SPSO decision report

Case: **201806513, Lanarkshire NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained on behalf of her in-law (Mr B) about the care and treatment provided to his wife (Mrs A). Mrs A was diagnosed with breast cancer and a full computerised tomography (CT) scan was carried out. The CT scan of Mrs A's chest, abdomen and pelvis showed liver and bony metastases (the development of secondary malignant growths) at a distance from a primary site of cancer. The head scan showed a 6mm lesion of uncertain significance on the left frontal lobe of Mrs A's brain. The consultant oncologist (a doctor who specialises in the diagnosis and treatment of cancer) involved in Mrs A's care advised her of the liver and bony metastases. However, they did not share the results of the head scan. Following this, the board's records indicate that the results of this scan were not shared with Mrs A by the consultant oncologist, the clinical nurse specialist (CNS) involved in her care, or any other member of staff.

Ms C complained that the board had unreasonably failed to disclose information about the lesion on Mrs A's brain. We took independent advice from an oncology adviser. We found that it was unreasonable for the board not to disclose this information to Mrs A. The board had advised that the medical professionals involved did not disclose this information to avoid causing further anxiety or upset to Mrs A. Even if the board had good intentions, we considered the evidence to strongly indicate that this was not a reasonable course of action to take and, under the circumstances, was not a medical professional's choice to make. This evidence included the General Medical Council's (GMC) guidance Good Medical Practice and Consent: Patients and Doctors Making Decisions Together. We concluded that it was not reasonable for information about the head scan not to be shared with Mrs A. Therefore, we upheld this aspect of the complaint.

Ms C also complained that, following the head scan, the board unreasonably failed to provide appropriate treatment to Mrs A or manage her condition appropriately. We found that, overall, Mrs A received a good quality of care and treatment. However, we noted that it would have been reasonable for a Magnetic Resonance Imaging (MRI) scan to be carried out, in line with the recommendations of the consultant radiologist (a specialist in the analysis of images of the body). This would have resulted in clearer information about the lesion on Mrs A's brain and identify whether there were other smaller lesions. Further MRI or CT scanning would also have helped identify whether brain radiotherapy would have been an appropriate or effective form of treatment.

We found that the evidence suggested that further scanning would not have extended Mrs A's life but may have made some difference to her treatment. We concluded that, by not carrying out further MRI or CT scans, the board failed to provide appropriate treatment to Mrs A or manage her condition appropriately. Therefore, we upheld this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to both Ms C and Mr B for the failings my investigation identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets

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

- Staff should be aware of the circumstances in which it is acceptable to withhold information from a patient.
- The board should reflect on their position on disclosing information to patients, as detailed in their response to my enquiries.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.