General Practitioner, Dr B
Medical Centre

A Report by the
Health and Disability Commissioner

(Case 19HDC00803)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a man by a general practitioner (GP). The man had a long history of elevated prostate-specific antigen (PSA), and had had his PSA level monitored since 2005 to check for prostate cancer. A urology specialist recommended that the man undergo a yearly follow-up of PSA and digital rectal examinations (DREs), and to return to the service if his PSA result went above 10.

2. The man first saw the GP in January 2015, and had consultations with him until September 2018, when the man transferred to another region. The GP did not perform a DRE at any of the consultations with the man. In September 2018, the GP received the result of the man's PSA test, which showed a PSA level of 10.3. The man was not informed of this result, and no referral to a specialist was made. The man was informed of this PSA result when he saw a new GP in April 2019.

3. This report highlights the importance of conducting appropriate and timely investigations and communicating test results to patients.

Findings summary

4. The Commissioner found the GP in breach of Right 4(1) of the Code for not conducting any DREs, not setting up recalls for DREs, not asking the man to return for a DRE following the high PSA result in September 2018, not recording his treatment plan and the abnormal PSA result in his clinical notes, and not using the recall system correctly. The GP was also found in breach of Right 6(1) of the Code, as he did not disclose the raised PSA result to the man promptly or discuss with him a treatment plan.

5. The Commissioner considered that the errors that occurred did not indicate broader systems or organisational issues at the medical centre, and found that the medical centre did not breach the Code.

Recommendations

6. The Commissioner recommended that the GP apologise to the man, arrange an independent audit of his patient recalls/reminders, and undertake further training on communication and informed consent, and that the Medical Council of New Zealand consider whether a review of the GP's competence is warranted.

7. The Commissioner recommended that the medical centre report back to HDC regarding the implementation and effectiveness of the changes it has made as a result of this investigation.

Complaint and investigation

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

- *Whether Dr B provided Mr A with an appropriate standard of care between 2015 and 2018 (inclusive).*
- *Whether the medical centre provided Mr A with an appropriate standard of care between 2015 and 2018 (inclusive).*

9. This report is the opinion of the Commissioner.

10. The parties directly involved in the investigation were:

Mr A	Complainant/consumer
Dr B	General practitioner (GP)
Medical centre	

11. Further information was received from:

Medical centre 2	
Dr C	GP

12. Expert advice was obtained from in-house vocationally registered GP Dr David Maplesden, and is included as Appendix A.

Information gathered during investigation

Introduction

13. This report concerns the care Mr A received from Dr B at the medical centre from 2015 to 2018, in particular the tests ordered, the examinations performed, and the lack of clear communication of prostate-specific antigen[1] (PSA) results to Mr A.

Background

14. Mr A had a long history of elevated PSA, and had had his PSA levels monitored from 2005 to check for evidence of prostate cancer.

15. Mr A's elevated PSA levels were investigated by the urology service at the district health board, and in 2013 Mr A had multiple prostate biopsies to check for the presence of prostate cancer. All biopsies were negative for malignancy. Mr A's elevated PSA was

[1] PSA is a protein produced by normal, as well as malignant, cells of the prostate gland. The PSA test measures the level of PSA in a man's blood.

attributed to benign prostatic hypertrophy.[2] The urology service recommended that Mr A undergo a yearly follow-up of PSA and digital rectal examinations (DREs), and return to the service if his PSA level went above 10.[3]

16. Mr A was a patient at the medical centre from 2012 until 2018. His regular GP was Dr B, who provided care to him from 2015 onwards.

2014 and 2015 consultations

17. On 28 March 2014, Mr A was seen by a doctor at the medical centre and had a PSA test and a DRE. It was noted that his prostate was normal.

18. On 6 January 2015, the clinical notes record that Mr A was informed of his PSA result of 7.09 following a test undertaken on 17 December 2014. As English is not Mr A's first language, he asked to see a doctor who spoke his language so that he could understand the results better. He then saw Dr B[4] regarding his PSA levels. It was noted that they had a long discussion about the significance of a PSA rise, and a re-test was scheduled in six months' time. The clinical notes do not record any discussion regarding DREs.

19. On 27 July 2015, Mr A had another consultation with Dr B. Mr A's PSA result at this visit was 7.08. The clinical notes record that they had "general talks about prostate"; however, there is no record of any discussion about DREs. Dr B stated:

> "I did claim funds for extended consult, so it is likely that I did offer him a DRE, although due to the long time elapsed, I am unable to recall the conversation clearly enough to confirm this."

2016 consultations

20. On 15 February 2016, Mr A went to the medical centre for another PSA test, and received his result of 6.8 on 24 February 2016.

21. Mr A's PSA was next tested on 2 September 2016, and the clinical notes on 12 September 2016 record that he was offered an appointment to discuss the result, as his PSA had increased to 8.9 on a background average of 6.7. On 22 September 2016, a staff member telephoned Mr A but did not receive a reply, so sent a letter regarding follow-up.

22. On 14 October 2016, Mr A had a consultation with Dr B about the elevated PSA result. Dr B explained to Mr A that the rise was likely to be caused by mechanical or inflammatory irritation of his prostate, and likely to be temporary, and that another PSA test should be repeated in two months' time. This was recorded in the clinical notes.

