General Practitioner

A Report by the

Health and Disability Commissioner

(Case 00/06335)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Dr B	Provider/General Practitioner, a Medical Centre
Dr C	A second General Practitioner consulted by Ms A
Dr D	A General Practitioner in the same practice as Dr B.

Ms A's medical records from two medical centres and a private hospital were obtained and reviewed. The Commissioner also sought expert medical advice from two independent general practitioners, Dr Chris Kalderimis, and Dr Keith Carey-Smith.

Complaint

The Commissioner received a complaint from Ms A on 20 June 2000 regarding the services she received between October 1999 and February 2000 from Dr B, general practitioner at a medical centre.

The complaint is as follows:

When Ms A consulted Dr B between 4 October 1999 and 14 February 2000, Dr B:

- *did not listen or act upon Ms A' description of her symptoms or her concerns*
- *failed to diagnose that Ms A had an atrial myxoma.*

An investigation was commenced on 4 October 2000. On 21 March 2001 a provisional no breach opinion was sent to Ms A. Ms A provided an extensive response to the Commissioner's provisional opinion. The matter was then referred to the Commissioner's expert advisor for further comment. Additional expert advice was also received from a further independent general practitioner.

Information gathered during investigation

Ms A, aged 42 at the time of the complaint, stated that she consulted the medical centre on 18 August 1999, as she required a medical report for insurance purposes. The completed report was lost, so Ms A made an appointment for 4 October 1999 at the medical centre to obtain another medical report.

Consultations with Dr B

Ms A consulted Dr B, general practitioner at the medical centre, on several occasions between 4 October 1999 and 14 February 2000.

4 October 1999

On 4 October 1999 Ms A consulted Dr B for an insurance medical check. Dr B undertook a full physical examination and ordered a urine test. The only abnormality detected was haematuria (blood in the urine). Dr B arranged to repeat the urine test the following week.

11 October 1999

Ms A consulted Dr B again on 11 October in respect of her persisting haematuria. Dr B referred Ms A for a renal ultrasound scan, and he advised her not to participate in a triathlon as she had planned. The results of the scan were received on 19 October. The report stated that both Ms A's kidneys appeared normal, that there was no evidence of stones, scarring or hydronephrosis (distension and dilatation of the pelvis of the kidney), and that the bladder appeared normal. The ureters were not seen.

23 November 1999

On 23 November Ms A consulted Dr D. She noted that the ultrasound scan taken in October was fine, but because the ureters were not seen, she ordered an IVP (intravenous pyelogram) and an RFT (renal function test) in response to Ms A's persistent haematuria. Dr D also arranged for "Electrolytes Master" and "Renal Function Master" blood tests. Tiredness and fluid retention were noted by Dr D in Ms A's medical notes. A further urine test was requested.

On 29 November 1999, Dr B saw Ms A and noted in her medical notes:

> "USS and IVU [intravenous urogram] both NAD [no abmormaility detected] micro haematuria persists. Ask [Dr E]."

A further entry in Ms A's medical notes on 2 December 1999 records:

> "Xray result […] 25/11/99. IVP Renal Function and appearances are within the normal limits. No abnormality seen in the lower urinary tract BM."

Consultation with colleagues

Dr B stated that the mild haematuria persisted so he proceeded to undertake the usual investigation of haematuria. This included renal function tests, urinary cultures (including TB and microscopy), urinary tract ultrasound scan and intravenous pyelogram, as discussed above. Dr B advised that all of these tests were normal apart from the presence of red blood cells in the urine. On 6 December Ms A consulted Dr B again with persistent

haematuria. Dr B requested further urine tests for Ms A, and noted that if the haematuria persisted he would arrange a kidney biopsy.

Dr B stated that during this time he consulted a urologist at a public hospital and a nephrologist at another public hospital, by phone. The notes at the medical centre record that Dr B contacted the urologist on 29 November 1999 and the nephrologist on 13 December 1999. Dr B stated he was informed that there were two possibilities for the cause of Ms A's condition. These were a form of haemoglobinuria (a condition often exasperated by strenuous exercise, infectious diseases or injury, where the haemoglobin released from disintegrating red blood cells cannot be taken up rapidly enough by blood proteins) or exercise-induced micro-haematuria. Dr B stated that Ms A was training hard for a marathon at that time so the nephrologist suggested an exercise break of two weeks to see if the haematuria stopped. In response to the advice from the specialists, Dr B requested Ms A to refrain from exercise for a short period of time, during which she was to receive early morning urine tests. It is not clear what length of time Dr B requested Ms A to refrain from exercise. Ms A advised that Dr B asked her to discontinue exercise for three days, not the two weeks suggested by the nephrologist.

From the medical notes it appears that Ms A underwent early morning urine tests on 7 and 10 December. The report for the 7 December test states: "Leucocytes: nil Red cells: 20 x 10 6/L". The report for 10 December states: "Leucocytes: nil Red cells: nil".

Laboratory forms for MSU (mid-stream urine) and C&S (culture and sensitivities) were recorded in the notes for 6, 7, 10, and 13 December. Dr B stated that he requested a repeat of the first urine test because a trace of blood in the urine can indicate serious underlying pathology.

13 December 1999
Ms A stated that after her urine test on 10 December 1999 a nurse at the medical centre informed her the test results were "just as it was last time". She thought this meant that there was blood in her urine. However, Ms A stated that on 13 December Dr B told her that the urine test taken on 10 December 1999 showed that no blood was present. Ms A advised that this was contrary to what the nurse had informed her. Dr B noted that Ms A's haematuria ceased when she was not training and started again when she recommenced training. The consultation notes for 13 December 1999 stated: "RCB's nil after 4 days of no exercise. Now 3+ again".

Dr B advised that he was "pretty sure" that he consulted the nephrologist again after the early morning blood tests, to advise him that Ms A's haematuria had ceased during her period of non-exercise, and started again when she resumed exercise. Dr B stated that the nephrologist advised him that the most likely cause of the haematuria had been Ms A's exercise and that nothing invasive should be done about the haematuria at that point, except monitoring. In response to the advice from the specialists, and the evidence of the reduction in blood during Ms A's period of no exercise, Dr B made a diagnosis of exercise-induced haematuria. Dr B stated that a cystoscopy was considered but this was delayed when the diagnosis of exercise-induced haematuria was made. Dr B advised that in accordance with the advice he received from the specialist nephrologist, he followed up Ms A's haematuria with later tests.

Ms A stated that while she was consulting Dr B he suggested that there was nothing wrong with haematuria and that it was probably due to "all that bloody exercise" she did. Ms A explained that she races in triathlons and multisports.

