Medical Practice and Medical Administration

Address to the
James Cook University Medical Students' Association
Townsville, 21 October 2005

by
Anthony J H Morris QC

The legal and medical professions have this much in common: both of our professions have long been a staple source of inspiration for television and movie fiction. At least in the case of the law – and I suspect it is the same with medicine – almost every TV series bears not even the slightest resemblance to anything which actually occurs in practice. But that has not prevented TV producers, especially in the US, continuing to churn out one legal series after another – from ***Perry Mason*** in the 1960s, to ***LA Law*** in the 1980s, to a spate of more recent offerings: ***Ally McBeal***; ***The Practice***; ***Law & Order***; ***Boston Legal***; not to forget the inestimable ***Judge Judy*** – and, I have no doubt, many, many more which have slipped under my radar.

When I was a law student, some 25 years ago, the most popular television programme amongst aspiring lawyers was ***Rumpole of the Bailey***, because – unlike most TV shows with a legal theme – it was fairly accurate in its portrayal of the English legal system, and therefore the Australian legal system. It helped that the scripts were written by a QC, John Mortimer. Probably the most accurate television legal drama since ***Rumpole*** was (predictably) another British series, ***Wing and a Prayer*** – though, even on the first run, you have to be an insomniac to catch it.

For every legal-themed television series, I guess there have been at least two based around medical practice. The great-grandfathers of this genre were contemporaries of ***Perry Mason*** – two execrable American programmes, ***Ben Casey*** and ***Dr. Kildaire***, and ***Dr Findlay's Casebook***, a typically homespun British series about a general practice in the Scottish highlands.

A little later, there came a British comedy series, ***Doctor in the House***, which was a spin-off from a very successful movie of the same name, in turn based on an extremely popular set of novels by Richard Gordon. The movie starred Dirk Bogarde as the hapless but idealistic medical student, Simon Sparrow, and James Robertson-Justice as the fearsome professor of medicine, Sir Lancelot Spratt. In the TV series, Sir Lancelot Spratt became Professor Sir Geoffrey Loftus – even today, older members of the medical profession may describe their more pompous and opinionated colleagues as a "Sir Lancelot Spratt" or a "Sir Geoffrey Loftus". The success of this series was guaranteed by the quality of the script-writing, led by John Cleese and Graham Chapman (of ***Monty Python*** fame) and Bill Oddie and Graeme Garden (of ***The Goodies***).

Another significant medical comedy of the same era was the movie ***Carry on Doctor***, although the humour on this occasion was rather less subtle – one memorable line was, "No, no, sister! I told you to ***prick*** his ***boil***!"

I would not even attempt to guess how many medical-themed television programmes there have been since the early days of broadcasting. They include programmes as absurd as ***Doogie Howser MD*** and ***General Hospital***. In the latter, it is difficult to imagine how the unbelievably handsome medical practitioners, and the unbelievably attractive nurses, ever managed to provide any clinical services, as not a single patient ever seemed to be present in the General Hospital – which is probably fortunate, given that the clinical staff were no doubt both physically and emotionally exhausted from their never-ending extra-curricular activities.

By contrast, at least some medical dramas have actually focused on the practice of medicine, of which some of the better examples include UK programmes like ***Casualty*** and ***Holby City***, the outstanding ***M*A*S*H*** series from the US (at least until it became overwhelmingly sanctimonious), and some Australian-produced programmes like ***GP***, ***A Country Practice*** and ***All Saints.*** One uniquely Australian innovation has been a "cross over" between the legal and medical drama genres, with the programme ***MDA – Medical Defence Australia***.

There is a reason for my mentioning these programmes. Many of those which purport to portray a medical practice, especially in a hospital environment, have a common theme – and I am not referring to the theme of doctors and nurses playing "Doctors and Nurses". Again and again, these programmes – or at least the more serious ones – focus on the tensions between hospital management and clinical staff.

Those of you who follow ***House MD*** – possibly the best American production in any genre at the present time – will have applauded the very unlikely outcome when the brilliant but anti-social and erratic Dr. Gregory House, played by Englishman Hugh Laurie, defeated Edward Vogler, the evil billionaire businessman whose massive donations to the hospital had secured his appointment as chairman of the board of directors. Of course, we were all on the doctor's side, but none of us expected him to win.

When I was appointed to chair the Bundaberg Hospital Commission of Inquiry, I must have been incredibly naïve – I assumed that such tensions between hospital management and clinical staff were simply a plot device created out of the fertile imaginations of television screenwriters. Surely, I thought, everyone involved in the public hospital system is on the same side – everyone wants to do the best for the patients! How wrong I was!

My naïve optimism was blown away in the very first days of evidence, when testimony was given by Dr. Peter Miach, a highly-respected nephrologist and the senior physician at Bundaberg Base Hospital. Dr. Miach described[1] an encounter which he had with one of the senior bureaucrats at the Hospital – a conversation which could have been plucked straight out of a script from ***House MD***. After Dr. Miach vented his frustrations about the problems he was experiencing with Jayant Patel, the bureaucrat responded, "You have to understand this is a business". Miach's response was: "You see, that's the problem. I think it's a hospital".