[2] Enlargement of the prostate gland.
[3] According to the Best Practice Advocacy Centre Zealand (BPAC), PSA results between 4 and 10 are considered mildly to moderately elevated, while levels over 10 are considered high. The higher the PSA, the more likely the presence of prostate cancer.
[4] Dr B is able to speak Mr A's first language.

23. Dr B told HDC that following the consultation in October 2016, Mr A did not respond to several messages from the medical centre to attend for a repeat PSA test. However, the clinical notes contain no record of any follow-up calls or messages to Mr A, and the notes throughout 2016 contain no record of a DRE having been conducted or offered to Mr A.

24. Mr A said that he cannot remember whether he received any follow-up messages from the medical centre.

25. Dr B told HDC that he is unable to provide evidence of having recalled Mr A for PSA levels between December 2016 and May 2017. Dr B stated:

> "It is possible that this information stems from a verbal conversation with the nurse or from memory. It is also true that there is no written proof that a DRE has been offered or conducted."

2017 consultations

26. On 25 May 2017, Mr A visited the medical centre for his repeat prescriptions and a PSA test. A nurse recorded in the clinical notes:

> "[Mr A] spoke about his PSA testing and the frustration he has had with ongoing issues by Medical Clinicians panicking about his prostate levels … he says he is a bit tired of all this sometimes — he has requested today PSA test though and knows that if it gets over 10 then he will need to get this checked again."

27. The test result for the PSA level on 25 May 2017 was 6.59. Dr B said that this was around Mr A's average.

2018 consultations

28. On 19 September 2018, Mr A visited the medical centre to have blood taken for his PSA level. He also consulted with Dr B about another issue concerning his eye. The clinical notes do not record whether Mr A was offered a DRE.

29. On 20 September 2018, Dr B received the result of Mr A's PSA test, which showed a PSA level of 10.3. Mr A was not informed of this result.

30. Dr B was aware of the advice from the urology service that if Mr A's PSA level went above 10, he should be referred to the service. Dr B decided not to inform Mr A of this PSA result, and told HDC:

> "As I was aware how [Mr A] felt that we were panicking about his prostate levels and his frustration with this, I decided to put him on my recall list for a follow-up visit four months later to investigate whether we were dealing with a concerning increase … or another irritative peak."

31. Dr B did not record this plan in the clinical notes, and no treatment plan or reasons for the decision were documented. In response to the provisional opinion, Dr B said: "I admit however that a repeat DRE should have been offered at this stage."

32. Dr B told HDC:

> "I did not wish to alarm [Mr A] unnecessarily in view of his frustrations about unnecessary panicking. I now know that he wanted to be made aware of this abnormal result at an earlier stage and I apologise that we did not inform him of the result at the time."

Transfer to new GP

33. Around mid-December 2018, Mr A moved to another area and enrolled with a new GP, Dr C, at another medical centre (Medical Centre 2).

34. Dr B said that when the recall came up in January 2019, he learned that Mr A had changed practices, and that his medical files had been transferred and he was under the care of a new GP.

35. Dr B told HDC that he was sure that the new GP would take over management of the two main reasons for Mr A's consultations — his blood pressure and his prostate.

36. On 12 April 2019, Mr A saw Dr C for the first time. Mr A was advised of his previous PSA result of 10.3 in September 2018. This was Mr A's first knowledge of the result, and he told HDC: "I was totally shocked, as I had no idea, my previous GP [Dr B] never ever informed me."

37. Dr C told HDC that when Mr A transferred to the new medical centre, no advice was received to repeat his PSA, and there was no formal recall in the system.

38. Dr B said: "[I]t is not current practice and policy at my organisation, nor has it been my own, to actively and spontaneously contact the new practice of the patient." He also told HDC:

> "[A]t my practice, and likely throughout the entire organisation, there is no notification system in place when a patient chooses to enrol with a new provider. Reminders in the PMS are often the only prompt to learn that this has obviously happened. This takes away the opportunity from the GP to create any handover to the new provider."

39. The medical centre told HDC that the authorisation of patient notes out of the practice by the patient's GP is not a general practice requirement, and it is not logistically feasible. The medical centre stated:

> "[T]he better solution as it is in any practice is to have the plan of care clearly documented for any health practitioner who may provide to the patient at any given point in time in the clinical record."

40. The medical centre said that usually it is not aware that a patient has transferred to another practice until it receives a transfer request, and this request is required to be actioned within 10 working days.

Subsequent events

41. On 16 April 2019, Mr A sent an email to Dr B and expressed his concern that he had not been informed of the PSA test result in September 2018.

42. On 17 April 2019, Dr B responded to Mr A's email as follows:

> "I am sorry to hear that result from a different health provider brought you in distress, which would have been avoidable if I had known that you were moving (which I wasn't aware of) …"

43. Mr A was not satisfied with Dr B's response, and on 18 April 2019 asked again why he had not been informed of his PSA level. On 26 April 2019, Dr B responded and apologised again. Dr B referred Mr A to his previous email on 17 April 2019 and also advised Mr A that he could "seek an opinion from other people knowledgeable in the field".