17 January 2000
Ms A had a further consultation with Dr B on 17 January. Ms A advised that she reported to Dr B that she was suffering from a lack of energy. No mention of a lack of energy was noted in the medical notes for this consultation, but Dr B ordered an 'iron studies master' blood test, indicating that the symptom of tiredness was communicated to him at this time. Dr B also noted that Ms A's haematuria was persisting, and ordered blood tests, including a renal function test, a glucose test, a B12 Folate test, a thyroid function test, and a complete blood count. Dr B also took Ms A's blood pressure.

Dr B received the blood test results on 18 January. The iron blood test report stated:

> "Low serum iron with a normal ferritin is consistent with infection or inflammation. In this setting this ferritin level is not high enough to exclude iron deficiency."

On 24 January Dr B informed Ms A that the results of her blood test were positive for iron deficit anaemia. She stated Dr B advised that this was probably due to her vegetarian diet and prescribed a course of ferrograd-folic (iron) tablets.

Last consultation with Dr B
Ms A advised that after taking the iron tablets for a few days, she developed stomach problems. On 14 February Ms A consulted Dr B again, complaining of loose bowels and what appeared to be a chest infection (tight chest and difficulty in breathing). Ms A suggested to Dr B the possibility that she was suffering from sarcoidosis, as two of her sisters had that condition. Ms A advised that Dr B dismissed this suggestion without investigation. Dr B diagnosed Ms A with an upper respiratory tract infection and exercise-induced asthma. He prescribed antibiotics and a steroid inhaler for Ms A and her iron tablets were discontinued.

Ms A stated that she did not see Dr B again, although her condition continued to deteriorate, because for a considerable period of time she had felt that Dr B was not listening when she described her symptoms and did not take them seriously.

Dr C
In late March 2000 Ms A coughed up blood during a coughing fit. She stated that this concerned her because again she thought it might indicate that she had sarcoidosis. Ms A stated that she saw a general practitioner, Dr C, at another medical centre because Dr B had already dismissed her fears regarding sarcoidosis, despite not conducting any tests.

27 March 2000
Ms A first presented to Dr C on 27 March 2000. She stated that he "… listened to my symptoms and family history and ordered tests immediately to discover the cause of my symptoms". The consultation notes for Ms A's first visit on 27 March 2000 recorded:

> "Tiredness and loss of athletic performance. No change in weight. In the past she has been investigated for microscopic haematuria – USS and IVP were normal – did have a 'low iron' and possibly anaemic. Faeces has not been checked – nor CXR.
>
> Mild asthma.
>
> Non smoker.
>
> FH – two sisters have Sarcoidosis.
>
> Mother had Ca. bowel at 47 yrs.
>
> O/E Looks pale.
>
> Pulse 76 reg. Abdo – nad.
>
> Check bloods; urine; FOB's as well as CXR." [1]

30 March 2000
Ms A saw Dr C again on 30 March 2000. The consultation notes stated that she had "general weakness and tiredness". There was a "discussion re bloods" and it was documented that Ms A required an abdominal ultrasound scan.

4 April 2000
Ms A had an ultrasound scan on 4 April 2000 and the resulting report noted the following:

> "… At the end of the examination, the opportunity was taken to scan the heart. This demonstrates a well defined echogenic mass in the left atrium measuring approximately 6.4cm x 4.7cm. This is mobile and during diastole protrudes through the mitral valve. The most likely diagnosis would be an atrial myxoma."

Ms A also saw Dr C on 4 April 2000. The consultation notes stated:

> "abdominal USS picked up large mass in left atrium which moves through to the left ventricle. d/w … probably left atrial myxoma but needs echo etc, will probably have surgery next Thur … in [the city]. … Both parents alive and well in their 80s, no hx of heart disease."

Referral to cardiologist
Dr C referred Ms A to a cardiologist. In a letter following his examination, the cardiologist stated that during the ultrasound of the abdomen on 4 April 2000, the ultrasonographer thought of scanning the heart and discovered the tumour. The cardiologist stated an echocardiogram had also been performed and this confirmed a large mobile tumour in the atrium which was consistent with a left atrial myxoma. The cardiologist noted that there was no family history of premature coronary artery disease and that Ms A had an "exemplary" lifestyle. He described symptoms of feeling "flat", tiredness, pain in her flanks,

[1] 'FOB' refers to Faecal Occult Bloods, and 'CXR' refers to a chest x-ray.

shortness of breath on exertion, an episode of coughing "gunk" and blood, and in recent times some palpitations and migraines.

Operation
On 13 April 2000 Ms A underwent an excision of a left atrial myxoma at a private hospital. She was reviewed by the cardiologist on 26 April 2000, 24 May 2000 and 8 August 2000, and he documented her continual recovery. In a letter dated 8 August 2000 to Dr C, the cardiologist stated that he believed Ms A had a familial form of myxoma.

Ms A advised that this is a serious condition and the size of the myxoma (8cm x 5cm), along with a significant enlargement of the left atrium, indicated that it had been developing for some time. She stated that surgery was performed at the earliest opportunity because she had a high risk of a stroke and/or heart failure. Ms A stated she understands that a myxoma is a very rare condition, but it was apparent from her initial blood tests and her symptoms that there was a serious problem. Ms A was concerned that Dr B did not look "outside the square" to determine why a healthy and extremely fit woman suddenly had no energy and had felt "off colour" for some months.

Dr B and the diagnosis of myxoma
Dr B stated that Dr C had decided to repeat the urinary tract ultrasound scan. When a scan of the urinary tract again appeared normal the ultrasonographer took the probe up into the chest and saw an unusual appearance in the atrium of the heart, which enabled the diagnosis of an atrial myxoma to be made.

Dr B stated that he spoke to Dr C when he became aware of the diagnosis. Dr C had no idea that Ms A might have an atrial myxoma and was very surprised when the ultrasonographer advised him of what she had seen on the chest scan. He stated that he has talked about Ms A's situation with his peers and all, apart from one, advised they were not aware that an atrial myxoma could cause haematuria. He stated that it is not mentioned in Murtagh's Medical Text under "rare causes" or "pitfalls in diagnosis of haematuria".

Dr B acknowledged that he failed to diagnose the atrial myxoma. He stated that he wished he had made the diagnosis and that the experience has been humbling for him. He is aware that it has been very upsetting for Ms A and can understand why she does not want to consult him again.

Dr B strongly denied that he failed to treat Ms A with respect and that he was contemptuous of her. He advised that he does his best to be patient centred and took the finding of haematuria seriously. He stated this is demonstrated by his consultation with the urologist and nephrologist. Dr B advised it is upsetting to think that he gave this impression to Ms A, but must accept that this was her experience of him.

