

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

When will Australians be able to count on receiving health care that is safe?

The *Oxford English dictionary* defines safety as “freedom from danger and risks”, and there is little doubt that the question of safety is foremost in the minds of many Australians on admission to our hospitals. These concerns were heightened when, 10 years ago, the *Quality in Australian Health Care Study* (QAHCS) revealed that admission to hospital was associated with a 16% risk of an adverse event, including permanent disability or death.¹ In the years that followed, public concerns about hospital safety were reinforced by a series of sensational scandals involving patient care at the King Edward Memorial Hospital in Perth, Western Australia (1999),² the Canberra Hospital in the Australian Capital Territory (2000),³ and Campbelltown and Camden Hospitals in New South Wales (2002).⁴ Not surprisingly, all these incidents had common characteristics:³ compromised patient safety not detected by sentinel event reporting; suboptimal clinical governance; health care professionals, who, frustrated by inaction after internal reporting of adverse events, brought the matter to the attention of politicians; and, finally, all incidents provoked one or more independent inquiries.³

There is little doubt that, *pari passu* with these scandals, the public's trust in hospitals and doctors has taken a pounding, as has the perception of the profession's ability to regulate itself.

And now, in 2005, we have the Bundaberg Hospital scandal in Queensland. Not surprisingly, this incident shares most of the features of the preceding hospital scandals. But it is also different — it reaches into the hearts of the Medical Board of Queensland, Queensland Health and the Queensland Government. The Bundaberg Hospital incident might revolve around the performance of Dr Jayant Patel, but it is in fact a symptom of an affliction affecting health care Australia-wide.

In 2003, Patel was appointed as a surgical medical officer at Bundaberg Hospital and subsequently promoted to Director of Surgery. Over the following 2 years, he operated on about 1000 patients, of whom 88 died and 14 suffered serious complications.⁵ A clinical review has since found that Patel directly contributed to the deaths of eight patients and “may have exhibited an unacceptable level of care in another eight patients who died”. The report noted that although “in the comfortable majority of cases examined, Dr Patel's outcomes were acceptable ... [he] lacked many of the attributes of a competent surgeon”.⁶

All this may not have happened had the 2003 registration of Patel by the Queensland Medical Board been more rigorous. An in-depth review would have uncovered that Patel was placed on probation for 3 years in 1983 for “gross negligence” in his practice at Rochester Hospital in New York State; that in 2000 the Oregon Board of Medical Examiners in the United States restricted the scope of his surgery; and, in 2001, under threat of having his licence revoked in New York State, he instead obtained permission to surrender his licence to practise.⁷ The subsequent questioning of Patel's performance at Bundaberg Hospital did not emerge from a clinical governance system but from concerns of individual doctors and nurses

about his surgical performance and prowess. It was a letter from the nursing staff about this matter which, when tabled in Queensland Parliament, resulted in the establishment of a Commission of Inquiry headed by Anthony Morris QC. In the meantime, Patel left the country unimpeded.

Inquiries are established to ascertain the facts, to learn from the events, to provide a catharsis for stakeholders, to hold people and organisations accountable, to reassure the public that something is being done, and to serve the interests of governments.⁸ It was hoped that the Morris Inquiry with these tasks and terms of reference⁹ would have shed light on:

- Patel's appointment to Bundaberg Hospital;
- the role of the Queensland Medical Board in assessing, registering and monitoring overseas-trained doctors deemed to be necessary for areas of need;
- the role of federal, state and territory governments and the clinical colleges in these processes;
- systems to ensure accountability and monitoring of appropriate performance of individuals and clinical services; and
- systems to receive, process and resolve complaints about clinical performance or services.

