SPSO decision report

Case: **201403956, A Medical Practice in the Tayside NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

In January 2013, Mr A attended the medical practice as he had ongoing chest pain and a cough. A chest x-ray and blood tests were arranged and the results came back normal. However, as his pain was continuing he was given painkillers. In March 2013, Mr A attended the practice again because his symptoms were continuing and he was referred to hospital for a specialist opinion. Mr A was seen in hospital in May 2013 although, in the meantime, the practice prescribed him increasing painkillers and his tests were repeated but again with no result. After a difficult diagnosis pathway, Mr A was advised over the phone by his GP in September 2013 that he had cancer, and he died in May 2014.

Mr C complained to the practice on behalf of Mr A's widow (Mrs A) that it had taken the practice too long to refer Mr A for appropriate tests and opinion and that there was a lack of urgency to provide him with any meaningful treatment. He further complained that a GP within the practice told Mr A of his diagnosis over the phone, which he said was inappropriate and showed a lack of compassion.

We took independent advice from one of our GP advisers and we found that while Mr A was treated reasonably and appropriately and that efforts were made to treat his pain, he was not referred to hospital in line with national guidelines for suspected cancer. His referral should have been urgent rather than routine. Because of this, there was a delay in him being seen in hospital and a delay in his treatment being started. While it was confirmed that Mr A had been told of his diagnosis over the phone, this was for the best of intentions in order to explain his increasingly strong painkillers. Nevertheless, this should not have happened and arrangements should have been made for a house call or for Mr A to attend the practice. In light of the advice we received, we upheld Mr C's complaint.

Recommendations

We recommended that the practice:

- make a formal apology to Mrs A for this failure;
- ensure that all medical staff familiarise themselves with the national referral guidelines for suspected lung cancer; and
- ensure that the GP reflects on the distress caused and he ensures that the matter is raised at his next formal appraisal. He should advise us that he has done so.