SPSO decision report

Case: **201508703, A Medical Practice in the Western Isles NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, no recommendations

Summary

Mrs C complained that the medical practice failed to identify that her father (Mr A) had cancer. Mr A had multiple health issues and regularly attended the practice but it was not until the family eventually took him to hospital that he was diagnosed with an aggressive tumour. He died nine days later. The practice noted that there had been no change to Mr A's longstanding symptoms other than some worsening in the weeks before he died, and they did not consider that his cancer could have been detected much earlier or would have responded to treatment.

We took independent medical advice from a GP who noted that the practice had arranged relevant investigations including chest x-rays, scans and blood tests. Although Mr A's liver function test results were noted to have been abnormal in the month prior to diagnosis, the practice had already arranged a colonoscopy and the adviser did not consider that further tests were indicated at that stage. When the tests were repeated two days prior to diagnosis, they showed a significant deterioration and the practice took appropriate steps to upgrade an existing ultrasound scan referral to urgent. The adviser noted that the hospital may have separately arranged investigations themselves around this time when Mr A self-presented with his family. However, we found that the practice had by then already taken reasonable and prompt action when they identified the deterioration in Mr A's liver function results. We therefore concluded that the practice did not unreasonably delay taking steps to have Mr A's cancer diagnosed and we did not uphold the complaint.