C O R R E C T E D V E R S I O N

STANDING COMMITTEE ON FINANCE AND PUBLIC ADMINISTRATION

Inquiry into public hospitals performance data

Melbourne — 18 August 2009

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Witness

Professor P. Dewan.

The CHAIR — I welcome Professor Paddy Dewan. I point out we have substituted members of the committee this afternoon. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. Any comments made outside the precincts of this hearing are not protected by parliamentary privilege. All evidence is being recorded by Hansard, and you will be provided with a proof version of the transcript in the next couple of days for any corrections. I now invite you to make an opening statement, if you wish, and the committee will then proceed to questions.

Overheads shown.

Prof. DEWAN — Thank you very much. Perhaps if I introduce myself first, I am here unofficially as a consumer representative, as a patient advocate. I am also currently a member of the executive of the Victorian state committee of the college of surgeons, and I have been on the state committee for some 10 years. I have also been a college counsellor for a period of 3 years over the last 10 years, and I am a paediatric surgeon currently not working at the Children's Hospital and Western Health. I would like to support my contention that I am a patient advocate by tabling a petition with 500 signatures on it and a number of letters from parents, if I may, just in support of that contention.

The CHAIR — Thank you.

Prof. DEWAN — There are many big-picture things that I could go through and give some opinion on. Certainly while sitting in the audience I have been able to identify a number of things that I would be able to comment on from my experience in the health care system at the administrative level, within the college and also on the statewide quality council when it was initially set up.

What I am going to go through today, if I may, is a series of events that highlight the more specific, because I think what has not been drilled down to in any of the presentations is how the micromanagement aspect of things so affects the big picture and the management of the money which is, as we have heard, the problem. The dollars are being managed well and there is a lot of reporting, as we heard from John McNeil, to the boards about money, but not about the very little issues about patient management and staff management that will actually affect the budget at the end of the day. It is a sense of vision but it is a sense of insights that I wanted to present, and I have taken the trouble of putting together some slides. I have also taken the trouble of suggesting the solutions before I highlight some of the problems, because I think what you want to find is solutions.

There is a common thread through the presentations that we really need greater support for clinicians with perhaps better computer technology available for them, but far beyond that, if a clinician is having a bad day, the hospital is there to support them, not to take them down because they might have made a mistake, and the colleges are expected to do that as well; that there is a non-adversarial management of clinical adverse events. Open disclosure has been unsuccessful because people do not feel safe in saying something went wrong. Doctors do not feel safe in admitting that they are human at the moment, and that is one of the problems. It is a cultural problem, and it is the cultural problem that is our biggest issue at the moment.

There needs to be independent, not management, managed review of clinician management conflict. Currently whenever there is conflict between clinicians and management it is managed by management, and therefore you cannot have good-quality systems when that is the case — when the person who might be perpetrating the crime is the judge as well. We need truly independent systems, and if we had that independence, I think the conflict would not occur as much.

There is not sufficient accountability from management around performance related to patient outcomes and related to staff treatment. That is no fault of their own. As doctors are human and make mistakes, administrators are human and make mistakes. When their job depends on whether they have got waiting times on the list, then they are going to err and create systems that protect their institution from the financial woe that might come if they do not meet those benchmarks. So we need to look at those and develop better systems and not allow for reinvention of the wheel, the same problem to occur again because administrators do not have performance criteria that protect them from making the mistakes that make them feel as if they are looking after their hospital whereas in fact they are not even doing that.

We certainly need far better consumer empowerment in service management, and we need consumer empowerment in clinical practice. We need the consumer to be reflecting back to us in a way where we have

systems that capture that information rather than reject that information, both at the one-on-one, clinician-to-patient level and for the management of clinics, the management of operating, the management of the hospitals and the management of the whole system. It is not about having people coming onto committees; it is about having people being able to advocate effectively for the consumer at the coalface.

If you will bear with me, I wanted to go through some of the contributions that people have made. Tony Morris was one of the commissioners on the Bundaberg inquiry into Dr Patel, and he pointed out what I think is a systemic, and that is institutional, dysfunction where Dr Patel is labelled as the problem in the media. It is not. It is incompetence in the management of the system, including his incompetence.

It is the inability to judge early enough to stop the whole thing ending up in that disaster, which was a disaster for everybody. It is the size of the bureaucracy. I have given the members of the committee a copy of the paper which talks about some pretty funny scenarios of armies no longer being at war and ending up trebling the size of their administration to cope with the lack of activity. That is indicated by what has happened in Queensland Health. I do not know what the data are for Victorian health.

