

MATTERS ARISING

The “Cam affair”: an isolated incident or destined to be repeated?

Be very afraid

Brad Frankum, Duane Attree, Andrew Gatenby,
Sandy Eagar, Anthony Aouad 362

Staff goodwill is running out

David Rosenfeld 363

Diagnosis before treatment: don't blame funding

Paddy A Dewan 363

In support of the HCCC

John H T Ellard 364

The healthcare complaints system needs reform, and politicians must accept ultimate responsibility

Martin B Van Der Weyden 365

The “Cam affair”: an isolated incident or destined to be repeated?

A recent editorial looked at the way the problems at Camden and Campbelltown hospitals were managed, and has attracted a range of opinions (*Med J Aust* 2004; 180: 100-101)

Be very afraid

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TO THE EDITOR: In reply to your question as to whether the crassly phrased “Cam Affair” was “an isolated incident or destined to be repeated?”,¹ doctors and administrators throughout our healthcare system should be very afraid. They may be next; this was no isolated incident.

We who continue to work in Macarthur Health Service (MHS) expect a daily dose of ill-informed and inaccurate “revelations” about our hospitals in the media. Our despair increases, however, when we read similar superficial comments from your esteemed publication.

For the record, before the leaking of the draft Health Care Complaints Commission (HCCC) report, some of the following systems and solutions had already been put in place at MHS (implementation date in parenthesis):

- Performance management of all staff — including 100% of all senior medical staff — with focus on Key Performance Indicators and implementation of the Clinician’s Toolkit (March 2003).
- Capital development at a cost of over \$100 million (ongoing).
- Appointment of 45 new consultants across a variety of specialties (2000 to September 2003).
- Appointment of an academic full time Director of Medicine (January 2003).
- Establishment of new and innovative services in ambulatory care, acute medicine, emergency short stay, paediatric emergency, stroke, palliative care, cancer therapy, rehabilitation/geriatrics, radiology, community maternity and paediatrics, and mental health.
- A local graduate nurse program with over 85% retention rate (1998–2003).

- Rigorous identification of all adverse events from acute settings by having dedicated staff and weekly multidisciplinary team review of cases (2001–2003).
- Weekly multidisciplinary grand rounds (January 2003).
- An active partnership with members of the community through a Community Council, community review of complaints handling and inclusion in MHS committees (2002).
- A functional and well represented Allied Health Council and Discipline Seniors Committee.
- Well attended and widely represented (including community) Clinical Advisory Council (December 2002).
- Multidisciplinary team meetings and quality review in all specialty departments (July 2003).
- Increase from one to three Royal Australasian College of Surgeons accredited surgical registrar positions since 2000.
- Successful Postgraduate Medical Council accreditation (2003) and recruitment of 6 additional Junior Medical Officers.

Are these the actions of an “indifferent administration”? Was there any attempt to place these adverse outcomes in the context of an extremely busy health service; one with historically the poorest staffing levels of any metropolitan hospital in New South Wales (Box) and a health service existing in a population with one of the highest growth rates in Australia?⁷

No one wishes to minimise the impact on the families of those who suffered

adverse outcomes. However, anyone who works in a public hospital knows that adverse events occur. The established rate internationally ranges from 3.7%–45.8%.⁸ Applying the accepted rate in Australia (16%), Camden and Campbelltown hospitals should have had 26 667 adverse events in the years 1998–2003. The number of cases highlighted in the various investigations (71) represents an adverse event rate of 0.043%.

The only appropriate way to deal with these events is through a rigorous quality framework making use of the expertise of staff at the coalface. The handling of our hospitals’ adverse events by various bodies has set this quality agenda back many years.

