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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint by Mr K against Dr D R Bohra.

A report by the Public Services Ombudsman for Wales

Case: 200901952

Contents

Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mr K.

Summary
Mr K complained about treatment that his mother, Mrs K, received from her GP, Dr Bohra ("the GP"). Mr K said that the GP failed to diagnose or refer Mrs K appropriately when she presented symptoms to him. Mrs K was later diagnosed with renal cancer in hospital and sadly died. Mr K maintained that an urgent referral from the GP may have prevented her death.

The Ombudsman found that the GP should have referred Mrs K urgently after one particular consultation. During that visit Mrs K told the GP that she had passed blood in her urine and had pain in her abdomen. The Ombudsman found that the GP should have referred Mrs K to a specialist for suspected cancer. Clinical guidelines indicate that blood in the urine should lead to such a referral under what is known as "the two week rule". This means that a patient is seen by a relevant specialist within the two weeks. By not doing so in this case, the GP made a significant error. The Ombudsman concluded that Mrs K would have had a much better chance of survival if the GP had made the referral. Therefore, whilst noting that the GP had acknowledged the matter, learned from it and apologised on various occasions, he upheld the complaint. The Ombudsman recommended that the GP apologise again and pay Mr K £3000 in recognition of the additional suffering he has endured due to the uncertainty about what outcome may have resulted from an appropriate and prompt referral.

The complaint

1. Mr K complained about Dr D Bohra of Clase Surgery, Swansea ("the GP") in relation to his mother, Mrs K. Mrs K sadly died of renal cell carcinoma (cancer of the kidney) on 14 September 2009 at age 55. Mr K said that the GP failed to diagnose Mrs K despite frequent visits in 2006 and 2007 and did not refer her to hospital for a scan in a timely manner. He added that Mrs K was eventually diagnosed with renal cancer at hospital in early September 2007 after a scan. He explained that she underwent treatment, which was not ultimately successful.

2. Mr K maintained that the GP mishandled his dealings with Mrs K. He stated that Mrs K may have had a different outcome if the GP had acted more appropriately and more promptly. He said that he will never be able to get over his mother's death.

Investigation

3. We started this investigation on 23 February 2010. I have considered information that has been provided by Mr K and the GP. We have referred the files to one of my professional advisers ("my Adviser"). He is an experienced GP. His name is Tim Owen. I have given an opportunity to Mr K and the GP to comment on a draft of this report.

4. I have not included every detail investigated but I am satisfied that nothing of significance has been overlooked.

Relevant clinical guidance

5. The National Institute for Health and Clinical Evidence ("NICE") provides guidance and sets quality standards to improve people's health in the UK. In June 2005, NICE published "Referral guidelines for suspected cancer". In terms of renal cancer, it states that a patient that presents with blood in the urine should be referred "urgently". The document defines urgent as being seen within two weeks of the referral.

6. In 2005 the Welsh Assembly Government issued its "national Standards for urological Cancer Services". (Urology includes renal cancers.) Standard 5.4 of this Welsh guidance states that a GP should refer a patient who presents symptoms within the criteria for suspected urological cancer and the referral should be classed as "urgent

suspected cancer". That section of the Welsh guidance is cross referenced with the NICE guidance cited above.

The background events

7. On 23 January **2007**, Mrs K saw the GP in his surgery. The notes indicate that Mrs K complained of nausea. The GP examined Mrs K's abdomen. He did not identify any abnormality. The GP prescribed medication for the symptoms.

8. On 20 March, Mrs K had a consultation with the GP in the surgery. Mrs K reported passing blood in her urine and pain in the right renal area and abdomen. The GP found no lump in the abdomen or tenderness. He treated Mrs K for an infection and arranged a urine test (which showed no infection). The GP recorded in the notes that he planned to arrange for Mrs K to have an ultrasound scan of her abdomen.

9. On 2 July, Mrs K telephoned the surgery. She said that she had not had an appointment for the ultrasound scan. The surgery contacted the hospital. The latter requested that the GP send another request. The GP faxed a new request.

10. On 6 August, Mrs K attended surgery and saw the GP. She complained of upper abdominal pain and nausea. According to her notes, she did not mention any urinary symptoms or passing blood in her urine. On examination, she was tender in the renal area. The GP suspected she might have gallstones. Mrs K told the GP that she was still waiting for an ultrasound. He told her to wait until the scan report.

11. On 28 August, Mrs K had the ultrasound scan. This led to a diagnosis of renal cancer after further tests, a few days later.

12. On 12 September, the hospital wrote a letter to another hospital about Mrs K. The letter said that Mrs K had a history of blood in her urine for six to seven months.

13. On 14 September **2009**, Mrs K died after lengthy treatment of her condition. The treatment involved an operation and regular visits to hospital.

