In the wake of hospital inquiries: impact on staff and safety

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ABSTRACT

- Mishandled concerns about clinical standards resulted in whistleblowing in four Australian hospitals.
- Official inquiries followed with recommendations to improve patient safety.
- In the aftermath of the inquiries, common themes included loss of trust in management and among clinical colleagues, and loss of trust from patients and the community.
- Without first rebuilding trust, staff will not report mistakes or other concerns about safety.
- Successful implementation of patient safety procedures requires policies to stress the professional duty of staff to report concerns about colleagues when they believe there is a risk to patients.

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Following a number of recent hospital inquiries, recommendations have been made to bring about system changes for safety and quality.[1-5] Although the need to change organisational culture has often been mentioned, little has been written about the difficulties in bringing about these changes in the aftermath of events like the Bundaberg Hospital inquiries. The impact of these events on both staff and patients can be severe, with effects felt throughout their local communities, along with unintended adverse impacts on safety. In this article, we describe the aftermath of recent inquiries into four hospitals[2-4,6] and set out some of the ways to regain the support of staff, which is necessary for implementing any recommendations. The authors of this article include the Directors of Medical Services who went into the hospitals following these events. Our aim is to describe the consequences for people of the events leading up to and after the inquiries, and to discuss how these situations in the aftermath can be prevented.

Synopsis of the hospital inquiries

The main inquiries into health system failures in Australia are related to four hospitals: King Edward Memorial Hospital, Canberra Hospital, Campbelltown and Camden Hospitals, and Bundaberg Base Hospital. The investigations arose after whistleblowers in each of the hospitals had made attempts to bring their concerns about patient safety to executive level, but were repeatedly rebuffed. The whistleblowers then directly approached politicians, who made these matters public.[4,6] The high level of media coverage following the disclosures suddenly placed hospital staff in the spotlight, and the ensuing publicity kept the hospitals under media scrutiny until well after the inquiries finished.

Bundaberg Base Hospital (BBH) and Queensland Health made national headlines in May 2005 as a result of Dr Jayant Patel, a general surgeon employed at BBH, being named in Parliament by the local Member of Parliament, who was briefed by the whistleblower, Ms Toni Hoffman. Dr Patel had withheld information that in 2001 he agreed to surrender his New York state licence to practise, and that the scope of his surgical practice was restricted in Oregon. A Commission of Inquiry into Queensland public hospitals investigated the deaths of close to 90 patients.[4] Another inquiry looked at the role of Queensland Health.[5] These events led to the resignations of the Queensland Minister for Health and the Director-General of Queensland Health; in BBH, the General Manager and the Director of Medical Services resigned, and the Director of Nursing was suspended. Dr Patel left Australia before investigations into his conduct were completed.

In 2002, several nurses at the Campbelltown and Camden Hospitals ("Cams"), frustrated in their repeated attempts to improve patient safety and care, complained to the State Minister for Health. The nurses were concerned that hospital management discouraged reporting of adverse events, and senior staff failed to take appropriate action when they had knowledge of misconduct. The inquiries that followed showed that these hospitals were poorly resourced, and that the surgeons and other staff were struggling in difficult circumstances.[3] Subsequently, several doctors were referred to the New South Wales Medical Board for investigation, but they have all since been exonerated.

At Canberra Hospital, a rehabilitation physician maintained pressure for several years at various levels in the health care system about the performance of a neurosurgeon, until the Australian Capital Territory Minister for Health set up an inquiry in 2000.[6] Other doctors had expressed concerns, but felt inhibited in making official reports.[7] The Inquiry's report, released in late 2003, raised sufficient concern that an external investigation was set up. The neurosurgeon was dismissed, but not before three other surgeons had been subjected to performance review — even though they were not the subjects of complaints.

In 1999, prompted by a report from the Chief Executive Officer (CEO) of King Edward Memorial Hospital (KEMH), the Health Service Board commissioned an investigation of quality and safety practices at the hospital. This was followed by a formal inquiry established by the Western Australia Minister for Health, which was completed over 2 years. The preliminary review found that the hospital appeared to have a high stillbirth rate when benchmarked against peer hospitals.[7] Subsequent reviews showed that this was not the case, and that the apparent excess mortality was the result of all stillbirths in WA being transferred to KEMH.[2] During the course of the investigations, the CEO dismissed the Director of Medical Services, the Director of Nursing and the General Manager.

Common themes: loss of trust

Four Australian hospital inquiries in a row have come to similar conclusions. These included the existence of organisational cultures inimical to safety, and inadequate clinical governance, particularly the absence of policies for dealing with poor clinical performance.[2-5] Many of these shortcomings had been brought to the attention of management over a number of years.

