When silence threatens safety: Lessons from the first Canberra Hospital Neurosurgical Inquiry

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Despite widespread institutional and professional support, the recommendations of the Bristol Royal Infirmary Inquiry may be insufficient to reduce patient risk from impaired senior medical practitioners. Using the First Inquiry into Neurosurgical Services at the Canberra Hospital as a case study, this article argues that the Bristol-type recommendations – which emphasise reformulation of clinical governance structures, including early reporting of “sentinel events” and compulsory clinical audits – will be ineffective without a reformed institutional ethos that encourages open transparency and respect for those committed to such processes. Such reformulation may need to commence in medical education and involve new strategies including the use of portable digital technology to facilitate self-assessment of performance and immediate reporting of adverse incidents.

INTRODUCTION

Between October 1998 and July 2001, a public inquiry, chaired by Professor Ian Kennedy, examined allegations by anaesthetist Dr Steven Bolsin that paediatric cardiac surgeons at the Royal Bristol Infirmary were causing unnecessary operative deaths. The Bristol Inquiry, in finding the impairments proven, drew attention to a “club culture” which focused power on a few senior practitioners and in which vulnerable children were not given priority in clinical decision-making.¹ It recommended, amongst other things, the creation of an overarching Council for the Regulation of Health Care Professionals, a Council for the Quality of Health Care and a national database of sentinel events with facilitated reporting and in-confidence, compulsory clinical audits.²

The repercussions for the career and family of Dr Steven Bolsin were severe. Dr Bolsin was at a disadvantage in never having been trained in how properly to respond to a situation where what are now termed clinical governance structures, fail. Patients at that institution suffered from the fact that the professional culture there appeared to regard health care whistle-blowing as a “pariah” activity that should not be taken seriously in a regulatory sense. Shunned by many senior colleagues in the United Kingdom, Dr Bolsin emigrated to Australia to take up a position as Associate Professor in peri-operative care at Geelong Hospital in Victoria.³

² Bristol Royal Infirmary Inquiry, n 1.
In the aftermath of the Bristol Inquiry, it was widely thought that the introduction of clinical governance initiatives would prevent the recurrence of such problems. Health care whistle-blowers, it was argued, were not necessary in a system with adequate peer review, regular audits and functional sentinel-event reporting. No recommendations about “whistle-blowing” were included in the medical education section of the Bristol Inquiry Report.

Since the Bristol Inquiry, many Australian public hospitals have been active in developing what are termed “clinical governance structures”. These generally involve a highly documented system of interacting administrative processes designed to continuously improve quality and safety in the delivery of health care. Components relate to clinical competence, clinical effectiveness, clinical audit, clinical risk-management and maintenance of best practice. In the spring of 2002 The Canberra Hospital (TCH) in the Australian Capital Territory implemented a clinical governance strategy for the first time.

This article analyses particular issues arising out of the actions of a rehabilitation physician at TCH to obtain an inquiry into neurosurgical services there. His story as a health care whistleblower is by no means unique. It is similar, for example, to the adverse experiences of the nurses whose whistle-blowing instigated the New South Wales Healthcare Complaints Commission investigation into Campbelltown and Camden Hospitals. What is particularly instructive in this case, however, is the extent to which appropriate regulatory processes – such as the investigative powers of a Health Complaints Commissioner and best practice clinical governance initiatives – can be frustrated by an institutional culture resistant to individual criticism, even after justification for those concerns have been established.

SENIOR STAFF’S POOR COOPERATION WITH THE INQUIRY

Dr Gerard McLaren is a rehabilitation physician and former Director of that service at TCH. From approximately 1995, he had first-hand experience of what he perceived to be unnecessarily adverse outcomes resulting from various forms of neurosurgery taking place at TCH.

Dr McLaren began collecting relevant data and evidence of cases of interest. On 21 April 1997 he wrote to the Medical Director of Surgical Services at TCH and soon after approached a member of the TCH Board to express his concerns. No formal attempt to investigate the allegations was made. This inaction may be partly explained by the absence of clinical governance pathways in the institution at that time.