In its report, the HCCC showed that it is a completely inappropriate body to be investigating a health service. It investigated and passed judgements on clinician performance without ever consulting individual clinicians. It convened expert panels unsuitable for the nature of the cases reviewed (eg, no Visiting Medical Officer [VMO] involvement on a panel that investigated over 30 cases of patients under the care of VMO physicians). Our State Health Minister shares this opinion.⁹

In 2003, MHS achieved 2 years’ accreditation with the Australian Council on Healthcare Standards.¹⁰ What, then, does this mean? In 2004, significant numbers of senior clinicians have resigned, the administration has been decimated, and there is widespread

Occupied bed-days, emergency department presentations and staffing levels at Sydney public hospitals

	Hospital				
	Bankstown	St Vincent’s	Macarthur	Sutherland	Hornsby
Admissions in 2002/03	26 225 ²	29 681 ³	29 409 ²	19 396 ³	16 964 ⁴
Emergency department presentations (for November 2003) ⁵	2 710	2 755	3 713	2 590	1 922
Salaried medical officers (FTE) ⁶	128.61	266.7	70.83	93.26	108.87

FTE = Full-time equivalent.

bewilderment among the hard-working, skilled and dedicated staff. The media and politicians on both sides have behaved poorly. Ironically, staff now fear to speak out publicly, because to do so may jeopardise the assistance and resources we may finally be afforded.

Obviously the government and bureaucracy would prefer the general public to believe that MHS is the only “sick hospital(s)” in the healthcare system, find some individuals to blame, play catch-up with resources, and watch the problem evaporate. Furthermore, a new threat is emerging: if you undertake investigation into adverse events, you risk confidential cases being easily identified and passed on to the media and regulatory bodies. If you are a clinician and you treat enough patients, one day you will make a mistake.

Be very afraid. The precedent is set — blame is back on the agenda.

1. Van Der Weyden MB. The “Cam affair”: an isolated incident or destined to be repeated? [editorial] *Med J Aust* 2004; 180: 100-101.
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4. Northern Sydney Health Service Annual Report 2002/03. Available at: www.nshs.nsw.gov.au/about/index.shtml (accessed Mar 2004).
5. Actual ED presentations for November 2003. Available at: www.health.nsw.gov.au/hospitalinfo/measures/data/Curr_ED_Qual_CM_H_lookup.html (accessed Mar 2004).
6. NSW Health Services Comparison Data Book 1998/99. NSW Health. Available at: www.health.nsw.gov.au/iasd/iad/yb9899/tables_vol1.html (accessed Mar 2004).
7. Australian Bureau of Statistics. Census 2001. Available at: www.abs.gov.au (accessed Mar 2004).
8. Barraclough B. Safety and quality in Australian healthcare: making progress. *Med J Aust* 2001; 174: 616-617. www.mja.com.au/public/issues/174_12_180601/barraclough/barraclough.html
9. Media Release: Minister for Health. Government responds to HCCC report in Camden and Campbelltown hospitals. 2003. Available at: www.health.nsw.gov.au/news/2003/dec/11-12-03.html (accessed Mar 2004).
10. The Australian Council on Healthcare Standards. Report on the organisation-wide survey for the ACHS Evaluation and Quality Improvement Program. Sydney: The Australian Council on Healthcare Standards, 2002. □

Staff goodwill is running out

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TO THE EDITOR: In response to your recent editorial,¹ I would like to point out the following. The Sydney Metropolitan Area Health Services, comprising Northern Sydney, South Eastern Sydney, Western Sydney, Central Syd-

ney, South Western Sydney and Wentworth, had a budget expenditure for 2001/02 of \$4581 million (information from internal Department of Health documents). The combined population of these health service areas was 3 887 142, and dividing this expenditure by the population gives annual expenditure of \$1178.66 per person.

In 2001, South Western Sydney Area Health Service (SWSAHS) had a population of 797 510,² making it the most populous of all these health areas. Dividing SWSAHS's expenditure by its population gives an annual expenditure of only \$920 per resident. Population projections (an increase of 14.9% from 2001 to 2006) show SWSAHS to be the fastest growing of all, which means the funding per resident will continue to deteriorate.