Common themes run through many of the instances of major failure in these four cases. These include loss of trust in administrators and among clinical colleagues, and loss of trust from

patients and the community. The Bundaberg scandal illustrates these themes more evidently, and so has had the worst aftermath. The inquiries showed that there had been problems for years at BBH between management and clinical staff. Policies and procedures were either absent or inadequate.[4,5] There were few exceptions:

> Glenys [Goodman, former Director of Nursing at BBH] did take me seriously, and she arranged meetings with the Medical Director . . . it was just the fact that they didn't want to listen. There were too many things at stake. — *Whistleblower.*

Both doctors and nurses could not trust that complaints would be acted on, so they did not report problems, or they managed around the problems.[4]

> A lot of us just wouldn't get Patel to do something if we had another option. And Dr X was totally managing around him, but we were all doing that to some extent. — *Physician.*

As in the other hospitals, apart from Canberra, the inquiries confirmed that the predominant concern of management was in balancing budgets rather than patient safety. The BBH story is an example of what happens when financial pressures prevail over the quality of care, leading to a culture of concealment.[8-11]

The relationship between doctors and patients depends on trust. In cases of professional misconduct, what often comes to light in inquiries is a history of abusing that trust.

> He [Patel] would instil a false sense of security and hope in people, and now we know just what he was doing. He was worse than the cyclone that came through here in terms of what he actually did to patients at Bundaberg. — *Whistleblower.*

Once the information has been made public through the inquiries, trust between patients and health professionals deteriorates across a broad front and beyond the hospital itself.

> There has been a decline in confidence in the medical profession in Bundaberg particularly. . . The big tragedy in this is the loss of trust that's happened in the medical profession . . . Patel betrayed the trust, and the consequences of that have been bad for the patients and they have been bad for Bundaberg, but in a sense it has sort of rocked the whole of the medical profession in Australia, hasn't it? — *Physician.*

At BBH, some doctors and nurses managed around Dr Patel, and their patients were unharmed. The victims of Dr Patel found this difficult to accept.

> At the Commission [of Inquiry] we heard nurses say they were frightened for their jobs, they had to watch patients die, and that doctors and nurses were hiding patients [from Patel]. We heard all these comments that made you reel in shock. From a patient's point of view that was the hardest thing for me to deal with. — *Patient spokesperson.*

The mistrust between patients and health professionals makes recruitment of new staff harder because people do not want to work in a place where the relationship with patients has been so damaged that there is an atmosphere of litigiousness.

> The Director of Medicine had about nine positions with locums who pulled out. When they hear "Bundaberg" they say, "Ah, no thanks" . . . it's a medicolegal minefield to work in . . . it's a very difficult environment . . . there are hardly any Queensland medical graduates. — *Physician.*

For staff, there is often loss of face and standing in the community. Some said events at work became topics of conversation from which they could not escape. Others described avoiding restaurants where they knew that fellow staff or patients would be sitting, and spoke about being insulted or even spat on in public places. The inquiries themselves, the tribunals, and the attendant media coverage made it harder for staff and the community to get back to normal.

> I think staff have been affected, of course, but more from the aftermath, not the actual happenings with Dr Patel. Not so much what he did and didn't do, but more from the events that happened after he left Australia. — *Former Director of Nursing.*

Senior clinical leaders at BBH and KEMH, and the District General Manager at BBH were stood aside. A consequence was that at a time when it was most needed, organisational memory was lost. Another consequence was that the senior middle managers were leaderless, and it is among executive directors and senior middle managers that the highest levels of absence related to stress and sickness can be found. Some will not return to work in the same institution, and others may be unfit for work in the long term.

Four circumstances, different aftermaths

There are important differences between the four cases that affect the introduction of safety systems following the inquiries. We think that what matters is who complained about whom, the length of time taken to conduct the inquiry, and the role played by the executive management.

At BBH, the whistleblower was a nurse, and doctors were also concerned about patient safety. At KEMH, the health professionals saw the CEO as the problem. At Canberra Hospital, the dispute was protracted, but largely restricted to one doctor concerned about the performance of another. At Cams, there was a definite division into two camps: the nurse whistleblowers versus surgeons. In each case, the breakdown of these relationships contributed to subsequent difficulties.

The length of time that the inquiries continue also plays a role. At KEMH, the CEO was fairly swiftly removed, and the hospital returned to normal quite rapidly. In contrast, safety systems have been hard to re-establish in BBH because of the prolonged period between the first concerns expressed by the whistleblower and the end of the inquiries, the intensity of media coverage, and the longstanding problems in Queensland Health.

At Canberra Hospital, although the allegations were made about one neurosurgeon, all neurosurgeons were investigated, which alienated them from management.

