SPSO decision report

Case: **201202445, A Medical Practice in the Fife NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C, who is an advocacy worker, complained on behalf of her client (Mrs A) about the care and treatment that Mrs A's husband (Mr A) received from the medical practice. Ms C said the practice failed to take appropriate steps to lead to an earlier diagnosis of Mr A's cancer and assured the couple that Mr A's 'bloods' had been checked when they had not. She also said that one GP unreasonably failed to follow up on blood tests and a second GP failed to deal with Mrs A in an appropriate manner when she went to the practice for support.

We took independent advice from one of our medical advisers on this case. Our adviser said that the practice had tried to care for Mr A in this very difficult situation. He said that the care and treatment they provided was appropriate and there was no evidence to suggest that they should have referred Mr A to hospital earlier or made a diagnosis of cancer themselves. The adviser said the evidence in the records did not suggest that the practice failed to take appropriate steps to lead to an earlier diagnosis.

We upheld the complaint about the assurance given to Mrs A about 'bloods'. We found that both parties agreed that the first GP at the practice indicated that she had 'checked Mr A's bloods'. However, we took the view that when the GP spoke to Mrs A, a layperson, it was reasonable for Mrs A to interpret this as meaning that the GP had checked Mr A's blood test results and not simply that she had taken blood samples for testing, which is what the GP suggested she meant. Given the language used, we considered that, on balance, the centre did tell Mrs A that Mr A's bloods had been checked when they had not.

On the matter of follow-up, the first GP had said that she went online to see where Mr A's blood test results were. She found that the results were not there and Mr A had been admitted to hospital. Our adviser indicated that this seemed reasonable, as from the point at which the first GP discovered that Mr A was in hospital, there would no longer have been any need for her to follow up on blood test results. We accepted the adviser's views and did not find that the practice unreasonably failed to follow up the blood tests.

On Mrs A's appointment with the second GP, the notes the GP made at the time did not contain any information that supported Mrs A's account of what had happened, and we could not uphold this complaint. It was Mrs A's word against the GP's and there were no independent witnesses or other means for us to verify whose version of events was correct.

Recommendations

We recommended that the practice:

- provide Mrs A with a written apology for not explaining clearly what had happened to Mr A's blood samples;
- feed back our views on the communication and record-keeping to the staff involved in this case;
- take steps to ensure that in future, clear language is used when communicating with patients and summaries of phone calls are recorded in patients' medical records;

- feed back our adviser’s comments on significant event analysis/audit to the staff involved in this case; and
- amend their procedures to include a requirement for significant event analysis/audit in future instances of this type.