Further information

44. Dr B said that he set his provider tasks or recalls for Mr A's PSA tests in January 2019. However, instead of ticking off the tasks as completed, Dr B deleted the tasks, and was unable to provide HDC with a list of completed tasks and recalls for Mr A.

45. Dr B stated:

> "I had a plan to notify the patient as soon as a constantly or increasingly rising PSA was established, so timely before any further action on this would be taken. Had I notified the patient in September, the more than likely recommendation by the specialist would have been to repeat the test in 6–12 weeks … in view of the previous history, I did choose a slightly longer interval of 16 weeks."

46. The medical centre told HDC that Mr A was on six-monthly recalls in the patient management system (Medtech Evolution) for PSA testing.

47. In relation to DREs, Dr B told HDC:

> "I am unable to clearly remember whether I have offered a DRE to [Mr A] and that has been declined by him, or whether I did [d]o one at some stage and failed to document it. I certainly discussed a DRE with [Mr A], as this is my common practice."

48. Mr A told HDC that he cannot recall ever having had a discussion with Dr B about DREs throughout his consultations from 2015 to 2018. Mr A said that Dr B never performed a DRE on him, and that he never received any reminders from the medical centre to have a PSA test, and he always returned after a year to ask for the test.

49. The medical centre told HDC that Mr A was not on a recall list for DREs, as this had not been requested by Dr B. The medical centre also said:

"We acknowledge the failure to follow up on the last PSA result with the patient … our review concluded that follow up on this patient was not in keeping with the recommendations from the urology specialist."

Changes made since incident

50. Dr B told HDC that as a result of this incident he has made changes to his practice, including the following:

a) He has reviewed the Prostate Cancer Management and Referral Guidance.

b) He will document the patient's personal decision and results on prostate cancer prevention in the clinical notes, and he will try to record clearer and more detailed documentation.

c) He will make sure that every relevant abnormal result is communicated to the patient, with an opportunity to discuss the result in a comprehensive way at the centre when developing an agreed management plan.

d) He will have a discussion with the medical centre regarding notification of the doctor in charge when a patient is requesting transfer of notes, and he will advise any new practice immediately about conditions or results that need follow-up, particularly if the patient may not have been made aware of the findings.

e) He will explore ways to use the dedicated in-built recall system of the PMS regularly for these and similar matters in an auditable way.

51. The medical centre told HDC that as a result of this incident, it identified areas for staff improvement, and made changes that included the following:

a) Institution of a policy regarding tumour markers, including PSA. The policy entails:

   i) Tumour markers can be ordered only by a doctor or a nurse practitioner. They are no longer to be added on by nursing staff unless directed to do so by a specialist.

   ii) Any tumour marker that is ordered must be followed up by the ordering clinician, and the result must be passed on to the patient.

   iii) Clinicians must reflect on why they have ordered the test and be explicit in directions for management of the patient in case they are not available.

b) Promotion of Manage My Health portal to all patients so that they can access their own health information and results.

c) Review of the authorisation of patient notes out of the practice by the patient's GP.

d) Automatic addition of patient medical records to MedTech when received electronically.

The medical centre's policy

52. The medical centre's Management of Test Results and Referrals (October 2017) (the Policy) states:

> "General Practitioner/Registered Nurse Responsibility:
>
> When a test is requested the Clinician will advise the patient on why they have requested the test, details of when their results can be expected and how the results will be conveyed to them. In general, patients will only be contacted if the results are abnormal or [i]f the patient requires follow-up."

53. The Policy also refers to the principles of *Cole's Medical Practice*, which is attached as an appendix to the Policy, and states:

> "[I]f you are responsible for conducting a clinical investigation you are also responsible for ensuring that the results are appropriately communicated to those in charge of conducting follow up, and for keeping the patient informed."

Responses to provisional opinion

Mr A

54. Mr A was provided with an opportunity to comment on the "Information gathered" section of the provisional opinion. He stated: "[Dr B] tries to portray me as somebody 'not responding to messages'. Believe me when you are in my situation you respond to everything from your GP."

Dr B

55. Dr B was provided with an opportunity to comment on the provisional opinion. Where appropriate, his comments have been incorporated into this report.

Medical centre

56. The medical centre was provided with an opportunity to comment on the provisional opinion. The medical centre said that it had "no further comments to make to the provisional opinion".

Relevant standards

57. The requirement for doctors to keep clear and accurate clinical records is set out in the Medical Council of New Zealand's statement, "The maintenance and retention of patient records".[5] The statement notes that doctors "must keep clear and accurate patient records that report relevant clinical findings; decisions made; information given to patients [and] any drugs or other treatment prescribed".

[5] Available from https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Maintenance-and-retention-of-records.pdf

58. The Medical Council of New Zealand's statement, "Information, choice of treatment and informed consent"[6] (March 2011), states:

> "Trust is a vital element in the patient–doctor relationship and for trust to exist, patients and doctors must believe that the other party is honest and willing to provide all necessary information that may influence the treatment or advice. The doctor needs to inform the patient about the potential risks and benefits of the options available and support the patient to make an informed choice."

Opinion: Dr B — breach

Standard of care

59. Mr A had a history of elevated PSA levels, and in 2013 a urology specialist recommended that he undergo a yearly PSA test and DRE, and to return to the specialist if his PSA level went above 10.

