General, Laparoscopic and Endoscopic Surgeon, Dr B

A Report by the Health and Disability Commissioner

(Case 01HDC00755)

Parties involved

Mrs A	Consumer
Dr B	Provider / General, Laparoscopic and Endoscopic Surgeon
Dr C	Abdominal and Laparoscopic Surgeon
Dr D	General Practitioner
Dr E	Clinical Psychologist / Counsellor
Dr F	General Practitioner

Complaint

On 17 January 2001 the Commissioner received a complaint from Mrs A about the services provided by Dr B. The complaint was summarised as follows:

- *Dr B performed a laparoscopic gastric banding procedure on Mrs A believing that it would not work.*
- *Dr B did not tell Mrs A that the success of the operation was dependent on fairly large amounts of exercise.*
- *Dr B did not present her with any alternatives to the procedure, and did not refer her to a surgeon who was developing other laparoscopic weight loss operations.*
- *Dr B proceeded with the surgery even though he believed that Mrs A had not lost the required amount of weight pre-operatively.*
- *Mrs A is concerned that another doctor may have participated in or observed her surgery, without her knowledge or consent.*
- *Mrs A developed post-operative complications and contacted Dr B on two occasions. He advised her not to attend the hospital even though the wound site was bleeding.*
- *On a number of occasions Mrs A asked Dr B why she had such major and extensive bruising after the surgery but was provided with different explanations.*
- *Mrs A advised Dr B that she had changed her general practitioner but he continued to send information to her former general practitioner.*
- *Mrs A is concerned that her general practitioner told her to continue taking Clexane but Dr B stopped it.*
- *On 30 March 2000, Dr B wrote to Mrs A's general practitioner incorrectly advising that she had lost 6kg that month.*
- *Mrs A believes Dr B used his correspondence to the general practitioner to blame her for her lack of progress.*
- *Dr B did not explain to Mrs A, or advise her general practitioner, why the lap band was not being inflated.*

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- *Mrs A believes Dr B failed to show her respect. She said he called her a liar, failed to consult her, continually blamed her for her failure to lose weight and ridiculed her attendance at the support group. Dr B also expressed anger towards Mrs A but would not tell her what it was about.*

An investigation was commenced on 12 February 2001.

Information reviewed

- Relevant medical records from Dr B, Dr C and Dr D
- Reports from counsellor Dr E, and the dietician
- Mrs A's medical records from the public hospital
- Report from an independent abdominal and laparoscopic surgeon, Professor Iain Martin

Information gathered during investigation

Background
Laparoscopic gastric banding is used in the treatment of morbid obesity. The procedure involves placing an inflatable band around the upper stomach to create a new and smaller partition. The aim of the procedure is to make the patient feel full with a lot less food.

In mid-1999 Mrs A saw a television programme during which Dr B, a general and laparoscopic surgeon, discussed laparoscopic gastric banding ("lap banding"). She telephoned Dr B's rooms and asked for information to be sent to her. Mrs A discussed lap banding with her general practitioner, Dr F, on 6 August 1999, but no referral was suggested.

Information about procedure
Dr B sent Mrs A a patient information sheet on lap-band surgery for treatment of morbid obesity, which stated the following:

> "…
>
> 'WHO IS SUITABLE'
> THIS IS ONLY FOR THOSE WHO ARE 'MORBIDLY OBESE'. This means you are in dire straights as your weight is causing dangerous health risks. These risks escalate dramatically when you are morbidly obese, as opposed to just overweight. Generally, we are talking about 100 lbs (45 kgs) over your ideal weight, or a Body Mass Index (BMI) over 30. This index is calculated from your present weight and your height. Not only must you be morbidly obese, but you must be suffering from a complication of your

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weight, whether it be illness, psychosocial, or physical impairments. You must also have evidence of real attempts to lose weight in the past.

'WHAT IS THE SURGICAL PROCEDURE'
The surgery is not a cure. It helps you to achieve a healthy diet and lifestyle by suppressing your appetite. It will not work unless you are committed to the programme. Unlike diets, it is a lifelong aid, and therefore requires a lifelong commitment from you.

The surgery involves placing a band around your upper stomach that can be inflated, deflated, or even removed to allow your stomach to return to normal. This requires a general anaesthetic, and placement of the band with laparoscopic ('keyhole') surgery.

'WHAT IS INVOLVED'
This is not simple surgery. Morbidly obese patients are a significant anaesthetic risk, and need careful pre-operative assessment and workup. Patients who are suitable will be assessed by a surgeon trained in laparoscopic surgery and qualified for this particular operation. They will then go to assessment by a clinical psychologist, dietician, specialist physician, and a specialist nurse. As it is a lifelong commitment, you will need to be seen regularly for the rest of your life, but eventually just once a year. You must be committed to a lifelong regime of correct eating habits, with rules. Hospitalisation is usually for 3 days, taking liquids only for the first month and then easing into more solid foods. Frequent visits to the clinic are needed to adjust the diameter of the band.

'IS THE PROCEDURE SAFE'
This is a relatively new procedure, although variations of the technique have been used for many years, but using conventional surgery. These other procedures were not easily reversible. The band is made of solid silicon as opposed to that used in breast prostheses, and therefore cannot leak. There is a significant risk in the procedure, which demonstrates the severity of problems faced by the morbidly obese. The beauty of this procedure is that the band can be removed at any time in the future, although that is not the intent of the operation.

'WHAT ABOUT THE COST'
It is no doubt expensive, as you will have to buy a new wardrobe if you are successful in your weight loss! The lap band alone costs $2,800! The total cost for the operative procedure and post-operative care, until you are back onto normal food, will probably be in the order of $10,000–$11,000.

'WHAT NEXT?'
If you think you may qualify, phone the clinic, giving your weight and height, and any medical illnesses you have. You will be told if you are morbidly obese and whether it is worthwhile to come in for an appointment for further evaluation and discussion. A referral letter from your GP detailing past illnesses and medications will be necessary. Names and addresses, preferably relatives, will be required to enable us to contact you in the future should we lose you in follow-up. This demonstrates our commitment to you, and stresses that this is indeed a lifelong commitment."

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Initial consultation – Dr B

On 6 September 1999 Mrs A consulted Dr B about the lap band procedure. She had made an appointment without a letter of referral from her general practitioner. Mrs A told Dr B that she needed to have hip joint replacement surgery and had a longstanding back injury, and that these were her reasons for seeking surgery to help her lose weight. She told Dr B that she believed her inability to control her weight was due to her back injury.

After the consultation Dr B wrote to Mrs A's general practitioner at the time, Dr F, as follows:

> "I saw [Mrs A] today, who came up to [me] to see about laparoscopic adjustable gastric banding for her morbid obesity.
>
> Her story is fairly typical though I did not delve too deeply into some of the background. In essence the hour was spent in getting some information about when and how weight became a problem, and her genetic background regarding weight. As usual with these patients, she has tried all sorts of diets, and is able to lose weight but is unable to sustain that weight loss. In fact the ultimate weight gain is higher than the weight at which the diet was started.
>
> There was no significant family history. She has various joint pains, and also I gather has established osteoarthritis.
>
> The main reason for seeking advice about her weight problem is her concern regarding her lack of mobility, and the pain in her joints. I gather the orthopaedic surgeon that she has seen in the past has strongly recommended some weight loss, and this conversation together with conversations held by you, led to this consultation.
>
> As she deals with stress counselling, and counselling of sexual abuse and marriage, she may find the programme a little of a problem. As I am not trained in this field, I use a clinical psychologist and counsellor to help. There is no point in me converting a morbidly obese patient to someone who is mildly overweight, but leaving them with the same problems that caused the weight gain in the first place. Therefore all these factors need to be addressed, but I leave it up to the appropriate person to do that. [Mrs A] might have a little difficulty in discussing this with a fellow counsellor.
>
> Her BMI is somewhere around 57-58. Unfortunately, I neglected to do the impedance studies on her, so I could not measure it exactly. This puts her at a severe risk for morbidity in the future.
>
> We discussed the whole problem of morbid obesity and the definition. The lap band was then demonstrated to her, together with what is involved in the surgery, and what the patient can expect pre and post operatively, as well as the ultimate goal. I have stressed repeatedly that the band is an aid to weight loss, in that it restricts the food intake somewhat but also helps in slowing eating down, but its main help is by suppressing appetite. Therefore, as an aid, it is really the patient's attitude that determines the success or not.

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> For that reason, we will not accept a yes from a patient for at least a month. In that month they are put into contact with the lap band support group so that they can ask people directly what is involved and how they dealt with it. If they do wish to proceed after a month of careful consideration, bearing in mind that this is a lifelong decision, they are then seen by the clinical psychologist and the dietician. Their job is to try to prepare patients so that they can handle the requirements of the lap band's diet post operatively. Sometimes there are many psychological problems unearthed, and in fact it would seem that some patients have just too many problems to be able to manage the compliance required by the lap band patients. In other words, we spend a lot of time in selecting patients who might be suitable, and in preparing them for their surgery.
>
> [Mrs A] has been invited to telephone us at any stage with further questions. The telephone contact number for the lap band support group has been given to her. If she does wish to proceed, I will make sure that you are kept informed. She may very well approach you for some further advice, feel free to call me on the [respective number]."

