# General and Gastrointestinal Surgeon, Dr B

# A District Health Board

## A Report by the

## Health and Disability Commissioner

## (Case C09HDC01315)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

## Overview

On 16 April 2009, Ms A (aged 44 years) attended an obesity surgery assessment at the public hospital on the referral of her general practitioner. The assessing surgeon, Dr B, used inappropriate language when talking to Ms A about the lifestyle changes required in order to be considered for the programme. Ms A was offended by the language Dr B used and his manner and wrote to the hospital that day to complain about him.

On 7 June 2009, Dr B wrote to Ms A responding to her complaint. He apologised for his language and approach during the consultation. But he went on to say that it was "clearly obvious" from her letter that they did not have a therapeutic relationship, and it was not in her best interests for him to continue to offer to help her with her weight problem. As a result of these events, Ms A feels she has been denied an opportunity to improve her health.

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## Complaint and investigation

On 5 June 2009 the Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by general and gastrointestinal surgeon Dr B. The following issues were identified for investigation:

- *Did Dr B treat Ms A with respect during a consultation on 16 April 2009?*
- *Did Dr B communicate effectively with Ms A during a consultation on 16 April 2009?*
- *Did Dr B comply with his legal obligation under Right 10 of the Code of Health and Disability Services Consumers' Rights in responding by letter dated 7 June 2009 to Ms A's letter of complaint dated 16 April 2009?*

An investigation was commenced on 3 September 2009.

Information was reviewed from:

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| Ms A | Consumer |
| Dr B | Provider/General and gastrointestinal surgeon |
| Dr C | Senior house officer, surgical team |
| Ms D | Registered nurse |
| Dr E | Medical Director, the District Health Board |

Others mentioned in this report:

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| Dr G | General practitioner |

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## Information gathered during investigation

*Background — 2003*
On 18 March 2003, general practitioner Dr G referred Ms A to District Health Board (DHB) consultant general and gastrointestinal surgeon Dr B's surgical outpatient clinic for assessment for obesity treatment. Ms A had a BMI of 55.13kg/$m^2$. Dr G advised Dr B that Ms A had been unable to lose weight because of a number of physical and psychosocial factors. Dr G noted that Ms A had normal blood pressure and blood sugars, but was on medication for fibromyalgia. Dr G advised that although Ms A had made "huge improvements in other areas of her life", she felt her "dreadful history of abuse" was sabotaging her efforts to lose weight. Dr G asked Dr B if gastric stapling for the treatment of obesity was still publicly available and funded. She had made enquiries and found that Dr B had seen some obesity patients in the past.

On 10 April 2003, Dr B replied to Dr G thanking her for the referral for Ms A. He advised Dr G that there was no funding at that time for primary surgery for obesity at the public hospital. Dr B stated that he had seen some patients at his outpatient clinic "as a screening tool", and to give them advice and information about this type of surgery. He stated that the advice he gives patients who are particularly keen to pursue surgery for obesity control and who wish to obtain more accurate and detailed information, is that a surgeon in another centre is the nearest surgeon providing this service. Dr B advised Dr G that he had not arranged a further appointment for Ms A.

*2008*
On 18 April 2008, Dr G again wrote to Dr B about Ms A. Dr G said she understood that he was planning to start bypass surgery in the near future and asked him to consider Ms A for this surgery. Dr G noted that she had been unable to weigh Ms A for years, but two years earlier she had been weighed at the Women's Health Unit. Her BMI was 60.14kg/$m^2$. Dr G advised Dr B that Ms A was working full time and had a three-year-old daughter. She kept reasonable health, apart from her fibromyalgia,[1] but recently, for the first time, had had a raised fasting blood sugar result.

*Clinic appointment — 2009*
Ms A was sent an appointment and, on 16 April 2009, attended the public hospital's surgical outpatient clinic for assessment of her obesity.

Senior House Officer Dr C conducted the initial interview with Ms A. He advised HDC that Ms A told him that she had tried a number of methods in order to try to lose weight. She had been on a number of diets but relapsed quickly without any beneficial loss of weight, and regained weight quickly following the relapse. She told Dr C that she exercised by swimming three times a week, but generally found exercise difficult because of the fibromyalgia.

