SPSO decision report

Case: **201908075, Highland NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about a failure to accurately diagnose and treat their parent (A)'s pancreatic cancer. A was being investigated by Raigmore Hospital in the months prior to their death. C complained that too many invasive tests were carried out and an accurate diagnosis was not established.

We took independent medical advice from a consultant surgeon, who noted that A had an advanced pancreatic cancer which can be difficult to diagnose. We considered that repetition of invasive tests was reasonably required in order to pursue a diagnosis. We noted, however, that A's lung abnormalities were discussed by a lung multidisciplinary team (MDT), but an upper gastrointestinal MDT was not involved despite the fact the suspicion of pancreatic cancer could not be ruled out. We fed this back to the board. However, overall, we considered that there was a comprehensive attempt to obtain a diagnosis. On balance, we did not uphold this complaint.

C also complained about a failure to communicate clearly with A and the family regarding the diagnosis. They said that they were never made aware of the suspected cancer diagnosis, despite this having been documented throughout the records. We found no evidence to support that timely and meaningful discussions took place with A and their family. A consented to multiple invasive tests without being made aware that suspected cancer was being investigated. We considered that the risks and benefits of these tests should have been clearly discussed with A, in order for them to have made a fully informed decision as to whether to proceed with them. In the circumstances, we upheld this complaint. We also noted that the board's response to C's complaint did not provide a sufficient explanation of the extent of the tests carried out.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C that timely and meaningful discussions did not take place with A and the family to inform them of the suspected cancer diagnosis and make them aware of the purpose, potential benefits and risks of invasive investigations; and that the complaint response did not comprehensively address the specific concerns raised. The apology should meet the standards set out in the SPSO guidelines on apology: www.spso.org.uk/information-leaflets.

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

- Patients should be provided with all the information they need to be able to make informed decisions about their care. This should include information about their diagnosis; any uncertainties in this regard; and a clear explanation of the purpose of any proposed investigations or treatment, including potential benefits and material risks. This should be adequately recorded in the case notes to evidence that meaningful dialogue has taken place.

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.