As the Inquiry progressed, it became overwhelmingly apparent that this mind-set was not confined to one or two bureaucrats in Bundaberg – it is a mind-set that is wide-spread, perhaps ubiquitous, amongst Queensland Health administrators.

NAMING RITES

Partly, it is a matter of names. The Department of Health almost never refers to itself as a Department – it is "Queensland Health", a catchy business name which does not carry the implication of being a governmental entity which exists only to serve the public. The Department's headquarters in Charlotte Street, Brisbane, are routinely referred to as "the corporate office", as if the Department were a corporation dedicated to making money for its shareholders, rather than a public sector body devoted to serving the community.

Medical Superintendents are no longer called "superintendents" – they are "Directors of Medical Services", apart from the more illustrious ones, who are "***Executive*** Directors of Medical Services". A clinician who wishes to implement a new initiative is not expected to produce a proposal or even a submission – he or she

[1] statement of Dr Peter Miach, at the Bundaberg Hospital Commission of Inquiry, exhibit 21; see also the transcript of his evidence, 26 May 2005, p. 343 lines 40 to 50.

must come up with a "business plan". Not even patients have escaped this process of terminological re-classification: they are no longer called "patients"; they are now "clients".

One of the most impressive witnesses to provide evidence at the Inquiry was Dr. Brian Theile, a world-class vascular surgeon, who, after a long and successful career in the United States, both as a practicing surgeon and as a medical academic, returned to his hometown of Bundaberg. He particularly objected to the use of the term "clients", inferring that this term places the relationship between a medical practitioner and a patient on the same footing as the relationship between a solicitor or accountant and their professional clients. Dr. Theile remarked[2]:

> "One of the important things doctors do with patients is we lay our hands on people and there is something very realistic about that … . People give us their trust in that regard … . I revolted against it [using the term 'clients'] and I will continue to revolt against it because we are not dealing with clients. These are not people who are separated from us by a display case with watches in it. These people are different, and you have to have a different mind-set when you deal with them. If you consider them clients, that's part of the problem."

The fact that medical administrators do not share the same mind-set as clinical staff is not, in itself, surprising. As has been noted[3] in relation to the UK National Health Service by Andrew Wall, a senior academic in the field of heath services management[4]:

> "Health service managers usually work with utilitarian assumptions and may describe their obligation as one of maximising benefits to the greatest number of patients. Doctors and other professionals may find this view at odds with their responsibility to their individual patient. For them the patient has the right to treatment and it is improper for a manager to interfere with that professional duty."

INFORMATION MANAGEMENT

One of the areas of medical practice where this dichotomy of opinion is brought into sharpest focus is in the context of information management. The renowned ethicisist, Geoffrey Hunt[5], has observed in relation to the (UK) National Health Service[6]:

> "The very notion of confidentiality, understood in the context of professional ethics, is being challenged by a notion of confidentiality which comes from quite a different environment – the environment of business. ... I think we may be seeing in some controversies a confusion of confidentiality taken from professional ethics, with the purpose of protecting patients and respecting their autonomy, with

---

[2] evidence of Dr Brian Thiele at the Bundaberg Hospital Commission of Inquiry, 01 July 2005; transcript p. 1847 line 32 to p. 1848 line 12.

[3] ***Whistleblowing in the Health Service – Accountability, Law and Professional Practice*** (London: Edward-Arnold (a member of the Hodder Headline Group), 1995) at page 29

[4] Senior Fellow, Health Services Management Centre, School of Public Policy, University of Birmingham; author of ***Ethics and the Health Services Manager***; and formerly District General Manager (for 18 years) of the Bath District Health Authority in the United Kingdom.

[5] Director of the European Centre for Professional Ethics, University of East London; National Coordinator of "Freedom to Care"; editor of ***Ethical Issues in Nursing*** (London: Routledge, 1994); co-editor of ***Expanding the Role of the Nurse*** (London: Blackwell Scientific, 1994); editor of ***Whistleblowing in the Health Service – Accountability, Law and Professional Practice (op.cit.).***

[6] ***Whistleblowing in the Health Service – Accountability, Law and Professional Practice (op.cit.)*** at page ***xxii***.

> commercial confidentiality and trade secrecy taken from the context of business, with the purpose of protecting competitiveness and profits."

Hunt's suspicion in relation to the NHS is readily demonstrated to be the fact in relation to Queensland Health. Even those charged with the responsibility for undertaking "ethical awareness" seminars on behalf of Queensland Health[7] seem oblivious to the difference between protecting information which is confidential to a patient, in the interests of the patient, and protecting information which is potentially embarrassing to Queensland Health, in the so-called "corporate" interests of the Department.

Indeed, the "corporate" analogy has been specifically invoked as justifying Queensland Health's rigorous policy of preventing unauthorised disclosure of potentially embarrassing information, through its "Code of Conduct" and employment contracts with its staff.

A case in point was revealed in evidence which the Commission received concerning a person named Berg, who was registered by the Medical Board, and who practised here in Townsville as a psychiatrist, but whose qualifications were subsequently called into question. It may be accepted that anyone – clinician, administrator or politician – involved in making a decision whether or not to release that information publicly faced a major dilemma, involving a reconciliation of a number of considerations.