There is a crisis in decision making in that when a decision is made it has to be checked by several committees, and there is a quite hilarious example given in Tony Morris's paper. Then there is this sense of misplaced loyalties. If you have KPIs that you have to meet, that your job depends on and the survival of the hospital depends on, then you lose sight of what is happening for the patients, and that is a very real institutional dysfunction.

Whistleblowers, Tony says, are essential, are vital, but in fact the phenomenonology around whistleblowing has not changed for 150 years. He gives one example, that of Florence Nightingale, who changed the mortality rate from 42 per cent to 2.2 per cent but only by making herself unpopular by insisting on changes. He regards her as one of the early whistleblowers. I thought I would inform the committee about one of the people who was the ultimate whistleblower — i.e., he lost his life. He went mad because people would not listen to him, with very good data, saying, 'Dear doctor, you must wash your hands'. He died at the age of 47. What he was saying was only accepted after his death, and all he was saying was, 'Wash your hands'. Pasteur had not given his paper at that stage, and you can see that he had reduced the death rate at birth due to sepsis down to 1 per cent. If only he had been listened to earlier, tens of thousands of women would not have died as a result of childbirth.

We have in Victoria a whistleblower, Steve Bolsin, who has come from Bristol. He has written in the *Medical Journal Of Australia* in 2004, and I have given you a copy of that paper as well. He also presents to us the institutional dysfunction that resulted in him having to come to Australia, and he highlighted that the Bristol hospital whistleblower was shunned and vilified. He tried to say there is a problem, and he became the problem because he had raised it for concern. There is not good support for the sense of indicating there might be a problem. I think it is evident from what we have heard throughout this hearing that the sense that people can say things honestly is one of the things that is problematic.

There have been three episodes that were published in that paper. There had to be nurses who were whistleblowers in New South Wales, there was a CEO who was a whistleblower in the King Edward Memorial Hospital; and a neurologist who blew the whistle about neurosurgical outcomes in Canberra. That was instead of there being a system in place that allowed the people who are the whistleblowers to be kept safe because their information was being regarded appropriately, the clinicians who were erring being kept safe and obviously the patients who were being harmed by the adverse events.

We have had a similar episode here in Victoria with what happened at the Alfred hospital, which was a complete shambles before it got sorted out. Surely you can collect all the data in the world, but if you do not actually review it in a constructive way, in a culture of caring way, then it does not make a difference. So we have had the Alfred hospital scenario here as just one example. Faunce and Bolsin indicated it was a poor institutional culture of self-regulation. That is not an insult; that is an expression of care towards the organisations that obviously needed help.

I come to my own personal circumstance because it is not personal; it is an indication of systemic dysfunction that I care about, because it impacts on the care of children in an organisation that is an icon. The Royal Children's Hospital is an organisation to which I think I have been the most devoted doctor as a result of being willing to sacrifice my career for the sake of the organisation without having misguided loyalties. The loyalty is

to the children, not to the organisation or my career. The assertions that I should not be re-employed were on the basis of two non-medical board members who were asked to assess bullying and clinical care. That is not appropriate. Subsequently, there was an external review that was managed by management, reviewing 26 cases where the administration restricted the terms of reference. The outcomes were not assessed, because no parents were approached, and none of my private notes were approached, where most of the outcomes were recorded.

Clinical issues were not explored, and I will go through a couple of those. Obviously bullying, which is something we do not deal with in our community and in the medical health-care system and which is very destructive, was not even investigated appropriately through that.

I just want to take you through two of the scenarios in the external review which are pivotal to the understanding of what we should try to drill down to to look for true quality of care for patients. Bladder exstrophy is where the bladder is on the outside when you are born. It is a complex operation that requires probably multiple surgeries with extensive care throughout the patient's life. A ureteric implant is a plumbing operation in the bladder, which I will come to.

I had simply been saying that in Victoria, with the development of a new operation by a surgeon who is one of the greats of paediatric surgery in Victoria, the results were not as good as we would want. If you look at the chart there for Victoria and Tasmania, the incontinence rate was 13 out of 20. It was not even as good as international best practice. I was excluded from the practice of bladder exstrophy surgery when I started to ask questions about whether there was a problem.

The data has subsequently been presented at the Royal Australasian College of Surgeons in Sydney in 2006. You see, though, no. 7 at the top is for no complications and 13 is where the wound had actually fallen apart. That is because there was a two-stage operation that in fact has not effectively carried on as the process. It has been a very good thing to try, but when it was going wrong it should have been possible for me to be a heard voice so that we all move forward together rather than me being locked out for even raising a concern. When the external panel looked at the question — sorry, I will go back. On bladder exstrophy, I had one name and one hospital number, and they did not match; therefore that subject was not even explored. I was accused of being a troublemaker because they did not match, which was an inadvertent typographical error.