Independent Advice to Commissioner

The following expert advice was obtained from Dr Chris Kalderimis, an independent general practitioner:

"The outline of the complaint is well summarised in your report; namely that [Ms A] consulted [Dr B] on 4 October 1999 when she needed to have an insurance medical. At that time it was discovered that she had microscopic haematuria ie blood in the urine that is not seen with the naked eye but seen only on testing of the urine, and [Ms A] consulted [Dr B] on a number of occasions through to 14 February 2000.

It was suggested to [Ms A] by [Dr B] in December, that the amount of exercise that she was doing could have been responsible for the haematuria. At that time [Ms A] was training for a marathon run. [Dr B] did investigate the haematuria at some length, and I will discuss this further on in the report, and ultimately he concluded, after consultation with two specialists, that the haematuria was due to the intensive exercise that [Ms A] was doing for her marathon.

[Ms A] then, over the next two months, went back to [Dr B] because she had been complaining of a lack of energy and in particular, on 17 January 2000, [Dr B] ordered blood tests and suggested that the results showed that [Ms A] was anaemic. Accordingly [Dr B] started her on iron supplementation. However, [Ms A] could not continue taking them as she developed side effects to the iron tablets.

As you state [Ms A] changed general practitioners in March 2000, in particular because she felt that [Dr B] had not considered her anxiety of sarcoidosis as being reasonable. Following investigations by her new general practitioner which included an abdominal ultrasound scan, it was found by process of good fortune really that she had a left atrial myxoma. It is noteworthy that the new general practitioner did not request a scan of the chest or heart but this was done by the ultrasonographer accidentally.

Following the diagnosis [Ms A] was referred forthwith to [a private hospital] for cardiac surgery and the myxoma was removed.

I will now go through the issues that you have raised.

1. Was [Dr B's] investigation of the haematuria appropriate? If so, why and if not, why?

   I feel that the investigation was very appropriate and in particular I note that [Dr B] sought the advice of two specialists, both of whom gave advice which he took, and in particular the specialist nephrologist and the specialist urologist both felt that there was significant tie-up between the training that [Ms A] was undergoing for her marathon, to the haematuria. As well it needs to be remembered that when the training for the marathon was in fact stopped, so did the haematuria.

2. Were there any other tests and/or investigations that [Dr B] should have conducted?

   Given the fairly exhaustive tests that [Dr B] did conduct it is hard to see what other tests he should have conducted. Again it needs to be remembered that he

did seek the advice of his specialist colleagues about the haematuria and he followed the advice. Thus, given that he took these steps it is impossible to see what else he could or should have done.

3. Was [Dr B's] diagnosis of exercise induced haematuria appropriate? If so, why and if not, why not?

   I feel the diagnosis was appropriate because firstly he took the advice of specialists and furthermore when [Ms A] followed the advice that was given to her by [Dr B] following consultations with his specialist colleagues, namely to stop exercising, the haematuria disappeared and only reappeared once the exercise was started again. Thus I feel this is a very reasonable conclusion to reach.

4. What, if any, symptoms did [Ms A] show of an atrial myxoma before her last consultation with [Dr B] on 14 February 2000? When responding to this question please comment on the blood test results.

   The symptoms that [Ms A] did show were those of shortness of breath and fatigue. However one needs to say that these are non-specific symptoms and a great many conditions may lead to these symptoms. The blood test results did show that [Ms A] was low in iron but once again, one cannot say with any degree of confidence that this was the reason for the symptoms. Certainly looking back now with the diagnosis known to us, it is easy to say that the symptoms that [Ms A] had were quite consistent with an atrial myxoma but it needs to be remembered when she presented the diagnosis was not known and furthermore, as I will discuss further, this condition is exceedingly rare.

5. Should [Dr B] have diagnosed that [Ms A] had an atrial myxoma?

   No, because the condition is so rare I feel that it is unfair to say that [Dr B] should have diagnosed this condition. It is an exceedingly rare condition and in fact was only discovered by accident when the ultrasonographer, who was asked to do the abdominal ultrasound, happened to also point the probe over the chest. Nobody thought of the diagnosis and one would have to say that we would see it, as general practitioners, so incredibly rarely that although I suppose that it could be included in a differential diagnosis of tiredness and shortness of breath, it would need to be right at the bottom of that differential diagnosis list.

6. How rare is an atrial myxoma and is haematuria one of the recognised symptoms?

   There are differing opinions regarding the frequency of atrial myxomas but the figures suggested that 6 cases per million people is perhaps an expected

incidence. Haematuria is certainly not one of the recognised symptoms and I have had occasion to look at a number of recognised medical textbooks and none of them include atrial myxoma as one of the causes of haematuria. The most authoritative that I looked at is "Harrison's Principals of Internal Medicine" and this does not include atrial myxoma as one of the differential causes of haematuria.

7. Are there any other issues arising from the supporting information?

This is an unfortunate case that in fact ended up very well. Certainly it would appear that [Dr B] and [Ms A] did not have a good professional relationship and clearly [Ms A] felt that she was not receiving a professional or confident service from [Dr B].

However, I feel that regarding the case of the non diagnosed atrial myxoma it is really impossible to blame [Dr B] in any substantial way for this. It needs to be said that it is quite possible that the haematuria had nothing to do with the atrial myxoma and it may well be that the haematuria was purely and simply due to the intense exercising that [Ms A] was doing.

Certainly the tiredness and the shortness of breath could be very definitely attributed to the atrial myxoma but given that there are many other conditions that can cause tiredness and shortness of breath it is not surprising that atrial myxoma was not thought of. In fact [Dr B] was quite diligent in sorting out other conditions that can cause this condition, such as anaemia, thyroid problems or diabetes. He did not find any of these diseases to be present and presumably would have ultimately referred [Ms A] on for a specialist opinion if her symptoms persisted.

I feel that over the period of time that [Dr B] was consulted about these symptoms he responded in an appropriate and professional way. Thus, in my opinion, [Ms A] was provided with medical service that complied with professional and other medical standards."

Response to Provisional Opinion

Ms A raised a number of concerns in her response to my provisional opinion. In particular, she raised a number of concerns regarding the comments of the independent advisor. Ms A was concerned that the independent advisor overlooked many important aspects of her case in formulating his advice.

Failure to follow up
Ms A was concerned that although Dr B had carried out tests to rule out the immediate causes of haematuria, he failed to follow up when the obvious causes were ruled out. Ms A's specific concerns were that no blood tests were carried out for more than three months after the haematuria was discovered, and that Dr B did not order the particular test that determines whether the blood originates from before or after the kidneys.