Exercise
Mrs A was concerned that Dr B did not tell her that the success of the operation was dependent on fairly large amounts of exercise. In her view this would amount to at least 30 minutes a day, which Dr B knew she was incapable of because she had osteoarthritis. Mrs A provided a post-operative information sheet from Dr B in which he advised: "By the end of the month you should be exercising a minimum of 30 minutes per day. If you have joint problems you will need to do non-stress bearing exercise." The information sheet describes the part exercise plays in post-operative weight loss, the first inflation, and a special section on informing the patient on things they may experience. It appears that Mr and Mrs A were given this information while Mrs A was waiting to be taken into theatre at a private hospital. Mr A said: "I met [Dr B] for the first time (the day his wife had surgery), I read the post-operation information and instructions that he gave her and I was surprised to read the amount of post-operative exercise that [Mrs A] had to do – 30 minutes a day – and thought that this would be impossible given her hips."

Dr B did not agree with Mrs A's statement. According to Dr B:

> "The statement that the operation doesn't work without exercise is completely incorrect. For many patients, the joint pains caused by morbid obesity prevents them from exercising, and as indicated in the consultation note, weight loss is recommended to allow joint surgery more safely. In fact, we have had several patients whose joint pain has totally disappeared, and even some who have cancelled (postponed) their joint replacement surgery."

Mrs A is also concerned that Dr B did not consult her orthopaedic surgeon about her physical ability to exercise given her arthritic hips and back injury. However, I note that Dr B was aware of Mrs A's joint problems.

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Surgical options
Mrs A was concerned that Dr B did not tell her about any alternatives to lap band surgery and did not refer her to a surgeon who was developing other laparoscopic weight loss operations. Dr B advised me:

> "The patient was referred specifically to me, and not to another laparoscopic surgeon. There are two other people in New Zealand who were doing this procedure at that time. I was unaware that [Dr C] was doing laparoscopic gastric bypass surgery at that point. There are several disadvantages to that procedure, which I think are not present with the gastric banding procedure, and in my view, the banding procedure is therefore the choice in most cases."

Dr C was the surgeon from whom Mrs A sought a second opinion and who subsequently performed her gastric bypass surgery. Mrs A said that Dr C told her, "Given my inability to exercise, he would not have performed the lap band surgery." Dr C advised me that he thought lap band surgery would provide the surgical answer for morbid obesity. At the time he saw Mrs A he was "becoming less and less keen" on the band because it was not as successful as he had first anticipated. It was within the context of his disappointment that he told her that, given her inability to exercise, he probably would not have recommended lap banding for her if he had seen her as a new patient. He has since stopped placing lap bands and performs only gastric bypass surgery.

Pre-operative counselling
Mrs A decided to proceed with the surgery. On 5 October 1999 Mrs A consulted Dr E, psychologist, for pre-surgery counselling. Mrs A said she asked Dr B if she could consult someone of her own choosing and was told that this was not permitted. Dr E wrote to Dr B as follows:

> "[Mrs A] presents after careful thought and the pressures that health concerns are starting to exert; she identifies that hip replacement surgery will be required and she needs to have dealt with the weight problem before then. [Mrs A] reports that she and her husband [Mr A] are together on this issue and are both ready to make the changes in diet and meal patterns needed to make the surgery work for her. Her reasons for surgery are health related (hip pain, back trouble, ankle problems and concern about diabetes), and she sees that she has a window for action open now, and that with each year it closes further.
>
> The main reason for weight gain appears to be the common combination of metabolic/genetic factors and the Kiwi meal pattern of larger than necessary meals with large dinners. Weight began to be a problem in her twenties, and slowly crept up, with meals staying larger than they needed to be for her activity level and a drop off in exercise and sport. There are some minor bad habits, which we discussed, things which centre around eating more than is needed for those in our age group. Exercise is a problem area. The challenge is to establish a sustainable program of water based exercise. She has access to a heated indoor pool and will explore an approved exercise programme with a specialist in [her city]. [Mrs A] is a perfectionist and to date has been an 'all or nothing' person. This trait or behaviour has been modified over recent years

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> and she feels ready to approach surgery now, prepared for the one or two year process of weight loss and stabilisation. She reports total support from [Mr A]. She is nervous before surgery and we discussed some simple techniques that she is well aware of, through her work as a counsellor, to apply.
>
> She could be a good candidate for surgery, pre-operative weight loss being predictive, as the liquid only diet will trigger now any negative behaviours that will ankle tap her success down track."

On 6 October Mrs A consulted a dietician on Dr B's referral. The report from the dietician (unsigned) stated:

> "… [Mrs A] has followed numerous diets and admits to doing well and being successful with the weight loss with a Dietitian in [her city]. Today she weighed 166kgs and as her height is 163cm her BMI 62.5. I have suggested to [Mrs A] she aims for weight loss of 36–40kg. …
>
> [Mrs A] does need to establish more balanced nutritional practices and reduce weight prior to surgery. I have encouraged her to start the liquid diet earlier to assist with this …
>
> [Mrs A] does eat a significant amount of high fat food and we need to monitor her carefully. I would strongly encourage her to see a Dietitian regularly in [her city] after surgery."

Mrs A said she was subsequently "surprised" when Dr B told her that the dietician noted her high fat diet. Mrs A said she explained to the dietician that the diet sheet she filled out for the previous week had been atypical, because she was living away from home. She had explained that for the previous year she had been following a low fat, non dairy regime because her husband had had high cholesterol levels.

Mrs A met with Dr B on 6 October 1999 to discuss ways of funding the operation. She wanted to discuss the possibility of approaching ACC for funding, given that her back problem was implicated in her weight gain. She also asked Dr B about pre- and post-operative requirements to be in his city, and what would happen if she became sick. Dr B's clinical notes recorded that Mrs A had "further questions re method" and that she was trying to obtain ACC funding for the procedure. Mrs A was subsequently unable to access funding through ACC or her private medical insurer.

Mrs A's records indicate that on 26 October she cancelled the lap band surgery booked for 1 November 1999. Mrs A advised me that a member of her family living overseas was ill and she went overseas to offer support. Mrs A's records contain a pre-operative checklist for 1 November recording her weight as 155kg.

Mrs A advised me that in October 1999 she consulted Dr F to discuss leaving his practice. On 8 November Mrs A met general practitioner Dr D, at a medical centre in her city. Dr D agreed to be Mrs A's new general practitioner. On 12 November she informed Dr B that

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her new general practitioner was Dr D. She also consulted an orthopaedic surgeon, who confirmed the need for hip replacement surgery after she had lost some weight. After these appointments Mrs A contacted Dr B and 13 December was confirmed as the date for her lap band surgery.

Surgery
Mrs A underwent gastric lap band surgery on 13 December 1999. Dr B sent a copy of his operation note to Dr F, which recorded the following:

> "…
>
> Procedure: General anaesthetic under intravenous perioperative antibiotic coverage. Bair hugger for temperature control. The patient operated on in the sitting position.
>
> The visiport was used to enter the abdomen under direct vision and the liver retractor and further trocars placed under direct vision. The anatomy was normal. Scanning the abdomen did not reveal any other problems. There was no hiatus hernia evident.
>
> The left Crus was dissected free, and the balloon catheter passed by the anaesthetist. The balloon was inflated, and withdrawn gently but there was firm resistance at the hiatus – ie there was no hidden hiatus hernia present. The tunnel for the band was then chosen, the balloon deflated and withdrawn, and a tunnel made behind the gastro-oesophageal region. Some minor difficulty was had in creating a tunnel but this was eventually achieved successfully. The lap band placement tool was then passed on the first pass, the lap band introduced, and then fitted around the gastro-oesophageal area and snugged in place over the reinflated balloon. Five interrupted tycron sutures were then used, with a suture medial and a suture lateral, and the rest anteriorly. Irrigation was then done to remove the small amount of blood left. Catheter brought out through the mid port, shortened, and attached to the access port and ligated.
>
> The access port was then sutured to a pocket over the rectus sheath, tested, and then left inflated with 2.0ccs. Areas infiltrated with marcain. Wounds then closed with subcuticular maxon and steristrips. The patient tolerated the procedure without incident."

Surgery observed by another doctor
Mrs A was concerned that another doctor may have participated in or observed her surgery, without her knowledge or consent. Dr B advised me:

> "I don't know who this other doctor is that she is alluding to. When I asked [the private hospital] to look at their records, someone had written the presence of another surgeon, but this name is unknown to me. It might be the name of another general surgeon who used to work here, whose name is somewhat similar. It is routine around the world for surgeons to observe colleagues, sometimes to give a second opinion about something unusual, and sometimes to pick up little techniques that improve their own surgery. When I have a request for another surgeon or medical professional to come into theatre, as the patient's advocate, I explain to the patient beforehand and obtain their permission.

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> This is also the policy of the [private hospital]. No such form is in the chart, so I'm not even sure if a surgeon was there or not, or why the name was on the operative form."

Mrs A's anaesthetic notes recorded a "professional visitor" in theatre during the operation.

Post surgery
Mrs A recalled that on the morning after surgery Dr B told her she had not lost weight prior to surgery but he had chosen to go ahead with the surgery. Mrs A was concerned that Dr B proceeded in these circumstances. He did not discuss this with her and told her at a previous consultation that to proceed before she had lost weight would be extremely dangerous. Mrs A advised me as follows:

> "I would not have proceeded with the operation if I had been given the choice at this time even though I knew that I had lost approximately 1 stone since my first meeting with [Dr B]. I believe that this would have alerted me to problems with his practice.
>
> A nurse, who has had the lapbanding operation with [Dr B], later informs me that there is at least a 10 kilogram difference between his scales and those at the hospital. [Dr B] knows that his scales weigh light because he has told me that the lapbanders like to get weighed on his!! Why has he not standardised the weights of his scales and the hospital in which he works if the initial weight loss is so important – he told me it was critical."