Ureteric reimplant is a bladder operation because kids have got reflux of urine from their bladder up towards their kidneys. I presented data that indicated that there had been a change in approach, and this is the post-operative days with the percentage number of patients that I have subsequently published. The trend was the same as when I was at the Children's in 2003. I was saying you do not need to use a catheter; they can go home earlier. You can see the majority went home within 24 hours. Also reviewed was the pain requirement. These are figures of my own patients where 56 per cent required an epidural infusion and a four to five-day stay in hospital when they had a catheter in the earlier series. Seventy eight per cent required no epidural. They only had oral Panadol after stopping using the catheter, so my results were very good.

The response of the institution and the response of the external review when I suggested that there was a problem about the comparison of data — and this is where we come back to the quality of data — when I suggested there needed to be a comparison of data, the hospital response was to develop two different care pathways. In other words, the patients were not compared because they were on two care pathways. That is hardly an appropriate way to manage the quality of care for a patient. I have shown significant quality of care improvement in pain relief requirement, and yet the hospital has not even wanted to look at that. And they had been shown data similar to this.

The average length of stay for the operation at the Children's at that stage was four days, whereas you can see with this different approach it was one day. The two different care pathways was the solution, which is obviously not appropriate. For pointing out that sort of thing I believe that is one of the reasons I do not work there any more.

The sham review, and I have a paper to present to you — and I am sorry I have not had a chance to review the literature on this subject as extensively as I might — from Medscape on the net. I do not think it has been distributed as yet, but it talks about the sham review where you decide on a set of terms of reference. It is:

> … characterised by draconian discipline — usually summarily imposed — that is founded upon little or no basis … charges are based on nebulous 'psychological' or personality issues …

And you can be regarded as the 'disruptive physician'. You can have a copy of that. There is quite a bit more literature on the sham review. You look for the result and then you do the investigation to get it.

Subsequently — and again it is one of the things that may not come under the umbrella of this committee, but it is one of the broader aspects of quality and data collection that is problematic in the Victorian health-care system — the medical board, when it takes 100 case scenarios, is unable to deal with them in the collective if there is not the political will to do so. Despite the fact of there being 25 of those related to one surgeon, no effective action has been taken. No formal hearing has been mounted as a result of that contribution to the medical board. Importantly, although doctors are employed as administrators and erring in their administrative role should be seen as part of what they are doing for the community and therefore should be able to be judged by an organisation like the medical board, they have been unable or unwilling to do anything about it.

One of the discussion points and part of the information that was looked at at the Children's Hospital was the management of situations like this. This is a barium enema, where there is barium in through the colon, the rectum here is enlarged and the management is through this plastic tube that goes in through the abdomen into the bowel. There are differences of opinion about that and there are different roles of surgery, and adequate discussion of that is one of the problems that has occurred. One of the surgeries that is possible is for the bowel to go from a very large piece of bowel going right down to the anus at this level, with the bladder here in front, to trimming it down in that way so that that washing out of the bowel every day for the rest of the life is not needed.

Unfortunately having a difference of opinion has resulted in a submission to the western network by a dear friend of mine who reported that I had caused irretrievable harm and permanently denervated a boy's perianal region. Unfortunately it is also written in documents that a clinical examination was not conducted before that letter was sent. A reflection on that communication constructively would have protected my dear friend Michael Harari. Unfortunately the western network suspended the surgeon from the roster as a result of that letter. They also suspended the paediatric surgical roster because that surgeon — i.e., myself — was providing at least 50 per cent of the on-call manpower. There were draconian restrictions — read sham review — on the surgeons, where I had to ring an adult general surgeon to ask permission to operate on a blocked kidney, about which he had no clinical experience to judge whether or not I would do that, even if I bothered to describe the clinical scenario to him at all. It was referred to the medical board, as one might.

I have recently come back from a meeting in Fiji where similar surgery is being conducted through a series in Sydney over the last few years covering the period that I have mentioned, where 15 cases have been similarly operated on, and yet the western network has reported me to the medical board for doing similar surgery.

Here we see that there is a lot of work being done at the Children's Hospital by John Hutson, very good work looking at the quality of life of slow-transit constipation, where a solution has been the antegrade continence enema, which is that little piece of plastic tube I showed you before. You can see that the honeymoon comes to divorce. In fact that is seen to be not quite the solution, as people see that the lower bowel operation is considered by the literature to be at least an option that should be strongly considered. In fact these two papers are talking about the transanal operation being a better option.