[1] Fibromyalgia is a disorder that causes muscle pain and fatigue. People with fibromyalgia have "tender points" on specific places on the neck, shoulders, back, hips, arms, and legs, which hurt when pressure is put on them.

The clinic registered nurse, Ms D, weighed Ms A and measured her height. Ms A had a BMI of 68.32kg/$m^2$, which placed her in the category of being morbidly obese.

*Dr B*

Dr B arrived to talk to Ms A about her treatment options. He advised HDC that he recognised that it had taken a lot of courage for Ms A to present at the clinic. She told him that she had some issues related to her weight, but did not want to discuss those issues.

Dr B explained to Ms A that her weight presented significantly high risks to her health, such as diabetes. He talked to her about the implications of the surgery, advising that it is not routine, and told her that for patients to be considered for gastric bypass surgery they need to fully grasp the concept that for the treatment to be successful there needs to be a major change in lifestyle.

Dr B advised HDC that the success rate for gastric bypass surgery is between 60% and 70%. He said that 30% of patients have no sustained reasonable weight loss. Sometimes this is due to technical problems with the surgery, but mostly it is because the patients do not grasp the concept and do not address their eating and lifestyle. Dr B stated that this is not a passive process and the patient must work at losing and maintaining weight loss. If the patient has not grasped the concept, the programme will not be effective. Dr B stated that this information makes up about three-quarters of the discussion he has had with the 30 to 40 patients he has seen at the clinic. He explained this information to Ms A.

Dr B stated that Ms A told him that she did not want to use the word "diet". He tried to impress upon her that she had to commit to a change of lifestyle, which included dieting. He told her that he did not consider her a suitable candidate for the programme.

Dr B recorded that Ms A wanted to be considered for gastric bypass surgery. He said she did not appear to be upset when she left the clinic. On 20 April Dr C wrote to Dr G stating:

> "She seems to be a little reluctant to discuss any dietary techniques for loss of weight, however she still wants to remain for consideration of bariatric surgery … We will put her on the list to be considered for surgery."

*Ms A*

Ms A advised HDC that it was a "big deal" for her to attend the appointment with Dr B because she was "exposing her obesity". She acknowledged her background as a Māori woman and said that the issues relating to her obesity are personal, and that she has many psychological problems that she needs to overcome. Ms A said, "I am more than a fat person."

Ms A tried to explain to Dr B that she wanted to take a holistic approach to her health and weight, and did not want to use the word "diet" because she had failed with diets. She said she did not explain herself well, and felt he was not listening to her.

Dr B told her that her "thoughts were f…d". Ms A said she "shut down" at this because Dr B's words brought back similar instances in her past, which she is trying to put behind her. Ms A said that Dr B may not have intended his words to be a personal attack, but it felt personal to her. She felt "really lousy" when she left the clinic, but held herself together until she got into her car, where she broke down.

*Ms D*

Clinical nurse Ms D has 20 years' experience in a variety of nursing positions. On 16 April 2009, Ms D was working in Dr B's surgical outpatient clinic, and was in the consulting room, acting as chaperone, when Ms A was seen.

Ms D stated that Dr B spent about 20 minutes with Ms A explaining what the surgery entailed and the changes she needed to make to her lifestyle. Ms D recalls that Dr B and Ms A had an "exchange" because Ms A did not want to use the word "diet". Dr B replied that she was going to have to go on a diet, and Ms A stated that she did not like the word. Ms D recalls that Dr B said to Ms A, "You are going to be on a f…ing diet."

Ms D said that there was "frustration on both sides", but Ms A did not appear to be upset when she left the clinic.

*Ms A's complaint*

On 16 April 2009, Ms A wrote to the DHB's Customer Relations Office about the "abusive behaviour [Dr B] surgeon exhibited" to her that day. Ms A detailed the consultation, stating that there was a lot of discussion and information disclosure about gastric surgery, her personal eating and exercise habits, and her history. Ms A stated:

> "What I noticed throughout the consultation was how flippant [Dr B] was with his swearing, using the word f...k at least three times within the conversation. Throughout the consultation [Dr B] had mentioned the word diet to me. I then informed him that I was trying to take this word out of my vocabulary as it had negative connotations and for me it was changing it (the word diet) to lifestyle.
>
> [Dr B] disagreed and said if I couldn't handle the word diet then he challenged my motivation and stated that I would never survive surgery because I was still bullshitting myself and therefore my thinking was still f….d. With this comment I was highly offended, although at the time I did not say anything as I was in shock. …
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> I have been waiting for years to attend this clinic and after being originally turned down. When … [Dr G] was able to resubmit my name for an appointment with [Dr B] I was really pleased, however, incredibly anxious as I have always believed that my obesity was more than just the physical, but the emotional. Recently acknowledging the seriousness of my weight and the impact that I was having on not only myself, but my whanau as well, attending this clinic was an option to deal with this life and death situation.

> I believe that his behaviour to me was unacceptable and offending, and insensitive to a matter that has taken me many years to address. I would appreciate this matter dealt with in a professional manner so that this does not occur to another person who may be seeking solace from attending this clinic."

On 7 June 2009 Dr B wrote a letter in response to Ms A's complaint. He stated, "I apologise for my language and approach during the consultation, which you have unfortunately badly misinterpreted as a personal attack."

Dr B advised Ms A that he speaks in "plain English" and does not "muck around" when speaking to his patients, because his clinical workload is high and the majority of his work is complex surgical "gut-related" problems. He reiterated the points he raised with Ms A during the consultation — that his patients needed to be strongly, continuously motivated to lose weight. That motivation is not just psychological, but needs to extend to lifestyle changes such as physical exercise and adopting other preventative health practices, as well as involving family and friends. The patient has to eat a drastically different diet, which means limiting meals to portions equal to one very small cup of solid, staple foods, three to four times daily, with no caloried snacks or drinks such as milkshakes. He noted, "If patients fail to accept these conditions/facts, then no treatment currently available world-wide will be effective on a sustained basis."

Dr B explained to Ms A that during the consultation he had "major reservations" about her commitment, and so felt the need to discuss these issues. He told her, "otherwise you and I would both be kidding each other" about the reality of her undergoing major surgery with its accompanying significant potential risks, in order to lose weight on a sustained basis.

In his letter of 7 June, Dr B advised Ms A:

> "It is clearly obvious by your letter that you and I do not have a therapeutic relationship so that I do not believe it is in your best interests for me to continue to offer to help you with your weight problem. Therefore I have taken your name off my list of potential patients for weight loss surgery. I am happy to help arrange for you to see another surgeon should you wish, but this will require travel outside [the region]. I cannot, however, make any assurances that [the DHB] will fund such treatment outside of this District Health Board."

**Contextual information**

*The DHB*

The DHB Medical Director Dr E advised HDC that Dr B is a highly qualified surgeon with an exemplary work ethic. Dr E stated that Dr B's clinical and surgical standards are very high. He genuinely cares for his patients and is trusted, skilled and a mentor for other medical staff. His medicine and messages are sound. However, it is well known throughout the hospital that Dr B has a "foul mouth" in stressful situations. Dr E said that Dr B is "direct and coarse" in his approach to his patients and, although he does not intend to be offensive, occasionally patients and staff take offence. He said, "[Dr B] intends to be frank and honest but it is the packaging that is the problem."

Dr E stated that he has addressed this problem with Dr B. Dr B knows that he has a problem, and he had been asked to moderate his language. Dr E said that this complaint has already had an effect on Dr B toning down his language, and believes that it would be a "terrible shame if severe penalties were imposed on [Dr B]". Dr E undertook to further engage with Dr B about his language and communication style, and said he would comply with any form of follow-up recommended by HDC.

*Gastric bypass programme*
Currently the DHB has no gastric bypass surgery programme. The Board has approved funding, but Dr B is yet to assemble a team to provide the service. Dr B advised HDC that word about the programme has spread informally because it is such an important health issue. He sees prospective patients in the surgical outpatient clinic to explain the issues and collect names for when the programme is available. Dr B has produced a seven-page information booklet about gastric bypass surgery, which he gives to his patients.

*Complaint management*
The DHB Customer Relations Coordinator advised HDC that she received a written complaint about Dr B from Ms A on 28 April 2009. She logged the complaint into the DHB database in the usual manner and on 29 April sent the complaint to the Group Manager Surgical Services. He delegated follow-up of Ms A's complaint to the Business Manager Surgical Services.