60. Mr A consulted with Dr B on 6 January 2015, 27 July 2015, 14 October 2016, and 19 September 2018. The clinical records made by Dr B do not document that a DRE was performed, or that DREs were discussed, at any of these consultations. Mr A told HDC that he cannot recall ever having had a discussion about DREs.

61. The medical centre told HDC that Mr A was not on a recall list for DREs, as this had not been requested by Dr B. Dr B said that he cannot remember whether he offered a DRE to Mr A during consultations, or whether he did DREs but failed to document them.

62. On 20 September 2018, Dr B received Mr A's PSA test result of 10.3. Dr B did not inform Mr A of this result, nor ask him to attend the medical centre for a DRE following the result.

63. Dr B said that he may have undertaken a DRE at the visit on 27 July 2015, but he cannot remember, and similarly he cannot remember whether he conducted a DRE during the consultation in October 2016. Dr B did not document any information about DREs in the clinical notes. Mr A said that DREs were never discussed with him, and DREs were never performed on him. Given the evidence available to me, I find that Dr B did not discuss or undertake DREs at the consultations in July 2015 and October 2016. I am critical that DREs were not performed during these visits. I also find that Dr B did not set up recalls for DREs to be performed for Mr A.

64. Expert advice was sought from HDC's in-house clinical adviser, GP Dr Maplesden, who advised the following:

[6] Available from https://www.mcnz.org.nz/assets/standards/edc0457381/Information-choice-of-treatment-and-informed-consent.pdf

a) A DRE should have been offered to Mr A at the consultation on 27 July 2015 and performed if Mr A consented. Dr Maplesden was mildly to moderately critical that this was not done;

b) He would be moderately critical if a DRE was not offered to Mr A, and performed if Mr A consented, at the consultation on 14 October 2016;

c) He would be mildly to moderately critical if there was no formal recall or reminder for the annual recommendation of DREs; and

d) There was a failure to perform a DRE as part of the assessment process following the abnormal result on 19 September 2018.

65. I agree with Dr Maplesden's advice. I am critical that despite the recommendations from the urology service, Dr B did not conduct any DREs over a four-and-a-half-year period, did not set up recalls for DREs, and did not ask Mr A to return for a DRE following the high PSA result in September 2018.

66. Dr B stated that following the consultation on 19 September 2018, he put Mr A on his recall list for a follow-up visit and a PSA test in four months' time. Dr B did not document this plan in the clinical notes, or the reasons for the treatment plan. Mr A transferred to a new practice in December 2018, and the new GP told HDC that when Mr A was transferred to the practice, no advice to repeat Mr A's PSA test was provided.

67. Dr Maplesden advised that there was "a failure to document the intended management plan, including reference to the abnormal result, in the clinical notes [and that] [t]his resulted in further delays in [Mr A] receiving a referral".

68. Dr Maplesden also said that the failure by Dr B to document his treatment plan meant that once Mr A transferred to the new GP practice, it was not readily apparent that Mr A had a high PSA result and should receive another test. I am critical that Dr B did not record his treatment plan and the abnormal PSA result in his clinical notes. This illustrates the necessity of clear records and documentation to ensure effective transfer of information to a new practitioner.

69. Dr B said that in January 2019 he set his provider tasks in Medtech for Mr A's PSA tests, and also for the other follow-up tests taken previously. However, instead of ticking off the tasks as completed, Dr B deleted the tasks, and was unable to provide HDC with a copy of the completed tasks and recalls he had set for Mr A.

70. I am critical that Dr B did not use the recall system correctly, and deleted all his recalls.

71. In summary, I consider that Dr B failed to provide appropriate care to Mr A for the following reasons:

a) Dr B did not conduct any DREs over a four-and-a-half-year period.

b) Dr B did not set up recalls for DREs.

c) Dr B did not ask Mr A to return for a DRE following the high PSA result in September 2018.

d) Dr B did not record his treatment plan and the abnormal PSA result in his clinical notes following the consultation on 19 September 2018.

e) Dr B did not use the recall system correctly, and instead of ticking off the tasks as completed, he deleted the tasks.

72. These failures resulted in delays in Mr A receiving a referral to specialist services. Taking into account these deficiencies, in my opinion Dr B did not provide services to Mr A with reasonable care and skill, and I find that Dr B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

Failure to inform patient about PSA result in September 2018

73. On 20 September 2018, Dr B received Mr A's PSA result, which was 10.3. Dr B did not inform Mr A of the result, and decided to set up a recall for another PSA test in four months' time. Dr B told HDC that this was to see whether the result was a concerning rise or another temporary peak as had occurred in the past. However, this plan was not documented in the clinical notes.

74. Dr B said that he decided not to inform Mr A of his PSA result, as Mr A had discussed with him that doctors may have been overly concerned about his PSA levels, and Dr B did not wish to alarm Mr A unnecessarily.

75. Dr Maplesden advised that there was a "failure to notify [Mr A] of a significantly abnormal result — significant in that the previous specialist advice had been to re-refer if the PSA level exceeded 10". Dr Maplesden said that a reasonable option may have been to perform a DRE and repeat the PSA test in 6–12 weeks' time, in accordance with the national guidance, but that if this was the intended management option, it should have been discussed with Mr A and agreed before the decision was finalised.

