General Practitioner, Dr B

Medical Centre

A Report by the

Health and Disability Commissioner

(Case 17HDC01992)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

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Executive summary

1. Between July 2014 and March 2016 (inclusive), Mr A presented to his general practitioner (GP), Dr B, at a medical centre.

2. Mr A's prostate specific antigen (PSA) was tested in July 2014, and retested in August 2014, both showing slightly elevated results. Dr B told Mr A that his prostate levels were "very slightly over normal — but [seem] to be stable", that specialist review could be arranged if there were any urinary problems, and that otherwise they would check his prostate levels 6–12 monthly. However, Dr B did not set a recall for a PSA test to be done within this timeframe.

3. Mr A requested repeat prescriptions in May and July 2015, via an online tool for patients to access their health information and request appointments and repeat prescriptions. At the time, the medical centre had just started using this tool, and had not yet recognised how easily patients were able to request prescriptions in the absence of an in-person consultation.

4. Dr B requested blood tests for Mr A in July 2015. A PSA test was not requested, with Dr B telling Mr A by email that he "shouldn't need PSA for another year".

5. Dr B issued further repeat prescriptions, including a prescription for Hytrin,[1] in September 2015 and January 2016.

6. On 15 March 2016, Mr A presented to Dr B with urinary retention. Blood tests were taken that day, including a PSA, which showed that Mr A's PSA level was 15.31µg/L.

7. Dr B referred Mr A to the hospital urology service. Mr A was later diagnosed with prostate cancer.

Findings

8. Dr B failed to meet his obligation to ensure that Mr A's PSA levels were managed appropriately. Dr B did not provide Mr A services with reasonable care and skill and was found in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

9. The medical centre did not have adequate processes in place to pick up that Mr A was due for a PSA test. The pattern of suboptimal care provided in this case reflected in part a system that did not deal with repeat prescriptions adequately. There was a lack of enquiry at appropriate times. The medical centre did not provide services with reasonable care and skill, and was found in breach of Right 4(1) of the Code.

Recommendations

10. It was recommended that Dr B provide a written letter of apology to Mr A for the breach of the Code identified in this report.

[1] Hytrin is a medication used for prostate management.

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11. It was recommended that the medical centre perform a random audit of patients to identify compliance with its amended Repeat Prescribing Process and Results Management Process, and provide to HDC the results of the audit and any changes made as a result.

Complaint and investigation

12. The Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided to him at the medical centre. The following issues were identified for investigation:

- *Whether Dr B provided Mr A with an appropriate standard of care between 2014 and 2016.*
- *Whether the medical centre provided Mr A with an appropriate standard of care.*

13. The parties directly involved in the investigation were:

Mr A	Consumer/complainant
Dr B	General practitioner (GP)/provider
The medical centre	Provider

14. Independent expert advice was obtained from Dr Gerald Young, a general practitioner, and is included as Appendix A.

Information gathered during investigation

Introduction

15. At the time of these events, Mr A (then aged 68 years) was registered with the medical centre. Mr A had been a patient of the practice since 2007. Dr B became his regular GP in 2014. Dr B has contracted his services to the practice since July 2011. Prior to that he had worked for the practice since 1991 under various ownership structures.

July 2014 to March 2016: care by Dr B

16. On 22 July 2014, Mr A presented to Dr B for repeat prescriptions. Dr B noted that Mr A's prostate specific antigen (PSA) needed to be rechecked as it had been slightly elevated in March 2014. The PSA was retested on 29 July 2014 and had increased slightly.

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17. On 1 August 2014, Mr A attended an appointment with Dr B to discuss the elevated PSA test result. Dr B suggested that the PSA be retested, with “free PSA” also to be tested.[2] The test occurred on the same day, and the result was slightly elevated.

18. Dr B emailed Mr A on 13 August 2014 telling him that his prostate levels were “very slightly over normal — but [seem] to be stable”, and that specialist review could be arranged if there were any urinary problems, but otherwise to “check it 6–12 monthly”. Dr B told HDC that unfortunately he did not set a recall for a PSA test to be done within this timeframe.