On the one hand, considerations favouring controlled public disclosure of the relevant facts included:

- the patients' right to know that they had been treated by a person whose medical and psychiatric qualifications were, at best, dubious;
- the risk that hospital records would not reveal the identities of all patients seen and treated by Berg;
- the risk that some patients seen or treated by Berg (including, possibly, some who could not be identified from hospital records) had received inappropriate medication or other treatment;
- the risk that some patients seen by Berg (including, possibly, some who could not be identified from hospital records) had inappropriately been refused medication or other treatment;
- the risk that, in the absence of controlled public disclosure, a garbled version of events would "leak out", possibly causing patients to lose confidence in other psychiatric staff at the Townsville General Hospital, the Hospital's Department of Psychiatry, and the Hospital generally;
- the risk that the facts would ultimately emerge, causing psychiatric patients to feel deceived by Queensland Health, and disillusioned with the medical (including psychiatric) services which it provides; and
- the risk that Berg, having (apparently) obtained registration and employment based on fraudulent qualifications, may have taken advantage of the status which that gave him, to the detriment – whether financial, personal, or otherwise – of patients.

On the other hand, considerations militating against public disclosure of the relevant facts included:

- the risk that disclosure would cause patients to lose confidence in the Townsville General Hospital's Department of Psychiatry, or even the Hospital generally; and
- in the case of psychiatric patients, the risk that this would lead to an abrupt termination of medication or treatment, to the harm of their mental health.

In the result, whilst local medical and administrative staff here in Townsville favoured disclosure – and even planned a publicity campaign to ensure that the information was released in a responsible way – they were over-ruled by head office in Brisbane.

---

[7] evidence of Glenn David Tathem at the Bundaberg Hospital Commission of Inquiry, 08 August 2005; transcript p. 3736 line 5 *et seq*.

Speaking only for myself, I cannot agree that the decision to conceal the facts was the correct one. In my view, patients who received treatment at Townsville General Hospital from a person, who had been held out by Queensland Health as a qualified psychiatrist, had an inalienable right to be told the truth as soon as it was discovered.

Whilst I accept that this may have presented some risk to some patients, who could have been inclined to take it as an excuse to terminate their medication or treatment, I believe that this situation could have been handled in the case of patients whose identities were known to health authorities, and who had continued to receive medication or treatment from other staff of the Psychiatry Department after Berg's departure.

In my view, by far the greater risk involved patients whose identities were unknown to health authorities, and who may have received inappropriate medication or treatment – or who may have been inappropriately refused medication or treatment – by Berg. The only way that Queensland Health could have helped such patients was by prompt, full and frank disclosure through the press and media.

Even without the benefit of hindsight, it is (in my view) perfectly obvious that a charlatan – a person who was capable of obtaining registration and employment based on falsified qualifications – was a person without any moral, ethical or professional restraints on his behaviour. To conceal such an incident involved the appreciable risk of also concealing any illegal or anti-social behaviour which Berg committed under cover of his status as a qualified psychiatrist employed by Queensland Health.

As events have transpired, that is precisely what occurred. It only emerged, following disclosure of these matters in the course of evidence before the Commission, that Berg has (allegedly):

- been convicted in Russia for paedophile offences;
- been convicted in the United States for an offence of dishonesty; and
- sexually molested the young son of a Townsville General Hospital patient, in circumstances where he (inappropriately) visited the patient's home – supposedly in connection with her treatment – and then undertook also to provide psychiatric treatment to the son, convincing both the mother (his original patient) and her partner to leave the son in his care for that purpose.

Of course, I accept without hesitation that there are two categories of information which require strict control: where the disclosure is inconsistent with patient privacy and confidentiality; and where the disclosure may involve harm to an "at risk" patient.

A patient's entitlement to expect rigorous preservation of his or her privacy, and the confidentiality of his or her medical condition and treatment, is absolutely fundamental to any healthcare system. A patient must be able to share the most intimate personal details with a clinician, without fear or suspicion that the information will be inappropriately disclosed or misused.

A breach of a patient's privacy or confidentiality may cause profound harm to the patient in a wide range of ways, including outside the clinical context. This is most obviously the case if the diagnosis involves a communicable disease, and especially if the disease is sexually transmissible. But serious damage can also be caused by the disclosure of a diagnosis which involves no moral opprobrium: for instance, disclosure of the fact that a patient is suffering from a potentially debilitating illness (such as a terminal cancer, a cardio-vascular condition, multiple sclerosis, or another profound neurological disorder) may lead to both social and employment problems. Inappropriate disclosure of hæmatology results, especially if they reveal the use of recreational drugs, may have similar consequences. The ethical dilemmas flowing from DNA paternity testing have been discussed in a recent article in the ***Journal of Epidemiology and Community Health***[8], the authors

[8] by Mark Bellis and others from Liverpool John Moores University, UK.

calling for "clear official guidance for GPs and health professionals on when and whether to disclose such explosive information".

The second category of information which requires the strictest possible control is information which, if released, may result in direct or indirect clinical harm to the patient or patients concerned. This category is especially, although not exclusively, relevant to mental health patients.

