MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 168/01/73D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against **MURRAY GEORGE WIGGINS** medical practitioner of Hastings

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr G D Pearson (Chair)

Mrs J Courtney, Dr J C Cullen, Dr R S J Gellatly, Dr B J Trenwith (Members)

Ms K Davies (Hearing Officer)

Mrs G Rogers (Stenographer)

Hearing held at Napier on Tuesday 7 and Wednesday 8 August 2001

APPEARANCES: Mr M F McClelland for the Director of Proceedings

Mr H Waalkens for Dr M G Wiggins.

The Charge

1. The Director of Proceedings has brought a charge against Dr Murray George Wiggins, who is a general practitioner with a practice in the Hastings suburb of Flaxmere. The charge states that the Director of Proceedings has reason to believe that a ground exists entitling the Tribunal to exercise its powers against Dr Wiggins, and charges that:

"On or about between 28 January 1999 and 5 March 1999 whilst providing medical services to your patient, Mrs Robyn Karauria, you being a registered medical practitioner acted in such a way that amounted to conduct unbecoming a medical practitioner, and that conduct reflects adversely on your fitness to practise medicine.

IN PARTICULAR YOU:

1. Failed to consider breast cancer as a differential diagnosis

OR

2. You considered breast cancer as a differential diagnosis but failed to take appropriate steps to confirm or exclude the differential diagnosis of breast cancer.

AND/OR

3. Failed to appreciate the significance of the number of consultations with your patient between 28 January 1999 and 5 March 1999.

AND/OR

4. You failed to appreciate the negative effect your communication manner had on your patient.

AND

5. *You failed to provide an atmosphere that enabled both your patient and yourself to communicate openly, honestly and effectively.*

AND/OR

6. *You communicated in a manner that caused your patient to feel unheard by you and/or to feel that you thought she was a hypochondriac.*

The conduct alleged in paragraphs 1 to 6 amounts to conduct unbecoming a medical practitioner and that conduct reflects adversely on your fitness to practise medicine. Paragraphs 1 to 6 either separately or cumulatively are particulars of that conduct unbecoming."

The hearing

2. Dr Wiggins denied the charge, and the matter proceeded to hearing.

3. The burden of proving the disputed facts is borne by the Director of Proceedings. It is well established that the standard of proof in disciplinary proceedings is the civil standard, namely, the Tribunal must be satisfied on the balance of probabilities that the material facts are proved. It is equally well established that the standard of proof will vary according to the gravity of the allegations, and the level of the charge. The facts must be proved to a standard commensurate with the gravity of what is alleged: ***Ongley v Medical Council of New Zealand*** [1984] 4 NZAR 369 @ 375-376.

4. The Director of Proceedings called five witnesses, namely:

- Mr Osborne Karauria, who was Ms Karauria's husband. Ms Karauria died on 10 July 1999 as a result of the consequences of breast cancer.

- Dr Pratyush Giri, he was a medical registrar who examined Ms Karauria on 5 March 1999 when she was first admitted to hospital due to breast cancer.

- Dr ABC, who was a locum practising in Dr Wiggins' practice ("Dr Wiggins' Locum"). Dr Wiggins' Locum saw Ms Karauria on 28 January 1999 in that

capacity. Dr Wiggins' Locum's name and identity were suppressed on the application of the Director of Proceedings, with the consent of Dr Wiggins.

- Dr Christian Kalderimis, who is a general practitioner at Wellington. Dr Kalderimis gave evidence as an expert concerning what was appropriate and acceptable conduct in relation to a patient presenting to a general practitioner in the circumstances Ms Karauria presented to Dr Wiggins.

- Ms Glenyse Anne Hargraves, who was Ms Karauria's sister. Ms Hargraves is a Registered Nurse and her evidence principally concerned a long telephone conversation she had with Ms Karauria on 4 March 1999.

5. Dr Wiggins gave evidence and called an additional three witnesses:

- Ms Bertien Wiersma, a clinical midwife at Hastings Hospital, who gave evidence concerning her experience of Dr Wiggins' communications and interactions with patients (generally, not with Ms Karauria).

- Ms Kui Ann Maria Tomoana, who is a patient of Dr Wiggins. Ms Tomoana gave evidence of Dr Wiggins role as a doctor for her whanau whanui, including Marae-based care provided by Dr Wiggins; and also evidence of Dr Wiggins' personal medical care for Ms Tomoana and her son.

- Dr Robert Charles Leikis, a consultant physician of Hawkes Bay. Dr Leikis gave expert evidence as to the proper approach in the circumstances Dr Wiggins found himself.

6. In addition to the oral evidence an agreed bundle of documents was admitted by consent. Another important element of the evidence was a video tape made by Ms Karauria and Mr Karauria. The purpose of the tape was to record Ms Karauria's complaint concerning her treatment by Dr Wiggins. The tape was recorded on 16 April 1999. There was an issue concerning the admissibility of the tape, and a ruling was given concerning that subject during the course of the hearing. In general terms, the Tribunal concluded that the

contents of the tape were relevant and admissible for the purpose of proving how Ms Karauria's illness developed, its symptoms, and how it was treated, and also as to the communications between Dr Wiggins and Ms Karauria. There were various comments made by Mr Karauria on the video that did not add to Ms Karauria's evidence and were not apparently relevant. In any case Mr Karauria was available to give oral evidence of those matters, and the Tribunal ruled that those passages were not relevant. There were also some other incidental points such as how Ms Karauria wanted the complaint against Dr Wiggins to be advanced that were not relevant. The Tribunal emphasised to Mr Waalkens that the ruling concerning relevance was not intended to inhibit cross-examination, as the Tribunal could only assess relevance against the charges at that stage in the hearing. If, for example, some statement impacted on a witnesses' credibility then it would be open to Mr Waalkens to pursue the evidence for that purpose. The Tribunal is conscious of the issues concerning the weight to be attached to evidence that is not subject to cross-examination, however for reasons that are discussed below we do not consider that is of particular concern in this case. The video tape was supplemented by a letter of complaint to the Health and Disability Commissioner, which Ms Karauria had written before her death.

