SPSO decision report

Case: **201300712, A Medical Practice in the Lothian NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C's late father (Mr A) saw a GP at his medical practice about, amongst other things, a cough. He had a chest x-ray, the results of which were normal. Some seven months later, in June 2012, he had three further consultations at the practice about chest problems and a persistent cough, and a further chest

x-ray, taken after the third appointment showed an abnormality in the lung. After collapsing and being admitted to hospital, Mr A went to the practice again in July and was referred urgently to the respiratory clinic because of his persistent cough. Mr A also attended a cardiology (heart) clinic where a scan was arranged. The clinic told the practice that the scan showed that Mr A might have a pulmonary (lung) tumour. The respiratory clinic then found that the scan showed metastatic malignancy (cancer that had spread) in his lung. They wrote to the practice about this and said they had not discussed the potential diagnosis with Mr A but had told him that there was a shadow on the lung that needed investigation. Several weeks later Mr A saw a GP, who did not explain the result of the scan but wrote in the medical notes that Mr A was aware that cancer was a possibility. Mr A was then referred to oncology (cancer specialism) and at the end of October a cancer nurse told the practice that Mr A had now been told his diagnosis. After this Mr A asked the practice for an appointment but they told him they could no longer treat him because he had moved out of their area. Mr A died shortly afterwards.

Mrs C complained that the practice did not provide reasonable care and treatment to her late father. She said that they did not carry out appropriate investigations and/or tests within a reasonable time and failed to communicate with him and his family about his diagnosis. Mrs C was also concerned that the practice refused to treat him after he moved house, although he had been a patient there for over 25 years and they were well aware of his medical history.

We took independent advice on this case from one of our medical advisers, who is a GP. Our adviser said that the failure to refer Mr A for a chest x-ray after his first two consultations in June 2012 was not reasonable and did not follow the guidelines for referral in such cases, although his care after the chest x-ray was eventually carried out was of a reasonable standard. The adviser also said that the practice's communication with Mr A was reasonable, and that it was the responsibility of hospital doctors to tell him about test results and treatment plans. We recognised how distressing it must have been for Mr A and his family waiting for results and a definitive diagnosis, but noted that the practice was not responsible for telling Mr A about these. Turning finally to the practice's decision not to treat Mr A after he moved house, our adviser said that while the practice acted correctly as far as the terms of the GP contract were concerned, they did have discretion to keep Mr A on their list on compassionate grounds if this was geographically feasible. In the circumstances, while accepting this was for them to decide, we took the view that the practice should have given more consideration to keeping Mr A on their list. Given this, and the failure to arrange a chest x-ray within a reasonable time, we upheld Mrs C's complaint.

Recommendations

We recommended that the practice:

- ensure that the GP who saw Mr A at his first two appointments in June 2012 discusses this complaint and findings as part of their annual appraisal and that the diagnosis and management of lung cancer forms part of their learning needs;
- consider their approach to de-registering patients in light of this case; and
- apologise to Mrs C for the failures identified.