Mr A confirmed that his wife had several consultations with Dr B before the operation. Mr A did not attend those consultations. When Mrs A decided to go ahead with the operation, they consulted Dr B again. Mr A confirmed that during one of her trips to Dr B's city, his wife was seen by Dr B's psychologist and the dietician. Mr A attended with his wife when she consulted the dietician, who advised his wife that she would need to have a pre-operative fluid diet, for three reasons: so that she could lose weight and her liver would shrink to make the keyhole surgery easier; and to reduce the danger of punctures of organs during the surgery itself.

Mr A could not recall Dr B advising his wife that to perform the operation without prior weight loss would be extremely dangerous. Mr A telephoned his wife the following morning after she had had the operation, and she told him that Dr B had told her she was very lucky he gave her the operation because she had not lost any weight beforehand. Mr A believes that Dr B expected his wife to lose weight but proceeded with the operation even though he knew she had not done so.

Dr B advised me:

> "In the discussion before this surgery, the two reasons for the two week fluid diet before this surgery is explained to patients. The two reasons are firstly to shrink the liver, and secondly, as a measure of compliance. I have no idea about her accusation that I had stated 'to proceed under these circumstances would be extremely dangerous'."

Between 13–21 December Mrs A remained in her city, in hospital and then at the home of a friend. The district nurse visited her to give her Clexane injections. Clexane is an

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anticoagulant prescribed to prevent the formation of clots during and after surgery. In Mrs A's case she was not able to wear anti-embolic stockings because her legs were too large.

Mrs A was concerned that despite advising Dr B that she had changed her general practitioner he continued to send information, including a copy of the operation note, to Dr F and not Dr D. In her opinion Dr B "endangered my health by his poor communication and inattention to details like the change of GP". Dr B confirmed that on 21 December he advised Dr F that Mrs A needed to continue her anticoagulants. Dr B advised me:

> "This is correct [that I wrote to Dr F]. This was an error on my part, and a regrettable one for which I had apologised to her."

Mrs A advised me that neither she nor Dr D received any apology from Dr B for sending information to her previous general practitioner.

Dr D's records indicate that on 15 December 1999 Mrs A telephoned to advise that she had had the operation in Dr B's city and required 10 injections of Clexane post-operatively, six of which were to be given in Dr B's city. When she returned to her city she would require four more injections. The nurse informed Mrs A that they would need special authority from the surgeon. Mrs A indicated that she had the authority and she would bring the medication and the authority from Dr B with her. The district nurse in Dr B's city administered Mrs A's Clexane on 16, 17, 18, 19 and 20 December. Mrs A then returned to her city and the relevant information was faxed to the district nursing service there.

Mrs A consulted Dr B on 21 December 1999. She said she was in "incredible pain" and cancelled her visit to the dietician while she was waiting for Dr B. She had so much pain that she had difficulty moving out of the chair. She discussed her pain with Dr B but he did not examine her or offer any explanation about a likely cause.

Dr B's notes for the consultation on 21 December record his examination of Mrs A and that she had "bruising ++ over the port site". Dr B wrote to Dr F advising him about the bruising:

> "[Mrs A] has made an uncomplicated recovery following her laparoscopic gastric banding, although there was more bruising than usual. However, her legs were such a size that we could not find any sequential compression devices for thromboembolic prophylaxis, and had to give her low dose heparin. I am sure this is the cause of her bruising. Further explanations have been given and I will see her in a month."

Post-operative complications / Clexane

Mrs A developed post-operative complications, primarily wound bruising and oozing as a result of the anticoagulant therapy. In relation to this issue, Dr B advised:

> "The correspondence that you have received from [Mrs A] explains quite clearly why low molecular weight heparin was used instead of the usual sequential compression device. Wound problems are common with morbid obesity, and hence the preference not to use low molecular weight heparin. However, deep vein thrombosis is a

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complication of any surgery over an hour. As indicated in my letters, I am sure the bruising was a result of this, which is a known and accepted consequence of the treatment."

On 21 December Mrs A drove to a town. She got caught in the traffic in Dr B's city, which was very heavy, and she was "just out of it" because the pain was so bad. In the town, Mrs A met her husband and they booked into a hotel. Her wound bled "over the couch and the floor at the [hotel] in [the town]". She recalled that "as per instructions in the event of encountering any problems, I rang [Dr B] and then called the emergency doctor". Mr A confirmed that his wife rang Dr B and asked him whether she should go to a public hospital or get a GP to come to the hotel. She reported that Dr B did not want her to go to the hospital because of the risk of infecting the wound in hospital. There is no record in Dr B's notes of any consultations between 21 December and 18 January 2000. Mr and Mrs A contacted the emergency doctor, who came to the hotel and told her to see her GP in the morning. They returned home the next day.

On 22 December Mrs A saw the district nurse, who cleaned and redressed her wound and commenced antibiotics. There is no record that Mrs A saw her GP.

On 23 December Mrs A telephoned Dr D's rooms because she was bleeding from one of five "port hole" abdominal wounds. Dr D's nurse recorded that Mrs A was on Clexane and that the district nurse was reluctant to give it that day because of the bleeding. The practice nurse telephoned Dr D, who ordered an INR blood test to assess Mrs A's blood clotting ability and asked that the Clexane be withheld until the INR result was available.

The district nurse also telephoned Dr B. He instructed her to re-dress Mrs A's wounds and "under no circumstances are we to pack or probe the wound". He ceased the Clexane and later confirmed this in writing. Dr B advised me that "stopping the low molecular weight heparin was recommended as per her description of what was happening in the wound i.e. bleeding continued".

The district nurse visited Mrs A on the evening of 23 December to renew her dressing. She noted that Mrs A had changed the dressing 2-3 times that day and would probably require two dressing changes the following day.

Mrs A telephoned the district nurse on 24 December. She cancelled the district nurse's visit because she intended to care for the wound herself. Mrs A advised me that the reason she cancelled the visit was because on a previous visit the district nurse had probed her wound, contrary to Dr B's instructions. Mrs A telephoned Dr D's rooms and it was on this date that she was told her "blood clotting screen was O.K.". Later that day Mrs A telephoned Dr D's rooms again because the wound had oozed blood through the dressing placed five hours previously. Dr D suggested that Mrs A attend the emergency department for review of the wound by the surgical team. Mrs A recalled that she telephoned Dr B and he told her not to go to hospital because of the risk of infection. Mrs A was confused but did not attend the hospital. Mr A confirmed that his wife rang Dr B, who advised her not to go to hospital. Later, he rang back and told her she could go to hospital.

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Mrs A's wound continued to bleed and on 31 December she telephoned Dr D's rooms again. The medical centre's clinical notes dated 31 December record the following:

> "Patient rang this am requesting info on dressings. We do not stock the ones she requires but suggested to try district nurses. Call 1½ hours later asking for district nurse referral which we did for [the public hospital]. At 2.30pm I received a call from the [the public hospital's] district nurses. They have assessed the wound and found a haematoma in situ. Patient says she has had blood oozing from site as well as serous fluid. District nurse said that patient looked anaemic and requests CBC test and to fax lab form to Diagnostics. Discussed with [Dr D]. Would like patient to see surgical registrar at [the public hospital], to start Fe tabs and authorised blood form to be faxed to Diagnostics. I rang the patient and gave her [Dr D's] recommendations. She has been informed by her surgeon not to attend any hospital as she will pick up infections. An appointment has been made for 5/1/00 at 9.40 with [Dr D]."

Mrs A also telephoned Dr B. Mrs A advised me:

> "I tell him that he is leaving me in no man's land. Thirty minutes later he rings back and says I can go to the hospital but tells me that I am to get the registrar to ring him before he touches the wound. The wound is cleaned out and stitched."

Dr B has a different recollection of what happened:

> "In fact, [Mrs A] contacted me directly whilst on my holiday at that time, and I pointed out that it was impossible to assess what was needed to be done at long distance, and she should therefore be seen by a surgeon. [Mrs A] herself did not wish to proceed to a hospital. Finally, after several calls, she did proceed to a public hospital, and I took the opportunity of talking to the Surgical Registrar who saw her at that time, and to give advice at that point."

On 31 December Mrs A went to the public hospital's Emergency Department with a port site haematoma and wound dehiscence. Mr A confirmed that his wife asked the registrar to ring Dr B to find out what to do. The registrar was reluctant to do this, but his wife insisted and provided him with Dr B's cellphone number. The surgical registrar spoke to Dr B. On instruction from Dr B the surgical registrar removed a clot and re-sutured Mrs A's wound. Mrs A was discharged home on antibiotics. On 2 January 2000 Mrs A was referred back to the district nurse for wound dressings. Her records indicate that the district nurse attended on 4, 10 and 13 January and 7 February.

Extensive bruising

Mrs A complained that on a number of occasions she asked Dr B why she had had such major and extensive bruising after the surgery and he told her that it was because she was fat or it was due to the medication used to prevent clots. During her gastric bypass surgery (on 23 November 2000) she received medication to thin her blood and bruising occurred at the injection site only. Dr B advised me that:

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> "… different low molecular weight heparin exist, and there appears to be a personal difference as to the bleeding tendency with these different medications. I am sure that knowing what happened with the medication she was given, [Dr C], I suspect elected to use a different type."

