Mr Richard Willis
Secretary to Committee
Parliamentary Health Inquiry
Parliament House
Spring Street
Melbourne

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Dear Sir,

The terms of reference for the inquiry into public hospital performance data read: to inquire into and report on the capacity of hospitals to meet demand, standards and quality of care, resourcing and access levels, and the accuracy and completeness of performance data for Victorian public hospitals.

I am willing, and would wish, to speak to the committee.

The capacity of the public hospital system to delivery good quality care depends, in part, on:

1. The ability of clinicians to speak freely about the management of resources.
2. Good clinical and administrative governance.
3. Clinical audit being conducted in a free and frank manner.
4. A work place free of bullying and harassment.

I will first provide general comments on systemic issues and highlight the above by providing comment on more personal matters.

There have been a number of episodes in the public health sector that suggest those who speak up are at risk of being targeted, which have included a Paediatrician, Peter Goss, in Gippsland and Dr Peter Lazarri, in Melbourne. Poor clinical governance and a lack of robust audit would seem to have contributed to the debacle involving the Alfred Hospital Emergency department, Dr Patel saga in Queensland and many other such scenarios. Other Victorian clinic staff reflect that they feel fearful of supporting targeted colleagues for

concern about their own job security, and concerned about mentioning governance, management and clinical deficiencies.

The State Government, in their submission, highlight that there are currently three Consultative Councils to heal us deal with audit, however the powers and resources of these bodies limit their effectiveness. Certainly, the empowerment of an "Open disclosure" culture within public health would be to everyone's advantage, but "Open disclosure" is still not part of the medical culture, as evidenced by the poo rates of reporting of surgical deaths through the newly formed surgical council. Largely because medicos are uneasy about discussing adverse events as the blame game is still common and because of the adversarial nature any investigations, via agencies as the Medical Board.

The Consultative Council on Obstetric and Paediatric Mortality and Morbidity: conducts research and analysis into incidents and causes of maternal deaths, stillbirths and the death of children under 18 years of age; data that is published and useful. However, the organisation does not have the resources to tie together prenatal diagnosis and outcomes, despite the common occurrence of renal anomalies, in particular. A mechanism to track prenatal dilated kidneys and the subsequent management would potential provide significant savings, while improving the care of these mothers and their children.

The ***Victorian Surgical Consultative Council***, now know as VASM, has voluntary reporting, and focuses on deaths, with less emphasis on near misses and adverse events; only a small proportion of the surgical deaths are currently being reported to that agency. This adds to the lack of clinical feedback that comes from the low autopsy rate in Victoria, which is largely a resource issues. Thus, the clinico-pathological loop is not complete, resulting in the clinician potentially not fully understanding the reason for the death of the patients, information that would allow subsequent patients to be better treated.

In Scotland there is an expectation of participation in an audit of deaths in order for a surgeon to remain a certified member of their College

The ***Victorian Consultative Council on Anaesthetic*** Mortality and Morbidity does aim to identify and advise upon issues impacting the safety and quality of anaesthesia practice and has good systems for monitoring such events, including near misses. However, the resources available to the Council are relatively limited.

The Coroner and the Medical Board usually deal with a single case, with the latter more focused on the individual clinician than on system errors that may have contributed to the outcome. Both these mechanisms are adversarial and confronting to doctors, whether they are guilty of wrong-doing or not. A review of the mechanisms for dealing with underperforming services and care providers, to enable a more proactive and collegial approach, while respecting the rights and obligations of the consumer, would be appropriate. We should not be critical of these agencies, but should recognise the limits of their powers and mechanisms. Greater integration between the Health Services Commissioner, the Medical Colleges, the Medical Board, the Coroner and DHS, with errors being seen as opportunities for learning, rather the combative responses that are currently seen, would be appropriate. Useful

mechanisms currently in place are both the vascular and cardiac surgical databases that allow for the proactive identification of excellence and underperformance. These should be in place for all specialties.

Paediatric specific issues

The College of Physicians points out in their submission that "there is an urgent need to develop an integrated paediatric service across the state that can support both high quality clinical service delivery as well as paediatric physician training in the two tertiary paediatric hospitals and at the outer metropolitan and rural hospital environments". This also applies to the provision of Paediatric Surgical services. The assessment of the delivery of the service should be judged on:

1. The number of major case of Paediatric surgery needing care.
2. The total population of children and the incidence of disease.
3. The capacity of the Royal Children's Hospital, Monash, the Northern Hospital, Sunshine and the Austin Hospital ability to provide care.
4. The capacity of the private hospitals to provide support for Paediatric Surgical patients.
5. The capacity of non paediatric specialists to contribute to the workload
6. Adequate audit processes involving all participants in delivery of those services.
7. Performance indicators to reflect the need for good clinical care, teaching and research output.

