SPSO decision report



Case: 201800677, Greater Glasgow and Clyde NHS Board - Acute Services Division Clyde NHS Board - Acute Division Clyde NHS Board - Acute Division Clyde NHS Board - Acute Division Clyde NHS Board - Ac

Sector: health

Subject: clinical treatment / diagnosis

Decision: upheld, recommendations

Summary

Ms C complained about the care and treatment provided to her late husband (Mr A) by the board in relation to treatment of his cancer. Ms C raised concerns that after a scan which showed progression of Mr A's cancer, neither the radiologist (a doctor who specialises in diagnosing and treating disease and injury through the use of medical imaging techniques such as x-rays and other scans) nor oncologist (a doctor who specialises in the treatment and management of cancer) involved in his care contacted him to discuss this with him. Ms C said that Mr A did not discover that his cancer had progressed until he contacted his GP several month later. Ms C also complained that when Mr A was having palliative chemotherapy (a treatment for terminal cancer to prolong survival and minimise suffering, but which cannot cure the disease) the oncologist failed to identify or investigate his low haemoglobin (a protein in the blood that carries oxygen).

We took independent advice from a consultant oncologist. We found that it was reasonable that Mr A's low haemoglobin was not identified as he had not been reporting unusual symptoms. However, we found that the failure to contact Mr A to discuss his scan results was unreasonable. We determined that this was due to a miscommunication between the oncologist and radiologist and that the radiologist had changed their practices as a result of this complaint. However, we upheld Ms C's complaint and made a further recommendation to the board regarding this failing.

Recommendations

What we asked the organisation to do in this case:

Apologise to Ms C for the breakdown in communication which resulted in neither the oncologist nor
radiologist contacting Mr A to discuss the scan results. 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:

• When two or more specialists are involved in a patient's care, it should be clear who is going to contact them to discuss their ongoing treatment, and this contact should be made in a timely manner.