HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Delayed diagnosis of prostate cancer due to lack of timely referral to a urologist

1. Mr A, aged in his seventies at the time of events, complained to HDC that his general practitioner (GP), Dr B at a medical centre, did not appropriately refer Mr A to a specialist in a 'timely manner'. Mr A considers that this led to a delayed diagnosis of his prostate cancer. This report considers whether Dr B and the medical centre provided a reasonable standard of care to Mr A.

2. Information was gathered from Mr A, Dr B, the medical centre, and Health New Zealand | Te Whatu Ora (Health NZ).

GP visits

3. Clinical records show that Mr A was seen by Dr B at the medical centre from at least November 2017. Mr A told HDC that he received yearly checkups when he visited his GP for his long-term medications.

2019

4. A routine blood test on 7 May 2019 recorded Mr A's total PSA[1] level as 11.8µg/L (reference range 0.00–3.99). The test result contained a note that recommended referral to a urologist if the PSA levels were repeatedly raised, if the DRE[2] was abnormal, and/or if there were other red-flag symptoms or signs.

5. In his clinic notes of 7 May 2019 Dr B noted that Mr A's PSA levels had increased from 3.3µg/L in 2014 and that he intended to see Mr A for a DRE '+/- referral Urology for biopsy[3]'. Dr B set a task in MedTech32 (the medical centre's patient management system) for a healthcare assistant to request that Mr A return for a DRE on the week of 20 May 2019.

6. Dr B told HDC that he believes he was 'not as clear as [he] should have been' when discussing the above with Mr A, as he was only 'considering, but not decided' on a referral to urology at this stage.

7. On 20 May 2019 Dr B recorded that a DRE had been 'done in [the] past, 2 [years] ago, only enlarged+'. He noted a significant increase in urinary frequency, but no dribbling, pain, or obvious blood in the urine. There is no documented evidence that a DRE was performed in 2017, nor of a repeat DRE having been completed at this appointment.

[1] Prostate specific antigen (PSA) is a protein made by the prostate. Testing of PSA levels is used to screen for prostate cancer.
[2] Digital rectal examination to check for abnormalities in the prostate.
[3] Removal of a piece of tissue or a sample of cells for testing.

2020

8. On 4 May 2020 Dr B had a telephone consultation with Mr A. Dr B noted that the PSA had increased further to 13.4µg/L,[4] but that Mr A's urine stream was ok and that there was no blood in the urine. Dr B recorded the following next to the elevated PSA result: 'Increasing Trend: contact Urology.' Dr B accepts that although he considered a referral, a referral was not completed. He stated that his personal circumstances (discussed further in paragraph 20) and the lack of urgency associated with the referral likely contributed to the oversight but that this 'does not excuse the oversight'.

9. Dr B noted in his clinic notes for 11 June 2020 to contact the Urology Department regarding Mr A's elevated PSA levels but that it was likely only a benign enlargement of the prostate 'as was found in 2019 May with [DRE]'. Dr B set a task for himself on MedTech32 to refer Mr A to the Urology Department for advice after receiving a new urine sample. However, the referral did not occur.

10. On 6 August 2020 Dr B set a task on Medtech32 for his healthcare assistant to contact Mr A for a urine sample and repeat PSA bloods. The urine sample returned clear on 7 August 2020, but there is no record of a PSA result, or a follow-up of any PSA results. The medical centre said that it is the responsibility of the clinician or nominated person to follow up on tasks set in MedTech32.

11. Clinical records show that Dr B set up a PSA recall in Medtech 32 on 19 December 2020, but there is no record of this recall having been followed up.

12. The medical centre told HDC that whilst tasks are the responsibility of the clinician or nominated person, it has a 'robust process' to ensure that a specific nurse reviews recalls daily and notifies patients. The medical centre's Inbox/Results Management Policy also states that the clinician who ordered the test is responsible for organising the tracking of the test and actioning of the result.

2021

13. Dr B saw Mr A on 3 February 2021 after PSA levels from a routine blood test showed a further increase to 17.3µg/L. Dr B recorded that Mr A had no urinary flow problems and noted next to the blood test result: 'Increasing [PSA] ref[er to] Urology for advice: done.' However, the referral was not completed. Dr B recalls making a 'clear decision' to refer Mr A but accepts that a referral was not sent, which may have been because he was 'most concerned' with Mr A's cardiac issues at the time, and this may have 'overshadowed' other issues and referrals.

14. On 19 February 2021 another staff member from the medical centre called Mr A and noted that Mr A had been made aware that Dr B would 'be doing referrals for [P]SA and [Blood Pressure]'.

[4] Noting that the reference range for PSA had increased to 0.00–6.49µg/L as Mr A had passed the previous age bracket.

