SPSO decision report

Case: **201303640, A Medical Practice in the Ayrshire and Arran NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, no recommendations

Summary

Miss C's mother (Mrs A) went to a medical practice with abdominal (stomach) pains. She was repeatedly referred for an ultrasound scan (a scan that uses sound waves to create images of organs and structures inside the body), but did not attend on three separate occasions and no further appointment was made. Ten months later, Mrs A again went to the practice and was treated for a suspected infection. However, Miss C was very concerned about her mother's weight loss and took her to A&E, where she was treated for a suspected urinary tract infection and discharged. Two months later, Mrs A went again to the practice with worsening back pain, nausea and weight loss. A GP told Mrs A that it was possible she had cancer, and arranged for x-rays, which showed that Mrs A had arthritis. However, as no cause for Mrs A's weight loss had been found, the GP arranged for an urgent abdominal scan, which showed possible cancer of the liver. Further tests confirmed this diagnosis and Mrs A died six weeks later.

A few days before Mrs A's death, the GP visited Mrs A at home and there was an altercation between the GP and the family. Miss C and the GP gave slightly different versions of what happened, including what was said about Mrs A's treatment and whether the GP intended to leave without prescribing pain relief. Miss C then complained that the practice had failed to investigate Mrs A's symptoms appropriately, causing a delay in accurately diagnosing her cancer, and that the GP did not appropriately communicate with Mrs A and her family during the home visit.

After taking independent advice from one of our medical advisers, we did not uphold Miss C's complaints. Our adviser said that the practice had acted correctly in referring Mrs A for a scan each time she went to them with abdominal pain. However, Mrs A had decided not to go for the scans. Once a scan was carried out, the practice acted promptly in making the appropriate referrals to confirm the diagnosis and arrange treatment. In relation to communication, our adviser said that the reasonableness of the GP's actions depended on precisely what had happened. As there were different versions of events, which were not resolved one way or the other by the GP's written records from the time of the event, we could not find evidence to uphold Miss C's complaint.