Subsequently — and this is where it comes to a problem of bullying in the system — there have been two reviews: one a SIAG investigation, where it was found a medical administrator was guilty of that type of action, but the terms of reference were manipulated by the management of the hospital, no action was taken, and the review was certainly not timely. Because the suspension from the roster went on for two and a half to three years before my sacking, there were many other events that I claimed were bullying, and therefore there was another external investigation done, but there was no medical expertise to judge when there was a different opinion, there were errors of fact in the conclusions, and there were lies to the investigator. In fact that review was not completed before I was sacked from Western Hospital.

This is a photo to educate the panel about one of the lies that was told by the divisional director of nursing. That lie was that nurses do not assist, directly, surgeons. If you look at the ACORN documents, which is the organisation for operating room nurses, it talks about their role as an assistant, and here are two nurses — one of them my assistant, the other the scrub nurse assisting — as an example that proves the lie.

I would very firmly state that bullying is not being well and appropriately managed in the health care system, and it is significantly present in the health care system. One of the things that indicates that is the contention by the western network that the services have not been affected by the suspension. This is data that I collected because I was head of the unit. I was participating in the heads of units meeting, and therefore I know something about the gastroscopy waiting lists, by the by.

The CHAIR — Professor Dewan, I am conscious that you have been speaking for about 20 minutes. The committee needs to proceed to questions; do you have more to say?

Prof. DEWAN — Could I have two more minutes? One point is that 12 patients per six months with a twisted testicle that might die had to be transferred instead of having an operation. The peer review — very problematic, and I am happy to talk about that. The suspension was a blunt instrument, as judged by the peer review. The final analysis was that administrative staff are unwilling to work with somebody who complains about bullying. Hearsay evidence was used to say that other surgeons did not want to participate in an audit, and I wonder why — another sham review.

Unfortunately I think people accepting that there is a problem is a big issue. I have recently received a letter from the minister that says, 'I note that the human services have been assured by Western Health that paediatric surgical services have not been curtailed'. I used to do 66 per cent of the work between 2007 and 2008, November to May, and in the previous audit it had come down from 282 to 232. Prior to that, when there was no suspension, or just after the suspension, I was doing 73 per cent of the work.

Jennifer Wheatley has resigned and my services have been curtailed and there has been no replacement. Since April 2006 there has been no on-call paediatric surgical service at Sunshine. Since April 2009 there has been no replacement of urological service, there has been no replacement of paediatric surgical sessions and there is no in-house paediatric surgeon, as evidenced by the agenda and minutes of the adverse events committee at Sunshine. I am happy to leave it at that.

The CHAIR — Thank you, Professor Dewan. Obviously the material you have presented in your slide presentation goes into a great deal of detail. This committee has not had an opportunity to look at that material before and, frankly, some of the matters you have raised go beyond the scope of what this committee is looking at, so we are not in a position at this point to comment to any great extent on what you have presented this afternoon. If we can obtain a copy of your presentation to look at in more detail, that would be appreciated.

I understand from what you are saying, and putting your own circumstances aside, essentially there are issues in the relationship between clinical staff and administrative staff and how that works. Do you have, or you aware of, a model that better manages that relationship between clinical and administrative staff in other jurisdictions, interstate or internationally?

Prof. DEWAN — The model that has been put up that I think helps protect the patients and the clinical staff is that of open disclosure. It has been very well shown that openness and honesty and communication about clinical events — —

When something goes wrong, you go and say, 'I am sorry'. That is the model that has been put up at a national level as being a solution for what was the medico-legal crisis that was in place a few years ago. I see that as the model for a solution for the interaction between administrative staff and clinical staff for the betterment of the patients.

We have heard the sense that there is not open disclosure about some of the waiting list information, some of the time to get into outpatients. That lack of open disclosure creates a distrust from the consumer, but also those types of behaviours within the hospital creates that lack of trust. There are no clear lines of information flowing between management and clinicians. The focus is on the way up, not on the way down. The administrators are not having their life made easier by having performance criteria that relate to patient outcomes so much; it is more to the budget, which is making them look away from the clinicians, look away from the patients, so I think an open disclosure model, applied to the different activities within the health care system would be better.

The CHAIR — However, you indicated earlier in your presentation that one of the difficulties with open disclosure was, you said, doctors do not feel safe. Can you elaborate on how that can be addressed? I assume you mean they do not feel safe in disclosing clinical errors?