Dissatisfied with the response he received, Dr McLaren approached the then Health Minister of the Australian Capital Territory. In May 1999 the Minister appointed a Committee comprising two United Kingdom neurosurgeons to conduct a clinical audit of neurosurgery at TCH. This was frustrated by one of the specialists declining to participate and the other suffering a neurologic emergency himself. On 4 December 2000, the Minister ordered the Health Complaints Commissioner to conduct an inquiry into the neurological services at TCH pursuant to s 11 of the Community and Health Services Complaints Act 1993 (ACT).

The terms of reference given by the Minister to the Commissioner were broad, with the inquiry to be concerned with the safety of patients and standard of practice and care provided at TCH. Section 43(1) of the Community and Health Services Complaints Act 1993 (ACT) gave the Commissioner discretion to conduct the investigation in such way as the Commissioner thought fit. Sections 45-47 of the Act provide the Commissioner with significant power to require a person to attend for examination, provide information, or produce documents or records. The penalty for refusal...
or failure to comply involves a fine or imprisonment for up to six months. The Commissioner may also apply to the Supreme Court for similar orders (s 47(2)). On their face, these powers were more than adequate to allow collection of all relevant data. The Minister did not, as was permitted under s 11(2) of the Act, specify the time within which the direction was to be complied with.

The process of inquiry first involved the Commissioner and a staff member (neither medically trained) collecting evidence and information. The evidence sought included statistical information and witness statements, as well as details of alleged adverse outcomes in individual cases. The investigators spoke with all neurologists and neurosurgeons at TCH, as well as a large number of nurses and physicians who had expressed concern about the issue.

The Commissioner expressly noted in his 2002-2003 Annual Report that a large number of health professionals, including all the neurosurgeons at TCH, failed to meet their statutory obligations to assist his investigation by responding to a “Notice to Provide Information”. The Commissioner chose not to compel the recalcitrant health professionals to provide information. One reason related to the need to maintain personal working relationships and future cooperation between the Commissioner and health service providers in this relatively small medical community. It was also the Commissioner’s belief that information and evidence procured by legal compulsion would not necessarily reflect the unadorned truth. These reasons appear to highlight the Commissioner’s problems with an “ethos” amongst senior staff at TCH that appeared not to favour full disclosure and was resistant to his investigation. They also emphasise, however, his reluctance to challenge that negative ethos openly.

Another evidentiary method considered, but rejected, by the Commissioner was to require direct peer monitoring of the neurosurgeon in question, so as to assess his operative competency. The Commissioner subsequently alleged, however, that the TCH Clinical Privileges Committee resisted the introduction of such outside experts to review the operative practice of its neurosurgeons as unduly threatening local professional reputations. That Committee also argued that the value of evidence collected through direct monitoring was limited. Under such pressured observance, they supposedly claimed, careless practitioners may become thorough, while meticulous practitioners may make uncharacteristic mistakes.

Conflicting understandings also appear to have existed between the Commissioner and the Chairman of the Australian Capital Territory Medical Board regarding expert assessment of evidence required for and involved in the Inquiry. In October 2002, as the Inquiry continued, a clinical governance strategy was implemented at TCH.

INQUIRY REPORT SUPPRESSED
The failure of many senior staff to provide uncensored information to the Inquiry was only one example of an institutional culture at TCH and the involved regulatory bodies that appeared inimical to full support of the staff member making the complaint and the Inquiry itself. This culture of hindrance appears to have continued after the creation of best-practice clinical governance guidelines. The Commissioner himself may have contributed to it by suppressing the Inquiry report.

On 11 February 2003, the Commissioner prepared a report of his findings and conclusions of the Inquiry, as required by s 51(1) of the Community and Health Services Complaints Act 1993 (ACT). This was some five months after work had begun on clinical guidelines for TCH and over two years since the Inquiry commenced. Copies were given to the Minister (as mandated by s 51(2)), as well as to TCH senior management, the Australian Capital Territory Medical Board and the relevant neurosurgeon at TCH. Neither Dr McLaren nor any of the patients whose cases were considered by the Inquiry received a copy.

