Medical Practitioner, Dr A

A Medical Centre

A Report by the

Health and Disability Commissioner

(Case 10HDC01250)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary

Complaint

1. Mr B has a family history of prostate cancer and for over a decade had blood tests to determine his prostate specific antigen (PSA) levels.

2. Mr B was first referred to a urologist in October 2003 when he had lower urinary tract symptoms and an enlarged prostate. Blood tests showed that he had an elevated PSA level of 47 ng/ml.[1] His PSA level returned to normal by July 2004.

3. Mr B became a patient at Medical Centre 1 in 1998 and became a patient of Dr A in July 2003, when she took over the practice.

4. Mr B's PSA test results remained within the normal range until 19 November 2006 when he went to the public hospital's emergency department with urinary retention and prostatitis.

5. On 22 November 2006, Mr B saw a private urologist, Dr F. Dr F told HDC that he did not report to Dr A following this visit as he had planned to see Mr B again a few days later. Mr B failed to return for the follow-up visit.

6. On 12 December 2006, Mr B saw Dr A and they discussed his appointment with Dr F. On this and later occasions, Dr A asked Mr B to request a report from Dr F. Dr A said that she was under the impression that Mr B remained under the care of Dr F for his prostate condition.

7. Mr B routinely requested PSA tests from Medical Centre 1. From May 2008 the results were slightly abnormal and from February 2009 they trended upwards. The results were not sent to Dr F. It was not until February 2010, when Mr B's PSA result was 28ng/ml, that a locum at the practice referred Mr B to Dr F.

8. Mr B had further tests, which confirmed that he had prostate cancer.

9. Dr A explained that her reason for not performing a digital rectal examination (DRE) of Mr B's prostate or contacting Dr F between 2006 and 2009 was that Mr B was very protective of his privacy, and she felt he wanted to control the flow of information. She also felt reassured that he was receiving care from Dr F.

Findings

10. Dr A's practice ordered PSA tests for Mr B. As his provider of general practice services and the doctor receiving the results, it was her responsibility to take reasonable steps to reassure herself that the abnormal results were being followed up.

[1] An elevated PSA level may occur for reasons other than cancer. For example, a urinary tract infection, recent ejaculation or benign prostate enlargement (see the usanz GP/Patient showcard) http://www.usanz.org.au/uploads/29168/ufiles/6%20%20PSA%20decision%20card%20041007.pdf

11. Dr A failed to have a recall system in place to ensure systematic PSA testing and review of the results, failed to discuss Mr B's treatment with him directly, failed to offer to perform a DRE for Mr B, and failed to make specific enquiries about the extent of Dr F's involvement. As a result, Dr A failed to provide services to Mr B with reasonable care and skill and breached Right 4(1)[2] of the Code.

12. Dr A's documentation of Mr B's care departed from expected professional standards and breached Right 4(2)[3] of the Code.

13. Dr A did not arrange for Mr B's test results to be copied to Dr F despite believing they were being ordered at his behest. She also failed to request Mr B's consent for her to communicate with Dr F to ensure that Mr B's symptoms and his rising PSA levels were being appropriately managed. As a result, Dr A breached Right 4(5)[4] of the Code.

14. The company operating Medical Centre 1 was found not to have breached the Code.

Complaint and investigation

15. On 19 July 2011, the Commissioner commenced an investigation into the following issues:

- *Whether Dr A provided services of an appropriate standard in relation to the monitoring and management of Mr B's prostate, including the adequacy of the information provided to Mr B.*
- *Whether the company which operated Medical Centre 1 provided services of an appropriate standard in relation to the monitoring and management of Mr B's prostate.*

16. The parties directly involved in the investigation were:

Mr B	Consumer
Dr A	Provider
Medical Centre 1	Provider

17. Also mentioned in this report:

Dr C	General practitioner
Dr D	General practitioner
Medical Centre 2	Provider

[2] Right 4(1): Every consumer has the right to have services provided with reasonable care and skill.
[3] Right 4(2): Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
[4] Right 4(5): Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

The public hospital	Provider
Dr E	Urologist
The medical laboratory	Medical laboratory
Dr F	Consultant urologist
Dr G	Locum
Ms H	Practice nurse
Ms I	Practice nurse
Ms J	Practice nurse

18. Independent expert advice was obtained from Dr David Maplesden, General Practitioner (attached at **Appendix A**).

Information gathered during investigation

Mr B — Background

19. Mr B told HDC that he has a family history of prostate cancer and that for over a decade he had blood tests to determine his prostate specific antigen (PSA) levels.[5] Mr B also recalls that a female GP who performed a digital rectal examination (DRE) on him in the late 1990s had told him that he had an enlarged prostate. Mr B's PSA levels were within the normal range until October 2003.[6]

20. Mr B joined Medical Centre 1 in 1998 and his regular GP was Dr D. Between January 2001 and October 2003, Mr B also attended Medical Centre 2 on a few occasions "for an emergency".

21. On 28 October 2003, Mr B (then aged 60 years) saw GP Dr C at Medical Centre 2 complaining of a three-day history of dysuria[7] and urinary frequency. Dr C performed a DRE and noted: "Prostate feels rather enlarged and rather firm ? malignant." Dr C ordered mid-stream urine (MSU) and blood tests, started Mr B on antibiotics, and referred him to the urology department at the public hospital. The tests showed a urinary tract infection and a high PSA level (47ng/ml).[8]

Contact with Dr E

22. On 31 October 2003 Mr B was admitted to the public hospital with cystoprostatitis,[9] under the care of urologist Dr E.

[5] The earliest result in his clinical records was 0.7ng/ml in April 1995.
[6] The normal range for PSA levels increases with age and is often reported as: 40–49 years <2.5ng/ml, 50–59 years <3.5ng/ml, 60–69 years <4.5ng/ml and 70–79 years <6.5ng/ml.
[7] Dysuria means pain during urination, or difficulty urinating.
[8] PSA levels can rise as a result of a number of non-malignant conditions including urinary tract infection.
[9] Cystoprostatitis is an inflammation of the bladder and prostate gland, often resulting in swelling or pain.

23. Dr E performed a DRE and noted an enlarged prostate that was not hard or irregular. Mr B was diagnosed with prostatitis[10] with urinary retention, and prescribed antibiotics and Hytrin.[11] Mr B was discharged five days later and followed up at an outpatient clinic.

24. Dr E saw Mr B again on 27 May 2004 and reported to Medical Centre 2:[12] "I would recommend that he review his lower urinary tract symptoms with you on an annual basis with a PSA and digital rectal examination." Dr A stated that she did not receive a copy of this letter.

25. Mr B's PSA dropped back into the normal range (2.9ng/ml) in July 2004.

Dr A

26. Dr A was provisionally registered with the Medical Council until 2009, when she obtained general registration. She has never had registration in the vocational scope of "general practice".

27. From 15 July 2003, Dr A worked at Medical Centre 1, which is owned by a limited liability company of which she is the sole director and shareholder. Dr A is employed by the company.

Medical records

28. In 2003, Dr D transferred his practice to Dr A. Dr D recalls that at the time most of the clinical records were in paper form and were transferred to Dr A.

29. In 2010, before HDC began investigating his complaint, Mr B uplifted his paper records from Medical Centre 1 and took them to his new GP at Medical Centre 2. Dr A did not keep a copy of the paper records that the practice's receptionist gave to Mr B. Medical Centre 2 has provided HDC with the clinical records for Mr B that they hold for the period 1 January 1987 to 26 January 2011, including those provided to them by Mr B from Medical Centre 1. The earliest record provided relating to Dr A was when she referred Mr B to a general surgeon for an unrelated condition in June 2004.[13]

30. Dr A began using electronic records in 2005, and she provided these to HDC. She stated that the paper records provided to HDC covering the period prior to 2005 are incomplete. Mr B had received, on request, the original paper records held by Dr A, through her receptionist.

31. Dr A told HDC that Mr B was given additional handwritten notes, which were not included in the material Medical Centre 2 provided to HDC.

[10] Inflammation of the prostate as a result of infection.
[11] Hytrin (terazozin) treats the symptoms of an enlarged prostate.
[12] The letter is addressed to "Dear Doctor" rather than any named clinician.
[13] A copy of this letter was provided by the DHB but was not contained within the paper records provided by Medical Centre 2.

Care provided in 2006

32. On 19 November 2006, Mr B was retaining urine and he presented at the emergency department at the public hospital. He was examined, and a DRE was performed. Mr B was catheterised and discharged with an indwelling catheter (IDC) in place. The report from the emergency department to Dr A notes that he was to be seen in the urology clinic "asap".

33. Mr B rang Dr A and asked her to arrange a referral to a private urologist. On 24 November 2006, she wrote a referral letter to a private urologist but, in the meantime, Mr B arranged to see another urologist, Dr F, by way of a self-referral.

34. Dr F's clinic note from 22 November 2006 states:

> "Present without referral. Apparently had an indwelling catheter placed in the public hospital after developing acute urinary retention. This has occurred once before about 2 years ago and he was given some type of medication to shrink the prostate. Very vague and difficult historian.
>
> On examination prostate is relatively small but broad. There is an indwelling catheter in place. Have started him on Quinolone antibiotics and Tamsulosin.[14] For a trial of removal of catheter in 2 days time and review following that."

35. Dr F told HDC that his plan was to review Mr B following the removal of his IDC. However, Mr B "did not come back for review therefore that plan was not carried through". Mr B recalls Dr F telling him to return if he had any other problems. Dr F stated that he had no further contact with Mr B until February 2010 and did not provide any further prescriptions.

36. On 12 December 2006, Mr B saw Dr A. In the electronic record of that visit, Dr A noted:

> "Has been seen [by] [Dr F], urologist, no report yet."

37. Dr A told HDC that she frequently did not receive written reports from specialists, and that her practice requests letters from either public hospitals or specialists on a daily basis.

38. Dr A also told HDC that she asked Mr B to:

> "inform [Dr F] that I was his GP so that I could receive information about the consultation. My sense was that [Mr B] was protective of his privacy with [Dr F], with my feeling that I had to be careful not to encroach."