The Customer Relations Coordinator stated that all complaints at the DHB are responded to, but the degree of investigation required varies. It was decided that Ms A's complaint was primarily about the communication between her and Dr B, so The Business Manager Surgical Services brought the matter to Dr B's attention. Dr B responded to the complaint in writing on 7 June 2009.

The Customer Relations Coordinator stated, "The complaint was managed in accordance with our usual processes."

## Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

*RIGHT 1*

*Right to be Treated with Respect*

*(1) Every consumer has the right to be treated with respect.*

*RIGHT 4*

*Right to Services of an Appropriate Standard*

*(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.*

*RIGHT 5*

*Right to Effective Communication*

*(2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.*

*RIGHT 10*

*(3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.*

*(4) Every provider must inform a consumer about progress on the consumer's complaint at intervals of not more than 1 month.*

*...*

*(6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that —*

*(a) The complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; ...*

*(7) Within 10 working days of giving written acknowledgement of a complaint, the provider must, —*

*(a) Decide whether the provider —*

*i. Accepts that the complaint is justified; or*

*ii. Does not accept that the complaint is justified; or*

*(b) If it decides that more time is needed to investigate the complaint, —*

*i. Determine how much additional time is needed; and*

*ii. If that additional time is more than 20 working days, inform the consumer of that determination and of the reasons for it.*

*(8) As soon as practicable after a provider decides whether or not it accepts that a complaint is justified, the provider must inform the consumer of —*

*(a) The reasons for the decision; and*

*(b) Any actions the provider proposes to take; and*

*(c) Any appeal procedure the provider has in place.*

## Opinion: Breach — Dr B

*Inappropriate language and lack of respect*
Dr B assessed Ms A on 16 April 2009 at his surgical outpatient clinic for suitability for gastric bypass surgery. During the consultation, he became frustrated with what he perceived as her inability to grasp the lifestyle change concepts necessary for this surgery to be successful. Dr B insisted that Ms A acknowledge that she needed to diet, while she tried to explain that because of numerous failed diets in the past she was trying to take a holistic approach and wanted to avoid using the word "diet".

In order to attend the appointment with Dr B, Ms A had had to overcome a number of issues relating to her obesity and being Māori. She had acknowledged that her weight was having a serious impact on her health — that it was a life and death situation, and the effect this was having on her family. Ms A was "incredibly anxious" about the outcome of the consultation, as she had been waiting years for the opportunity to attend this appointment. She was dismayed to find that Dr B was "flippant" and that he used the word "f...k" at least three times during his conversation with her. Ms A recalls that when she tried to explain to Dr B her rationale for not wanting to use the word "diet", he told her that her "thoughts were f...ked." She interpreted his manner and language as a personal attack. Although she appeared not to be upset at the time, Ms A became very distressed by the time she got into her car.

The registered nurse who assisted at the consultation advised HDC that there was "frustration on both sides" when Dr B and Ms A were talking about the prerequisites for gastric bypass surgery. She heard Dr B say to Ms A, "You are going to be on a f…king diet."

Dr B admits that he used the language complained about by Ms A. He apologised to Ms A in writing for his language and approach during the consultation, but said that she had "unfortunately badly misinterpreted" this as a personal attack. He told her that "by necessity" he speaks plainly, and does not "muck around", and the words he used that most offended her were for "stressing certain vital points".

In my view, Dr B's language and conduct during the consultation with Ms A were demeaning, insulting and unprofessional. He showed disrespect for a patient who understandably felt embarrassed about her obesity. I conclude that Dr B breached Right 1(1) of the Code.

*Ineffective communication*
Dr B failed to communicate effectively with Ms A and to create an environment for good dialogue. Other clinicians have heavy workloads yet manage to stress the importance of vital points to their patients without the need to use foul language.

Dr B also did not provide services (including his communication of information) in a manner that "optimise[d] the quality of life" of Ms A, as required by Right 4(4) of the Code. Interestingly, "optimise the quality of life" is defined in clause 4 of the Code to mean "take a holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances". Dr B showed no understanding whatsoever of the vulnerability of an obese Māori woman in her forties. There was no justification

for his "bull at a gate" tactics. I conclude that Dr B also breached Right 4(4) and Right 5(2) of the Code.

