SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201301095, A Medical Practice in the Greater Glasgow and Clyde NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, no recommendations

Summary

Ms C, who is an advice worker, complained on behalf of Ms B about the care and treatment given to her late father (Mr A) by the practice in the year before his death. Ms B was unhappy with the attitude of staff there, saying that the practice had not taken sufficient account of her father's symptoms, that they dismissed certain issues, and would only address one issue at a time. She thought that this meant they had missed symptoms that would have led them to identify his final diagnosis of lung cancer earlier.

Mr A attended the practice on numerous occasions in the year or so before his death. He reported a range of symptoms, including chest infections, incontinence, possible dementia, mobility issues, a dry mouth and a cough. He was referred for chest x-rays early in the year and again towards the end of the year, which were reported as showing no signs of active disease. He was also referred to urology and for a geriatric medicine review. It was at this review, a month before he died, that specific concerns were first raised about a possible cancer diagnosis. Mr A was referred for a scan, which found lung cancer that had spread to other parts of his body. Mr A died three days after the diagnosis.

We noted that Ms B complained that the practice were dismissive of her father's symptoms and that their attitude indicated they did not take his concerns seriously. As, however, there was no objective evidence of this, our investigation focused on Mr A's medical records. We took independent advice from one of our medical advisers, who reviewed the practice's actions in respect of each of the issues Mr A had told them about. The adviser said that the practice referred Mr A for x-rays appropriately. While they could have done more to assist him with his reports of incontinence, what they did was fairly standard practice. In relation to Mr A's mobility, our adviser said that the practice assessed the situation appropriately. There had been some confusion around whether Mr A had a diagnosis of dementia, and our adviser indicated that the records showed that he did not. He said that there were references in correspondence which could have led to this confusion, and that Mr A may have been told that he had mild dementia. However, when Mr A raised his concerns with the practice, they had responded appropriately.

We found that the care and treatment given to Mr A was appropriate. He was referred for specialist opinion appropriately, and the practice took action to investigate concerning symptoms. Although they could have done more to assist him with the management of his continence issues, we noted that the adviser identified what they did as being standard practice.