Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

# A Decision by the Deputy Health and Disability Commissioner

# (Case 22HDC00826)



## Introduction

1. This report is the opinion of Deborah James, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to Mr B by Dr C[1] at a medical centre.[2] Unfortunately, following receipt of the complaint made by Mr B's son, Mr B passed away, and I extend my heartfelt condolences to his family.

3. The following issue was identified for investigation:

- *Whether Dr C provided Mr B with an appropriate standard of care between April 2021 and March 2022 (inclusive).*

4. The parties directly involved in the investigation were:

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|---|---|
| Mr A | Complainant and consumer's son |
| Mr B | Consumer |
| Dr C | General practitioner (GP) |

[1] Dr C is a Fellow of the Royal New Zealand College of General Practitioners.
[2] Dr C is a director and shareholder of the medical centre.

5. Further information was received from:

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| Medical centre | Group provider |
| Private hospital | |
| Health New Zealand\|Te Whatu Ora[3] | District healthcare provider |

6. Also mentioned in this report:

| | |
|---|---|
| Dr D[4] | GP |
| Dr E | GP |
| Dr F | Rheumatologist |

7. In-house clinical advice was obtained from GP Dr David Maplesden (included as Appendix A).

## Background

### Introduction

8. Mr A submitted a complaint to the Health and Disability Commissioner (HDC) on behalf of his father, Mr B, regarding Dr C's management of Mr B's lower urinary tract symptoms (LUTS), which may have led to a delayed diagnosis of prostate cancer.

9. In April 2021 Mr B, in his seventies at the time, first presented with LUTS to Dr C at the medical centre. Mr B has a family history of prostate cancer.[5]

10. Mr B raised his LUTS with Dr C at four further appointments[6]; however, Dr C did not test Mr B's prostate-specific antigen (PSA) levels[7] at any stage. Mr B was also seen by two of Dr C's colleagues regarding his LUTS, on 21 January 2022 and 4 March 2022, and again no PSA testing was completed.[8] Following a rheumatologist appointment on 24 March 2022, Mr B was diagnosed with metastatic prostate cancer.

### Timeline of events

*15 April 2021 appointment*

11. On 15 April 2021, Mr B presented to the medical centre with LUTS and joint pain and was seen by Dr C. This was the first time Mr B raised concerns relating to his LUTS. Clinical notes record that Mr B had joint pain, and that he had been noticing larger amounts of urine during the night since 'at least [six] months ago' and had been urinating about three times a night.

[3] Previously a District Health Board, then Te Whatu Ora|Health New Zealand. On 1 July 2022 the Pae Ora (Healthy Futures) Act 2022 disestablished all district health boards.
[4] Dr D is a Fellow of the Royal New Zealand College of General Practitioners. Dr D is also a director and shareholder of the medical centre.
[5] Dr C said that he was not aware of this family history until the appointment on 25 March 2022.
[6] On 9 September 2021, 11 November 2021, 9 December 2021, and 17 February 2022.
[7] PSA is a protein in the blood that is produced by normal, as well as malignant, cells of the prostate gland. Higher than normal PSA levels may indicate prostate cancer.
[8] There is conflicting information regarding whether a PSA test was completed following the 4 March 2022 appointment, but the outcome was that no PSA levels were recorded (see paragraph 24 for further details).

Following this appointment, Dr C sent a rheumatology referral to the public hospital for Mr B's joint pain.

12. Dr C told HDC that although LUTS was reported at this appointment, Mr B 'mainly discussed' his joint pain during this consultation. With Mr B's primary concerns being polyuria (excessive urination) at night and joint pains, Dr C referred Mr B to a rheumatologist, but felt that it was 'premature' to evaluate Mr B's PSA levels at this stage. Dr C also told HDC that although Mr B was not worried about the nocturia (night-time urination), he checked Mr B to ensure that there was no suggestion of heart failure and noted no evidence of shortness of breath, chest pain, or ankle swelling. Dr C said that Mr B had a medical history of heart disease and various other conditions, for which he was taking medication, but Mr B's family history was recorded as 'no relevant family history'.

*September 2021 to October 2021 appointments*

13. On 9 September 2021 Mr B presented to the medical centre again with LUTS and shoulder pain. Dr C recorded that Mr B's polyuria was becoming worse (occurring both day and night), but there was no hesitancy (difficulty urinating) and no dysuria (pain or burning during or after urination). Dr C requested a blood test (which did not include testing of PSA levels), prescribed a trial of doxazosin,[9] and took Mr B off nifedipine,[10] with a further note to refer Mr B to a urologist if his polyuria did not improve.

14. Dr C told HDC that the persistent polyuria without obstruction led him to consider that Mr B's symptoms were a side effect of medication or fluid retention, rather than prostate-related issues, and he ordered blood tests to cover some potential causes for polyuria, such as diabetes and kidney issues.

15. Dr C also told HDC: 'Although not recorded in the notes, both of us later recalled that I did a rectal examination on this date. This is reported in the clinical note of 11/11/2021 …' HDC shared Dr C's response with Mr B, who did not dispute that Dr C performed a rectal examination on this date. The clinical notes on 11 November 2021 regarding the digital rectal examination (DRE) (discussed further in paragraph 19) record that Dr C found a 'normal, slight[ly] enlarged prostate'. Dr C told HDC that he is certain there were no suspicious features on palpation of the prostate because he would have referred Mr B to urology had this been the case. Dr C said that although it would have been preferable to have discussed a PSA test during the September 2021 consultation, he did not consider this at the time as there were no suspicious features present during the prostate examination, but he started Mr B on doxazosin in view of his enlarged but not suspicious prostate.

16. The results of the blood tests were noted as follows:

[9] Typically used to treat symptoms of an enlarged prostate (such as polyuria and nocturia) by relaxing muscles in the prostate and bladder.
[10] Typically used to treat high blood pressure.

- On 10 September 2021, Mr B's blood test showed that his creatinine[11] level was 145µmol/L (ref range 50–110µmol/L) and his eGFR[12] was 40ml/min (ref range 87–167ml/min). On 14 September 2021, Dr C sent an electronic message to Mr B advising him that his kidney function had 'dropped a bit' and to increase his fluid intake and reduce his salt and alcohol intake. Dr C also advised Mr B to have his kidney function checked in four weeks' time.
- On 11 October 2021, Mr B was sent a text message advising him to complete a blood test to check his kidney function. A telephone call was also made but this was unanswered.
- On 14 October 2021, a further text was sent to Mr B advising him to complete a blood test. The blood test was completed on 20 October 2021 and showed that Mr B's creatinine level had improved to 111µmol/L and his eGFR to 56ml/min.

17. On 22 October 2021, clinical notes written by a practice nurse recorded: '[Kidney function] dropped last time, did have polyuria, if not better: refer to nephrology.'

*11 November 2021 appointment*

18. Mr B's presenting complaint on 11 November 2021 was listed as prostatism (LUTS). Clinical notes record that Mr B was on doxazosin and had had only one instance of nocturia the previous night. The notes also record that stopping nifedipine had not made a difference, so it would be restarted, and that the dosage of doxazosin could be doubled if the nocturia increased. Dr C ordered a urine test to exclude infection. The test was completed on the same day and showed '[n]o [s]ignificant [g]rowth'.

19. As referred to in paragraph 15, the clinical notes record that a rectal examination had been completed two 'weeks' ago, and that the prostate was slightly enlarged. Dr C told HDC that this note refers to the rectal examination that was completed in September 2021 (and therefore two weeks was an error). Dr C said that at this appointment he suggested a rectal examination to Mr B, but Mr B reminded Dr C that this had been done at the previous consultation.

