

Reflections on the Bundaberg Hospital failure

Anthony P Morton

Present-day public hospitals are often lacking in humanity, costing more and doing less, and run by executive staff with minimal clinical knowledge

Jayant Patel is a general surgeon, based in the United States, who was employed at Queensland's Bundaberg Hospital from 2003 to 2005. He withheld information that in 2001 he had agreed to surrender his New York State medical licence, and that prior to that the scope of his surgical practice was restricted in Oregon.¹ These matters were not investigated in his assessment by the Queensland Medical Board, and he was appointed Director of Surgery at Bundaberg Base Hospital in 2003. It is alleged that his work in Bundaberg was seriously substandard, and the deaths of close to 90 patients were being investigated by a Commission of Inquiry² headed by Anthony Morris QC. The Commission was examining issues connected with Dr Patel's appointment (and the registering and monitoring of overseas-trained doctors in general); allegations and complaints about procedures conducted by Dr Patel; and improvements to Queensland Health to ensure that future clinical complaints and allegations are properly received, processed, and investigated. With the Inquiry's recent termination on the basis of a perception of bias, a final report will not be forthcoming.

A concurrent Queensland Health Systems Review³ headed by Peter Forster, a consultant with wide experience in the review of government organisations, released an Interim Report in July 2005 that is critical of Queensland Health.

The current obsession with finding and punishing "Dr Death", as Patel has been called, instead of dealing with the system that sponsored him, seems likely to ensure that, when the dust has settled, the status quo will prevail. The Bundaberg Hospital scandal is a symptom, and more attention needs to be paid to the underlying causes. Work is performed within systems and its quality is determined by the quality of those systems. People generally do what the system requires. With all the media mayhem, we should not forget that many able people work for organisations like Queensland Health.

I believe that the current problems in Australian hospital systems have their roots in the "reforms" of the 1980s: the development of corporate structures and managerialist management systems.^{4,5} Corporate structures devalue clinical involvement, alienate hospital communities, diminish humanity, and result in a burgeoning corporocracy. The managerialist approach produces staff and bed shortages, long waiting lists and excessive bed usage.⁶ It concentrates on business plans and targets, and negative short-term financial objectives, producing perverse economic activity; managers are rewarded for "quick fix" solutions.

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This can result in inaction and deferral of work. For example, there are concerns about waiting lists for surgery and delays with specialist referrals.^{3,6}

The period since the 1980s has also seen considerable politicisation of public services in Australia.^{7,8} This can result in bias, inappropriate appointments and excessive use of secrecy and spin.

Good systems are designed deliberately to produce high quality work.⁹ By eliminating waste, delay and the need to redo substandard work, they achieve long-term cost effectiveness. All good hospital departments have leaders who are clinically competent, but they must also be just, transparent, energetic and committed. They have the ability to transform their staff into effective teams. Team "ownership" results in people working to improve systems instead of merely using those systems to further their own ends.

When I was a junior resident medical officer in Townsville Hospital in 1960, the hospital was of intense interest to the local community, and this "ownership" was a strong incentive to hospital staff. In addition, the Medical Superintendent was a competent and active general surgeon. The hospital made remarkably efficient use of the resources available to it. I don't remember there being any waiting lists.

Contrast this with present-day public hospitals — they are likely to be isolated from their communities, lacking in humanity, costing more and doing less,¹⁰ and run by executive staff with minimal clinical knowledge.

There are other problems besetting Australian hospitals. For example, many have been slow to adopt safe systems. New intravenous device technology has been demonstrated to reduce the risk of needlestick injury.¹¹ Many hospitals are yet to define and mandate best practice for the use of intravenous devices — the major source of hospital acquired bacteraemias.¹² Although the immediate costs of such initiatives may be considerable, the treatment of a potentially preventable blood stream infection that endangers life can cost tens of thousands of dollars, and an injury with a contaminated needle may lead to chronic illness, substantial economic loss and potentially shortened life.

In addition, hospital systems have not capitalised on the advantages of information technology. Communication and the dissemination of knowledge are vital in the complex dynamic systems that are modern hospitals, and this requires efficient communication systems.³ Yet, hospital IT departments can become corporate empires dedicated to the control of computer hardware and software — they often seem to do more to inhibit communication than to facilitate it.