Ms A further observed that the independent advisor did not address the shortness of breath and fatigue, and offered no explanation as to why no attempt was made to diagnose these problems.

Ms A stated that, by failing to undertake such enquiries, Dr B failed to listen or act on her continuing and worsening ill health and was seriously negligent in his approach to investigation and diagnosis.

Diagnosis of exercise-induced haematuria
Ms A was also concerned that Dr B did not investigate the levels of exercise required to cause exercise-induced haematuria, or investigate the actual level of exercise being undertaken, before he reached his diagnosis. She was concerned that the independent advisor did not specifically address these issues. She noted that she:

> "… took independent advice from a doctor at the time, who confirmed my theory that the level of exercise I was doing at the time was highly **unlikely** to be the cause of the haematuria. He suggested I obtain a second opinion. From research of my own it appears that exercise induced haematuria is most likely to occur in very thin, serious marathon runners. In October of 1999 I was neither, but by February 2000 I was becoming quite thin with virtually no exercise."

In addition, Ms A raised the concern that although the nephrologist expert Dr B consulted recommended that she discontinue exercise for two weeks, Dr B advised her to discontinue exercise for only three days. It is Ms A's concern that Dr B's diagnosis that the haematuria was exercise induced was supported by neither the symptoms she was presenting nor her lifestyle.

Diagnosis of anaemia
Ms A raised further concerns about Dr B's diagnosis of anaemia. She expressed particular concern that Dr B did not order a blood test until three months after the discovery of haematuria, and that his interpretation of the test to determine that she suffered from anaemia was misguided. She was also concerned that he had not examined the damage to her blood cells in more detail to determine whether the blood in her urine was originating from before or after the kidneys. Although the independent advisor mentioned her low iron,

Ms A was concerned that he did not fully address the issue as to whether the blood test results indicated that further investigations were required. She was concerned that the results of the blood test were not included in the report or commented on by the independent advisor.

Failure to refer
Ms A was concerned that the independent advisor commented that Dr B merely did not get to the "bottom of the differential diagnosis list" when, in her opinion, he "hardly even started going down such a list!". Ms A was also concerned that the independent advisor stated that Dr B "presumably would have ultimately referred Ms A on for specialist opinion, if her symptoms had persisted". Ms A re-emphasised that she had been attending consultations with Dr B for five months by that stage, during which time there was no mention of a referral, and that it is unlikely she would have lived for more than a few months from that time without a serious complication.

Further Independent Advice

In response to the issues raised by Ms A, the following further independent advice was obtained from Dr Chris Kalderimis:

> "Haematuria
> The presence of haematuria, which had been a feature for some time and never resolved until the diagnosis of atrial myxoma was made, is clearly a significant issue.
>
> What could be said about this is that [Dr B] did go to some effort to ascertain a reason for the haematuria and, although he did not come up with the right conclusion, I believe that overall he did demonstrate that he did not take the presence of blood in the urine lightly and made some considerable effort to ascertain the reason for it. While it is true that looking at the shape of blood cells in the urine might have been useful, I do not believe that overall this is a major failing in the care that [Dr B] provided [Ms A].
>
> Anaemia
> The diagnosis of iron deficiency anaemia, I would have to agree, is not necessarily the first diagnosis that one would have to consider when viewing the results of [Ms A's] blood tests. While iron deficiency anaemia could be seen as a possible diagnosis, I would have to agree that this is not the first diagnosis that would necessarily come to mind to explain the abnormality of the tests.

Change of Doctors

I accept that the reason that [Ms A] changed doctors was that she had had a coughing episode that concerned her that she might have sarcoidosis and clearly [Dr B] did not take this possibility seriously. Thus, not inappropriately, Ms A changed doctors. Clearly her relationship with [Dr B] at this time was less than adequate.

I do not think however that I would take a chiropractor's recommendation that she change GPs to have much validity.

Independent GP's Review

Comments 1, 2 and 3

The question of why it took three months before any blood tests were ordered by [Dr B] is difficult to answer. I am not sure that this is a major failing, however, but nevertheless one could accept that it is possibly a valid criticism. It is often quite difficult to estimate the amount of exercising an individual is taking and the question of whether or not three days or two weeks is an adequate time to not exercise before testing the urine for presence of blood is a difficult call.

Regarding the question of the urine tests, it is notable that the test on 18th January 2000 showed there was only one plus of haemoglobin present in the urine whereas the test that had been carried out on 14th December 1999 showed three pluses of haemoglobin. Thus I can see why [Dr B] did think that the problem with haematuria was potentially getting better.

General practitioners will often ring specialists for advice regarding the signs or symptoms that a patient may have. This will occur more often when a GP is in a small town, such as this, and there is not a specialist in the appropriate speciality living in the locality. I often ask for specialist opinion, even though I am working in the city, and I value these opinions. Thus I do believe that specialists' opinions are of relevance, even when they do not physically see a patient.

Often, when you are a general practitioner and are involved in the day-to-day care of an individual, it is very difficult to stand back with a totally objective eye. Often, because you do care and want to do your best for that individual, it is sometimes very difficult to stand back and look dispassionately at a situation the way that Ms A wishes had happened. Once again, one would have to say that it is easy with the advantage of hindsight to say this should be so; it is not so easy at the time.

Comments 4-6

It is impossible for me to give an explanation as to why the shortness of breath and fatigue were not further investigated. I think these should have been but suspect that the issue of the haematuria overshadowed these symptoms to a degree. Likewise undoubtedly the blood test that was done on the low iron was misinterpreted but again, oftentimes, the clues that a particular test may suggest can be easily misinterpreted at the time and the true sense of it not seen until later on.

When a diagnosis is made, obviously the practitioner believes that he/she has got the correct diagnosis, but we have to accept that medicine is imperfect and often what we believe to be the correct one may later be proven to be incorrect.

Once the diagnosis of atrial myxoma was known clearly the haematuria could have been explained thereafter but this is with the advantage of hindsight. The fact that the cardiologist could hear the myxoma with a standard stethoscope does not necessarily mean that the general practitioner could hear an abnormality with a standard stethoscope.

Comment 7

I would have to agree that most general practitioners have a very low level of knowledge of atrial myxoma because they are so rare. I have been in practice for more than 20 years and I have still not come across one in any of my patients. I have discussed this matter with many of my GP colleagues, all of whom have been in practice for a great many years and none of them has come across atrial myxoma either. Thus I would definitely have to agree that GPs do have a low level of awareness of atrial myxoma simply because the great majority of us have not come across such a case. I would certainly expect a cardiac surgeon who knows about this problem in more detail to not be surprised by the presence of haematuria.