*December 2021 to February 2022 appointments*

20. Clinical notes of 9 December 2021 record Mr B's presenting complaint as prostatism, with Mr B reporting 'no problems' with his LUTS while he was working, but increased frequency at home during the day, but no dysuria. A further urine sample was taken to exclude infection, and the dosage of doxazosin was doubled. Dr C recorded that if the prostatism did not improve, the plan would be to order an ultrasound of the prostate.

21. On 21 January 2022, Mr B was seen by Dr E, another GP who works at the medical centre. Clinical notes state that Mr B's presenting complaint was elbow pain and nocturia up to six

[11] Measured to indicate kidney performance.
[12] Estimated glomerular filtration rate — a more accurate measure of kidney function.

times a night even on the doubled dosage of doxazosin. Dr E recorded that Mr B would be taken off nifedipine and prescribed furosemide.[13]

22. Clinical notes from Mr B's consultation with Dr C on 17 February 2022 record that furosemide had been ineffective for Mr B, with urinary frequency becoming 'much worse' in the past six weeks, with dysuria in the evenings and two episodes of urinary incontinence (loss of bladder control). Dr C prescribed prednisone [14] and referred Mr B to a rheumatologist because of his atypical joint pains. Clinical notes from an online consultation on 18 February 2022 record that the prednisone had acted like a 'magic bullet', with most of Mr B's pain in his arm gone, and his having woken only briefly for a toilet stop.

*4 March 2022 appointment*

23. On 4 March 2022, Mr B was seen by Dr D, another GP working at the medical centre, with Mr B's presenting complaint listed as 'urinary frequency'. Clinical notes state that a DRE performed by Dr C 'last month'[15] had noted an enlarged prostate. The notes record that Dr D ordered blood tests, including a PSA level, and a prostate ultrasound following this appointment; however, it is unclear whether the blood tests and/or the prostate ultrasound were actually carried out (explained further below).

24. Mr B was referred to a private hospital by Dr D for blood tests (including a PSA level) and a prostate ultrasound on 4 March 2022, but Mr B did not follow through with these tests, even after reminder texts were sent on 5 March 2022 and 20 March 2022. However, Mr B told HDC that 'at no time' would he go against the advice of a doctor and not get a blood test when told. He said that the pain from his joints was so 'severe' that any test that could lead to a resolution was 'welcome'.

*24 March 2022 appointment*

25. Following the referral by Dr C on 17 February 2022, on 24 March 2022 Mr B was seen by rheumatologist Dr F at the public hospital for his joint pain. Dr F's clinical letter to Dr C noted (amongst other symptoms) 'marked' prostatism, with nocturia, daytime frequency, post-urinary dribble, low volume urinary stream, and clinical signs of urinary retention. The letter also noted Mr B's family history of prostate cancer.[16]

26. Dr F recalled having been concerned about Mr B's LUTS at this appointment. A test of Mr B's PSA level was requested, which returned an elevated level of 240µg/L (reference <6.5µg/L). Dr F told HDC that Dr D was immediately informed of Mr B's elevated PSA level (after which Dr D referred Mr B to a urologist on 25 March 2022 and Mr B was diagnosed with metastatic prostate cancer[17]).

[13] A medication that helps the body to get rid of extra salt and water by increasing urination.
[14] A steroid typically used to treat illnesses associated with inflammation.
[15] This is the only written record/evidence of a DRE having been performed in February 2022. Dr C did not tell HDC that he performed a DRE in February 2022.
[16] This is the first mention of Mr B's family history of prostate cancer in the clinical records provided to HDC.
[17] The exact date and manner in which Mr B received this diagnosis is unclear.

27. Mr B told HDC that there was 'no … offer' of a prostate examination by Dr F,[18] but Dr F recommended that blood and urine tests be taken straight after the consultation, which 'was done' before he left the hospital.

**Subsequent events**

*28 March 2022*

28. Clinical notes record that Mr B had a telephone consultation with a practice nurse for dysuria and 'frequency', during which Mr B mentioned that he had been going to the toilet three times an hour at night over the previous weekend but that when he went there had been only a 'dribble' and he had felt there was a 'blockage', and he had pain in his penis. Following the telephone consultation, Mr B was seen by Dr C on the same day. A urine sample was taken, which showed the presence of white blood cells and glucose (sugar), and Dr C prescribed nitrofurantoin[19] and booked a prostate ultrasound for the next day.

29. Dr C told HDC that no abdominal examination was conducted at this appointment as Mr B did not report any abdominal discomfort, and his symptoms suggested a bladder infection, with antibiotics being prescribed following the urine test results. Dr C said that it is not his 'standard practice' to perform an abdominal examination for urinary tract infection (UTI) symptoms without signs of obstruction or abdominal complaints.

30. Mr B told HDC that on 26 March 2022 he had only half an hour of sleep between having to go to the toilet at night, and only a dribble would come out, which caused unbearable stinging. Mr B said that this carried on during the day on 27 March 2022 and worsened in the evening to a frequency of every 15 minutes, with 'unbearable' stinging continuing. Mr B stated that by 28 March 2022 he was 'almost climbing up the walls' and it felt like 'a day from hell', and he saw Dr C around 10am and was prescribed antibiotics. Mr B told HDC that he had the 'worst night of the lot' that night and could not sleep on 28 March 2022.

*29 March 2022*

31. Mr B told HDC that he went to the private hospital at 8.30am on 29 March 2022 for his prostate ultrasound (amongst other ultrasounds). Later that day, Mr B sent an online message to Dr C saying: 'I just had another night from hell, the pain in my penis is excruciating, as if I was passing broken glass … it's been [three] nights with little sleep and I am reaching the end of my tether.' Dr C recorded that he rang a urology consultant, who advised Ural sachets and an urgent bone scan. The clinical notes also record that Dr C then called Mr B, and, because Mr B seemed to be in retention and '[could] not urinate at all anymore', he asked Mr B to come to the clinic immediately. Dr C told HDC that he spoke to the sonographer who had performed Mr B's prostate ultrasound, and the sonographer confirmed that Mr B was in retention. Clinical notes record that when Dr C examined Mr B, Mr B had a bladder 'full up to [the] umbilicus (navel area)', and, when he was catheterised,[20] one litre of fluid came out. A bone scan request and an acute urology referral were also sent.

[18] Mr B provided this response to a quote referring to the 4 March 2022 appointment, but considering the reference to Dr F, I have interpreted this as referring to the 28 March 2022 appointment.
[19] An antibiotic used to treat urinary tract infections.
[20] Insertion of a thin tube into the urethra to let urine flow from the bladder into a drainage bag.

Mr B told HDC that the catheterisation provided 'instant relief', but there was 'no clarity on what's next' following this appointment.

**Further information**

32. Dr C told HDC that benign prostatic hypertrophy[21] can give symptoms such as frequency of small volumes, hesitancy with reduced flow, and dribbling after stopping. Mr B's main symptoms were polyuria, with no reduced flow or dribbling, which Dr C believes were not typical prostate symptoms. In addition, since the doxazosin did not help, and Mr B's prostate was only slightly enlarged, Dr C did not pursue benign prostatic hypertrophy further as it did not seem that the symptoms were related to this diagnosis. Dr C also said that Mr B's joint pain was more prominent than his urinary symptoms.