To spend the 2001 average on SWSAHS residents would require increasing this health service's budget by \$205 million. This is the crux of the whole problem. For far too long, residents of SWSAHS have lagged far behind their metropolitan neighbours in healthcare expenditure. These figures do not even take into account the marked disparity in research funding flowing to other metropolitan areas compared with SWSAHS, nor all the private hospitals and level of privately insured patients in other health areas, which would probably more than double the health expenditures already listed. Further, SWSAHS has the highest ethnic population in the country and is the most socioeconomically disadvantaged; our expenditure on interpreter services and social workers consumes a disproportionate percentage of our funding.

The state Department of Health has long recognised this disparity, and has been trying to redress the problem. However, unless significant additional funds can be generated, resources will need to be redistributed from other Area Health Services. This can be extremely difficult — long-established teaching hospitals have very well resourced support networks and links that go back many years.

SWSAHS includes Liverpool Hospital, which is a tertiary referral service still funded as a district hospital. Unfortunately, the only real surprise to staff working there is that the recent prob-

lems have not happened before, and that they have not happened at more of the hospitals in SWSAHS.

Medical research in SWSAHS is extremely limited. We struggle to appoint advanced trainees. We are trying to teach our undergraduates in an environment with shrinking teaching resources, and the promise of \$5 million is a couple of zeros short of what is needed.

It is only through the goodwill of staff, and their extraordinary commitment, that we have survived this long. Senior medical staff are now leaving in significant numbers because of “burnout” and overwork.

The solution is not money alone, and it is certainly not “working smarter”. Colleges need to make rotation compulsory for advanced trainees so that they can be exposed to a wider variety of clinical cases. There need to be inducements locally to attract staff — including not charging them more for parking than any other hospital!

There are no simple answers, but blaming inadequately trained and resourced staff, who are placed unwillingly in situations beyond their competence, is severely damaging to all SWSAHS staff.

1. Van Der Weyden MB. The “Cam affair”: an isolated incident or destined to be repeated? [editorial] *Med J Aust* 2004; 180: 100-101.
2. Australian Bureau of Statistics. Census 2001. Available at: www.abs.gov.au (accessed Mar 2004). □

Diagnosis before treatment: don't blame funding

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TO THE EDITOR: In your recent editorial, you make the statement “it is hoped that something more substantial than yet another list of blameworthy individuals will emerge from the inquiry”, and then blame funding shortages for substandard care,¹ highlighting how pervasive blame and guilt are!

Nonetheless, your suggestion that we have a sick, politically motivated healthcare system is accurate. Improvement will occur if we, as medical service providers, take responsibility for the deficiencies and accept that we and our system are inadequate for a whole host

of reasons, including less-than-perfect science, and competition rather than collaboration between specialties and specialists, to name just a few. Even more importantly, we are constrained by an unfriendly work environment in much of the public hospital system, for which we blame the budget. Money never made anyone happy!

Unfortunately, hospital administrators are usually not “in for the long haul” and often seem poorly focused on the needs of the patients, let alone the emotional needs of staff — an administrator’s career is more dependent on meeting “targets”. The workplace environment is further marred by the limited ability of some of our clinical colleagues who have been “elevated” to management positions, where they manage budgets, complex interpersonal issues and patient complaints. Strategic planning, root-cause analysis and staff satisfaction are terms without real meaning to many of these doctors, who appear to be set up to fail. Once in the clinical administrative position there seems little in the way of “staff caring” performance review. Interpersonal conflict and politics often predominate, and bullying is facilitated by these high-stress environments, exacerbated by the threats of litigation from patients, some of which occur because unhappy staff lash out at consumers.

As we tend to view adverse events as something for which families will seek legal solutions rather than seeing such events as opportunities for change, we are frightened. Because we are stuck in a culture of fear and blame, we avoid these patients rather than try to share the hurt that comes from an adverse outcome. Thus, minor imperfections are dismissed as inevitable, and for more major adverse catastrophes we seek qualified privilege to feel protected. However, we are not protected by hiding; we are protected by dealing with a complaint as a challenge to improve rather than a reason to abuse the person who points out a deficiency.