Obviously no one will ever be able to prove whether or not [Dr B] would have referred [Ms A] for further tests had her symptoms persisted, but it is certainly my impression he would have done so.

7. Errors in the Independent Practitioner's Report

The results of the blood tests that [Dr B] used to diagnose anaemia were in fact included in the report. The finding of [Ms A's] atrial myxoma by the ultrasonographer I would still say was an accident. I have ordered a great many abdominal ultrasound examinations and in none of them has any comment been made about the heart. That is simply because the ultrasonographer has been instructed to perform an ultrasound examination of the abdomen and not the chest cavity.

Thus [Dr C] did not in fact order an examination of the heart but simply ordered an ultrasound examination of the abdomen.

8. Other Issues

I felt that [Ms A] makes a very good point in bullet point 5 and that is that most myxomas are not diagnosed by the primary practitioner but are diagnosed after they have caused the heart attack or stroke when a bit of them has broken off. Thus most primary practitioners do not in fact diagnose them before a catastrophe actually occurs.

That to a large degree is my point because I do believe that the great majority of doctors probably would not diagnose such a condition easily.

While it would certainly have been very good if the fatigue and shortness of breath suffered by [Ms A] had been pursued perhaps more aggressively, there is no guarantee that the atrial myxoma would have been diagnosed through such investigations.

I certainly agree that GPs should listen to what patients are saying to them, but even when they do, sometimes they will not reach the correct conclusion.

I feel this reply will probably not be satisfactory to [Ms A] but I do nonetheless feel that I have tried to cover the issues as fairly as I can."

Dr Kalderimis provided further advice during an interview on 12 September 2001. Notes of the interview were taken, which Dr Kalderimis subsequently viewed and signed as accurate:

"***Haematuria***

- Dr Kalderimis agreed on analysis of haemoglobin except that 17 January 2000 showed ++.
- [Dr B] rang and obtained specialist advice, which was followed. This was critical.
- If [Ms A] had longer than a three day break from exercising that would be a bigger test. If it was only for three days it would not be sufficient, as the break was not long enough to test the exercise-induced theory. Two weeks would have been a better test.
- Liver function: Went back to the text books and what was taught at medical school and agree that hypothetically it is an issue. But the reality is that at the coal face, it is not something that would override the advice that was sought. It would not be a usual test. In [a public hospital] they [patients] can be directed to a specialist. In [this town] they don't have that clinical option.
- It is not an issue [whether [Ms A] ran marathons or competed in triathlons]. The point is that she was a serious athlete. It is splitting hairs [to make a distinction].

Overall I think he did listen and overall he did meet the required standard in that he did his best.

Anaemia

- 18 January 2000 – This was the first iron analysis test and it could possibly have been done earlier, but it depends on specialist advice. That test showed iron was a little low. Other factors were normal. The test didn't tell a hell of a lot. On the bottom of the blood test form it was written that the results were 'normal for age/sex'. If I saw these results it would not mean there was an iron deficiency. It was pretty near to normal. It was not strictly speaking anaemia. Under the strict definition, it's not anaemia. [Ms A] had marginally low iron. Normal iron is 10-30. This was 7, just below the posi factor in the laboratory margins. This would indicate that iron pills may be required as a preventative measure.
- The fact that [Ms A] was a vegetarian and had been on iron pills in the past was not significant.

Shortness of breath

- Fatigue. This is a very common complaint and may have a number of causes, some serious, some not.
- In [this city] one can refer to a Cardiologist. It is easy in [this city]. It is not so easy without access to those services.
- This may have been able to be treated more aggressively. A referral to a cardiologist in [another area] or a chest physician. This may be to query a heart problem or to check oxygen delivery from lungs.
- [Ms A] was diagnosed with asthma in 1991] – Mild asthma is a trap. Shortness of breath can be attributed to asthma, especially exercise induced asthma. This may have led [Dr B] to the wrong conclusion.
- If asthma was considered tests that may be used are a peak flow test or listen to the chest. This would not rule out exertion induced asthma.

Sarcoidosis

- No tests for sarcoidosis. In [this city] [we can do] chest x-ray and lung function – these may not [have been] available. Also there may have been breakdown in relationship [between [Dr B] and [Ms A]] and he may have said 'don't think so' and sent her away.
- Sarcoidosis is a sporadic disease and not considered to be genetically inherited.
- There was no reason to believe this woman was presenting with sarcoidosis.
- ESR blood test may be an indicator although not definitely diagnostic.
- Overall [the standard of care that [Dr B] reached on this issue] wasn't perfect but was reasonable.
- A possible basis for conclusion could be derived from peak flow test. Listen to chest (are lung fields clear?).

Overall consideration of presenting conditions

- This point is rather pivotal. Unfortunately we [doctors] are often focusing on an individual condition.
- It was reasonable to view them [all above symptoms] independently, rather than in a cluster."

Further expert advice was obtained from independent general practitioner Dr Keith Carey-Smith.

"**Whether [Dr B] provided services to [Ms A] with reasonable care and skill, and that complied with appropriate standards, between 4 October 1999 and 14 February 2000.**

RIGHT 4: Right to services of an appropriate standard.
My opinion is based on the standard of care and skill to be expected of a competent general practitioner in a rural setting. This includes conducting an appropriate examination, and arranging appropriate tests and referral.

In particular, a general practitioner would not be expected to diagnose the very rare condition of atrial myxoma. Neither myself nor the two experienced colleagues I work with have ever seen a case, although the condition was mentioned during our

medical training. Many general practitioner textbooks do not even mention the condition. The only specific sign 'tumour plop' is not generally covered in non-specialist medical training; all other symptoms and signs are non-specific (see below under Question 5) (Ref 1, 2). As [Ms A] pointed out, atrial myxoma is in many cases only diagnosed when serious complications occur, and it is indeed fortunate that the lesion was picked up by the experienced ultrasound technician. Haematuria and haemoglobinuria are not listed in standard textbooks as complications of myxoma and general practitioners would not be expected to have knowledge or skills in this area.

Standard management of haematuria by a competent general practitioner should include brief general enquiry and examination (eg blood pressure and heart) to check for systemic causes, abdominal examination, exclusion of vaginal blood contamination, and full urine examination. Ideally blood tests including blood count and renal function tests should be done. If the haematuria is confirmed, referral for appropriate investigation such as ultrasound becomes necessary. Exercise induced haematuria (which I have never heard of), and 'march haemoglobinuria', are not conditions likely to be considered by most general practitioners, nor are they listed in standard texts (Ref 1/2/3). However if a rare condition is suggested as the cause of such a finding by a trusted consultant, general practitioners usually accept that opinion without further research or questioning (unless the clinical situation changes or further information becomes available).