Inflation of lap band
Mrs A consulted Dr B again on 18 January 2000. Dr B advised me that at that appointment Mrs A did not want to be weighed but she told him that her weight was "probably about 140kg" and that she had probably lost some weight. In his experience some overweight people feel guilty for not losing weight and, as he would rather work with the patient than against them, he did not insist that she be weighed. Dr B did not inflate the band and Mrs A understood that it was because of a slight surface infection present. Dr B wrote to Dr F after the consultation advising him as follows:

> "Since my last letter, [Mrs A] has been through quite a bit, which has been emotionally and physically quite debilitating. The extensive haematoma [bruising] broke down causing a minor wound dehiscence [separation of the layers of a surgical wound], which is difficult to judge long distance. However, I put her in touch with a surgical registrar, who let me know what was going on, and he was able to suture the wound with a good result. A tiny superficial infection is present in the skin, and we will wait until that has totally settled before I start inflating the band. We will keep you informed."

Mrs A consulted Dr B on 24 February 2000 when she expected him to inflate the lap band. On arrival she was told that Dr B had been called to assist another surgeon. She was so disappointed that she left the surgery in a "tearful" state. She saw Dr B the following morning. Dr B recorded the following:

> "Hungry. Wound dry. Weight 136kg. Dysphagia – bread. No heart burn or reflux – inflation to 3.0cc …"

Dr B wrote to Dr D on 25 February 2000 advising:

> "[Mrs A] gave [Dr F] as her GP, and I have been sending correspondence to him. I understand that she has in fact changed and is attending you, and that you have obtained her chart. In particular, regarding her laparoscopic gastric banding for morbid obesity, she developed wound problems as a result of her obesity combined with the severe bruising from the low molecular weight heparin that was required at the time of her surgery. However, this has settled and the wound has healed well, and I was able to inflate the band today for the first inflation. Further guidelines and follow-up have been organised. I will make sure that you are kept informed of progress and outcomes."

Lack of weight loss
Mrs A consulted Dr B on 30 March 2000 expecting that Dr B would inflate the band. She had not lost any weight and he did not explain his reasons for not inflating the band. Dr B noted in the clinical records that Mrs A's weight was 130kg. Dr B wrote to Dr D on 5 April advising:

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> "After the last inflation of her lap band, she felt that there was no benefit and her appetite stopped. She still gets dysphagia within the first couple of mouthfuls, which then settles. However, she is not hungry. She is fortunate that she can eat meat and appears to have a good diet. However, she has lost 6kg since last month.
>
> I have again explained to [Mrs A] that the band is working and therefore an inflation is not indicated as it may cause problems. I have constantly reminded her that the lap band is an aid, and attitude and following instruction is essential.
>
> I will keep you informed, and we will keep working with [Mrs A] until we get a better result."

Mrs A was concerned that Dr B incorrectly advised Dr D that she had lost 6kg that month. Dr B advised me:

> "On the 18 January I saw [Mrs A], at which stage she did not wish to be weighed, and she told me her 'weight was probably about 140 kg'. This explains my letter to the GP saying that she had lost some weight, and as mentioned before, we can only work with the information that the patient gives us. I would also point out that many morbidly obese patients feel guilty about their weights, and it is not uncommon for them to avoid being weighed when they are not losing weight. As we are aware of this, and would prefer to work with them rather than unnecessarily upset them, we do not insist on weights."

Mrs A next consulted Dr B on 18 April 2000. He did not inflate the band. Dr B recorded that Mrs A was "still having problems with many foods", she was not losing weight and she was not hungry. He queried why she was not losing weight and noted that Mrs A was for "impedance studies and dietician with programme". Dr B also recorded in the clinical notes:

> "Understandably down in the dumps – disappointed with the results. Will try to persuade her to see [Dr E, psychologist] again."

On 2 May Dr B held a "discussion with GP. Explained situation."

Mrs A telephoned Dr B on 6 June 2000 "to ask him how we should proceed". She recalled the conversation as follows:

> "I spontaneously tape the conversation. I am desperate about the lack of weight loss, I do not understand why I am not receiving inflations and I need to find a way to proceed as I am in agony with my hips and back and am gradually losing my ability to walk, sit and stand. [Dr B] talks about 'playing along with the client' and tells me that he would have put money on my not losing weight with the lap band operation. I am shocked by what [Dr B] says. I feel violated as he tells me that he has carried out an operation on me which he believed would not work. Any vestiges of hope that I had been holding onto were wiped away by his words. I am so shocked that I am unable to address it in the conversation. I change the subject."

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Mrs A supplied me with a tape recording of her conversation with Dr B. She told Dr B that she was concerned about her lack of progress, that the band was "not working the right way" and described her problems with certain foods. She told Dr B that she was having problems controlling the "bulimia" which she was experiencing "quite a bit". Dr B asked her if she was vomiting, which she confirmed. Dr B told her that if the band was in position, there were "only three reasons for that that we've been able to identify for the lack of weight loss". The only way to know if the band was in place was "to do a special x-ray", which involved swallowing barium meal. The barium swallow could be done in Mrs A's city and he could arrange it for her if she decided to proceed.

Dr B told her that some patients do not lose weight and the cause is not known. He said: "Right from the start we've always said it's going to be a long struggle and it's not just a straightforward way to go down … where you're just going to lose a steady weight loss all along, and that most people have problems here and there along the line."

Dr B told Mrs A that over-inflating the band "can actually cause problems … so it's a matter of trudging along and working with the patient and finding out what the problem is …". Mrs A said to Dr B: "So are you surprised that I've had this problem, or not surprised?" Dr B said: "Not at all. No, I would have put money on it." When Mrs A asked why, Dr B told her: "I think because of your attitude. …" Dr B elaborated with the statement "we thought that you were probably going to rely on the band quite a bit – too much on the band". Mrs A asked what brought him to that conclusion and Dr B replied, "Oh, from the beginning, just the evidence of what we've been through before and just a gut feeling, I suppose." Mrs A told Dr B that she was "a little perturbed by all of this" and asked where they went from there. Dr B told her they needed to find out the cause of her problem (whether it was the band itself or a problem with the patient, eg, a nutritional problem). He told her he could organise for her to see another dietician or he could arrange a barium x-ray study at a public hospital. Dr B stated that the decision they needed to make was whether to investigate further at this point, or whether they should just continue and get her analysed to see if there was a nutritional problem. Mrs A told Dr B she would give it some thought. Dr B suggested she contact him if she wanted to proceed with the x-ray. If not, he suggested he would arrange for her to have a lipotrak test and gave her the necessary instructions.

Dr B recorded the conversation in the clinical notes as follows:

> "Still upset about not losing weight.
> Explained again why no inflation done.
> Explained only two causes:
> – band not in place
> – or instructions not followed. …"

Dr B advised me:

> "It is quite incorrect that I did the procedure thinking it would not work. The whole process is designed to try and avoid unnecessary surgery … In the selection process, we

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> can only work with the information the patient gives to us, and therefore make decisions based on that information."

On 16 June Dr B's receptionist telephoned Mrs A. Mrs A's clinical records noted the following:

> "Phoned and left a message. [Mrs A] phoned back and I explained the new dietician and GP (…) coming aboard for weight management team. Their hours were also explained as she will be in [Dr B's city] next week. Invited to phone for an appt. at her leisure. Also passed another message re Abdo x-ray to clarify position of lap band. [Mrs A] will get back to us re decisions."

Mrs A was concerned that Dr B did not explain to her, or advise her general practitioner, why the lap band was not being inflated. Dr B advised me:

> "This accusation is not correct. As the correspondence and notes will show, the only three reasons for not losing weight are well documented, and it is worthwhile to note that it took a lot of persuasion for [Mrs A] to have the X-ray to see if the band was in place and working. You will note that I also went to the trouble of speaking directly to the Radiologist in [Mrs A's city], as well as the subsequent fax that was sent."

Mrs A advised me that it is incorrect for Dr B to say that she took a lot of persuasion to have the x-ray. Dr B told her that he was keeping in mind the costs and not doing unnecessary radiation. He mentioned the x-ray and advised her to phone him back and let him know whether she wanted to proceed. He said he would call her back as soon as they had it set up and give her instructions for the lipotrak test at that time. Mrs A recalled that she asked whether she could have the tests done while she was in Dr B's city. Dr B did not refer her to anyone else after the telephone conversation on 6 June and the final consultation with him on 20 June. Mrs A had consulted Dr D on 1 May 2000 about her concerns that she was not losing weight. Dr D undertook to telephone Dr B for further information. Dr B spoke to Dr D on 2 May but there is no record that Dr D provided any information to Mrs A. On 12 June Dr D recorded that Mrs A decided to seek a second opinion.

Summary of band inflations

The purpose of a lap band is to suppress appetite. Mrs A was concerned that Dr B did not inflate the band. She was not losing weight, and he did not explain the reasons why. The evidence is as follows:

- January consultation – Mrs A reported not hungry and she had an infection so the band was not inflated.
- February consultation – Mrs A reported she was hungry and the band was inflated.
- March consultation – Mrs A described difficulty swallowing and had no appetite. Dr B explained that the band was working – no inflation.
- April consultation – Mrs A was still having problems with some foods, had no appetite, and had not lost weight – no inflation. Dr B discussed a consultation with a specialist general practitioner and Dr E.
- May consultation – No weight loss and band not inflated.

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- June phone call in which Mrs A explained that she was still bulimic. Dr B was unable to explain why she was having problems with some foods and not others. He queried whether the band was slipping. Dr B's office notified Mrs A in June about the new dietician and general practitioner.

