Sara Bird
MBBS, MFM(clin), FRACGP, is Medicolegal Claims Manager, MDA National. sbird@mdanational.com.au

Failure to diagnose: prostate cancer

Case histories are based on actual medical negligence claims or medicolegal referrals; however certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.

This article discusses a claim involving a failure to follow up an abnormal prostate specific antigen result. The case highlights the importance of good medical records, especially when a number of general practitioners are involved in a patient's care.

Case study

The patient, 62 years of age, saw his general practitioner, Dr Baldwin, on 10 November 2001 for a check up. The patient had hypertension. He was obese and smoked 20 cigarettes a day. The patient was on an angiotensin converting enzyme inhibitor (ACEI) for management of his blood pressure. Dr Baldwin ordered some blood tests, including a prostate specific antigen (PSA) test. The record for the consultation was as follows:

'Well
P 80/reg
BP 150/95
Abdo NAD
For FBC, E/U/C, LFTs, PSA, BSL'.

The patient returned for review on 15 March 2002 at which time he complained of fatigue, although he stated he was sleeping well. Dr Baldwin noted the patient's BP was 160/105. He increased the ACEI and asked the patient to return in 1 week for review. The following record of the consultation was made:

'Fatigue. Sleeps well.
P 80/reg
BP 160/105
Increase Tritace'.

On 28 April 2002, the patient attended the pathology collection centre to have blood taken for the tests ordered by Dr Baldwin on 10 November 2001. A pathology report was sent to Dr Baldwin which noted, in part, that the PSA was 8.5 µg/L. A note at the bottom of the pathology report stated: 'Elevated PSA values up to 10 µg/L are most often associated with benign prostatic hypertrophy, although prostatic carcinoma cannot be excluded'.

Dr Baldwin recorded the following handwritten notation on the pathology report: 'Rpt 6/12'. No other mention of the PSA result was made in the medical records or the 'health summary' sheet.

On 6 May 2002, the patient saw Dr Baldwin again. Repeat prescriptions were provided. A record of the consultation was made as follows:

'Feeling better with increased medication.
P 75/reg
BP 160/85'.

The patient next attended the practice on 18 December 2002 at which time he saw a new GP in the practice, Dr Ferrie. Repeat prescriptions were provided at this consultation. No other record was made in the medical records about the consultation other than an electronic record of the prescriptions provided.

On 2 February 2003, the patient was again seen by Dr Ferrie. The patient's BP was noted to be 140/90. Dr Ferrie ordered further blood tests, but no PSA test was requested at this time.

On 17 April 2003 the patient returned to see Dr Ferrie. He informed the patient of the results of the pathology tests and provided repeat prescriptions for the patient's medications.

On 27 August 2003 the patient was again seen by Dr Ferrie, who noted the patient's BP was 170/90. Further blood tests were ordered. No PSA was requested. The following record was made:

'BP needs better control.
BP 170/90
Blood tests'.

The patient was next seen by Dr Ferrie on 21 December 2003. His BP was 140/100 and his antihypertensive medications were increased. Dr Ferrie ordered a 24 hour urine cortisol and a chest X-ray (CXR).

The patient was seen by Dr Ferrie again on 6 April 2004 at which time he informed the GP that he had had some mild upper abdominal pain. Abdominal examination was unremarkable and Dr Ferrie thought the pain was most likely due to gastro-oesophageal reflux. He prescribed an H2 antagonist and provided a referral to a gastroenterologist for consideration of an endoscopy. The GP noted the patient had not had the CXR and asked the patient to have this performed.

On 1 July 2004, the patient returned for review. The CXR was

noted to be normal. The patient had not made an appointment to see the gastroenterologist. The following record was made of the consultation:

'CXR – NAD.

BP 150 /90'.

At review on 20 November 2004, another referral was made for the patient to see a gastroenterologist for review of his upper abdominal pain. Further blood tests were ordered, including a PSA. The records noted:

'Letter for gastro

BP 150/80

Bld tests'.

The patient finally attended to have the blood collected on 7 June 2005. The PSA was noted to be 25.0 µg/L. The pathology results were sent electronically to Dr Ferrie. On receipt of the results, he phoned the patient and asked him to attend the surgery as soon as possible. No record of this telephone call to the patient was made in the medical records.

The patient attended Dr Ferrie on 1 July 2005. Dr Ferrie informed him of the elevated PSA level and performed a digital rectal examination. This revealed an enlarged, firm prostate. An urgent referral was made to a urologist. Dr Ferrie personally rang to make the appointment on behalf of the patient. Dr Ferrie also informed the patient that his PSA had been slightly elevated in April 2002 and that the level had markedly increased since this time.

A biopsy revealed prostate cancer. On 21 July 2005, the patient underwent a radical prostatectomy and pelvic lymph node dissection. He subsequently underwent a course of radiotherapy.

The patient (now a plaintiff) commenced legal proceedings in 2008 against both Dr Baldwin and Dr Ferrie alleging a delay in diagnosis of his prostate cancer, resulting in the loss of a chance of a better outcome in terms of his treatment and prognosis.

