# SPSO decision report

**Case:** **201401690, A Medical Practice in the Fife NHS Board area**
**Sector:** health
**Subject:** clinical treatment / diagnosis
**Outcome:** some upheld, recommendations


## Summary

Mr C complained about the care and treatment his late brother (Mr A) received from the medical practice. Mr A had been suffering from a cough, shortness of breath and chest pain and died of a pulmonary thromboembolism (a blood clot which forms at one point in the circulation, becomes detached and lodges at another point) in April 2014. Mr C said that he believed the practice had contributed to the death of his brother.

Mr C complained that Mr A's GP did not treat his condition as worsening on his last visit to the practice. He also said that the day before Mr A's death, a receptionist had not allowed Mr A to speak to, or see, a GP when he called the practice to get the results of tests.

Mr C complained to the practice but was unhappy with the response he received. He said that there were several things which he felt were inaccurate or incorrect in their response. Mr C questioned why the GP had not considered or recognised that Mr A's condition was worsening and disputed the practice's version of what was said during the phone call with the receptionist.

We took independent advice from one of our medical advisers, who is a GP. We found that the medical records depicted a series of events consistent with a chest infection with some additional signs which needed further investigation and that the appropriate tests had been arranged, so we did not uphold Mr C's complaint about his brother's treatment.

However, our adviser also said that the role of reception staff is to facilitate communication between a patient and a GP, and, therefore, they should not be making a decision that a patient who has specifically asked to speak to a GP should not have this option. Our adviser said the information should be passed to the GP who has clinical knowledge and responsibility for patient care to make the decision as to how to proceed. On this basis, we upheld the complaint about the care given to Mr A by the practice.


## Recommendations

We recommended that the practice:

- carry out a significant event analysis paying particular attention to their system of contacting an on-call doctor;
- ensure GPs involved in Mr A's care discuss this complaint at their next appraisal;
- apologise to Mr C for the failings identified;
- establish, using the practice's appointment system, which receptionist spoke to Mr A on the date in question;
- review the details of the GP's complaint response in relation to the information received from reception staff, and write to Mr C to explain the findings;
- review and revise where appropriate the practice system for passing requests by patients to speak to a doctor; and

- consider enhanced staff training for the receptionists in terms of their interactions with patients and practice guidelines on responding to patients who request to speak to a doctor.