14. On 1 December, Mr K wrote a complaint letter to the relevant Local Health Board for the area in which the GP practiced. The letter said that Mrs K had attended the GP's surgery on "frequent" occasions. It added that she had often raised concerns about pain and blood in her urine before he referred her for an ultrasound scan.

15. On 5 January **2010**, The GP responded to the complaint submitted by Mr K. The letter said:

- He had seen Mrs K in January 2007 but had not found any abnormality to account for the nausea.
- Mrs K complained of pain in the renal area and blood in her urine at the consultation of 20 March 2007. The GP arranged tests for an infection and kidney stones. However, this was the first time that Mrs K had mentioned blood in the urine.
- He did not see Mrs K again until 6 August. In the meantime, he had faxed another request for the ultrasound scan after Mrs K had told the surgery that the appointment had not been made.
- There is a "robust" system in place in the surgery regarding keeping scan requests. He cannot explain how the referral was not acted upon by the hospital. Nevertheless, he intended to analyse the matter as a "significant event". As such, it would be discussed at a practice meeting.
- The GP offered Mr K a meeting and offered his condolences to Mr K.

16. On 13 January, a meeting took place involving Mr K and the GP. The GP outlined events as he saw them. His explanation was consistent with his letter of 5 January. At the meeting the GP expressed his "sincere apologies" to Mr K and suggested that he seek an independent review if he needed a further explanation.

17. On 14 January, my office received Mr K's complaint.

18. An undated meeting of the surgery discussed the case as a significant event. The notes show that the meeting went over the events in question. The meeting focussed on the failed attempt to arrange Mrs

K's ultrasound scan. It was agreed to implement changes to try to avoid the problem recurring (see paragraph 19).

19. On 22 March, the GP wrote to Mr K after I started the investigation into his complaint. The letter to Mr K set out what he had done since the complaint had arisen. First, he had discussed the missing request for an ultrasound scan with the hospital. Second, he had talked over the case with a GP colleague from a different practice. That doctor had concurred with his clinical judgements and actions. Third, the surgery had learned lessons concerning the need to follow-up investigation requests. Finally, the surgery had devised an action plan. This incorporated seven aspects. These included: developing a robust policy of following up requests; faxing requests; maintenance of a manual register which can be monitored; IT changes and more information to patients about what to expect after a referral is made.

The GP's evidence

20. The GP supplied Mrs K's medical records, complaint papers and a response to the issues raised by my investigation. The GP said that the surgery has analysed the complaint in depth and learned lessons. The response referred to NICE guidance for referral of suspected cancer in that context. The GP acknowledged that he was not aware of the need to refer Mrs K under the "two week rule" for suspected cancer when he saw her in March 2007. He said that was despite his efforts to keep up to date with relevant guidance. The GP added that if the referral for the ultrasound scan had not been lost, Mrs K would have had her scan within about four weeks. He summarised the position:

> "I now realise that the appropriate management of [Mrs K] would have been a referral under the two week rule and I would like to apologise for not having acted in accordance with accepted guidance. However, as a result of this case, I have learned a great deal.
>
> I have reviewed carefully the 2005 guidelines from NICE and I have included as a learning objective, as part of my appraisal, the need to keep updated with guidance relevant to my work. In this way I will strive to avoid a similar situation occurring in future".

Professional advice

21. My Adviser read the investigation files and the medical records. He provided a commentary on the clinical aspects of the case and drew conclusions in so doing.

22. As well as the NICE guidelines, my Adviser referred to guidance from the General Medical Council in its booklet 'Good Medical Practice'. It states:

> "Good clinical care must include:
> (a) Adequately assessing the patient's conditions, taking account of the history (including the symptoms and psychological and social factors), the patient's views, and where necessary, examining the patient.
> (b) Providing or arranging advice, investigations or treatment where necessary.
> (c) Referring a patient to another practitioner where this is in the patient's best interests."

My Adviser assessed the case in the context of this guidance.

23. My Adviser said that the complaint that Mrs K made repeated presentations with abdominal pain and blood in the urine but was ignored by the GP does not correspond with the medical records. He said that the computer records indicate that Mrs K's visits to the GP were infrequent until her cancer was diagnosed. His view was that the records seemed complete. My Adviser said that on 23 January 2007, Mrs K was seen with nausea which could have been an early feature of her developing illness. However, my Adviser noted that the GP looked for causes, found nothing and treated symptomatically. He said this was reasonable. He did not consider that further investigation at that stage would have been required of normal practice.

