the care and treatment she received at Queen Elizabeth University Hospital. Ms C attended a follow-up orthopaedic (the branch of medicine involving the musculoskeletal system) clinic at the hospital after hip surgery and explained she was experiencing discomfort in her ankle. She was found to have deep vein thrombosis (DVT, a blood clot in a vein) in her calf. However, other tests also showed that she may have secondary liver cancer. It was later found that she had primary breast cancer which had spread to her liver. Ms C complained about the way she was told about her diagnosis and that she was given inconsistent information about her illness. She also complained that her care was not appropriately personalised for her.

We took independent advice from consultants in acute medicine and clinical oncology (cancer treatment). We found that the doctor who told Ms C about her diagnosis had made a conscious decision to wait overnight before giving her the details because they wanted the opportunity to discuss the matter first with the breast cancer team. While we considered that this was a reasonable approach, when Ms C was told the following day, she was alone. This does not follow Scottish Cancer guidelines and Ms C appeared not to have been appropriately supported. Therefore, we upheld this aspect of Ms C's complaint. However, we did not find that Ms C had been given inconsistent information and we found that staff had adapted her care, as far as possible, to suit her needs. Therefore, we did not uphold these aspects of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to support her properly when giving her bad news. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Patients should be adequately supported when being given bad news and discussions with patients/relatives should be fully documented in medical records.