76. Dr Maplesden also stated:

> "[Mr A's] expressed frustration with his PSA monitoring might be regarded as a mitigating factor but this did not obviate the need to notify him of his result and discuss management options, in a timely manner."

77. In my view, a reasonable consumer in Mr A's circumstances would expect to be told of his PSA result, which was more than 10. Dr B should have disclosed the PSA result to Mr A promptly, and should have discussed his treatment plan. Accordingly, I find that Dr B breached Right 6(1) of the Code.

Opinion: Medical centre — no breach

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

79. As detailed above, I have found that Dr B breached the Code. Dr Maplesden advised that the deficiencies were "decisions made by Dr B rather than representing a deficiency in practice systems". Dr Maplesden also stated that the medical centre's recall system and policy were appropriate.

80. For these reasons, I consider that the errors that occurred did not indicate broader systems or organisational issues at the medical centre. Therefore, I consider that the medical centre did not breach the Code.

Recalls for PSA test — other comment

81. Mr A told HDC that from 2015 to 2018 he never received any reminders from the medical centre about PSA testing. He said that he was aware that he needed an annual PSA test, and initiated his visits to Dr B himself. The medical centre told HDC that Mr A was on six-monthly recalls in the patient management system (Medtech Evolution) for PSA testing. Dr B told HDC that he had also had his own recalls for Mr A, which he had deleted. The clinical notes record that Mr A was contacted and offered an appointment on 12 September 2016 and on 22 September 2016, and that the medical centre also sent a letter for a follow-up visit.

82. Dr Maplesden advised that he would be critical if Mr A was not contacted regarding the PSA test.

83. I agree with Dr Maplesden, and would be critical if Mr A was not recalled for his PSA tests. I note that from 2015 to 2018, Mr A did have at least one PSA test per year. There were also documented notes that Mr A was frustrated by the constant issues about his prostate. The clinical notes also record that he was sent a follow-up letter in September 2016, and that the medical centre tried to contact him to offer him an appointment.

84. I have considered all of the information provided by both parties, and from the available information I am unable to make a finding on whether the recalls were sent to Mr A.

Transfer to a new practice — other comment

85. Mr A transferred to a new GP practice in December 2018. He saw the new GP in April 2019, and was informed of his increased PSA result. As discussed above, owing to the lack of documentation by Dr B, the new GP was unaware that Mr A's PSA level had increased, and that there was a plan for another PSA test in January 2019.

86. Dr B told HDC that at the medical centre there is no notification system in place when a patient chooses to enrol with a new provider, and that this takes away the opportunity for the GP to create a handover for the new provider. The medical centre said that it does not

inform the patient's GP or seek authorisation from the GP when the patient moves to a new practice, as this is not feasible logistically.

87. Dr Maplesden advised:

> "I cannot understand why this should not be a practical proposition … and I think it is important the patient's GP is given the opportunity to formalise the handover of care, even if there is generally reliance on the content of the notes … to facilitate such transfer."

88. However, Dr Maplesden also noted that this is not a universal or required practice. In my opinion, the medical centre should at least inform the patient's GP when a patient transfers to a new practice. This would enable the GP to advise the new practice of any concerns or information about the patient that may not have been documented in the notes. This also emphasises the importance of clinical notes being recorded adequately, as the absence of clear documentation and information means that continuity of care can be compromised.

Recommendations

89. I recommend that Dr B:

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

b) Arrange an independent audit of 30 patients to check that appropriate recalls/ reminders have been put in place, and that appropriate records have been documented in the clinical notes. The results of the audit are to be sent to HDC within four months of the date of this report, and if any concerns are identified, Dr B is to advise HDC of the further action that will be taken.

c) Undertake further training on communication and informed consent, and provide HDC with evidence that the training has been completed, within four months of the date of this report.

90. I recommend that the Medical Council of New Zealand consider whether a review of Dr B's competence is warranted.

91. I recommend that the medical centre report back to HDC regarding the implementation and effectiveness of the changes made as a result of this investigation (as stated at paragraph 51 of this report), within four months of the date of this report.

Follow-up actions

92. 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.

93. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Royal New Zealand College of General Practitioners and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Dr Maplesden:

"1. Thank you for providing this file for advice. To the best of my knowledge I have no conflict of interest in providing this advice. I have reviewed the available information: complaint from [Mr A]; response from [Dr B]; clinical notes [the medical centre]; clinical notes [Medical Centre 2]. [Mr A] complains about the failure by [Dr B] to notify him of an abnormal PSA test in September 2018, the result of which he became aware only when he visited his new GP in March 2019.

