

SPSO decision report

Case: 202500059, Greater Glasgow and Clyde NHS Board - Acute Services Division

Sector: Health

Subject: Communication / staff attitude / dignity / confidentiality

Decision: upheld, recommendations

Summary

C complained that the board's communication around their spouse (A)'s care and treatment was unreasonable. C complained about a lack of face-to-face appointments, delays and the board not following their diagnostic pathway. C said that they were informed of A's prostate cancer over the phone, with no support provided to help them come to terms with the diagnosis or deciding on treatment which, due to A's co-morbidities, was more complex.

The board apologised that not all of the appointments were face-to-face but explained that this was due to demands on the service. They acknowledged that this was not ideal but it was necessary to reduce delays. The board said that the MRI result clinic was omitted from the diagnostic pathway in order to expedite A's biopsy. The MRI results were shared at the biopsy appointment. An MDT discussion took place a week after the biopsy results were reported and the diagnosis was shared with A by telephone rather than waiting a further four weeks for a face-to-face appointment.

We took independent advice from a consultant urologist (a doctor who specialises in the male and female urinary tract, and the male reproductive organs). We found that the board's communication was unreasonable. There was a lack of explanation about why the MRI results clinic was omitted from the pathway, as well as an inadequate explanation of the MRI result itself. It is clear that A did not understand the likelihood of cancer that prompted the biopsy and their understanding was not checked until the point of diagnosis. Therefore, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A and their family for the poor communication around the MRI results and the diagnostic process. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies.

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

- Communication should be in line with General Medical Council guidance on Good Medical Practice.

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.