15. Mr A was seen by '[a staff member][5]' on 22 February 2021 to follow up on his referral. The staff member noted that the referral[6] had 'still not [been] done', and that they had 'templated it with [Dr B] to discuss [that] afternoon'. The clinical records do not show that '[the staff member]' followed up with Dr B or that a referral was completed.

16. The medical centre told HDC that it received a call from Mr A on 14 April 2021 expressing his concern about the lack of referral. Subsequently, a note was made in Dr B's appointment book to seek the task regarding the referral. The medical centre told HDC that this was noted by Dr B later that day and it was actioned. However, the clinical records show that a referral was completed to an internal medicine specialist for management of blood pressure, rather than to a urologist for Mr A's PSA levels.

Referral and diagnosis

17. Blood test results from 29 April 2021 showed that Mr A's total PSA was now at 29µg/L, and a semi-urgent urologist referral was sent on 30 April 2021 and acknowledged by Health NZ the same day.

18. On 6 May 2021 Mr A's referral was accepted, triaged, and placed on the 'semi-urgent waiting list', and subsequently Mr A was seen by a urologist on 17 June 2021. The urologist noted Mr A's elevated PSA levels and absence of symptoms, and that Mr A had no family history of prostate cancer. The urologist took biopsies and arranged for a bone scan for further investigation, after which Mr A was diagnosed with grade 3 prostate cancer on 24 June 2021.

Further information

19. Dr B sincerely apologised for not being clear in his communications with Mr A, and for the delay in actioning a urology referral. He accepts that there was a delay in referring Mr A to the Urology Department and maintains that the delay was not intentional. Dr B said that he deeply regrets the additional stress caused to Mr A at such a difficult time.

20. Dr B told HDC that he had several personal medical situations that required multiple absences from his work. He said that while he did his best to provide appropriate care throughout these situations, it is possible that his absences and remote work impacted on the continuity of care able to be provided. The medical centre told HDC that Dr B had a graduated return-to-work plan from 10 September 2018 for a period of four months (to January 2019), and he required further time off in March 2020 for surgery, but he returned to work remotely on 30 March 2020. Dr B told HDC that he also worked remotely in August and September 2020.

21. The medical centre's Inbox/Results Management Policy states that if a GP is unwell, the practice will ensure that inboxes are checked daily, and time-critical results are dealt with appropriately. In addition, the physician's assistant is to check inboxes daily to ensure that time-critical tests from the previous day have been dealt with, and designated staff are to

[5] The identity of this staff member is unknown.
[6] It is unclear from the clinical records whether this related to the Urology referral or the referral regarding Mr A's blood pressure.

check all provider inboxes twice a week to ensure that nothing is sitting with an inactive provider.

22. The medical centre's working from home policy states that remote employees are expected to maintain the same level of professionalism and compliance with relevant policies and regulations as if they were working on site. The policy clearly states that clinicians working remotely are responsible for any tests they order, and that test results should be directed to their inbox, and that it is their duty to follow up with the patient as needed.

23. Subsequently, Dr B left the medical centre, but he continues to practise as a GP in New Zealand.

Clinical advice

24. In-house clinical advice was received from Dr Fiona Whitworth (Appendix A).

Dr B

25. Dr Whitworth advised:

- Mild to moderate departure for no evidence of an informed consent discussion surrounding PSA testing on 6 May 2019;
- Moderate departure for the lack of current clinical symptoms documented in the 30 April 2021 referral form;
- Moderate departure for multiple missed opportunities to make a timely referral to a urologist;
- Moderate departure that a checking process did not occur regarding repeated blood tests and referrals; and
- Mild to moderate departure for a lack of complete urological history-taking, and that a DRE was not undertaken.

26. In addition, Dr Whitworth advised that there were significant documentation omissions and a lack of adherence to the health pathways advice.

Medical centre

27. Dr Whitworth advised:

- Moderate departure for an inadequate system to ensure that nominated persons undertake tasks assigned to them; and
- Mild to moderate departure for a lack of regular performance review of task and inbox completion by clinicians.

Responses to provisional decision

28. Dr B, the medical centre, and Mr A were provided with an opportunity to comment on the provisional decision. They confirmed that they had no further comments to make.

Decision

29. Mr A's GP, Dr B, began to monitor Mr A's increasing PSA levels from at least 7 May 2019 until late April 2021. Dr B noted that he contacted Urology at multiple points throughout this time, but he acknowledged that a Urology referral was completed only on 30 April 2021. Subsequently, Mr A was diagnosed with grade 3 prostate cancer in June 2021.

Dr B — breach

30. Having reviewed all the information received, I consider that Dr B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) for his inadequate clinical assessment, inaccurate documentation, and the lack of timely referral and follow-up processes regarding Mr A's care.

