SPSO decision report

Case: **201304174, A Medical Practice in the Fife NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained about the treatment that her late mother (Mrs A) received from her medical practice between September and November 2012. Mrs A was eventually diagnosed with lung cancer and Mrs C said that the family had made repeated requests for a chest x-ray but these were ignored. The family believed that an earlier x-ray might have allowed Mrs A's cancer to be diagnosed sooner. They were also concerned that the practice failed to follow up blood test results as they should have done and which again they thought would have led to an earlier diagnosis.

We took independent advice on this case from one of our medical advisers. Our adviser said that the practice had not failed to follow up on blood tests arranged by the hospital. However, he considered that the practice did not take reasonable steps in light of the results of blood tests they themselves organised. The adviser said that there were repeated and high levels of inflammatory markers shown on blood tests in late October 2012. These should have created a higher degree of suspicion, and led to consideration of a referral rather than just arranging repeat tests. The test results should have been considered in the context of an unwell adult and consideration given to referral for other possible conditions, although he also said that it was unlikely this would have led to an earlier diagnosis. The adviser also thought that Mrs A should have been referred for an x-ray in early November, when swollen lymph glands were noted.

We concluded that, whilst Mrs A's care was reasonable up to the end of October 2012, and that earlier diagnosis was unlikely in her case, on balance there were failings by the practice from early November 2012 onwards.

Recommendations

We recommended that the practice:

- apologise to Mrs C for the failings identified; and
- review our adviser's comments on this complaint, reflect on the decision-making processes used by GPs individually and collectively in assessing Mrs A in early November, and provide us with evidence of this reflection having taken place and its outcome.