The events from the perspective of Ms Karauria and her family

7. The starting point for dealing with this case is the perspective of Ms Karauria and her family.

8. In January 1999 Ms Karauria was 45 years of age, married to Mr Karauria since 1972, and they had four children. Ms Karauria worked as a caregiver, mainly assisting elderly people. Ms Karauria was close to her sister Mrs Hargraves (and no doubt other family members, who did not give evidence).

9. The Tribunal cannot of course have a full appreciation of Ms Karauria's role in her family. However, it was more than evident that Ms Karauria was a greatly loved wife, mother and sister, whose passing has left her family with a deep sense of loss and distress.

10. The Tribunal has had the opportunity of hearing Ms Karauria's concerns as they were recorded in the video tape produced in evidence. The Tribunal accepts Ms Karauria's genuineness and truthfulness in the account she gave. It is none-the-less important to also recognise that Ms Karauria was the victim of an extremely aggressive cancer, and the symptoms she experienced changed quite quickly. Accordingly, to be accurate in understanding exactly what condition Ms Karauria was in at specific points in time it is important to supplement Ms Karauria's (and her family's) best recollection. Fortunately it is possible to do that with notes taken at the time by doctors (not only Dr Wiggins), and also with what Ms Karauria told her sister Mrs Hargraves.

11. Ms Karauria and other female members of her family had experienced lumps in their breasts over a number of years. Ms Karauria's mother had a lump in her breast excised and examined, it proving to be benign. In 1992 Ms Karauria had been referred to the Hastings Hospital to investigate discomfort in her left breast, which was accompanied by a small nodule in her armpit (approximately 5mm diameter). The surgeon who examined her did not find any cause for concern. Ms Karauria and her sister discussed the issue of monitoring their breasts, were conscious of the need for breast self-examination, and practised it.

12. On 28 January 1999 Ms Karauria went to Dr Wiggins' practice. Dr Wiggins was not there, Dr Wiggins' Locum was attending and he saw Ms Karauria. Ms Karauria complained of tender swelling in her left breast, and explained that it had been troubling her for 2 months. Dr Wiggins' Locum wrote a letter of referral to Hastings Hospital in these terms:

"I would be grateful if you could send an appointment out to this 45 year old lady who for many years has complained of lumpy sore breasts premenstrually. However over the past two months she has been complaining of discomfort in the left breast associated with a lump. This has not changed since she first noticed it almost eight weeks ago.

On examination the right breast appeared normal, the left showed some thickening of the breast tissue of the upper outer quadrant and I could also palpate a lymph node in her left axilla [armpit].

In light of the above findings and her persistent symptoms I thought further assessment is warranted. I am grateful for your help in this matter."

13. The next step was on 9 February 1999 when Ms Karauria went back to Dr Wiggins' practice. This time Dr Wiggins was there and Ms Karauria saw him. Ms Karauria had pain in the front left of her chest, left upper back, and left shoulder. Ms Karauria said she thought it might be related to the issues she had raised with Dr Wiggins' Locum, namely breast swelling and a lump in her armpit. Ms Karauria had not had her hospital appointment, but that process was still in place. Ms Karauria had made inquiries at the hospital, but had not been able to speed up the process, so she had gone to see Dr Wiggins as an alternative. Dr Wiggins prescribed voltaren, as he thought that she had some musculoskeletal problem (Ms Karauria understood it was arthritis). Ms Karauria said that Dr Wiggins felt lumps under her arms, and that Dr Wiggins assured her they were small and she should not worry about them.

14. The third visit to Dr Wiggins' practice was on 23 February 1999. Ms Karauria was still experiencing pain; the pain had extended to her right shoulder. Dr Wiggins again examined Ms Karauria's breasts, and upper body. He detected tenderness but no significant abnormality in the breast. Dr Wiggins thought that Ms Karauria had a rheumatological disorder. He prescribed more voltaren, and added amitryptiline as pain relief, and arranged for Ms Karauria to have a blood test.

15. Dr Wiggins received the blood test results, and they showed results that were consistent with a rheumatological problem. Dr Wiggins responded to that information by having the practice nurse attempt to contact Ms Karauria by telephone. When that failed, a letter was written asking Ms Karauria to come to see Dr Wiggins. Ms Karauria returned to see Dr Wiggins on 1 March 1999. Ms Karauria understood Dr Wiggins thinking to be that she had "arthritis". Dr Wiggins referred Ms Karauria to a rheumatologist.

16. The next development was on 4 March 1999. Ms Karauria's pain had continued to get worse, she had difficulty coping with her work. On the evening of 4 March 1999 Ms Karauria telephoned her sister and they spoke for a long time. There is no doubt that Ms

Karauria was feeling quite desperate by this time. Ms Hargraves description of the telephone conversation is perhaps the best information regarding how Ms Karauria felt at this time:

“.....