Now, with the termination of the Inquiry on the grounds of perceived bias, the public and the profession will have to wait.¹⁰ But, despite this, answers to these issues will have to be unearthed. They are not only pertinent for Queensland — they have national implications. We have had report after report¹¹⁻¹³ on quality and safety, and bodies devoted to safety and quality such as the Australian Council on Healthcare Standards, the Australian Council for Safety and Quality in Health Care, the National Institute of Clinical Studies and, more recently, the NSW Clinical Excellence Commission. And the list goes on. Yet we continue to suffer hospital scandals affecting lives and limbs, which, for all we know, are only the tip of the iceberg. Ten years after the QAHCS and 5 years after the establishment of the Australian Council for Safety and Quality in Health Care, we still have no nationally accepted framework for clinical governance to ensure the safety and quality of Australian health services or the means to comprehensively monitor these indices.¹⁴ Based on QAHCS outcomes, 25 patients die each day in our hospitals from preventable adverse events and another 22 suffer preventable permanent disability (Dr R M Wilson, Director, Northern Centre for Healthcare Improvement, Royal North Shore Hospital, St Leonards, NSW, personal communication, 2005). Whether, 10 years after QAHCS, being treated in Australian hospitals still results in the same number of preventable human tragedies, we simply do not know, and this ongoing vacuum is an indictment of our health ministers and organised medicine. The time has long passed for Australia's political leaders to abandon their leisurely bureaucratic approach to quality and safety¹⁵ and to insist on fast-tracking a national program that ensures quality and safety for all Australians accessing health care. It can only be hoped that the

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Bundaberg Hospital scandal will prompt out political leaders to act more decisively.

In tandem with the dismantled Morris Inquiry, there is a wide-ranging Inquiry into the health system in Queensland, instigated by the Queensland Premier in April this year. This Inquiry, driven by two eclectic working groups, both headed by Peter Forster, issued an interim report at the end of July which is not flattering of Queensland Health.¹⁶ It is depicted as a gigantic dysfunctional conglomerate with a corporate centre that is more concerned with performance indicators, revenue generation and cost control, than with people. It appears to be preoccupied with tortuous decision processes and ineffective workforce management systems, and with workforce planning that is not linked to service delivery. In short, its command-and-control ethos has resulted in a chasm between administration and front-line health services. In the field, Queensland Health's focus on cost containment and revenue raising has caused concern, frustration and even anger among clinicians who "feel undervalued and marginalised from a system which does not allow them sufficient time to undertake teaching and research, where they face ever increasing patient loads ... [and] have limited ability to influence the way the health system is run".¹⁶

There is an even deeper reason for clinicians' discontent — Queensland is an impoverished health care state! It has the lowest number of doctors per head of population in Australia and is critically dependent on overseas-trained doctors, who now account for nearly one in four doctors in Queensland.¹⁶ But there is more. Queensland's average recurrent expenditure on health is the lowest in the nation, and in 2002–03 its recurrent expenditure on public hospitals was 20% below the national average, and this is despite the greater geographic dispersion of health care facilities in Queensland. And to top off this bleak picture, the remuneration of hospital-salaried medical staff is the second lowest in the country.¹⁶

These telling statistics might be trumpeted by politicians and bureaucrats as reflecting good fiscal management, or blamed on the politically convenient federal–state health divide. But others may see it as an inhumane and unnecessary capping of the health budget. Whatever the rhetoric, the impoverishment of the Queensland health system cannot be sheeted home to Queensland Health. It lies squarely with the Queensland Premier and it will be interesting to follow the Queensland Government's response to the final report of the Forster Inquiry, which is due at the end of this month. But the response will not require rocket science. There is a dire need for Queensland Health to be dragged into the 21st century by a restructuring of its monolithic and disconnected organisation into more diverse and discrete health structures. These should be open, transparent and, most importantly, connected to local communities and to clinicians empowered to make decisions about health care delivery. Queensland could do no worse than to emulate the clinician-led ongoing reform of NSW hospitals.¹⁷

Queensland is also in dire need of a boost to its health budget. It also needs to consider attracting clinicians to work in Queensland hospitals — by making its recruitment and retention packages for salaried staff competitive with those of other states, and by providing incentives for clinicians to work in non-metropolitan areas. The reward system does not have to be all monetary. It could include innovations such as a program of continual professional development and refreshment of non-metropolitan doctors through regular periods of secondment to major metropolitan centres. An attitudinal change to the role of visiting medical officers in public hospitals might also help.

Despite having more medical schools than any other Australian state or territory, Queensland will be dependent on overseas-trained doctors for some time to come.¹⁸ There is a risk of some of these doctors not being suited to the local culture and practice expectations, or not having the necessary skills.⁶ Their continuing professional and cultural development needs to be met by structured programs involving the clinical colleges, as well as regular monitoring and constructive feedback. It's time to cease the apparent neglect of overseas-trained doctors, not only in Queensland but nationwide.¹⁹

In a recently released book, *Patient safety: achieving a new standard of care*, there is a simple statement: "Americans should be able to count on receiving health care that is safe."²⁰ So should all Australians, whether in provincial Queensland or elsewhere.

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