Blame for lack of progress
Mrs A complained that Dr B used his correspondence to her general practitioner to blame her for her lack of weight loss. Mrs A attended Dr B on 20 June 2000. She recalled:

> "Because of the GP's inexperience with the lapband, I decide to meet with [Dr B] for one final attempt. I am concerned that the GP will inflate: I have not let go of the idea that there must be some good reason for no inflations to be taking place!! [Dr B] talks about a woman who almost died because of being over inflated. (Much later when I say this to [Dr C], he laughs and I begin to understand that he has used a horror story to keep me from questioning why I have not had inflations.) I leave the consultation early and in great distress. This interview confirms for me that he cannot be my doctor."

Dr B's clinical notes for 20 June record that Mrs A had "demanded to see me". Mrs A advised me that this was not correct. She had telephoned Dr B's receptionist prior to travelling to Dr B's city and had been given an appointment to see Dr B when she got there. She had travelled from her city to Dr B's city specifically to be introduced to Dr B's new general practitioner, whom she also understood to be a bariatrician in a group situation. Mrs A discovered that this new general practitioner had been in practice for only two weeks and was still learning to do inflations. Given that she was experiencing problems she felt it prudent to consult with Dr B while she was in his city and so asked to see him. On Friday 16 June Dr B offered her a lipotrak test on Monday 19 June, but she was then told the test was no longer available. During the telephone conversation Dr B said to Mrs A about the x-ray: "You phone me back and let me know. If you are not happy with it or think I don't want the radiation, it's only another week or so then we'll call you back as soon as we've got it set and give you the instructions for the lipotrak test at that time."

Dr B's records state:

> "Refused to see ATM or bariatrician – demanded to see me.
> BF – porridge. No sugar, mod to size
> L – soup + 11/2 toast
> D – Variety. Can tolerate lean steak and mince … three types of veges
> – over last 1/12 [month], side plate, more heaped
>
> Admits to being able to eat heaps less – seems to be accepting fact that wt is problem.
> Explained yet again appetite and stretch receptors, and importance of using band as an aid – not relying on it.
> States she has lost trust in me – sympathetic to her feeling that way, hence taking time to explain and encourage.
> Tried to make light of a comment to ease her feelings
> – stormed out (has done this before)
> – wouldn't listen to any further reason

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> – slammed door.
> Also discussed previously with … and possibility she [Mrs A] would perhaps discuss things more openly with a woman.
> What to do now? Wait and see if she settles. Call GP."

Dr B telephoned Mrs A on 21 June 2000. Mrs A recalled that Dr B apologised for his remarks on the previous day. Dr B recorded the following:

> "Additional facts recalled.
> – Wanted to know why she could eat as much as she wanted. Explained again about appetite and stretch receptors.
> – When asked if her questions were all answered, she said: '1/2 … still missing.'
> – Wouldn't explain when I offered any further explanations if required.
> On further reflection:
> – Better to have …
> – I phoned her to apologise and explain my remark (no answer on cell phone).
> Explained. Think about it."

Dr B also wrote to Dr D advising:

> "[Mrs A] and I are having a bit of a personality battle here – probably because we are both a bit overworked. However, a goal is to get [Mrs A] to lose weight, which she is not doing. The question therefore is why. If the band is in place, then it works. If there is no weight loss, it's simply a problem that the band is in the wrong place, or the food going into the stomach is of the wrong quality or quantity.
>
> I indicated to you previously, we are all very suspicious that there are some unresolved issues in [Mrs A]'s background, and she may have difficulty in discussing these with me. Hence the offer to talk to our female bariatrician and female dietician. This was declined, but at this point I'm hoping that [Mrs A] will proceed with a barium swallow with cineradiography down in [her city]. I will talk to the radiologist before that to let them know exactly what I'm looking for."

Mrs A said she phoned Dr D to "discuss the problems" and Dr D forwarded her a copy of Dr B's letter of 21 June 2000. Mrs A said:

> "This letter was yet another final straw. His letter says that there is a personality battle, that he suspects unresolved issues from my past and that I declined offered appointments with his GP and Dietician. Contrary to the letter I talk very freely about my cares and concerns and secondly I did not refuse to meet with the new GP and Dietician and, in fact, travelled to [Dr B's city] specially to meet with them. I asked [Dr B] if I could do the Barium Swallow in [Dr B's city] at a Radiologist that he preferred. He indicated that he was having problems with them. My GP, [Dr D], and I discuss ways to get an unbiased second opinion, including the possibility of going [overseas] for this."

Dr D's clinical notes on 29 June 2000 recorded:

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"Discussion re ongoing problems. Is to have barium swallow."

Dr B's clinical notes on 29 June recorded:

"Patient called us – wishes x-ray at [another public hospital]. Discussed with rad[iologist]. Information faxed."

Dr B faxed a request to the radiology centre on 29 June for a barium x-ray. He noted that the first swallow was the most important "to see what happens as the barium reaches the small pouch above the band".

On 12 July Mrs A undertook a barium swallow x-ray at the radiology centre. Results of the barium swallow recorded:

"FINDINGS: A lap band is present inferior to the gastro oesophageal junction. With the patient in a semi-erect position, barium was given and passes freely through the lap band into the body of the stomach. There is a normal primary peristaltic stripping wave within the oesophagus. Only a small pouch is present superior to the lap band which does not increase in size or fill with more barium over time. No gastro oesophageal reflux or hiatus hernia was elicited. Barium passes freely through the remainder of the stomach into the duodenum. There is no abnormality seen elsewhere.

CONCLUSION: Barium passes freely through the lap band with a very small pouch superior to the band. A video has been included with the patient's films."

Lack of respect
Mrs A believes Dr B failed to show her respect. She said he called her a liar, failed to consult her, continually blamed her for her failure to lose weight and ridiculed her attendance at the support group. Dr B responded as follows:

"Again, I would disagree with these actual conversations. I would like to point out that on many occasions I spent a lot of time with her, and she failed to understand the problem, and on one occasion stormed out of the office without speaking to the Receptionist. There was one incident where her personal attack and transference of her problems on to me got a bit too much, and I was rather sharp with her. As this was a normal response to an incorrect accusation, I don't think this qualifies as failure of respect. In actual fact, I followed this up with a phone call a day or two later, to apologise, and to explain that we both wanted her to lose weight, so we should try to work together. However, I realised it might have been difficult for her to continue with myself, so explained the availability of the female Bariatrician and the addition of a female psychologist."

Second opinion/gastric bypass
Dr D wrote to Dr C on 25 July 2000 advising:

"[Mrs A] wishes to avail herself of a second opinion because the lap band is not working in the way it should. Although she has lost some weight this predated the first inflation.

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> There have not been further inflations of the band. A recent barium swallow shows a small pouch but barium passing freely into the stomach; she has a video of the procedure.
>
> The breakdown in communication with [Dr B] is such that he is no longer responding to her concerns."

Dr D's clinical note dated 25 August 2000 recorded:

> "Needs referral to hydrotherapy [for her back]. Saw [Dr C] in [the town] who said he would never have done the surgery [Mrs A] had …"

Dr B sent his clinical notes to Dr C on 18 September. Dr C advised me that Mrs A originally saw him with a request to take over her band care. She was initially seen by his surgical assistant who adjusted the amount of fluid in the band up to the maximum that was reasonable. Mrs A was obviously regurgitating and was not losing weight. Dr C saw her on 30 October and introduced the idea of gastric bypass.

On 30 October Dr C wrote to Dr D advising:

> "I reviewed [Mrs A] today and removed 1ml of fluid from the band as she is getting a lot of regurgitation. She has come to the end of her tether with the band and is requesting gastric bypass. She wants the anaesthetic time to be as short as possible and therefore has requested that this be done open.
>
> I have explained to her the expected outcomes, the risks, benefits and particularly the added risk of leaks. She appears to be understanding of this and we will therefore proceed in the near future, remove the band and do a straightforward gastric bypass."

On 23 November Dr C removed the lap band and performed gastric bypass surgery at the respective hospital. Dr C advised Dr D that the surgery was uncomplicated, that Mrs A had been "discharged well" and that she had a follow-up appointment at his rooms on 1 December 2000.

Dr C advised me that he had performed 18 lap band operations (May 2002), two of which needed conversion to open surgery, which is completely different from lap band surgery. There was no mechanical reason why Mrs A did not lose weight with the band because it was in the right place, the stitching was normal and there was no slippage or pouch dilation.

Dr C provided me with the information about morbid obesity surgery that he now gives his patients. Patients are advised that the results of obesity surgery vary widely and are dependent on a number of factors. Operations that require greater co-operation and "won't" power result in slower weight loss than operations that physically reduce stomach size or cause poor absorption of food. Patients who exercise regularly do better than those who do little, and patients who eat sensibly and obey nutritional rules do better than those who continue to eat poorly. The average loss with gastric banding is 50%, gastric bypass 70%, and after biliopancreatic diversion 80%:

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> "However, within these groups there will be some who lose no weight, and others who get down to their ideal weight. No one can predict the results in an individual."

Instructions specifically about lap banding surgery state that the band is the safest form of obesity surgery and works by adjusting the size of the food passage through the stomach, which means that the patient feels full after eating a small amount of food and loses weight purely from restriction. The downside of the operation is that it requires a significant amount of will power on the part of the patient. Dr C advised that there will be some patients who develop difficulty swallowing or who cannot tolerate the fluid in the band:

> "The major problem with the band has been the need for patients to co-operate. The successes are great for those who take ownership of their lives and work with the band, but in those who can't, weight loss can be minimal, or even non existent!"