5. *On Thursday evening (4 March 1999), Robyn was crying and in great distress with pain when she rang. We talked for about two and a half hours and Robyn remained in pain and was extremely distraught throughout the entire length of the conversation. This was the first time I learnt the extent of what Robyn was going through. She said she was ringing me both as a sister and as a nurse to ask my advice and to see what I thought.*

6. *When she began to describe to me what was happening for her, I asked her to take me back to the start and go forward so I could form a mind image of what had and was occurring.*

7. *She said it had really started in December and that she had made an appointment to see her local General Practitioner - Dr Wiggins. He was absent at the time and she was seen by a Locum. She had gone because she had pain in her left shoulder, which would go down into the shoulder blade and a large lump in the left armpit. She told and showed the Locum the lumps in her left breast and under the left arm - I can’t remember if she said she had the lumps in the side of her neck at that time or not.*

8. *The armpit lump was very hard and extended the width of the armpit. This made moving her arm extremely painful to the extent that the pain restricted the movement of her arm. She said that some days she couldn’t raise the arm up to shoulder height and her grip was also affected.*

9. *The Locum gave her painkillers and told her to come back and see Dr Wiggins if the pain didn’t go away. I asked Robyn if she could remember the name of the painkillers she was given and she thought they were Voltaren.*

10. *Robyn told me she did go back and see Dr Wiggins. I can’t remember if Robyn said she just told Dr Wiggins about the lumps or whether she showed him as well but I do remember her saying that they discussed them. She told Dr Wiggins she had more lumps now than she had had when the Locum saw her. Dr Wiggins asked Robyn if she was concerned about the lumps. Robyn told me that that question threw her as she felt that if the Doctor* wasn’t *concerned about the lumps then she shouldn’t be either. Robyn had very much got the inference from Dr Wiggins that the lumps were of no concern and that he was more concerned with the pain in her shoulder and the loss of movement in the left arm.*

11. *I queried her on this point as I felt any Doctor should be concerned about any increase in the number of lumps and with my background in Infectious*

Diseases I wondered if they could be Tuberculosis nodes. I asked Robyn to describe to me where the lumps were at that time and what they were like? - were they painful? - was the level of pain more at any time than another? - did anything make either the pain or the lumps better or worse? - what was she taking for the pain? - how many tablets was she taking? - were they effective?

12. *The lumps were in the breast, under the left arm (large, hard, painful and restricting movement), going up the chest wall and along her neck by the bone. She described the lumps as sticking up and visible under the skin. She felt that they came and went and were worse with her period. The lump under her arm was the most painful. It was extremely hard, very large and protruding out of her armpit. The armpit was very sweaty, smelly and painful to use - she said that some days she had little or no movement in that arm and that her arm felt funny - sort of numb and heavy. We are not a family that perspires very heavily and so the amount of sweating Robyn was describing was unusual and it was only on that one side.*

13. *Robyn said that Dr Wiggins diagnosed the shoulder pain as Arthritis and wrote a referral letter to a Specialist. As Robyn had no medical insurance and minimal income, she was unable to pay to see the Specialist privately and was put into the hospital system. Robyn described the pain level as increasing to the point where she was now sleeping only for short periods at any given time. The pain would wake her up and when she rolled out of bed she would be unable to stand upright and had to crawl on her hands and knees to the shower.*

14. *The shower was over the bath and Robyn said she would kneel in the bath with the water playing on her back to help ease the pain. She said she would often not remember getting into the bath and would suddenly rouse to find herself there. She would then go and lie on the couch in the living room for a few hours and snatch short periods of sleep until daylight. Robyn said she was having between 5-6 showers in a day.*

15. *1 asked Robyn about her work and about driving the car. (Robyn worked as a Caregiver and for a catering firm when extra staff was needed.)*

16. *Robyn was still working but said it was getting increasingly hard and that she had had to give up some clients and now mainly cared for those whom she had had for some time and who knew her well. She said that vacuum-cleaning and making beds were what caused her the most pain as she had to stretch her arm out and this action had caused her to black out on a couple of occasions and the old people had had to pick her up. She admitted to days where she couldn't make it to work. Robyn said she knew that it was dangerous for her to continue to drive in this state.*

17. *I asked what her husband Osborne thought about the whole thing. She said Os had been very supportive and had tried to help but they were both at their wits*

end and didn't know what to do anymore. She said he had massaged her back and shoulders to try and relieve the pain and he had brought her a 'wheat-bag', which she could heat in the microwave. After she had seen Dr Wiggins that second time and he wasn't worried about the lumps they wondered if it was in her mind and so Os used to tell her to get on with things and not be such a wimp. This was extremely hard for both of them and neither of them liked or believed in this course of action.

18. *Robyn described most things as helping to ease the pain for short periods but that it never completely went away and that she would plan her day around the pain, and whether she could stand upright or walk.*

19. *I asked about the Specialist - she said that she had told her daughter Anita that if the appointment from the hospital didn't come through very soon, she would find the money from somewhere and go to see him privately - even just for a couple of visits to get the pain under control so she could manage.*

20. *It was the pain, the loss of the use of her arm that was getting to her the most. She was also very conscious of the smell from her armpit and the amount of sweat coming from it. Robyn felt that if these things were under control then she would be able to sleep and once she could sleep then she could get through the day. Robyn was not a person to complain of pain and for her to admit to this, I knew the pain must be intense.*

21. *By this point in our conversation, I no longer really believed that Robyn had arthritis and I told her so. We then had a bit of an argument around this. I told her that I thought Dr Wiggins was wrong in his diagnosis and that she should either go to another GP or next time she collapsed, ring an ambulance and get herself admitted to hospital. Robyn then told me I was only a nurse and that she had gone to Dr Wiggins since they moved to Flaxmere all those years ago and she believed in him. OK she had heard that he didn't listen to women but he was a busy doctor who was involved with his own practice, the air ambulance and I think she said the prison as well.*

22. *To the idea that she ring an ambulance, Robyn was appalled. She saw that as pushing in front of someone who was sicker than she was and so more in need of the hospital services.*

23. *Robyn was becoming more and more upset with me at this stage and I realised that I had to change my approach - she was extremely distraught by now and I asked her what she would really like to do.*

24. *1 suggested that she make an appointment the next day with Dr Wiggins and I gave her suggestions as to what she should say to him. We practised about four times what she should say and do in an effort to describe to him exactly what was happening for her. My idea was to make him aware of the extent to which the lumps and the pain were affecting her general lifestyle and to get*

what I felt would be more appropriate investigations, diagnosis and treatment. I told Robyn that I didn't believe that she had arthritis and that something else was going on.