RIGHT 1. To be treated with respect.
RIGHT 2. Freedom from discrimination.
RIGHT 5. Effective communication.

Judgement on these issues is largely subjective, based on letters from [Ms A] and [Dr B]. However certain inferences can be made from the information given and action taken by both parties (see below).

Discussion

The complaints relate to consultations carried out between 4/10/99 and 14/2/00. [Dr B's] notes do not specify which entries were consultations, and which were actions/comments without seeing the patient. The following dates are listed (with brief summary of content):

- 4/10/99. Repeat insurance medical. Discovery of haematuria
- (11/10/99. Haematuria persisted, referral for renal US)
- 23/11/99. Complaint of tiredness/fluid retention (?rhinitis). Blood test and IVP ordered.
- (29/11/99. Haematuria persists, tests NAD. [Urologist]consulted)
- (6/12/99. Early morning urine ordered. (note to refer for kidney biopsy if blood persists))

- 13/12/99. Urine noted clear after 4 days no exercise, then relapse. Contacted [Urologist].

- 17/1/00. Haematuria persists. BP checked. Ordered blood tests and to return 1 mth.

- (24/1/00. Absent record of consultation; iron/folic acid prescribed)

- 5/2/00. (notes recorded after consultation). 'URTI causing flare of asthma' Lungs clear. Prescribed asthma medication. See again if necessary.

In general the letters (A,G) and transcript (c) from [Ms A] agree with this record. However [Ms A] states that she kept on telling [Dr B] that she lacked energy, whereas [Dr B's] notes only mention this once (23/11/99), at which time he commenced investigations. The urine, blood and other results provided correspond with the comments in the notes (early morning urine appears to have been ordered before and after the period of rest, but these were not tested for haemoglobin, only for red cells. These were absent in the second specimen).

[Ms A] says that when she came on 5/2/00 she had a tight chest, difficulty breathing and loose bowels. Notes are incomplete and do not confirm all of this; however the notes provided confirm that the consultation was related to her chest complaints. There is some confusion evident relating to the iron deficiency noted on the blood tests ordered by [Dr B] on 18/1/00. Iron levels were mildly reduced, but no anaemia was noted on the blood count. The ESR result, often elevated if more serious disease is present, was normal (this was elevated in March when checked by [Dr C], suggesting significant progression of disease over the intervening two months). The January results do not point to 'serious infection or cancer' as commented by [Ms A], and would be consistent with mild dietary deficiency as concluded by [Dr B].

It is possible that [Ms A's] worsening health and associated anxiety about the haematuria and possible sarcoidoisis, and possible other factors, resulted in a degree of breakdown in the important doctor-patient relationship. If this occurs, there is potential for failure of communication in both directions, and even loss of objectivity by the doctor. However, there is no direct evidence (apart from the letters from [Ms A]) that this occurred.

Particular questions:

1. **Did [Dr B] conduct appropriate tests and examinations when [Ms A's] urine showed a trace of blood? If not, why not?**

Haematuria is unusual in young or middle aged women and the urine should always be rechecked (to exclude benign causes such as menstrual contamination). If confirmed, the haematuria should be followed up by appropriate enquiry, examination and investigations as outlined above. [Dr B] correctly repeated the urine examination several times, undertook appropriate further investigations (all normal), and consulted appropriate specialists. In a rural area such as [this town],

telephone consultations are appropriate in the first instance, with later referral of the patient to the city specialist depending on the telephone opinion. In this case [Dr B] was reassured by the two diagnoses suggested (both benign conditions) and appropriately took the matter no further. No further specific tests (eg on the urine haemoglobin or red cell morphology) were suggested to [Dr B] by the consultants. I am not in a position to be able to comment on the opinion of the specialists.

A full physical examination (the insurance medical) had been performed by [Dr B] (and previously by a colleague) at the time of discovering the haematuria on 4/10/99, although for completeness it would have been appropriate to repeat a brief general examination during November/December (there is no evidence this was done). It is unlikely that any significant additional abnormality would have been found if this had been performed.

In conclusion, I consider that [Dr B] conducted appropriate examinations, tests and consultation to exclude serious pathology causing the haematuria.

2. Was the diagnosis of exercise induced micro-haematuria reasonable? If not, why not?

On the evidence supplied, including letters from [Dr B] and [Ms A], I consider it was reasonable for [Dr B] to accept the diagnosis of exercise related haematuria suggested by the consultants (see also under 1. above). Prior to doing this he carried out all appropriate investigations to exclude serious pathology, as detailed above. An opinion from a urologist would further assist in elucidating this question.

3. When [Ms A] continued to present with blood in her urine, and symptoms of tiredness and difficulty breathing, did [Dr B] order the appropriate tests and examinations and react appropriately to the results of those tests? If not, why not?

[Dr B] noted tiredness as a symptom on 23/11/99; he apparently made a decision to initially investigate the renal tract and kidneys, proceeding to further investigations two months later (the initial investigations all proving negative). Tiredness is a non-specific symptom which would only require further investigation if history, examination and routine tests indicated significant disease. All of these were carried out appropriately over the 3-4 month period in question, the haematuria was appropriately investigated, and the mild iron deficiency treated. I am unable to determine whether [Dr B] gave appropriate further attention to the tiredness in January, since the records relating to 17/1/00 and 5/2/00 do not mention tiredness. He did carry out appropriate blood tests, but there is no mention of a physical examination (other than urine test and blood pressure) appropriate to this complaint. Ideally, a further cardiovascular and brief general examination should have been performed again (since it was over 3 months since the last one). I note that weight loss was not checked for.

There is a delay of a month or more (13/12/99-17/1/00) before the subsequent tests were ordered and there is no clear explanation for this, apart from the fact that [Ms

A] did not come for a consultation. It is clear that by late March tiredness was the main complaint.

Possible explanations for the lack of further mention of tiredness in [Dr B's] records are:

- The tiredness had developed gradually and not been considered acute enough to necessitate serious attention by either [Dr B] or [Ms A].

- The complaint was repeated by [Ms A] but not remembered, taken seriously or recorded by [Dr B].

- The complaint was considered by [Dr B] to be related to iron deficiency and/or functional (eg anxiety) causes.

Since the records and [Dr B's] letter do not cover this issue I am unable to determine which explanation is correct.

With regards to the shortness of breath, this was addressed on 5/2/00, put down to an upper respiratory infection exacerbating the known asthma, and treated accordingly. The chest was appropriately examined, but again ideally the heart should have been auscultated. On the information given, I do not consider further investigations such as chest x-ray were warranted. [Ms A] was asked to return if necessary, and failure of the treatment prescribed would then have necessitated further investigation and/or referral. I note that [Dr B] does not comment on this consultation in his letter. I also note that there is no mention of breathing difficulty in [Dr C's] records from 27/3/00 onwards, which suggests that this problem had improved or resolved after Dr B's treatment.