As I have said, I cannot accept that the correct decision was made in the Berg case. Any justification for the decision depends on the proposition that it was judged to be in the best interests of patients – a conclusion which I find difficult to sustain, for the reasons previously mentioned, and especially in circumstances where the ***only*** documented psychiatric opinion favoured disclosure. But what causes even greater concern is that the Berg case is illustrative of a tendency, on the part of Queensland Health, to "cover up" embarrassing information.

WAITING LISTS

Another illustration of the same tendency has been the continued misrepresentation and falsification of waiting list statistics by Queensland Health. But in this context, it is not merely a matter of concealing embarrassing truths – it is a matter of disseminating information which is positively and deliberately mendacious.

If Queensland Health was really a "corporation" – as it likes to pretend – rather than a Department of State protected by governmental immunity, such false and misleading conduct would clearly bring it within section 75AZI of the Federal ***Trade Practices Act***, which relevantly provides:

> "A corporation must not, in trade or commerce, engage in conduct that is liable to mislead the public about the nature, the characteristics, the suitability for their purpose, or the quantity, of any services.
>
> "Penalty: 10,000 penalty units."

A "penalty unit", you may be interested to know, is currently worth $110.00[9] - making a maximum fine of $1.1 million. That is the fine which a private healthcare provider could (and, I think, would) be ordered to pay if it deliberately and persistently made false and misleading representations regarding the quality of its services, such as the length of time a patient may have to wait in order to see a specialist or to receive treatment.

It is, you may think, a curious feature of our health system that private corporations are required to be honest with their patients – and are subject to massive fines if they are not – yet Queensland Health is not subject to any similar requirement. Of course, I should not wish to be taken as suggesting that private healthcare providers are truthful with their patients ***only*** because they risk huge fines if they tell lies. I am sure that most (if not all) such corporations are truthful with their patients, if not because they are inherently honourable organizations, then – at the very least – because market forces would drive them out of business if they were found to be untruthful.

Yet it still seems strange that Queensland Health is not expected to live up to the same standards as the law prescribes for profit-making companies like Ramsay Health Care – let alone charitable organizations like the Sisters of Mercy (who operate the Mater Hospitals), the Sisters of Charity (who operate the Holy Spirit and Mount Olivett Hospitals in Brisbane and St Vincent's in Toowoomba), and Uniting HealthCare (which

---

[9] ***Crimes Act 1914***, s.4AA

operates St Andrew's in Brisbane and the Wesley Hospitals in Brisbane and Townsville, as well as several other private hospitals in regional centres). Why should Queensland Health, alone amongst healthcare providers, have a licence to deceive?

What is interesting about Queensland Health's dishonesty with regard to waiting list statistics is that nobody has even attempted to justify its conduct as being based on a consideration of the best interests of patients, or other clinical factors. And it takes only a moment's thought to realize why any such attempt would be hopeless.

It is only by telling people the truth about waiting lists that GPs can give their patients realistic advice, and patients can make intelligent and informed decisions about their own medical care. Why would any GP suggest that an elderly patient should book for hip-replacement surgery at a public hospital, if the truth of the matter is that the hospital's waiting list is significantly longer than the patient's life expectancy? What is the point in telling a patient that he or she should book for an endoscopy or colonoscopy at a public hospital, if the patient may have developed inoperable cancer before their number comes up?

Possibly the worst feature of Queensland Health's culture of dishonesty is the fact that Queensland Health lies, not only to its patients, but even to its own clinical staff. Shortly before my Commission of Inquiry was shut down, our investigators had uncovered a situation in a major provincial centre – just a few hours drive from Townsville – where qualified doctors (including specialists) had been entering patients on waiting lists as "Category One" (the category which are supposed to receive treatment within 30 days) and "Category Two" (the category which are supposed to receive treatment within 90 days), only to have a junior clerk in the hospital management re-classify the patients as "Category Three" (the category of patients who, theoretically, can wait indefinitely). This allowed the hospital management to claim – falsely – that virtually all "Category One" and "Category Two" patients had received treatment within the prescribed waiting periods.

Unfortunately, it seems that the more limited Terms of Reference of the Commission of Inquiry now being conducted by Mr Davies have not permitted him to explore this, and similar, issues.

It has been hinted that Queensland Health's policy of falsifying waiting list statistics can be justified as designed to maintain public confidence in the health system, and to prevent panic. That, I suggest, is a bit like arguing that surf lifesavers should not warn bathers about an approaching school of five-metre white pointers, lest it cause any unnecessary commotion. If there is a problem in our public health system, the public has a right to know about it, so that they can:

- plan for their own healthcare needs, such as by taking out private cover if they can afford to do so;
- decide whether to pay the extra cost involved in consulting a private specialist;
- seek treatment at a different public hospital, in a different part of the State, if their local public hospital's waiting lists are too long;
- choose to receive treatment, at their own expense, at a private hospital; or
- if all else fails, express their disgust at the state of our public hospital system – in the appropriate democratic way – through the ballot box.

The chilling part of all this is not merely the fact that people are misled or deceived – it is not merely the fact that people are given unrealistic expectations, and are then disappointed – it is not merely the fact that people, who are often the people least able to afford it, are subjected to significant inconvenience and expense when consultations are cancelled or operations are postponed. The most chilling part is the fact that people can die – that people ***do*** die – whilst waiting for treatment in this State's public hospitals.