39. Mr B recalls that at the appointment on 12 December 2006 he and Dr A discussed what had happened at his appointment with Dr F. He did not recall that Dr A requested him to contact Dr F to obtain a report from him. Mr B stated that he

[14] Tamsulosin (Flomaxtra, Flomax) treats the symptoms of an enlarged prostate.

"thought [Dr F] would obviously let [Dr A] know" and that his expectation was that Dr F would have contacted Dr A.

40. Mr B stated that Dr F prescribed Flomaxtra (tamsulosin). In contrast to Dr F's account, Mr B stated that he returned to see Dr F "on two or three other occasions" and that he thought his next visit was about five months later. Mr B stated that Dr F removed the IDC (although Dr F's records indicate that the IDC was to be removed two days later at the next visit, which did not occur).

Care provided in 2007

41. In January 2007, Mr B was seen at the public hospital's urology clinic following his emergency department presentation on 19 November 2006. The registrar noted that "apparently he has been seen by [Dr F] in [his clinic] since he was referred to see us". The report to Dr A says that Mr B was "reluctant to be examined today". In contrast, Mr B told HDC that he does not recall ever telling anyone that he was reluctant to be examined.

42. Mr B was provided with a further prescription for tamsulosin, and the plan was to see him again in about three months' time.

43. The clinical records obtained from the public hospital include a letter from the urology department to Dr A dated 17 August 2007, discharging Mr B, as he was reporting no symptoms. The urologist suggests that in view of Mr B's past problems "it would be prudent for him to check with you on an annual basis by way of review of symptoms, digital rectal examination and PSA". However, Dr A says she does not recall receiving this letter, and there was no copy of the letter in the records provided to HDC.

44. Mr B saw Dr A on a number of other occasions in 2007, for other issues.

PSA test requests and results

45. The electronic clinical records for Mr B that Dr A supplied to HDC include the results of his PSA tests (see **Appendix D** for a summary of Mr B's PSA tests and the follow-up actions undertaken between 2005 and 2010).

46. Mr B stated that "for the past 10, 12 years, maybe longer, every three months [he had] been going and getting a PSA test because [he] knew prostate cancer was in the family".[15]

47. Dr A's records indicate that she first ordered a PSA test for Mr B in December 2005, the result of which was normal (3.2ng/ml).

48. Mr B's records show that the next test was reported on 2 May 2008, the result of which was slightly elevated above normal (4.85 ng/ml), with a free:total ratio of

[15] The earliest PSA result in his clinical records was 0.7ng/ml in April 1995.

33.7%.[16] Thereafter, the tests appear to have been more regular. Dr A stated that she became aware that the nurses were ordering the tests on Mr B's instruction. She stated that this was not the standard practice of Medical Centre 1.

49. Mr B told HDC that he routinely requested that Medical Centre 1 perform his PSA tests. He said he remembered when they were due by marking his due dates on a calendar, and that he was not recalled by the practice for these tests.

50. The PSA test requests were ordered by sending laboratory request forms to the medical laboratory. The forms include the typed name of the doctor ordering, and a space is provided for the name of any other provider the results are to be copied to. In Mr B's case, six request forms between 2 May 2008 and 8 October 2009 recorded Dr A as the ordering doctor. Only one of the forms was signed by Dr A, the remainder being signed by the practice nurses. A seventh request in February 2010 had a locum as the ordering doctor.

51. Practice nurses working at Medical Centre 1 confirmed that if a patient requested a laboratory test, Dr A would need to authorise it, although the request forms could then be signed on her behalf by the practice nurses.

52. Dr A stated that she "understood that the test results that were being received on behalf of Mr B had been requested by his specialist", as she understood that Mr B was under Dr F's care.

53. In contrast, Mr B said that he would make an appointment to see Dr A for his results a few days after each test. Mr B said that the nurses never gave him his results and, each time when he saw Dr A, she did not tell him the results but just said, "You're fine." He said that the first time Dr A told him the result was when it was "10.5".[17]

54. Dr A told HDC that:

> "laboratory results are received in the laboratory inbox and they cannot be transferred into the patient notes until the doctor sees them. If the doctor is not immediately available, the nurse will go through and check the results for urgency, but the test results are not transferred until actioned by the doctor. Once the doctor has looked at the laboratory result, she will then task the nurse to do one or more of the following:
>
> Arrange a patient appointment
>
> Label it urgent
>
> Ring the patient for a prescription

[16] Most PSA in the blood is bound to serum proteins. A small amount is not protein bound and is called "free PSA". In men with prostate cancer the ratio of free (unbound) PSA to total PSA is decreased. When the total PSA is moderately raised, a percentage of free PSA of less than 20 suggests a higher probability of carcinoma.

[17] The records do not indicate a result of 10.5; however, in October 2009 Mr B had a test result of 10.87. Dr G discussed this result with Mr B.

Ring the patient for a blood test to be done."

Care provided in 2008

55. The electronic record indicates that on 2 May 2008, Dr A ordered a full blood count (FBC), Lipids (fasting), PSA test, and urea and electrolytes (U & E). No reason is recorded for this request. The results were normal, except for a PSA level of 4.85ng/ml, which was slightly above normal levels (<4.5ng/ml).

56. A further note in the electronic record dated 18 May 2008 says: "Pathology: PSA" indicating that a laboratory request form was generated on this date, but there is no corresponding result entered. It is not clear whether this laboratory request form was given to Mr B.

57. In her response to HDC, Dr A stated:

> "[Mr B] approached our nurse on the 19/05/2008 with a request for a PSA blood test which she gave him the forms for. After receiving the results showing a PSA of 4.85, I instructed the nurse to give him a call and advise him of the results … and to make inquiries about whether he had any symptoms that warranted more investigation. The nurse passed on his response to me at that time — that he did not have symptoms at present but sometimes he had difficulties passing urine at night. He was advised to make an appointment if he developed symptoms or his intermittent problems with urination at night got worse."

58. The records indicate that in August and November 2008, Mr B again contacted a nurse at Medical Centre 1 to arrange PSA tests. The November tests included other routine blood tests. The result of the PSA test in August was again slightly elevated at 4.78ng/ml with a free:total PSA ratio of 39.7%, and in November it was 5.14ng/ml with a free:total PSA ratio of 31.9%.

59. On 27 November 2008 there is a note that Mr B was to see the doctor about his results. The notes record that Mr B "popped in" for the results on 28 November 2008 and that these were provided by the clinic nurse, who advised Mr B that the doctor wanted to see him the following week. Dr A said that she "called [Mr B] in for the 5 December 2008 consultation to ensure that he was aware of his results and to ensure that he was seeing his specialist as he had advised her that he was doing".

60. Dr A told HDC that the 5.14ng/ml result concerned her because "[a]lthough this result was within the normal range I was concerned to see a trend of going up and that he was seeing the nurses rather than me".

61. The electronic record of the 5 December 2008 appointment records:

> "Here to discuss latest PSA. BP 130/80. He has been seen by [Dr F] who prescribed some medications, apparently expensive. He feels fine. No letter at all from [Dr F] — for [patient] to organise letter to be sent to us."

62. In her response to HDC, Dr A confirmed the discussion as recorded in the electronic record, and also stated that Mr B said he had been taking "some expensive medication

which I understood was arranged by his specialist though he could not name it. I explained the importance of knowing what medication he is on." She also explained to HDC that she did not perform a DRE or contact Dr F, because she felt Mr B was reluctant for her to intrude, and that he said he would arrange for her to receive the letter from Dr F.

63. In contrast, Mr B denied telling Dr A that he was under Dr F's care. However, he said that he told the practice nurse, Ms I, "I'm getting treatment from a specialist for my [urinary] problems." Ms I was employed as a practice nurse at Medical Centre 1 from 4 November 2007 to 17 September 2009. Ms I recalls having informal conversations with Mr B at the nurses' station about his life and family.

Care provided in 2009

64. On 22 January 2009, Mr B saw Dr A. The electronic record notes that Mr B had advised that the name of the medication that Dr F prescribed was "flomaxo", and there was a "copy of script in file". A copy of the script was not in the records provided to HDC. Mr B recalls showing Dr A a packet of his tablets rather than a prescription. He stated that these tablets were prescribed by Dr F later than 2006, and that Dr F prescribed a total of four packets of Flomax. As stated above, this information is incorrect, as prior to 2010 Dr F prescribed medication for Mr B only once. However, the registrar at the public hospital had recorded on 8 January 2007, "I have given him another prescription for Flomax to have in case his condition deteriorates." On 17 August 2007, Dr E reported that Mr B had "been off the a-blocker[18] … for the past four months".

65. Dr A stated that she again raised with Mr B his "getting information from his specialist". The record notes: "Pt. still has to contact [Dr F] re. consult notes."

66. Dr A told HDC that the discussion and script reassured her that Mr B's specialist was monitoring and treating his urological problems. When HDC asked her what reassured her, she said she was unable to answer because she could not access the script.

67. On 22 January 2009, an X-ray and ultrasound of Mr B's abdomen were ordered. Dr A explained that the reason for this was that Mr B had pain in his lower abdomen.

68. The report from the radiologist included the opinion "marked enlargement of prostate seen". Mr B recalls telling the radiologist that he knew he had an enlarged prostate.

69. On 3 February 2009, the electronic record notes that Mr B saw Dr A, and records: "[H]ere to discuss latest [ultrasound scan] result." Dr A told HDC that her usual practice is to give the patient a copy of any ultrasound reports to give to his or her specialist.[19] In the area for "Actions", the record notes: "Pathology: PSA." Dr A told

[18] Flomax is an alpha blocker. When alpha receptors in the bladder neck and prostate are blocked there is a relaxation in smooth muscle and less resistance to urinary flow.

[19] The scan was not included in the records obtained by HDC from Dr F.

HDC that she did not forward a copy of the scan to Dr F because she believed he would have been aware of Mr B's enlarged prostate.