33. Dr D told HDC that following HDC's contact, the medical centre undertook an internal review of Mr B's care in early 2023, and Dr C and Dr D made the following findings:

- The diagnostic process: The delay in diagnosis was attributed in part to Dr C not pursuing the possibility of prostate cancer. The medical centre realises the importance of considering a patient's long-term symptoms when undertaking the diagnostic process.
- Patient feedback: There was inconsistent reporting of symptoms over the years by Mr B, which were not always related to his initial complaints. Mr B's report of significant improvement in joint symptoms with prednisone was considered as an indicator of appropriate care by Dr C at that time.
- Documentation: Dr C's failure to record findings from the DRE during consultation was a deviation from best practice in note-taking.
- Continuity of care: Dr D was responsible for overseeing Dr C's patients while Dr C was hospitalised for two weeks in February 2022. Due to the evolving COVID-19 situation, patient interactions were modified to reduce contact, with patients waiting outside and consultations being briefer than usual. COVID-19 restrictions are now removed, meaning the practice is back to usual consultation times, which allow for more thorough review of patient files. Extra care must be taken when seeing patients regularly cared for by a different doctor.
- Referral and follow-up: Where it is noted that a patient has been sent several reminders that have not been actioned, the medical centre will ensure that the patient's details are correct and follow up with a phone call reminder, with the standard being two texts/emails and then a phone call.[22]

**Relevant standards**

34. The 'Good Medical Practice' standards set by the Medical Council of New Zealand state that practitioners must:

[21] A condition in which the prostate gland is enlarged and not cancerous.
[22] In response to the provisional opinion, Dr C clarified that a letter (by mail) is sent for blood test reminders, not a phone call.

'… provide a good standard of clinical care … [which includes] … taking suitable and prompt action when needed'

'… keep clear and accurate patient records that report … relevant clinical information [and] decisions made …' and that these records should be made 'at the same time as the events you are recording or as soon as possible afterwards'.

### Responses to provisional opinion

*Mr A*

35. Mr A was provided with an opportunity to comment on the 'information gathered' section of the provisional report, and he had no further comments to make.

*Dr C*

36. Dr C was given the opportunity to respond to the provisional report. Dr C expressed his sincere regret for the delay in the diagnosis of prostate cancer for Mr B and acknowledged the impact this had on Mr B and his family. Dr C disputed some of the provisional findings and his views have been considered in reaching my final decision. Dr C's comments have been incorporated into this report where relevant.

*Dr D*

37. Dr D was given the opportunity to respond to the provisional report. Dr D accepted the findings and proposed recommendations.

*Medical centre*[23]

38. The medical centre was given the opportunity to respond to the provisional report.

39. The medical centre noted the shortcomings in the management and communication of Mr B's care across providers at the practice and agreed to investigate further changes to its processes (set out in the recommendations section below).

40. The medical centre clarified that the current procedure with blood test reminders is to send two text or email reminders, and then a letter by mail, but it will make changes regarding this (set out in the recommendations section below).

41. Further comments by the medical centre have been incorporated into this report where relevant.

## Opinion: Dr C — breach

### Introduction

42. Taking into account the responses received, my in-house clinical advice, and the rights outlined in the Code, I consider that Dr C breached Right 4(1)[24] of the Code of Health and

[23] This response was provided by Dr C on behalf of the medical centre.

[24] Every consumer has the right to have services provided with reasonable care and skill.

Disability Services Consumers' Rights (the Code). I set out my decision and the reasons for this below.

**Failure to discuss PSA testing**

43. Between April 2021 and March 2022, Mr B was seen by Dr C on multiple occasions for his LUTS (amongst other symptoms). Mr B expressed concern that he was not offered a PSA test and that this led to a delay in his prostate cancer diagnosis.

44. Dr C told HDC that in April 2021, Mr B's main symptoms were polyuria, with no reduced flow or dribbling, which Dr C believes were not typical prostate symptoms. Dr C said that the persistent polyuria without obstruction, in addition to the joint pain, led him to consider that the symptoms were a side effect of medication or fluid retention, rather than prostate-related issues, and he ordered blood tests to cover some potential causes such as diabetes and kidney issues. In addition, Mr B's prostate was only slightly enlarged, so Dr C did not pursue prostate pathology further as it did not seem that the symptoms were related to this diagnosis. Dr C also said that Mr B's joint pain was the main concern for him, and LUTS were mentioned only in passing during the consultation.

45. By September 2021, Mr B's LUTS were ongoing, requiring further consultation with Dr C. In response to the provisional opinion, Dr C told HDC that as Mr B had no signs of prostatism or urinary infection, he did not perform a urine test. In addition, PSA testing was still not performed. Dr C acknowledged that while it would have been preferable to have discussed the PSA testing in September 2021, he did not consider PSA testing at this time as there were no suspicious features present during the DRE. For the avoidance of doubt, notwithstanding the lack of contemporaneous notes recording the DRE at this appointment, I accept that Dr C did perform a DRE at the September 2021 appointment, and that during this examination, Dr C identified a slightly enlarged prostate but no other abnormalities.

46. Dr Maplesden advised that while there is a range of potential causes for LUTS, prostate pathology (primarily benign prostatic hypertrophy) should have been considered as a differential diagnosis. Best practice would have been to discuss the option of PSA testing with Mr B in April 2021, with such discussion mandatory by September 2021, and not doing so would be a mild to moderate departure from the accepted standard of care. Dr Maplesden noted that it is also accepted practice to perform a urine test for both investigation of impaired renal function and investigation of prostatic symptoms.

47. Mr B presented to Dr C with LUTS on two further occasions, in November and December 2021. Again, there were no discussions relating to PSA testing. Dr Maplesden advised that he is moderately critical of Dr C's decision not to undertake a discussion in relation to PSA testing on these occasions. Dr Maplesden noted that there was no obvious cause for Mr B's LUTS found on the blood and urine tests, his symptoms were apparently somewhat responsive to doxazosin, and a diagnosis of prostatism had been recorded.

48. By February 2022, Mr B had presented to Dr C with LUTS at least four times. Dr Maplesden advised that while the clinical picture was still consistent with a diagnosis of benign prostatic

hypertrophy, in formulating this diagnosis there should have been at least a discussion of the role of PSA testing, and Mr B should have been provided with the option of such testing.

49. In response to the provisional opinion, Dr C expressed his view that, although there were factors that influenced his thinking that it was not prostate cancer, it would have been best practice to discuss PSA testing with Mr B at an earlier stage, potentially in September 2021, if not November or December 2021.

50. I accept Dr Mapleson's advice that Mr B's LUTS warranted further consideration and discussion. Following the initial 15 April 2021 appointment in which Mr B first raised his LUTS, the presenting complaint in the clinical notes of at least half[25] of Mr B's appointments with Dr C was LUTS. By September 2021, it is apparent that Mr B's LUTS was worsening. Dr C's notes record suggestions of referrals to urology on 9 September 2021 and a prostate ultrasound 'if prostatism doesn't improve' on 9 December 2021. I consider that Dr C should have discussed PSA testing with Mr B on at least one of these occasions, as per accepted practice.

51. I therefore accept Dr Maplesden's advice that there should have been a discussion of PSA testing in September or, failing that, in November or December 2021 when no obvious cause for Mr B's LUTS had been found, and that this represents a moderate departure from the accepted standard of practice. I note Dr C's comment that discussing PSA testing with Mr B in September, November, or December 2021 would have been 'best practice', but I remain of the view that, as advised by Dr Maplesden, the failure to do so was a departure from the accepted standard of practice.