31. Regarding Dr B's documentation, it is unclear (despite his written intent on 7 May 2019) whether a DRE was performed on 20 May 2019, including any related informed consent discussions, and/or the results of the DRE. This led to further incorrect documentation in the clinical notes of 11 June 2020 that a DRE had been performed in 2019, when there is no documented evidence to support this. These incorrect statements of a DRE being performed ultimately meant that no DRE was performed during this time (against standard practice), when such an assessment may have supported timely escalation of Mr A's referral. Dr B recorded in his notes on 3 February 2021 that a urologist referral had been 'done', but there is no documented evidence of this. This error (which led to Dr B's mistaken understanding that a referral had been processed) unintentionally withheld and delayed referral for Mr A for another two months. I consider that these deficiencies in clinical documentation by Dr B affected the provision of care to Mr A.

32. Dr Whitworth advised that there were 'numerous [missed] opportunities' for referral, which, along with the lack of a checking process, meant that tests and referrals were not completed or followed up. I accept this advice.

33. It is clear that as Mr A's GP, Dr B had ultimate responsibility to ensure that Mr A's care was escalated appropriately. From May 2019 there were at least six recorded opportunities[7] for Dr B to have actioned and/or followed up on a urologist referral but failed to do so. Despite his written intent to contact Urology from at least May 2019,[8] Dr B processed a referral for Mr A only two years later. Although there are certain systems improvements that may have provided better support for Dr B (discussed further below), it was Dr B's responsibility to send the referral.

34. Although it was important for the medical centre staff and systems to support Dr B in his roles and responsibilities as a GP, as per the medical centre's policy and Dr Whitworth's advice, ultimately it was Dr B's responsibility to organise the tracking of the relevant tests and to action the results. It was also Dr B's individual responsibility to document and escalate Mr A's care appropriately. I do not consider that Dr B's personal circumstances and

[7] 7 May 2019, 4 May 2020, 11 June 2020, 6 August 2020, 19 December 2020, 3 February 2021.
[8] Acknowledging that Dr B told HDC that his note of 7 May 2019 indicated only a consideration of contacting Urology, as opposed to a definite decision.

the medical centre's failures (set out below) sufficiently mitigate against this finding of a breach of the Code.

Medical centre — adverse comment

35. Considering the information provided, I am critical that the medical centre and its systems did not support Dr B appropriately during his illness and whilst he was working from home.

36. According to the medical centre's explanation of Medtech32, the responsibility of the 6 August 2020 task was with the nominated person (the healthcare assistant), and the responsibility of the 19 December 2020 recall should have been with the relevant nurse. In both instances, there is no record of the PSA test results being followed up by the appropriate staff members.

37. In addition, on 22 February 2021 it was noted by '[the staff member]' that the referral would be discussed with Dr B that afternoon, but there is no evidence that this discussion occurred. There also seems to have been some confusion between the medical centre staff and Mr A regarding whether the referral was to a urologist, or to Internal Medicine, as these referrals were being considered concurrently during 2021. This is evidenced by the medical centre's response to HDC that after having received a call from Mr A on 14 April 2021, it actioned 'the referral' 'later that day'. However, only a referral to an internal medicine physician for Mr A's blood pressure was completed, and not a referral to a urologist.

38. Clinical and non-clinical support staff had a responsibility to support Dr B to fulfil his role, and, as Dr B's employer, it was essential for the medical centre to ensure that its systems did so adequately. I am critical that staff did not support Dr B adequately by following up as requested, and that these failures were not picked up via a review/audit system, nor by the staff required to check clinicians' inboxes daily and weekly. However, I acknowledge the medical centre's policy and Dr B's individual responsibility as the clinician ultimately responsible for Mr A's care as mitigating factors against finding the medical centre in breach of the Code.

Changes made

39. I acknowledge Dr B's statement that he has improved his practice since this event to 'diligently follow up' on referrals and to end consultations with a clear articulation of next steps, and that he has reviewed the relevant referral guidelines. Dr B also told HDC that currently he is enrolled in a Masters in Functional Medicine (which includes a module on male health), and he has applied for a course in Male Medical Problems: Prostate.

40. The medical centre told HDC that it undertook a peer review session, after which it was decided that the recall process for abnormal PSA results would be the task of a specific physician assistant for uniformity in future cases. The medical centre said that it is 'very aware' of the pressures on doctors to check their inbox daily amidst their consultations, and it now addresses this issue by allocating dedicated time every day for this work and employing five assistants to help check these results and discuss any urgent and/or abnormal results with the GP. The medical centre told HDC that this support was not in place for Dr B when he worked at the medical centre.

Recommendations

41. In addition to the above changes, I recommend that Dr B:

a) Provide a written apology to Mr A for the breach of the Code identified above. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

b) Reflect on the deficiencies in care identified in this case, and the related guidelines, particularly around documentation standards, communication, and referrals management, and provide a written report on his reflections and changes to practice as a result of this case, within three months of the date of this report.

c) Provide evidence of attendance at the Male Medical Problems course and a written reflection on his learnings from the course, within three months of the date of this report.