At the Royal Children’s Hospital, Melbourne, a senior clinician expressed concern about quality of care, for which he was progressively marginalised, put through an unjust request for resignation, and exposed to a hospital board review conducted with no clinical

expertise and little understanding of bullying. The clinician’s appointment was then terminated because he went to the media, and his termination was justified by a clinical review with restrictive terms of reference. The circumstances were similar to those of the “Cam affair” in the Macarthur Health Service.

The public and the medical community can only conclude that politics, and not standards, drive the health agenda, a view that was confirmed during a recent Victorian parliamentary inquiry into community advisory committees of hospital boards that did not allow major concerns of selected people to be heard by the public. This lack of transparency, and lack of partnership, at all levels, should be replaced with a more open, trusting culture with greater accountability, less blame and less hollow jargon.

When will we ever learn!

1. Van Der Weyden MB. The “Cam affair”: an isolated incident or destined to be repeated? [editorial] *Med J Aust* 2004; 180: 100-101. □

In support of the HCCC

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TO THE EDITOR: Your recent editorial¹ raises some very interesting questions.

The Health Minister commented in his press release that the “HCCC [Health Care Complaints Commission] does not go far enough in terms of finding anyone accountable for these failures”.² He could have set his mind at rest by consulting the relevant articles in the *Encyclopaedia Britannica*. In essence, in the system of government that we have, with Cabinet responsibility, he is the person with the ultimate responsibility. If his departmental and administrative heads did not keep him properly informed and advised, then surely their heads should roll rather than that of the HCCC Commissioner, whose report demonstrated that there were big problems.

I believe that one of your suggestions — that of dismantling the “highly centralised HCCC” and replacing it with regional panels — is very likely to make things worse rather than better.

The first question to be answered in an inquiry of this kind is whether or not there was medical error, incompetence or impropriety. This involves a careful and detailed examination of the information available about the event or events in question. There are allegations and responses, and there is often a large body of clinical notes, hospital records and laboratory results to be read most carefully and considered.

Sometimes the issues are simple, and sometimes they are complex, requiring the assessor to have considerable experience, detailed specialist knowledge and to make literature searches. Not every local area will have a sufficiently wide range of expert assessors. The capacity to find competent, experienced, unbiased assessors diminishes as the geographical and administrative areas to be considered become smaller. Remember that the HCCC has to deal with all the registrable healthcare professions — not only medical practitioners, but psychologists, nurses, physiotherapists, osteopaths and the like. Consider the amount of time and effort required to set up the panels in all these activities in each local area.

I will conclude by indicating what I believe to be the fatal error in your suggestion. Imagine that the preliminary inquiries strongly suggest that the problems in question arose from a lack of resources and that the government of the day is substantially responsible for what happened. I have the greatest difficulty in believing that the area’s state and federal politicians would be capable of coming to an opinion which laid the fundamental blame on the government of the day, if it happened to be that of their party. I believe that the “Cam affair” provides an indication of what would happen.

I have been associated with the present system since it began as the Complaints Unit and then became the HCCC. I do not suggest that it has reached perfection, but long observation convinces me that it has played a valuable role and that many errors and improprieties in medical practice have been much diminished because of its good work.

No profession has ever welcomed scrutiny from outside its ranks, and there are still those in medicine who hold that position. I am in firm disagreement.

1. Van Der Weyden MB. The "Cam affair": an isolated incident or destined to be repeated? [editorial] *Med J Aust* 2004; 180: 100-101.
2. Newsroom. Minister for Health. Government Responds to HCCC Report on Camden and Campbelltown Hospitals. 11 December 2003. Available at: www.health.nsw.gov.au/news/2003/dec/11-12-03.html (accessed Dec 2003). □

The healthcare complaints system needs reform, and politicians must accept ultimate responsibility

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IN REPLY: We at the Journal welcome criticisms as treasures from which we always learn. The recent editorial on the "Cam affair" has certainly provoked responses from a number of our readers.