Prof. DEWAN — It comes from leadership. That is why I put the minister's letter in for your edification, to indicate that I suspect he has been ill-advised by people to say that the service has not changed. It is clear that the service has changed. It requires that DHS really look for the truth and report it, and that the minister is able to be well informed with that sort of information. That would make people feel safer about it.

The CHAIR — What about at a health-system level? That is more of a DHS whole-of-government level.

Prof. DEWAN — There are various committees that can be utilised to approach that; the Statewide Quality Branch, the other consultative councils for anaesthesia for surgery can be used to set the agenda related to open disclosure, and a meeting of the colleges and DHS to work through how that can be done as well is one of the deficiencies we have at the moment. There have been very few meetings between the college of surgeons and the Minister for Health, and there is the sense that anything too sensitive cannot be on the agenda. You can hardly have free and open communication when that is the case.

The CHAIR — Can I ask you about KPIs? You indicated in your presentation, and indeed your comments before, the issue of KPIs being directed to financial matters rather than patient outcomes. What type of KPIs are required, in your view, to ensure that the focus of health services is on patient outcomes?

Prof. DEWAN — We have the sentinel events, which is one of the processes that is in place, but the sentinel events are a group of things which are in the extreme. It would seem that we need to develop the political will to not just look in the extreme but to do what I had discussions with DHS in the past about and that is taking differences in outcome — for instance, the difference between one organisation and another related to, say, hip replacements might be what is the length of stay — and then taking the initiative of saying, 'There is a difference in length of stay here. Is longer better?'. It is not, 'Your stay is longer, that must be bad', it is, 'Let us look at the difference'.

Differences in the numbers of tonsillectomies done throughout Australia, for instance, between the states; the difference in caesarean section rates between the states — looking at those and saying, 'There is a difference. Let us look constructively at why there is a difference', and it would seem there is not the political will to take on that challenge. In my area of practice there is prenatal hydronephrosis diagnosis, which is an absolute quagmire of misinformation because we have not had the leadership to pool all the different specialties together to say, 'We do not yet understand this; let Victoria be the leader in understanding prenatal dilated kidneys so that a very small percentage will end up going into renal failure, that not being an expense on the community, while we look after all those patients as well, and we improve the relationships between practitioners because we are providing leadership over this last group of people who are trying to provide the care'.

There are many diseases like that. I can give you half a dozen where we do not have the sense of everybody involved in the care of that condition having a common view as to what would be the best practice for that patient. That hardly seems right in our modern day.

The CHAIR — It makes it particularly hard to assess datasets accordingly.

Prof. DEWAN — I do not think it is that hard. I think it just requires the political will and culture to say there is a difference — pull people into a room and say, 'Let us look at the difference'. I think it is that easy. It is a matter of having the culture and the political will to do something that people might initially be challenged by.

The CHAIR — You would see that as an ongoing process?

Prof. DEWAN — Yes. There would be a sense of if there are differences in practices. The example is the ureteric reimplant catheter-no catheter. To have an organisation that is able, because the culture supports it, to say, 'All right, we have clinicians in conflict about what is the right thing to do'. I might have been a cowboy — I am not, by the way, for the record — but instead of looking at the matter constructively and saying, 'Let us stop the cowboy', or 'Let us bring the others along for the ride', the approach, the cultural milieu, was saying, 'No, that is going to be difficult; let us separate them'.

The CHAIR — The committee heard evidence yesterday from Professor McNeil about the cost of collecting the type of data we are talking about here. Should those datasets only be collected for the innovative like you are talking about, or is it something that should also be collected for the rudimentary — —

Prof. DEWAN — I agree with John McNeil about the registries and collecting that type of information, but there are different layers of information and some of it is already available to DHS. We were talking about gastroscopies before. That data is known at the western network and is presented at heads-of-units meetings. I known there is a three-year waiting list, from the discussion around the table one day. I know there have been two patients who have had unresectable carcinoma of the stomach as a result of being on that waiting list. That data is known. The waiting time for TURPs et cetera is known. There is the access to elective surgery committee of DHS that looks at that. There are a couple of different issues there, if I might just go on.