2. [Mr A] had a long history of elevated PSA and was investigated by [a urology service] between 2011 and 2013 with multiple prostate biopsies including MRI directed biopsies in June 2013 after a prostate MRI scan had shown possible suspicious changes at the base of the left prostate. All biopsy results were negative for malignancy and [Mr A's] modestly elevated PSA (mid 5s to mid 6s) was attributed to benign prostatic hypertrophy (BPH). In a letter to [Mr A] and his GP dated 5 July 2013, management recommendation was: *In terms of follow-up you should have an annual follow-up with a PSA and rectal examination and return to us if the PSA goes over 10.*

Comment: Accepted practice on receipt of such a letter would be to set up a recall or reminder system in the PMS for the recommended monitoring, and to undertake the monitoring as recommended. While the patient was aware of the monitoring recommendations, a prompt from the practice (recall letter) is accepted practice either at the time the procedure is due or within a reasonable time frame if overdue unless the patient declined this. I am unable to establish whether any formal recall or reminder system was used to facilitate the recommended monitoring in [Mr A's] case but would be mildly to moderately critical if it was not (unless [Mr A] had declined this support).

3. There is no entry in the GP notes around the time the letter from [the radiology service] was received in July 2013. [Mr A] had a PSA performed on 21 March 2013 (unsure who ordered this) and the result was 6.20. On 24 March 2014 [a GP] recorded notifying [Mr A] of his result per phone and she noted: *Advised needs annual rectal exam — not actually due till mid 2014 but will come in this Friday. Also needs CVRA.* [Mr A] attended [the medical centre] on 28 March 2014 seeing [another GP]. Digital rectal prostate examination (DRE) was normal and there was general discussions recorded on awareness of BPH symptoms and possible medical treatment for this should the symptoms occur. PSA was recommended in six months (not sure of clinical rationale for this given [the radiology service] recommendations — previous PSA in April 2013 was 6.42) but it is unclear if a recall system was set up for this (see above).

Comment: Management at this time was consistent with accepted practice assuming there was an agreed effective recall system in place. I would be mildly to moderately critical if there was no such system in place. If [the radiology service's]

recommendations were to be followed, both DRE and PSA would be due around March 2015.

4. [Mr A] had his next PSA performed on 17 December 2014 (7.09). On 6 January 2018 [Dr B] spoke with [Mr A]. Notes are: *long discussion about significance of PSA rise. Advice: retest in 6 months.* The PSA result is annotated by [Dr B] as *He is already refer.*

Comment: Management at this time was consistent with accepted practice assuming there was an agreed effective recall system in place, with comments as above if there was no such system in place. Given the rise in PSA from previous recordings, but noting the likely diagnosis of BPH based on extensive previous investigation, it was reasonable to consider repeating the PSA level in six months. DRE was due in three months' time.

5. [Mr A] saw [Dr B] on 27 July 2015 in regard to headaches and hypertension. Notes include: *general talks about prostate* and [Mr A] had his PSA checked the same day 27 July 2015 (7.08). I am unable to confirm if/when [Mr A] was notified of this result. Recall record suggest a recall was set for repeat of the blood tests in 12 months (due 15 August 2016) although PSA was repeated within this time frame (see below).

Comment: It was appropriate to recheck PSA on 27 July 2015 given the previous sequential rise (although a variable pattern had been previously shown). I believe a DRE should have been offered to [Mr A] at this time and performed if [Mr A] consented. It was 19 months since his previous DRE and specialist recommendation was for annual assessment, presumably because of the slight doubt over the left basal MRI changes. I am mildly to moderately critical this recommendation was not followed (unless [Mr A] did not consent to the examination), mitigating factors being stability of his PSA, apparent absence of lower urinary tract symptoms (LUTS), and history of multiple previous negative prostate biopsies.

6. On 15 February 2016 [Mr A] next attended [the medical centre] for the purpose of a PSA blood test (practice nurse). Result was 6.80 (annotated by [Dr B] as *please inform pt*) and was provided to [Mr A's] partner on 24 February 2018. The practice nurse has recorded, at the time of venesection, *PSA due every 6 months, will modify if not elevated.* [Mr A] saw the same nurse on 2 September 2016 when he requested a repeat PSA test and was also assessed by the nurse with mild respiratory tract infection symptoms. The nurse noted (with respect to the PSA) *GP to f/up. If normal we will not contact.* PSA result was 8.94 (annotated by [Dr B] as *plse offer apt*) and on 12 September 2016 the nurse recorded: *wants a printout of his blood results. Needs to see a Dr, recalled for this, was offered an appt but declined?*

Comment: Nurse management over this period was most likely consistent with accepted practice. I am unable to confirm that [Mr A] had been formally recalled for GP review following the PSA result of 2 September 2016. If there was a notification in the PMS that [Mr A] was overdue for his DRE (and this does not appear likely) I would be mildly critical that this was not discussed with him by the nurse.

7. [Dr B] saw [Mr A] next on 14 October 2016 when his most recent PSA level was discussed. [Mr A] denied any LUTS. The documented plan was to repeat the PSA in two months.

Comment: In his response, [Dr B] states [Mr A] was sent several messages recalling him for the repeat PSA but he did not respond until May 2017 (see below). I am unable to confirm the nature or number of messages sent from the documentation available to me. I think the decision to repeat the PSA in two months was reasonable from a clinical perspective, particularly given [Mr A's] pattern of PSA level variability (up and down), absence of LUTS and previous normal biopsies. If [Mr A] was sent reminders to have his PSA repeated and declined to act on this, I feel this aspect of his care was satisfactory. However, I would be moderately critical if a DRE was not offered to [Mr A] at this time, and performed if [Mr A] consented. It was by now over two and a half years since [Mr A's] last documented DRE and the specialist recommendation had been for annual DRE. The PSA recorded on 2 September 2016 was the highest to date although the previously variable pattern is noted. I would be moderately critical if [Mr A] was not contacted regarding the overdue PSA test (due December 2016) and no documentation has been provided that confirms he was ever contacted in this regard. [Dr B] has commented in his response regarding [Mr A's] attitude that clinicians were over-reacting to changes in his PSA level and this frustrated him somewhat, and this might be regarded as a mitigating factor.

