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Creation Date:	30/07/2004 1:00pm
From:	Toni Hoffman
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Bundaberg-District.WBAY-BURNETT	Delivered	30/07/2004 13:00:03
Karen Stumer BC (Karen Stumer)	Opened	11/08/2004 20:57:48
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MESSAGE	780	30/07/2004 13:00:02
TEXT.htm	573	
ICUISS~3.DOC	31232	30/07/2004 12:29:54

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see what you think of this and whether anythig should be changed , ta T

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph: 07 4150 2311
Fax: 0741 50 2319

Created 30.7.04
1pm

– opened
31.7.04
by M. Carter
11.00

→ Then asked me nothing specific
I gave them nothing specific

ICU ISSUES WITH VENTILATED PATIENTS;

Designated level one unit, capable of ventilation for short periods of time 24-48hrs Consistently exceed this. Can do this for short periods of time, but not longer than a few days. Level of Unit made clear to surgeons and this has appeared to distress some of the surgeons when their patients are going to require long term ventilation and be moved to Brisbane. Usually the process works well except when Dr Patel's patients are involved. When Dr Patel first came to BBH it was explained to him that we do not have the resources to ventilate long term patients. He then stated he would not practice medicine like this and would resign. He stated that he would not transfer his patients to other hospitals. He has consistently denigrated the ICU and made such comments such as:

"This would not have been missed on the wards" (Gentamycin being written up by physicians.)

He stated to one of the R.N's that he had "contacts" in Brisbane and would use them to block a patient being transferred. Dr Patel consistently vents his frustration at the current system by being insulting to the nurses and the ICU. He consistently talks loudly to his PHO and JHO about "How difficult it is to work in this ICU" How backward it is and how it is like working in the third world for him. He does not usually do ward rounds with the ICU physician and this causes problems with the ICU nursing staff when they are receiving conflicting orders about treatment. Dr Patel will not converse with the NUM.

The Director of the Unit, Dr Carter, is usually supportive and proactive about transferring patients, except when Dr Patel's patients are concerned. Dr Patel creates such an atmosphere of fear and intimidation in the unit that his behaviour is rarely challenged. Dr Patel has repeatedly threatened to

A) Resign
B) Not put any elective surgery in ICU.
C) Complain to the Medical Director
D) Refuse to complain to the Medical Director any more and go "straight to Peter Leek" as "I have earned him ½ million dollars this year."

Dr Carter has approached the NUM several times about increasing the Nursing FTEs so that we can "care for Dr Patel's patients properly". It was explained to him that it is a complicated process that requires much more than an increase in FTE's. We do not need more nurses when we are acting in our designated capacity. It is when we consistently act outside of this role for extended periods of time that these issues arise.

. There is such a feeling of disunity in the ICU at present, it is upsetting to the nurses and they literally refuse to care for Dr Patel's patients because of the disunity that exists. With Dr Patel's ventilated Patients it needs to be again reiterated that they will need to be retrieved to Brisbane after 24-48 hrs , or sooner if there are two ventilators in ICU. The admission and discharge policy of ICU must be adhered to.

On several occasions when Dr Patel's Patients have been in the ICU, he has refused to transfer his patient to Brisbane, even when the patients have deteriorated and have been in ICU for much longer than 24-48 hrs.

I have voiced my concern regarding the level of care required for some of Dr Patel's patients several times. I have accompanied Dr Jon Joiner to meet with Dr Darren Keating when the issue of doing oesophagectomies has arisen in the unit.

This week we had a critically ill patient transferred back to ICU in extremis. He was a 46 year old male with a crush injury to his chest, multiple # ribs and a flail segment. He was shocked, in pain, tachycardic and hypotensive. The Anaesthetist in charge attempted to place an arterial line and a central line as well as transfuse the patient. At one point the patient went into ventricular standstill. Dr Patel was seen to make a comment to another surgeon and laugh. Dr Patel repeatedly stated in a loud voice the comments that this patient did not need to be transferred to Brisbane. He stated the patient did not need a thoracic surgeon. He asked the PHO "how much trauma had he done". He went on to say "no more trauma should be done at this hospital, if we cannot handle it" All of these comments were said in front of staff and other patients. A bed was arranged at PAH, and booked at around 1430 hrs. The clinical

coordinator only needed to be notified to organise the retrieval. It was decided, before the clinical coordinator would be called a CT needed to be done. There was a delay in obtaining an anaesthetist due to one being required for a perforated bowel. Dr Patel insisted the surgery for the perforated bowel be performed prior to the CT, despite the patient requiring ongoing resuscitation. I called Dr Carter and he agreed to transport the pt to CT. On return from CT it was agreed the patient would be transferred to Brisbane. I had previously voiced my concerns to Dr Gaffield that although I had heard Dr Patel say the patient did not need transfer as he did not need a thoracic surgeon, there were other issues such as a lack of pathology and blood bank support and the fact we did not have an intensivist or other equipment. The patient was sent to CT and then it was decided to definitively transfer him to Brisbane. There was some delay in contacting the clinical coordinator as they were doing a ward round. After about fifteen minutes the clinical coordinator phoned back and spoke with Dr James Boyd. This was about 1930 hrs, 4-5 hrs post the initial confirmation of the bed being available at the P.A. During this time Dr Younis had been trying to resuscitate the patient, insert central and arterial lines, administer blood and intubate and ventilate the patient. Three ICU nurses were involved with this patient throughout his stay. The Retrieval team arrived about 2215 and whilst attempting to prepare the patient for transfer he deteriorated and died.

My concerns are:

The staff in the ICU is expected to function outside of the role of the level one unit.

The behaviour of Dr Patel in intimidating, bullying, harassing and insulting the staff in ICU.

The interference of Dr Patel with this particular patient which delayed his transfer. (Dr Patel was asked to review the patient).

My concern that the personal beliefs of DR Patel concerning the types of patients he can care for here, actually endangers the lives of the patients as these patients that would be transferred to Brisbane are not being transferred early enough.

A Secondary concern of mine is the level of surgery which is performed that should only be performed in a tertiary hospital.