Ex (456)

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

STATEMENT OF MICHAEL ALLSOPP

1.1 I, **Michael Allsopp**, District Manager, Fraser Coast Health District c/- Hervey Bay Hospital, Cnr Nissen Street and Urraween Road, Pialba, in the State of Queensland, acknowledge that this written statement is true to the best of my knowledge and belief.

1.2 This statement is made without prior knowledge of any evidence of information held by the Commission of Inquiry ("the Inquiry") which is potentially adverse to me and in the expectation that I will be afforded procedural fairness should any adverse allegation be raised against me.

1.3 Attached and marked **MA1** is a copy of my CV which provides details of my qualifications and experience.

1.4 The following statement is provided in response to the *Review of Orthopaedic Health Care in the Fraser Coast Health Region* ("the Review"). As well as a summary, I have provided detailed comments on –

- the background to the request for the Review;
- the issues and allegations raised in the Review; and
- the strategic direction for orthopaedic services in the Fraser Coast Health Services District ("the District").

1.5 I request that the Inquiry treat this submission as confidential. Publication of my comments in relation to Dr Mullen and the Australian Orthopaedic Association ("the AOA") may hamper the necessary bridge building required to restore vital orthopaedic services to the District.

SUMMARY

2.1 From my experience in the health system there is no service or organisation that can claim to be entirely safe, although all are trying to achieve this goal. The dependence on the variability of human performance and patients regularly results in adverse events that increase the morbidity of the patient. The test is whether the level of adverse event is acceptable to the community and the clinicians providing those services.

2.2 The challenge in the District has been to improve the safety of services while balancing the requirement to meet the demand for the delivery of those services with the human resources that are available.

2.3 There was no signal from the relevant stakeholders that the orthopaedic services provided by the District were unsafe. When safety issues arose, the District acted responsibly and sought the Review.

2.4 The Review recommendations need to be examined in relation to their validity and whether they represent the balance between community need, appropriate risk management and acceptable outcomes compared to the standards set by the AOA for the delivery of those services.

2.5 The legitimacy of the AOA standards also need to be challenged as to whether those standards reflect the litigation safety net for the practitioner or the safety for the outcome of the patient and community benefit. The issue of reasonable risk and access also needs to be evaluated.

2.6 It is also essential that there be comparative studies of patient outcomes from accredited AOA sites and the District to determine whether there is an outcome

gap and the extent of that gap. The limitation of the Review is that it is primarily based on subjective rather than objective assessment.

2.7 There is substantial evidence to demonstrate that the District has responded to the need to change services to meet safety needs during my time as District Manager. This demonstrates the awareness and commitment of the District to continual improvement.

2.8 It is my hope that orthopaedic services will be re-established with acceptable safety constraints that represent the new balance of safety versus community access and benefit.

BACKGROUND TO THE REQUEST FOR THE REVIEW

3.1 The District requested the AOA to undertake an independent review of orthopaedic services with a view to improving those services.

3.2 The terms of reference for the review, agreed between Queensland Health and the AOA, were articulated to achieve the objective of orthopaedic service improvement to the residents of the District.

3.3 The Director General of Queensland Health subsequently approved the appointment of two investigators from the AOA to undertake the review.

3.4 The catalyst for the District to seek the review was the publication in the Courier Mail of AOA concerns in relation to the orthopaedic services in the District. These concerns related to the adequacy of clinical skills and the extent of clinical work undertaken by Senior Medical Officers ("SMOs"). This was the first occasion that the concerns of the AOA were brought to my attention.

3.5 There was no indication from the following key stakeholders/gatekeepers/risk triggers that there was reason for concern in relation to either patient safety and outcomes or the clinical performance of any individual medical practitioner/s within orthopaedic services:

- patient complaint trends;
- Ministerial complaint trends;
- representations by clinical staff;
- representations by non clinical staff;
- General Practitioners who referred their patients and received them back for aftercare;
- Local members of Parliament, State and Federal;
- District Health Council;
- Local Branch of the Australian Medical Association;
- Queensland Medical Board;
- Litigation cases;
- Infection control surveillance, attached and marked **MA2** infection control annual reports;
- Operating Theatre Review Committee, attached and marked **MA3** are the terms of reference for the committee;
- Surgical Services Management Advisory Group which comprises medical and nursing clinicians providing surgical services including orthopaedics, attached and marked **MA4** are the terms of reference for the committee; and
- Quality Management analysis in terms of meeting the standards of the Australian Council of Healthcare Standards particularly on return to operating theatre clinical indicators, attached and marked **MA5** are general comparison – hospital wide clinical indicators.

3.6 Also, contrary to statements in the Review, I do not recall when any orthopaedic surgeon made a formal representation or complaint to me as District Manager in relation to patient safety.

3.7 There were however concerns by all stakeholders that there had been delays in accessing elective orthopaedic services due to the high demand within the District and the limited number of medical practitioners. The District has a demographically skewed elderly population that places a high demand on orthopaedic services. The demand is highest in the areas of joint replacement (arthroplasty) services. The prime obstacle in meeting that demand has been the inability to recruit accredited orthopaedic surgeons to the District.

3.8 In being presented with the concerns of the AOA that service quality could affect patient safety and outcomes, the District acted responsibly and transparently in seeking the review. This included the development of appropriate and agreed terms of reference with the AOA.

3.9 One desired outcome of the review was that the AOA would bring peer pressure on the existing Visitng Medical Officer ("VMOs") Surgeons to increase their commitment to the public sector services particularly in coverage of on call on weekends.

