Delayed Referral in Suspected Cancer: A GP Expert Witness Perspective on Breach, Causation, and Missed Opportunity

by Dr Samah Boulis, GP Expert Witness.

Abstract

Delayed referral for suspected cancer remains one of the most litigated and clinically significant areas in primary care negligence. For clinical negligence solicitors, these cases sit at the intersection of evolving guidelines, diagnostic uncertainty, and the realities of time-pressured consultations. This article examines how delayed referral claims arise, how they are analysed from an expert witness standpoint, and where the strongest—and weakest—cases tend to lie.

Why Delayed Referral Cases Matter

Timeliness is a critical determinant of cancer outcomes. Even relatively short delays in referral can result in disease progression from a potentially curable stage to one where treatment is palliative. In medico-legal terms, delayed referral cases are often compelling because they present a structured framework for analysis:

- Established national guidance defining thresholds for urgent action
- Discrete and identifiable clinical decision points within primary care
- Potentially quantifiable harm in terms of stage migration, treatment burden, and prognosis

Yet they are rarely straightforward. General practice operates in a setting of low prevalence and high uncertainty—most symptoms that could indicate cancer do not. Clinical decision-making must therefore balance the risks of over-investigation against the consequences of missed or delayed diagnosis.

Central to this framework in England has traditionally been the Two Week Wait (2WW) referral pathway, ensuring patients with suspected cancer are seen by a specialist within two weeks. These pathways are grounded in guidance from the National Institute for Health and Care Excellence (notably NG12), which provides symptom-based thresholds for urgent referral.

However, since October 2023, the NHS has reformed cancer waiting time standards, replacing the Two Week Wait target with the Faster Diagnosis Standard (FDS). This standard requires that patients referred with suspected cancer receive a diagnosis—or have cancer ruled out—within 28 days of referral. The emphasis has therefore shifted from speed of first specialist assessment to timeliness of diagnostic resolution.

Urgent suspected cancer referrals (still commonly referred to as "2WW") remain in clinical use and continue to be guided by NG12 criteria. However, they now function within a broader diagnostic pathway that prioritises rapid investigation, often through straight-to-test models, rather than an initial outpatient appointment.

From a medico-legal perspective, the FDS does not alter the legal test for negligence, which continues to be determined by established principles of reasonable clinical practice. However, it is increasingly relevant as contextual evidence of expected timeliness within the NHS. In particular, it reinforces the importance of prompt referral decisions in primary care, as any delay may postpone entry into a pathway designed to deliver diagnosis within 28 days.

These pathways frequently form the benchmark against which GP conduct is judged—but crucially, they operate within, not instead of, established legal tests for negligence.

The Legal Framework: Bolam and Bolitho in Practice

In determining breach of duty, the court relies on principles that are both longstanding and highly relevant to modern general practice. The foundations lie in Bolam v Friern Hospital

Management Committee, subsequently refined by Bolitho v City and Hackney Health Authority. Together, they provide the framework within which GP decision-making is scrutinised in delayed cancer referral claims.

Under Bolam, the central question is whether the clinician's actions would be supported by a responsible body of reasonably competent general practitioners. It recognises that medicine is not an exact science and that a range of acceptable clinical approaches may exist, particularly in the early presentation of potentially serious disease.

However, Bolam does not operate in isolation. The refinement introduced by Bolitho requires that any such body of professional opinion must also withstand logical analysis. It is not sufficient for a practice to be merely accepted; it must be capable of withstanding scrutiny as rational, evidence-based, and consistent with the assessment of clinical risk.

In practical terms, this dual test is critical in delayed referral cases. A decision not to initiate urgent investigation or referral may be defensible if supported by a responsible body of opinion. However, where that decision appears to disregard recognised risk factors, established referral thresholds, or national guidance—such as that issued by the National Institute for Health and Care Excellence—it may fail the logical scrutiny required under Bolitho.

Accordingly, the expert's role is not simply to identify whether a decision was made by some practitioners, but to assess whether it represents a defensible standard of care when measured against both professional consensus and reasoned clinical judgment.

