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30/1/04

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Special Commission of Inquiry into Campbelltown and Camden Hospitals

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Dear Mr Walker,

I enclose by email a submission to the Inquiry into Campbelltown and Camden Hospitals.

My own CV is that I trained in medicine at the University of Sydney, graduating M.B, B.S. in 1975. I studied surgery, being at Royal Prince Alfred for two years, Port Kembla for a year, in the UK at teaching hospitals in Nottingham and Leeds for eighteen months and at Royal North Shore for eighteen months. In Australia I rotated through a number of different jobs and hospitals. I did a year of economics in 1977 and a year of law at the Barristers Admission Board.

I did my Fellowship of the Royal Australasian College of Surgeons Primary Exam in 1977, and my Fellowship of the Royal College of Surgeons in England in 1979. My hospital experience was surgical and somewhat skewed towards emergency and intensive care work. I did two years of general practice in a number of locations in Sydney and the Australian Country, and worked in Occupational Medicine at Sydney Water for 11 years, and in private practice for 3 years before entering parliament in 1998. I obtained by Master of Applied Science in Occupational Health and Safety at UNSW in 1995 with a thesis on workplace absence and health. The Masters had epidemiology as well as safety management and risk management theory. From 1981 I took a great deal of interest in the campaign against tobacco, so this and my occupational medicine at Sydney Water gave me a good insight into preventive health and institutional interactions with professionals, both in medicine and other disciplines such as engineering. I have had some personal experience with the New Zealand Health system and its quality control as my sister in law died of a somewhat mismanaged brain tumour there and I practiced there briefly and was asked to advocate for her.

My submission derives comments from my medical and surgical knowledge, hospital experience with a number of Australian hospitals, the New Zealand and the British National

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Health Service, and bureaucratic experience within Sydney Water, which was in a time of great managerial change while I was there. I have drawn on my knowledge of safety management, looked at the opportunity costs of intensive care and was well placed to compare preventive expenditures with intensive care ones, as I have practical experience of and have studied at both ends of the spectrum. Since being in Parliament I have been on the General Purpose Standing Committee Number 2 which is responsible for Health and Disability, which did an inquiry into the treatment of Dr Owen James by the Health Department, and inquiries into standards and accountability of NSW Country Hospitals and Port Macquarie Hospital in particular. I have also been on the Social Issues Committee and I initiated the DoCS Inquiry, and the Mental Health Inquiry. This has given me some insight into the process of resource allocation. I do not have personal experience of the hospitals named in this inquiry, but have been approached by some of the protagonists with anecdotal evidence of poor treatments and outcomes in Macarthur Health.

The submission is principally concerned with the methodology of the Inquiry and the outcomes likely. I am concerned that an adversarial approach is unable to deliver good practices in quality control. The political process, which is modelled on an adversarial legal model may deliver justice, but may not deliver a good safety management system in the sense that optimum work practices for the health of patients may not be achieved.

I believe that your terms of reference need to be expanded to deal with this subject adequately, and will pursue other avenues to attempt to achieve this.

I would be pleased to clarify any aspects that may interest you.  
Sincerely

Arthur Chesterfield-Evans M.B.,B.S., F.R.C.S.(Eng.), M.Appl.Sci.(OHS), M.L.C.

This submission relates to the methodology used for investigation and aspects of handling of complaints about Campbelltown and Camden Hospitals.

The author has considerable experience in examining case notes particularly where a problem has occurred, and has read a number of the case histories, but does not have first hand experience of these particular hospitals or cases.

### **Methods of Investigation**

The HCCC report suggested that it did not feel that it was resourced to carry out an investigation as extensive as this. This may well have been for logistic reasons. It tended to minimise the number of cases, so that it only examined 68 incidents of 117 presented to it, and reported on 47. It was, in epidemiological terms a series of case reports with a commentary on them, rather than a systematic analysis of the hospitals' function. It also illustrated the problems with the legal methodology.

### **Legal methodology:**

1. Assumes that there is an answer which can be deduced from piecing together statements from witnesses who have partial or complete knowledge of the facts
2. Does not do prospective investigations, or sample cases
3. Is adversarial in nature
4. Cannot quantify the certainty of its conclusions.

**Scientific methodology** is an alternative paradigm in social thinking. The scientific approach:

1. Assumes that the answer is not known and
2. Proposes stated hypotheses that it tests transparently
3. Ideally uses population sampling, rather than just cases notified
4. Is consensual rather than adversarial and
5. Clearly defines what is known and what is uncertain in probability terms.

