SPSO decision report

Case: **201907009, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained to us regarding the treatment that they had received from the board relating to a diagnosis of liver cancer. They told us that there had been significant delays in carrying out appropriate tests and that they considered that their care had been very self-driven, stating that they had to chase up and request treatment on a number of occasions. They told us that they had received an unreasonable prognosis when being given their cancer diagnosis, being told that they were terminally ill with only months to live. They told us that they were only referred to a liver surgeon at their request, who was subsequently able to operate successfully.

They also complained that a consultant had written an unreasonable letter to their GP about one consultation, suggesting that their appearance had given cause for concern.

We took independent advice from a consultant oncologist (cancer specialist). We found that there had been unreasonable delays in carrying out C's tests. In particular, a failure to appropriately refer on the results of a scan, resulting in C having to chase this up and request a referral through their GP, and, a failure to mark the request to carry out a biopsy as urgent, resulting in a further delay.

These failures contributed to a delay in providing both diagnosis and treatment for C which was well out with normal guidelines for cancer treatment. In addition, the fact that C was required to seek a referral from their GP to further consider the results of their scan was considered to be evidence that their care had been unreasonably self-driven. We also found that an unreasonable prognosis had been given to C, as it was clear that the consultant in question was not best placed to provide a prognosis and further consultations were required before an accurate prognosis could be given. We therefore upheld these aspects of C's complaint.

However, while we noted C's strongly held view that the consultant's assessment of their appearance had been unreasonable, we were unable to find sufficient evidence to refute the consultant's record of that consultation. We therefore did not uphold that aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for unreasonably delaying investigations into C's liver lesion, for failing to refer their MRI results to the Multi Disciplinary Team (MDT), and for providing an unreasonable prognosis. 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:

- Discussions about prognosis should take place with the appropriate clinician in light of a full consideration of the treatment options available.

- Requests for liver biopsies should be marked as urgent where necessary.
- The board should ensure all investigations into possible cancer are completed within the timescales set out in guidelines, wherever feasible.
- Where appropriate, MRI results should be referred to the MDT and actioned promptly.

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.