Regrettably, I cannot give you any hard statistics. The reason for that is obvious enough: given Queensland Health's track-record of dishonesty in relation to waiting list statistics, you could hardly expect them to be scrupulously honest when it comes to revealing the number of patients who have died on their waiting lists – or, perhaps more significantly, the number of people who might not have died if they had been told about the true situation, and chosen to obtain treatment outside the public system. Nor is it easy to be definitive: a patient may have waited 18 months for a colonoscopy which reveals an inoperable bowel cancer, but it may be impossible to say whether earlier intervention could have saved the patient's life.

This much, however, I can say: there is strong anecdotal evidence that Queensland Health's misleading waiting lists have contributed to a significant number of deaths. Professor Con Aroney – one of the State's leading cardiac specialists – has identified a number of specific cases of this nature[10]. If his evidence is accepted, the problem is unlikely to be confined to a single area of specialisation, at a single hospital. If it is permissible to extrapolate from the cases identified by Professor Aroney, across all areas of specialisation and all public hospitals throughout the state, the 13 deaths associated with sub-optimal care on the part of Jayant Patel pale into insignificance.

THE LESSONS

One lesson which flows from this discussion is, in my view, this: non-disclosure (or concealment) of information may, in some circumstances, be justified as protecting the interests of "at risk" patients; but it is all too easy to use this as a pretext to cover up information which could cause embarrassment to medical administrators. I am very strongly of the opinion that, in the absence of compelling reasons to the contrary, information which has the potential to cause embarrassment to Queensland Health should ***always*** be made public, because its very potential to cause such embarrassment is the clearest indicator that disclosure is in the public interest.

The second lesson is that concealment of information – and, worse still, dissemination of false information – is potentially lethal. I have observed that, due to oddities in our legal system, Queensland Health has a licence to deceive. But that licence to deceive may also, in significant numbers of cases, be a "James Bond style" licence to kill.

I cannot advise you that there are never any circumstances in which a clinician would be justified in deceiving his or her patient. In fact, I am sure that there are some situations – such as situations involving pædiatric and mental health patients – where dishonesty may conceivably be the best policy. Perhaps there are other extreme situations where conscious dishonesty is permissible, such as cases where, by telling the unvarnished truth to a particular patient, you may indirectly cause harm, either to the patient or to another member of the patient's family[11].

I do not envy your profession, in occasionally having to make "tough calls" of that nature. But I find it difficult to imagine that there can ever be a justification for being less than totally frank with a mature-aged patient who is psychologically capable of handling the truth, unless it is because the truth presents a greater risk, either to the patient or to someone else. In any event, such a decision can only properly be informed by

[10] evidence of Professor Constantine Nicholas Aroney, at the Bundaberg Hospital Commission of Inquiry, exhibit 263; see also transcript, 10 August 2005, p. 3923 line 1 ***et seq.***

[11] Just as an example, one such situation may arise in the context of a family environment based on fundamentalist values, where disclosure of the truth – say, with respect to the patient's sexual health, conduct or orientation – may expose one member of the family to harm from other family members. But one hopes that such cases are exceedingly rare.

clinical considerations – not the so-called "corporate interests" of the organisation for which the clinician is working.

The third – and hardest – lesson is this: On some occasions, a clinician's ethical obligations to his or her patients may conflict with the clinician's legal obligations as an employee of a particular health institution, whether it be Queensland Health or even a private employer.

The case of Toni Hoffman, in Bundaberg, is just the most recent example of a clinician who reached a moral judgement that the interests of patients compelled her to speak out – to "blow the whistle" – even though she was breaching Queensland Health's so-called "code of conduct".

WHISTLEBLOWERS

The fact is that, both here in Australia and in the United Kingdom, whistle-blowers like Toni Hoffman have been responsible for exposing most of the medical scandals which have come to light in recent decades. In 1987, two biomedical researchers, Phillip Vardy and Jill French, exposed instances of manipulation and invention of scientific data by the leading medical researcher, Dr William McBride. In 1995, the notorious Bristol Infirmary case in the UK was brought to light by Dr Steven Bolsin, a specialist anaesthetist. A recent article in the ***Medical Journal of Australia***[12] examined three similar cases in this country: issues at King Edward Memorial Hospital in Western Australia, brought to light in 1999 by both medical and nursing staff; issues at the Canberra Hospital, brought to light in 2000 by a rehabilitation physician; and issues at the Campbelltown and Camden hospitals in New South Wales, brought to light in 2002 by a group of nurses.

The authors found a common thread running through all of these cases:

- Each investigation arose after whistleblowers alerted politicians directly, having failed to resolve the problems using existing intra-institutional structures;
- None of the substantiated problems had been uncovered or previously resolved by extensive accreditation or national safety and quality processes;
- In each instance, the problems were exacerbated by a poor institutional culture of self-regulation, error reporting or investigation;
- Even after substantiation of their allegations, the whistleblowers, who included staff specialists, administrators and nurses, received little respect and support from their institutions or professions.

I am confident that there are many other clinicians out there – doctors and nurses – prepared, if necessary, to take the same risks and make the same sacrifices for the ultimate protection of patients. But the viability of our public health system cannot be left to depend on individuals willing to take such risks or to make such sacrifices. I can only agree with Donald M Berwick, President of the Institute for Healthcare Improvement in the UK; writing in the ***British Medical Journal***[13], he observed:

> "We should applaud heroes, and hope that they are among us, but to base our hope of remedy in ordinary systems on the existence of extraordinary courage is insufficient."