25. I told her she had to describe the not sleeping, not being able to walk upright and having to crawl around on her hands and knees and the blackouts. In particular I had stressed the importance of showing him the lumps and of not leaving the surgery until she had something positive - even an earlier appointment with the Specialist. (I was more than happy to be proven wrong in what I was thinking). She was to ask for a mammogram and for further investigations and a Mantoux Test.

26. Robyn agreed to make an appointment with Dr Wiggins for the next day. I believed that she would - I didn't know if she would say what we had rehearsed, but I felt that if Dr Wiggins could see her and that if Robyn said only a fraction of what we rehearsed that it would make a difference to the diagnosis of arthritis.

...."

17. Ms Karauria did see Dr Wiggins the next day, 5 March 1999. At that consultation Ms Karauria was distressed, and in pain. Ms Karauria's impression of that consultation was that Dr Wiggins treated her as though she were a hypochondriac and discouraged her from returning until the 14th of the month. Dr Wiggins prescribed diazepam as a muscle relaxant and prednisone.

18. Later that day, after taking the diazepam and prednisone, Ms Karauria was very unwell, and was transported to hospital by ambulance. When Ms Karauria got to hospital she was examined and a chest x-ray was taken. As a result, Ms Karauria was diagnosed as having a pleural effusion (fluid accumulation in the outer layers of her left lung). After further investigation and surgery the diagnosis was made of breast cancer that had developed secondary malignancy, affecting Ms Karauria's upper body.

19. From the perspective of Ms Karauria and her family, she was a person who had been conscious of the need for breast self-examination, she had gone to Dr Wiggins when she found suspicious signs, Dr Wiggins had ignored her condition and concluded she had arthritis, she became so ill she collapsed and was immediately diagnosed as having advanced secondary cancer. Ms Karauria and her family accordingly believe that Dr Wiggins failed Ms Karauria, and prevented her getting the medical help she needed.

The case for the Director of Proceedings

20. The case for the Director of Proceedings involved an assessment by Dr Kalderimis of Wellington, based on the facts as the Director contended them to be. Dr Kalderimis addressed two issues, reflecting the charges. The issues being first diagnosis and response to a diagnosis; and second communication.

21. In respect of communication, the facts as Dr Kalderimis understood them to be were set out in this way:

> *"Mrs Karauria states that Dr Wiggins at the final consultation said to her:*
>
> *'You are a bit funny aren't you, what are we going to do with you?'*
>
> *And*
>
> *'I don't want to see you back here before the 14th of the month.'*
>
> *She also says that he stated that she was a hypochondriac. If Dr Wiggins did make such statements then in my view it was inexcusable. Such comments are disempowering and demeaning."*

22. Dr Kalderimis analysed each of the consultations that Ms Karauria had with Dr Wiggins from 9 February 1999 onward. There was no dispute that there were four such consultations, and Dr Kalderimis' views were:

- In relation to the 9 February 1999 consultation he said that the apparent diagnosis of musculoskeletal pain was plausible, and possibly reasonable, but concluded that with hindsight it was obviously wrong.

- In relation to the 23 February 1999 consultation given the level of pain Ms Karauria was experiencing he thought that she should have been admitted to hospital for diagnosis. He also said that the *"investigation that needed doing was a fine needle aspiration of that lump"*.

- In relation to the 1 March 1999 consultation Dr Kalderimis considered that Dr Wiggins diagnosis of a possible musculoskeletal condition was not reasonable. Dr Kalderimis considered that *"there were enough signs (the thickening or lump in Mrs Karauria's left breast, the axillary lumps and the very severe pain that Mrs Karauria was experiencing) pointing to potential malignancy"*.

- In relation to the last consultation on 5 March 1999 Dr Kalderimis considered that *"Dr Wiggins should have undoubtedly admitted Mrs Karauria [to hospital] forthwith on 5 March for a fine needle biopsy to be done"*.

23. Dr Kalderimis expressed his conclusion as being that Dr Wiggins *"did not treat Mrs Karauria's situation carefully, thoroughly or with any degree of consideration."* Dr Kalderimis placed considerable emphasis on the degree of pain he considered Ms Karauria was experiencing.

24. Dr Kalderimis was very clear in his evidence that Ms Karauria's death could not have been prevented if a diagnosis of her malignancy had been made earlier. Dr Kalderimis was correct to make that acknowledgment as the evidence clearly demonstrated Ms Karauria was the victim of an extremely aggressive cancer, that would be unlikely to have been successfully treated at any stage when it could have been detected, and certainly not by January 1999.

The Tribunal's factual conclusions

25. Some of the facts in this matter cannot be known with absolute precision. In particular the details of just how Ms Karauria appeared to Dr Wiggins, and the exact of communications between them. In saying that, we have not taken the view that either Ms Karauria or Dr Wiggins were either unreliable or less than frank in what they said, simply that it is notoriously difficult to accurately gauge communications where each party will have their own perceptions. Similarly, how a patient may feel and how they may appear are not necessarily the same; furthermore two competent doctors examining a patient at different times may reach different conclusions, even about the presence of a physical feature. As discussed below, that in fact occurred in this case.

26. Having regard to the difficulty of attempting to analyse the facts of this case simply on the basis of Ms Karauria and Dr Wiggins' best endeavours to describe them, it is fortunate that Dr Wiggins was only one of several doctors who examined Ms Karauria about the crucial period of time. The Tribunal has had careful regard to the whole of the medical record from the time Ms Karauria was seen by Dr Wiggins' Locum, on 29 January 1999.