12 Interview by law students with K Patterson, Community and Health Services Complaints Commission (ACT Health Building, 3 October 2003).
13 See n 12.
14 See n 12.
15 The Canberra Hospital, n 7.
When silence threatens safety: Lessons from the first Canberra Hospital Neurosurgical Inquiry

The relevant legislation is somewhat ambiguous concerning the entitlement of patients and complainants when a s 11 inquiry is involved. The Commissioner also appears to have considered that suppression best protected patient confidentiality and that natural justice requirements concomitant with release might further delay resolution of the Inquiry. The report, in his view, had never been prepared for public viewing. The reluctance to release the report could not have fostered public confidence that TCH had achieved a thorough resolution of the issue.

Dr McLaren received a letter from the Chairman of the Australian Capital Territory Medical Board on 24 March 2003, highlighting the Chairman’s concern about this lack of transparency, the consequences of the Inquiry receiving inadequate evidence and the reluctance of health professionals to come forward:

The members of the Medical Board are not entitled to read the report, but members of the Professional Standards Committee of the Board have reviewed it.

Their advice was that there was insufficient evidence to justify the holding of a formal inquiry into the practice of any registered medical practitioner mentioned in the report. At its meeting on 21 March 2003, the Board resolved to accept this advice…

The report highlighted deficiencies in procedures at The Canberra Hospital when concerns are raised about standards of practice…

Members of the Board remain frustrated by the conduct of many of our colleagues who are all too ready to criticise others, but who will not agree to make formal complaints on which the Board can act.

We are very grateful for your attempts to bring your concerns to notice and we appreciate that this may have been at considerable cost to your health and career.

Early in October 2003 the Commissioner, in his Annual Report, for the first time set out a summary of his findings on the Inquiry into neurosurgical services at TCH that had commenced almost three years before. He noted that “some surgeons claimed not to be in a position to comment on another surgeon’s patients”. He also reported that “some health professionals failed to meet their statutory obligations to assist the Commissioner’s Investigation”. The critical finding was as follows:

A highly respected and independent neurosurgeon reviewed a number of cases where concern had been expressed about the standard of care. The reviewer was critical of the standard of care in some cases but, in the light of actions already taken by those criticised, he advised that no further action was needed to ensure public safety. The information available to the reviewer, although extensive, was not sufficient to allow him to form a final view about the standard of practice issues. Further investigation would have been necessary if the changes had not occurred in order to make a definitive finding.

The “actions already taken” referred to the decision of the neurosurgeon chiefly investigated to cease practice at TCH, though he continued to practise as a private consultant from his rooms. Whether this action truly resolved the situation from the patients’ or the general public’s point of view is debatable. Though the surgeon’s decision was relevant to the safety of further surgical patients, it said little, however, to those patients who may already have suffered unnecessary injury and for whom a more “definitive finding” would have been important, regardless of whether the neurosurgeon decided to continue active work.

The Commissioner made a variety of recommendations apparently designed to enhance transparency and willingness to cooperate amongst the professional culture that had, to a large extent, hampered his investigation. He recommended that a body independent of the Commissioner have power to review the actions taken by him in response to a complaint at the request of a complainant or service provider. He also proposed that rules about who can receive copies of investigation reports should be changed so that complainants could receive more information relevant to their concerns. He moved towards mandating that registered health professionals report failures to meet professional

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16 Interview by law students with K Patterson, Community and Health Services Complaints Commission (ACT Health Building, 3 October 2003).
18 ACT Community and Health Services Complaints Commissioner, n 17, p 57.
19 ACT Community and Health Services Complaints Commissioner, n 17, p 57.
20 ACT Community and Health Services Complaints Commissioner, n 17, p 57.
standards, particularly when such failures result in a significant risk to the public. He recommended extending the definition of categories of people who have a legal right to complain to his office. He also called for the capacity to inform patients that his office was investigating the standard of their care, whether or not that patient had lodged a complaint. 21