I certainly hope that none of you will ever be called upon to make the decision whether to place the interests of your patients above your legal duties to your employers.

---

[12] ***Three Australian Whistleblowing Sagas: Lessons for Internal and External Regulation***, by Thomas A Faunce and Stephen N C Bolsin: MJA 2004; 181 (1): 44-47

[13] BMJ, 6 June 1998; 316:1736

I have repeatedly urged the view that clinicians should not have to face such ethical dilemmas – that our community needs added protection for whistleblowers in the public health system, including provisions enabling clinicians to report their concerns to Members of Parliament, unions, professional associations, and the media. Sadly, Mr Peter Forster, in his recent review of Queensland Health, rejected that proposal. Until the law is changed, it remains the case that members of the medical profession – along with nurses and other allied clinical professionals – will continue to bear the full brunt of legal, administrative, professional, employment and social pitfalls facing the conscientious whistleblower.

RESOURCE ALLOCATION

Another area of acute tension between clinical and administrative staff concerns the allocation of resources. However big the healthcare budget, it will always remain finite. And that means, quite simply, that there will always be disputes as to how the cake is cut.

To date, the bureaucrats are winning – in fact, they are winning by the length of the straight. Out of some 64,000 employees of Queensland Health, fewer than one in five are clinicians. From the billions of dollars provided by the Federal Government to the Queensland Government to pay for this State's public hospitals, only about 20 cents in the dollar gets through to clinical care for patients.

Even these statistics probably understate the degree of disproportion in relation to resource allocation. For example, when I say that one in five Queensland Health employees are clinicians, that includes all of the employees who are registered medical practitioners or nurses. In fact, many of the medical practitioners and nurses on the Queensland Health payroll are employed in primarily administrative positions: they may never visit a ward or an operating theatre or an outpatients clinic, and spend all or the greater part of their working lives performing non-clinical duties. So the 20% figure can be regarded as a maximum.

The immediate relevance of these statistics can be seen in the context of current debate, following the release of Mr Forster's report into Queensland Health. In his "Executive Summary", Mr Forster said[14]:

> "… given funding limitations and workforce shortages in the public sector rationing of certain health services is inevitable and may get worse. If significant enhancements are sought to the public health system, the Queensland Government and community may need to give consideration to:
>
> - the need to raise additional revenue to support health services, whether it be through State taxes or means-tested co-payments for public health services;
> - potential means testing for eligibility of services to public health services, with services targeted to more urgent procedures and those who can least afford to pay for healthcare;
> - reviewing the current set of public health services which should continue to be provided through the public health system."

Before we talk about increased taxes, means testing, co-payments, healthcare rationing, and the like, we should focus on this simple and demonstrable fact: the major costs in Queensland Health are ***not*** – I repeat, ***not*** – concerned with the provision of clinical services. As a matter of simple arithmetic, if we could reduce the number of bureaucrats and other non-clinical staff by as little as one-quarter, we could double the number of clinical staff. If we could reduced the expenditure on administration and other non-clinical activities by as little as one-eighth, that would produce a 50% increase in the amount available to spend on clinical services. I am not making up these figures: they are fully documented, and have not been disputed by Queensland Health. They represent ***the facts.***

---

[14] Queensland Health Systems Review Final Report, "Executive Summary", page xii

But let me say, immediately, that I am not proposing a reduction in the number of bureaucrats and other non-clinical staff – or a reduction in expenditure on administration and other non-clinical activities – of anything like one-quarter or even one-eighth. According to Mr Forster's own report, "an additional $100.8 million in funding for surgical services … would be required to ensure that patients received treatment within clinically appropriate timeframes and to address unmet demand from access blocks in specialist outpatients"[15]. That $100.8 million represents less than 2% of Queensland Health's $5.4 billion budget. In other words, using Mr Forster's own figures, we need to save between 2 and 2½ cents out of every dollar spent on non-clinical activities, in order to address the crisis in the provision of clinical services.

Elsewhere in his report, Mr Foster says it is "estimated that Queensland Health would require an additional 170 beds per annum over the next two decades … to meet future demand"[16]. I will not dwell on the fact that, when the Royal Brisbane and Princess Alexandra Hospitals were rebuilt (within the last 15 years) the total number of beds was actually ***reduced*** by some 600[17]. Mr Forster suggests that the extra 170 beds per annum may require, at current levels of expenditure, additional recurrent expenditure of between $40 and $50 million each year[18] - that is, less than 1% of Queensland Health's current annual budget. Again, using Mr Forster's own figures, we need to save less than 1½ cents out of every dollar spent on non-clinical activities, each year, in order to address the projected shortage of public hospital beds.

Please do not misunderstand me: I am not saying that the solutions are easy, or can be achieved without a certain amount of pain. But, by the same token, I believe that talk about increased taxes, means testing, co-payments, healthcare rationing, and so on, is just plain scare-mongering. The real solution is to make better use of the available resources – to reduce wastage on non-clinical activities – rather than a significant increase in total resources. Indeed, I find it interesting that, when Mr Forster proposes "rationing", it apparently only applies to the 20% of the health budget spent on the provision of clinical care for patients. If "rationing" is needed, why not begin by applying it to the 80% of the health budget expended on non-clinical activities ?

