

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

The problems of staff and funding shortages implicated in this affair may not be confined to the hospitals in question

IN DECEMBER 2003, PUBLIC CONFIDENCE in New South Wales hospitals was severely shaken by the release of the Health Care Complaints Commission (HCCC) report on the “Cam affair”.^{1,2} This had erupted from the allegations of four nurses who had voiced their concern, some 13 months earlier, over questionable patient care, disregard for quality and safety, and an indifferent administration at the Campbelltown and Camden hospitals of the Macarthur Health Service in Sydney’s southwest.³ The HCCC report detailed a raft of symptoms of a sick hospital and administration system, and outlined a blueprint to rid the health service of this sickness.⁴

The response by the NSW Minister for Health, Morris Iemma, was surgical and swift: two doctors were suspended and another nine were referred to the NSW Medical Board; disciplinary proceedings were commenced against four administrators; 19 deaths examined in the HCCC report were referred to the State Coroner; and the South West Area Health Board, ultimately responsible for the two hospitals, was dissolved.⁵ To this point, the minister’s actions had the right political resonance and were ostensibly defensible.

But then came a decision at odds with the wisdom of focusing on the message, and not the messenger. The minister noted, “The report does detail in great length instances of clinical failure, deficiencies in management systems, and the failure to ensure appropriate supervision. But for an investigation that took 13 months to complete, *the HCCC doesn’t go far enough in terms of finding anyone accountable for these failures* [my emphasis].”⁵ He then dismissed the HCCC commissioner, Amanda Adrian. This baffling, and as yet unexplained, decision might reflect information to which the minister alone is privy, or simply poor advice from his minders. In any event, the commissioner went.

To drive home the political focus on accountability, the minister announced yet another inquiry.⁵ Its brief is not only to retrace the HCCC investigation, but also to “make recommendations as to further actions against individuals, and to refer any matter or person for disciplinary action” and to “make recommendations on the regulatory and administrative arrangement of the HCCC.”⁵ It is hoped that something more substantial than yet another list of blame-worthy individuals will emerge from the inquiry.

To the casual observer, the Cam affair resembles the United Kingdom’s high profile Bristol case.⁶ Both were the result of whistleblowers’ altruism, and their frustration when their complaints about unacceptable patient care and safety fell on institutional deaf ears. In both, the whistleblowers (seven nurses in the Cam affair and an anaesthetist in the Bristol case) paid a high personal and professional price for their public stance.^{4,7} In both, there were long initial

investigations followed by other inquiries.^{5,7} But there the similarity ends.

The Bristol case revolved around issues of professional competence and self-regulation,⁶ whereas the Cam affair centres on, among other things, a mismatch between clinical capacity and clinical demand⁴ — 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.^{8,9}

But what to do? What are the pathways out of this situation?

The HCCC remedial blueprint and the recommendations for change made by the Macarthur Expert Clinical Review Team led by Bruce Barraclough, Director of the NSW

Institute of Clinical Excellence,¹⁰ have much in common. The Macarthur Expert Clinical Review Team, at the behest of the minister, examined the embattled hospitals in August 2003.

Its recommendations include the need for:

- significant leadership in the clinical and administrative spheres;
- increased clinical service capacities in workforce and resources;
- involvement of academic institutions and clinical colleges to enhance the professional attractiveness of the hospitals for postgraduate training and senior staff; and
- an ethos that encourages open reporting, review and remediation of problems — an ethos that is patient and safety centred.

These conventional approaches to troubled healthcare systems are laudable, but the Cam affair also provides opportunities to explore innovative approaches that might be transferable to our troubled hospitals in other jurisdictions. These include:

- confronting the “silo” mentality of our hospitals by appointing staff, not to specific hospitals, but to health areas, so that expertise and services are available area-wide according to need (there is a pressing need to develop more flexible service capacity within healthcare services);
- developing clinical services on the basis of area-wide need rather than political or academic opportunism;
- establishing a tertiary care teaching hospital at the hub of the health area, with real and transparent service or training links with the area’s other hospitals; and
- developing indicators, or clinical “Plimsoll lines”, which signal higher risks to proper patient care and required quality and safety.

At a global level, politicians need to be made more individually aware of, and accountable for, health services. This may be achieved by:

- dismantling the highly centralised and adversarial HCCC and replacing it with local-area health ombudsmen,

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accountable to an independent panel comprising the area's state and federal politicians along with community and health-discipline representatives (such a system would be far more responsive to local difficulties and more in tune with concepts of accountability and quality); and

■ increasing the proportion of bipartisan local, state or federal politicians serving on area health boards, along with limited-tenure members selected for professional prowess rather than political patronage.

But change and innovation alone will not allay a real anxiety about whether the Cam affair was an isolated incident or is destined to be replayed elsewhere. The unstoppable demand for hospital services during a medical and nursing workforce crisis, compounded by inadequate hospital funding,¹¹ suggests that the latter is more likely. The community, through its politicians, has a confronting choice: either reinvigorate our hospital services by increasing the number of doctors and nurses and attend to our hospitals' waning capacity and infrastructure through adequate funding, or await the next Cam affair.

Ironically, the Macarthur Health Service's quality policy statement throughout this affair outlined a commitment to the principles of customer focus, strong leadership, striving for best practice, evidence of outcomes, and a culture of

improving.¹² But the Cam affair illustrates that, for our hospitals, there is more to quality than rhetoric.

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