70. Mr B recalls Dr A discussing the ultrasound result and saying, "[Y]ou seem all clear." Mr B said that she told him he had an enlarged prostate, which he already knew. Mr B said that Dr A did not give him the scan results to take to Dr F.

71. On 4 February 2009, Mr B's PSA level was 7.15ng/ml with a free:total PSA ratio of 28.4%. The result was not entered on the electronic record and there is nothing to indicate that this result was communicated to Mr B.

72. A further PSA test was ordered by Dr A on 25 June 2009. The notation in the electronic record appears to be from Dr A to the nurse, requesting her to print off a PSA form as Mr B had been told to have the test done every three months. The result was 7.43ng/ml, and the electronic record for 26 June made by Dr A states: "Patient phoned and advised of above and to see gp sooner if symptoms." As stated, Mr B told HDC that Dr A had never called him, and whenever he asked Dr A what his PSA result was she did not tell him the level but told him that he was fine.

73. On 8 October 2009, Dr A ordered a further PSA test. The result was 10.87ng/ml. On 16 October 2009, Mr B discussed this result with the locum at Medical Centre 1, Dr G. Dr G queried whether it was possible that the result was a false positive because Mr B had been riding his motorbike for four hours before the test.[20] Dr G recorded: "Given a copy of results and recommended him to give a ring to his Urologyst [sic] and discuss about it. Let us inform if any news." Dr G did not perform a DRE.

Care provided in 2010

74. On 2 February 2010, Mr B had another PSA test, which returned a result of 28ng/ml. On 5 February he saw Dr G, who performed a DRE and found that Mr B's prostate was enlarged and there was a hard nodule on it. Dr G noted:

> "He explained [to] me that he rang his Urologist and he could [not] find him as he was on holiday. Then [Mr B] went abroad for a long trip [overseas]."

75. On 8 February 2010, Dr G sent a referral to Dr F, enclosing a graph of Mr B's recent PSA results (see **Appendix C**).

76. On 31 March 2010, Dr F reported to Dr A that the result of an ultrasound and biopsy performed by him in March 2010 showed no evidence of malignancy but there was an atypical small eosinophil proliferation in the left proximal gland, which suggested that there was about a 50% chance of finding prostate cancer on a subsequent biopsy. Dr F planned to review Mr B in three months' time.

77. On 4 April 2010, Mr B attended the public hospital emergency department with painful urination. His PSA level was 44ng/ml, and he was provided with antibiotics. The plan was for his GP to review him in a month's time for a further PSA test.

[20] False positives can occur for a number of reasons.

78. On 7 April 2010, Mr B saw Dr A to obtain a letter to assist him while travelling. Dr A noted that he was not taking medication regularly, and she advised him that he needed to do so.

79. In July 2010, Dr F ordered a further PSA test. The result was 43ng/ml.

80. Dr A said that Mr B "popped in" on 27 July 2010 to see the nurse and ask for his PSA results. The results had not been received, so the nurse contacted the laboratory and the result was faxed to Dr A.

81. Ms H was employed as a practice nurse at Medical Centre 1 from 29 June to 8 October 2010. The electronic notes show that Mr B saw Ms H on 27 July 2010 and state:

> "PSA result 43
>
> Ordered by [Dr F], Urologist. Informed [Mr B] that [Dr F] would most likely be in touch with him regarding the result, as the result had nearly doubled in the last 6 months."

82. Ms H told HDC:

> "My first recollection in meeting [Mr B], he arrived at the Practice requesting results of a blood test which had been ordered by his Specialist whom he had been seeing in [city] before an overseas trip. I phoned the laboratory for the results which they faxed through. The results were extremely abnormal, suggestive of prostatic abnormality, and I advised [Mr B] he needed to follow this up with his Specialist, or with [Dr A].
>
> [Mr B] had a visit with [Dr A] not long after this incident (perhaps a week or two), and I recall discussing his abnormal results with her at this stage. She was very upset with me for not bringing this to her attention prior to his visit."

83. Dr A said that Mr B attended Medical Centre 1 on 3 August 2010, and at that time his major concern was the price of the Flomax medication. Dr A wrote to Dr F with a copy of the PSA result, asking for his assistance.

84. On 13 August 2010, Mr B called Medical Centre 1 and said that he wanted to have an appointment with Dr F as soon as possible.

85. On 3 September 2010, Mr B called Medical Centre 1 and spoke to practice nurse Ms J regarding his laboratory tests. On 6 September 2010, Mr B's PSA level was 78ng/ml. It is not clear from the information provided to HDC which doctor requested this test, although a copy of the result was sent to Medical Centre 1. On 16 September 2010, Mr B collected his paper clinical records from Medical Centre 1.

Mr B's account

86. Mr B told HDC that he has a good memory but has difficulty recalling the dates of events. Mr B recalls that when his PSA was "10.5" Dr A told him that he was fine and

said that if she sent him to hospital they would only keep him under observation. As stated above, Mr B said that Dr A had not previously told him the numerical result of his PSA tests and never gave him a copy of his PSA results to take to anyone else.

87. Mr B told HDC that if he had any "problems" he would go private and that if he had seen Dr F he would have told Dr A.

88. Mr B said that he has never declined an examination and does not recall Dr A asking to perform a DRE. He stated that he has had DREs performed by six or seven people, including a female GP in the late 1990s, and a number of urologists.

89. Mr B recalls that after Dr A advised him that his PSA was "10.5" he went overseas for approximately six weeks. He said that on his return, he visited Medical Centre 1 and requested a further PSA test. He recalls the practice nurse telling him that it was only two months since his previous test but he insisted on being tested. Mr B recalls that he returned to Medical Centre 1 four days later and saw a young woman by the name of Ms H, who told him that his PSA result was "34". Mr B asked to see Dr A but was told that she was busy and that he would need to come back the next day. Mr B said that he returned to Medical Centre 1 the next day and spoke to Dr A, and then uplifted his medical records.

90. Further testing confirmed that Mr B had prostate cancer.

Response from Dr A

91. Dr A explained that she did not have Mr B in her computer recall system because she understood Mr B's urological care was with a specialist.

92. With regard to arranging regular reviews, including PSA tests and DREs, as recommended by the urologist from the public hospital, Dr A stated:

> "(i) I had not received the opinion of [Dr E] that this was necessary.
>
> (ii) [Mr B] had consulted [Dr F] privately and did not encourage my participation in this consultation process.
>
> (iii) There were no ongoing symptoms described by [Mr B].
>
> (iv) There is varied evidence on the efficacy of PSA screening.
>
> (v) As [Mr B] had been diagnosed with benign prostatic hypertrophy, it would be expected that there would be some elevation in the PSA reading."

93. Dr A told HDC that she understood that Mr B's urological care was being managed by a specialist and that Mr B did not wish her to be involved in this process. She also told HDC:

> "… in this case [Mr B] had been constantly persistent with me that he did not want me to manage his prostate, and my understanding was that I could not force him to let me examine him, if he did not want to."

94. Dr A told HDC that she didn't ask Mr B whether Dr F was performing DREs, as she did not consider that an appropriate question. She said that she wishes she had contacted Dr F to find out why he was not sending her any referral letters.

Further actions

95. Dr A has advised this Office that she has "learnt a lot from this case" and has reviewed her practice. Dr A said that in future, if one of her patients is seeing a specialist and she does not receive a report, she will inform the patient that she will contact the specialist directly. Dr A has instructed her practice nurses not to issue laboratory request forms to patients without consulting her. If a specialist requests any follow-up actions, these are now entered into the practice's recall system.

96. Dr A advised that Medical Centre 1 has gained accreditation under the Royal New Zealand College of General Practitioners' "Cornerstone" programme.

97. On 19 July 2011, I notified the Medical Council of New Zealand of my investigation of Mr B's complaint against Dr A. The Medical Council subsequently advised that it has required Dr A to undertake a six-month recertification programme, which has been completed, and in December 2012 it resolved that no further action was required.

Response to provisional opinion

98. In response to my provisional opinion, Dr A's legal counsel stated:

> "[Dr A] has, since the complaint was received in late 2010, always expressed the view that she regretted not making contact with [Dr F] to discuss the escalating PSA test results, and would not let herself get into this position again, due to the request, and/or behaviour, of any of her patients. As your opinion notes, [Mr B] told a number of clinicians, and not only [Dr A], that he was being treated over time, by [Dr F], Urologist. This information was given to [Dr A], [Dr G], [Medical Centre 1] staff, and the clinicians at the public hospital. A doctor/patient relationship must proceed on a level of trust between not only the patient and the doctor, but the doctor and the patient. [Mr B] at no stage advised [Dr A] that he had only seen [Dr F] on one occasion in November 2006, nor, when her notes clearly show she raised her expectation that [Dr F] was involved in his care, did he correct that view. That of itself is extremely unusual, and would be very rare behaviour for a patient."

Opinion: Breach — Dr A

Introduction

99. This investigation highlights the importance of appropriate testing, coordination of care between primary and specialist services, and effective communication with the patient, to ensure appropriate care.

100. Mr B uplifted his paper records from Medical Centre 1 in 2010 and passed them to Medical Centre 2. Dr A has stated that the records now held by Medical Centre 2 are incomplete. Accordingly, it has been difficult to ascertain with certainty the events that occurred in this matter, as Mr B's account differs substantially from that of Dr A.

101. As his general practice provider, Dr A had primary responsibility for ensuring that Mr B was receiving appropriate care. In this case, her care of Mr B was hindered because she believed he was receiving specialist care from Dr F, when in fact Dr F played no part in Mr B's care between November 2006 and February 2010.

102. On 22 November 2006, Dr F recorded that there was an IDC in place and that Mr B was "for a trial of removal of catheter in 2 days time and review following that". However, Mr B did not return for the follow-up visit as arranged, and HDC has been unable to ascertain who removed the catheter. Mr B stated that Dr F removed the IDC (although Dr F's records indicate that the IDC was to be removed two days later at the next visit, which did not occur).

