SPSO decision report

Case: **201304679, A Medical Practice in the Lothian NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C went to her medical practice because she had been having headaches for a few months. She was given migraine medication to try, and an appointment was made for her to come back a week later. Mrs C did not go to the appointment but had called NHS 24, where the on-call doctor thought she might have acute sinusitis (inflammation causing facial pain). Later that month, Mrs C went back to the practice with her sister. She said the medication had not worked. She also had other problems, including being increasingly unable to socialise or attend to her personal hygiene. She was treated for sinusitis, but her symptoms became even worse, and she went back to the practice at the end of the month. She described increasing withdrawal, problems with her eyesight and that she had been off work for a number of weeks. The day after this appointment, NHS 24 were called again, and Mrs C was immediately admitted to hospital for a scan. She was diagnosed with a brain tumour and had an operation to remove it.

Mrs C complained that the GP at the practice failed to pick up on her serious illness and refer her to hospital. She said that as a consequence her life had been put at risk.

We obtained all the complaints correspondence and Mrs C's relevant clinical records and took independent advice from one of our medical advisers, who is a GP. Our investigation found that the GP missed a number of classic features associated with brain tumours. The adviser said that on her second visit to the practice Mrs C was demonstrating enough of these to merit urgent referral. He said that although some of the changes could be interpreted as being associated with depression, in his opinion that would be a secondary consideration in a patient with persistent headache and such a significant change in personality. The symptoms should have alerted the GP to a possible serious diagnosis and she should have made a comprehensive assessment including a detailed clinical examination, then referred Mrs C urgently if she felt that any element was beyond her clinical competence. We made recommendations, noting that the GP had already acknowledged that she had missed an important diagnosis and apologised for this, and that the practice had carried out a significant event analysis.

Recommendations

We recommended that the practice:

- formally apologise to Mrs C for a failure to properly examine her and then refer her on;
- confirm the actions taken to amend their procedures; and
- provide evidence that the matter has been addressed at the GP's next appraisal.