SPSO decision report

Case: **201405524, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C complained to us about the care and treatment he received from Stobhill Hospital when he had a circumcision operation. He complained that he had received poor treatment from nursing staff immediately after his operation. When he developed an infection in the wound, he sought specialist input. However, he complained that the surgeon did not examine him properly and dismissed his concerns. He returned to the same surgeon two more times over the following year, and was told that the wound had healed and nothing could be done to improve his discomfort. Mr C was then referred to a different surgeon who identified an issue with the way the scar had healed. He had another procedure which corrected this problem. Mr C said this should have been identified earlier. He also raised concerns about the way his complaint was handled.

We took independent advice from a nursing adviser and an adviser specialising in urology (relating to the urinary system and male reproductive system). They reviewed the care and treatment Mr C had received. The urology adviser noted that there was very little evidence that Mr C had been appropriately informed of the risks involved in the procedure prior to providing consent. However, he was satisfied that the operation was conducted appropriately, and that the follow-up consultations were reasonable. He said that the differences in the conclusions of the two surgeons related to their professional opinions about the scar, and this was reasonable. The nursing adviser was satisfied that nurses had monitored Mr C appropriately after his operation, and noted that the concerns he raised were not evident from his medical records.

We concluded that, while Mr C's operation had been reasonable, it appeared that he was not given enough information to provide informed consent, so the procedure was not conducted appropriately. We were satisfied that Mr C's subsequent examinations were reasonable. However, we found that the board had not provided a reasonable response when Mr C first raised concerns. When he persisted with his complaint, the board then took too long in providing a final response.

Recommendations

We recommended that the board:

- consider revising their leaflet for patients having circumcision taking into account the guidance from the British Association of Urological Surgeons and the Royal College of Surgeons;
- take steps to ensure adequate information is provided on the risks and potential complications of this procedure at an appropriate time prior to any decision being made to proceed with it, and that this is recorded;
- feed back the findings of this investigation to relevant staff; and
- apologise to Mr C for the failings identified.