103. Dr F advised that he did not report to Dr A because Mr B had self-referred. The records show that Dr A asked Mr B several times to request Dr F to report to her. However, there is no evidence that Dr A sought Mr B's consent to contact Dr F directly prior to 2010, even when Mr B's PSA level began to rise.

104. I accept that Mr B gave the impression to Dr A, Medical Centre 1 staff, and Dr G that he had an ongoing clinical relationship with Dr F during this period, despite having seen him only once, on 22 November 2006. When interviewed by HDC, Mr B stated that he returned to see Dr F "on two or three other occasions" after 22 November 2006 and that he thought his next visit was about five months after the first visit. As stated, this recollection is incorrect.

105. Dr A did not perform a DRE on Mr B. She stated that the reason for this was that she believed that Mr B was under the care of Dr F, and that Mr B gave her the impression that he did not want her to be involved in the treatment of his prostate. She stated: "My sense was that [Mr B] was protective of his privacy with [Dr F], with my feeling that I had to be careful not to encroach." In contrast, Mr B stated that he has "never declined an examination and does not recall [Dr A] asking to perform a DRE". However, in January 2007 the registrar at the public hospital reported that Mr B was "reluctant to be examined today". I find it is more likely than not that Dr A did not directly advise Mr B that a DRE was necessary, nor did she offer to carry one out. I also accept that Dr A believed that Mr B was reluctant for her to be involved in the treatment of his urinary and prostate issues.

106. This report examines whether the services Dr A provided to Mr B were appropriate in light of her belief that Dr F was managing Mr B's prostate concerns.

107. There are two issues:

- The responsibility Dr A had in terms of regular review of Mr B's prostate, including offering to perform a DRE.
- The responsibility Dr A had for ensuring continuity of care with Dr F.

Review of Mr B's prostate

108. My in-house clinical advisor, general practitioner Dr David Maplesden, provided clinical advice about the accepted level of review for men with symptomatic prostate concerns. While there is dispute about the efficacy of PSA screening for men who have no symptoms, from October 2003 Mr B had intermittent symptoms — an enlarged prostate and lower urinary tract symptoms — that warranted regular review.

109. I have divided the care provided by Dr A into three periods. The first is from November 2006 until the beginning of May 2008, during which Mr B appears to have been largely asymptomatic, although he is recorded as sometimes having problems passing urine at night. The second is from May 2008 to February 2010, when Medical Centre 1 ordered PSA tests for Mr B approximately every three months. As stated, from 2006 until February 2010, Dr A believed that Mr B was under the care of Dr F.

110. The third period of care was after February 2010, when Mr B's care was largely managed by Dr F.

November 2006–May 2008

111. Dr Maplesden advised that the recommendation made in the letter from the urology department in May 2004, that Mr B have an annual review of symptoms including PSA tests and DRE, reflects standard practice where a man presents with a normal PSA level, but an enlarged prostate and lower urinary tract symptoms (LUTS).

112. However, Dr A has advised that she did not receive a copy of this letter in 2004, and so she was not aware of this recommendation. Dr A's first recorded consultation with Mr B in relation to prostate concerns was in November 2006, after Mr B had presented at the public hospital with urinary retention and an enlarged prostate. He was referred to the urology clinic through the hospital, but he also asked Dr A to make a private referral to a urologist, which she did. However, Mr B self-referred to urologist Dr F. Dr F advised HDC that he did not report to Dr A because Mr B had self-referred.

113. Medical Centre 1's clinical record for 12 December 2006 notes that a report had not been received from Dr F. Dr A said that she told Mr B to tell Dr F she was his GP so that she could receive information about him, but her sense was that Mr B was "protective of his privacy with [Dr F]". There was a reference to Dr F in the reporting letter from the public hospital's urology clinic in January 2007.

114. I acknowledge that Dr A thought Mr B was receiving specialist care from Dr F throughout, and felt that it was his preference to receive treatment from Dr F. I accept Dr Maplesden's advice that Dr A's care was largely consistent with expected standards until August 2007. Furthermore, as there is no evidence that Dr A received the letter dated 17 August 2007 from the urology clinic at the public hospital, I accept that her care was appropriate until May 2008.

May 2008–February 2010

PSA tests and results

115. Medical Centre 1 ordered regular PSA tests for Mr B from May 2008, although Dr A did not have Mr B on a system for recalls for PSA tests. Dr Maplesden advised that the PSA tests and offers of DREs should have been arranged in a structured fashion, rather than on an ad hoc basis. Although the forms indicated that Dr A was the ordering doctor, they were mainly signed by the nurses. Dr A saw the results of the tests and she became aware that the clinic staff were ordering PSA tests at Mr B's request. She stated that she understood that Dr F had asked Mr B to have the tests and that the results were being passed to Dr F. She said that when she saw Mr B in December 2008 to discuss the results, Mr B confirmed that he was seeing Dr F.

116. In my view, the prudent course of action would have been to provide on the order form that the results were to be copied to Dr F. Alternatively, Dr A could have sent a copy of the results to Dr F or given a copy to Mr B to take to him.

DRE

117. Dr A did not ask Mr B whether Dr F had performed a DRE, nor did she offer to do the examination herself. The two main reasons she gives for this were that she believed that Mr B was receiving urological care from Dr F, and Mr B did not want her to examine him. However, there is nothing in the medical record to suggest any discussion between Dr A and Mr B about the level of care being provided by Dr F.

118. I accept that Mr B had the right to refuse to discuss his urological treatment with Dr A and to decline an offer to have her perform a DRE. However, in my view, to fail to discuss Mr B's treatment with him directly because she "felt he was reluctant for her to intrude" was not adequate care. Dr A should have made specific enquiries about the extent of Dr F's involvement with Mr B and, in particular, whether he had performed a DRE. The questions and responses should have been clearly recorded, especially if Mr B declined a DRE.

119. Dr Maplesden identifies two particular points where further investigation, including a DRE, was warranted. The first was in November 2008 after the third slightly elevated PSA test reading (of 5.14ng/ml), although the free:total PSA ratio remained non-alarming. Dr A said that although she considered that this result was "within the normal range", it concerned her because of the upward trend. The second was after the ultrasound in January 2009, when a marked enlargement of Mr B's prostate was noted.

120. The electronic record for the appointment with Mr B on 5 December 2008 notes that Dr A discussed the latest PSA result with Mr B, confirmed that Dr F was providing care, and asked Mr B to organise for Dr F to send a letter to her.

121. I agree with Dr Maplesden's advice that because of the misinformation about the urological surveillance Mr B was receiving, Dr A's failure to offer a DRE at that time was a minor departure from accepted standards.

122. In January 2009, after the ultrasound results were reported to Dr A, the electronic record notes only that Mr B attended to discuss the scan results. At this point, with elevated PSA levels over a period of time, a scan showing an enlarged prostate, and no report from Dr F, Dr A should have taken steps to reassure herself that Mr B was receiving appropriate follow-up care and examination. Dr Maplesden advised that he would have expected active management from at least February 2009 in terms of DRE, mid-stream urine testing and a probable urology referral.

123. In February 2009 and June 2009, two PSA tests returned increasingly elevated results. There is no evidence that Mr B was told the result of the February test (7.15ng/ml), and after the June test (7.43ng/ml) he was told to contact Dr A if he had symptoms. Either of these results should have prompted further action by Dr A.

124. I consider that by February 2009, Dr A should have recognised the need to be more proactive. The appropriate action would have been to request Mr B's consent to contact Dr F directly to discuss Mr B's ongoing management. Dr A should have asked Mr B whether Dr F had conducted a recent DRE and offered to examine Mr B herself. In my view, Dr A's lack of action was sub-optimal, even though it was largely a consequence of the misinformation provided by Mr B.

125. I acknowledge that when Dr G first saw Mr B on 16 October 2009, following Mr B's PSA result of 10.87ng/ml, he also did not perform a DRE and formed the impression that Mr B was seeing Dr F. However, Dr G did give Mr B a copy of his results to take to Dr F and, when he next saw Mr B on 2 February 2010, he performed a DRE and made a referral to Dr F.

February 2010–September 2010

126. After Dr G referred Mr B to Dr F, Mr B's care was largely managed by Dr F. I note that when a PSA result of 43ng/ml was returned in July 2010, Dr A sent a copy to Dr F with a letter asking for his assistance. This was appropriate.

Documentation

127. Mr B joined Medical Centre 1 in 1998 and his regular GP was Dr D until Dr A took over Dr D's patients in July 2003. Dr D said that he kept paper records, which were transferred to Dr A, none of which have been provided to HDC. Dr A stated that she would have made handwritten notes prior to the practice changing to electronic records in January 2005, and said that she did not see the letter from the public hospital's urology department dated 17 August 2007. She said that on 22 January 2009 she took a copy of Mr B's prescription. None of these documents were later found in Mr B's notes. I accept that, as Mr B uplifted his paper clinical records from the medical practice, there is some doubt as to whether the records supplied are complete.

128. Dr A had a professional and legal responsibility to keep "clear and accurate patient records that report relevant clinical findings, decisions made, information given to patients, any drugs or other treatment prescribed".[21]

129. The importance of good record-keeping cannot be overstated. It is the primary tool for continuity of patient care. A patient's clinical record must therefore be dated, legible, and accurate, and comprehensively document all relevant aspects of a patient's symptoms, signs, diagnosis and treatment.[22] As an independent expert advisor has noted in a previous opinion:[23]

> "Adequate notes are important for many reasons. These reasons include allowing more reliable comparison of findings than simple memory of events should a patient return for review of the same or a different problem by the same doctor. Notes are critical for informing another doctor in the practice, or a locum, of the prior status of the patient, which can have a large impact on the current and future care of patients."

130. Dr A's notes for most of Mr B's appointments are brief and do not detail the information provided to Mr B or explain Dr A's rationale for her decisions.

131. Dr Maplesden advised that Dr A should have documented the follow-up of Mr B's raised PSA result on 5 August 2008.

132. On 22 January 2009, Dr A requested an ultrasound scan of Mr B's abdomen. No clinical history, physical examination or rationale for requesting the scan was documented in the notes. On 3 February 2009, Dr A documented "Here to discuss latest USS result" but not the content of this discussion, including whether the "marked enlargement of prostate" finding was discussed. Dr Maplesden advised that Dr A's documentation of these two appointments in particular was a moderate departure from expected standards.