27. Dr Wiggins' Locum's examination and treatment plan for Ms Karauria was a very important element of this case. The first point to recognise is that Dr Wiggins' Locum considered the possibility of malignancy in Ms Karauria's breast, though unlikely, needed to be excluded. Dr Wiggins' Locum wrote a letter of referral to the Hastings Hospital. Dr Wiggins' Locum referred to Ms Karauria having some discomfort associated with a lump. As the evidence established, pain is not a usual presentation for a malignant lump in the breast. Furthermore, Dr Wiggins' Locum did not find a discrete "lump" in the breast, he did find some thickening of breast tissue. Accordingly, the lump that Ms Karauria had appeared to have varied. The evidence established that for non-malignant lumps and other irregularities in breast tissue it is not unusual for them to vary with the patient's menstrual cycle. Indeed Mrs Hargraves explained that Ms Karauria had experienced such variations, the variation is a pointer against there being malignancy.

28. Dr Wiggins' Locum did find a lump in the lymph nodes in the axilla. That could have had a variety of causes, including malignancy in the breast. Dr Wiggins' Locum appropriately referred Ms Karauria for investigation to ascertain whether there was malignancy in the breast, even though that was not in the forefront of his thinking. He thought the most likely condition was *"Benign thickening of breast tissue with incidental axillary lymph node"* involvement.

29. It is very important to recognise that when Dr Wiggins next saw Ms Karauria the referral to Hastings Hospital was in place, and remained in place throughout the remainder of the relevant period. Dr Wiggins was expecting Ms Karauria to be seen at the hospital about five weeks after the letter of referral. In his evidence he made it clear that he knew the referral was in place.

30. On 9 February 1999 Ms Karauria attended Dr Wiggins' surgery and complained of left anterior chest and shoulder pain, and said she thought it might be associated with the breast lump she had previously complained of. Dr Wiggins examined Ms Karauria, including examining her breasts. Dr Wiggins did not find any abnormality in Ms Karauria's breasts. That conclusion in respect of the breast examination is substantially in accord with Dr Wiggins' Locum's examination (and others discussed below). Accordingly, Dr Wiggins was dealing with a patient who had presented with no identifiable pathology in the breast from the examination he was able to conduct. Furthermore Ms Karauria was exhibiting musculoskeletal symptoms. From medical investigation that occurred later, the best view of what was in fact occurring at that time is:

- Ms Karauria had a very aggressive malignancy that developed in her left breast,
- The malignancy in the breast did not develop in the form of a tumour that presented as a lump in her breast, instead the breast became permeated with malignant plaques,
- The malignancy spread from Ms Karauria's breast tissue into the lymph system, and caused at least one swollen lymph node in her axilla,
- The malignancy had also spread into Ms Karauria's spine where metastases were present (but not detectable by examination),
- The result of the metastatic malignancy in Ms Karauria's upper body was to provoke an inflammatory response, with musculoskeletal symptoms secondary to the spread of the cancer.

31. Accordingly, Dr Wiggins was dealing with a patient who had advanced breast cancer with the very unusual presentation of a breast that was free of apparent abnormality, or at least substantially so. In relation to the question of abnormality in the breast, as discussed below, the condition was changing very rapidly, and some doctors detected abnormalities while others did not. However, the difficulty of diagnosis is clearly shown by the fact that after Ms Karauria had been admitted to hospital, and diagnosed as having metastatic breast cancer, she had a mammogram that came back "clear".

32. Accordingly, we consider that Dr Wiggins acted appropriately when he considered that he should treat Ms Karauria's symptoms as musculoskeletal. What Dr Wiggins had not detected was the cause, namely breast cancer. However, that was not detectable on any basis available to Dr Wiggins, and he was aware that Ms Karauria was to be examined to have any possibility of breast cancer explored at the hospital. The musculoskeletal problems could not reasonably have been seen as a basis for expediting the exploration of possible breast cancer.

33. When Ms Karauria returned on 23 February 1999, she was essentially presenting with the same symptoms as the 9 February 1999 visit. However, the indication of a musculoskeletal problem appeared to be all the more likely as the pains Ms Karauria was suffering from had spread into her right shoulder. Dr Wiggins conducted a full examination again, including an examination of Ms Karauria's breasts, and arranged for a blood test. The blood test results indicated that Ms Karauria was suffering from a musculoskeletal problem. The three relevant elements being: ESR of 57 (normal being 2 - 25), CRP of 32 (0 - 5 being normal), and rheumatological factor of 73 (normal being less than 20). As indicated, Ms Karauria was indeed suffering from a musculoskeletal problem due to the inflammation associated with the metastatic cancer.

34. The next step is significant. Dr Wiggins of his own volition arranged for Ms Karauria to be contacted by his practice nurse, and she came back to see Dr Wiggins on 1 March 1999. Dr Wiggins then arranged for Ms Karauria to be referred to a rheumatologist for further investigation and diagnosis. Accordingly by this time Ms Karauria had a specialist referral for both investigation of possible breast cancer, and also the musculoskeletal symptoms that were contributing to Ms Karauria being in pain.

35. The final consultation Ms Karauria had with Dr Wiggins was on 5 March 1999. On this day Ms Karauria returned to Dr Wiggins, in significant distress. In fact she was suffering not only from the musculoskeletal symptoms, but also from a pleural effusion. Dr Wiggins again examined Ms Karauria's upper back, neck and shoulders. Dr Wiggins thought the complaints of pain were consistent with his assessment of muscle spasm. Dr Wiggins said that Ms Karauria had had little sleep the night before, and was experiencing a lot of pain.

Dr Wiggins did not think that Ms Karauria looked unwell enough to require admission to hospital at that point. Dr Wiggins was not aware of the pleural effusion, and he had no reason to be, as Ms Karauria had not said anything about breathing difficulties. He said *"She looked tired and was upset and the lack of sleep and things all fitted the description she had given me of the previous night or day or so"*. In understanding the subsequent events of that day it is significant that Dr Wiggins prescribed diazepam as a muscle relaxant, and prednisone to explore whether his thoughts as to the possible cause of the musculoskeletal problems were correct. One of the side effects of those drugs is to suppress the patient's cognitive processes. Accordingly, having regard to Ms Karauria's actual state of health at that time, it is not surprising that she "collapsed" later in the day. The hospital admission records made when Ms Karauria arrived at hospital recorded *"Presents with a history of confusion and ataxia after taking Diazepam and Prednisone"*. The ambulance officers had recorded that Ms Karauria had taken one pill of each of the drugs and woke approximately an hour later feeling confused and uncoordinated. Accordingly, it would be wrong to consider that Ms Karauria presented to Dr Wiggins in a near state of collapse because that is what happened later in the day. Taking the prescribed drugs was an important element in her being in the state she was when she arrived at the hospital.

