

# The weakest link?

Kathy Eagar

THE EXTRAORDINARY COVERAGE of complaints of poor and dangerous patient care at Macarthur Health Service (Campbelltown and Camden Hospitals) has all the hallmarks of a pulp novel — relentless and emotional media coverage, tragic personal stories, political intrigue at high levels and eloquent legal argument. Never before has New South Wales experienced such an event, nor most other jurisdictions for that matter. Perhaps only the coverage of King Edward Hospital in Perth comes close.

Clinicians at the two hospitals have been variously portrayed as everything from doctors and nurses who were happy to turn their backs on dying patients through to one of the many victims of a fundamental political, policy and structural failure to distribute health care resources in proportion to need. In the same vein, the local hospital-management group has been portrayed as either an incompetent and corrupt group who engaged in cover-ups, shredding documents and targeting anyone who raised concerns, or as a caring but embattled group who were doing their best to manage a continuously increasing gap between demand and supply.

Likewise, the nurses who publicly raised the allegations have been variously portrayed as either whistleblowers acting solely in the public interest, who were punished and sacked for bringing the truth to light, or as vexatious troublemakers seeking revenge on hospital managers who had previously disciplined them for bullying, harassment and/or poor clinical care.

And, as usual, the truth lies somewhere in between.

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**Kathy Eagar**, PhD, Director.

Centre for Health Service Development, Faculty of Commerce, University of Wollongong, Wollongong, NSW.

Correspondence: Professor Kathy Eagar, Centre for Health Service Development, Faculty of Commerce, University of Wollongong, Wollongong, NSW 2522.

[Kathyeagar@optusnet.com.au](mailto:Kathyeagar@optusnet.com.au)

## The complaints in context

The Macarthur region consists of three local government areas spread over 3000 square kilometres. The major population centre, Campbelltown, is 50 kilometres from Sydney, NSW. The region is typical of new growth areas on the urban fringe. It has experienced rapid population growth since the 1970s. With a current population of about 240 000, it is now about the same size as Geelong, Eastern Adelaide, Fremantle and Southern Tasmania.

The two hospitals at the centre of the story have grown and developed considerably during that period. By 2003, the Macarthur Health Service employed 1236 full time equivalent staff (SWSAHS [South Western Sydney Area Health Service] 2004) across a range of services, including the Campbelltown and Camden hospitals. Campbelltown Hospital now has 260 beds while Camden Hospital has 72 beds (SWSAHS 2004). However, on all the evidence, the growth in the health service and its clinical infrastructure has not kept pace with the increased population demand.

## The complaints and their outcomes

The initial complaints of patient care go back to June 1999. In the 4 years up to the investigation by the NSW Health Care Complaints Commission (HCCC), Macarthur Health Service treated about 100 000 inpatients. It also had 180 000 Emergency Department attendances and about 2 million other non-admitted occasions of service (SWSAHS 2000, 2001, 2002, 2003). In evidence given at various inquiries, Macarthur Health Service indicated that during this period 3500 clinical and non-clinical incidents were reported and reviewed internally.

A total of 69 cases were initially referred to the HCCC for investigation by the NSW Minister for Health based on information provided to him by a

group of nurses who have subsequently been known as the 'nurse informants'. Following the dismissal of the head of the HCCC for a perceived failure to adequately investigate these initial allegations (see below), a Special Commission of Inquiry into Campbelltown and Camden Hospitals by Bret Walker SC was established. The nurse informants subsequently made additional allegations to this Inquiry. These included nine allegations that went back as early as 1992. In total, the Special Commission investigated 128 allegations (excluding duplicates). Of these, 126 were allegations of poor patient care.

The allegations represent 0.04% of hospital patients treated between 1999 and 2003. Under oath in a recent parliamentary inquiry, the previous general manager stated that all of the most serious initial cases were known to the organisation at the time and that all but one had been reviewed before the public allegations. Sixteen of the cases were rated in the internal reviews as very serious (a NSW Severity Assessment Code of 1 or 2), 19 were moderate, and 12 cases were rated with the lowest Severity Assessment Code of 4. An internal review of the cases had concluded that quality and safety problems contributed to the deaths of seven patients. On this basis, Macarthur Health Service disputed the findings in the other cases (General Purpose Standing Committee Number 2 2004, p. 2).