133. I note that a number of the health professionals who saw Mr B described him as a difficult or vague historian. Under these circumstances, it was particularly important to keep clear and accurate notes to ensure continuity of care. By failing to document comprehensive clinical notes, Dr A breached Right 4(2) of the Code.

Continuity of care — 2006–2010

134. Although not vocationally registered under the scope of general practice, Dr A was providing general practice services to her patients.[24] Many patients require specialist

---

[21] MCNZ, "The maintenance and retention of patient records", August 2008. Available from www.mcnz.org.nz.
[22] Ian St George (ed), "The medical record" in *Cole's Medical practice in New Zealand* (2011) at pg 101. Previous editions include identical wording. Available from www.mcnz.org.nz.
[23] Opinion 06HDC12164.
[24] The vocational scope of general practice is defined by the Medical Council pursuant to the Health Practitioners Competence Assurance Act 2003 as an academic and scientific discipline with its own educational content, research, evidence base and clinical activity, and a clinical specialty orientated to primary care. It is personal, family, and community orientated comprehensive primary care that includes diagnosis, continues over time, and is anticipatory as well as responsive.

assistance. However, this does not mean that the role of the general practitioner is over. As noted in *Cole's Medical Practice*:[25]

> "It is in patients' best interests for one doctor, usually a general practitioner, to be fully informed about, and responsible for maintaining, continuity of a patient's medical care."

135. Mr B was approaching Medical Centre 1 regularly through most of the period to arrange PSA tests. Dr A's name is on six of the seven PSA tests requested between 2 May 2008 and 2 February 2010. Given her belief that the tests were being ordered on behalf of Dr F, it is unclear why she did not copy the results to Dr F, rather than discussing the results with Mr B.

136. Dr A said that she understood that the three-monthly PSA tests were arranged at Dr F's request. Presumably, her expectation was that Mr B would advise Dr F of the results himself. However, there is no record in the clinical record that this was her expectation or that this was Mr B's preference.

137. In my opinion, Dr A was responsible for ensuring that the test results were communicated to Dr F, noting her own concerns or observations. This was a missed opportunity to clarify the situation as, if Mr B had refused consent for her to communicate with Dr F to ensure that Mr B's rising PSA levels were being appropriately managed, this may have been a signal that the circumstances were not as she thought. If he had agreed for her to send the results to Dr F, Dr F would have advised her of his lack of involvement. By doing this early on, she would have then realised that Dr F was not actively involved in Mr B's care and been able to take further action herself.

138. Furthermore, the ultrasound scan in January 2009 showing a marked enlargement of the prostate should have been provided to Dr F. I note that Dr A stated that it is her practice to give a copy of ultrasound reports to patients to take to their specialist if the specialist is not noted as receiving a copy. However, there is no record that she did so in this case.

139. At the appointment on 22 January 2009, Dr A documented that the medication prescribed by Dr F was Flomaxo and that a "copy of [the] script [was] in file". She recorded: "Pt still has to contact [Dr F] re consult notes." She advised that the conversation reassured her that Dr F was "monitoring and treating [Mr B's] urological problems".

140. Mr B's only prior contact with Dr F had been in November 2006. Dr A stated that she "did not consider that [Mr B] would have been presenting a script containing inaccurate information for her consideration". It is unclear what inaccurate information was included in the script she saw. I do not accept that a prescription dated 2006 could have provided any reassurance to Dr A over two years later. In my

[25] *Cole's Medical Practice in New Zealand (2011*) at page 130. Previous editions include identical wording.

view, Dr A had a responsibility to co-ordinate Mr B's care to ensure that he received quality and continuity of services. I do not accept that her actions were sufficient in this case.

141. Dr A has accepted that she should have contacted the specialist directly. An early, frank discussion with Mr B or a phone call to Dr F may have prevented this misunderstanding, and Mr B may then have received the care he needed.

Conclusions

142. Dr A's practice ordered PSA tests for Mr B. The test results showed a clear rising trend. As his provider of general practice services, and the doctor receiving the results, it was Dr A's responsibility to take reasonable steps to reassure herself that the abnormal results were being followed up.

143. By failing to have a recall system in place to ensure systematic PSA testing and review of the results, failing to discuss Mr B's treatment with him directly, failing to offer to perform a DRE for Mr B, and failing to make specific enquiries about the extent of Dr F's involvement, Dr A failed to provide services to Mr B with reasonable care and skill. Accordingly, I find that Dr A breached Right 4(1) of the Code.

144. Dr A's documentation departed from expected professional standards and breached Right 4(2) of the Code.

145. Dr A did not arrange for Mr B's test results to be copied to Dr F, despite believing they were being ordered at his behest. She also failed to request Mr B's consent for her to communicate with Dr F to ensure that Mr B's rising PSA levels were being appropriately managed. As a result, the quality and continuity of the services provided to Mr B were impaired. Accordingly, in my view, Dr A also breached Right 4(5) of the Code.

146. Dr A has advised that she has made a number of changes to her practice in light of Mr B's complaint. My clinical advisor, Dr Maplesden, has reviewed those changes and advised me that he considers that the changes Dr A has made to her practice, particularly around communication with specialists when expected information is not forthcoming, are appropriate. Dr Maplesden also described Dr A's current recall system and pathology request processes as consistent with expected practice.

Further comment — communication

147. This complaint highlights the importance of good communication in the partnership between consumers and GPs.

148. The HDC website includes this guidance for consumers:[26]

> "Communication is about reaching a shared understanding of the issues under discussion — about talking and about listening, and recognising the messages that are conveyed by means other than words. Both parties need to feel comfortable in the environment for effective communication to occur. Exchange of information is

[26] http://www.hdc.org.nz/education/getting-the-best-from-your-health-or-disability-service##Tips

an intrinsic part of effective communication and underlies the diagnosis and treatment processes: research indicates that the patient provides around 80% of the information their doctor needs to make a correct diagnosis; (other forms of information, such as physical examination, tests and medical records, provide just 20%)."

149. For many men, talking about prostate health may be difficult, and it appears in this case that Dr A assumed that Mr B was reluctant to have her involved in this aspect of his care, preferring to rely on specialist care.

150. Mr B led Dr A, Dr G, Medical Centre 1 staff, and the clinicians at the public hospital to believe that he was under the care of Dr F. However, Mr B was not receiving specialist care from Dr F between 2006 and 2010. This enduring misunderstanding was a significant factor that contributed to various providers' assumptions that Mr B was receiving specialist input.

Opinion: No Breach — The Medical Centre

151. A company operated Medical Centre 1 in which Dr A provided services to Mr B. The company employed Dr A and the staff. Dr A is the sole director and sole shareholder of the company.

152. Mr B requested the majority of his PSA tests from the practice nurses at Medical Centre 1. Dr A stated that this was not the normal practice at Medical Centre 1. The practice nurses confirmed that if a patient requested a test it would need to be authorised by Dr A and they could then sign the form on her behalf. Dr A has acknowledged that she was aware of the test results. I am satisfied that Dr A was responsible for the relevant PSA tests ordered between 2005 and 2009.

153. There were appropriate systems in place for ordering tests and reviewing the results. There was also a system for setting recalls for repeat tests, which Dr A did not activate for Mr B's PSA tests. It is my view that Dr A's failures to discuss Mr B's treatment with him directly, make adequate enquiries about the extent of Dr F's involvement, and seek Mr B's consent to communicate directly with Dr F were not related to the systems operating in the practice. Accordingly, I do not consider that the company operating Medical Centre 1 breached the Code.

Recommendations

154. In my provisional opinion, I made the following recommendations:

1. Dr A provide a written apology to Mr B for her breaches of the Code.

2. Dr A review her practice in light of this report, particularly as it relates to co-ordination of care, review of test results processes, and communication with other providers, and provide evidence to this Office of the review and subsequent changes.

3. The Medical Council of New Zealand undertake a competency review of Dr A.

155. In response to my provisional opinion, Dr A has advised me that:

1. In relation to recommendation 2, she has reviewed her practice and made a number of changes. I am satisfied that those changes are appropriate.

2. In relation to recommendation 3, as mentioned in paragraph 97 above, the Medical Council of New Zealand required that Dr A undertake a six-month recertification programme, which has been completed. Therefore, I have decided not to recommend that the Medical Council undertake a competency review of Dr A.

156. As per my provisional recommendation 1, I recommend that Dr A provide a written apology to Mr B for her breaches of the Code, to be forwarded to HDC by **8 March 2013** for sending to Mr B.

Follow-up actions

157. 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 the District Health Board responsible for the region in which Dr A practises, and they will be advised of Dr A's name.

158. 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 will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent clinical advice to the Commissioner

The following clinical advice was obtained from my in-house clinical advisor, vocationally registered general practitioner Dr David Maplesden. Parts of the advice have been removed for the purpose of brevity.

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mr B] about the care provided to him by [Dr A]. To my knowledge, I have no personal or professional conflicts of interest. I have examined the available documentation: complaint from [Mr B]; response from [Dr A]; GP notes including specialist letters and blood results.

2. The complaint summaries on file (dated 28 and 30 March 2011) accurately summarise the sequence of events and will not be reiterated here. I have been asked for specific comment on the following issues:

(i) Whether [Dr A] should have ensured that [Mr B] was having regular PSA tests and digital rectal examinations from 2004.

(ii) Whether [Dr A] responded appropriately to [Mr B's] rising PSA levels in 2008 and 2009.

