# Another inquiry into public hospitals?

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*The problems are already well known; what we need are solutions and health care reform*

The New South Wales Government has announced another investigation into the health care system. This latest inquiry was triggered by the Deputy State Coroner, Carl Milovanovich, who called for a "full and open inquiry into the delivery of health services in NSW".[1] The stimulus for this call was his review of the case of 16-year-old Vanessa Anderson, who died after being admitted to Sydney's Royal North Shore Hospital. Although mooted to be broader in scope, this inquiry swiftly follows an external review[2] and a parliamentary inquiry[3] into another patient mishap at the same hospital. In this issue of the Journal (*page 469*), Joseph and Hunyor, two of the Royal North Shore Hospital clinicians who gave evidence at the parliamentary inquiry, provide a first-hand account of the inquiry process and argue the case for clinicians' active involvement in health care reform.[4]

This most recent examination of the health system is yet another in a series of investigations in NSW, reaching back to the Chelmsford Inquiry into deep-sleep treatment between 1988 and 1990,[5] and, more recently, to the reviews into Camden and Campbelltown Hospitals, where, earlier this decade, aggrieved whistleblowers asserted that the quality of care was poor.[6] That grievance was subject to a Health Care Complaints Commission inquiry,[7] the Walker Special Commission of Inquiry[8] and several Independent Commission Against Corruption investigations.[9] This multiplying effect suggests that inquiries seem to have a way of taking on a life of their own.

In the Anderson case, the coroner found that the young woman's death was due to the depressant effects of opiate medications, which led to respiratory failure. These medications were given as a result of a combination of factors at the hospital, including a lack of communication, poor management, staff inexperience, and poor record-keeping.[10] Will another inquiry identify additional systemic problems of which we are not already aware? The answer, the evidence suggests, is no. Our research shows that patient safety inquiries across the world consistently identify the same recurring problems as the cause of iatrogenia: health care below promulgated standards; lack of quality-monitoring processes; patients, family members and concerned staff being ignored and excluded; whistleblowers being vilified; and persistent deficiencies in teamwork, systems and communication.[11]

If the problems are well known, what is the actual purpose of another inquiry? Peay, reviewing the role of inquiries after homicides committed by psychiatric patients, found that inquiries generally serve four functions: learning, discipline, catharsis and reassurance.[12] The learning function incorporates understanding the determinants of problems, as well as learning about solutions. The catharsis and reassurance elements appear self-evident. Announcing an inquiry serves as a way of regaining public confidence that the issue will be investigated in an open manner, and that witnesses, including patients, the community and staff, might be considered as important stakeholders, not only in compiling the evidence but in any activities leading to reform, or even healing, of the health system. As for discipline, inquiries of the type recently announced are generally more concerned with establishing broad principles of system reform than with disciplining individuals, which is most often left to the courts and professional bodies.[12]

In theory, the discipline function of an inquiry is intended to ensure that the government and relevant department are held accountable not only for inquiry processes, but for implementing recommendations. In practice, however, implementing recommendations is not necessarily a straightforward task that will result in the desired outcome. Two fundamental questions need to be considered before naïvely assuming the government will implement inquiry recommendations. First, is it possible and appropriate to implement the recommendations? Taking the commonly cited issue of deficiencies in teamwork as an example, how does one begin to break down barriers to the way people work together? Who is primarily responsible for addressing deficiencies in teamwork: universities, governments, hospitals or professional groups? Second, what evidence is there to say that implementing the recommendations will improve the quality of patient care? The answer to this invariably requires significant research, thought and expertise.

As soon as this latest inquiry was announced, the state Liberal Opposition argued on the front page of the *Sydney Morning Herald* for a Royal (rather than Special) Commission, as this, it was asserted, would have greater powers to "overhaul" the system.[1] There is no doubt that an inquiry can result in an overhauling. The Walker Inquiry was at least partially responsible for the restructuring of the whole NSW Health system, which took years to accomplish and is still not "bedded down". However, in the aftermath of that restructuring, there is no clear evidence that the number of errors is decreasing across the NSW Health system, nor that restructuring health systems will contribute to a reduction in errors[13] — nor that inquiries will, either.

The latest inquiry will provide a space for the witnessing of the experiences of patients and staff. It has already begun to fill the newspapers and nightly news slots with interest stories. It will also seek to identify systemic and institutional issues affecting the delivery of health care in NSW.[14] Explaining why things went wrong seems to be the underlying purpose of inquiries. Identifying solutions to these problems and undertaking health care reform that results in improved quality of patient care — in other words, actively learning from what occurred — is a separate and undoubtedly more difficult issue. Too often, these fundamentally important tasks are left untouched by the ever-growing number of inquiries.

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