In conclusion, I consider that [Dr B] took appropriate steps with regard to the haematuria, since a diagnosis had already been suggested. The lack of a further physical examination during December/January, and the delay of a month or more in undertaking further investigations, is of concern. However, these are consistent with the absence of further mention of the tiredness complained of by [Ms A] (see discussion above). [Dr B] appropriately managed the breathing difficulties, with the exception of lack of record of a heart examination. The above deficiencies in my opinion do not constitute a serious lack of care and skill.

4. Should [Dr B] have referred [Ms A] at any point for specialist examination?

[Dr B] appropriately consulted two specialists concerning the haematuria (see above). There was no subsequent change in the renal tract signs or symptoms to

justify further action up to the date of [Ms A's] transfer to the new General Practitioner.

The mild iron deficiency, the tiredness, and the respiratory difficulty did not in my opinion justify immediate referral, although lack of response to the treatment prescribed on 5/2/00 could become a reason for further referral (see under 3 above). Clearly the worsening fatigue (mentioned by [Dr C] on 27/3/00) and coughing up blood (mentioned by [Ms A] but not [Dr C]), necessitated further investigation including chest Xray.

5. Should [Dr B] have diagnosed [Ms A] with atrial myxoma?

As mentioned above (under Standards relevant to case), atrial myxoma is not a condition an experienced general practitioner would be expected to diagnose. Symptoms are largely nonspecific and can mimic many other diseases. Several examinations for the heart by Dr B (4/10/99, ?5/2/00), his colleague (18/8/99), and Dr C (27/3/00) failed to pick up the classical signs ('plop' and murmur) later detected by the cardiologist (11/3/00). It is clear that no signs of heart failure or abnormality of chest Xray (suggesting serious heart pathology) were present, even as late as 11/3/00. This would suggest that heart failure was not missed by [Dr B]. The abnormal ESR result reported in March was not present in January.

6. Other issues arising from the documentation

[Dr B's] records appear full and complete when detailing earlier consultations (eg 22/1/99). This would suggest his normal practice is to write adequate notes, and would imply that the deteriorating health mentioned by [Ms A] over the period in question was either not communicated to, or not picked up by, [Dr B]. I am unable to determine which explanation applies.

CONCLUSIONS

With regard to whether [Dr B] exercised reasonable care and skill in providing services to [Ms A], I conclude that:

- [Dr B] exercised appropriate care and skill in his management of haematuria, iron deficiency, and breathing difficulties, including appropriate examination, investigation and referral, although there is an unexplained one month delay in investigation during the period in question.

- There is uncertainty as to whether [Dr B] managed appropriately the deteriorating tiredness and general health complained of by [Ms A], since it is not clear whether these symptoms were communicated to, listened to, or recorded by [Dr B]. If they were, in my opinion a repeat examination would have been appropriate in December-February. Even if a full examination had been performed by [Dr B] during that period, it is unlikely that the myxoma would have been detected. The only way would have been by ultrasound,

echocardiography, or referral to a cardiologist, none of which I consider were indicated by to 5/2/00.

Refs:

1. Current Medical Diagnosis and Treatment Lange 1990

2. Merck Manual 16th Edition

3. Davidson's Principles and Practice of Medicine."

Code of Health and Disability Services Consumer's Rights

RIGHT 4

Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

Opinion: No Breach – Dr B

Right 4(1)

Having considered the complaint against Dr B, I am of the opinion that he did not breach the Code of Health and Disability Services Consumers' Rights.

Investigation of symptoms and concerns
Ms A expressed concern in her complaint that Dr B failed to listen to or act upon her symptoms or concerns. Between 4 October 1999 and 14 February 2000, Ms A presented to Dr B with haematuria, fatigue, breathing difficulties, and a general deterioration of health.

Haematuria
Dr Carey-Smith advised me that the standard management of haematuria by a competent general practitioner should include a general enquiry and examination, abdominal examination, exclusion of vaginal blood contamination, and full urine examination. My advisor stated that ideally blood tests including blood count and renal function tests should be undertaken and, if the haematuria persists, referral for appropriate investigation such as ultrasound.

Ms A consulted Dr B on 4 October 1999 with haematuria. Dr B monitored the haematuria. On 11 October the haematuria was persisting, so Dr B referred Ms A for a renal ultrasound scan. On 23 November Dr D arranged an intravenous pyelogram, renal function test, and blood tests ('electrolytes master' and 'renal function master'). Between October and December, a series of urinary tests were undertaken. All the results for these tests were normal, apart from the presence of the red blood cells in the urine. Dr B consulted with two specialists, a nephrologist and a urologist. The nephrologist suggested the possibility of exercise-induced haematuria, and recommended that Ms A refrain from exercising for two weeks to test the diagnosis.

Ms A complained that Dr B requested that she refrain from exercising for three days, and not the two weeks recommended by the nephrologist. However, during the three days that Ms A did not exercise, her red blood cell count dropped from "20 x 10 6/L" to "nil". I accept that it was reasonable for Dr B to diagnose Ms A with exercise-induced haematuria in mid-December 1999, after three days of no exercise, as he was guided by the advice of the specialists he consulted, and the blood test indicated an improvement when Ms A refrained from exercise. As stated by Dr Kalderimis:

> "It is often quite difficult to estimate the amount of exercising an individual is taking and the question of whether or not three days or two weeks is an adequate time to not exercise before testing the urine for presence of blood is a difficult call."

I note that when the haematuria persisted in mid-January, Dr B commenced further investigation, and ordered appropriate blood tests.

Both Dr Kalderimis and Dr Carey-Smith advised that Dr B's investigation and management of Ms A' haematuria was appropriate. Dr Kalderimis stated:

> "[Dr B] did go to some effort to ascertain a reason for the haematuria and, although he did not come up with the right conclusion, I believe that overall he did demonstrate that he did not take the presence of blood in the urine lightly and made some considerable effort to ascertain the reason for it."

Dr Carey-Smith stated:

> "[Dr B] correctly repeated the urine examination several times, undertook appropriate further investigations (all normal), and consulted appropriate specialists … In conclusion, I consider that [Dr B] conducted appropriate examinations, tests and consultation to exclude serious pathology causing the haematuria."

I am guided by the advice of my expert advisors that Dr B's investigation of Ms A's haematuria was appropriate. Accordingly, it is my opinion that Dr B did not breach Right 4(1) of the Code in this regard.