3. [Mr B] had PSA tests irregularly from 1995 (approximately every three years). His father apparently had had prostate cancer — this history is relevant in that it increased [Mr B's] risk of prostate cancer to about two and a half times that of a man without such a family history.[27] As far as I could see, this family history was not documented in GP notes or specialist letters. I am unable to determine from the GP notes whether [Mr B] had a history of LUTS (lower urinary tract symptoms) prior to October 2003. The presence of LUTS impacts on whether and how often screening for prostate cancer should be undertaken. Recommendations on management of men in whom prostate cancer might be suspected is summarised in Appendix [B]. The screening of asymptomatic men (ie those without LUTS) is controversial and a decision on whether or not, and how, to screen is generally made after informing the patient on limitations, potential risks and benefits of such screening. The Ministry of Health has circulated recommendations to GPs on how to approach this issue with patients.[28] Assuming [Mr B] did not have any history of LUTS prior to October 2003, whether or not he was being screened for prostate cancer would be the result of discussion between himself and his GP. The PSA levels obtained between April 1995 and April 2003 were within normal age adjusted results.

4. On 28 October 2003 [Mr B] developed LUTS suggestive of a urinary infection. Appropriate treatment was commenced by his GP ([Dr C]) who also found [Mr B's] prostate to be enlarged and firm and referred him to urologist [Dr E]. Before he could

[27] BPAC. PSA screening in asymptomatic men. 2010. Available at: http://www.bpac.org.nz/resources/bt/2010/july.asp?page=3
[28] NZGG. Screening for prostate cancer. Information for health care practitioners. 2008. Available at: http://www.bpac.org.nz/resources/bt/2010/july.asp?page=3

be seen he presented to ED at the public hospital in urinary retention. PSA was elevated to 47 µg/L (normal < 4.5) almost certainly as a result of the diagnosed prostate infection. There was follow-up with [Dr E] who, in a letter to [Medical Centre 2] on 27 May 2004, noted that [Mr B's] PSA had returned to normal but there was moderate prostatic enlargement and ***I would recommend that he review his lower urinary tract symptoms with you on an annual basis along with a PSA and digital rectal examination.*** My expectation is that [Mr B] would have been placed on the PMS recall system at this point to ensure the recommended examinations were undertaken. It is not sufficient to rely on the memory of either the patient or practitioner to ensure such follow-up occurs when there are easily accessible and effective electronic alternatives. I cannot determine from the information available whether this occurred or who [Mr B's] GP was at the time this information was received (although [initials] are attached to the filed document).

5. [Dr A's] notes are supplied from January 2005. The first follow-up PSA and digital rectal examination (DRE) would have been expected about mid-May of that year. A PSA in July 2004 (ordered by [Dr E]) had been within normal limits at 2.9. [Dr A] ordered a PSA blood test in December 2005 although this is not documented in the notes. The result was normal (3.2). There is no record of a DRE. The first reference to [Mr B's] urinary problems in [Dr A's] notes is a record on 12 December 2006 *Has been seen by [Dr F], urologist, no report as yet.* [Mr B] had self-presented to [Dr F] […] a few days after presenting to [the public hospital's] ED with urinary retention and prostatitis. There is a clinic note dictated by [Dr F] dated 22 November 2006 but with no reference to copies going to the GP. This noted [Mr B] to be a vague historian, *prostate is relatively small but broad,* treatment given with antibiotics and tamsulosin (Flomax), *for trial of removal of catheter in 2 days and review following that.* […] [Dr A] asked [Mr B] to obtain the record but this was not forthcoming.

6. On 24 November 2006 [Dr A] had sent a referral letter to [a urologist] requesting a private appointment for [Mr B]. This was done following a telephone request by [Mr B] and no consultation took place. [Mr B] was seen in [the urology outpatient clinic (OPC) at the public hospital] on 8 January 2007 (registrar for [Dr E]), evidently as a result of the OPC referral made from [the public hospital's] ED following [Mr B's] attendance there on 19 November 2006. He had been off any treatment for a month and had some reduction in flow but no other LUTS. He declined to be examined. The report concludes *I have given him another prescription for Flomax to have in case his flow deteriorates…we plan to see him again in about three months' time.* This follow-up did not occur for reasons that are unclear.

7. [Dr A's] notes refer to provision of a form for routine blood tests including PSA on 2 May 2008, request initiated by [Mr B]. The result was minimally elevated at 4.85 (normal < 4.5) with a %Free:Total ratio of 33.7% — ratio of under 20% suggesting a higher probability of cancer. At [Dr A's] request, the practice nurse phoned [Mr B] to inform him of the result and enquire whether he had any LUTS — *No real symptoms at present. Sometimes has problems passing urine at night. Informed pt to make appt if symptoms get worse.* This was followed up with a letter to [Mr B] which included a lab form to repeat the PSA in three months. At this point [Mr B's] last DRE had been that done by [Dr F] in November 2006 (no abnormal features, but [Dr A] had not

received this report), he had not had a PSA test since December 2005, and the PSA was mildly elevated but with a non-alarming free:total ratio.

8. Repeat PSA was performed on 5 August 2008 and was 4.78 (slight decrease from previous). There was no follow-up for this documented in the GP notes. [Mr B] himself initiated request for another form three months later and the PSA reading on 24 November 2008 was 5.14. This was outside the normal range (although [Dr A] in her response maintains it was within the normal range) and a mild increase from the previous results, although the free:total ratio remained non-alarming. [Dr A] requested that [Mr B] see her to discus the results and the consultation took place on 5 December 2008. Notes include *He has been seen by [Dr F] who prescribed some medications, apparently expensive. He feels fine. No letter at all from [Dr F] — for pt to organise letter to be sent to us.* [Dr A] states in her response that she would normally have undertaken a DRE at this point but was under the impression [Mr B] was under the care of [Dr F]. She regrets not contacting [Dr F] directly to get updated information.

9. At this point [Mr B] had not had a DRE for two years and had an increasing PSA although levels were just outside the normal range. His LUTS were apparently well controlled on Flomax. It is difficult to determine why [Mr B] would imply he was currently being monitored by [Dr F] when there has apparently been no recorded contact between the two for over two years. [Mr B] may be able to elaborate on this. I have the following comments referring to management to this point:

(i) it was a mild to moderate departure from expected standards for [Dr A] not to have ensured that [Mr B] was receiving the recommended annual PSA and DRE examinations in a structured rather than ad hoc fashion. Mitigating factors are the sub-optimal communication [Dr A] received from [Dr F] (although she could have contacted [Dr F] for a copy of the missing report or to clarify what ongoing contact there was), the intermittent specialist involvement with no subsequent specialist letters confirming [Dr E's] original recommendations, [Mr B's] lack of clarity over the ongoing urological care he was receiving, and [Mr B's] lack of ongoing concerning LUTS.

(ii) the most appropriate management of [Mr B] by the time his third 3-monthly PSA was received (and had remained elevated) would have been review with DRE. If the DRE was entirely normal, and with the knowledge [Mr B] had previously been diagnosed with benign prostatic hypertrophy (BPH), had well controlled symptoms that were not progressive, and the free:total PSA ratio was not suspicious, it might have been reasonable to perform another PSA in three months to determine whether the PSA was rising sequentially before referring for specialist review if there was a further rise. Because the DRE did not take place, [Dr A's] management must be a departure from expected practice. However, given the confusion over what urologist surveillance [Mr B] was receiving (although [Dr A] could have asked when [Mr B] actually had had his last DRE) the departure is mild at this point. It is not clear from the notes whether [Dr A] informed [Mr B] his PSA should be repeated in three months, or what follow-up arrangements were to be. This is also a mild departure from expected standards of clinical documentation.

10. [Dr A] next saw [Mr B] on 22 January 2009. She notes in her response that he showed her his prescription for Flomax (presumably signed by [Dr F]) which reassured her he was under urological review. She organised an ultrasound scan for [Mr B's] complaint of left groin and left iliac fossa pain (obtained from request form). Ultrasound result showed no cause for the pain but **marked enlargement of the prostate** was recorded. There is no reference in the consultation notes to the pain complaint or any physical examination findings. This is a moderate departure from expected standards of clinical documentation — some history was documented but only on the ultrasound request form. The results were conveyed to [Mr B] on 3 February 2009. Under actions on this day is recorded *Pathology PSA* although the only notes recorded are *Here to discuss latest USS result.* [Dr A] does not elaborate on this consultation in her response. PSA result on 4 February 2009 was 7.15 (again non-alarming free:total ratio). At this point [Dr A] was aware [Mr B] had a very enlarged prostate (USS report) and had had sequential rises in his PSA over the preceding six months at a velocity that was not normal, levels all being outside the normal range. While the picture may have been consistent with [Mr B's] known BPH, [Dr A] should have at least ensured there were no suspicious features on DRE at this point, either by performing an examination herself or satisfying herself beyond doubt that [Mr B] was receiving appropriate care by contacting [Dr F] directly. Her failure to undertake either of these actions was a moderate departure from expected practice given the clinical scenario. It is not clear whether [Dr A] arranged for copies of the PSA results to be forwarded to [Dr F].

11. On 25 June 2009 GP notes record a request for further PSA — *He was told to get it done every three months.* Result on 26 June 2009 was 7.43 (no comment on ratio) and result is to be repeated in three months with patient to *see gp sooner if symptoms.* On 8 October 2009 another PSA form was provided and result was 10.8. This was reviewed by locum [Dr G] who noted on 16 October 2009 *risen PSA. He drives motorbikes currently and he did the test after 4 hours driving. False +ve PSA? Given a copy of results and recommended him to give a ring to his Urologist and discuss about it. Let us inform if any news.* The result was, in fact, consistent with the sequential rise evident over the preceding year and had [Dr G] regarded the result in this context he may have been alerted to the fact that the pattern of results was increasingly alarming. It was not established whether [Mr B] was symptomatic. However, [Dr G] did recommend [Mr B] contact his specialist and provided a copy of the results, but stopped short of providing a formal referral letter.

12. A further 3-monthly PSA form was provided by [Dr A] (according to the notes) on 2 February 2010. The result was 28. [Mr B] was seen by [Dr G] on 5 February 2010. He established that [Mr B] had been unable to contact his specialist. [Dr G] records that [Mr B] *has symptoms of prostatism, O/E DRE: showed enlarged hard and irregular prostate. Lump on 9 o'clock. Urgent referral to Urologist privately.* A referral was made to [Dr F] privately. Management at this point was consistent with expected standards and is the strategy I would have expected probably a year earlier (see 10).