42. In addition to the changes made above, I recommend that the medical centre:

a) Report on the effectiveness of its task and recall system. This should be measured via an audit of clinical records to determine the degree of compliance between setting of tasks/recalls against the actioning of these tasks/recalls. A summary of the findings with any corrective actions (including consideration of setting a timeframe for follow-up of tasks and recalls set) is to be provided to HDC within three months of the date of this report.

b) Conduct a review of its policies and processes regarding handover when a staff member takes time off, as well as its working from home policy, and provide a written report to HDC on reflections and any changes to practice it has instigated as a result, within three months of the date of this report.

Follow-up actions

43. A partly anonymised copy of this report will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name.

44. A copy of this report with details identifying the parties removed, except the in-house clinical advisor, will be sent to the Royal New Zealand College of General Practitioners, Health New Zealand|Te Whatu Ora, MedTech, and the Cancer Control Agency and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Carolyn Cooper
Deputy Health and Disability Commissioner

Names (except the advisor on this case) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from GP Dr Fiona Whitworth:

'CLINICAL ADVICE — MEDICAL

TO	**:**	**INV**
FROM	**:**	Dr Fiona Whitworth
CONSUMER	**:**	[Mr A]
PROVIDER	**:**	[Dr B]
		[The medical centre]
FILE NUMBER	**:**	C21HDC01686
DATE	**:**	16/9/2024

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1. My name is Dr Fiona Whitworth. I am a graduate of Oxford University Medical School and I am a practising general practitioner. My qualifications are: MA 1991, BM BCh 1994, DCH 1996, DCRCOG 1996, MRCGP 1999, PGCMed Ed 2011, FRNZCGP 2013, PGDip GP 2016, FAEG 2020. Thank you for the request that I provide clinical advice in relation to the complaint from [Mr A] about the care provided by [Dr B]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. **Documents reviewed**

26/7/2021	Complaint
17/8/2021	S14 Response and Clinical Records — outgoing referral letters are not included.
17/1/2023	[Dr B] response to notification
27/10/2023	[The medical centre's] Response and Enclosures
20/9/2021	[Dr B] S14 Response
7/9/2021	[Health NZ] Clinical records

3. **Complaint**

On 26 July 2021 the HDC received a complaint from [Mr A] about the care provided to him by [Dr B] at [the medical centre]. [Mr A] raised concerns that there was a delay in progressing his referral to specialist services for investigation of an enlarged prostate and increased PSA result (since 2019).

[Mr A] had a raised PSA level in May 2019 and the test result noted the "PSA exceeds the recommended level for referral to a urologist, or if DRE (digital rectal exam) is abnormal". [Dr B] acknowledges that he did not do a Direct Rectal Exam (DRE) in 2019 as [Mr A's] previous DRE in 2017 found an enlarged prostate which [Dr B] thought

explained the raised PSA result. [Dr B] considered it was appropriate to monitor [Mr A's] PSA, and that PSA levels were not concerning until 2021 when the PSA was significantly higher.

4. **Provider response(s)**

From [the medical centre]
It is noted that a verbal complaint was received on 14/4/2021 regarding a lack of referral. A task was sent to [Dr B] and it is stated that this was actioned on the same day.

[Dr B]
His provider report is clear and detailed and he has apologised for the delay in referrals. He has acknowledged that he should have referred after a second abnormal PSA result in June 2020 and that he again failed to refer in February 2021 when there was again an increasing PSA level. He has noted that there were considerable mitigating circumstances including several periods in which he was unwell and subsequently working remotely.

He has provided a further email response in which he notes when referring in a GP capacity for specialist opinion he explains the rationale behind the referral and the expectations he has for management and that there can be a delay in seeing hospital specialists. He notes that if there is any gross abnormality that he refers immediately.

He notes that in the case of [Mr A] there was a delay in referring as he was not constantly in the practice and unwell himself.

He has stated that referrals made are captured on Medtech Evolution clinical system and that with all referrals or plans to refer he uses his staff task list which when in practice he checks regularly.

He has outlined the reasons for delay in referral.

He notes he has reviewed the Guidelines for referral to urology re concerns in PSA. He also has stated he has applied for a course in Male medical Problems: prostate …

He has stated his intention to follow up on any referral he makes to hospital to ensure no delays. If there are delays contacting patients to check whether there are any changes in their clinical condition.

He also notes his intent to delegate these responsibilities to colleagues if he is unwell or unable to do his tasks.

