Follow-up of abnormal PSA test results
(16HDC00592, 30 June 2017)

General practitioner ~ Medical centre ~ Test results ~ PSA test ~ Prostate cancer ~ Information ~ Documentation ~ Investigations ~ Rights 4(1), 6(1)

A man regularly attended a medical centre, and over a period of several years had five prostate-specific antigen (PSA) tests — all of which were recorded as being within the normal range expected for his age at the time of testing.

In late 2014, the man then presented to a locum general practitioner (GP) who conducted a digital rectal examination (DRE) and ordered blood tests, including a PSA test. The man's PSA was 7.2µg/L (normal range 0.0–6.5µg/L). A second GP reviewed the result and recorded in the medical notes: "[R]epeat PSA [in six months' time] probably a [benign prostatic hyperplasia]." There is no record that the GP set a recall within the practice management system, and the man was never informed of the PSA result or the GP's plan to re-test the man's PSA levels.

In mid-2015, a third GP ordered a number of blood tests including a PSA test.

The man's PSA result was 10.5µg/L. The third GP told HDC that he considered this result to be "borderline", and that he did not inform the man of the result but decided to recall the man for further testing in three months' time. The third GP did not document that he reviewed the result, or his plan for further PSA testing. An audit of the practice management system showed that the third GP did set a recall in the system, and the man was sent another letter by the practice nurse inviting him to have blood tests to assess his cardiovascular risk profile. No reference was made in the letter to a PSA test. A series of blood tests were ordered for the man, but a PSA was not requested.

In late 2015, the man presented to the second GP complaining of urinary related symptoms. The second GP conducted a DRE and found the man's prostate moderately enlarged and nodular, and made a plan to conduct a PSA test and mid-stream urine test. The man's PSA result was 15.3µg/L. The second GP referred the man to a urologist, and it was confirmed that the man had prostate cancer.

Findings

It was held that the second GP breached Right 6(1) by failing to inform the man of the 2014 test result, its implications, and the management plan to re-test his PSA level in six months' time.

It was held that the third GP breached Right 4(1) by failing to order further tests to rule out other causes for the elevated 2015 PSA test result, and by failing to document relevant clinical information, including the reasons for ordering a PSA test, his assessment of the PSA result, and his plan to conduct further PSA testing in three months' time. He also breached Right 6(1) by failing to provide the man with information regarding the ordering of a PSA test, the PSA test result, the implication of the elevated result, and the plan for further testing in three months' time.

The medical centre owed a duty of care to the man when managing recalls for future blood tests. By failing to contact the man for further PSA testing, the medical centre breached Right 4(1). Adverse comment was also made regarding the test result policy current at the time of these events.

Recommendations

It was recommended that the second GP provide the man with an apology for breaching the Code. It was also recommended that the GP undertake a random audit of his clinical records to demonstrate that he had communicated the results of tests to patients appropriately.

In his response to the provisional report, the third GP provided the man with an apology for breaching the Code. It was recommended that the GP undertake a random audit of his clinical records to demonstrate that he had assessed, recorded, and communicated the results of tests to patients appropriately. It was also recommended that he arrange for further training regarding effective communication with patients, diagnosis and management of prostate cancer, and record-keeping and management of test results. It was recommended that the Medical Council of New Zealand consider undertaking a review of the third GP's competence.

It was recommended that the medical centre provide the man with an apology for its breach of the Code. It was also recommended that it undertake an audit of the practice's clinical records and practice management system to ensure that all PSA test results received for a one-month period were reviewed and annotated correctly, and recalls for further testing set. It was further recommended that all staff involved in the management of test results meet to discuss the findings of the report and the practice's new test results and medical records management procedure.