13. Subsequent management was largely dictated by [Dr F]. On 31 March 2010 transrectal ultrasound and rectal biopsies were performed. The results did not indicate

malignancy but [Dr F] felt it was likely this was a false negative result. The PSA rose further to 44 in April 2010 but this was in the context of a urinary infection (seen at ED [at the public hospital]). However, PSA ordered by [Dr F] in July 2010 was still 43. [Dr A] wrote to [Dr F] on 3 August 2010 to ensure he was aware of this result. On 9 August 2010 [Mr B] had an MRO of the pelvis that indicated likely metastatic involvement of local lymph nodes and [Dr F] referred him to a [specialist in another region] for further management. The referral letter includes the comment that [Mr B] had *an exponential pattern of PSA elevation… from about July 2009*. Prostate cancer was subsequently confirmed and [Mr B] was commenced on androgen deprivation therapy. GP management, from the time of formal referral to [Dr F] in February 2010 to present, was consistent with expected standards.

14. An ongoing confusing factor in this case is the lack of clarity over precisely what ongoing contact there was between [Dr F] and [Mr B] prior to the formal referral in February 2010: Was [Dr F] regularly prescribing for [Mr B]? Was he receiving blood results? Was he advising about frequency of PSA testing? Was he being seen in private or public? Why was there no communication with [Dr A] over this period if he was being seen? Why was [Mr B] intimating he was under regular specialist review if this was not the case? These issues require clarification and may have some impact on the apportionment of responsibility for [Mr B's] ongoing management.

Dr David Maplesden
Clinical Advisor
Health and Disability Commissioner"

Further independent clinical advice to the Commissioner

The following further clinical advice was obtained from Dr David Maplesden, Clinical Advisor:

"The following comments should be read in conjunction with my original preliminary advice [above]. I have reviewed the additional information supplied and have taken the following factors into consideration.

1. [Dr A] has no recollection of seeing a letter from Urologist [Dr E] (addressed to 'Doctor' at [Medical Centre 2]) dated 27 May 2004 in which annual PSA and digital rectal examination (DRE) were recommended as [Mr B] had an enlarged prostate and had had lower urinary tract symptoms (LUTS). Given it is not clear who [Mr B's] primary practitioner was at this time, I cannot comment on [Dr A's] role in annotating the recommendations into the clinical notes and ensuring they were carried out at this point. However, on 17 August 2007, [Dr E] sent a letter addressed specifically to [Dr A] noting [Mr B] was currently asymptomatic off Flomax but *In view of the problems he has had in the past I think it would be prudent for him to check with you on an annual basis by way of review of symptoms, digital rectal examination and PSA.* My expectation would be that [Dr A] would then recall [Mr B] according to these

recommendations, and set up an appropriate reminder in her system to ensure this was done. There is no evidence she did this. There is no indication a copy of this letter was sent to [Dr F], and no reference to any ongoing involvement by [Dr F] in [Mr B's] care. Given the lack of clarity over [Dr A's] access to the letter of 27 May 2004, and taking into account her referral of [Mr B] to [a Urologist] in November 2006 (even though [Mr B] did not attend this appointment), involvement of the DHB Urology clinic, and impression given to [Dr A] by [Mr B] that he was previously seeing [Dr F] on an ongoing basis, I feel [Dr A's] management of [Mr B] until August 2007 was largely consistent with expected standards. It would have been prudent for her to have contacted [Dr F] to request clarification of his involvement when no formal report from him was forthcoming. The reason for this lack of reporting (relating to the consultation of 22 November 2006 when [Mr B] had self-referred) was [Mr B's] failure to come for review as instructed after the preliminary assessment by [Dr F]. [Dr F] did not consult again, and had no ongoing contact, with [Mr B] until March 2010 following a referral from [Dr G]. However, it is evident from the clinical notes of [Dr A] and [Dr G] that [Mr B] gave both doctors the impression he was receiving ongoing specialist care after August 2007 when this was apparently not the case.

2. [Mr B's] PSA results showed a significant sequential rise from November 2008. [Dr F] did not request any PSA tests until 5 July 2010, nor was his name in the 'Copy to' portion of results received by [Dr A] from May 2008, or on the request forms generated under [Dr A's] name. The PSA requests from 2 May 2008 to 8 October 2009 (six requests) all list [Dr A] as the requester, although at least three of the request forms have been signed by a practice nurse on behalf of the GP. The test of 2 February 2010 was requested by [Dr G]. Responses from some of the practice nurses employed at the surgery over the period in question indicate all lab forms, other than those relating to annual diabetes checks, had to be requested or approved by the GP. There was some variation in response over which requests nurses could sign for on behalf of the GP, although all maintained the PSA requests would only have been provided with the knowledge and approval, or on the direction, of [Dr A]. If a patient requested a lab test other than for annual diabetes review, [Dr A] was still required to authorize it before a form could be provided. [Dr A] received all blood results generated in her name. My understanding therefore is that [Dr A] would or should have been aware of the PSA tests [Mr B] was having performed between May 2008 and October 2009, and not been misled into thinking these requests had come from [Dr F]. [Dr A] reviewed five of the six results returned over that period ([Dr G] reviewed the result of 8 October 2009). While the PSA level was well monitored over the period in question, given the progressive rise in levels between August 2008 (4.78), November 2008 (5.14) and February 2009 (7.15), and taking into account [Dr E's] recommendations of 17 August 2007, I would have expected active management from at least February 2009 in terms of DRE, mid stream urine (to exclude infection as a cause for the rise even though [Mr B] had no new urinary symptoms) and probable urology referral (refer to point 10 in my original advice). In fact, there is nothing in the clinical notes to indicate [Mr B] was informed of his result of 4 February 2009 (level of 7.15, listed normal range <4.5). When the PSA remained elevated at 7.43 in June 2009, [Dr A] again failed to actively manage the situation in a manner consistent with expected practice.

3. The additional information provided regarding the August 2007 letter from [Dr E] and the PSA request forms confirms the comments outlined in point 10 of my original advice ie that [Dr A's] failure to perform a DRE in light of the sequential PSA results available to her, her failure to inform [Mr B] of his significantly abnormal result of 4 February 2009, or to ensure beyond doubt that [Mr B] was receiving a specialist opinion by contacting the specialist directly, or at least providing him with copies of the PSA results (noting the requests for the results in question all originated from [Dr A's] surgery with no copy to any other provider), was a moderate departure from expected practice. Had [Dr A] ensured appropriate information was being conveyed to [Dr F], I would temper my criticism. Had [Mr B] not claimed to be under specialist care, I may have been more critical of [Dr A's] actions. However, I cannot say with certainty that a DRE would have been abnormal at this point, and I note TRUS biopsy taken in March 2010 did not detect cancer, although in hindsight this was a false negative result.

4. [Mr B] continued to get his PSA performed approximately three-monthly on forms generated under [Dr A's] name. Result of 8 October 2009 was 10.8 and was managed by the locum [Dr G]. [Dr G] has provided a response noting he was concerned about the PSA level and pattern of increase, and discussed this with [Mr B]. [Mr B] wondered if the elevation could have been due to a prolonged motorbike ride shortly before the test was taken and although [Dr G] agreed it was a theoretical possibility, he thought it was unlikely. [Mr B] told [Dr G] *that he had seen a private Urologist due several problems of his prostate in the past, so he always felt free to call him for an advise or discussion any issues* [sic]. [Dr G] *strongly recommended* [Mr B] contact his urologist, and gave him a copy of the blood test results to pass on, and asked [Mr B] to report back on the urologist's response. [Mr B] did not do this but obtained another PSA request form from the practice on 1 February 2010. Result the following day was 28 and [Dr G] was undertaking a locum for [Dr A] again when [Mr B] returned on 5 February 2010 to discuss the result. [Mr B] stated he had not contacted his specialist. By this stage he had significant LUTS, [Dr G] performed a DRE and noted an abnormality, and an urgent referral was made to [Dr F]. […] I note he reinforced on [Mr B] the potential seriousness of his situation and gave him results to pass on to the specialist. As a locum, [Dr G] would not have been aware that there had never been any concrete evidence [Mr B] was consulting with [Dr F], and that lab results were not being routinely forwarded to the specialist. It appears [Mr B] was clear in his explanation he was having ongoing contact with a specialist, and [Dr G] has outlined in his response several factors that led him to believe [Mr B] was most likely being treated for benign prostatic hypertrophy. [Dr G] asked [Mr B] to report back after consulting the specialist, but was not at the practice to ensure timely contact had been made. […]

5. Once referral had been made to [Dr F] (February 2010), management was largely out of the hands of [Dr A], although I note she did write to [Dr F] in August 2010 to ensure he was aware of [Mr B's] increased PSA level.

6. In summary, I feel the overall management of [Mr B] by [Dr A] departed from expected standards to a moderate degree with respect to clinical management of his progressively elevated PSA from February 2009 (section 3 of this advice and section

10 of my original advice). Her failure to ensure the urologist recommendations of August 2007 were followed (with respect to annual DRE) was a mild departure from expected practice, mitigated by [Mr B's] assertion he was seeing a specialist on an ongoing basis and his relative lack of symptoms. The standard of clinical documentation departed from expected standards to a moderate degree as discussed in section 10 of my original advice, mainly relating to consultations of 22 January and 3 February 2009.