19. Mr A requested repeat prescriptions online on 6 May 2015 and 29 July 2015. Dr B requested blood tests on 29 July 2015, but a PSA level was not requested despite it being almost 12 months since the previous PSA test. Dr B told Mr A by email dated 29 July 2015 that he “shouldn’t need PSA for another year”.

20. Dr B told HDC that this was an error on his part, and he recognises that he should have advised Mr A to have another test. Dr B told HDC that he sincerely regrets not being more proactive on this occasion, and that he is deeply sorry.

21. Dr B issued further repeat prescriptions, including a prescription for Hytrin,[3] on 30 September 2015 and 23 January 2016.

22. On 15 March 2016, Mr A presented to Dr B with urinary retention. Blood tests were taken that day, including PSA, which showed that Mr A’s PSA level was 15.31µg/L.

23. Dr B referred Mr A to the hospital urology service, and Mr A was later diagnosed with prostate cancer.

The medical centre

24. The practice told HDC that at the time that Mr A requested his prescriptions online, “the tool had just started to be used by the practice, and the practice had not yet recognised how easily patients were able to request prescriptions in the absence of an in-person consultation”.

25. The practice told HDC that since these events it has amended its Repeat Prescribing Process and Results Management Process. It now ensures that patients are seen at appropriate time intervals, particularly if there are any red flags or the patient is prescribed more than five medicines. When a request for a repeat prescription is received, a nurse will now screen the request (meaning that both a nurse and a doctor will check each prescription). The nurse will also check the patient’s observations, and that relevant blood tests have been organised. Where there are “red flags”, patients are also put on to the practice’s “recall system”.

[2] A PSA free:total ratio test provides an indication of whether any raised PSA is caused by a benign or malignant problem.
[3] Hytrin is a medication used for prostate management.

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Responses to provisional decision

Mr A

26. Mr A was given an opportunity to comment on the "information gathered" section of the provisional decision and provided a response to HDC.

Medical centre

27. The medical centre was given an opportunity to comment on the provisional decision. The practice responded that it would like to apologise to Mr A, and stated that it has always had policies in place for clinical processes, and regularly checks and adjusts the procedures to fit with best practice as it evolves.

Dr B

28. Dr B was given an opportunity to comment on the provisional decision. He agrees that the quality of his care for Mr A at the time was inadequate. Dr B told HDC that he has now made changes to his practice.

Relevant standards

29. The Medical Council of New Zealand's publication *Good Medical Practice — A guide for doctors* (2008) states:

> "…
>
> Acting with integrity:
>
> Be honest and open when working with patients; act with integrity by:
>
> - Acting without delay to prevent risk to patients
>
> …
>
> Remember that you are personally accountable for your professional practice — you must always be prepared to justify your decisions and actions.
>
> …
>
> Medical care
>
> Good clinical care — a definition
>
> 2. Good clinical care includes:
>
> …
>
> - Providing or arranging investigations or treatment when needed
> - Taking suitable and prompt action when needed
>
> …

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Communication

…

Giving information to patients about their condition

13. Give patients all information they want or need to know about:

…

Treatment options, including expected risks, side effects, costs and benefits.

…

Keeping up to date

73. Keep your knowledge and skills up to date throughout your working life:

Familiarize yourself with relevant guidelines and developments that affect your work …"

Opinion: Dr B — breach

30. Results of the PSA tests for Mr A received in March 2014, July 2014, and August 2014 were slightly elevated. After receiving these elevated PSA results, Dr B advised Mr A that his PSA levels should be checked 6–12 monthly.

31. My independent expert advisor, GP Dr Gerald Young, advised that the management of the slightly elevated PSA at this time was reasonable, as the results were only slightly outside of the normal range and did not show progressive elevation. Dr Young also commented that it is not uncommon for men with benign prostatic hypertrophy — of which Mr A had a known history — to have slightly elevated PSA levels.

32. Dr Young advised that Dr B did not depart from a reasonable standard of care by not referring Mr A at this stage, and it was acceptable to review the PSA in 6–12 months' time.

33. Mr A requested repeat prescriptions on 6 May 2015, 29 July 2015, 30 September 2015, and 23 January 2016. These were issued by Dr B.

