

**Communication of significance of PSA test, and loss of referral
(08HDC06165, 3 October 2008)**

Health clinic ~ District health board ~ General practitioner ~ PSA ~ Prostate ~ First specialist assessment ~ Urology ~ Cancer ~ Tests ~ Follow-up ~ Patient responsibility ~ Referral ~ Communication ~ Waiting times ~ Rights 4(1), 4(5), 6(1), 6(1)(c)

A 70-year-old man consulted his GP at a health clinic with urinary symptoms that suggested an enlarged prostate. As part of his assessment, the GP performed a PSA blood test. The result of this test was elevated, which raised suspicion of prostate cancer, and the GP decided that a repeat PSA should be performed in three months' time. Although the practice wrote to the man to remind him to have this further PSA test, he did not attend for the test, and no further attempt was made to remind him to have a repeat test.

A year later the man consulted the GP about blood in his urine. A PSA test was taken and showed a higher level than the previous year, and the man was immediately referred to a urology specialist. Following prioritisation by a consultant urologist the referral was received by the DHB urology service nearly three weeks later. However, the referral was misplaced, and not actioned until the following month. Despite being prioritised as needing to be reviewed within four to six weeks, the waiting time was actually four to six months, due to resource constraints. The man was subsequently diagnosed with prostate cancer which had spread.

It was held that the clinic breached Right 6(1) in failing to properly inform the man about the need for the PSA tests and the results of the first test. Doctors are often quick to talk about patient responsibility and patient compliance, but a 70-year-old man who did not know why he needed to have a blood test, nor what the results were, cannot be held responsible for not having a follow-up test on the basis only of a standard form letter.

The DHB did not have an appropriate referral receipt system in place for urology services at that time. In handling the referral, they failed to co-operate with the man's GP to ensure continuity of care, breaching Rights 4(1) and 4(5). It was also held that the man was provided with misleading information about the expected wait for a first specialist assessment appointment. Accordingly, the DHB breached Right 6(1)(c).