PRESSURE TO RELEASE THE INQUIRY REPORT

Dr McLaren presented three de-identified versions of cases from the suppressed Inquiry at TCH Grand Rounds on 13 August 2003. This was at a time when the Inquiry report was still suppressed and no details of it had been released by the Commissioner. Protection of the Public Interest Disclosure Act 1993 (ACT) by right extended to Dr McLaren, since his disclosures concerned the conduct of the neurosurgeon operating at a public hospital (a “public official”) whose impugned actions, if true, amounted to a “substantial and specific danger to the health and safety of the public” (ss 3 and 15). Further, Dr McLaren’s concerns were expressed chiefly to the Chief Executive Officer of TCH and its governing body either directly or indirectly though mechanisms such as the Grand Rounds and the clinical governance pathways of that institution. 22 Dr McLaren, however, believed he had experienced conduct from many of his colleagues that closely resembled “unlawful reprisals” or “harassment and intimidation” that causes “detriment”. 23 Such “reprisals” are difficult to prove, however, as a defence arises whenever a “reasonable ground” can be shown to have existed under s 25(2) of the Public Interest Disclosure Act 1993 (ACT).

As a result of the Grand Rounds presentation, a general practitioner sent a post-neurosurgical patient to Dr McLaren. Her case had been considered by the Inquiry. 24 On 15 October 2003, Dr McLaren, together with the patient, presented her case to the Professional Standards Committee of the Medical Board of the Australian Capital Territory. The Health Complaints Commissioner’s Inquiry now being complete, the Medical Board felt able to consider this case separately. Dr McLaren also informed the Medical Board on that occasion that he was aware that the neurosurgeon in question had applied for clinical privileges at a private hospital in the Australian Capital Territory.

During this period the law student authors of this article interviewed both the Commissioner and the Chairman of the Australian Capital Territory Medical Board about the Inquiry. They focused solely on administrative deficiencies in the Inquiry process, including the suppression of its report and the reluctance of health professionals to provide evidence to the Inquiry. In November 2003 the first author presented a paper on this issue to the Australian Institute of Health Law and Ethics (AIHLE) Annual Conference in Hobart, Tasmania.

Eventually, evidence began to emerge of a shift in the institutional culture concerning these complaints. The Chief Executive of ACT Health, in a letter to Dr McLaren dated 31 October 2003, stated:

I can assure you that this matter is being taken seriously at senior level within ACT Health and I will oversee the process with consideration of your concerns with the Commissioner or the Medical Board personally.

On 10 December 2003 the Minister tabled in the Australian Capital Territory Legislative Assembly the long-suppressed Report of the Commissioner’s Inquiry. He also indicated that external reviewers would conduct a retrospective review of all the neurosurgeon’s cases over a specified period, as well as reinvestigate all the cases in the first Inquiry. The Canberra Times published the name and photograph of the neurosurgeon primarily concerned and announced that a “hotline” had been established for concerned patients. Within a few months it had received well over 100 responses. The Canberra Times also carried a separate story and picture about the patient Dr McLaren had presented to the Medical Board.

21 ACT Community and Health Services Complaints Commissioner, Legislation Regulating the Commission (Canberra, 2002); see http://www.healthcomplaints.act.gov.au/chec.
22 Public Interest Disclosure Act 1993 (ACT), s 3.
23 Personal correspondence with Dr G McLaren, December 2003.
24 The patient has given her express permission for this information to be made public.
After reading the Report of the Inquiry, one is left with considerable doubt that its suppression served the public interest rather than that of the health care system. The evidence collected and the findings of the external reviewer appear to more than justify the concerns expressed by Dr McLaren and to cause significant doubt about why senior specialists declined to cooperate with the Inquiry. One eminent respondent is quoted as mentioning a case where the particular neurosurgeon had attempted to place a subcutaneous ventriculo-peritoneal shunt to relieve hydrocephalus. The patient had bled to death on the operating table. The coroner found that the trocar used to insert the shunt had lacerated her pulmonary arteries and liver. No action was taken against the neurosurgeon.