7. The standards on which I base my opinion have been referred to in my original advice (publications by BPAC and NZGG). While I note these publications were available only part way through the events in question, they merely documented what had been expected and standard practice with respect to management of elevated PSA in the preceding few years, apart from increased emphasis on age-specific PSA levels, rather than introducing any sudden change in standards or management strategies. There has been, and remains, considerable debate on the merits of prostate cancer screening in asymptomatic men and the evidence for and against such screening continues to accumulate. However, [Mr B] had made a (presumably) informed decision to commence screening some years before he came under [Dr A's] care, and whether or not, or how, he should have been screened is not the issue. The issue is management of elevated PSA, or progressive rise in PSA, in a man who was being screened and was intermittently symptomatic, and who had been previously advised by his urologist to have annual PSA and DRE. While the levels at which further investigation of an elevated PSA is recommended may have become more refined (with respect to age specificity and overall risk) in recent years, it has been standard practice for many years to further assess patients with PSA levels elevated outside of the reported normal range (0–4.5 at the time of this case), or with abnormal DRE[29]. Depending on the degree of elevation, such further assessment might include DRE and repeat PSA, usually by three months and DRE/MSU/specialist referral if the level remained elevated or increased at a greater than acceptable velocity (both of which occurred in [Mr B's] case), or referral if DRE was abnormal irrespective of PSA level. However, a significant number of men with 'abnormal' PSA levels will not have prostate cancer, while some of those with 'normal' levels may still have the disease. My comments with respect to standards of clinical documentation are based on RNZCGP recommendations contained in Aiming for Excellence — RNZCGP Standard for New Zealand General Practice 2011–2014.

8. There is nothing in the information on file that explains why [Mr B] gave his providers the impression, between August 2007 and August 2010, that he was in regular contact with [Dr F] when this was not the case. This did complicate his management somewhat and may well have contributed to the standard of care he received. However, [Dr A] had ample opportunity over the period in question, particularly when there was concern over [Mr B's] PSA levels, to clarify with [Dr F] his role in [Mr B's] care and she failed to do this. As noted previously, she also failed to ensure [Dr F] was receiving the information he might require (PSA levels,

[29] For example: Canto EI, Slawin KM. Early management of prostate cancer: how to respond to an elevated PSA? Annu Rev Med. 2002;53:355-68.

ultrasound result showing markedly enlarged prostate) to appropriately manage [Mr B], had he been providing a service. [Mr B's] clinical picture until at least February 2009, when the velocity of his PSA rise increased, may well have been consistent with benign prostatic disease but this diagnosis should not be assumed until a DRE has been performed and found to be normal, and the need for prostate biopsy considered depending on the clinical picture. While the ultrasound in January 2009 showed significant prostatic enlargement, there was no comment regarding suspicion of malignancy although I note no urinary history, or record of PSA levels, was included in the ultrasound referral, ie it was not a specific prostate ultrasound. [Dr A] has stated she assumed [Mr B] would have had a DRE performed by his specialist over the period in question, but she had no concrete proof this had been undertaken, either through contact with the specialist or specific verbal reassurance (date of examination and findings) from [Mr B]. Certainly no such information was ever documented.

9. [Dr A] has reflected on the events in question and made changes to her practice, particularly around communication with specialists when expected information is not forthcoming. She has described her current recall system and pathology request processes which appear consistent with expected practice. These actions are appropriate. I have no further comments."

Appendix B — Recommendations from New Zealand guidelines on suspected cancer in primary care[30]

(i) A man presenting with lower urinary tract symptoms and found to have a hard, irregular prostate on digital rectal examination should be referred urgently to a specialist

(ii) A man presenting with lower urinary tract symptoms and a high PSA (10 ng/ml or more) should be referred urgently to a specialist

(iii) A man with lower urinary tract symptoms in whom the prostate is normal on digital rectal examination but the age-specific PSA† is raised or rising, should be urgently referred to a specialist. For a man whose clinical state is compromised by other comorbidities, a discussion about management options with the man and/or a specialist in urological cancer may be more appropriate

† Age-based PSA values (upper limit of normal):

40–50 years: 2.5 ng/ml 50–60 years: 3.5 ng/ml

60–70 years: 4.5 ng/ml 70 years and over: 6.5 ng/ml

(iv) A man should be recommended to have a digital rectal examination and a PSA test if he has any unexplained symptom suggestive of metastatic prostate cancer:

• lower back pain

• bone pain

• weight loss, especially in the elderly

(v) Prior to PSA testing, a practitioner should exclude urinary infection, especially in a man presenting with lower urinary tract symptoms. The PSA test should be postponed for at least 1 month after treatment of a proven urinary infection

Good practice points:

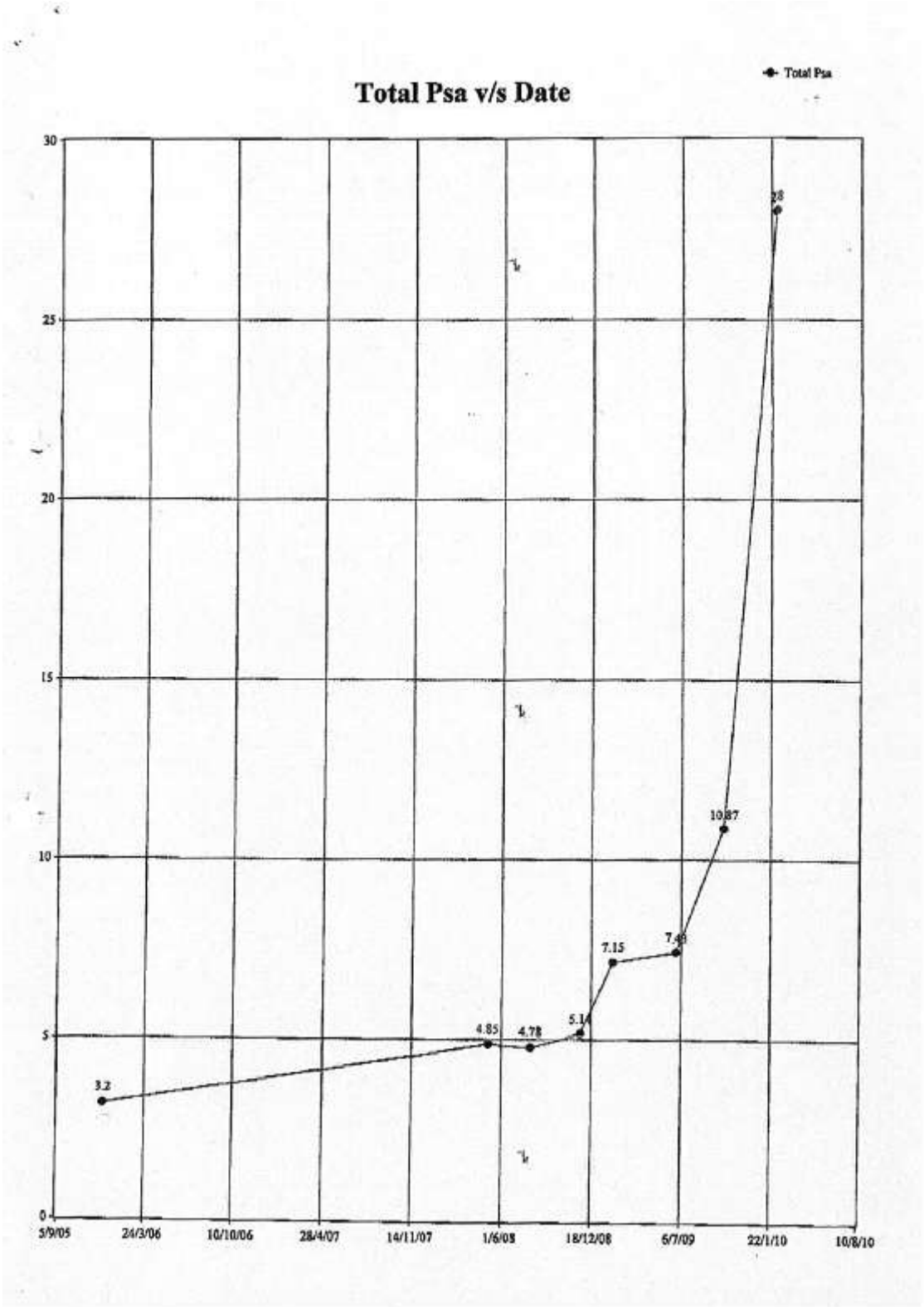
(vi) A man presenting with macroscopic haematuria should be referred urgently to a specialist

(vii) A man found to have an enlarged, smooth prostate on digital rectal examination and a normal PSA should only be referred to a specialist if they have macroscopic haematuria

(viii) An older man presenting with lower urinary tract symptoms (frequency, hesitancy, nocturia) should be recommended to have a digital rectal examination and a PSA test.

[30] NZGG. Suspected cancer in primary care. Wellington. 2009. Available at: http://www.moh.govt.nz/moh.nsf/pagesmh/9524/$File/suspected-cancer-guideline-sep09.pdf

Appendix C — Graph of PSA Results



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

Appendix D — Mr B's PSA Results from 2005 to 2010

Date test performed	Requesting doctor	PSA result	Action
19/12/05	Dr A	3.2	Normal result. No clinical notes provided around this date.
2/05/08	Dr A	4.85	On 20/5/08, Dr A documented that she phoned Mr B with the result and asked him to repeat the test in three months and to make an appointment sooner if he had symptoms. Mr B denies ever being called by Dr A.
5/8/08	Dr A	4.78	No documentation relating to follow-up of this result.
21/11/08	Dr A	5.14	Dr A requested Mr B make an appointment to discuss his result, which occurred on 5/12/08. Dr A asked Mr B to contact Dr F for a letter.
3/2/09	Dr A	7.15	No documentation relating to follow-up of this result.
25/6/09	Dr A	7.43	Dr A documented that she phoned Mr B with the result the following day and asked him to repeat the test in three months and to make an appointment sooner if he had symptoms. Mr B denies ever being called by Dr A.
8/10/09	Dr A	10.87	On 16/10/09, Dr G advised Mr B to contact his urologist about his results and inform the practice of the outcome.
2/2/10	Dr G	28	On 5/2/10, Dr G conducted a DRE and referred Mr B to Dr F.
4/04/10	The public hospital	44	Result included in discharge summary to Dr A with a recommendation that Mr B see his GP in one month for a PSA test.
5/7/10	Dr F	43	On 13/08/10, Dr F referred Mr B to another urologist enclosing the latest PSA result. Dr A was copied into the letter.
6/9/10	Unknown	78	Dr A received a copy of this result.