8. [Mr A] eventually returned to [the medical centre] on 25 May 2017 for repeat blood tests including PSA. He was seen by a nurse who noted: [Mr A] *spoke about his PSA testing and the frustration he has had with ongoing issues by Medical Clinic panicking about his prostate levels — he says he has seen 2–3 times in specialist clinics where the doctors have found no issues or concerns that determine the increasing PSA number — he says he is a bit tired of all this sometimes — he has requested PSA test though and knows that if it gets over 10 th[at] he will need to get this checked again. When results come he would like them e-mailed to* [address provided]. The blood test was taken and result was 6.59 (no GP annotation).

Comment: Nurse management on this occasion was consistent with accepted practice. The PSA result was reassuringly lower than the previous result. I am unable to determine from the clinical notes whether/how [Mr A] was notified of the result or what follow-up advice was provided to him.

9. [Mr A] saw a practice nurse for blood pressure check on 22 February 2018. [Dr B] next saw [Mr A] on 19 September 2018. I am unable to determine if he was recalled for a PSA test (due May 2018) in the interim. The GP consultation note for 19 September 2018 refers to assessment of a skin lesion but [Mr A] also apparently requested a PSA test and saw the nurse for venesection. Nurse notes include: *GP to f/up. If normal we will not contact.* The result was 10.33. There is no reference in the notes to an action plan following receipt of the result, and [Mr A] states he was not notified of the result. There is no GP annotation on the result. Recall records record a PSA blood test due on 1 August 2019.

Comment: In his response [Dr B] states: *As I was aware how* [Mr A] *felt that we were panicking about his prostate levels and his frustration with this, I decided to put him on my recall list for a follow-up visit four months later, to investigate whether we were dealing with a concerning increase (which would then lead to further investigations like another biopsy or at least an MRI), or another irritative peak.* I am moderately critical of several aspects of [Dr B's] management of [Mr A] on this occasion:

- The failure to notify [Mr A] of a significantly abnormal result — significant in that the previous specialist advice had been to re-refer if the PSA level exceeded 10. It might have been considered a reasonable option to perform a DRE and, if normal, repeat the PSA in 6–12 weeks as per national guidance[1] (taking into account the altered PSA threshold based on specialist advice), but if this was to be the intended management option, it should have been discussed with [Mr A] and agreed before the decision was finalized. [Mr A's] expressed frustration with his PSA monitoring might be regarded as a mitigating factor but this did not obviate the need to notify him of his result, and discuss management options, in a timely manner. [Mr A] had been told he would not be notified of a 'normal' result so there was no reason for him to enquire about the result.

- The failure to activate a task or formal recall reminder in the PMS to ensure [Mr A] had a repeat PSA within an appropriate time frame.

- The failure to perform a DRE as part of the assessment process following the abnormal result. It was now over four and a half years since the last DRE. Mitigating factors are as discussed previously.

- The failure to document the intended management plan, including reference to the abnormal result, in the clinical notes. This resulted in further delays in [Mr A] receiving a referral as noted below.

10. [Mr A] shifted to [another area] and a request for transfer of his clinical notes to [Medical Centre 2] was received by [the medical centre] on 13 December 2018 with notes imported in to [Medical Centre 2] on 14 December 2018. I note [Mr A] attended [the medical centre] on 12 December 2018 and requested a repeat prescription of his blood pressure medication which was provided. It is not clear if he spoke with a nurse on this occasion. [Mr A's] old notes were evidently reviewed during December. [Mr A] requested a repeat prescription of his antihypertensive medication from [Medical Centre 2] on 18 March 2019 and was told he would have to see a GP before the prescription could be provided. He attended [Dr C] on 12 April 2019 and cardiovascular assessment was undertaken. Notes include: *I note high PSA last year at previous GP clinic. Let recheck this. Previous 2 TRUS nad last 2014 …* PSA was ordered and result (12 April 2019) was 11.83. [Dr C] referred [Mr A] to [the urology service] on

[1] Prostate Cancer Working Group and Ministry of Health. 2015. Prostate Cancer Management and Referral Guidance. Wellington: Ministry of Health.

16 April 2019 and a prostate MRI was authorized by VU and undertaken on 2 May 2019 with no suspicious findings reported (findings consistent with BPH).