The latter point concurs with the College of Physician view that: "*The tertiary hospitals have a duty to the community beyond clinical service delivery which includes support for peripheral hospitals and involvement in the child health agenda and advocacy within the state. Performance indicators evaluating training output linked to DHS-identified workforce should be developed"*.

Other submissions to the Parliamentary have noted similar issues, particularly in the multiple similarly worded submissions from the AMA, which include the following:

a. Lack of accountability of Government reporting of hospital performance data
b. Difficulty in recruitment and retention of staff
c. Low morale in the workforce
d. Lack of administrative support
e. Lack of clinical support time
f. A sense of disillusionment with the public hospital system
g. Poor working conditions
h. Pressure to work unpaid overtime
i. Cultural problems surrounding hospital governance
j. Bullying and general treatment of junior medical staff
k. Standards and quality of care provided at Victorian public hospitals

It is no coincidence that there is a commonality of the AMA submissions, and those patients and doctors. The number of submissions reflecting these problems indicates that there is a systemic problem.

I would particularly concur that "there is a lack of accountability and transparency of hospital administration and, that a lack of accountability means, issues of morale and staff disillusionment will continue to be of concern". Those who are experts in workplace harassment know that such an environment is the driver to bullying.

Examples of the above are the need to outsource many ultrasound investigations to private companies because of lack of ultrasonographers because of resignations, and the suspension of the out-of-hours Paediatric Surgical services at Sunshine for the last three years. And, I am lead to believe that waiting times for gastroscopies have lead to patients having advanced cancers prior to investigation, despite the waiting time for plastic surgery being less. Others would be able to provide additional examples and such discrepancies between the waiting for specialties should be looked at from the care perspective, rather than the WEIS focus that hospital administration needs to do because their budget is the principle performance measured.

A major system deficiency appears to be dispute resolution in hospitals and across networks, but the freedom of administration to spend, what appears to be unlimited funds on legal representation by Hospital Networks. The cost of legal fees for disputes with doctors should be audited.

An example of the problems in administration is that surgical managers (and other clinical heads of units and divisions):

1. Are often appointed without appropriate training.
2. Have little or no allocated funded time.
3. Have no expertise in conflict resolution.
4. Are not educated in the real nature of harassment and bullying.
5. Often have a conflict of interest when making decisions about the role of other surgeons.
6. Are not held accountable for their decisions related to service changes.
7. Are not held accountable for decisions that adversely affect staff.

Despite there being a policy of "zero tolerance to bullying", and the presence of policies and procedures related to harassment and bullying, including the "no-one can be disadvantaged for having complained about bullying", there does not appear to be either an adherence to the principles of natural justice or an understanding of how to deal with harassment. In fact, there appears to be a pattern of propagation of the behaviour.

Events at Sunshine

The specific details indicate a pattern of behaviour, and is presented as such. .

The recent events at the Sunshine hospital indicate the problem of management performance criteria not being sufficiently linked to patient clinical outcome (as opposed to through-put outcomes). Following a single letter from one doctor about the outcome of one patient, a

meeting was called (which has been subsequently found consistent with harassment by an external investigation), at which the suspension from the roster of that surgeon occurred. The boy had not had an adverse outcome, and his clinical problem does not relate to the patients who would present via the Sunshine emergency. The impact was:

1. There has been no out-of-hours Paediatric Surgery service at Sunshine for 3 years.
2. Up to 80 patients have been transferred to the Royal Children's Hospital in a six month period.
3. In-patients had no consultant cover.
4. Boys with twisted, dying testes had delayed treatment.
5. Children with appendicitis were not able to be treated in the same time-frame.
6. Children with an abscess had delayed treatment.

The suspension and various other events were lodged as formal complaints, the investigation of which had not reached its conclusion at the end of 18 months of 3 monthly extensions of surgeon's contract. The terms of reference for the investigation into the harassment were restrictive, not all events were allowed to be considered and events that were the action of committees had to have an accused person attached to the complaint. The hospital has thus far refused to provide the full report into the allegations, and have sacked the surgeon for complaining he has been harassed.