52. It cannot be determined retrospectively whether, had Mr B been offered the option of PSA testing earlier and consented to it, this would have resulted in his cancer being detected earlier or different treatment options being available to him. Nevertheless, I consider that by not discussing PSA testing at an earlier stage, Dr C did not provide care to Mr B of an appropriate standard and did not demonstrate 'suitable and prompt' actions as a general practitioner in the circumstances.

**Retrospective documentation of DRE**

53. As set out by the 'Good Medical Practice' standards, it is the responsibility of practitioners to keep clear and accurate patient records, which should be written at the same time as the events or as soon as possible afterwards.

54. Dr C told HDC that he completed a DRE in September 2021, but this was recorded retrospectively in the clinical notes on 11 November 2021. In addition, the retrospective documentation was recorded incorrectly, with the DRE being recorded as having been performed two 'weeks' ago, as opposed to two months.

55. Dr Maplesden advised that the retrospective documentation of the DRE examination, even in cases where the results are normal, is a mild departure from the accepted standard of care. Dr C accepts that it would have been prudent to have recorded the DRE in the clinical

[25] Three of six appointments — 9 September 2021, 11 November 2021, and 9 December 2021.

notes on the day of the examination, and that this was an omission from normal practice. In response to the provisional opinion, Dr C told HDC that although he 'should have' documented the DRE on the day of the examination, he does not agree that it is a departure from the expected standards of care. Dr C referenced the Medical Council of New Zealand (MCNZ) statement on 'Managing patient records' (December 2020), which provides guidance for when doctors need to correct or add to notes after an event. He also commented that although it is 'best practice' that retrospective documentation is free from typos, a typo does not meet the threshold of a departure from the accepted standard of care. The internal review also identified that Dr C's failure to document was a deviation from best practice in note-taking.

56. I note that, like the 'Good Medical Practice' standards referred to in paragraph 53 above, the MCNZ guidance cited by Dr C in response to the provisional opinion also states: 'Records must be completed at the time of the events you are recording, or as soon as possible afterwards.' I acknowledge Dr C's views on this matter in his response to the provisional opinion, but I accept Dr Maplesden's advice and remain of the view that Dr C documenting the DRE two months after he performed it was a mild departure from the accepted standard. For the avoidance of doubt, while unfortunate, I am not overly critical of the mistake in the retrospective note that said that the DRE had been performed 'two weeks' earlier, as opposed to 'two months'. I am pleased that Dr C has improved his clinical documentation process in light of this (as set out in the 'Changes made since events' section below).

**Absence of abdominal examination**

57. The 'Good Medical Practice' standards state that practitioners must provide a good standard of clinical care, which includes taking suitable and prompt action when needed.

58. During the telephone consultation with a nurse on 28 March 2022, Mr B stated that over the previous weekend he had needed to go to the toilet three times an hour at night, but when he went there was only a 'dribble', and he felt a 'blockage' and pain in his penis. Mr B was seen by Dr C that day, and clinical notes state that a urine dipstick test showed white blood cells and sugar in Mr B's urine. A prostate ultrasound was booked for the next day, and nitrofurantoin was prescribed.

59. Dr C told HDC that no abdominal examination was conducted as Mr B did not report any abdominal discomfort, and Mr B's symptoms suggested a bladder infection with frequency and dysuria. In response to the provisional opinion, Dr C stated that Mr B did not report symptoms of obstruction to him. Dr C said that it is not his standard practice to undertake an abdominal examination for UTI symptoms without symptoms of obstruction or abdominal complaints.

60. Dr C's response that there were no symptoms of obstruction does not appear to align with Mr B reporting in his phone consultation with the nurse that he was passing very small amounts of urine and felt that there was a 'blockage'. Given that the nursing notes preceded Dr C's review, and noting Dr Maplesden's comments that Mr B's symptoms were consistent with both infection and bladder obstruction, I accept Dr Maplesden's mild to moderate criticism that an abdominal examination was not performed on 28 March 2022. As Dr

Maplesden noted, if the abdominal examination had been undertaken at this point, it may have resulted in catheterisation 24 hours earlier than was actually undertaken.

**Conclusion**

61. In conclusion, I am critical of Dr C's management of Mr B's LUTS between April 2021 and March 2022. Specifically, that Dr C:

- Failed to discuss PSA testing with Mr B from September 2021 onwards;
- Did not request or undertake a urine test in September 2021;
- Did not conduct an abdominal examination on 28 March 2022; and
- Retrospectively documented his clinical findings from the DRE in September 2021.

62. I consider that the above issues amount to a failure by Dr C to have provided services to Mr B with reasonable care and skill and, therefore, I find that Dr C breached Right 4(1) of the Code.

**Family history of prostate cancer — other comment**

63. Mr B's family history of prostate cancer was not recorded in the clinical notes from any of his consultations with Dr C. I note that Dr C told HDC that Mr B's family history was recorded as 'no relevant family history'. The first reference to Mr B's family history of prostate cancer was in Dr F's clinical letter to Dr C from the 24 March 2022 appointment.

64. Dr Maplesden advised that Dr C did consider the diagnosis of benign prostatic hypertrophy from September 2021 onwards, and that in this scenario, it would be best practice to assess for any factors that might increase the risk of prostate cancer, such as significant family history, and this would form part of the informed consent process relating to PSA testing. In addition, Dr Maplesden advised that if Mr B did proactively inform Dr C of his family history, then Dr C should have documented this.

65. In response to the provisional opinion, Dr C told HDC that Mr B did not inform him of any family history of prostate cancer when asked. Dr C said that had he been informed of this history, he would have advised Mr B to have testing done even with a negative DRE. Dr C explained that entering a patient's family history into their notes is not a 'tick box' or auto-populated entry, and therefore the entry of 'no relevant family history' is a meaningful entry that confirms that family history has been specifically asked of a patient. Dr C cannot explain why Mr B's family history was not revealed at the time.

66. In the absence of further evidence, I am unable to determine what communication occurred between Dr C and Mr B regarding relevant family history. For the avoidance of doubt, I would be concerned if Dr C did not enquire as to any relevant family history or failed to document it if it this was disclosed.

67. Although I am unable to make a definitive finding on this matter, I encourage Dr C to reflect on the effectiveness of his communication with Mr B.

## Opinion: Medical centre — other comment

68. As healthcare providers, medical centres have an organisational responsibility to provide services in accordance with the Code. As previously set out by the HDC,[26] practices must ensure that robust systems exist to ensure continuity of care when a consumer is seen by multiple clinicians.

### Review of clinical notes

69. When Mr B raised issues of nocturia with Dr E on 21 January 2022, Dr E's resulting action was to trial stopping nifedipine, despite the ineffectiveness of this treatment option having already been explored and recorded by Dr C two months earlier (11 November 2021). Although it is not unreasonable to explore treatment options multiple times, considering the ineffectiveness of stopping nifedipine having been noted only two months previously, I am concerned that this may indicate that such information was not considered by Dr E during his assessment of Mr B. Had Dr E been aware that this option had been explored, it is possible that alternative pathways (such as PSA testing) could have been explored instead, or at least concurrently.

70. In addition, Dr D recorded in the clinical notes of 4 March 2022 that Dr C had completed a DRE in February 2022, but there is no other evidence within the clinical notes of a DRE having been completed by Dr C in February 2022. This is either an inaccurate reference to the DRE Dr C performed on 9 September 2021, or it refers to another DRE that Dr C failed to record.

71. Taking into account the above two matters, I am concerned that there was insufficient information sharing between providers, and Mr B's clinical notes were not being reviewed thoroughly. Extra care should be taken when providers are reviewing each other's patients for the first time, to ensure that the patient's care is managed appropriately and comprehensively.