34. Blood tests were requested on 29 July 2015. Dr B had the responsibility to ensure that a further PSA test be done, as planned, 6–12 months after the slightly elevated PSA results in July and August 2014. Dr B did not ensure that this test was performed, and erroneously advised Mr A that he should not need his PSA tested for another year. Dr Young advised that Dr B made an error when he told Mr A by email dated 29 July 2015 that he should not need another PSA test for another year.

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35. Dr Young advised:

"The departure from a reasonable standard of care occurred when the follow-up of the slightly elevated PSA in July and August 2014 was not done as planned at 6 to 12 months interval, especially as there was adequate opportunity to do so with a blood test being done on 31 July 2015. This error was further compounded by [Dr B] when he failed to check the status of [Mr A's] PSA testing when he issued repeat Hytrin scripts on 1 October 2015 and 23 January 2016."

36. The Medical Council of New Zealand's publication *Good Medical Practice — A guide for doctors* (2008) states that doctors should provide or arrange investigations or treatment when needed, and take suitable and prompt action when needed.

37. I accept Dr Young's advice, and find that Dr B failed to meet his obligation to ensure that Mr A's PSA levels were managed appropriately. Accordingly, Dr B did not provide Mr A services with reasonable care and skill and, therefore, breached Right 4(1) of the Code.[4]

38. Dr B accepts the error on his part, and has told HDC that he has made changes to his practice as a result.

Opinion: The medical centre — breach

39. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code.

40. Dr Young advised:

"[The medical centre] as a group of providers failed on a number of occasions to pick up that overdue tests and examination reviews were due. Being a group practice with a number of doctors and patients being free to attend any doctor of their choosing, clear protocols are required to ensure that there are not gaps in patients' ongoing care. Unfortunately, this occurred with [Mr A] with his prostate screening.

…

[The medical centre] needs to ensure that they have clear and comprehensive protocols for the management of repeat scripts. When repeat scripts are requested [practices should ensure] that there is a system in place to check that all tests and follow-ups that are due are attended to. There did not appear to be a robust system in place at [the medical centre] based on [Mr A's] case where repeat prescriptions were issued on many occasions without evidence of any reviews being performed to check what tests, examinations or follow up reviews were required."

[4] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

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41. I accept Dr Young's advice and am critical that the medical centre did not have adequate processes in place to pick up that Mr A was due for a PSA test. I acknowledge that since these events the medical centre has amended its Repeat Prescribing Process, to reduce the likelihood of a similar error occurring again. Nonetheless, the pattern of suboptimal care provided in this case reflects in part a system that did not deal with repeat prescriptions adequately. There was a lack of enquiry at appropriate times. I find that the medical centre failed to provide services with reasonable care and skill in this case and, therefore, breached Right 4(1) of the Code.

Recommendations

42. I recommend that within three months of the date of this report, Dr B provide a written letter of apology to Mr A for the breach of the Code identified in the report.

43. I recommend that the medical centre perform a random audit of 50 patients from the past three months, to identify compliance with its amended Repeat Prescribing Process and Results Management Process. A documented report of the results of this audit, and any changes made as a result of the audit, should be provided to this Office within six months of the date of this report.

Follow-up actions

44. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name.

45. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the district health board, and it will be advised of Dr B's name.

46. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Dr Gerald Young, a general practitioner:

"**Advice on [Dr B] […] at [the medical centre].**

I have been asked to provide specific advice regarding [whether] the care provided to [Mr A] by [Dr B] […] was reasonable in the circumstances, and why.

In particular, please comment on:

[…] 2. The standard of care provided to [Mr A] by [Dr B], including the adequacy of the management plan following the elevated PSA result in July 2014.

3. The standard of care provided to [Mr A] by [the medical centre].
4. Any other matters in this case that you consider warrant comment.

In preparing the advice on this case to my knowledge I have no personal or professional conflicts of interest giving advice in this case.