5. **Review of clinical records**
Exetimibe10mg/simvastatin 20mg 1 od
Omeprazole 40mg 1 DO
Betaloc CR 190mg 1 OD
Spironolactone 12.5mg DO

Candesartan 8mg 1 BD

6. **Comments**

28/4/2016	**GP Consultation [staff]**
	BP review and medication issued
13/9/2016	Consultation [GP]
	Hand issue
1/12/2016	Prescription issued
30/1/2017	Consultation [GP]
	Here for forms and prescriptions issued.
29/5/2017	Consultation [GP]
	Review of warts and BP and prescription issued
22/8/2017	Prescription issued [GP]
16/11/2017	GP Consultation [Dr B]
	URTI assessment Prescription issued
20/2/2018	Prescription issued
21/5/2018	Prescriptions issued
14/8/2018	Order for bloods completed prior to annual review

20/8/2018 Consultation [GP]
Hypertension review BP 156/83. Noted discharged from … surveillance.
Some concern re memory given did not remember a rectal camera. FOB negative.

14/11/2018 Prescriptions issued
14/4/2019 Prescriptions issued

15/4/2019 Consultation [GP]
Noted to have a swollen right eyelid, ongoing cyst 2 years. Also non healing lesion on left ear. Action booked with GP re prescription and lesion on ear. Booked to see … for eye.

15/4/2019 GP Consultation [GP]
Diagnosed stye and possible cellulitis treated with cephalexin 500mg bd
Comment there has been no review of his ear lesion or general review regarding his medications.

6/5/2019 GP Consultation [Dr B]
Left ear examined noted keratosis and treated with topical liquid nitrogen. BP 140/70 noted to be stable. Routine bloods ordered.

Comment
There is no note of any informed consent process surrounding the use of the PSA test.

7/5/2019 Blood results [Dr B]
PSA elevated. Noted 2014 = 3.3 highlighted "*to see patient for DRE and +/- referral Urology for biopsy*"

8/5/2019 Message sent by [Dr B] to ask staff to book a follow up appointment week of 20/5/2019.

20/5/2019 GP Consultation [Dr B] …
"DRE done in past, 2 yrs. ago, only enlarged+ Frequency++ no drippling No pain No blood obvious"
I note a follow up blood form has been issued.

Comment
The Clinical notes provided including 2017 do not confirm that a DRE was done at this time.

[Mr A] has been specifically brought back for review following an elevated PSA. No DRE has been undertaken and it is unclear what the diagnosis is or the further management plan.

No urological referral has been made at this stage. It would be common practice to repeat the PSA in 6–12 weeks' time.

6/8/2019	[GP] Prescription issued
16/8/2019	[GP] Prescription issued.
5/11/2019	[GP] Prescription issued.
28/1/2020	[GP] Prescription issued.
4/5/2020	Consultation … In for BP review, discussion with [Dr B] to organise blood test today. HbA1c taken — 41

4/5/2020 GP Phone Consultation Triage [Dr B]
It is unclear from the notes why he was consulting — "*guided care call … doing well … bit of a headache." "PSA elevated last visit, stream ok. No haematuria"*
Prescription issued.

Comment
However it has been noted that he had a previously elevated PSA. Further blood tests have been ordered. No DRE has been advised. There is a considerable lack of clinical documentation surrounding a urological history. There is no documentation of enquiry re any family history of prostate cancer. This has been a missed opportunity for referral.

4/5/2020 Blood review [Dr B] …
PSA 13.4
noted to have "*increasing trend contact urology"*
Other bloods stable.

Comment
It is not clear from the notes what has been told to [Mr A].

No referral letter is noted to have been sent. There is no documentation of a phone call to urology or other advice sought.

8/5/2020 GP Phone Consultation [Dr B]
Noted to be part of guided care, that he is doing well and that he has had his blood tests done.

Comment
This is a missed opportunity to check that the referral had been sent.

9/5/2020 Phone Consultation [GP]
Concern re BP readings discussed (172/96). Discussion with [Dr B] re treatment options and noted to have deteriorating renal function eGFR 45. Appointment booked for review.

11/6/2020 GP F2F Consultation [Dr B]
Blood pressure reviewed and started on candesartan (inhibace stopped)

"+ to contact Urology due to Prostate enzyme — likely only enlargement as was found in 2019 May with exam"

Comment
There appears to be some confusion regarding the previous examination. There is no documented DRE from May 2019. I note the intent is again to contact urology regarding his PSA elevation. This was not done.

24/6/2020 HCA Review of BP

Blood pressure readings undertaken. It is stated that [Mr A] is feeling great. The notes state [Dr B] will be informed.

4/8/2020 Prescription issued [Dr B] Blood tests requested.

Comment
This is a missed opportunity to check that the referral had been sent.

5/11/2020 Prescription issued [Dr B]

Comment
This is a missed opportunity to check that the referral had been sent.

26/1/2021 HCA Review of BP

Some symptoms booked for GP review

3/2/2021 GP F2F Consultation [Dr B]
Concern re his BP noted — advised to get repeat blood results then for appointment with medical team regarding treatment options.