At Cams, the allegations were made by nurses about surgeons who were later exonerated. The surgeons felt even more embittered because they knew they had been working in a poorly resourced hospital for many years, without registrars, and doing their own nights on call. The relationship between surgeons and nurses remained poor. Consequently, the surgeons went from holding open morbidity and mortality meetings to holding them behind closed doors with no nurses present. It seems likely that adverse event reporting has declined. People are more cautious about what they write in clinical notes and the net effect is less openness, honesty and cooperation in striving for better patient safety.

At both Cams and KEMH, there were longstanding problems that had not caused harm, but were also not handled well, and there was a lack of management systems. At Cams, the subsequent reduced openness in communication was an adverse aftermath for patient safety. At KEMH, events came to a swift climax and the

People interviewed to provide information for this article

- Dr Bill Beresford, Medical Director at Bundaberg Base Hospital (BBH) from September 2005 to July 2006. For 2 years, he was Acting Chief Executive Officer (CEO) of King Edward Memorial Hospital after the CEO was dismissed.
- Professor Sir Graeme Catto, President of the General Medical Council, United Kingdom.
- Ms Beryl Crosby, President of the Bundaberg Hospital Patients Support Group.
- Mr Geoffrey Davies AO, QC, Commissioner, The Queensland Public Hospitals Commission of Inquiry.
- Ms Glenys Goodman, Director of Nursing at BBH until retiring in September 2003.
- Ms Toni Hoffman, Charge Nurse, Intensive Care Unit, BBH.
- Professor Reginald S A Lord, Director of Surgery, Campbelltown and Camden Hospitals, and Professor of Surgery, University of Western Sydney.
- Mr Anthony Morris, QC, formerly Chairman of the Bundaberg Hospital Commission of Inquiry.
- Dr Wayne Ramsey, Deputy General Manager — Clinical at The Canberra Hospital in 2002 and 2003.
- Dr Martin Strahan, Physician, Visiting Medical Officer, former Chair of the Local Medical Committee and Director of Medicine, BBH. ◆

hospital returned to normal quite quickly. At Canberra Hospital, there was a slow response to the concerns raised by the whistleblower. The media reaction to the response was highly critical, with concomitant loss of trust from patients and the community.

Rebuilding trust

What we have learned from examining the four cases is that, above all else, there needs to be a way in which health professionals can be sure that their concerns about clinical standards will be openly and impartially investigated, and that where it turns out that the issue is poor professional performance, good policies exist to deal with it.

The two outstanding features of all four cases were that concerns were not investigated to the satisfaction of the whistleblowers, and that policies did not exist for investigating allegations of poor professional performance. The result was that whistleblowers went outside the system to have their concerns investigated, which resulted in a damaging aftermath in two of the four hospitals. In saying this, we are not blaming the whistleblowers, but are making the point that open, honest, and timely investigation undertaken within the organisation avoids a potentially damaging aftermath that, paradoxically, can make individuals fearful of disclosing mistakes.[12]

Unfortunately, many health care organisations are renowned for their gap between rhetoric and reality. Some even have a culture of concealment, blame, and scapegoating that goes back decades.[13] It is not surprising that many health care professionals have little faith that anything will change. The change has to come from management establishing its honesty, which leads to trust and a belief that things can change. Part of a successful approach for CEOs and Directors of Medical Services is to walk the job, and to talk to staff in a way that allows them to discuss any threats to patient safety, rather than relying on written policies and procedures alone.

Although we know what to do to make health care systems safe,[12] actually doing it is proving difficult.[13] It requires the organisation to be able to learn from its mistakes, which in turn requires a culture that encourages honest and open disclosure when mistakes are made.[14,15] One way to rebuild trust is for senior managers to show a commitment to managing complaints in a manner that includes all the elements of natural justice. Trust cannot be rebuilt in isolation from other structural reforms required to deliver cultural change. Senior management must lead the movement for greater patient safety and have a comprehensive set of governance arrangements. Otherwise, the organisational culture will not be sufficiently robust.

Our conclusion is that health care providers can set up systems that deal satisfactorily with concerns about clinical competence.

Following events in Bristol and elsewhere in the United Kingdom, there are now ethical obligations enforced by the General Medical Council (GMC) — National Health Service policies and procedures that require doctors who have doubts about a colleague's professional performance to take action.[16-18] These policies, which should be well understood by every doctor, are set out in local procedures usually managed by Directors of Medical Services in the first instance.[19] In Australia, there has been a similar response in some jurisdictions, but not all.[20,21] The consequences of such policies are that patients can have faith that the medical profession is tackling poor performance, and that doctors themselves know that satisfactory and judicious local resolution commonly occurs.

> The issue is not a conceptual one, but one of practical application . . . In today's environment . . . if there's a risk to patients . . . we expect people to pipe up, but pipe up locally. — *President, GMC.*

The damaging aftermath of events like Bundaberg can be avoided.

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Competing interests

James Dunbar and Prasuna Reddy were previously consultants to the Hay Group, which obtained a contract to provide leadership training for Queensland Health.

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