The Special Commission of Inquiry into Campbelltown and Camden Hospitals by Bret Walker SC has now reported, and its findings supersede those of the HCCC investigation. The power of the Special Commission under NSW law was limited to referring practitioners who had a potential case to answer to the (newly revamped) HCCC for investigation. In total, Walker referred 36 cases for investigation. His reports found no case to answer in the other cases. The NSW Medical Registration Board has already cleared four of the doctors (Sydney Morning Herald 2004a). The Box shows the final outcome of the Special Commission of Inquiry.

In summary, the Special Commission dismissed 71% of the allegations and has referred 28% for investigation. This figure is surprisingly low given that one of the nurse informants had access, through her membership of the hospital Critical

### Outcomes of the allegations investigated by the Special Commission of Inquiry

Outcome	Total	Percentage
No case to answer, no further action warranted	91	71.1%
Referred for investigation or assessment:	36	28.1%
doctor/s only	18	14.1%
both doctor/s and nurse/s	11	8.6%
nurse only	6	4.7%
doctor/s and nurse/s and physiotherapist	1	0.8%
Already under ICAC investigation	1	0.8%
Total	128	100.0%

Care Committee, to information about many of the cases, and most allegations related to incidents already identified by hospital staff.

Importantly, the Special Commissioner found that there was "no cover-up" of inadequate patient care by the administration of Macarthur Health Service (Walker 2004b, p. 2) and he made no significant adverse findings against either the South Western Sydney Area Health Service or Macarthur Health Service managers. He accepted evidence to the inquiry that the death and complication rates at Macarthur Health Service were no higher than at other comparable hospitals (Walker 2004b, p. 9).

Walker's findings do not suggest that Macarthur is a classic case of 'whistleblowing', a simplistic perspective presented so often in the media. Nor do they provide support for the way that politicians, most commentators and the media have portrayed the staff and systems of Macarthur Health Service. Given this, it is important to consider how what has now become a saga unfolded as it did.

### The HCCC inquiry — a systems review or an investigation of patient complaints?

The HCCC inquiry took over a year and, according to the HCCC, was a 'systems' review. The final report pleased almost no one.

Some, including the NSW Minister for Health and the nurse informants, thought it had not gone far enough. The Minister stated: “The process has damaged my confidence, and I believe, the public’s confidence in the HCCC as an effective investigative body. It was expected that the HCCC would respond to the shocking evidence before it by conducting a thorough investigation and delivering strong findings” (Iemma 2003). The appointments of both the General Manager of Macarthur Health Service and the HCCC Commissioner were subsequently terminated and the Area Health Board was dismissed.

Others condemned it for what they saw to be its lack of procedural fairness and for inadequate process. The Special Commissioner, Bret Walker SC, shared that view. Walker argued the case well in his first interim report (Walker 2004a). Under the NSW *Health Care Complaints Act 1993* (HCC Act), the HCCC had the option of deciding that the respondent to the complaints was Macarthur Health as an organisation, or the individual clinicians involved in the cases, or both. The HCCC Commissioner had decided that, in its investigation leading to its final report, only Macarthur Health Service would be the respondent to the complaints, and not the individual clinicians. It left open, but never pursued, the possibility of investigating specific clinicians in the future.

This decision meant that the HCCC was under no obligation during its investigation to interview the clinicians involved in the cases or even to notify them that a complaint had been made. It did not notify them, nor did it interview them as part of the investigation. The first many clinicians knew of the allegations was when the (inadequate) interim report of the HCCC was leaked to the media in September 2003. The leaking of the draft report, together with earlier HCCC correspondence, triggered a media frenzy that continues to this day. Walker was later to describe the leaking of the report as a “regrettable act” that had “devastating consequences for those working at the hospitals” (Walker 2004b, p. 28).

Despite the decision that only Macarthur Health Service would be the respondent to the complaints, the HCCC proceeded with an investigation of individual patient complaints, largely through a

paper-based investigation of the actions of specific clinicians. In many cases, it concluded that a complaint about inadequate patient care was ‘substantiated’ based only on a review of a medical record. It did so without ever notifying the clinician or hearing their side of the story. Both would have been a requirement under the HCC Act if the respondent had included the individual clinicians.

Walker’s conclusion, in effect, was that the HCCC tried to have it both ways. It ‘substantiated’ complaints about individual clinicians while denying them procedural fairness. He described this as “offensive to a sense of fairness” (Walker 2004a, p. 9). As noted above, Walker has now referred specific clinicians to the HCCC based on his assessment that certain allegations warrant investigation. In doing so, he has determined that the individual clinicians are also respondents to the complaints. Nearly two years after the original allegations, the clinicians involved in 36 cases over four years will finally have the opportunity to respond to the allegations made against them. These allegations represent 0.1% of Macarthur hospital patients during the period and 28% of the total allegations of the nurse informants. All remain as allegations only, with none being proven at this point.