24. My Adviser commented that the clinical records stated that on 20 March 2007, Mrs K presented with some abdominal pain and blood in the urine and the GP treated her for an infection. The GP also records planning an ultrasound of the abdomen. My Adviser noted that this was delayed. He said that, from the evidence in the file, it seems that the

original scan request was made but somehow lost. My Adviser observed that further investigation about what happened to the referral for the scan would be unlikely to be useful. He said the next consultation was on 6 June 2007, when Mrs K again had abdominal pain and the GP wondered about gall stones and recorded that she was waiting for a scan.

25. My Adviser said there is no evidence in the notes that frequent presentations were ignored. However, my Adviser said the GP did not refer under 'the two week rule' after the consultation of 20 March 2007. He explained that if the GP had followed the advice in the NICE guidance, he would have made an urgent referral. This would have fallen within the two week rule mechanism whereby the Practice makes an outpatient request to the hospital and the patient has to be seen within two weeks of that request. He stated that it is used for cases where cancer seems to be a likely or possible diagnosis. My Adviser said that at the time of these events, this mechanism would have been open to the GP and would have achieved a faster and as it turns out, more reliable access to investigation and secondary care. He said that this clearly would have been a better option rather than waiting for a scan.

26. My Adviser stated that Mrs K presented symptoms including blood in her urine on 20 March 2007. He suggested that if the GP had followed the rule, the latest Mrs K would have been seen by the Urology Department was the beginning of April. My Adviser said that the five month delay, in being seen by the Urology Department, could have had an effect on Mrs K's deteriorating health. He said that if Mrs K had been referred through the two week rule for a Urology review; she would have had a greater chance of recovery. In support of this view, my Adviser explained that renal cancer "shows a large gradient in terms of prognosis between the different stages of tumour growth". He referred to information produced by Cancer Research UK about renal cancer. He provided it to me. He said that there are four stages of renal cancer. My Adviser commented that Mrs K was at stage four by the time that she was diagnosed in September 2007. He suggested that she may have been at stage three or even stage two, five months earlier. The statistics

that he enclosed from Cancer Research UK show a marked difference in likely five year survival rates between the various stages.

27. My Adviser said that, as a result of this case, the Practice has done an impressive amount of work to look at its systems and to improve them. Nevertheless, my Adviser concluded that it remains the case that an appropriate urgent referral should have been implemented for Mrs K and that would have led to rapid access to a specialist opinion and investigation, giving her a better chance of surviving her illness.

Analysis and conclusions

28. In arriving at my findings set out below, I have given due weight to the analysis of my Adviser. I regard his submission as balanced, thorough and plausible.

29. To some extent, I do not agree with the comments made by Mr K in his complaint to me. It seems to me, based on the evidence and my Adviser's comments, that Mrs K did not present worrying symptoms to the GP frequently. The evidence indicates that the first and only time that blood in the urine was mentioned by Mrs K was on 20 March 2007. My Adviser has no criticism of the GP for his actions apart from his decision-making in relation to Mrs K's consultation on that occasion. However, his concern with respect to that event is of huge significance. In that context, I conclude that the GP should have referred Mrs K for suspected cancer under the so called two week rule. I also consider that it was disappointing that the GP did not come to this conclusion when responding to Mr K's complaint. Moreover, I find that, even in the absence of a two week target for seeing a specialist, the GP should have made an urgent referral in any case. NICE and Welsh Guidelines are clear that the appropriate action based on Mrs K's symptoms was to refer urgently. I note that the GP has accepted that in his response to me. I commend him for so doing.

30. It was extremely unfortunate that the referral for an ultrasound scan was delayed for reasons which will never be clear. If this had not happened, Mrs K would have probably been diagnosed much sooner. I also note that the GP has taken appropriate and robust action to address his own concerns about the matter of the lost ultrasound scan

referral. Nevertheless, the GP should not have been reliant on the ultrasound scan referral, which he made due to his suspicion that Mrs K had kidney stones. He should have referred her urgently for suspected cancer.

31. We will never know how an earlier diagnosis of cancer may have affected the outcome for Mrs K. I consider that this will be a source of distress for Mr K for the rest of his life. He has my sincere sympathy. I also acknowledge the apologies and condolences offered to Mr K by the GP. Despite the uncertainty, my Adviser has said that an earlier referral would have given Mrs K a better chance of recovery as evidenced by the five year survival rate data compiled by Cancer Research UK. I uphold the complaint.

Recommendations

32. I recommend that the GP:

- apologises to Mr K for the failure to refer Mrs K urgently on 20 March 2007 to an appropriate specialist with suspected cancer
- pays him £3000 for the distress associated with the uncertainty, with which he has to cope, concerning how a prompt referral may have made a difference to his mother's prognosis
- pays Mr K an additional £250 for his time and trouble in having to make this complaint to me.

33. The GP has agreed to implement the recommendations set out in paragraph 32.

Peter Tyndall 01 December 2010
Ombudsman

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