I do not believe the categorisation of patients is adequate. If you have somebody who has an aortic aneurysm, they have a vessel in their abdomen that might rupture and might kill them in a short period of time. There are various things where you can subcategorise those according to the general state of the patient, their comorbidities, whether or not they have calcification on the plain abdominal film, so without too much effort you can end up with data that is going to be able to say, 'This patient is going to die if we operate on them anyway, therefore they should not be on a waiting list'. You can collect that sort of information by saying, 'If we do not operate on this one now, it is going to cost them as a person a lot more in suffering and it is going to cost the community a lot more in medical service to them'. Instead of having a category 1, where you have should not operate versus should operate tomorrow, you have a category 1 that is not about 30 days, it is about making sure the patients and the systems are being well looked after, which might take a little bit more effort, but I do not think that would take a lot more effort.

The other data that DHS does have is differences in rates of operation and complication rates. They have that sort of information, but when as the chairman of the state committee I suggested that we take that information and, as the information expert surgeons, help the department interpret it, we were never given the opportunity to do that. That is the type of linkage that could be very productive, where the information expert colleges put the effort into assisting DHS in being able to evaluate the clinical significance of the data that they already have. You do not have to put more money into that data collection; you just have to be more clever in its interpretation.

Mr HALL — First of all, thank you, Professor Dewan, for your contribution to our hearing this afternoon. I will start with a couple of the general comments that you made in your presentation here today, the first being: clinical management conflict needed to have some independent resolution mechanism. Do you have any suggestion about the exact model or who or what body would be appropriate to act as an independent resolutor?

Prof. DEWAN — I would take advice after discussion. I think a process that explores what might be the options would be the first step that I would suggest, and considering the roles of the colleges, the Health Services Commission and the medical board but looking to see we have an approach of can do and caring for the clinicians involved — and the administrators.

The two episodes that I have been through have been hell for the administrators as well, not just for me. I recognise that. It has been a very bad experience all round, just like the Alfred situation is a bad experience all round. I think it is absolutely urgent that the problem is at least, 'Yes, it is a problem'; that is the first step. I would not suggest the solution, but there being a process that looks for a constructive solution that would be good for everybody is the way to go, involving each of the organisations. None of them really has the make-up. It may need to be a selection through those rather than necessarily those organisations doing it.

Mr HALL — Have you considered legal mediation models that exist?

Prof. DEWAN — I have learnt a lot, and I am willing to share the education that I have had in relationship to this. Unfortunately at the professional level things like compensation for termination of employment does not occur, because it costs you more than you would ever be compensated for, and the model is such that you would never be re-employed. Unfortunately legal redress — Mr Viney, I apologise — is not really resolution.

Mr HALL — I suppose I am referring to the mediation model used in a legal profession as such, not to bring about a legal compensation or whatever.

Prof. DEWAN — I think all those sorts of models being looked at and being used proactively would be very appropriate. I have not formulated a solution, because I do not think I know all the resources that might be put into it.

Mr HALL — You also spoke about the need to increase consumer empowerment. How do you do that?

Prof. DEWAN — The documents that I have tabled — there have been hundreds of communications to various people at various levels along this journey where there has usually been no response to them. That is one level. If a parent of a patient is making a statement to somebody who has the responsibility for the care of that person, like their local member of Parliament, the health minister or the CEO of the hospital, then they deserve to see that that contribution is at least recognised and that there is some taking into account of that type of information. Consumers being on committees at various levels within the health network and people being on the committees at various levels within DHS is part of the solution, but if you do not solve the cultural problem, then it is not going to work. If no-one is empowered within that committee, then it is not going to work.

What I particularly mean is when consumers are one on one with the health service — they come to the outpatients, they see the doctor, they are sitting across the table — they are treated as experts. If I was able to run a program of improvement of health care in Victoria, it would be to regard patients as accepting that they are experts and doctors and nurses accepting that they are experts, because they know their body and they know what they have been through before. Yes, you can have an electronic record to track it all, but if you have great respect for the person who comes as the patient, then that supports the contribution of the patient; it is not the only thing that you are relying on. That is the empowerment that I am particularly focused on. It is the one on one: you are respected as a patient.

Mr HALL — In terms of your personal issues, have you ever used provisions under the whistleblowers act?

Prof. DEWAN — I have made every effort that I can to stop the noise and get the solution in relationship to paediatric surgical services. I have tried everything at every level to see that the patient becomes the primary focus. Unfortunately there is a big target on my back, so yes, I have.

Mr HALL — Do you consider provisions within that act satisfactory to bring about the sort of outcome that you want to see achieved?