There is undoubtedly a significant amount of fat to be trimmed. Again, using Mr Forster's own statistics, an "estimated 4,590 positions … directly report to or are within Central Office"[19]. That is more than three times the total number of medical practitioners employed by Queensland Health throughout the State. Surely – ***surely !*** – we do not need three pen-pushers in Charlotte Street for every doctor employed in every hospital anywhere in Queensland!

Just imagine how many more bureaucrats will be required, if Mr Forster gets his way, and a system of means-testing and co-payment is introduced. Will patients be expected to bring their group certificates, tax returns and inventories of their assets when they front up for a consultation in outpatients ? Perhaps we will need a co-payment to the co-payment, to cover the cost of assessment and auditing.

Curiously, I haven't been able to identify, anywhere in Mr Forster's report, any costings – even indicative costings – for the process of means-testing each and every patient who comes through the doors of a public hospital in this State, and determining and recovering the co-payments which are proposed to be charged to those who fail the test.

---

[15] ibid., p.xiv
[16] ibid., p.xi
[17] evidence of Dr David Molloy, Queensland President of the Australian Medical Association, at the Bundaberg Hospital Commission of Inquiry, 31 May 2005; transcript p. 578 lines 19 to 22.
[18] Queensland Health Systems Review Final Report, "Executive Summary", page xi
[19] ibid., p.xiv

Of course, Queensland Health will tell you that all these bureaucrats make a really important contribution to the provision of healthcare services in this State. I guess it would be churlish to ask what they were all doing when Berg was prescribing mind-altering substances to patients here in Townsville, and (as it is alleged) engaging in a bit of kiddie-fiddling on the side. I guess it would be equally churlish to question what contribution these legions of bureaucrats made whilst Jayant Patel was making his own contribution to the problem of over-crowded waiting lists in Bundaberg, by removing patients from the list – permanently.

However, I don't ask you just to take my word for it that there are too many bureaucrats, or that they are not all especially productive. I ask you, instead, to listen to the testimony of Dr John Wakefield, who holds an interesting position within the Queensland Health administration. It seems there is something called the "Innovation and Workforce Reform Directorate". That Directorate comprises six divisions, of which one is called the "Patient Safety Centre". The Patient Safety Centre, in turn, comprises three units, of which one is called the "Safety Improvement Unit". The Safety Improvement Unity, in turn, consists of five teams. Dr Wakefield is the Executive Director of the "Patient Safety Centre". From that perspective, this is his sworn evidence[20]:

> "If you're asking me whether I believe that the bureaucracy has become too big and that we need to stop producing policy … that's not implemented or is … unnecessary, then the answer is a resounding yes. I think that there is a need to critically appraise bureaucracy and really consider what value that adds to patient care, and if the answer is that that adds significant value, then it needs to continue, and if it doesn't add significant value, then the question has to be raised about whether it should be there. So that's the long-winded answer, but the short answer is yes, I think we have too much bureaucracy, yes, I believe we have too much policy, we could do away with a lot of it and just have the important policy that really leads to improving patient care and let our intelligent, well-trained staff have the leeway to make decisions about things that are not necessary to have policy about."

THE FIGHT FOR CONTROL

I have already discussed two areas of tension between clinicians and administrators – information management, and resource allocation. But I think that both are subordinate to, or perhaps consequences of, a third area of tension: who is in charge.

Two fundamental administrative changes have taken place within Queensland Health over the last 15 years or so. First, direct administration of hospitals was taken out of the hands of regional Hospitals Boards, and given to full-time bureaucrats – district and zone managers. The Hospitals Boards were replaced with Advisory Councils, which, as the name suggests, have no actual authority to do anything other than provide advice – and even if their advice was heeded, it would be difficult for them to provide meaningful advice when the bureaucrats ensure that they are kept in the dark about operational issues. Just as an example, the chair of the Bundaberg District Health Advisory Council[21] learnt about the problems with Jayant Patel, at the same time as the rest of us did, when he read about it in the ***Courier-Mail***.

The second change is to transfer day-to-day administrative control away from practising clinicians – the former medical superintendents and nursing superintendents – and place it in the hands of managers. Some of these managers are qualified as medical practitioners or nurses, but they are not practising clinicians.

---

[20] evidence of Dr John Wakefield, at the Bundaberg Hospital Commission of Inquiry, 19 August 2005; transcript p. 4527 lines 27 to 43

[21] evidence of Vivian Chase, at the Bundaberg Hospital Commission of Inquiry, 17 August 2005; transcript p. 4373 ***et seq.***

Even Mr Forster has acknowledged[22] that:

> "Queensland Health has a bureaucratic mechanistic structure characterised by highly centralised formal authority and hierarchical layers of decision making and separate directorates which do not support a responsive, integrated and efficient health system. A key problem with the structure relates to bottlenecks in decision making particularly as the position of Senior Executive Director of Health Services is responsible for more than 80 percent of the department's resources. This slowed down the flow of information and the capacity of the organisation to implement new policy or respond to service delivery pressures."