In the Statement of Claim, the plaintiff alleged he had never been informed of the elevated PSA result in April 2002. The allegations against Dr Baldwin included failure to:

- ensure that the plaintiff's PSA levels were tested following the consultation on 10 November 2001
- inform the plaintiff of the results of the pathology report dated 28 April 2002
- warn the plaintiff that the PSA result of 28 April 2002 may be indicative of prostate cancer
- conduct repeat PSA testing in October 2002
- conduct any further diagnostic or clinical testing for prostate cancer following receipt of the PSA result dated 28 April 2002
- review the plaintiff's medical records to remind himself of the PSA result dated 28 April 2002
- design and/or implement a system of ensuring that diagnostic pathology reports are reviewed and followed up.

The allegations against Dr Ferrie were failure to:

- review the plaintiff's medical records to inform himself about the pathology report dated 28 April 2002
- inform the plaintiff of the results of the pathology report dated 28 April 2002
- warn the plaintiff that the PSA result of 28 April 2002 may be indicative of prostate cancer
- undertake any further diagnostic or clinical testing for prostate cancer before June 2005.

The Statement of Claim included an expert report by a GP, which concluded that Dr Baldwin had breached his duty of care to the plaintiff by not ensuring the plaintiff was informed of the PSA result and his options in relation to further management. The GP expert opined that the plaintiff should have had a digital rectal examination performed on receipt of the elevated PSA, a repeat test should have been ordered within 3 months and consideration should have been given at this time to referral to a urologist.

In relation to Dr Ferrie, the expert opined that he was negligent for not properly reviewing all of the plaintiff's medical records, including the pathology results ordered by Dr Baldwin. The expert emphasised that Dr Ferrie had ample opportunity during at least eight consultations between December 2002 and June 2005 to review the pathology reports and follow up the abnormal PSA result. The expert also considered that the practice should have had a policy in place to 'identify patients with abnormal or concerning test results which ensured that patients were reminded to attend for review and follow up tests'.

An expert opinion was also served by a urologist who concluded that if the plaintiff's prostate cancer had been diagnosed around April 2002, then he could have been treated with brachytherapy and cured. The urologist opined that the plaintiff's prostate cancer probably became incurable toward the end of 2004.

Expert GP opinion was obtained on behalf of the GP defendants. With regard to Dr Baldwin, the GP noted that waiting 6 months to repeat such a significantly elevated PSA would not be considered reasonable clinical practice. The GP was also critical of the fact that there was no notation of the abnormal result in the medical records or health summary, nor any record of a discussion with the patient about the abnormal PSA result, other than 'Rpt 6/12' on the pathology result.

In relation to Dr Ferrie's management, the defendant GP expert noted that: 'Within group practices, patients will usually end up presenting to more than one GP over time. If it was apparent to Dr Ferrie that the patient was now seeing him as his treating GP, he should have taken a brief past history of relevant medical problems, looked at the previous entries in the medical records of at least the last one or two consultations, and reviewed the health summary sheet and medication list to assist in continuity of care. Unfortunately, in this case, Dr Ferrie did not see the pathology report of 28 April 2002 until after he had received the pathology report including the markedly elevated PSA in June 2005. The medical records were sadly deficient. It would be expected that if an abnormal result had been identified by a previous GP, this would have been noted in the records as a reminder to follow up. This may occur in the clinical records, on the summary sheet, as an additional note to the paper file in a prominent place or as a computer reminder or 'action note'.

Based on the critical GP opinions, the claim was promptly settled.

Discussion

Diagnostic errors, including missed, delayed or wrong diagnoses, are a frequent cause of medical errors and negligence claims. The majority of medical negligence claims related to diagnostic errors involve cancer diagnoses. Although some diagnostic errors occur when signs of a disease are atypical or absent, diagnostic errors are often attributable to preventable factors such as cognitive errors (eg. faulty information or clinical reasoning) and/or systems related factors (eg. problems with policies and procedures, inefficient processes and poor communication). Examples of events leading to diagnostic error include failure to use an indicated diagnostic test, misinterpretation of a test result, and failure to act or follow up on abnormal results.[1]

A United States study of testing process errors in a family physician setting found that errors occurred in:

- ordering tests (12.9%)
- implementing tests (17.9%)
- reporting results to clinicians (24.6%)
- clinicians responding to results (6.6%)
- notifying patient of results (6.8%)
- general administration (17.6%)
- communication (5.7%).

Charting or filing errors accounted for 14.5% of errors. Adverse clinical outcomes occurred in 13% of the testing process errors in the study.[2]

Risk management strategies

This case is a timely reminder that good medical records are an integral part of good medical care. It highlights the importance of reviewing previous entries and test results in the medical records, especially when taking over the care of a patient from a colleague. Keeping the health summary sheet up-to-date is also an important tool in assisting in the identification of issues that require follow up.

Conflict of interest: none declared.

References

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AFP CORRESPONDENCE afp@racgp.org.au