Independent advice to Commissioner

The following independent expert advice was obtained from Professor Iain Martin, an abdominal and laparoscopic surgeon:

> "I, Iain Gregory Martin, have prepared this report at the request of the Health and Disability Commissioner. It details the care received by the patient between September 1999 and February 2001. The report has been prepared using the following written information:
>
> 1. Clinical notes from [Dr B]
> 2. Clinical notes from [Dr C]
> 3. Clinical notes from the family doctors concerned
> 4. Transcript of events provided by the patient
> 5. A transcript of a phone conversation between the patient and [Dr B] was also provided. This was recorded without [Dr B's] knowledge or consent. As such I feel I cannot consider the information in my review because I do not feel that such information would be legally admissible should any further action stem from this complaint. I have informed the office of the Commissioner of this decision.
>
> The report will consist of four parts:
>
> 1. A chronological summary of the relevant events;
> 2. An interpretation of said events;
> 3. Answers to specific questions raised by the Commissioner;
> 4. An opinion as to the standard of care.

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Part 1: Chronological Summary

- 6th September 1999. [Mrs A] (DOB ….) consulted with [Dr B], consultant surgeon, …. [Mrs A] had seen [Dr B] on a television documentary discussing the role of the laparoscopic adjustable gastric band in the treatment of clinical morbid obesity. [Mrs A] weighed 150kg and had a body mass index of $57kg/m^2$. [Mrs A] had significant problems with arthritis that was made significantly worse by her obesity and was the primary driver for the consultation. The operation of laparoscopic adjustable gastric banding (LAGB) was explained to [Mrs A] by [Dr B]. It was clear from the clinic letter that it was made clear that the band was not a solution to weight loss in itself but one part of a solution. It would appear that no other surgical options were explored. Arrangements were made for [Mrs A] to be seen by both a dietician and a clinical psychologist.
- 5th October 1999. [Mrs A] was seen by [Dr E], clinical psychologist. A number of issues were discussed and the conclusion of the consultation was that 'she could be a good candidate for surgery, pre-operative weight loss being predictive ….' It was also noted that [Mrs A] would find the exercise programme after surgery a challenge, but that a sustainable programme of water based exercise should be established.
- 6th October 1999. [Mrs A] was seen by a dietician. I was unable to find a written record of this consultation in the notes. It is clear that the dietary requirements following LAGB were discussed.
- 13th December 1999. [Mrs A] underwent LAGB, performed by [Dr B]. According to the operation note, the procedure was conducted in a standard manner.
- 21st December 1999. [Mrs A] was reviewed by [Dr B]. Noted to be making an uncomplicated recovery although some bruising at the operative wounds was noted.
- 31st December 1999. The wound on [Mrs A's] abdomen under which the insufflation reservoir partially broke down, probably following a haematoma. The wound was resutured in [the public hospital's] emergency department following a telephone discussion with [Dr B].
- 18th January 2000. [Mrs A] again reviewed by [Dr B]. As the wound related to the reservoir had not fully healed it was decided by [Dr B] not to inflate the band.
- 25th January 2000. [Mrs A] reviewed by [Dr B] and band inflated with 3cc of saline.
- 5th April 2000. [Mrs A] reviewed by [Dr B]. [Mrs A] reports no benefit in terms of weight loss. [Dr B] reports 6kg weight loss. [Dr B] felt that band inflation was not indicated as [Mrs A] had significant difficulties with swallowing more than a few mouthfuls of food.
- 21st June 2000. [Mrs A] reviewed by [Dr B]. It is clear from both the notes of [Mrs A] and [Dr B] there was a breakdown in the doctor patient relationship and there was considerable dispute about the need to inflate the band.
- 12th July 2000. A barium swallow demonstrated that the lap band was correctly placed and the pouch size was very small.
- 25th July 2000. [Mrs A] was referred by her GP to [Dr C] in [the town] for a second opinion.

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- August – 30th October 2000. [Dr C] reviewed [Mrs A] and tried to further inflate the band. This resulted in regurgitation but not appreciable weight loss. On the 30th October, [Dr C] discussed the possibility of converting the LAGB to a gastric bypass. The operation was explained and a comprehensive leaflet provided.
- November 2000. [Mrs A] underwent gastric bypass, which was performed by [Dr C]. Uneventful recovery.
- 21st December 2000. [Mrs A] seen by GP. 10kg weight loss since surgery.
- 25th February 2001. [Mrs A] reviewed by [Dr C]. Doing well, 25kg weight loss.

Part 2: Interpretation of events

[Mrs A] was a lady with very significant obesity who needed to lose weight because of other health problems, most notably severe osteoarthritis. She self referred herself to [Dr B] after she saw the LAGB procedure on a television documentary. She was seen by [Dr B] and the operation explained. She was also seen by a clinical psychologist and a dietician. As far as I can ascertain, there was no discussion of alternative surgical procedures.

I have some concern regarding the mechanism of referral and this may reflect my UK based training and consultant practice. I feel that it is usually inappropriate for a specialist to see a patient without a referral from a GP. This step provides protection for both patient and specialist and helps to ensure continuity of care.

The LAGB procedure was carried out using a standard technique and there is no evidence at all that the band was misplaced.

After surgery, [Mrs A] did not lose weight, despite adhering to the diet. For any surgical operation to work energy out has to be greater than energy in for a considerable period of time and it seems that because of [Mrs A's] arthritis this was not possible.

The band was inflated with 3cc of saline, which is for most patients more than sufficient, and again there was no weight loss.

As a result of a significant breakdown in the doctor patient relationship, [Mrs A] sought a second opinion from [Dr C] in [the town]. After further unsuccessful inflation of the band, [Mrs A] underwent a gastric bypass operation with good effect in terms of weight loss.

There is great debate in the international surgical community as to the role of LAGB. In Europe it is by far the most commonly performed procedure across a wide range of patients, but in North America the gastric bypass procedure is the standard operation. Most surgeons with a broad interest in surgery for morbid obesity regard gastric bypass as the procedure to which all others should be compared. The LAGB was widely introduced in the mid 1990s and it is fair to say that surgeons differ widely in their opinion of the results of the procedure but many continue to use the procedure as their standard approach to patients such as [Mrs A]. My own personal preference for patients such as [Mrs A] is to use the gastric bypass in preference to a pure restrictive procedure

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such as LAGB because I feel that the results are more predictable and there is greater long-term weight loss. However, as [Dr C] has pointed out gastric bypass is associated with greater short and long-term morbidity. Gastric bypass is in itself insufficient to result in weight loss unless accompanied by dietary changes and graduated increases in exercise. There is no surgical procedure for obesity that is guaranteed to produce weight loss. The information sheet provided by [Dr C] to [Mrs A] concisely summarises the current state of the practice of obesity surgery.

Part 3: Answers to specific questions

- *What particular standards apply in this instance?* Patients with clinical morbid obesity present considerable management problems. There is however general agreement that surgery may play a useful role in the management of some selected patients. The selection relies on assessment by the surgeon and others (such as nurse / dietician / psychologist) over a period of time. Essentially a value judgement is made as to the suitability of the patient for surgery: there are few absolute indicators predicting success or failure. I also believe that it is important to indicate to patients that there is a range of surgical operations and that each has its own profile of benefits and risks. In terms of the work-up of [Mrs A], [Dr B] gave generally what I would regard as very reasonable information and certainly did not guarantee success. There is clearly a difference of opinion between [Dr B] and [Mrs A] as to the emphasis that was placed on increasing energy expenditure. The involvement of dietician and psychologist in this case was in keeping with good practice in this area. These two professionals did not give an indication that [Mrs A] was unsuitable for the proposed operation. Personally I would have liked to have seen a discussion take place between [Dr B] and [Mrs A] regarding other surgical options for treating obesity in order to ensure that consent is fully informed. I note that this is the policy of [Dr C], as illustrated by his information booklet. With the exception of the discussion of other operations, I believe that the selection of [Mrs A] for surgery is in line with standard practice. The standard reference textbook for obesity surgery is Mervyn Deitel's 'Surgery for the morbidly obese patient'. This was published in 1987, with a second volume update added in 2000. The chapters in the update volume on 'Criteria for selection of patients for bariatric surgery' and 'Performance standards in Bariatric Surgery' would support the views expressed above.

  I cannot fault the technical aspects of the operation. Much has been made of the lack of inflation, but 3cc of saline were placed without effect. Further inflation by [Dr C] did not produce anything but side effects.

  It is also important to point out that this was a relatively new operation in 1999 and that experience with the operation and its results is evolving. It is now far clearer that the LAGB's results are not as uniformly satisfactory as would have been suggested by the results published in the late 1990s.

  Should the operation have been done on a patient with limited exercise tolerance such as [Mrs A]? This is very difficult to answer. There are certainly some patients who would do well and some who would fail to achieve significant weight loss.

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Whilst there was no guarantee of success given by [Dr B] to [Mrs A], I feel that it should be made explicit that not all patients lose significant amounts of weight and that some patients do not lose any weight at all.

To summarise, the only areas in which I would question [Dr B's] practice is that he did not document discussion of other alternative surgical procedures and that the risk of less than expected weight loss was possibly not emphasised sufficiently (see the patient information sheet provided by [Dr C]). This is not to say that LAGB could have been reasonably seen as the wrong operation for [Mrs A] when taken in the context of Australasian and European practice in 1999.