Although the Morris Inquiry was clearly essential, its base cost has been estimated at about \$6 million.² In addition, compensation of those who may have been injured, and repair of those injuries, is likely to entail a substantial financial burden. Ultimately, this money has to come from the pockets of taxpayers and the Queensland economy, and is therefore unavailable for treating patients or educating children. This is quite apart from the moral and personal costs involved, and the damage to staff morale when a job is either not done or done badly.

So, what can be done? Unfortunately, the culture of the managerialist corporocracy is so deeply embedded in public administration in Australia that no quick answer seems likely. And, according to the late popular historian Barbara Tuchman, when something fails, it seems humans are inclined to believe that the solution lies in doing it twice as hard.¹³

One thing that could be done now is to make central offices behave like coaches rather than controllers and judges. Good coaches are able to mould effective teams, they are expert at dealing with poorly performing players, and they themselves are expendable if the team persistently underperforms. In addition, really good coaches think of the longer term. Politicians and senior staff in central offices need to relearn the motto of the schools some of them attended: "cui servire est regnare" — to serve is to rule. Quality is always positive; we can only ever do better by having better systems and by learning how to make better use of them. This requires careful systems analysis and systems optimisation.⁹ A fundamental requirement is trust, and this demands justice and transparency.

However, if we are to improve the quality, safety and economy of hospitals in the long term, we need an "idea whose time has come", to quote Victor Hugo (<http://www.geocities.com/Paris/LeftBank/9640/otherq>). Like Maynard Keynes, who found a way to end the Great Depression, we can only hope that succeeding generations will be able to see more clearly the reality of things as they are. To create an enduring and worthwhile hospital system, public administration has to move beyond corporate structures and managerialist management approaches.

Competing interests: None identified.

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(Received 22 Jun 2005, accepted 9 Aug 2005)

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BOOK REVIEW

Nitschke's euthanasia

Killing me softly. Voluntary euthanasia and the road to the peaceful pill. Philip Nitschke, Fiona Stewart. Melbourne: Penguin, 2005 (xi + 354pp, \$32.95). ISBN 0 14 300303 8.

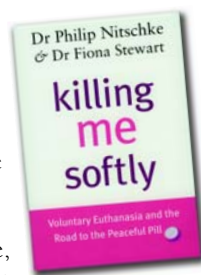
FOR ANY DOCTOR who has followed the euthanasia debate in Australia over the past decade, *Killing me softly* will provide some personal insight into the psyche of the leading protagonist for the pro-euthanasia argument, Dr Philip Nitschke.

In this book, written in a semi-autobiographical style, Nitschke narrates his journey as one of an activist-in-waiting, in search of a cause, who stumbles upon a cause célèbre.

That cause arrives in the form of the Northern Territory's Voluntary Euthanasia legislation.

Dr Nitschke himself is very critical of the medical profession and how he perceives our role in the end-of-life decisions of our patients. He describes himself as being possibly "the most harassed doctor in the country" and as the "chosen walnut ... to be ... crushed by the sledgehammer of the thought police", but seems to see himself as the saviour of the sick and dying.

As you might expect with the first-person narrative of an extreme view, opposing or moderating opinions are articulated only for the purpose of contradicting them.



Nonetheless, the issues he raises are certainly of enormous relevance to many doctors and patients. It is his solution with which you might take issue. It is the very complexity of this ethical territory that stops governments from being able to formulate legislation to govern end-of-life decisions.

During my Presidency of the AMA, I argued, against some fierce opposition, to invite Nitschke to the 2002 AMA National Conference to participate in a policy debate on end-of-life decisions. This was based on the belief that good policy can only be formulated when the breadth of opinion is directly canvassed. The lively and at times passionate discussion on the conference floor demonstrated the ethical and practical dilemmas many doctors face in providing compassionate care for the dying patient.

Whether you agree or disagree with Nitschke's arguments for physician-assisted suicide or for the development of a "peaceful pill", you are likely to agree or disagree strongly. I do not believe any doctor could read this book and remain impartial to its contents.

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