### Absence of policy for follow-up of tests

72. As set out in paragraph 81, Dr D also told HDC that a follow-up policy regarding patients not carrying out clinical tests has now been implemented, suggesting that such a policy was not in place previously. I consider that the lack of such a policy at the time placed both providers, and the patients seen by the providers, at risk of not having comprehensive follow-up processes. Follow-up is necessary to ensure that the provider's clinical directions are actually followed through, and I am pleased to see that such a policy has since been implemented.

73. I am concerned that there may have been shortcomings in the management and communication of Mr B's care when he was seen by other providers on behalf of Dr C. I consider that there are areas for improvement in the handover processes at the medical centre to ensure that its employees are exercising effective communication and continuity of care when seeing each other's patients.

[26] Opinion 19HDC01583.

## Opinion: Dr D — educational comment

74. On 4 March 2022, Mr B was seen by Dr D for ongoing LUTS. This included three months of overactive bladder symptoms, frequency day and night, poor flow, and inability to postpone urination. An abdominal examination was not completed.

75. Dr Maplesden advised that Dr D's overall management was reasonable, but that Dr D's management of Mr B may have been improved by performing an abdominal examination and percussing the bladder. Dr Maplesden advised that this would have helped to exclude urinary retention in a patient who was presenting with LUTS, particularly when solifenacin[27] is prescribed, as this can exacerbate urinary retention.

76. In relation to Dr Maplesden's advice, Dr D said that Mr B's history was not suggestive of urinary retention on 4 March 2022, but Dr D accepted that the management of Mr B could have been improved by performing an abdominal examination.

77. Dr Maplesden recommended that Dr D review HealthPathways guidance around ultrasounds, particularly the following: '[A]rrange ultrasound and ensure it includes a post void residual volume[28] if: the bladder is palpably enlarged; abdominal mass; reduced eGFR suspected to be due to chronic urinary retention.' Dr D reviewed the suggested guidance and accepted that although ultrasound indications are not an exclusive list, Mr B's history was 'sufficient' to justify arranging an ultrasound.

78. I am pleased that Dr D has reviewed the relevant guidelines, as advised by Dr Maplesden, to improve Dr D's practice. As such, I have no further comments in this regard.

79. Dr D advised HDC that Mr B 'did not' follow through with the blood test requested on 4 March 2022, despite two text reminders on 5 and 20 March 2022. I consider that Dr D could have been more proactive in ensuring that Mr B completed the requested blood tests and ultrasound, by calling and confirming with Mr B. Following up with Mr B regarding the tests at this stage (4 March 2022) may have resulted in discovery of the elevated PSA levels at an earlier stage.

## Changes made since events

80. Dr C informed HDC that since the events, he has made the following changes:

- He has subscribed to an artificial intelligence program that automatically generates clinical notes and improves note-taking efficiency.
- He has sought additional knowledge on prostate cancer by reviewing relevant literature regarding PSA testing to guide his practice in future situations of a similar nature. In his response to the provisional opinion, Dr C told HDC that he has given a presentation to increase awareness of prostate cancer and prostate cancer testing.

[27] Used to treat bladder control problems and urinary conditions such as overactive bladder, incontinence, and urinary frequency.
[28] Amount of urine left in the bladder after urination.

- He now considers a patient's long-term symptoms during consultations when undertaking the diagnostic process.

81. Dr D and Dr C[29] also made the following changes:

- Reminded clinical staff to take extra care when seeing patients regularly cared for by a different doctor, and to familiarise themselves with a patient's history and previous medical records when they are not the doctor's usual patient.
- Reminded clinical staff to consider a patient's long-term symptoms when undertaking the diagnostic process.

82. Dr D informed HDC of the following changes made:

- Dr D reviewed the Community HealthPathways guidelines regarding benign prostate hypertrophy as recommended by Dr Maplesden.
- Dr D is now aware of taking extra care when seeing patients regularly cared for by a different doctor and is committed to following up with a telephone call if patients do not complete requested clinical tests after two text/email reminders.

## Recommendations

83. I acknowledge the changes made by Dr C. I recommend that in addition, Dr C:

a) Provide a written apology to Mr B's family for the deficiencies identified within this report. The apology is to be forwarded to HDC within three weeks of the date of this report, for forwarding to the family; and

b) Review his practice in light of this report and Dr Maplesden's recommendations, and report back to HDC on his learning, within three months of the date of this report.

84. I acknowledge the changes made by Dr D. I recommend that in addition, Dr D reflect on the deficiencies in care identified within this report and provide a written report on these reflections and the changes to practice, within three months of the date of this report.

85. In response to my recommendation made in the provisional opinion, the medical centre agreed to investigate implementing a documented process/policy to ensure continuity of care when managing other doctors' patients and how this could be audited. Therefore, I now recommend that the medical centre provide a copy of this process to HDC and conduct an evaluation of its effectiveness following its introduction, via an audit of accuracy of clinical notes, within six months of the date of this report.

86. In response to my recommendation made in the provisional opinion, the medical centre agreed to implement a process to ensure that patients are followed up with a phone call if they do not complete requested clinical tests after two text/email reminders. In light of this, I recommend that the medical centre provide HDC with a copy of this process and evaluate

[29] Noting that Dr D was speaking on behalf of the medical centre.

its effectiveness by conducting an audit of compliance, within six months of the date of this report.

## Follow-up actions

87. A copy of this report with details identifying the parties removed, except the clinical advisor on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr C's name.

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

## Appendix A: In-house clinical advice to Commissioner

The following advice was obtained from GP Dr David Maplesden:

'**FINAL CLINICAL ADVICE — MEDICAL**

**FROM**: David Maplesden

**CONSUMER:** [Mr B]

**PROVIDER:** [Dr C]

**FILE NUMBER:** C22HDC00826

**DATE:** 31 January 2023; **Addenda 5 April 2023 (s 4) and 12 December 2023**

1. My name is David Maplesden. I am a graduate of Auckland University Medical School and I am a vocationally registered general practitioner with current APC. My qualifications are: MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. 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 C] of [the medical centre]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following information:

- Complaint from [Mr B]
- Response from [Dr C]
- GP notes [medical centre]
- Clinical notes [private hospital]
- Response from [the DHB]
- Clinical notes [public hospital]
- **Addendum 18 December 2023: Response dated 12 December 2023 from [Dr C] to preliminary clinical advice (s4)**

As a representation of accepted practice in the management of male patients with lower urinary tract symptoms (LUTS) I have reviewed [the] Community HealthPathways section on benign prostatic hypertrophy and the 2020 BPAC publication *Testing for prostate cancer: helping patients to decide*[1].

3. [Mr B] (B: [Year of birth]) complains about delays in his diagnosis of prostate cancer. He states he saw [Dr C] in late 2021 with a several month history of LUTS including nocturia and daytime frequency. Some investigations were performed, and medication prescribed. There were concurrent issues with joint pains. The LUTS worsened and [Dr

[1] https://bpac.org.nz/2020/prostate.aspx Accessed 31 January 2023

C] altered [Mr B's] medication and made a referral to a rheumatologist ([Dr F]) for review of the joint issues. [Dr F] reviewed [Mr B] on 24 March 2022 by which stage his joint issues had largely resolved. However, [Dr F] noted [Mr B's] history of worsening LUTS and established he had a strong family history of prostate cancer …. [Dr F] ordered further tests including PSA (which had not been previously ordered). The PSA returned 240 ug/L (reference range < 6.5) and [Dr F] referred [Mr B] for further review by his GP and for urgent urology assessment. [Dr F] also ordered a liver ultrasound in light of abnormal liver function results. [Mr B] had increasing dysuria and difficulty passing urine over the next few days which was investigated by [Dr C] and treated with antibiotics. [Mr B] eventually required urinary catheter insertion (undertaken by [Dr C]) and a bone scan was ordered. This has shown evidence of bony metastases and [Mr B] has been commenced on androgen deprivation therapy as a palliative measure. He is concerned that [Dr C] did not discuss PSA testing with him when he first experienced LUTS, and that this has resulted in a delay in his diagnosis of prostate cancer.