References provided to complete the report:

1. Letter of complaint dated […]

[…] 3. [Dr B's] response dated 26 March 2018

4. Clinical records from [the medical centre]
5. Clinical records from [the] District Health Board

Other references used:

1. 'Testing for prostate cancer: a consultation resource.' Ministry of Health. 2008 Ministry of Health
2. 'Diagnosis and Management of Prostate Cancer in New Zealand Men. Recommendations from the Prostate Cancer Taskforce.' Ministry of Health May 2013
3. 'PSA Screening in Asymptomatic men — the debate continues.' BPAC July 2010

Advice:

[…]

2. The standard of care provided to [Mr A] by [Dr B], including the adequacy of the management plan following the elevated PSA result in July 2014.

The standard of care provided by [Dr B] to [Mr A] was a moderate departure from the standard of care expected.

22 July 2014: [Mr A] started to attend [Dr B] as his regular GP. This was for repeats of his medications. It was noted by [Dr B] that the PSA may need to be rechecked as it was slightly elevated in March 2014 at 4.7 (normal for age <4.5).

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The PSA was retested on 29 Jul 2014 with another slight increase to 5.0.

01 Aug 2014. [Mr A] was seen by [Dr B] to follow-up the elevated PSA result. The significance of the very slight rise of the PSA test was discussed. [Dr B] suggested that the PSA be repeated with 'free PSA' to be also tested.

It is noted that written information on PSA testing was given to [Mr A]. Also, a CT scan was discussed and discounted as being not helpful at this stage. [Dr B] also assured [Mr A] that he could '… always email urology for help' if required.

The PSA was retested on 01 Aug 2014 with the total PSA of 4.7 and Free PSA = 21%.

[Dr B] emailed [Mr A] and reassured him that '… prostate blood test is very slightly over normal but seems to be stable'. If there were any urinary problems, then specialist review could be arranged otherwise '… check in 6–12 monthly'.

The management of the slightly elevated PSA at this time was reasonable. The level was only slightly outside the normal range for age of 4.5. The PSA level on 3 tests March 2014, July 2014 and August 2014 were reasonably stable and did not show progressive elevation. Also, it was noted that [Mr A] had a known history of benign prostatic hypertrophy (BPH) having a previous transurethral resection in 2003. A previously elevated PSA of 6.02 was noted in 08 Dec 2008 and this subsequently settled back into the normal range.

It is not uncommon for men with BPH to have slightly elevated PSA levels. PSA levels can also be elevated with recent ejaculation or prostatic infection/inflammation.

It was reasonable not to refer [Mr A] at this stage and to do a follow up PSA at 6 months but certainly should have been repeated within 12 months.

[Mr A] had repeat prescriptions issued by [Dr B] on 6 May 2015 and on 29 July 2015.

Blood tests were requested on 29 Jul 2015, but a PSA test was not requested even though it was due to be done as it was almost 12 months since the last test of Aug 2014. [Dr B] erroneously advised [Mr A] by email that [he] 'shouldn't need PSA for another year'.

Clearly this was an error on [Dr B's] part, as the repeat PSA was due. [Dr B] did not elaborate in his reply how this error occurred. It is also noted that [Mr A] did not question this advice as it was some time, almost 1 year since the last PSA test and previous advice given in Aug 2014 that PSA would be retested in 6–12 months.

Further repeat scripts including Hytrin for prostate management were issued by [Dr B] on 1 Oct 2015 and 23 Jan 2016. No blood tests were done.

15 Mar 2016: [Mr A] presented with increasing difficulty to pass urine, with poor flow and dribbling. Rectal examination revealed a firm prostate with no nodules palpable.

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Blood tests were requested including a PSA, which was elevated at 15.3.

[Mr A] was advised that the PSA was elevated and was referred to the hospital urology service.

It is noted that the urology outpatient clinic initial assessment on 31 May 2016 confirmed the symptoms of outflow obstruction, with an enlarged prostate which was '… possibly slightly firm on the right side'. The initial working diagnosis was that his outflow obstruction was caused by inflammation of the prostate possibly prostatitis.

A follow-up PSA showed that the PSA had reduced but was still elevated above the normal range for his age at 11.83. Prostatic biopsy confirmed prostatic cancer.

