SPSO decision report

Case: **202205437, A Medical Practice in the Highland NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained on behalf of B about the care and treatment provided to B's spouse (A) by the practice. A attended the practice on a number of occasions over a few years with ongoing and worsening abdominal and lower back pain. C complained that the practice assumed A was suffering from a musculoskeletal problem and failed to consider other diagnoses sooner. A was later diagnosed with lymphoma and died at the time of diagnosis.

In responding to C's complaint, the practice undertook a Significant Adverse Event Review (SAER) and noted it was not clear when the lymphoma started. The practice also found that A had several normal or reassuring examinations and tests, and that several of A's presentations and tests pointed towards other diagnoses including liver disease and prostate disease. The SAER ultimately concluded that it seemed very unlikely that A had lymphoma for a long period of time given the very aggressive nature of their disease.

We took independent advice from a GP. We found that a number of tests and investigations were reported as normal and therefore there was no cause to refer A to specialists on suspicion of cancer. However, when concerns were raised about a possible missed renal cause for A's pain, we found that further investigations should have been undertaken at this time. These did not occur until almost a month later. A was suffering from an aggressive and difficult to diagnose cancer and, while the care and treatment provided by the practice was generally considered to be reasonable, the review should have triggered further tests at the time. On balance, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to B for the issues identified in this decision. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- That the practice share this decision notice with their GPs with a view to identifying any points of learning.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.