A clinician respondent is quoted in the Inquiry Report as stating: “This single event certainly caused a lot of people who had been expressing concern about [the neurosurgeon’s] practice and demanding some action to withdraw from the field, as they felt it was highly unlikely anything would ever be able to be done about it.”25 The reviewer noted of this case: “There was a significant failure of duty of care.” He was “concerned that [the neurosurgeon] failed to recognise the significance of where the introducer was when it was exposed in the abdomen”.26 The apparent inaction of the regulatory process here may have itself contributed to an institutional culture that was not conducive to reporting such issues.

A senior specialist in medical imaging at TCH was reported as stating: “I have worked with [the neurosurgeon] for approximately 15 years… I do not believe that [he] has the skills required to practise neurosurgery and I have advised him of this personally.” This radiologist is quoted in the Inquiry Report as citing “five instances of poor judgment, three instances of impatience and five instances of poor surgical techniques”.27 Such remarks become quite disturbing when set, as they must be, in the context of a Report that had been suppressed for over a year and an Inquiry that was hampered by lack of peer-review evidence.

CHANGING THE NEGATIVE ETHOS WITH EDUCATION

One important lesson from the first Canberra Hospital Neurosurgical Inquiry is that, even with best-practice clinical governance standards in place, and a Health Complaints Commissioner with adequate powers to compel the production of evidence, health care quality and safety will be compromised if a negative institutional culture is permitted to persist. How do we initiate the required change? One approach at the Australian National University Medical School has been to design a curriculum in which medical students are taught to understand the mix of conscience, medical ethics, legal and human rights principles that feed into clinical governance pathways to justify the act of “whistleblowing” when they are frustrated by a negative ethos. It is hoped that this may soon be linked with programmed portable digital technology facilitating self-assessment and incident reporting.28 Learning when to conciliate, when to consult, when to rely on existing peer-review structures and when to move to external sources of review, involves a complex balancing process that must be taken seriously in medical education. It cannot be left to chance.

The “good faith” whistle-blower in clinical medicine (one who has first “exhausted” all extant clinical governance strategies) and whose public allegations are made in good faith in the public interest and are not vexatious, should be promoted to medical students and amongst the profession as a true inheritor of the foundational professional virtue of loyalty to the relief of patient suffering. The World Medical Association’s International Code of Medical Ethics, for example, provides:

A physician shall, in all types of medical practice, be dedicated to providing competent medical service in full technical and moral independence, with compassion and respect for human dignity… A physician shall strive to expose those physicians deficient in character or competence, who engage in fraud or deception.29

25 ACT Community and Health Services Complaints Commissioner, A Final Report of the Investigation into Adverse Patient Outcomes of Neurosurgical Services Provided by the Canberra Hospital (February 2003) p 44.
26 ACT Community and Health Services Complaints Commissioner, n 25, p 79.
27 ACT Community and Health Services Complaints Commissioner, n 25, p 49.
There are many reasons why the current system of clinical governance in our public hospitals, however effective it appears on paper, will struggle to cope with disclosures of risk to patients arising from the actions of impaired senior medical practitioners. The eminence of such individuals is fenced in by a medical culture that continues to support a myth of infallibility and error-free performance. This means that, despite increased encouragement to report sentinel events and engage actively in peer review, many errors and adverse events are still not openly discussed.

The medical profession, unlike the financial sector, lacks detailed mandatory reporting procedures that displace threats of civil and criminal suits for acts of “whistle-blowing” in the public interest. Instead, doctors are under what is primarily an ethical obligation and a duty of loyalty to patients to conduct appropriate peer review. Often that obligation is in conflict with a perceived need to be loyal to one’s colleagues. That appears to be why doctors who “blow the whistle” on others cause such consternation in the profession.

Commentators have remarked that expeditious transparency in resolving such issues in the medical workplace would not only allow doctors to learn from their mistakes but also lessen the trauma for patients who have suffered. It is surely ethical to be open and truthful when confronting what appears to be a medical mistake, even though this may compromise tortious liability. Society has an obligation to ensure personal accountability and the replacement of a “silence-or-blame” culture in the medical profession.

35 McNeill and Walton, n 31 at 223.