36. Another element at this point is the level of pain being experienced by Ms Karauria. There is no doubt that Ms Karauria was in a great deal of pain, and Dr Wiggins acknowledges that. However, it does appear that Ms Karauria was a very strong and determined woman who tended to minimise her own difficulties. Despite being very ill Ms Karauria endeavoured to carry on with her work. The ambulance officers recorded an extreme level of pain (10 on a scale of 0 - 10), and made a specific note *"NB Patient calm and undistressed"*. The hospital records similarly recorded that after being admitted Ms Karauria was *"not distressed. ... Settled down to read"*. Ms Hargraves also said that while Ms Karauria *"would admit to pain [she would] play it down and say she was managing"*.

37. After Ms Karauria was taken to Hastings Hospital she was first examined by Dr Quigley, who did not give evidence. Dr Quigley referred Ms Karauria to Dr Giri, who was a

medical registrar at the Hospital. Dr Giri gave evidence of his examination and diagnosis of Ms Karauria. Dr Giri suggested in evidence that malignancy was obvious. However when cross-examined, considerable doubt was cast on the proposition. More significant, it is important to recognise that Dr Giri was in a considerably different position in the hospital setting than Dr Wiggins as a general practitioner. In fact, Dr Giri's differential diagnosis on 5 March 1999 - the day Ms Karauria was admitted to hospital - has five alternatives, in this order:

1. Cancer - lung
2. Cancer - breast
3. Lymphoma
4. Infection
5. Pulmonary embolism (Unlikely)

38. The significant advantage Dr Giri had was a chest x-ray, which showed the pleural effusion. That presented a clinical picture pointing to metastatic cancer. Dr Wiggins was in a very different position. He did not have the advantage of a chest x-ray, and no reason to suspect the pleural effusion, and there was nothing pointing to an identifiable primary tumour as the source of metastatic cancer, only the musculoskeletal symptoms.

39. In relation to the difficulty in diagnosing an abnormality in the breast it is significant that:

- Dr Wiggins' Locum had detected "thickening" of breast tissue, which he did not think was sinister, but was worthy of investigation;
- Dr Wiggins had detected no breast abnormality;
- Dr Giri detected a "palpable mass" in Ms Karauria's left breast on 5/3/99;
- The following day Dr McPherson an endocrinologist who is experienced in diagnosing cancers did "not feel anything in the breast";

- Dr McPherson did report that "the surgeons felt a small nodule";
- On 7 March 1999 Dr Metzger a doctor at Hastings noted there was a breast mass which "feels benign", however Dr Metzger reported an indrawn nipple that he considered was sinister. This appeared to be a new development which none of the three (or more) doctors who had recently examined Ms Karauria had seen;
- On 9 March 1999 a mammogram was undertaken, and the report was in these terms: *"There are some benign calcifications present. No evidence of malignancy is detected"*.

40. The evidence demonstrates two things. First, that Ms Karauria's breast did not present as being in a condition that pointed clearly to malignancy. Second, that the situation was changing very rapidly, the "sinister" abnormality of the nipple appeared in the course of some two days. We have carefully considered all the evidence regarding breast lumps, but consider that the record made at the time clearly points to there being no detectable malignancy during the period of time Dr Wiggins examined Ms Karauria.

41. In the absence of a reasonably detectable abnormality in the breast, the abnormalities in the lymph node in the axilla cannot be seen as strongly suggestive of breast cancer. Furthermore, the fact that Ms Karauria had been referred to have it investigated by a specialist should not be lost sight of.

42. The other dimension of the charge is issues relating to communication between Dr Wiggins and Ms Karauria. We accept that Ms Karauria felt she had been treated as a hypochondriac, however that is not the end of the matter. Ms Karauria was in a position where, as she understood the issues, she had advanced cancer, and her doctor had given her some pills for arthritis. However, that is not what happened.

43. It is clear beyond any doubt that Dr Wiggins did not think Ms Karauria was a hypochondriac. Dr Wiggins knew that Ms Karauria was being referred to have her breast assessed by a specialist, he left that arrangement in place. Dr Wiggins prescribed a range

of drugs that could be expected to alleviate the symptoms Ms Karauria was reporting. Dr Wiggins arranged for a blood test to be taken, and knew from the results that Ms Karauria was experiencing the musculoskeletal symptoms she was reporting. Dr Wiggins arranged a specialist referral for the symptoms being reported. Dr Wiggins plainly neither thought Ms Karauria was a hypochondriac, nor acted as though she was.

44. The question then is whether despite knowing that Ms Karauria was significantly unwell he communicated with Ms Karauria in a manner that was negative or inappropriate. The Tribunal recognises that communication skills are very important, and significant disciplinary issues can arise when miscommunication occurs. Communication is essential to ensure that a patient receives effective diagnosis and treatment. None-the-less, no matter how skilful a communicator is, misunderstandings and misperceptions will occur. It is inevitable that a doctor and patient will gain different perceptions of a consultation. An obvious illustration of such a misunderstanding was in relation to the problems Ms Karauria was experiencing. Ms Karauria was sure that Dr Wiggins was telling her she had arthritis. In fact he suspected she had polymyalgia rheumatica, or some other rheumatic condition. But it would not be at all surprising for Ms Karauria to have understood a rheumatic condition to be "arthritis".