While it may be argued that the above summary is simplistic, it cannot be disputed that the different nature of the two processes cause considerable trouble at the interface when one methodology examines the other, such as when scientific evidence is given in court, or science examines the evidence on which laws are based. In this case a legal model can test hypotheses through cross examination, though at times the cross examination relies on the subject being unaware of the hypothesis being tested.

The adversarial approach of the legal approach makes a defensive response more likely. This means that it is more difficult to discover the truth in each case, and more significantly, the adversarial approach stops the transparent and open discussion which allows hospital personnel to learn from each case and a good preventive system to be created.

The tort system is currently assumed to be the standard for assuring quality control in hospitals and medicine generally. This means that if treatment is suboptimal, the plaintiff sues, the doctor or system is brought to justice, and recompense is paid. There are a lot of problems with this:

### **Problems of the Tort System as it Effects Hospitals**

1. The adversarial approach means that the mistake is often hidden.
2. This means that many cases plaintiffs are unaware or are outside the statute of limitations, so access to the law is uncertain.

3. People within the system are reluctant to testify against each other as they are aware that they too could make a mistake, and they do not want to make professional enemies.
4. The inconvenience of the system is such that high fees are charged, as there is a possibility of a long court case at some indefinite future date disrupting work schedules as well as the acrimony referred to in (2) above).
5. The court system is so slow that the outcome is not known for years, so any lessons cannot really be implemented into the same framework to prevent other incidents. Personnel and practices will have changed considerably in any case.
6. There is no prevention, except a general fear of litigation, which tends to add to costs, but not really make much difference to preventive aspects, especially as the adversarial framework means that incidents will not be discussed to analyse where the weaknesses are.
7. The costs of insurance against poorly quantifiable risks are so great as to be changing career decisions with older practitioners retiring, or capable people not entering professions because of the barriers. This means also that there are fewer practitioners in marginal areas, such as Camden.
8. The patterns of practice are changed by the fear of litigation, with many unnecessary investigations and consultation being performed and an unwillingness to trust clinical judgement. This has a large opportunity cost, as if many unnecessary tests are done, there is less resources available for others to have necessary ones.
9. In terms of society's management of risk, the adversarial approach assumes that there is someone to blame. It is necessary that everyone is born (no matter how risky this may be seen to be), they everyone lives in society and that almost everyone is treated in the health system. It is therefore possible to sue the doctor if one is born with a defect, with a payment that aims to be compensation and costs for a lifetime. The cost of this is being borne by so few as to make the premiums prohibitive. By contrast it is somewhat absurd to be able to fall off a ladder in a domestic situation and by permanently injured yet receive no compensation at all. Society would be better served to accept more risks and to maximise prevention.

It is therefore recommended that the tort system be abolished for hospital work, and an alternative system be instituted with a highly preventive and quality control focus. This means that a 'no fault' system where there would be compensation if negligence were found, but it would be impossible to sue. The quid pro quo for this would be that all practices and all records of doctors and outcomes be openly discussed by quality control committees. There would be re-education for mistakes, and the Medical Board, and Medical Disciplinary Tribunal, and possibly the Administrative Decisions Tribunal would deal with misdemeanours.

It is recognised that this recommendation may be beyond the terms of reference of this inquiry, but the resolution of what is to be done about the suboptimal treatments that the HCCC Report identified, will require that this Inquiry decide if prosecutions or re-educations are warranted and if so, how many, and of whom. If there are many prosecutions and few re-educations, it will reinforce the tort model of blame and shame, and make the preventive model outlined in the Appendix more difficult to achieve.

### **Resource Implications of Tort Costs**

The success of the health system is relative. It achieves what it can within a number of parameters:

1. The health of the population

2. The incidence or prevalence of diseases
3. The current level of scientific understanding of disease causation and treatment
4. The level of technology potentially available
5. The level of resources to purchase that technology
6. The organisation to make the resources available in a practical sense
7. The level of knowledge in the staff delivering the service
8. The morale, norms and motivation of those staff
9. The organisation, cooperation and coordination of the staff, the degree to which management leads the staff, optimises resource use, and takes responsibilities for the outcomes of the system.