Let me state from the outset that I fully understand the tension so evident in the remarks of Frankum and his colleagues from the Macarthur Health Service. However, I am not sure why our choice of the phrase "Cam affair" has caused so much apparent distress. The *Concise Oxford Dictionary* defines an affair as:

"1 a concern; a business; a matter to be attended to (*that is my affair*). 2 a celebrated or notorious happening or sequence of events. **b** *colloq.* a noteworthy thing or event (*was a puzzling affair*). 3 = *love affair*. 4 (in *pl.*) **a** ordinary pursuits of life (*current affairs*). **b** business dealings. **c** public matters."

The unfortunate events within the Macarthur Health Service over the last year certainly constitute "an affair" which will be remembered for some time; whether its use is "crass" is in the eye of the beholder.

I am heartened to read the administrative and clinical progress listed by Frankum et al. However, as late as August 2003, the Macarthur Expert Clinical Review Team recommended, among other things, the need for significant leadership in the hospitals' clinical and administrative spheres, and the involvement of academic institutions and clinical colleges to make the hospitals more professionally attractive for postgraduate training and senior staff. Central to all this is the importance of doctors in training in Sydney's south-west to be seen to successfully withstand

the scrutiny of our clinical colleges, on par with other metropolitan hospitals. This will only come with an enhanced academic presence in all major clinical disciplines of the Macarthur Health Service. Again, I am heartened to read that this is happening, albeit slowly.

Rosenfeld's data reinforce one of my editorial's contentions, that the Cam affair was a system failure, a "mismatch between clinical capacity and clinical demand — a mismatch exacerbated by the chronic 'poor country cousin' status of Sydney's outer metropolitan hospitals compared with their 'rich city cousins', the established inner city hospitals".

However, transfer of resources alone will not solve the problems. Our public hospitals are 19th-century institutions at sea in the 21st century, and they need reform. This will require urgent short-term and long-term solutions to meet the obvious funding and workforce deficiencies, but also fundamental system reform. How long do doctors and other healthcare professionals have to send out SOSs that the public hospital ship is sinking before bureaucrats and their political masters respond?

Dewan's comments are apt; our healthcare culture is not good at confronting criticism. Witness the experiences in Bristol¹ and Winnipeg.² We desperately need an open, blameless and depoliticised environment which allows individuals to speak frankly about individual or systemic shortfalls and failures, and clear pathways for these to be addressed.

Finally, Ellard is not certain that dismantling the highly centralised Health Care Complaints Commission is a good idea. Modern management principles eschew top-down, people-insensitive systems as appropriate quality improvement tools, and the HCCC allegedly has all these attributes. Further, the Commission provides politicians, as aptly noted by Ellard, with another means of dodging their responsibilities.

It is evident that the healthcare complaints system needs reform. Thus, my suggestion for local complaints panels headed by an ombudsman, and involving local health professionals and politicians, was meant not only to promote debate, but also to engage an inclusive, bottom-up approach.

I am not rigidly committed to the local entity, but whatever strategies and recommendations emerge from current parliamentary enquiries they must ensure the integrity of systems and locate these close to where the health-care action is played out. It is also imperative that local politicians on both

sides of politics are involved along with healthcare professionals, and that the current emphasis on investigation of individuals is shifted to investigation of systems. Finally, it is crucial that any reporting undertaken is directed, not to health bureaucrats or the Minister for Health, but to Parliament as a whole.

Our politicians must take collective responsibility for healthcare in the communities they purport to represent. Anything else is political bastardy.

1. Bolsin SN. Professional misconduct: the Bristol case. *Med J Aust* 1998; 169: 369-372.
2. Sibbald B. Why did 12 infants die? Winnipeg's endless inquest seeks answers. *CMAJ* 1998; 158: 783-789. □