45. In deciding what has been established regarding the communications between Dr Wiggins and Ms Karauria, we have had regard to the direct evidence as to what was said. To deal with the apparent conflict we have had regard to what Ms Karauria and Dr Wiggins knew and understood at the relevant time, their actions, and confirmed our conclusions by having regard to the evidence as to Dr Wiggins' character, and general communication skills and practices.

46. Ms Karauria said she felt Dr Wiggins made her "feel like" she was a hypochondriac, that he ignored her concerns, and that he did not believe her. Furthermore, Ms Karauria's evidence was *"he just says what do you want this time sort of thing"*, and that *"you're a bit funny aren't you Robyn what are we going to do with you sort of thing"*; and also that *"I don't want to see you back here before the 14th of the month … He said yeah, don't want to see you back here again."*

47. If Dr Wiggins made those comments, they would clearly be a serious disciplinary issue. Dr Wiggins denied making comments of the kind alleged, and denied that his communications with Ms Karauria were negative, disbelieving, or dismissive.

48. We accept Dr Wiggins evidence. But, in doing so we are not doubting in anyway that Ms Karauria was accurately reporting what she believed was happening to her. The foundation for the misunderstanding was that Ms Karauria was quite correct that she did not have arthritis (or some other musculoskeletal condition), and that she was far more gravely ill than Dr Wiggins suspected - or could reasonably have supposed. Ms Karauria inevitably thought she was being ignored and her concerns were being minimised, even though Dr Wiggins was responding to the symptoms identified. In that environment there was a great deal of room for misunderstanding. While it is only possible to speculate, in such circumstances a doctor saying *"Come back on the 14th"*, will very understandably be reported as the patient hearing *"The doctor does not want to see me again until the 14th"*. Similarly a doctor saying that a patient's condition was *"funny"* in the sense that it was peculiar and not responding to treatment in the way the doctor expected, could easily be misunderstood as an adverse comment about the patient.

49. In reaching this conclusion we have placed significant weight on the fact that Dr Wiggins was very actively responding to the symptoms Ms Karauria presented with. We derive some further support for Dr Wiggins' account of the communications from the various testimonials as to Dr Wiggins' good character, and high standards of professionalism that were presented to the Tribunal by colleagues; and also evidence from Ms Wiersma and Ms Tomoana.

50. Ms Wiersma is a clinical midwife at Hastings Hospital who has worked closely with Dr Wiggins over the past 15 years or thereabouts. Ms Wiersma stated that Dr Wiggins had impressed her as a caring and empathetic doctor, who has good relations with his patients. Ms Wiersma said that in her experience Dr Wiggins would give his patients time and opportunity to express themselves, appeared to genuinely enjoy his patients and be interested in them, and have the ability to communicate with them effectively. Ms Tomoana gave evidence on behalf of her whanau whanui, and said that over the last 13 years she

and four generations of her whanau whanui have been patients of Dr Wiggins. Ms Tomoana gave evidence of Dr Wiggins' personal qualities and professional capabilities. Ms Tomoana said:

"In my experience, Dr Wiggins has shown great respect for cultural considerations. He cares well for each individual, but has also provided Marae-based care in an effective and caring manner.

Through the experiences of my immediate whanau, I know that Dr Wiggins has an ability to communicate effectively across a broad spectrum of age groups. Family from 5 year olds to 11 year olds, young mothers to mature mothers, grandmothers to great grandmothers in their 80s all trust and respect Doctor Wiggins' ability to hear and respond appropriately to their every health need. Such is the trust, that our Kuia can confidently ring him at any time and speak personally with him.

As a whanau whanui, Dr Wiggins is one of the few professionals who we trust to communicate clearly and to actively follow-up on health issues regarding our Kuia. He is familiar with our networks and is able to activate them, with respect to both lore and law.

…

I am very surprised at the elements of the charge in relation to communication between Dr Wiggins and his patient. I believe it would be most out of character for him not to provide open channels of communication or to fail to listen to a patient. He has certainly never made me or any member of my whanau whanui feel as if their concerns are not worth listening to."

Dr Kalderimis' opinion

51. As outlined above when describing the Director of Proceedings' case, Dr Kalderimis was the expert witness for the Director of Proceedings. Dr Kalderimis was forthright in his condemnation of what he thought to be Dr Wiggins' response to Ms Karauria's symptoms, and what he thought to be the communications between Ms Karauria and Dr Wiggins.

52. In relation to the issue of communications Dr Kalderimis made the statement appearing in the quote at para. 21 above. If the comments were made in the sense conveyed, it would of course be completely unacceptable conduct. However, there is no evidence that Ms

Karauria ever claimed Dr Wiggins said she was a “hypochondriac”, rather that she felt as though she was a hypochondriac. In fact Mr Karauria gave evidence that there was no question of Dr Wiggins having ever said Ms Karauria was a hypochondriac, rather that was how she felt. In relation to the other points, we have concluded that the facts were not as Dr Kalderimis had assumed they were.

53. A significant element of Dr Kalderimis’ opinion was based on how Ms Karauria communicated the pain and distress she was suffering to Dr Wiggins. When cross-examined on the basis for that understanding, the exchange proceeded in this manner:

> *“Q. Is it fair to say the opinion you originally provided to the Health and Disability Commissioner and the one you provided to the Tribunal today has had to make to a large extent an assessment of the pain that Mrs Karauria was under as well as what information she imparted to Dr Wiggins?*
>
> *A. Yes.*
>
> *Q. Because both of those factors are important aren't they?*
>
> *A. Yes.*
>
> *Q. And do you think its fair to say you've largely assumed what the Karaurias said about Mrs Karauria’s pain is correct.*
>
> *A. Yes.*
>
> *Q. And yet that that’s largely evidence written after the event isn't it.*
>
> *A. Yes.*
>
> *Q. And do you recognise any unreliability of patients after the event trying to look back and recall their status at any given time.*
>
> *A. Yes I do.*
>
> *Q. You don’t give any qualifications to that effect in your statement about the patients unreliability of recall.*
>
> *A. I was struck by the passion with which the letter was written and the apparent distress that was caused - that struck me as being real, but you're right I did not qualify that.*

Q. And to be fair the passion of a complaint can equally be explained by anger or concern about the doctor?

A. Yes."

54. As we have made clear, it is our view that it is entirely understandable that Ms Karauria and her family would have extremely strong feelings on the basis of the facts as they understood them to be. However, it is our view that rather than regarding the strong feelings as a basis for undiscerning acceptance of the recollection and description of events, it points to the need to carefully examine the records and observations made by a number of independent medical professionals during the relevant period.