Prof. DEWAN — No. The last line on this slide is 'my immediate reinstatement' — I am a dreamer! That is one of the problems. The whistleblower act is a toothless tiger — an absolutely toothless tiger. At the moment all it does is ensure that there is process in place; that is all it does. I have gone through two sham processes — four sham processes in effect — with no reasonable outcome because there is no recourse that enables the whistleblower legislation to protect the management to help guide their day and make them happier people and not have them focus on the target on my back. That is one of the things I would call for, that if we want to have a good outcome for the health care system we need to strengthen the whistleblower act to make it do a job that protects people when they are raising concerns but also stops people making vexatious claims. It has to do both those things, I think.

Ms HARTLAND — Further to the whole issue about whistleblowing and what happens within the health system, would you say that your situation is not uncommon and there are other situations within the health system, and that would mean that it would have to affect morale? Could you talk a little bit about that?

Prof. DEWAN — Yes, the ministerial inquiry into morale — I think one of the things that was not recognised is that people lose trust and faith in the system when they see what is happening to somebody like me, where it has been very public. Lots of people will not say what is going on because they are afraid it will happen to them, so they keep quiet.

If there is something going wrong they are not happy about they are losing the sense of enjoyment in the day because they are not allowed to say, 'Let's fix this', because they might get taken down as a result. There have been several examples. In my written submission I talked about a couple of them, Peter — —

Mr HALL — Peter Goss.

Prof. DEWAN — Peter Goss, one of the emergency physicians — sorry, I had forgotten his name — and — —

Mr HALL — Peter Lazarri, was it not?

Prof. DEWAN — Peter Lazarri, who also made a submission to this committee. I am told by the AMA that there are something like six of these types of episodes around the town at any one time. I know of another general surgeon in the Box Hill region who went through a similar sort of sham review-type process. I have in my submission one of the surgeons from the Children's Hospital, saying to me, 'I know there is a problem, I know there is a problem with that surgeon, but I have got a wife and kids and I don't want to lose my job'. I do not have a recording of that, but I can tell you honestly that that was said.

Ms HARTLAND — One of the issues that has come up a bit in this inquiry over the past two days is about transparency around data and collection. I think your situation is different from that, but how do you think services to the community are undermined if the time of doctors and administrators is taken up in these kinds of disputes?

Prof. DEWAN — Absolutely. One of the points I make is that I think there should be accountability around legal costs for health networks. If that was one of the performance criteria, then maybe I would not have been beaten up so much because I would not have had the funds to do it.

Ms HARTLAND — Can you talk about how much it cost? Are you aware of what the cost was?

Prof. DEWAN — No, I do not — it must have been half a million dollars with all the legal time, including here this afternoon. The other — sorry, can you just reiterate — —

Ms HARTLAND — I was asking about those issues around the cost and the fact that it must undermine morale, and does that mean that you spend your time, instead of treating patients, dealing with the politics of the situation?

Prof. DEWAN — Yes. For instance, the minutes and the agenda of the committee at Sunshine talking about, yet again, the patient with appendicitis not having anybody with the appropriate skills to care for them — that took a lot of energy, and — this is the personal circumstance that highlights the general — when there was the suspension from the roster, that draconian act was like, 'There is no roster'. But what about patients, who are in hospital overnight, of myself? There was no provision made as to what would happen for those.

What about the patients who were in the hospital with a twisted testicle and needed immediate surgery, and yet I was in the hospital but I was taken off the roster? No provision had been made for that. Others had to put a lot of energy into undoing some of the harm that had been done by the whistleblower-type reaction. That is where the energies get taken up. And certainly there are other people who see problems and do not get to do anything about them — at the heads of units discussion, where you have a six-month wait for an apronectomy, you have a three-year wait for gastroscopy and you are thinking, 'Hang on, as a doctor I do not feel very comfortable about that because there have been two patients who have had a malignancy as a result of that wait'. So that takes up the energy. Instead of saying, 'What is the greater care formula for these patients?' — as the doctors, that is what we are there for — but the greater input is coming from the management of the WIES and the dollar, and the influence of the doctor on that is not there. Therefore that sense of lack of morale is generated from that because you cannot enact what is the best outcome for the patient within the resources that are already there.

Ms HARTLAND — And do you think those issues actually stop people coming here to present today? I am aware there are legal officers in the audience from the Children's and the Western, which somewhat makes me think that other people would be hesitant to actually give evidence.

Prof. DEWAN — If I can just highlight the legalistic rather than the care structure approach that is the culture at the moment: when I was in the medical board being falsely accused, the legal representative was, without notice, in the audience at that situation; here am I, an employee of that organisation which has sent along the legal team to see what is happening, without there being any sense of their being there as what I am part of the family of. I think that is a very sad reflection on the culture of care. It can change, and I think cultural change can happen tomorrow; it requires leadership, and that is why I have put my reinstatement down there as real leadership looking at real issues related to patients with consumer empowerment. If we all focus on the patient, what is the problem with me being there?