Noted to have "*no urinary flow problems. Although PSA high last test."*

Prescriptions have been issued and blood tests ordered.

Comment
This is a missed opportunity to check that the referral had been sent.

3/2/2021 Blood results [Dr B]

PSA 17.3 *"Increasing red Urology for advice: done"*

Comment
The referral was again never sent.

19/2/2021 Telephone call [GP]

Patient informed that [Dr B] will be doing referrals re his PSA and his blood pressure.

22/2/2021 Conversation with [staff]

Enquiring about his referrals. Had not had his phone call returned last week. It is noted *"Unfortunately still not done, had templated it with [Dr B] to discuss this afternoon … HCA"*

17/3/2021 Health Link form [Dr B]

Comment
It is unclear if this was an initial urology referral but given there was no acceptance letter from the hospital this is unlikely.

24/3/2021 GP Phone consultation [Dr B] …
Informed of advice from Medical Team … to increase his candesartan.

Comment
This is a missed opportunity to check that the urology referral had been sent.

9/4/2021 GP Consultation [Dr B]
Re BP — some dizziness. Plan further review from …

Comment
This is a missed opportunity to check that the urological referral had been sent.

14/4/2021 Referral done to …
29/4/2021 PSA 29 Noted by [Dr B]

30/4/2021 Health Link [Dr B] E referral semi urgent urology — [Dr B]

Comment

The urology referral has now been undertaken. I note that there has still not been a DRE although this is unlikely to have changed the speed at which he was seen in clinic. It is possible that if a prostatic mass had been felt the referral may have been prioritised. I note that when examined in clinic the DRE is stated to be abnormal. I also note that there is minimal urological history in the clinical notes.

I have not been provided with a copy of the referral so I cannot comment on the standard of the referral. If obtained at a later date I can amend this advice.

6/5/2021 Inbox Urology acknowledgement of referral — semi urgent urology appointment.

17/6/2021 Urology Outpatients
PR noted a fixed T3–T4 prostate, suggestive of malignancy.

Prostatic biopsy undertaken.

Histology Prostatic adenocarcinoma Grade 3 — Mr …

18/6/2021 Radiology — for radiation treatment and bone CT
15/7/2021 Urology letter

Confirmation ISUP 3 lesion in 4/7 cores CT and bone scan unremarkable. Options discussed hormonal treatment =+/- radiation. Start zoladex at 3 monthly.

	PSA µg/L	[Mr A's age]
7/5/2019	11.8	69 and 5 months
4/5/2020	13.4	70
3/2/2021	17.3	71
29/4/2021	29	71

7. **Additional Information**

Employment History
I note that [Dr B] was employed at [the medical centre] from … – …

…

He underwent sick leave in … and when he returned to work on … he worked from home during COVID 19 lockdown.

Test result policy [at the medical centre]
It is noted that the ordering clinician is responsible for organizing the tracking and actioning of the tests.

It also notes that if a GP is on leave or unwell that the practice will ensure that inboxes are checked daily and time critical results dealt with appropriately — this is done by the Physician Assistant. Additionally twice per week all provider inboxes are checked to ensure nothing is sitting in an inactive provider.

It is noted that all significant test results are tracked and notified. Abnormal results should be told to the patient by GP or a delegated person.

It is the provider's responsibility to inform the team what to do with results when they are on leave.

General Advice
There has been comprehensive guidance on PSA testing and referral provided for GPs both from the Ministry of Health and Regional Health pathways (both referenced). Alongside this BPAC gave a comprehensive GP focused review in 2020.[1]

I note however that there is some difficulty in defining the definite course of action in May 2019 that was regarding asymptomatic testing however. If he had been over 70 at the time of testing then "there is no strong evidence to suggest that testing men over the age of 70 years reduces mortality from prostate cancer in this age group."[2] I note that on 7/5/2019 he was [< 70]. The latter testing occasions he was > 70.

I am **mild to moderately critical** that there is no evidence of informed consent discussion surrounding PSA testing on 6/5/2019.

Generally the higher a man's PSA level, the more likely it is that he has prostate cancer[3]. However, some men will have prostate cancer even in the absence of a raised PSA[4]. Increased PSA levels can be transient, which is why men should always have a repeat PSA test after 6–12 weeks to confirm the result. The exceptions to this are if a man has a raised PSA level and an abnormal DRE or if a man has a raised PSA level and one of the red flags.

Levels at which PSA levels are defined to be abnormal can vary with age. A man <71years and abnormal PSA is defined as >4µg/l whereas a man 71–75 the level is >

[1] https://bpac.org.nz/2020/prostate.aspx
[2] https://www.health.govt.nz/system/files/2015-09/prostate-cancer-management-referral-guidance_sept15-c.pdf
[3] Heidenreich A. 2008. Identification of high-risk prostate cancer: role of prostate-specific antigen, PSA doubling time, and PSA velocity. European Urology 54(5): 976–7; discussion 978–9.
[4] Thompson IM, Pauler DK, Goodman PJ, et al. 2004. Prevalence of prostate cancer among men with a prostate-specific antigen level < or =4.0 ng per millilitre. New England Journal of Medicine 350(22): 2239–46.