Fatigue

Tiredness was first recorded in Ms A's medical notes on 23 November 1999 during a consultation with Dr D. Dr D commenced investigations of Ms A's renal tract and kidneys. The results of these tests were normal. Dr Carey-Smith advised:

> "Tiredness is a non-specific symptom, which would only require further investigation if history, examination, and routine tests indicated significant disease. All these were carried out appropriately over the 3-4 month period in question … "

Dr Carey-Smith did express concern in his advice that although Dr B noted Ms A's tiredness on 23 November 1999, there was a lack of further mention of tiredness in Dr B's notes between December 1999 and January 2000. However, although Ms A consulted Dr B on several occasions over this period, there is no evidence that tiredness was mentioned again as a symptom until 17 January 2000, when Dr B ordered a blood test and diagnosed Ms A with iron deficit anaemia. In the absence of such information I am unable to form an opinion on the appropriateness of Dr B's follow-up investigations into Ms A's fatigue. I note, however, that where it is clear that tiredness was mentioned as a symptom, appropriate investigations were undertaken.

I note that Ms A also expressed concern that the blood test taken on 17 January 2000 indicated a serious infection, and not iron deficit anaemia. My expert advisor, Dr Carey-Smith, noted:

> "The January results do not point to 'serious infection or cancer' as commented by [Ms A], and would be consistent with mild dietary deficiency as concluded by [Dr B]."

I am guided by the advice of my expert advisors. I accept that when tiredness was mentioned as a symptom Dr B conducted appropriate investigations. Accordingly, it is my opinion that Dr B did not breach Right 4(1) of the Code in this regard.

Shortness of breath

Ms A consulted Dr B on 14 February 2000 complaining of difficulty breathing. Ms A was concerned that her shortness of breath might be indicative of sarcoidosis, and complained that Dr B dismissed her concerns without conducting appropriate tests to rule out that possibility.

I have been advised that sarcoidosis is a sporadic disease, not considered to be genetically inherited, and that there was no reason to believe that Ms A was presenting with sarcoidosis. Dr B investigated the shortness of breath and diagnosed an upper respiratory tract infection and asthma. Dr B further noted that on examination, Ms A's lung fields were clear.

My expert advisor, Dr Carey-Smith, stated that ideally Ms A's heart should have been auscultated when she presented with shortness of breath. Nevertheless, Dr Carey-Smith concluded that Dr B exercised reasonable care and skill in his management of this condition. Dr Carey-Smith stated that further investigations, such as a chest x-ray, were unwarranted at that stage. I note that Ms A did not consult Dr B again after 14 February to enable him to follow up her shortness of breath.

I am guided by the advice of my expert advisors. Accordingly, it is my opinion that Dr B did not breach Right 4(1) of the Code in this regard.

Failure to diagnose atrial myxoma
My expert advisors note that atrial myxoma is an exceedingly rare condition, occurring in approximately six cases per million people. Although a cardiologist would have more knowledge and experience of the condition, it would be unreasonable to expect a general practitioner to immediately diagnose the condition if it had not previously been encountered. Dr Carey-Smith advised that:

> "[m]any general practitioner textbooks do not even mention the condition. The only specific sign 'tumour plop' is not generally covered in non-specialist medical training; all other symptoms and signs are non-specific."

Ms A's symptoms were haematuria, fatigue, and difficulty breathing. Both my advisors noted that standard textbooks do not include atrial myxoma as one of the differential causes of haematuria. Shortness of breath and fatigue are non-specific symptoms, which could be caused by a large number of conditions. Dr Carey-Smith advised that the symptoms of atrial myxoma are non-specific and can mimic many other diseases; in addition, it is clear that no signs of heart failure or abnormality of chest x-ray (suggesting serious heart pathology) were present, even as late as 11 March 2000, which would suggest that the heart failure was not missed by Dr B.

I have been advised by both my expert advisors that the diagnosis of exercise-induced haematuria was appropriate in the circumstances, and that it is by no means clear that further investigation of the haematuria would necessarily have led to a diagnosis of atrial myxoma. I accept that it was quite by chance that the atrial myxoma was finally picked up by the ultrasonographer during the ultrasound scan.

I am guided by the advice of my expert advisors that Dr B's diagnosis of exercise- induced haematuria was appropriate, and that his failure to diagnose the atrial myxoma was understandable. Accordingly, it is my opinion that Dr B did not breach Right 4(1) of the Code in failing to diagnose Ms A's atrial myxoma.

Overall management of Ms A' symptoms
Ms A expressed concern that Dr B did not consider the symptoms of haematuria, fatigue, shortness of breath, and general deterioration of health together as indicative of a greater underlying pathology, and that had he looked at her case with an 'objective' eye, he would have realised this.

Ms A's symptoms arose gradually and independently. Ms A presented to Dr B with haematuria on 4 October 1999. It was not until 23 November that Ms A first complained of tiredness, and there is no evidence that this symptom was mentioned to Dr B again until 17 January 2000. Ms A first reported breathing difficulties to Dr B on 14 February 2000, which was her last consultation with Dr B. I note that tiredness and breathlessness are very non-specific symptoms, which can have a number of causes.

I have been advised by my expert advisor, Dr Kalderimis, that although together these symptoms may suggest a serious underlying pathology, it was reasonable to view all the symptoms that Ms A exhibited independently. Furthermore, I have been advised by both my expert advisors that Dr B's overall management of Ms A's case was in accordance with

good professional practice. Dr Carey-Smith advised that in his opinion Dr B exercised appropriate care and skill in his management of haematuria, iron deficiency, and breathing difficulties, including appropriate examination, investigation and referral.

In addition, while I acknowledge Ms A's concerns about her deteriorating health at the time, I feel it is important to emphasise that the various symptoms she presented with to Dr B were ultimately found to be attributable to an atrial mxyoma. I am advised that this was a condition that Dr B was unlikely to detect. In my opinion, the difficulty of this diagnosis is an important factor in the determination of whether Dr B's services in addressing Ms A's symptoms were of the appropriate standard. It is all too easy to judge Dr B's actions with the benefit of hindsight. To do so would be onerous and unfair.

I accept that Dr B's attempts to address Ms A's symptoms were not exhaustive and that the atrial mxyoma was life-threatening, but he was faced with a cluster of symptoms, which became meaningful only when the atrial mxyoma was detected.

On this basis, and the advice of my expert advisors, it is my opinion that Dr B did not breach Right 4(1) of the Code in his response to Ms A's symptoms and concerns.

Actions

- A copy of this opinion will be sent to the Medical Council of New Zealand.
- A copy of this opinion with identifying features removed will be sent to the Royal New Zealand College of General Practitioners, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.