

## The Bundaberg Hospital scandal: the need for reform in Queensland and beyond

*In the aftermath of Bundaberg, the MJA Editor's call for Australia's political leaders to fast-track a national program ensuring quality and safety in health care prompted a medley of responses. (MJA 2005; 183: 284-285)*

### Public reporting of individual surgeon performance

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**TO THE EDITOR:** Last year, three of us made a case for the public reporting of individual surgeon performance information.<sup>1</sup> We argued that considerations of safety and accountability strongly justify the collection of individual outcomes data, and that considerations of patient choice make it very hard to argue against the public reporting of collected data. The public trust in health care in Australia has, in the words of a recent *MJA* editorial, "taken a pounding" as a result of a series of scandals at the King Edward Memorial Hospital, Perth, in 1999, the Canberra Hospital, in 2000, and the Campbelltown and Camden Hospitals in NSW, in 2002.<sup>2</sup> We noted that recent developments in public reporting of surgeon performance information in the United Kingdom were driven in large part by the Bristol Royal Infirmary Inquiry, and we warned of the danger of waiting for a scandal like Bristol to occur before acting to improve performance management.

Unfortunately, a scandal, perhaps on the scale of that at the Bristol Royal Infirmary, has now occurred in Bundaberg. Although this scandal is ostensibly about the failings of one badly performing surgeon, it is widely seen as symptomatic of a failure of regulation of health care throughout Australia. The Queensland Health Systems Review, headed by Mr Peter Forster, was established in April this year as a result of public disquiet resulting from the Bundaberg scandal.<sup>3</sup> The Premier received the report on 30 September and has recommended a wide range of reforms including increased performance monitoring of a range of health care outcomes (Recommendation 13.2), and the insistence that information on health system outcomes be made public (Recommendation 13.3).

We welcome the review's recommendations as both a necessary component of a successful system of management of the health care system and a means to begin to restore public trust in the health care system. Unfortunately, we suspect that this may not be enough to restore trust in the system. A system in which a plainly incompetent surgeon has been allowed to continue operating is one where, in the eyes of the public, the performance of all surgeons working within that system is called into question. A public reporting system that provides reliable and valid information about individual surgeons, as well as hospitals' clinical performance, would be a significant step towards restoring the public's confidence and ensuring transparency within that system.

1 Neil DA, Clarke S, Oakley JG. Public reporting of individual surgeon performance information: United Kingdom developments and Australian issues. *Med J Aust* 2004; 181: 266-268.

2 Van Der Weyden MB. The Bundaberg Hospital scandal: the need for reform in Queensland and beyond [editorial]. *Med J Aust* 2005; 183: 284-285.

3 Queensland Government. Queensland Health Systems Review. 30 Sep 2005. Available at: <http://www.healthreview.com.au/> (accessed Oct 2005). □

### Measurement, monitoring and clinical governance

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**TO THE EDITOR:** The article by Morton<sup>1</sup> and the editorial by Van Der Weyden<sup>2</sup> raised some important points. Investment in redesigning the health bureaucracy and recruiting more clinicians to work in Queensland is clearly important, but we also need to address more fundamental issues to ensure optimal quality of care. The following two matters require particular attention: lack of measurement and monitoring; and developing clinical governance.

We cannot know how hospitals are performing unless we have well developed and validated markers of quality of care that can be risk-adjusted and benchmarked. Measurement and benchmarking are fundamental components of quality assurance in virtually every industry other than health care, and it is difficult to see how standards can be guaranteed and improved unless they are adopted more widely in health care.

In contrast to Bristol, where data on cardiac surgery were collected but not used effectively,<sup>3</sup> we also need systems in place to react to poorly performing individuals, units or hospitals. Effective monitoring is also currently limited by an inability to link data, such as deaths, re-admissions and complications.

Clinical performance has depended too much on personal capabilities — training, experience, memory and vigilance. Although important, the avoidance of human error will necessitate change to a more system-focused approach to patient care.

This will involve greater coordination of care to improve efficiency and to build layers of safety into our daily work practices. Currently, supervision of medical practice is extraordinarily diffuse. The accountability of medical practitioners must be made more explicit, and greater attention paid to ensuring that skills are gained under adequate supervision and maintained over time. Simulation offers great potential for identifying vulnerabilities in a learning environment and in the adoption of new technologies into routine practice.

Doctors have traditionally been reluctant to adopt clinical pathways or decision support tools to supplement memory and record clinical information and results. However, these can help standardise clinical care and reduce human error by ensuring that uniform, evidence-based practices are adopted. These strategies will also provide the basis of effective clinical governance.

1 Morton AP. Reflections on the Bundaberg Hospital failure. *Med J Aust* 2005; 183: 328-329.

2 Van Der Weyden MB. The Bundaberg Hospital scandal: the need for reform in Queensland and beyond [editorial]. *Med J Aust* 2005; 183: 284-285.

3 Department of Health. The Inquiry into the management of care of children receiving complex heart surgery at the Bristol Royal Infirmary: final report. London: Bristol Royal Infirmary Inquiry, 2001. Available at: <http://www.bristol-inquiry.org.uk/> (accessed Oct 2005). □