Examination or analysis of whether a hospital or health system is successful must look at this. In that the current tort system shifts resources into non-productive investigations, it drains them from better use. It is now a major factor in determining practice patterns and resource allocation. It also immensely damages potential quality control systems. In the article quoted below in the Appendix, the author contrasts competent safety practice in industry with the tort system as currently applied in hospitals. The article on medical indemnity was published in the Canberra Times, and suggests a new approach to quality control in hospitals based on a preventive approach, which is really only a statement of well known safety management theory, but is a radical departure from the direction of a political witch hunt.

### **Implications for the Inquiry's Findings**

The dilemma for the inquiry is whether it should go for no blame or punishment, which might lead to change, or blame and punishment leading to a number of people being relatively unemployable, morale being very low, and the adversarial scapegoating model being reinforced.

Reading the HCCC report suggests that the HCCC may not have been set up to conduct extensive examinations of hospitals, and was rather set up to look at the model of an individual case with simple errors or communication failures. Its report on Campbelltown and Camden hospitals was also criticised for not blaming those at fault. There is currently a political unwillingness to grasp the nettle of the management of incompetence within the medical system. The use of the Treasury Managed Fund to give medical indemnity cover does not overcome the costs of the adversarial system. The HCCC has tried not to have an adversarial system in its report, and has been criticised for this, which suggests that the political system is still in a 'blame and shame' paradigm. On the other hand, the legal system of torts and the reliance on torts as the ultimate coercing force in the maintenance of medical standards reinforces the legal adversarial model and makes open discussion and prevention difficult.

The whistleblower nurses have stated that there is a culture of systemic cover-up, indifference and incompetence, particularly at a managerial level, but also with senior staff that can influence norms. If this is proved and accepted it is necessary to have a major culture change. Yet the careers of those who may have been involved in considerably suboptimal outcomes will continue. Their norms will need to be changed, and the administrative and personal power bases must not protect them or allow the continuation of these suboptimal norms. The storm must not 'blow over' leaving the same people doing the same things in the same places. The whistleblowers feel that they can never fit into the system again, because these people will not change, and the enmities already created will blight their careers. If they are shown to be right, (and my reading of the cases I have seen makes me unashamedly believe that they are), then they should be hailed as heroes, and their integration into the system taken as a vindication. If

they cannot be reintegrated without discrimination, it is an important litmus test of the degree of culture change. Management assurances that all is now well, are simply not good enough. They are routine after any management change, and are a reflection of managerial ego and optimism rather than anything more substantial. While there is an adversarial framework, it is almost impossible that they can ever be reintegrated into the Health system in NSW, which is another point emphasising how destructive this is.

### **What the Inquiry Should Do**

It is suggested that the following methodology be used.

- The investigations be of all cases where misadventure is alleged, and strenuous efforts be made to identify these cases by looking at dates, admission to other hospitals and asking questions of those likely to know.
- There be attempts to find other cases of misadventure both from the public and from staff.
- To this end there be advertising that cases with confidential settlements are also discovered, as otherwise, these relatives will have been informed that their cases are ineligible for investigation. Also the records of AHS solicitors who had made compensation payments be obtained so that cases where there were confidential settlements are also included. The names of the cases would be all that is required, as they should be investigated in the same way as others.
- Ideally there would be a systematic study of a sample of cases, but as this is likely to be labour-intensive with tight time frames and hopefully lower yield-rate of mistakes it might be left. If it not done, however, the investigation should state clearly that it is not a quantitative study and cannot comment on the prevalence of mistakes or suboptimal management of cases.
- When cases are investigated a matrix or spreadsheet should be produced with the cases down one axis, and the personnel or managers responsible on the other. At the end of the process, the whole history of involvement of the personnel in the cases should be looked at and tailored plans be made for those involved in mismanaged cases. These plans should be the responsibility of a continuing education body, such as the Institute of Clinical Excellence (ICE), overseen by the Medical Board. The fact that people are on this programme should be known, so that justice is seen to be done. The fact that they are re-educated rather than disciplined in a clinical sense means that their careers can be ongoing. Naturally this does not mean that if crimes are committed that require sentencing that they should be immune. No doubt others are more aware of possible alternative disciplinary procedures than the author of this report.