*Response to complaint*
Ms A's complaint letter was received by the DHB on 28 April. The letter was logged as a complaint received and passed to the DHB Surgical Services Group Manager for attention. It is not clear when Dr B was informed of Ms A's complaint, but he did not respond until 7 June.

Dr B advised HDC that his letter to Ms A was intended to be an apology for using language that she found offensive. If so, it was a half-hearted apology, full of self-justification. Dr B claimed that Ms A "unfortunately badly misinterpreted" the language he used and his approach as being personal. It is hard to see how Ms A could have interpreted the comments he made to her as other than personal.

In his letter to Ms A, Dr B reiterates the explanation he gave her during the consultation on 16 April, and his major reservations about her commitment to the gastric bypass surgery process. A number of the comments made by Dr B in his letter are far from conciliatory. Furthermore, even though Ms A had already been placed on his list of potential patients following the consultation, Dr B told her that he had taken her name off his list because her complaint made it "clearly obvious" that they did not have the necessary therapeutic relationship. This appears to be retribution on Dr B's part for Ms A's action in laying a complaint.

Dr B failed to facilitate the resolution of Ms A's complaint. I conclude that he breached Right 10 of the Code.

## Opinion: Breach — The DHB

*Vicarious liability*
Under section 72(2) of the Health and Disability Commissioner Act 1994, employers are responsible for ensuring that employees comply with the Code. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing or omitting to do the things that breached the Code. Dr B was employed by the DHB. As an employer the Board is potentially vicariously liable for Dr B's breaches of the Code.

*Professional standards*
It was well known at the hospital that Dr B frequently used foul language, was direct and coarse in his approach to his patients and, at times, offended patients and staff. He had been spoken to by senior staff and asked to moderate his language. However, he is viewed as a skilled and dedicated surgeon, and it appears that to an extent his unacceptable language was tolerated. In my opinion, the DHB did not take adequate action to address Dr B's behaviour and is therefore vicariously liable for his breaches in respect to his behaviour towards Ms A. I conclude that the DHB is vicariously liable for Dr B's breach of Right 1(1) of the Code.

*Complaint management*
Ms A complained to the DHB that Dr B's manner towards her on 16 April 2009 was "unacceptable and offending". In my view this was a serious complaint. However, when this complaint was received by the DHB Customer Relations Coordinator, it was considered to be a communication rather than professional standards issue. The DHB Surgical Services Group Manager was delegated to address the complaint. He in turn delegated this responsibility to the Surgical Services Business Manager, who advised Dr B about the complaint. There is no evidence that management followed up on the complaint.

Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code) states that every provider must have a complaints procedure that facilitates the "fair, simple, speedy, and efficient resolution of complaints", acknowledges complaints within five working days, and informs the consumer about progress of their complaint at intervals of not more than one month. The DHB's complaints process did not meet these time frames.

The DHB advised that Ms A's complaint was managed according to its usual processes. However, Dr B did not respond to Ms A's complaint until 7 June, and did so in a manner that did not facilitate resolution.

Although the DHB had systems in place to respond to complaints, in my opinion it did not take sufficient steps to ensure that Ms A's complaint was responded to appropriately and in the stipulated time frames. In these circumstances the DHB is vicariously liable for Dr B's breach of Right 10 of the Code.

## Recommendations

I recommend that Dr B:

- Undertake a communication skills course by **30 June 2010**, and advise HDC when he has completed the course.

I recommend that the DHB:

- Arrange a meeting between Ms A and her whānau and Dr B to address Ms A's concerns, and advise HDC of the outcome of the meeting, by **31 March 2010**.
- Review its complaint management process in light of this report, and advise HDC of the outcome of its review by 31 March 2010.
- Ensure that Dr B undertakes a communication skills course by **30 June 2010**.

## Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand.
- A copy of this report with details identifying the parties removed, other than the name of Dr B, will be sent to the Royal Australasian College of Surgeons.
- A copy of this report, with details identifying the parties removed, will be sent to the Federation of Women's Health Councils Aotearoa, Women's Health Action Trust, Eating Difficulties Education Network, and all district health boards, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.