SPSO decision report

Case: **201405584, A Medical Practice in the Fife NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C complained about the care and treatment she received from her GP practice. She had an operation to fit a catheter, during which she sustained an injury to her bowel. This injury was not identified at the time and she subsequently experienced a lot of pain. She consulted the practice and a number of tests were carried out but the damage to her bowel was not diagnosed. It was not detected until she was admitted to hospital two months after her initial surgery. Further surgery was carried out to correct the damage. Ms C complained about the practice's failure to diagnose the bowel injury. She also complained that the practice refused to prescribe two drugs that had been recommended by hospital specialists; that they failed to appropriately treat her urine infections and that they failed to provide the hospital with details of her medical condition prior to an emergency attendance.

We took independent advice from one of our GP advisers. Our adviser considered that the tests the practice carried out were reasonable and that the damage to Ms C's bowel would have been difficult to diagnose. However, as Ms C's pain was not resolving and no cause for this pain was identified, the adviser considered that further assessment should have been arranged. She stressed the importance of keeping a wide differential diagnosis in mind when investigating unexplained symptoms in patients (a systematic method of diagnosing a disorder that lacks unique symptoms or signs). We accepted the advice we received and upheld this complaint. We recommended that this should be fed back to the doctor concerned.

We did not uphold Ms C's other complaints. Our adviser noted that the practice had not prescribed the two drugs recommended by specialists as they were concerned about potential interactions with other drugs Ms C was taking. Our adviser considered that this was reasonable and in line with safe clinical practice. She also noted that the urine tests in question had produced no evidence of infection and that no treatment was, therefore, required. Finally, she noted that the practice spoke with the hospital and faxed details to them prior to Ms C's emergency attendance. We therefore concluded that the actions of the practice were reasonable in this regard.

Recommendations

We recommended that the practice:

- issue a written apology to Ms C, acknowledging the failings identified; and
- confirm that the doctor in question will discuss our findings as part of their yearly appraisal and ensure that they reflect on the importance of keeping a wide differential diagnosis in mind when investigating unexplained symptoms in patients.