10µg/L. In [Mr A's] case all his age defined levels were abnormal on each occasion he was tested from 2019 onwards.

I am **moderately critical** that despite numerous opportunities to send the referral letters in the context of telephone and in person consultations with [Mr A], [Dr B] did not send these.

I am **moderately critical** that a checking process to ensure [Mr A] completed his follow up bloods was not in place, in addition to a process by which [Dr B] had a reminder task to send a referral to urology.

I am **mildly to moderately critical** at the lack of a complete urological history in the notes and that a DRE was not undertaken.

Specific Advice requested

1. Whether the actions taken in relation to the May 2019 PSA result by [Dr B] were adequate/appropriate, including whether any further examination or referral was indicated, and whether it was reasonable not to perform a DRE based, in part, that a DRE undertaken two years prior found an enlarged prostate (noting there does not appear to be documentation of a previous DRE).

Comment

This was a first abnormal PSA reading. It would have been standard practice to have repeated this alongside an MSU and undertaken a DRE. After which the appropriate urgency of referral made according to Health Pathways[5]. If the DRE was normal then a non-acute urology assessment for prostatic biopsy to be completed within 4 weeks should have been done. However if the DRE had been abnormal then the timeframe for the request for biopsy changes to 2 weeks.

Over time there has been varying advice regarding undertaking DRE routinely when assessing a man's prostate health. The international consensus appears to be that DRE is of no value in asymptomatic men in a primary care setting[6]. The RACGP in their info leaflet from 2015 states: "Digital rectal examination, where the doctor inserts a finger into the anus to examine the prostate, is no longer recommended in addition to PSA testing."[7]

[5] https://midland.communityhealthpathways.org/25409.htm accessed 16/9/2024

[6] Naji L, Randhawa H, Sohani Z, Dennis B, Lautenbach D, Kavanagh O, et al. Digital Rectal Examination for Prostate Cancer Screening in Primary Care: A Systematic Review and Meta-Analysis. Ann Fam Med. 2018 Mar;16(2):149–54.

[7] https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/national-guide/chapter-15-prevention-and-early-detection-of-cance/early-detection-of-prostate-cancer

However the NZ advice is still currently that it is recommended that DRE is included as part of prostate cancer testing, in combination with PSA testing, as it is estimated that up to 17% of cancers are missed by PSA testing alone.[8]

However in the context of a raised PSA result it would be standard practice to have undertaken a DRE at that stage and consistent with Health pathways advice.

I note that I cannot find any documentation of a previous DRE in 2017. However even if one had been done at that time a further DRE should have been undertaken at this stage to assess prostatic size and the presence or not of any focal abnormality.

It would have also been good practice to have set a recall to ensure this PSA was completed.

I note that there is no recollection of a task being set to ensure that [Mr A] repeated his PSA blood test in a timely fashion (6–12 weeks).

2. Whether the actions taken in relation to the May 2020 PSA result by [Dr B] were adequate/appropriate, including whether any further examination or referral was indicated.

It would have been standard practice to have undertaken a DRE and to have referred [Mr A] to the urology department for investigation of possible prostate pathology including both BPH and prostatic cancer, as per the previously stated pathways.

It would have also been good practice to have set a recall for a further PSA in 3 and also to check that he had been seen at the hospital.

3. Whether the care provided in June 2020 and August 2020 was reasonable, noting that:

   a. In June 2020 there was a note to contact urology, and there does not appear to be related action/follow up.
   b. In August 2020 a repeat test for PSA was ordered but it does not appear to have been completed by [Mr A], and there does not appear to be related action/follow up.

Comment

The care provided was not reasonable — a referral to urology for further assessment and investigation should have been made in June 2020.

[8] Prostate Cancer Taskforce. Diagnosis and management of prostate cancer in New Zealand men: recommendations from the prostate cancer taskforce. 2013. http://www.health.govt.nz/publication/diagnosis-and-management-prostate-cancer-new-zealand-men-recommendations-prostate-cancer-taskforce

There should have been a system to ensure appropriate follow up of him not undertaking his repeat blood tests in August 2020. I commonly see GP colleagues setting a Task for themselves.

4. Whether the actions taken in relation to the February 2021 PSA result by [Dr B] were adequate/appropriate, including whether any further examination or referral was indicated.

Comment
The care provided was not reasonable, a DRE and a referral to urology for further assessment and investigation should have been made as previously stated above.

