Monitoring of repeat PSA testing
17HDC01992, 29 March 2019

General practitioner ~ Medical centre ~ PSA test ~
Online patient portal ~ Right 4(1)

A man presented to his general practitioner (GP) at a medical centre. The man's prostate specific antigen (PSA) was tested and retested the following month, with both showing slightly elevated results. The GP told the man 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, the GP did not set a recall for a PSA test to be done within this timeframe.

The man requested repeat prescriptions through an online tool set up by the medical centre for patients to access their health information and request appointments and repeat prescriptions. At the time, the medical centre had just started using the tool, and had not yet recognised how easily patients were able to request prescriptions in the absence of an in-person consultation.

The GP requested blood tests for the man a year after the elevated PSA tests, but a PSA test was not included, and the GP told the man by email that he "shouldn't need PSA for another year". The GP issued further repeat prescriptions, including a prescription for Hytrin for prostate management in the following months.

The following year, the man presented to the GP with urinary retention. Blood tests were taken that day, including a PSA, which showed that the man's PSA level was 15.31µg/L. The GP referred the man to the hospital urology service, and he was later diagnosed with prostate cancer.

Findings

The GP failed to meet his obligation to ensure that the man's PSA levels were managed appropriately. The GP did not provide the man 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).

The medical centre did not have adequate processes in place to pick up that the man 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).

Recommendations

It was recommended that the GP provide a written letter of apology to the man. It was also 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 HDC with the results of the audit and any additional changes made.