Comment: [Dr C's] management of [Mr A] following the consultation of 18 March was appropriate although best practice might have been to perform a DRE (if [Mr A] consented) prior to referral which, if suspicious for malignancy, might be taken into account when prioritizing the referral. Nevertheless, [Mr A] had an MRI performed very promptly and this was reassuringly normal ie there has been no apparent patient harm as a consequence of the management issues identified. In his response, [Dr B] states: *When the recall came up* [I presume referring to the 'repeat PSA in four months' recall following the result of 19 September 2018] *I learned that* [Mr A] *had changed practices in December 2018.* [Dr B] does not state if he made any attempt to notify the practice of the recall (presumably due about 20 January 2018), and I am unable to determine if the recall would have been apparent (in the 'Recall' module of the PMS) to [Mr A's] [Medical Centre 2] providers. As noted previously, on review of the clinical notes alone, [Dr B's] management plan regarding the elevated PSA following the 19 September 2018 consultation was not readily apparent. This situation raises two issues:

- The process for transfer of medical notes at [the medical centre]. Many medical centres require the patient's registered GP to authorise transfer of notes which gives the GP the opportunity to provide a medical summary or other note to the new provider regarding any important outstanding issues (in this case the plan to repeat PSA about mid-January 2019). However, I cannot state that this is a universal or required practice.

- The process for reviewing incoming notes varies from practice to practice but should involve detection of any outstanding clinical issues/diagnoses (should be evident from patient classifications, regular medications list and/or review of specialist letters), patient alerts including allergies, and review of recall module for any overdue or imminent recalls. Comment from [Medical Centre 2] might be required in relation to their 'old notes' review process, and particularly if there was any information in the notes they received referring to [Mr A] being due for PSA testing in January 2019.

11. Additional comments

(i) The [medical centre's] policy on management of test results and referrals appears similar to policies I have reviewed from other medical centres and is fit for purpose.

(ii) [Dr B's] statement regarding his management of abnormal PSAs seems reasonable in principle but I recommend he review the cited national guidance which has age-specific PSA levels at which referral should be considered."

The following further advice was obtained from Dr Maplesden:

> "1. I have reviewed additional responses from [Dr B] (dated 22 August 2019) and [the medical centre] (12 August 2019). There is also a brief e-mail from [Dr C] stating there was no advice in the GP notes received regarding repeating [Mr A's] PSA and *we did not see any formal recall in our system.*
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> 2. There is no new information from [Dr B] which alters my original opinion that his management of [Mr A's] PSA result of 10.33 ng/ml (19 September 2018) was a moderate departure from accepted practice. The reasons for this opinion are discussed in section 9 of my original advice. A decision to deviate from the specialist recommendation previously provided regarding [Mr A's] monitoring (referral if the PSA exceeded 10 ng/ml), while it might have been reasonable from a clinical perspective, should not have been made without a full informed discussion with [Mr A]. The failure to document the intended management plan in the notes or to consider offering a DRE (which was well overdue) as part of the decision process were aggravating factors. These were decisions made by [Dr B] rather than representing a deficiency in practice systems.
>
> 3. [Dr B] notes he has previously deleted Task Manager entries once completed rather than recording them as completed and it is not possible to retrieve the entries to confirm the efforts he made to recall [Mr A] for PSA testing or to convey results. In particular, [Dr B] states he is sure he set a Task Manager reminder to recall [Mr A] for a repeat PSA in January 2019 (four months after the September 2018 result) but he is unable to provide a record of this. If it is accepted [Dr B] intended to recall [Mr A] for a repeat PSA in January 2019 and set a recall task for this, the reference in section 9 of my original advice to his failure to do this could be removed, but this does not alter my overall opinion of his management of [Mr A] at this time.
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> 4. [Dr B] states it is likely he discussed DRE with [Mr A] at some stages during his management and a DRE may have been performed or declined. However, there is no documentation relating to such discussions, formal declining of a DRE or results of an examination if performed. The fact remains that by the time of the September 2018 PSA result, and despite specialist recommendations [Mr A] have an annual DRE, there had been no DRE performed for over four years. It is clear there was no discussion regarding DRE following receipt of the September 2018 PSA result, and unless there had been a recent normal DRE (and there is no such examination recorded), I believe discussion regarding indications for performing the examination should have been undertaken even if [Mr A] had previously declined such examinations. If DRE had previously been discussed and either performed or declined, this should have been clearly documented in the notes and the failure to do this represents a deficiency in clinical documentation of moderate degree.
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> 5. The remedial measures noted by [Dr B] in his response appear appropriate and I have no further comments or recommendations in this regard.

6. The [medical centre's] response states [Mr A] was on a 6-monthly recall for PSA in the practice management system (recall module which is separate to the Task Manager module). There was no recall for DRE as this was not requested by [Dr B]. The systems described in the [medical centre's] response appear similar to systems used in comparable organizations, and the improvement measures outlined in the response are appropriate. [Dr B] notes in his response that he was not informed [Mr A] had transferred to another practice and therefore did not have the opportunity to provide any formal handover to the new GP. [The medical centre] states in its response that it is not logistically feasible to gain authorisation of the patient's GP prior to transfer of notes. I cannot understand why this should not be a practical proposition (my own practice follows this process) and I think it is important the patient's GP is given the opportunity to formalize the handover of care, even if there is generally reliance on the content of the notes (including disease and allergy coding, recall list, prescription list) to facilitate such transfer. In [Mr A's] case, there were deficiencies in the clinical documentation meaning it was not obvious to a new provider that a follow-up PSA was planned, and [Mr A] himself had not been notified of the plan and therefore could not advocate on his own behalf.

7. I have no further comments or recommendations."