4. [Dr C] notes [Mr B's] past history of ischaemic heart disease, atrial fibrillation (on dabigatran, bisoprolol), hypertension (losartan), dyslipidaemia (atorvastatin), Raynaud's syndrome (nifedipine) and ex-smoker status. Clinical notes have been provided from November 2021 to current but [Dr C] states [Mr B] first presented a six-month history of LUTS on 15 April 2021, predominantly nocturia. On 9 September 2021 [Mr B] reported his LUTS had become more troublesome in the preceding month with daytime frequency, nocturia up to five times and apparent increased amounts of urine (polyuria). There was no report of decreased flow, hesitancy, dribbling or dysuria. Blood tests were ordered to exclude diabetes or renal issues. [Dr C] states a digital rectal examination (DRE) was performed at this consultation, but the result was not recorded at the time. He states: *The prostate was enlarged. I am certain there were no suspicious features on palpating the prostate as I would have referred him to urology had this been the case. In view of his symptoms, and the enlarged but not suspicious prostate, I started him on doxazosin and stopped his nifedipine.*

Comment: I recommend [the medical centre's] clinical notes (including all test results) are obtained for the whole of 2021. On the basis of [Dr C's] response, [Mr B] first presented a history of LUTS (primarily nocturia) in April 2021 as part of a consultation for unrelated issues. While there are a range of potential causes for LUTS, prostate pathology (primarily benign prostatic hypertrophy) should be considered in the differential diagnosis and it is accepted practice to discuss the role of PSA testing as part of investigation of LUTS (irrespective of the DRE result) and to undertake such testing if the patient makes an informed decision to proceed. This is different to use of PSA for prostate cancer screening in asymptomatic males when such screening might be considered inappropriate if the patient has a life expectancy of less than 10 years. [Dr C's] response suggests the nocturia symptom was presented in passing at the consultation in April 2021 and was not of particular concern to [Mr B] at the time. However, by September 2021 it was causing sufficient concern to warrant performing a DRE, ordering of blood tests to exclude other causes, and trial of an alpha-blocker (doxazosin). These actions imply [Dr C] felt it was possible [Mr B's] symptoms were related to prostate pathology in September 2021. I believe best practice would be to

have discussed PSA testing as part of investigation of LUTS in April 2021, although the fact the symptoms may have been mentioned "in passing" as part of a consultation about unrelated issues might be regarded as a mitigating factor. By September 2021, when the LUTS had become more significant, I believe such discussion was mandatory and would be accepted practice, and the failure by [Dr C] to undertake this discussion would be met with **moderate** disapproval by my peers (although I cannot predict [Mr B] would necessarily have consented to PSA testing). It is also accepted practice to perform urinalysis in this clinical scenario. If a DRE was performed in September 2021, it is accepted practice to document the result even if it was normal and the failure to do so represents a **mild** departure from accepted standards of clinic documentation noting there is later (retrospective) documentation of the examination (see below)).

**Addendum 5 April 2023: Additional clinical notes from the start of 2021 have been reviewed. There was a consultation on 11 March 2021 when [Mr B] presented symptoms of right elbow and left wrist pain and rheumatoid Arthritis screening blood tests were performed (results negative). At the consultation of 15 April 2021 the leading note reads: *since at least 6 months larger amounts of miction* [micturition] *during night, about 3 times and decent amounts, did once have swelling feet at night but not normally … not worried about nocturia …* The remainder of the notes refer to [Mr B's] complaint of worsening and more generalised arthralgia and myalgia with limited assessment findings (upper limbs) documented. A trial of NSAID was prescribed and rheumatology referral completed (triaged as routine priority — at least six months). Consultation notes dated 9 September 2021 include: *polyuria, since a month he thinks but mentioned the same in april this year, but then mainly at night, now day and night, no dribbling, normal flow, no hesitancy, nocturia 3 times (varies 1–5 times) no dysuria*. Blood pressure, weight and BMI are recorded but no additional assessment findings or differential diagnosis. Blood tests ordered (no PSA, no MSU) with plan: *stop nifedipine, if polyuria not better restart and start doxazosin* (prescription provided), *if not better referral urologist?* Blood results showed impaired renal function with eGFR 40 mL/min (reference range ≥ 90 although expected to decrease with age) and elevated creatinine at 145 umol/L (50–110), with borderline elevation of HbA1c (41 mmol/mol (20–40)). On 14 September 2021 [Dr C] sent [Mr B] a message: Y*our renal function has dropped a bit comparing to last time. Please drink at least 2 liters of fluid like water and tea and low salt and low alcohol. We will check in 4 weeks again if better.* Blood tests repeated on 21 October 2021 showed an improvement in renal function (eGFR 56, creatinine 111).**

**Addendum 18 December 2023: In his later response, [Dr C] emphasises that [Mr B's] LUTS in April and September 2021 appeared to be primarily polyuria (increased volume of urine) causing urinary frequency rather than the symptoms being obstructive in nature (no reduced flow, hesitancy, dribbling). [Dr C] states: *Although, for me, these symptoms were not typical prostate symptoms, I did mention his prostatism and started him on doxazosin.* [Dr C] notes assessment and investigation of [Mr B's] joint pains were seen as a priority on both occasions, but the polyuria was investigated with blood tests in September 2021 (no clear cause found). [Dr C] acknowledges it would have been prudent to have documented the results of the DRE**

**undertaken on 9 September 2021 contemporaneously. The fact [Mr B's] LUTS did not appear overtly obstructive in nature, and the prostate on DRE did not feel abnormal being only mildly enlarged, influenced [Dr C's] management decision not to consider PSA testing. Taking into account potential causes of polyuria were being investigated in September 2021, while I remain of the belief discussion of PSA testing at this time represents accepted management of recent onset LUTS, considering the factors presented in [Dr C's] response I downgrade my criticism of [Mr B's] management in April and September 2021 to a mild to moderate departure from accepted practice. However, based on the clinical notes from 6 November and 9 December 2021 (see below), when there was no obvious cause for [Mr B's] LUTS found on blood and urine testing to date and his symptoms were apparently somewhat responsive to doxazosin (with increase in dose recommended on both occasions) and diagnosis of prostatism recorded, I am moderately critical there was no discussion regarding PSA testing on these occasions. I acknowledge [Mr B] may not have consented to such testing when presented with the pros and cons of identifying prostate cancer in his age group and with his associated co-morbidities, but he was not given the opportunity to consider such information. I acknowledge also that identifying an elevated PSA in April or September 2021 would not necessarily have altered the treatment options available for [Mr B].**

**Addendum 24 April 2024:**

**(i) On review of this advice, I note I have omitted to comment on the relevant factor of family history of prostate cancer. The cited BPAC guidance includes: *The risk of prostate cancer increases as more men in the immediate family (e.g. father or brother) or more distant family (e.g. grandparent) are affected. Compared to those without a family history, risks are:***