System problems highlighted by these events are:

1. The lack of organisation will to appropriately deal with complaints of harassment.
2. The inability of Hospital networks to deal constructively with complaints.
3. The availability of processes that can be devoid of natural justice.
4. There is a distinct lack of understanding of corporate level harassment, for which an education program should be conducted, and performance criteria developed.

The further investigation at Sunshine, the ***Peer Review***, has failed to apply natural justice, and the process had not been robust. The 20 people interviewed were not considered by the surgeon being investigated to be able to give adequate input to the committee (particularly as three had been on the committee that had suspended the surgeon from the roster), the terms of reference were predicated on the assumption that the surgeon should not be re-employed, limited time was given to the input of the surgeon under investigation and input was taken from outside the 20 listed, without disclosure to the surgeon about their input or identity.

The draft report (inappropriately) contained new allegations, and the final report details case events concluding that there is no concern about the quality of care provided by the surgeon, hear-say and the contention that an administration is unwilling to work with an employee that complains about harassment (events that flowed on from the inappropriate suspension). The investigation was tainted by individuals having to contract to a confidentiality agreement or not be allowed to speak, and staff reported that expressing their concern at the process put them at risk.

The Board of the Western Network subsequently concluded that the surgeon's contract should not be renewed because of relationship breakdown with management and concerns that the surgeon had made complaints to the medical board about the outcome of other Paediatric Surgeons.

The systemic issues are that an employee should be able to object to being unreasonably treated and, when there is a genuine concern about how cases are managed, a clinician has an obligation to ensure the public is protected. If all other mechanisms have been closed off, resorting to the Medical Board and Parliamentary inquiries should not lead to the surgeon being victimised.

A Paediatric Surgeon has been lost to the public health service, which is symptomatic. There should be an investigation of how many such cases have occur across the public health system, with an attempt to take a root cause analysis approach to understanding the collected group of resignations and sackings of senior staff. Certainly, such events underpin the Government's recorded high level of dissatisfaction on the medical workforce.

There have been other systemic issues:

1. Waiting times for different networks and surgeons for children's surgery differs greatly – the public would appropriately be informed of these difference.
2. Patients on the Sunshine waiting list have been informed that waiting times are longer than reality, to encourage them to go privately.
3. Patients on a single public list wait longer for simple surgery with one surgeon than another.
4. Patients are quarantined for simple surgery by a surgeon.

Systemic issues

There are a number of wider system problems, two of which are:

1. Hospital performance criteria relate more to through-put than outcomes.
2. Protocols for common conditions are not state-wide – for example the management of the twisted testicle in emergency department.
3. Where there is difference in length of stay data between institutions and surgeons, there is no process to investigate those differences to reflect on both the budget and clinical difference (longer may be better). An example is the operation of ureteric reimplant in children.
4. Medical staff obligations to fulfil quality assurance and contractual obligations to rosters are not enforced.

In 2003, the same surgeon was dismissed for then questioning the care of one surgeon in particular, in a culture that was supported by comments like "if you don't get on with me I am going to get you" and "if someone comes to you for a second opinion you should agree with the first person". The Board of the Royal Children's Hospital appointed two untrained members to investigate the bullying and clinical care concerns. The surgeon was sacked,

despite the subsequent report indicting there was some cause for concern. These events and the events subsequently are those of Sham reviews that have marginalised and victimised an individual. ***However, the public should realise that the Royal Children's Hospital provides a wonderful standard of care and has my strongest support for its excellent work,*** but the Executive and Board, in 2003, failed to identify the role of the whistle-blower, which has lead to the subsequent victimisation. A Paediatric Surgeon currently appointed by the Royal Children's recently stated: "I know there is a problem, I know his (a surgeon at the Royal Children's) standards are of concern, but I have a wife and children and I need to keep my job".

A conciliation process should be orchestrated, so that all Paediatric Surgeons are able to appropriately contribute to the care of children in Victoria, while all should be held equally accountable for their clinical care, while respecting the view of the consumer. Also, mechanisms should be put in place to ensure accountability of medical administrative staff both for the outcome for clinical staff and the welfare of patients. In addition, protocols for harassment and bullying are not enough: without a culture of caring for staff, good doctors will continue to leave the public health system because of harassment by management. Remembering that harassment limits the ability of someone to do their job – my ability to do my job has certainly been limited.

I am please to have the opportunity to submit to the Parliamentary Health Inquiry, with the intention of contributing to the betterment of the Victorian Health services, and to assist in the Parliament developing a view of how to better serve the public need for health care, while hoping to also contribute to the welfare of those who work within public hospitals.

Yours Sincerely

Professor Paddy Dewan

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