### **Points to Consider**

In terms of hypotheses to be tested, a few points need to be made:

1. A previous chief administrator of Hunter Health, Dr Owen James, appeared before an inquiry of General Purpose Standing Committee Number 2 (GPS2) of the upper House. His complaint in essence was that he was managing Hunter Health at the time of the building of the John Hunter Hospital. As the Hunter Area Health Service's budget was being exceeded, he was asked to close Wallsend hospital. He replied that if this happened, the Hunter would have the longest waiting lists in the State. He said that naturally while a new hospital was being built, the budget would be exceeded, as existing services had to be maintained. He would be happy to close the old hospital, as soon as the new one could take up the task. He was told that if he closed Wallsend, he would have to take public criticism, but 'would be looked after' having done so. He still

declined, and said that he was then subjected to three corruption inquiries in 6 months, none of which found anything of substance. He was then pilloried in the media and sacked, at considerable personal and financial cost. He had come to GPS2 for redress, of his name at least.

2. The analogy of this situation is that if Camden Hospital were refurbished and given obstetrics in order to win the seat, Jennifer Collins would have been aware that she did not have the resources to staff it adequately. If this were the case, it is likely that she would have informed her superiors, and it is certainly possible that she was told to manage the situation as well as possible, and take any flak that was extant, and she would be looked after- deal reminiscent of that offered to Dr Owen James. If so, she took a different option to Owen James, with a different outcome.
3. It has been alleged that obstetric services were kept open at Camden for political reasons. Midwives were used, as they are increasingly being, as they are cheaper than Obstetricians. Clearly a full obstetric service cannot be offered unless there are emergency surgical facilities available and this also requires anaesthetics. Private consultants were used at huge cost per birth, in the absence of the ability to staff it from AHS personnel. Costs were not saved, but appearances were. This suggests a political imperative, rather than a good management one. If this is the case, the reasons for the decisions should be examined.
4. Ambulances have a list of priorities, and inter-hospital transfers are low on the priorities, as it is assumed that the patients are being looked after, and thus the transfer is assumed to be elective (i.e. not time-critical). If however, the patient needs to be seen by a surgeon and none could be got to Camden, or if surgical facilities were not available there after hours, the assumptions underlying ambulance priority ratings would have been incorrect. If Emergency staff had previously had to have 'stand-offs' with ambulance personnel or police in not accepting patients when they were dangerously overloaded, this would have made procedures difficult to overcome by personal interventions.
5. It is also well known in management theory that whatever is measured improves, often at the expense of what is not measured, but still important. Jennifer Collins was seen as an excellent manager until very late in this saga. It is thus likely that the Clinical Care committee did not look adequately at suboptimal case management, or if they did, they were not able to get their concerns heard within the AHS, perhaps for the reason suggested in 2 above.
6. It may be that as the Macarthur AHS was seen as less desirable from the point of view of key medical personnel. If this were the case, continuing good news about how well the service was performing may have changed this perception and helped the marketing of the AHS, (not to mention Collins career). It is possible a culture of 'Good News' at a public level was pursued, despite the fact that resources to deliver them did not exist.
7. In funding decisions, there is always a tendency to build capital works, as being permanent and visible, while trying to cut down on the personnel costs, which are the major running expense. This results in a situation where facilities improve as staff resources are at their most stretched, so when things appear most improved they are most at risk. It might be noted that there are no pictures on the wall in Campbelltown Hospital, and minimal landscaping suggesting that costs have been trimmed to the bone.
8. Anecdotal evidence suggests that as hospital stays have shortened, the logistics of getting people out of hospitals have become more important. There are thus more management functions, and the percentage of managers who have no direct connection with patients increase. These managers then use various figures or measurements as

proxies of quality, and there is pressure to improve the figures, even if people on the ground say that things are getting worse. Those who do not have direct contact can thus get out of touch. Dr Chesterfield-Evans observed this in the British National Health Service in the late 1970 and early 1980s, where doctors were demoralised and had no faith that decisions made had a realistic basis. This acceptance that silliness existed and nothing could be done, led to acceptance of poor standards of care and unnecessary deaths. It is Dr Chesterfield-Evans opinion that the number of people in the system without direct patient contact should be kept to an absolute minimum, that administrative duties should be performed as a by-product of actually dealing with people to the highest extent possible, and that people involved in administration should be based in wards or other patient facilities where they are maximally exposed to the people and concerns that they purport to serve. People involved in clinical care within the NSW Health system have commented that they spend so much time writing risk management plans that it impedes them actually doing work that would mean that management were at less risk. These risk management plans tend to reflect political risk to the system. There is a noteworthy parallel with the Social Issues Inquiry into DoCS, where managers commented that they were so busy managing which cases to manage, and writing justifications for cases that were likely to have poor outcomes that they had little time for useful work, let alone prevention or staff training on the job.