The departure from a reasonable standard of care occurred when the follow-up of the slightly elevated PSA in July and August 2014 was not done as planned at 6 to 12 months interval, especially as there was adequate opportunity to do so with a blood test being done on 31 Jul 2015. This error was further compounded by [Dr B] when he failed to check the status of [Mr A's] PSA testing when he issued repeat Hytrin scripts on 1 Oct 2015 and 23 Jan 2016. As discussed above the plan to wait and retest in 6–12 months was reasonable in [Mr A's] case with his known clinical history of BPH with previous surgery and previously elevated PSA test. Clinical examination of the prostate had not revealed any palpable signs of prostate cancer.

3. The standard of care provided to [Mr A] by [the medical centre].
The standard of care provided to [Mr A] with respect to the management of his prostate by [the medical centre] was a mild departure from a reasonable standard of care.

The reason for this finding is that the [medical centre] as a group of providers failed on a number of occasions to pick up that overdue tests and examination reviews were due. Being a group practice with a number of doctors and patients being free to attend any doctor of their choosing, clear protocols are required to ensure that there are not gaps in patients' ongoing care. Unfortunately, this occurred with [Mr A] with his prostate screening.

[Mr A] was on Hytrin for management of outflow obstruction secondary to benign prostatic hypertrophy and had discussed concerns about his prostate and indicated he wished to have regular monitoring of his prostate health. The fact that he was on regular medications for his prostate should have made checking that the annual PSA test and DRE of the prostate was done or offered, relatively straight forward, as [Mr A] had to get repeats of these medications every 3 months. However as discussed above in relation to […] [Dr B] these annual checks were over looked. They were also over looked by other doctors in the practice, for example in Feb 2012 [Mr A] requested a repeat of his Hytrin script, however the annual PSA test and DRE of the prostate were due but were not done or offered. Ideally [Mr A] should have been notified that his PSA test and DRE of the prostate were due, and he should attend to have these done with the doctor as well as getting the repeat of his medications. If for some reason the

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patient was not able to attend on this occasion, a note should be made in the record regarding this and the recall reset for the agreed time or the next repeat script date.

[Dr B] in his reply also admits that he did not set a recall for the follow-up PSA test that was agreed to be re-tested in 6–12 months from 01 Aug 2014. Irrespective of not setting the recall the protocol for repeat scripts should be robust enough to have picked up that the PSA re-test that was to be done had not been done well before [Mr A] re-presented with acute symptoms on 15 March 2016. [Dr B] in his reply states that he made an error in not requesting a PSA with the repeat bloods done on 1 Aug 2015. However repeat Hytrin scripts were issued by [Dr B] on 1 Oct 2015 and 23 Jan 2016 but no checks were done to ascertain whether all the associated management tests and examinations were up-to-date.

It should be routine practice that before any repeat medication is issued whether in a consultation setting, via phone or online that a check is done to confirm that all tests, examinations and/or any other follow-ups required are attended to. If for whatever reason these cannot be done by the patient at this point, this should be documented in the records and agreed future date set for them to be undertaken. At the next repeat script, the whole process is re visited and updated.

[The medical centre] needs to ensure that they have clear and comprehensive protocols for the management of repeat scripts. When repeat scripts are requested that there is a system in place to check that all tests and follow-ups that are due are attended to. There did not appear to be a robust system in place at [the medical centre] based on [Mr A's] case where repeat scripts were issued on many occasions without evidence of any reviews being performed to check what tests, examinations or follow up reviews were required.

4. Any other matters in this case that you consider warrant comment.

In any practice, but especially in a larger group practice it is important that robust protocols are in place for recalls and repeat prescriptions. With a number of doctors being involved in patient care, especially if the patient's history is not well known to a doctor in the group, practice recalls and protocols help to ensure that no gaps occur in providing general practice care to patients.

I note that [the medical centre] use[s] [practice management software] … once a recall has been actioned the system doesn't rollover automatically to the next recall period. The recall must be manually reset for the next one. … if the system default was that recalls were automatically reset for the same period as previously set unless changed, this would help to mitigate the common human error of forgetfulness. …

… it is hard to see on one screen at a glance all the outstanding tasks for each patient… This can add to relevant information being overlooked or not reviewed.

Please contact me if any part of my opinion requires clarification.

Yours sincerely,

Dr Gerald Young."

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