- *Was [Mrs A] suitable for LAGB?* This question is at the centre of the case and cannot be answered directly from reading the case notes. The decision whether to consider a patient for obesity surgery depends to a great extent on information gathered during the consultation that often is difficult to fully convey in clinic letters. As far as this case goes, the pre-operative assessment by dietician and psychologist support [Dr B's] view that surgery was suitable. Certainly there was recognition of [Mrs A's] limited exercise tolerance that in itself is not a contraindication provided the patient is aware of this limitation. There is clearly variation in the opinions of [Dr B] and [Mrs A] as to the pre-operative consultation period and the requirements to demonstrate pre-operative weight loss prior to surgery.

  Provided that [Mrs A] was aware of the limitations of LAGB then I would state that she was suitable for the operation. I find it difficult to assess how many of the limitations of the operation were explained and again there is considerable variation in the opinion of [Dr B] and [Mrs A]. Again [Mrs A] would have met international standards for patient selection for obesity surgery as outlined in Deitel's 'Surgery for the morbidly obese patient'.

- *Did the alleged failure to lose weight place [Mrs A] at additional risk?* I do not believe that [Mrs A] was placed at additional risk by her failure to lose weight.

- *Should [Dr B] have referred [Mrs A] to another surgeon?* I believe that the pre-operative consultation should have included a discussion of all of the surgical options available for treating morbid obesity especially the debate between pure restrictive operations and the restrictive/malasorbtive procedures such as gastric bypass. If at the end of the consultation [Mrs A] opted for an operation not provided by [Dr B] then she could have been referred on to another surgeon. Whilst this approach is not adopted by all bariatric surgeons it is certainly recommended as good practice by the international society of obesity surgeons.

- *Was the use of Clexane appropriate?* The answer to this question is straightforward – yes. There is no doubt that undergoing surgery for morbid obesity places the patient at increased risk of developing a deep vein thrombosis and I (and every bariatric surgeon I am aware of) uses thrombosis prophylaxis including low molecular heparins such as Clexane. I have no concerns at all regarding the use and stopping of Clexane.

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- *When should the LAGB have been inflated?* I think the first inflation was carried out at an appropriate time. It would not have been appropriate to inflate the band when the wound had not fully healed. 3cc of saline was injected which was at the upper end of the volume that would be used at a first inflation. Should a further inflation have been made? Whilst it may have been desirable for [Mrs A] to at least see whether a further inflation would have had further benefit it was [Dr B's] opinion that it was unlikely to be effective. This opinion was supported by the failure of a further inflation under [Dr C's] supervision to produce meaningful weight loss. I cannot therefore say that the inflation protocol adopted by [Dr B] fell below appropriate standards.

- *Was the overall postoperative care appropriate?* The postoperative period was defined by the deteriorating relationship between [Dr B] and [Mrs A]. This coloured all aspects but within this limitation there were no specific concerns with the postoperative care.

Part 4: Opinion of the standard of care

The primary issue in this case is whether the preoperative consultation and consent process were appropriate and carried out to an acceptable standard. Whilst there is some discussion regarding other issues such as the use of Clexane and whether a further inflation was indicated, there is no evidence that I have seen to suggest a fall in the standard of care below an acceptable standard in these areas.

There is no reason to suggest that [Mrs A] was unsuitable for obesity surgery. The use of the dietician and psychologist as part of the process reflect good practice. As indicated above, I feel that the preoperative consultation should have included wider aspects of bariatric surgery and other options should have been discussed. It is however important to recognise that the limitations of the LAGB were not so clear in 1999. Whilst it is implicit in the information sheet signed by the patient that weight loss is not guaranteed I think this point should have been made somewhat more explicit. The information sheet provided by [Dr C] is very much in line with the sort of information that bariatric surgeons would now provide patients. The relevant question here is 'what would a reasonable patient expect to have been told' and I believe that other options should have been discussed. One could produce an argument that the patient referred herself for the LAGB procedure specifically and as such there is an increased onus on the patient to research the procedure and the chances of success, however I believe that in the context of medical practice in New Zealand this fact does not remove from the doctor the need to explore alternatives.

I could not however state that LAGB was the wrong operation for [Mrs A] – clearly in retrospect it was but I do not feel there is evidence to state that this was so prior to surgery. The fact that one surgical procedure did not work as desired and a subsequent operation did does not *de facto* mean that there was a fault in suggesting the first procedure.

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I would also add that I believe it is unwise for a specialist to see a patient without a referral from either a GP or another specialist. In this case I am forced to wonder whether the fact that the patient first approached [Dr B] following a television documentary has contributed to the problem that arose in the doctor-patient relationship when the result was not as expected.

As indicated in the opening paragraphs of this report I have not used any of the recorded transcripts between [Dr B] and [Mrs A] in reaching this conclusion."

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

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

…

5) *Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

RIGHT 6
Right to be Fully Informed

1) *Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –*

   a) *An explanation of his or her condition; and*
   b) *An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and*

   …

   d) *Notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; …*

Opinion: Breach – Dr B

Mrs A was concerned that Dr B did not inform her about other surgical options for weight reduction, such as gastric bypass surgery.

Mrs A contacted Dr B herself after seeing a television programme on lap banding and he sent her information. She then made an appointment to see him. In Dr B's view she had decided this was the surgery she wanted before she consulted him. She made it clear to him that she was prepared to travel from her city for the surgery and follow-up care. In his opinion Mrs A's surgical opinions, at least within New Zealand, were limited. Dr B was one of a few surgeons performing lap banding in New Zealand and he did not know that Dr C had commenced laparoscopic gastric bypass surgery at the time.

My surgical advisor noted that it would have been prudent for Dr B to have discussed other surgical weight loss options with Mrs A, highlighted the risk of less than expected weight loss, and recorded their discussion. I accept this advice. I do not consider that the fact Mrs A self-referred for a specific operation excused Dr B from his obligation to provide adequate information about alternative treatments. Mrs A was still entitled to the information that a reasonable patient, in her circumstances, needed to make an informed choice. Arguably, Dr B faced a greater obligation to provide information about alternative procedures because Mrs A sought information following a television programme which gave information about only one operation.

I consider that Dr B generally provided Mrs A with (as stated by my advisor) "very reasonable information" about the lap band procedure about which she had enquired. Nevertheless, Mrs A was entitled to be informed about all her surgical options before she consented to surgery and Dr B failed to provide her with this information. Accordingly, Dr B breached Right 6(1)(b) of the Code.

Opinion: No breach – Dr B

In my opinion Dr B provided adequate information about lap banding and treated Mrs A appropriately, and there is no evidence to substantiate the claim that he failed to treat her with respect. It follows that Dr B did not breach the Code of Health and Disability Services Consumers' Rights in relation to the following matters.

Suitability for surgery
Mrs A was concerned that Dr B performed the lap band procedure on her even though he believed that it would not work.

Mrs A was morbidly obese, weighing 160kg and with a BMI of 57–58. She had tried various diets unsuccessfully, and her weight was causing significant health problems. She met the criteria for surgery as an aid to weight reduction. Mrs A saw a television programme about lap band surgery which prompted her to telephone Dr B for more

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information about the procedure. Lap band surgery was relatively new to New Zealand and was one surgical option available to aid weight loss.

The evidence shows that Dr B took considerable care to assess Mrs A's suitability for surgery. He had a preliminary meeting with her, discussed the operation, demonstrated the lap band, described how the band worked to suppress appetite and emphasised that the band was an aid to weight loss. Because the success of the operation depended on patient commitment, he took particular care to discuss the patient's pre- and post-operative obligations. He gave her written information to consider at her leisure. He asked Mrs A to think about the information he had given to her and not to consult him again unless she had further questions. He also gave her contact details for the Lap Band Support Group and urged her to meet with them to discuss the life-long implications of lap band placement.

Dr B had several consultations with Mrs A, in person and by telephone, for the purpose of assessing her suitability for lap band surgery, and sought opinions about her suitability from a clinical psychologist and dietician. My surgical advisor noted that Dr B's pre-operative assessment met international standards. I note in particular my advisor's comments that because a surgical procedure does not produce the desired outcome, it does not mean there was a fault in suggesting that procedure.

Although Dr B may have believed that Mrs A would have initial problems with the band, there is insufficient evidence to conclude that Dr B performed the operation believing that it would not work. Furthermore, there is no evidence that the surgery was clinically inappropriate for Mrs A, or that the lap band procedure would not work for her.

I am satisfied that, in assessing Mrs A's suitability for surgery, Dr B provided services with reasonable care and skill and did not breach Right 4(1) of the Code.

Pre-operative weight loss

Mrs A stated that in the pre-operative consultations Dr B told her that because of the risks the operation would not proceed if she did not lose weight beforehand, yet he proceeded to operate believing she had not lost weight pre-operatively. I am faced with a conflict of evidence as Dr B denied making this statement. However, I note that there is no evidence that Mrs A needed to lose a certain amount of weight before she had lap band surgery. As a morbidly obese person she was, as are other obese people, at substantial risk during and following surgery because of her size.

Furthermore, prior to surgery, Mrs A's dietary habits were assessed by a dietician. The dietician commenced Mrs A on a fluid-only diet, which is prescribed for patients undergoing this surgery for two reasons: to reduce liver size and as an indication of compliance. Mrs A said she lost about a stone in weight before the surgery and the documentation supports this.

Although Dr E suggested to Dr B that pre-operative weight loss could be a predictor of post-operative success, my advisor informed me that Mrs A was not placed at any additional risk because she had not lost more weight before the operation. There is no evidence that Dr B considered Mrs A unsuitable because she had not lost a specific amount

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of weight prior to the surgery or that this placed her at additional risk. Accordingly, in my opinion Dr B did not breach Right 4(1) of the Code by performing the lap band procedure on Mrs A notwithstanding her failure to lose weight pre-operatively.