- ***Two times greater for males with one first-order relative (e.g. father or brother) with prostate cancer***
- ***Five to eleven times greater for males with more than one first-order relative (e.g. father and one or more brother) with prostate cancer***
- ***Males with two or more relatives diagnosed at an early age, e.g. before age 55 years, are more likely to develop prostate cancer earlier but have the same chance of developing aggressive cancer as patients without a family history.***

**(ii) There is no record of [Mr B] providing a positive family history of prostate cancer to [Dr C] at any of the consultations related to LUTS, or to provider … on 4 March 2022 when a form was provided for PSA blood test (see s8). There is no record at these consultations of [Mr B] being questioned about family history of prostate cancer. I am unable to find any reference to historical coding of either a positive or negative family history of cancer including prostate cancer.**

**(iii) [Dr C] did not suspect [Mr B's] LUTS were related to prostate cancer but, as discussed, he gave some consideration to diagnosis of BPH from September 2021 noting the nature of [Mr B's] symptoms and the benign DRE findings. I believe it is**

**best practice to assess for any factors that might increase the risk of prostate cancer in this scenario (mainly significant family history) as this would form part of the informed consent process relating to PSA testing. However, I note questioning regarding family history is not mentioned in the cited Health Pathway on BPH although *PSA, following joint decision making with the patient* is recommended. Family history is mentioned in the context of screening for prostate cancer in the 'Prostate Cancer — Diagnosis' Health Pathway. In many primary care clinical notes I have reviewed in relation to suspected prostate cancer diagnosis, my impression is that relevant family history is not well recorded and the failure by [Dr C] to enquire after family history, if that is the case, would not in my opinion be a departure from common practice particularly as he was not suspecting a prostate cancer diagnosis. However, I believe obtaining relevant family history is important (per the BPAC guidance) to facilitate informed discussion on PSA testing in a patient with suspected BPH (or when PSA is used as screening in an asymptomatic patient) and I believe obtaining such information represents best practice.**

**(iv) It is unclear if [Mr B] proactively informed [Dr F] of his significant family history of prostate cancer or whether this was in response to direct questioning by [Dr F]. If [Mr B] did proactively inform [Dr C] of the positive family history I would be at least moderately critical this was not recorded and taken into consideration in the management decisions made regarding [Mr B's] LUTS. However, there is no reference in the complaint to such an omission.**

5. Clinical notes for the next consultation (11 November 2021) suggest there had been some improvement in [Mr B's] nocturia with advice to increase doxazosin from current dose of 2mg nocte to 4mg nocte if the nocturia worsened again. On this occasion a MSU was ordered (unremarkable result) and there is reference to the previous DRE as: *rectal examination 2 weeks ago normal, slightly enlarged prostate.* [Dr C] reviewed [Mr B] on 9 December 2021 noting: *prostatism … if working no problems during the day. If at home — frequency. No dysuria, no orthostatic hypertension.* A further MSU was ordered (result again unremarkable).

Comment: I believe [Dr C's] management on these occasions would be regarded as reasonable had he (with [Mr B's] consent) earlier excluded any abnormal rise in PSA. In the presence of a normal PSA and prostate examination consistent with benign prostatic hypertrophy (BPH), and in the absence of significant obstructive LUTS, there would be no particular indication for urology referral at this point unless the symptoms were severely impacting on [Mr B's] lifestyle. However as noted previously, there had been no discussion of PSA testing with [Mr B] and I remain moderately critical of this oversight.

6. On 21 January 2022 [Mr B] presented to another [medical centre] provider ([Dr E]) with symptoms of recent onset bilateral elbow pain and lower leg swelling. Notes include: *Nocturia x 6 even on doxazosin 4mg nocte.* Cardiorespiratory examination was normal and [Mr B] was prescribed a diuretic (Frusemide) and referred for elbow X-rays and blood tests (elevated HbA1c consistent with impaired glucose tolerance and mild

reduction in eGFR only significant positive results). On 28 January 2022 [Dr C] reviewed [Mr B] noting he now had more extensive upper limb joints pain and morning stiffness which improved with ibuprofen. Further blood tests and X-rays were ordered (primarily to exclude a significant rheumatological disorder) with results showing slight deterioration in renal function (?related to diuretic trial) and modest elevation in liver enzymes GGT and ALP. Inflammatory markers were normal. On 31 January 2022 [Dr C] sent [Mr B] an electronic message: *Hi [Mr B] the lab was ok besides your liver test was a bit up. I will do a referral for a liver ultrasound in …. Please cancel if you feel better. And if any worse or no better in 2–3 weeks please see me again.* There was further electronic communication on 2 February 2022 regarding a query from [Mr B] about the role his Covid vaccination might have played in the development of his joint pains. There is no reference in the consultation of 28 January 2022 to discussion of urinary symptoms.

Comment: The preliminary investigation of [Mr B's] joint pains was consistent with accepted practice. Liver ultrasound was ordered primarily as a response to the elevated enzymes noted on blood testing, the picture suggestive of possible cholestasis, and this was an appropriate action. Follow-up blood tests were intended and it was appropriate to monitor both liver function and renal function although there is no specific reference in the notes to the observed deterioration in renal function.

7. X-ray reports dated 15 February 2022 show osteoarthritic changes in [Mr B's] neck, elbows and hands. At review by [Dr C] on 17 February 2022 [Mr B] noted deterioration in his joint symptoms — mainly upper limb and shoulder girdle. There was also discussion of urinary symptom as: *since 6 weeks frequency. Some days much worse. Can have dysuria. In evening between 10pm and 12: every 20 minutes. 2 incontinence. Got frusemide … it did not help.* MSU was ordered (result normal) and referral made to the hospital rheumatology service with trial of prednisone in the interim. On 18 February 2022 [Mr B] reported a marked and immediate improvement in his joint pains after taking prednisone.

Comment: The ongoing investigation and management of [Mr B's] joint pains was consistent with accepted practice. [Mr B] complained of increasing LUTS, apparently irritative rather than obstructive in nature. It was reasonable to re-test urine for infection and best practice would be to have performed an abdominal examination to exclude chronic urinary retention with overflow although this appeared less likely in the absence of preceding obstructive symptoms. While the clinical picture was still consistent with a diagnosis of benign prostatic hypertrophy, as discussed previously in formulating this diagnosis there should have been at least discussion of the role of PSA testing in the assessment of male patients with LUTS and [Mr B] provided with the option of such testing. It appears the addressing of [Mr B's] distressing joint symptoms was a priority at this point and this seems a reasonable action. However, given the increasing disruption being caused by his LUTS I am mildly critical there was no apparent plan in place to further address these symptoms if no treatable cause was found on receipt of the MSU result although [Mr B] did attend a colleague of [Dr C] two weeks after the consultation of 15 February 2022.

8. On 4 March 2022 [Mr B] was seen at [the medical centre] by [Dr D] who noted: *urinary frequency … 3 months overactive bladder symptoms, frequency day and night, poor flow, can't postpone, has had 3 accidents wetting himself, some relief doxazosin but not great … DRE done by [Dr C] last month, enlarged …* weight and BMI documented but no other examination … *Plan: PSA, prostate ultrasound, trial Vesicare* [solifenacin]. Blood test form was provided for tests including PSA and radiology form completed for prostate ultrasound. It appears [Mr B] did not complete these blood tests although another blood test request form was completed on 5 March 2022 (no PSA) and blood tests ordered by [Dr C] (no PSA) were undertaken by [Mr B] on 23 March 2022. The sequence of events in relation to this testing is not entirely clear.