Mr TEE — I am looking at your written submission and reflecting on your evidence. I think you said that doctors do not feel safe. You said that a couple of times, yet in your written submission the example you give is

a circumstance where there is a doctor who is concerned, who writes a letter, and that letter then leads to the process which you have identified. I am wondering if you see that there is a conflict between on the one hand your statement that doctors do not feel safe and on the other hand your written submission with an example of a doctor who did feel safe and did commit a concern about a patient to writing. I am just trying to reconcile these two views.

Prof. DEWAN — Yes, it is a very good question, because if you remember I referred to Michael as my dear friend, because there is no animosity towards the individual. The animosity is towards the people who have taken that stick and used it inappropriately. It is not even animosity — it is almost sympathy for how pathetic that is, because it is pathetic.

Here is a person who has expressed a difference of opinion about the management of a patient, done it in a very clumsy way where he has declared irretrievable harm without examining the patient, and therefore he has been negligent in his role as a medical practitioner. But what he needs is a mate to go have a beer with him or whatever he does in his spare time, to say, 'Are you okay?'.

That is what I would like to be able to do: have that letter, the medical director rings me saying, 'We have had this letter saying you have done very badly with this patient'; 'Hang on, I will give him a call and have a chat with him' — which I did. After I had been suspended I rang Michael and said, 'I do not think I really agree with this; can I tell you what really happened from my perspective?'. Unfortunately he had not had that reaching out and caring before, and therefore the response was not as positive as I might have hoped. But I would be very happy to go and have a social occasion with him, because he has been hurt by this. He has been hurt by somebody else using his letter.

Mr TEE — Yes, although I suppose it does not address it; he certainly felt safe enough to put it in writing, I suppose is the point I am making.

Prof. DEWAN — Yes, he did, but there are many other circumstances, and there has been much other problematic reflection on what happened. A case example is I said on a grand round where a case was discussed with a neurological problem. It had had two MRI scans seen by two neurologists, and the diagnosis had been missed. What we do not have in that situation is the ability of people to have a process that results in an expectation of feedback and education that results in that person feeling that they have learnt from how they might have erred.

Of course there will be people who are not good enough at their job, but if you are recording all those events, you will then see a trend of those who are not just erring but are making repeated mistakes. At the moment we do not have a way of being able to record those because we do not have the culture to record them, and we do not have a way of picking up a person who might be underperforming, except in a couple of examples like the vascular audit that has been set up by the vascular society here in Victoria.

What they have is a sense of mateship at the end of the audit to go out and say to the person who might be not coming up to the average, 'Are you okay? Have you had a bad day? Is there anything I can do to help? And now let's talk about what happened with the outcomes of your cases'.

Mr TEE — The other issue that occurred to me as I was going through the submission was in terms of the rigour of the process that you identify. You talk about the complaint — there is a meeting; as a result of that there is a suspension; there is then a peer review which you describe as 26 cases are investigated and 20 people are interviewed; there is a draft report and then a final report, and then subsequently the contract is not renewed.

On one reading that is a very vigorous and rigorous investigation and review and process. I am not in a position to judge the merits of the case and the outcome, but certainly from a process perspective, on the basis of the submissions, it appears rigorous.

Prof. DEWAN — That is the problem that administrators have out in the networks at the moment; it is that they can go through the process of ticking boxes. It is like bullying in a workplace: it is about taking the process boxes, so if you have education sessions, if you have the various series of things, then you can tick the boxes and you have done the job of looking at that satisfactorily — which is obviously not the case.

When you have a situation where a network is basically investigating complaints against senior executives, and they are manipulating the terms of reference, when they are manipulating who is being interviewed, when the allegations for clinical inappropriateness have been just obviously pulled out of nowhere for the sake of trying to throw mud, it is like the financial accountability. You have misleading data that comes in because the drivers through the collection of the information are not the correct drivers.

In this situation we have also got the driver of the investigation being the accused, so Western network has been asked by the minister, 'Have you committed a crime towards Professor Dewan?', and Western network says no. Western network has got a person who has decided they want to get rid of me, and they enter a process which gets ticked off, which is not natural justice at all, and an independent investigation would show that categorically.

The CHAIR — Professor Dewan, thank you for your submission and evidence here this afternoon and your presentation. We will appreciate receiving copy of your presentation. We will get a proofed version of the transcript to you in the next couple days, and we may have some further follow-up matters. Thank you for your time.

Committee adjourned.