Mr Forster's solution to what he describes as a "bureaucratic mechanistic structure characterised by highly centralised formal authority and hierarchical layers of decision making" is this: he proposes to add yet a ***further*** layer of bureaucratic control. This will involve the creation of "Areas Health Services". Their functions, as Mr Forster describes them, will involve "increased leadership, management, policy, planning and performance monitoring capacity coinciding with greater budget responsibility, accountability and decision making authority"[23].

You will probably have already anticipated my response: the last thing our health system needs is ***another*** layer of bureaucracy. Why we ***do*** need – what both clinicians and the public are crying out for – is ***less*** bureaucracy, and a greater decision-making role for local community representatives and practising clinicians.

I have to be careful, because each time I mention the need for a greater decision-making role on the part of clinicians, the same thing happens: the Queensland Health apparatchiks, and their supporters, deliberately distort and misrepresent what I am saying. Clinicians, they cry, are too busy to run hospitals; in the modern medical environment, we need professional administrators.

I agree. Clinicians are far too busy to run hospitals. And what a waste of community resources, when we provide 6 or 8 or 10 years' training to produce a single medical practitioner, if he or she is asked to do a job within the competence of a middle-manager with little or no academic qualifications. Of course our hospitals have to be run by professional administrators, rather than clinicians.

But that is not the point. The issue is not who fills in the time sheets, or who orders the medical supplies, or who prepares the nursing roster, or who gives instructions to the catering staff, or who signs the overtime voucher. Professional administrators can, and should, so all of those things. The point is whether the person who deals with the day-to-day administrative minutiae is also the person in charge of the hospital. In my view, that is both unnecessary and inappropriate.

In every other branch of government, and in most areas of private enterprise, organisations are under the control of people who are experts in the organisations' core functions – not experts at bean-counting and paper-shuffling. Police stations may have administrative staff, but the administrative staff report to the senior police officer, not the other way around. In schools and universities, the top executive positions are held by people – principals and vice-chancellors – whose expertise is education, not business management. Law courts are headed by the senior judge or magistrate: the Chief Justice or Chief Magistrate is not told how to run his court by an administrative functionary. The Under-Secretary of the Department of Foreign Affairs is a senior diplomat, not a senior bureaucrat. Building companies are run by builders, mining companies are run

---

[22] Queensland Health Systems Review Final Report, "Executive Summary", page xiii-xv
[23] Ibid, page xiv

by miners, retailing chains are run by retailers, insurance companies are run by underwriters, banks are run by bankers, churches and religious communities are run by clergy.

Only in the healthcare sector have the experts – the medical practitioners and other healthcare professionals – allowed their control of their own working environment to be gazumped by people who have no relevant expertise or qualifications. A person may become a hospital administrator without knowing the difference between an infection and an infarction – without being able to distinguish a stethoscope from a colonoscope – without being able to tell a Lap-Coli[24] from a Border Collie.

To be brutally frank, the medical profession largely has itself to blame for this situation. Doctors have been outmanoeuvred by bureaucrats. They have been seduced by the attraction of allowing others to deal with the detritus of boring managerial chores, whilst they do the glamorous and exciting work like draining sebaceous cysts and undertaking rectal examinations. Doctors who spend 70 hours a weeks looking after patients are no match for bureaucrats who spend 40 hours a week looking after themselves.

But there is some good news. Occasionally – just occasionally – you will come across a hospital administrator who is a clinician at heart; who believes that caring for patients is more important than balancing the budget or ensuring that the paperwork is in order. By an extraordinary coincidence, Townsville has managed to attract two of these rare, exotic and valuable specimens at the same time – Dr Andrew Johnson, your Director of Medical Services, and Mr Ken Whelan, District Manager of the Townsville Health Service District. You have no idea how lucky you are to have these two men here; you are the envy of public hospitals and clinicians everywhere else in the State.

For those who are not so fortunate, I can only offer you the advice given by the Russian-born American writer, Ayn Rand[25]:

> "In the name of the best within you, do not sacrifice this world to those who are its worst. In the name of the values that keep you alive, do not let your vision of man be distorted by the ugly, the cowardly, the mindless in those who have never achieved his title.
>
> "Do not lose your knowledge that man's proper estate is an upright posture, an intransigent mind and a step that travels unlimited roads. Do not let your fire go out, spark by irreplaceable spark, in the hopeless swamps of the approximate, the not-quite, the not-yet, the not-at-all.
>
> "Do not let the hero in your soul perish, in lonely frustration for the life you deserved, but have never been able to reach. Check your road and the nature of your battle. The world you desired can be won, it exists, it is real, it is possible, it's yours.
>
> "But to win it requires your total dedication and a total break with the world of your past, with the doctrine that man is a sacrificial animal who exists for the pleasure of others. Fight for the value of your person. Fight for the virtue of your pride. Fight for the essence of that which is man: for his sovereign rational mind. Fight with the radiant certainty and the absolute rectitude of knowing that yours is the Morality of Life and that yours is the battle for any achievement, any value, any grandeur, any goodness, any joy that has ever existed on this earth."

[24] i.e., laparoscopic cholecystectomy

[25] ***Atlas Shrugged***