SPSO decision report

Case: **202001643, A Medical Practice in the Lothian NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, no recommendations

Summary

C and B complained about the care and treatment that their adult child (A) received from the practice. A had sought advice and treatment for a lack of energy, loss of libido and difficulty gaining weight. They were referred to the metabolic unit in hospital and, subsequently, to an adult eating disorders service. A had been diagnosed with a hormonal deficiency and a number of potential causes for their symptoms were considered. However, A and their family were concerned about the practice's clinical management of A's condition and the lack of a clear diagnosis or effective treatment plan.

A subsequently completed suicide. Following a meeting and written correspondence with the practice, C and B remained dissatisfied with a number of aspects of the treatment A received.

We took independent advice from a GP. A's case was complex and whilst with hindsight it was clear that A had an underlying mental health condition, a physical cause for their symptoms could not be ruled out. We were satisfied that the practice arranged numerous tests and investigations to explore a physical cause of A's symptoms. Additional tests were carried out by third parties and we found that the practice appropriately reviewed these and communicated clearly with A as to the results, their significance and the next steps in terms of finding a clear diagnosis.

We found that the practice considered at an early stage that there may have been a mental health element to A's condition. However, A was not keen to pursue this. We were satisfied that it would have been inappropriate in the circumstances for the practice to push further investigations into A's mental health. We were also satisfied that the practice communicated well with secondary care specialists and managed A's overall diagnostic pathway reasonably. Therefore, we did not uphold these aspects of C and B's complaint.

However, we were critical of the practice's communication with C and B. It was A's clear intention that they be included in conversations regarding their health. Although the practice were not able to communicate via C and B's preferred medium, they did not take reasonable steps to ensure clear communication between all parties and the communication broke down as a result. We also found that the practice failed to instigate an internal review following A's death and, having completed a review following C and B's complaint, they failed to provide them with a copy of their findings. Therefore, we upheld these aspects of C and B's complaint. We did not make any recommendations due to the appropriate action already taken by the practice.