SPSO decision report

Case: **202006353, A Medical Pracitce the Highland NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their sibling (A) by the practice. A had previously been diagnosed with breast cancer a number of years ago. A became ill and attended the practice on several occasions over the year. The GP considered A had gastroenteritis (inflammation of the stomach and intestines). A's symptoms persisted and A was referred to hospital for a colonoscopy (examination of the bowel with a camera on a flexible tube). The request was rejected. A presented at the practice with the same symptoms on two further occasions and the practice made an urgent 'suspicion of cancer' referral to the health board. A scan showed a tumour attached to A's right kidney. A died some months later.

C complained that despite A's multiple attendances at the practice and concerns that the cancer had returned, the practice failed to reasonably respond to A's worsening condition and delayed or failed in carrying out appropriate investigations and associated tasks.

We took independent advice from a GP adviser. We found that initially there was no unreasonable delay in the practice recognising the seriousness of A's symptoms and that the appropriate referrals for a colonoscopy and ultrasound scan (a scan that uses sound waves to create images of organs and structures inside the body) were made. We also noted that it would not have been appropriate for the practice to have undertaken a CEA blood test (carcinoembryonic antigen test, a blood test used to help diagnose and manage certain types of cancers) and that the actions of administrative staff in filing away test results was appropriate and in line with established good practice.

However, we found that there was a failure to include clinically important information in referrals and in consultation documentation, and that there was a delay in sending A's suspicion of cancer letter. We also found that the practice should have considered undertaking some additional blood tests when it was clear A was deteriorating, or documented the awareness of any blood tests undertaken by the hospital during this period. Therefore, on balance, we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the specific failings identified in respect of the complaint. 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:

- Appropriate and timely blood tests should be considered when it is clear a patient is deteriorating in cases similar to A's or awareness of any blood tests undertaken e.g. by hospital documented.
- Notes of consultations should include appropriate detail including a description of the length and progression of symptoms along with any potentially relevant past history.

- Referral letters should include a clear history, examination and relevant background information.

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.