55. Dr Kalderimis, on the basis of the facts as he perceived them to be, was very critical of Dr Wiggins, he said that in his opinion *"Dr Wiggins did not treat Mrs Karauria's situation carefully, thoroughly or with any degree of consideration"*.

56. However, it is not evident from Dr Kalderimis' evidence that:

- He appreciated Ms Karauria was experiencing a real musculoskeletal problem, being an inflammatory response to the metastatic cancer she was suffering from, or that
- Dr Kalderimis evaluated Ms Karauria's clinical condition primarily from the medical records (made by several health professionals), rather than Ms Karauria and her family's recollection of the particular period of time.

57. After being cross-examined, the Tribunal asked Dr Kalderimis to reconsider how he now regarded Dr Wiggins' management of Ms Karauria. The evidence was in these terms:

"Q. Doctor, you reached conclusions in your brief of evidence and you have been cross-examined on a number of points, and you have conceded certain points and expanded on others.

Now just to capture your view of the conduct, do you regard the overall conduct as a lapse from good practice or unacceptable professional conduct?

> A. *All of us can make mistakes, that is part of medicine unfortunately, none of us are immune to that, we can all do. We all make lapses - this is probably one of them in my view.*
>
> Q. *One that would be regarded as serious enough to require censure by colleagues?*
>
> A. *That is a difficult question, it really is - not necessarily - I think we can learn and wish we had done better - I would not necessarily say it is one that required censure."*

58. Accordingly, Dr Kalderimis substantially resiled from the position he had taken in his evidence in chief.

Conclusion

59. The Tribunal has concluded that the charge brought against Dr Wiggins must fail, as the allegations have simply not been made out. The Tribunal's conclusions in respect of the particulars of the charge are:

Particular 1

Dr Wiggins failed to consider breast cancer as a differential diagnosis.

This particular fails as Dr Wiggins was well aware that Ms Karauria, at all material times, had a referral to a specialist to investigate the possibility of breast cancer. Dr Wiggins, for proper and adequate reasons, concluded that Ms Karauria's symptoms pointed to another cause for the symptoms she suffered from.

Particular 2 (in the alternative)

Dr Wiggins considered breast cancer as a differential diagnosis but failed to take appropriate steps to confirm or exclude the differential diagnosis of breast cancer.

This particular fails, as the referral to a specialist was in place. Had Dr Wiggins attempted to expedite the referral on the basis of the demonstrated musculoskeletal problems, he would very like have considerable difficulty in justifying his actions. The absence of the type of abnormality in the breast that is usually present with breast cancer made Ms Karauria's true condition very difficult to diagnose.

Particular 3

Dr Wiggins failed to appreciate the significance of the number of consultations with Ms Karauria between 28 January 1999 and 5 March 1999.

This particular fails, as Dr Wiggins was very responsive to Ms Karauria's concerns and suffering. He prescribed three drugs to assist Ms Karauria, he ordered a blood test, when the results of the blood test pointed to a musculoskeletal problem he asked Ms Karauria to come in and see him, he then arranged for referral to a rheumatologist.

Particular 4 - 6

Dr Wiggins failed to appreciate the negative effect of his communication manner had on Ms Karauria.

And

Failed to provide an atmosphere that enabled both Ms Karauria and Dr Wiggins to communicate openly, honestly and effectively.

And

Communicated in a manner that caused Ms Karauria to feel unheard and/or feel that she was a hypochondriac.

These particulars fail, as the Tribunal is not satisfied that Dr Wiggins did have a negative communication manner, failed to provide an appropriate atmosphere for communication, or was responsible for Ms Karauria's feelings. The proof was no higher than that Ms Karauria, in very difficult circumstances, felt that Dr Wiggins failed to respond to her. While Ms Karauria's feelings are very understandable, we are not satisfied that they proceeded from Dr Wiggins' attitude or comments, rather that Ms Karauria had a very serious illness, and for reasons we have discussed that illness was not recognised or treated, because of the very unusual way in which it presented itself.

60. Accordingly, whether the particulars are viewed individually, or cumulatively, the charge has not been established.

61. The Tribunal considers that Dr Wiggins is entitled to have it recorded that this is not a case where the Tribunal found shortcomings on a doctor's part, which were not serious enough

to warrant a disciplinary finding. The Tribunal has carefully considered the whole of the circumstances, and has had the advantage of knowing the findings of a series of doctors, and the ambulance staff, who examined Ms Karauria, and made a record of their findings. Having considered all the evidence, the Tribunal is satisfied that it has been established Dr Wiggins' management of Ms Karauria in early 1999 was competent, appropriate, professional and diligent. This was an extremely unusual and difficult case, due to the way in which breast cancer developed in Ms Karauria.

62. The Tribunal equally records, that nothing in its findings should be taken as indicating that Ms Karauria and her family have been anything other than honest in what they have said about the very unfortunate events. The Tribunal understands the family's feelings of bewilderment, anger and sadness at the death of Ms Karauria at such a young age, and with such complex and rapidly changing circumstances.

DATED at Wellington this 27th day of August 2001

....

G D Pearson

Deputy Chair

Medical Practitioners Disciplinary Tribunal