5. Whether the actions taken in relation to the April 2021 PSA result by [Dr B] were adequate/appropriate, including whether any further examination or referral was indicated.

Comment
The care provided was not reasonable, a DRE should have been undertaken alongside a full urological history including enquiry re red flags and family history.

I note however a referral to urology for further assessment and investigation has been made as previously stated above.

14/1/2025 Addendum to previous Advice

I have been provided with additional information.

1 Comment on referral of 30/4/2021
The referral is marked as urgent. It clearly states concern regarding prostate cancer with an abnormal rectal examination and increasing levels of PSA from 17 to 29 over a short duration. It contained detailed past medical history and medications. It also contained the clinical contact from 20/5/2019. The PSA results from 29/4/2021 and 3/2/2021 were appropriately included.

I am moderately critical at the lack of current clinical symptoms documented. I note that no IPSS[9] was included.

2 A timeline of tasks has been provided by the practice.
7/5/2019 A request to ask patient to return for a digital rectal examination the week of 20/5/2019.

This then occurred although a DRE was not done.

11/6/2020 A task has been set by [Dr B] to himself to refer for urology advice after obtaining new urine specimen.

[9] https://urologyinstitute.co.nz/assets/Uploads/International-prostate-symptom-score-IPSS.pdf

A referral was not completed.

6/8/2020 A task from [Dr B] to HCA requesting a further urine sample and blood tests as a referral to urology was planned. It is noted that a path lab form was completed and it was suggested he could go to …

A referral was not completed — there does not appear to have been any follow up action on this task. It is not clear whether [Dr B] completed this task to himself or left it open for follow up.

19/12/2020 [Dr B] set up a PSA recall on Medtech 32.
It is unclear what the timeframe was for this and why he did not send a message at this point for the PSA to be repeated.

Comment
I remain moderately critical that a checking process did not occur with regard to repeated blood tests and referral.

This criticism is directed mainly at [Dr B].

However, a task was sent to an HCA to ask for repeat urine and blood tests — there is therefore some criticism of the practice system in that it appears there was not a system to ensure that this was undertaken. I am unsure if the HCA was checking the completion of these investigations.

I would also be mildly to moderately critical if there was not a regular performance review of task and inbox completion by clinicians undertaken by [the medical centre].

It was the responsibility of [Dr B] to send the referral. It is the responsibility of [the medical centre] to ensure that their clinicians have adequate time to undertake administrative tasks and to offer additional support at times when a clinician has been unwell.

3 The reply from [the medical centre] from …
It is stated that there is a robust recall process in place in which a specific nurse will notify a patient of a required action e.g. getting a blood test done.

If a clinician sets himself a task to ensure an action is completed e.g. getting a blood test, then it is stated that this is the clinician's personal responsibility to ensure the test has been done. It is stated the responsibility can fall to the nominated person the task was forwarded to — in this case the HCA.

I note that the practice has undertaken a peer review session and it has been agreed that the recall process for abnormal PSAs will be the task of a specific physician assistant to ensure going forward there is uniformity in how they are handled.

I note a recent audit of 104 abnormal PSA has shown appropriate actions have been completed.

A review of the notes has not found evidence of a DRE being undertaken in 2017 or 2019.

Comment
I would state that it is commonly seen for a practice senior leadership team to monitor a clinician's performance which would include the completion of tasks and clearing his inbox. That there should be a protocol regarding the completion of tasks in an expected timeframe.

The clinician is responsible for completing the clinical tasks that have been set e.g. in this case following up on requests for urine and blood tests and sending referrals in a timely manner.

However, the practice should have systems in place to ensure that clinicians are able and supported in completing their clinical workload, supporting them at time of incapacity (inbox support) and allowing enough time for the administrative load of a GP to be completed.

I have concerns that [Dr B] has stated his inbox was not checked during his illness.

The practice has taken a constructive and reflective approach to this case and put systems in place with the use of a physician assistant to improve the inhouse processes.

4 [Dr B] has considered the previous advice.
I note the clarification that during this period of time [Dr B's] personal health was severely impacted.

He states that the medical practice where he was working did not follow up on his inbox results in his absence.

It was noted that due to [Mr A's] underlying cardiac health complications that these were addressed prior to a referral to urology.

He specifically notes that a DRE was done by a previous GP.

He notes that he discussed and explained follow up blood test results with [Mr A].

I note that he participated in a discussion regarding follow up of PSA and referrals within his medical practice and highlighted the need for inboxes to be checked in the absence of a GP due to illness.

I note that he has updated his knowledge of prostate clinical care. And the referral process.

Comment

I note the significant mitigating factors of [Dr B's] personal ill health during this period.

I note that he has undertaken education on prostate cancer and urology since this episode.

However, this does not change my previous advice that there were missed opportunities for referral and that there was a delay in referral of [Mr A] to urology for his abnormal PSA result.'