Comment: Management by provider [Dr D] might have been improved by performing of an abdominal examination/bladder percussion to exclude obvious urinary retention in a patient presenting with the LUTS as described in the consultation note, particularly when solifenacin (which can exacerbate urinary retention) was being prescribed. The previously cited HealthPathways guidance notes: *Ultrasound is not required routinely. However, arrange ultrasound and ensure it includes a post void residual volume, if: the bladder is palpably enlarged; abdominal mass; reduced eGFR suspected to be due to chronic urinary retention.* Management by [Dr D] was otherwise reasonable but I recommend they review the cited HealthPathways guidance.

9. On 24 March 2022 [Mr B] consulted with rheumatologist [Dr F]. [Mr B's] joint symptoms had largely resolved but were reviewed by [Dr F]. [Mr B] also presented urinary symptoms to [Dr F] documented in the clinic letter as follows: *His other pressing concern at this time is with his ongoing prostatism: he describes significant nocturia (up 7 times last night) and daytime frequency (multiple stops on his drive through to [the public hospital] today). He tells me he is passing urine so frequently he has now developed discomfort at the tip of his penis. He is sure this is related to frequency rather than any other cause. He has not been aware of any blood or discharge. He also describes poor urinary flow and post-micturition dribble. He has been on Doxazosin 8 mg daily but was not aware of why this started and has certainly not noted any improvement on this. He has noted ankle oedema. He otherwise remains systemically well … He has [a family history of] prostate cancer … Abdomen was soft and non-tender, but his bladder was percussible/clinically distended …* It does not appear [Dr F] was aware [Mr B] had been recently commenced on solifenacin. [Dr F] ordered various blood tests including PSA and on return of the elevated result the following day, an addendum was added to the clinic letter: *ADDN: PSA 240ug/L, mildly abnormal LFTS noted: I have requested/arranged a PR exam through your practice. I have requested a liver USS. I will arrange a urology referral and have discussed these results with [Mr B].* [Mr B] later requested [Dr F's] assistance in accessing a private urologist and a further referral was provided by [Dr F] in this regard on 31 March 2022.

Comment: [Mr B's] management by [Dr F] was conscientious and clinically appropriate even though he had not been referred to [Dr F] for the urinary symptoms.

10. There is a consultation note dated 25 March 2022 (provider [Dr D]) which includes a note from [Dr C] referring to recent blood results showing [Mr B] to be anaemic and plan for referral for colonoscopy/CT colonography and liver ultrasound. It is difficult to determine whether [Dr D] actually saw [Mr B] on 25 March 2022 or whether a phone consultation was undertaken. It appears [Dr D] established [Mr B's] family history of prostate cancer and made a semi-urgent referral to the [public hospital] urology service on 25 March 2022.

Comment: A referral for urology assessment was made in a timely manner (by both [Dr D] and [Dr F]). It does not appear [Dr D] was in receipt of [Dr F's] report at the time the referral was made. Had the report been available, I would expect [Dr D] to have noted the assessment findings by [Dr F] suggesting chronic urinary retention and to have considered stopping the solifenacin.

11. On 28 March 2022 [Mr B] was reviewed by [Dr C] after experiencing increasing urinary frequency and dysuria. Phone triage notes (nurse) include: *On Saturday and Sunday night up to toilet 3x an hour over the night. Urinary frequency — states when he goes there is only a dribble. States feels like there is a blockage. Pain in penis.* [Dr C's] notes refer to [Mr B's] symptom of dysuria and *US prostate tomorrow … dipstick urine trace RBC, glc ++ …* MSU was sent for culture and prescription provided for nitrofurantoin. On 29 March 2022 [Mr B] reported worsening of his symptoms in a message to [Dr C]. [Dr C] contacted a urologist who advised Ural sachets and ordering of a bone scan. Meanwhile on the morning of 29 March 2022 [Mr B] had an abdominal and prostate ultrasound performed. [Dr C] contacted [Mr B] regarding the urologist advice and established [Mr B] was now no longer able to pass urine so urgent GP review was arranged. On contacting the radiology service, [Dr C] established the ultrasound had shown a large residual urine volume (600ml) and on reviewing [Mr B] he noted: *bladder full up to umbilicus …* A catheter was inserted and referral made for catheter cares, update urology referral and bone scan referral. The scan was undertaken on 11 April 2022 and confirmed bony metastatic disease. There are no urologist reports on file but I understand from [Mr B] he is now receiving androgen deprivation therapy.

Comment: I believe an abdominal examination was indicated when [Mr B] was reviewed by [Dr C] on 28 March 2022 with symptoms suggestive of bladder obstruction with overflow or infection and I am mildly to moderately critical if such an assessment was not performed. This might have resulted in consideration of catheterisation 24 hours earlier than was eventually undertaken if the abdominal findings were similar to those recorded the following day although if [Mr B] was still passing some urine and not in severe discomfort, catheterisation might have been deferred until the response to antibiotics was noted. It was also reasonable to exclude infection and treat empirically as was undertaken by [Dr C]. With respect to the ultrasound scan, it appears there had been referrals at various times and by various providers for an abdominal (liver) scan as well as the prostate scan and this would explain the possible confusion regarding which region should be prioritized when the scan was undertaken on 29 March 2022. I have no particular criticism in this regard. I recommend [Dr C] review the HealthPathways and BPAC guidance cited in section 2.

**Addendum 18 December 2023: There is no new information presented in [Dr C's] response that alters my comments in sections 6–11. The remedial measures [Dr C] has undertaken since this complaint appear comprehensive and appropriate and I have no further recommendations in this regard.**'

The following further advice was received from Dr Maplesden on 10 June 2024:

'I have reviewed [Dr C's] response to the PO with my response (per his headings) as noted below:

**Failure to discuss PSA testing** — no change in my opinion

**Did not request or undertake a urine test in September 2021** — no change in my opinion (urine test indicated for both investigation of impaired renal function and investigation of prostatic symptoms).

**Did not put a plan in place to address [Mr B's] ongoing LUTS in February 2022** — I acknowledge [Dr C] had done some preliminary investigations and trials of therapy for [Mr B's] LUTS although the symptoms persisted. [Dr C] states in February 2022 [Mr B's] rheumatic symptoms were more problematic for him than the LUTS which is why he pursued these symptoms (and some rheumatic conditions do have associated LUTS) by referral to the rheumatologist. I acknowledge this strategy was possibly reasonable (although the rheumatologist immediately saw the need for further investigation of the LUTS by way of PSA testing). I am happy for this criticism to be withdrawn.

**Absence of abdominal examination ([Dr C]) —** no change in my original opinion. Note this refers to the assessment in March 2022 (s 11 of my advice) when nurse notes indicate [Mr B] reported a feeling of obstruction to passage of urine and was passing very small amounts of urine (a dribble at times) frequently. While the symptoms may have been consistent with infection, they were also consistent with obstruction and diagnosis of acute urinary retention and required consideration (abdominal examination to assess for palpable bladder).

**Retrospective documentation of DRE** — no change in opinion.

**Family history of prostate cancer —** I am not quite sure what [Dr C] is stating in his response. If he did ask [Mr B] whether he had a family history of prostate cancer and [Mr B] stated he did not (although this seems somewhat unlikely taking into account the interaction with [Dr F]) then I would withdraw any criticism related to not assessing family history.

**Blood test reminders** — issue clarified (transcribing/selection error).

**Changes to my practice** — no new comment.

**Reconsideration of breach finding —** not my decision but I would regard the failure to present option of PSA testing in a timely fashion (at least November 2021) and as indicated by the clinical scenario presented (which is at the core of the complaint) to be a departure from accepted practice rather than "best practice".'