### **What is the system and what is a ‘systems approach’?**

The decision that Macarthur Health Service would be the only respondent to the complaint had an important flow-on effect with troubling implications. It meant that only the Macarthur Health Service or its parent organisation (South Western Sydney Area Health Service) could be responsible for any problem. And, in a highly charged political and emotional climate and with many media commentators calling for ‘heads to roll’, that meant blaming those who manage the ‘system’. Whether or not the HCCC anticipated that middle managers would be blamed is a moot point. But, by taking the approach it did, it inadvertently made local and area managers responsible for every alleged action by every clinician. Not many of the managers remain in their jobs today.

A false dichotomy was created: systemic problems are the fault of middle and senior managers while non-systemic problems are the fault of clinicians. Either way, individuals are at fault. The real systemic issues are lost in the process.

A key reason is that the HCCC did not undertake, as it claimed, a 'systems review'. A 'systems review' could have been undertaken on Macarthur Health Service, using either of two possible approaches. One approach would have been to review the whole organisation in a way that an accreditation agency might. But this is not the role of the HCCC, whose mandate is to investigate complaints. It is not a quality assurance or accreditation agency, nor does it have the expertise or the resources to be so. Further, Macarthur Health Service was reviewed in the middle of the HCCC investigation by the Australian Council of Healthcare Standards and, somewhat ironically, received two years accreditation and many commendations.

The other approach would have been to investigate the complaints within a framework that would systematically examine their root causes. No doubt this is what the HCCC attempted to do. But it is clear from the final report that the HCCC and its investigators lacked the resources, expertise and methodology to undertake such a review.

Nearly two years on, and despite many inquiries, there has still been no systematic root-cause analysis other than that undertaken internally within Macarthur Health Service. Many have asked, and answered, questions about what happened.<sup>1</sup> And there is still little agreement on that.

But no one has seriously researched the root causes. Why, for example, did this particular junior doctor incorrectly diagnose the patient presenting

to the Emergency Department? Was there adequate supervision? If not, why not? Did Macarthur have sufficient clinical resources given its role and throughput? Why did that nurse not record vital signs? How many patients was he looking after at the time? After the event occurred, was it adequately investigated and acted upon? How many staff were available to undertake such an investigation? And so on. The answers to many of these questions may reflect systemic issues at a level much higher than Macarthur Health Service.

### **Does quality cost or pay?**

The literature is full of small studies that conclude that providing quality care saves more money than it costs. These studies typically examine specific interventions such as, for example, cannula management. In fact, there is now strong evidence that quality care can save money at the level of some specific interventions.

But few studies have taken a system perspective. One notable exception is recent Canadian research on the relationship between patient outcomes and nursing staffing levels (McGillis Hall, Doran & Pink 2004). It found that quality care costs: that the more nurses, and the more that they are supported, the better the patient outcomes. These results have significant face validity at the coalface. They are yet to penetrate at the policy and political levels. A similar study funded by NSW Health is currently under way.

### **Equity**

Relative to most other Australian jurisdictions, NSW has made real progress in moving closer to achieving the equitable distribution of resources. Its Resource Distribution Formula (RDF) is designed to achieve the equitable distribution of available dollars and is used to 'inform' the allocation to each Area Health Service. The performance of NSW over the last 15 years has been impressive, with most Areas now at or close to their RDF shares, although this is after adjusting for the flow of patients between Areas (NSW Health 2004a). South Western Sydney, with its rapidly growing population, has had significant

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<sup>1</sup> Reports to date include the HCCC interim and final reports, the Barraclough Inquiry (whose conclusions largely relied on the HCCC report and appear unsupported by other evidence), the NSW Upper House Inquiry into Complaints Handling in NSW (whose conclusions appear to be determined on party lines) and the interim and final reports of the Special Commission of Inquiry into Campbelltown and Camden Hospitals. Still pending at the time of writing is an ICAC inquiry into various allegations, the report of the Coroner on each of the deaths and the outcomes of the Walker referrals for investigation back to the HCCC.

budget increases (both capital and recurrent) but is still further from its RDF share than any other NSW Area. One reason is simply that growth funds have not caught up with population growth. The recent government decision to increase funding by \$300 million over 4 years (Iemma 2004) should help address this.