9. It is worrying that the Australian Council on Healthcare Standards accredited the Hospital while all this suboptimal care was being delivered. Perhaps indices, policies and procedures looked good, despite the non-implementation of these in a significant number of cases. It does suggest that there may be methodological problems in the accreditation process.
10. In the mid 1980s, management theory, principally from Harvard stated that one did have to be able to perform a procedure to manage it. There was in many industries a rush to write down policies and procedures. This was regarded somewhat askance by practitioners with specific expertise, as a management method of getting the basics of the skill in order to interfere in it. Professionals in a number of fields have spoken to the author about the objective of having the basic practices of tasks simplified and codified so that those with less training are able to do the tasks, and that in some areas this has allowed managers to dictate in areas where previously they would not have dared, and also enabled the 'dumbing down' of staff to the level of the practice and procedure. Arguably this shift of power away from the people involved in patient care, and the new emphasis on indices of throughput have adversely affected patient care. This is particularly the cases if those involved in the decisions do not see the practical implications of their decisions on the patients at a human level.

## **Appendix 1**

### **Time for a Total Rethink on Medical Indemnity Insurance**

The medical indemnity crisis is actually a situation crying out for a sensible safety management solution," says The Hon. Dr Arthur Chesterfield-Evans MLC.

The current stoush over the medical insurance levy shows how restricted our thinking on public liability has become. An argument over who pays for the doctors' insurance makes a lot of assumptions, including: that there will be mistakes, that money can fix them and that doctors should be the ones to pay.

What is needed is a fundamental rethink.

The standard way of reducing industrial accidents is to set up a safety department, and record all injuries that cause a loss of work time. These are then investigated systematically and recommendations are made as to how they can be prevented in future. As the sophistication of the system increases, incidents or practices that may cause injury are recorded and scrutinised. Risk managers quantify the probabilities of misadventure and cost solution options. Unsurprisingly, blurred responsibility or unclear communication creates special risks. It is acknowledged that accidents are often system failures with miscommunications, inappropriate procedures, changes in shifts or personnel, as well as mechanical failures, fatigue and misjudgements. Laziness, incompetence or even malice exist but are not usually primary causes.

No one seriously suggests that a lot of money fixes a medical misadventure. If a person dies, or a fatal diagnosis is missed, the money is cold comfort. Prevention is even more important than usual. What is needed is a system that analyses medical practice to identify errors and possible sources of future errors. It must involve and educate personnel, so as to change suboptimal procedures and identify changes needed.

The administrative foundation is to set up a standard reporting system for medical procedures. This can be very basic for most procedures, but more detailed if there are complications likely to have long term consequences. A quality control team could compare hospitals, doctors, and the many other professionals and management systems involved in the increasingly complicated delivery of modern medicine. The system would endeavour to be open and have a non-blaming culture with a major focus on prevention. Evidence suggests that there is a lot of scope for improvement in many aspects of the health system. Doctors could opt in to this if they wanted to, with reduced premiums as the incentive. If it were a credible system, it is hard to believe that they would not do so. The true enemy of good practice is the current adversarial system where there is a huge incentive to hide mistakes, or if that becomes impossible, to spend large amount of resources trying to shift blame.

Some medical personnel might need to be re-educated, but this is happening anyway. Some management practices would have to change. The simplistic idea that all medical problems are due to 'doctors mistakes' is simply nonsense. A more inclusive and analytic framework with counselling of those with alcohol or performance problems can cut industrial accidents. The medical system can be similarly improved.

But, "What about the patients redress?" some cry. The major point is that in the system suggested, there would be less patients harmed. An accident prevented gets no attention, but everyone is obviously better off. In terms of those who are injured, a finite benefits system, which relates payments to needs, and systematically co-operates in rehabilitation, retraining and long-term support is far better than a lump sum years later if the patient wins the legal system lottery.

Why is this simple suggestion not implemented? Perhaps because everyone is scared of a 'bureaucracy' which is what the quality control system would be. If bureaucracy is inefficient, this must be compared with the costs of the insurance and legal systems, where most of the money goes to insurance

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companies or the court system.

The current Howard solution is to subsidise the doctors' indemnity payments without altering the system at all. It is a non-solution. What is really needed is a rethink about how to deal with medical risk.

Dr Arthur Chesterfield-Evans M.B.,B.S., F.R.C.S.(Eng.), M.Appl.Sci.(OHS), MLC is a doctor with a degree in surgery and a masters in occupational health and safety who has been in the upper house in NSW parliament for 5 years

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