Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

GP who delayed advising man of prostate cancer results breaches Code

21HDC00473

The Deputy Health and Disability Commissioner has found a GP breached the Code of Health and Disability Services Consumers' Rights (the Code) for his delays in advising the results of a prostate specific antigen (PSA) test to his patient. The man, who is also the GP's relative, went on to develop prostate cancer.

Deborah James found the GP breached Right 4(1) of the Code. This concerns the right to services provided with reasonable care and skill. She said the GP did not take appropriate action following receipt of the man's abnormal test result and his management of the results was not consistent with Ministry of Health guidelines.

Ms James found that the GP breached Right 6(1); the right to information that a reasonable person would expect to receive in those circumstances for failing to inform the man of the abnormal test within a reasonable time.

The complaint relates to events beginning in 2017 when the man undertook routine screening blood tests, the results of which indicated raised PSA levels. He was not told of this by his GP, nor was he referred for further investigation. The man has a family history of prostate cancer.

The man visited his GP several times over the next three years for ongoing symptoms however the GP did not advise him of his PSA result at any time during these visits. In 2020, a repeat PSA test was taken and the man was diagnosed with metastatic prostate cancer.

Ms James was also critical of the GP treating a relative (the man), and of his use of administrative aids when dealing with patient test results. She recommended the GP undertake self-learning on the importance of sharing test results, audit current policies at his practice to ensure they are appropriate in light of her findings and reflect on how treating a relative may have affected his care.

Ms James has recommended that the GP provide a written apology to the man and recommended the Medical Council of New Zealand consider a review of the GP's competence.

The GP has put in place several changes to his practice following this report including:

- Implementing a prostate screening policy to achieve the Royal New Zealand College of General Practitioners standard
- Attending teaching by a urologist to improve his knowledge and practice
- Improving his patient recall administration processes

- Undertaking a learning module on a prostate cancer testing decision support tool
- Implementing a patient portal so patients can see their results and other information.

18 September 2023

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

Learn more: Education