However, dollars, alone, are not the whole picture. One reason is that the 'buying power' of the various Area Health Services is ignored. This buying power is linked to a fundamental failure in workforce planning, exacerbated by the inherent difficulties in attracting clinicians to the new growth areas. The relative share of dollars has shifted in NSW, but neither senior clinicians nor training positions have kept pace. The 'sandstone teaching hospitals' remain able to use their dollars to pay for staff specialists and registrars. Without access to an equitable share of these positions, Macarthur Health Service has been forced to use its dollars to pay (more) for visiting staff, agency staff and services secured under contract. Many of the clinicians now under investigation are not on the staff at Macarthur but, instead, fall into these categories.

The contrast between St Vincent's Hospital, Sydney, and Macarthur Health Service is but one example of the inequity. Both treat a similar volume of patients, with about 105 000 bed-days a year. St Vincent's has a more complex casemix but, even after adjusting for this, there is no plausible way to justify St Vincent's having 184 consultants and 61 registrars compared with the 74 consultants and 10 registrars who were employed at Macarthur Health Service in 2002, the peak year of the complaints (NSW Health 2002). The inequity is further exacerbated if the availability of senior research fellows, university-funded clinical academics and trust funds is taken into account. Given this stark contrast, the recent offer by St Vincent's Hospital to take over the management of Macarthur Health Service presented some interesting possibilities (Sydney Morning Herald 2004b).

Without a workforce strategy to complement its RDF strategy, workforce planning and distribution has been left largely to the professions. One stated goal of the recently announced reorganisation of the area structure in NSW is to address this

problem (NSW Health 2004b). However, clinical colleges and clinical leaders in NSW appear not to have grasped its significance. There remains a sense of comfort that the needs of the major referral hospitals should be met first, with any remaining surplus then being made available to those on the periphery.

## The aftermath

Macarthur Health Service in 2004 bears the scars of the relentless, and often highly inaccurate, media reporting and the many investigations of varying quality to which it has been subjected. The effects on staff have been profound. Many experienced clinicians have left, and the difficulties in attracting new staff have increased (Frankum et. al 2004). Many staff still employed remain traumatised. The local community has also paid a high price and has little confidence in its local hospitals.

The government response to the events at Macarthur has been swift. A new clinical plan for South Western Sydney has recently been released. The government has announced growth funding of \$300 million over four years for the South Western Sydney Area Health Service and sweeping management changes have been implemented.

Despite these changes, distressing stories about adverse events continue to be reported in the media, and many continue to believe without question that Macarthur Health Service killed 19 patients and then attempted to cover up its tracks. Likewise, despite the fact that none of the nurse informants were dismissed, and that both the HCCC and the Special Commission found that their disciplinary proceedings were unrelated to (and, in fact, preceded) any public concerns they raised about patient care, the media continues to report that they were punished and dismissed for 'blowing the whistle'.

## A happy ending?

There are many people who are comfortable with the idea that Macarthur Health Service is an aberration, hospitals with unique quality problems that need firm parenting, to be punished

and to be pulled into line. But there is simply no evidence to support that view (see, for example, Wilson et. al 1995). Others are more realistic. They know that what happened at Macarthur could have happened at any equivalent hospital. For them, "There but for the grace of God go I".

Macarthur is, on all of the evidence I have seen over more than a decade, no different to numerous hospitals we can identify in almost every jurisdiction. These hospitals are typically, but not always, on the urban fringe or in a rural region, without their fair share of senior clinicians and without adequate diagnostic and clinical infrastructure. They simply do not have the resources to provide services at a level commensurate with community, political and media expectations.

All of us — clinical leaders, managers, academics, commentators and politicians — are guilty of simply accepting, and remaining silent about, the size of the pie and how fairly it is sliced. The truth of the matter is that there are not enough resources and clinicians in the public sector to meet community expectations and to systematically deliver high quality care. And many good people — patients and their families, doctors, nurses, managers and support staff — have paid the price of our silence.

## Competing interests

Professor Kathy Eagar is Director of the Centre for Health Service Development (CHSD) at the University of Wollongong. Kathy is a member of the NSW Resource Distribution Formula (RDF) Advisory Committee, and she and the CHSD have undertaken numerous commissioned R&D projects for NSW Health over the last decade. She has well-established relationships with many key stakeholders involved in the recent events in Macarthur, both locally and more broadly in NSW, including a relative working at Campbelltown Hospital. Kathy was previously a clinician and a senior manager in (what was previously) the western metropolitan region of the NSW Department of Health. She has worked with, or undertaken research in, Macarthur regional health services for over twenty years.

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