Establishing Breach of Duty

In delayed referral cases, breach usually hinges on deviation from accepted practice. The following factors are central:

1. Guideline Adherence

Failure to follow established referral thresholds—particularly for "red flag" symptoms—can strongly support breach. However, guidelines are not absolute rules. A defensible departure may exist where:

- Symptoms were atypical or transient
- Examination findings were reassuring
- Safety-netting was robust and documented

2. Documentation Quality

The medical record is often decisive. Poor documentation can transform a defensible decision into an indefensible one. Experts scrutinise:

- Symptom duration and evolution
- Examination findings
- Differential diagnoses considered
- Explicit safety-netting advice

Absence of evidence frequently becomes evidence of absence in legal proceedings.

3. Safety-Netting

Clear, documented safety-netting can mitigate liability even where referral was not immediate. Conversely, vague or absent advice significantly strengthens a claimant's case.

Causation: The Harder Hurdle

Even where breach is established, causation is often the battleground.

The key legal question:
Would an earlier referral have made a material difference to outcome?

This requires careful oncological expert analysis:

- Tumour biology and growth rate
- Stage progression timelines
- Survival probabilities at different stages

Not all delays are causative. Some cancers are aggressive enough that earlier detection would not have altered prognosis. Others, particularly colorectal, breast, and some skin cancers, are far more sensitive to delay.

From an expert standpoint, causation opinions must be:

- Evidence-based
- Quantified where possible (e.g. loss of chance)
- Transparent about uncertainty

Common Litigation Themes

Certain patterns recur in delayed referral claims:

Missed "Red Flag" Symptoms

Examples include persistent rectal bleeding, unexplained weight loss, or haematuria. These cases often have strong prospects if documented clearly but not acted upon.

Repeated Consultations Without Escalation

Multiple attendances with evolving symptoms raise concern. A single missed opportunity may be defensible; repeated inaction is harder to justify.

Over-Reliance on Initial Diagnosis

Anchoring bias—persisting with a benign diagnosis despite changing features—is a frequent issue.

Inadequate Follow-Up Systems

Failure to track test results or act on abnormal findings can convert system errors into negligence claims.

What Makes a Strong Case for Solicitors?

From an expert witness perspective, strong claimant cases typically include:

- Clear guideline-triggering symptoms
- Good documentation of those symptoms
- No referral or significant delay
- Evidence that earlier diagnosis would likely have improved outcome

Weaker cases often involve:

- Vague or poorly recorded symptoms
- Reasonable alternative diagnoses
- Appropriate safety-netting
- Uncertain or minimal impact of delay on prognosis

Practical Insights for Case Selection

For solicitors assessing potential claims, early expert input is invaluable. Key questions to ask at the outset:

1. What exactly was documented at each consultation?
2. Did the symptoms meet referral thresholds at that time?
3. How long was the delay?
4. Is there credible evidence that earlier diagnosis would have altered staging or survival?

Conclusion

Delayed referral for cancer remains a high-stakes area of clinical negligence litigation. For expert witnesses, the task is to disentangle hindsight from contemporaneous reasoning, and to apply both clinical and legal standards rigorously.

For solicitors, success lies in identifying cases where breach and causation align—not merely where an adverse outcome has occurred.

Ultimately, these cases are not just about accountability. They highlight the enduring challenge at the heart of general practice: making high-consequence decisions under uncertainty, where the cost of delay can be profound.

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As a GP expert witness, I prepare independent reports in clinical negligence cases, with a focus on informed consent, standards of care and decision-making in primary care.

My overriding duty is to the Court. All reports are prepared in accordance with CPR Part 35, Practice Direction 35, and the Guidance for the Instruction of Experts in Civil Claims (2014).

I welcome instructions from clinical negligence solicitors and counsel in England, Scotland and Northern Ireland.

If you would like to discuss a potential instruction or expert witness query, please feel free to get in touch: **spboulis@doctors.org.uk**