Success dependent on exercise
Mrs A believes that she was not a suitable candidate for lap banding because, in her view, success depended on a programme of at least 30 minutes of exercise a day. Mrs A provided me with an information sheet that Dr B gave her after the operation, advising that one month after surgery she should be exercising for 30 minutes a day. She could never exercise to this extent because she had osteoarthritis. Dr B knew this and therefore, in Mrs A's opinion, he did not adequately assess her ability to exercise.

Morbidly obese patients are often unable to exercise because of their size. Dr E identified Mrs A's inability to exercise as a "problem" but noted that she had access to a heated pool and suggested this as a "sustainable program" for exercise. He advised Dr B that Mrs A would pursue this as an exercise venue.

My advisor noted that although Mrs A would have been more likely to lose weight if she had been able to undertake a sustained exercise programme, her inability to exercise did not preclude her from lap band surgery.

There is no evidence that there was a requirement to exercise for at least 30 minutes a day from the time Mrs A had the lap band placed or that Dr B misled her. In my opinion Dr B did not breach Right 4(1) of the Code by performing lap band surgery knowing that her ability to exercise was limited.

Clexane
Mrs A was on anticoagulant therapy to prevent blood clots, which could be life threatening. Mrs A continued with the injections after leaving the hospital and upon her return to her city. My surgical advisor noted that this was "absolutely appropriate" because Mrs A was at substantial risk of developing a deep vein thrombosis.

Clexane inhibits blood clotting and can cause bruising and bleeding particularly around surgical wounds and at injection sites. Dr B informed Dr D about the Clexane and explained its effects to Mrs A. When her wound continued to ooze he stopped the medication. I note that the literature provided by Dr C indicates that people who are obese are more prone to wound complications.

Mrs A said that she was confused when Dr B told her to cease Clexane contrary to the advice from her general practitioner. My surgical advisor noted that it was entirely appropriate for Dr B to prescribe Clexane and to stop it when Mrs A's wound ooze continued. I accept this advice. In my opinion Dr B's instruction to stop taking Clexane was appropriate and he did not breach Right 4(1) of the Code.

Communication with other providers
Mrs A has the right to co-operation between providers, including her general practitioner and district nurses.

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Dr B acknowledged that he did not update his records and continued to send information to her previous general practitioner. He apologised for this mistake. From 25 February 2000 he communicated directly with Dr D. There is no evidence that Dr B's mistake in any way endangered Mrs A's health.

Mrs A had direct communication with Dr B from December 1999, when she was discharged from hospital, until she transferred to Dr C in August 2000. She was able to contact Dr B during his holidays. He communicated directly with the district nurses in both cities, and the district nurse in Mrs A's city telephoned Dr B about the Clexane injections. Dr B and the surgical registrar discussed the most appropriate treatment for Mrs A before she was admitted to the public hospital. In his letter to Dr D on 25 February Dr B brought her up to date with Mrs A's wound problems and band inflations. Dr B wrote to Dr D again on 5 April and telephoned her on 2 May about Mrs A's lack of weight loss.

In my opinion Dr B did not attempt to mislead Dr D about Mrs A's weight loss. The evidence suggests that Dr B went to some lengths to keep Dr D and Mrs A's other health care providers well informed about her treatment and progress. In these circumstances, Dr B did not breach Right 4(5) of the Code.

Blaming Mrs A for lack of success

There is no evidence to substantiate the claim that Dr B used his correspondence with Dr D to blame Mrs A for her lack of weight loss. To the contrary, the evidence suggests that Dr B was concerned that Mrs A was not losing weight, and corresponded with Dr D to organise appropriate tests to find the reasons. He referred her to a dietician and a counsellor, and for a barium swallow to see if the band was in the correct place. My surgical advisor noted that Dr B provided services in accordance with professional standards.

It is clear that while Mrs A expected a slow, steady weight loss from the lap band, Dr B knew this rarely happened and problems could be expected along the way. Clearly, communication between Dr B and Mrs A broke down. However, I am satisfied that Dr B was genuinely trying to find the reasons why the lap band was not working. I have no reason to believe that Dr B misled Dr D or attempted to blame Mrs A for the lack of success.

Explanation about band inflations

Mrs A complained that Dr B did not inflate the lap band when she was not losing weight but did not explain his reasons. Dr B said he told Mrs A that in his opinion the band was working and it would be dangerous to over inflate it.

It is clear that Mrs A expected that at each consultation Dr B would inflate the band. She knew, from the pre-operative information, how the lap band acted as a means of suppressing appetite, and that she would need to attend the clinic frequently to have the band adjusted. The evidence is that Mrs A knew why Dr B did not inflate the band on 18 January. She had a slight wound infection and she was having problems swallowing some foods. Dr B inflated the band with 2cc of fluid at the completion of surgery and added 3cc of fluid on 22 February. At the April consultation Mrs A reported that she was not hungry

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and was still experiencing difficulty swallowing. During her telephone conversation with Dr B in June, she told him she continued to have problems with "some foods" and vomiting.

It is clear that there are particular criteria for band inflation. My surgical advisor informed me that it was appropriate for Dr B not to inflate the band when the wound remained infected and to inflate the band with 3cc of fluid when Mrs A reported feeling hungry. This was "the upper end of the volume that would be used at a first inflation". My advisor noted that while it might have been appropriate to attempt further inflations he accepted that Dr B thought it would be ineffective. This was borne out by Mrs A's inability to tolerate further inflations under Dr C's supervision.

My surgical advisor commented that Mrs A's post-operative care was "defined by the deteriorating relationship" between Mrs A and Dr B. Dr B recognised that he was unable to provide Mrs A with the post-operative care she needed. I agree with this assessment. In my opinion Dr B attempted to provide Mrs A with information that a reasonable patient, in her circumstances, needed and did not breach Right 6(1)(a) of the Code.

Post-operative complications
Mrs A developed extensive bruising around her wounds and bleeding. She complained that Dr B did not appropriately advise her of its cause, and that his instruction not to go to hospital was unhelpful.

Dr B told Mrs A that her bruising was probably caused by the anticoagulant and because of her size. Dr B was in his city and Mrs A in hers. Dr B said that he wanted Mrs A to go to hospital but she was reluctant to do so. Finally, he contacted the surgical registrar and instructed him how to treat Mrs A's wound.

I am faced with a conflict of evidence. Mrs A said that Dr B told her not to go to hospital; Dr B said that he did advise her to attend hospital. The evidence shows that Dr B spoke with the registrar at the hospital to arrange appropriate surgical treatment for Mrs A.

In my opinion Dr B's explanation about the likely cause of wound complications was appropriate and accurate. I have been unable to resolve the conflict of evidence concerning whether Dr B instructed Mrs A not to attend the hospital. However, I note that Dr B discussed Mrs A's case with the surgical registrar to ensure she received appropriate care for her wound complications. In these circumstances, Dr B did not breach Right 6(1)(a) of the Code.

Visitor in theatre
Mrs A claimed that there was an observer in the theatre, or another doctor participated in her surgery, and that she was not consulted about and did not agree to this. Dr B advised me that it is not unusual for another surgeon to observe surgery as part of his or her education. It is Dr B's usual practice, when asked if an observer can attend, to seek the patient's permission. In this instance he was not aware, until he checked the private hospital's record, that there was another doctor in the theatre and he cannot recall how this happened. No other doctor participated in the surgery.

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Mrs A had surgery in a private hospital. The anaesthetic notes recorded that a "professional visitor" was present. Mrs A had not been asked if he could observe her surgery. She was entitled to be asked, under Right 6(1)(d) of the Code. However, I have no reason not to believe Dr B's assurance that he had no prior knowledge of a professional visitor and that he cannot recall an observer being present. In these circumstances, I am satisfied that Dr B did not breach Right 6(1)(d) of the Code.

Respect

Under Right 1 of the Code Mrs A has the right to be treated with respect. She said that Dr B called her a liar, failed to consult her, blamed her for her failure to lose weight and ridiculed her attendance at the Lap Band Support Group.

Whether Dr B called Mrs A a liar has not been established but I can find no evidence that Dr B failed to consult her. Furthermore, Dr B provided Mrs A with the contact details of the Lap Band Support Group pre-operatively and after surgery, when she was becoming disheartened at not losing weight. In light of this I doubt that Dr B would have ridiculed her attendance at the group.

It is clear that Mrs A's and Dr B's relationship became strained. Mrs A was frustrated by the lack of success and Dr B's attempts to seek a solution. Mrs A told Dr B that she no longer trusted him and he acknowledged why she would feel this way. Recognising that his communication with Mrs A was unproductive he attempted to distance himself by referring her to other members of the weight reduction team and suggesting further investigations in Mrs A's city. Dr B acknowledged their frustrations in his letter to Dr D but indicated that the most important thing was to establish why Mrs A was not losing weight.

I acknowledge Mrs A's feeling that Dr B did not treat her with respect; however, in my opinion, Dr B's behaviour did not demonstrate disrespect for Mrs A but a genuine attempt to reconstruct a deteriorating relationship. I am satisfied that Dr B provided services that were reasonable in the circumstances and did not breach Right 1 of the Code.

Actions taken

- Dr B has added information about alternative surgical weight loss treatment to the information available on his website.

- In response to my provisional opinion, Dr B provided a written apology to Mrs A for breaching Right 6(1)(b) of the Code.

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Further 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, will be sent to the Royal Australasian College of Surgeons and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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