SPSO decision report

Case: **201901024, Tayside NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment they had received from the board and that the board failed to communicate reasonably with them. C was diagnosed with breast cancer and felt they were not able to have a full discussion of the treatment options for their condition and that they were not being given the opportunity to make informed decisions about their care.

C sought a second opinion from a different health board and said they were offered a much fuller discussion of their treatment options, including some tests which were not offered by Tayside NHS board. C complained to the board about the differences in the treatments offered. C noted that the board appeared to be alone in not using a specific test and that their approach was outdated and not patient centred. C did not feel the board's justification, that the test might cause anxiety amongst its patients, was in line with patient centred medicine. C also pointed to a Healthcare Improvement Scotland (HIS) report into practices within the board's oncology (study and treatment of tumours) department. This had found areas for improvement, including communication with patients and the use of the test in question.

The board said they did not agree that the tests offered to C when they received their second opinion were necessary or required by clinical guidance. The board had accepted the findings of the HIS report, but did not agree that the test should have been offered in C's case.

We took independent medical advice from a consultant oncologist. We found that the majority of oncologists would have offered the test in dispute, as it would have helped to guide discussions with C. In addition, the medical records did not record whether a detailed discussion was held with C about their treatment options. We found that C's care and treatment had fallen below a reasonable standard as they were not able to have a full discussion of all the treatment options available to them and because they were not offered testing, which they could reasonably have expected to receive had they been patients of another health board in Scotland. We also found the standard of communication with C was not of a reasonable standard. We upheld both aspects of C's complaint. However, as communication with patients had been addressed by the HIS report, we did not make any recommendations in this regard.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to offer particular testing, or to discuss fully the treatment options available to them. 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:

- The board should provide patients with copies of the letters from their clinics.

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.