3.10 In addition, by raising the profile of demand for services in the District with the AOA it was anticipated that the association would actively seek to encourage and assist the District through their collegial contacts in the recruitment of additional orthopaedic surgeons.

3.11 The District has a history of responding to concerns raised by staff and relevant stakeholders in relation to patient safety and outcomes. The most notable of those was in relation to the development of a District Service Plan in 2003 and the review into the provision of Maternity Services in 2003. Also, in early 2005, there was the implementation of a contingency plan for the management of medical patients resulting from the inability to recruit accredited Specialist Medical Physician staff.

3.12 All service changes within the District are developed through a consultative process and governance structure that has as its fundamental core the participation of the clinical staff that provide the services from both Maryborough and Hervey Bay Hospitals.

3.13 In implementing changes based on patient safety requirements the District has met with adverse community response. In particular, changes to services at Maryborough Hospital have been seen by the Maryborough community as being a downgrading of their local services. However, all service changes within the District have been necessitated by the inability to recruit and retain sufficient accredited medical specialist staff to maintain the existing services at a safe clinical level.

3.14 The major risk to clinical service sustainability in the District is also attributable to the inability to recruit and retain a full range of medical staff. This also affects community confidence in the services provided by the District.

ISSUES AND ALLEGATIONS RAISED IN THE REVIEW

General comments

4.1 The Review provided value in terms of improvements that can be made to the risk management process. However, the subjectivity of the Review limits its value to address the broader objective that the District sought in its commissioning.

4.2 The Review has deficiencies in both process and accuracy. The majority of the recommendations are based on hearsay evidence rather than objective criteria. The majority of the Review is not based on the objectives of evidence based practice in clinical management which is the contemporary standard for service evaluation. This is also the standard that the District is seeking to achieve on its growth continuum.

4.3 Comments in the Review also demonstrated that the AOA investigators had little or no understanding of the management, governance structures and processes of the health service nor did they seek to obtain that information.

4.5 The Review did not address all of the terms of reference.

4.6 The timing of the release of the Review was in May 2005 with the investigation undertaken in July 2004. This is a significant time lag. During this period substantial changes were made in the delivery of orthopaedic services within the District which were not evaluated prior to publication of the report and its recommendations. It is hoped that the Inquiry considers these improvements in their deliberations as an indication of the commitment of the District to work to improving its orthopaedic services. These changes are detailed later in this statement.

4.7 The employment of a locum full time Orthopaedic Surgeon also occurred for the period from January 2005 to the end of June 2005 (as Dr Naidoo was on planned leave). During this period this surgeon provided close supervision for the SMO's, conducted weekly Morbidity and Mortality reviews, instigated new procedures in terms of bed management and infection control, provided on call services, and participated in the Operating Theatre Review Committee and the Surgical Services Management Advisory Committee. These changes will be imbedded in future service delivery.

4.8 This respected surgeon then resigned his post based on the recommendations of the Review. At no stage did the AOA investigators seek to review changes instigated in the District prior to the release of their report to ascertain the currency and validity of their original recommendations. I find this a significant anomaly in the Review.

Section 1 – General information on the inspection process

Non supply of information requested by the investigators

4.9 I do not recall receiving a copy of the AOA request for information referred to. District staff have reviewed files to locate such a request and none can be located. This situation is extraordinary as any request would have been made a priority. No mention was made to me as District Manager by the investigators prior or at the time of interview that information requested was not forthcoming. No reminder or call was received by me prior to the visit of the investigators to the effect that requested information was not supplied. Given that it was the District that requested the review there was no reason for non supply of the information requested. If the District had received the request the information would have been supplied and in a timely manner.

4.10 If the investigators considered they were not adequately prepared in terms of information they should have sought a deferment of the visit or in the very least articulated their concern to either myself as District Manager or the Director General who appointed them as investigators.

4.11 The District requested a review by the AOA in November 2003. The actual site visit by the AOA was in July 2004. The lack of urgency by the AOA indicated to me that the concerns of the AOA were not major in terms of patient safety. The fact that the site visit was only one day also reinforced that assessment. If the AOA had serious concerns in relation to patient safety the review would reasonably have taken the format of an initial earlier site assessment followed up by a comprehensive review including a practical surgical competency assessment. A final report would emanate from that process plus the introduction of interim risk management strategies pending that final outcome.

Adequacy of the interview process

4.12 The process of a review necessitates that statements given by those interviewed are documented and signed by those persons as being a true record of the interview. This is necessary to ensure that there is no misinterpretation by the interviewers of the information given. This did not occur in my case.

4.13 I have not canvassed the staff interviewed to check whether this obvious process deficiency also occurred in relation them. However, the Inquiry may consider it appropriate to ascertain whether or not the comments attributed to staff and assessments made in the Review reflect what was meant by those staff in the interview process.

Terms of Reference

4.14 Not all of the agreed terms of reference were addressed in the report. In particular in seeking to grow the service the District sought specific comment on Terms of Reference 1 to 4 of a total of 8 items that were agreed to be addressed. These items were not specifically addressed in the Review.

4.15 This issue is significant as Terms of Reference 1 to 4 dealt with patient safety and risk management and were the highest priority items. The Terms of Reference related to the services provided by the Senior Medical Officers and the delineation of their clinical privileges i.e. scope of practice.

Sections 2 and 3 – General information on the District hospitals and Investigators' report on the medical staff of the District

Dr Sean Mullen - VMO at Hervey Bay Hospital

4.16 Of particular concern to me is the assessment on page 17 of the Review that both Dr Hanelt and I "revealed animosity toward Dr Mullen". I bear no animosity towards Dr Mullen. I respect Dr Mullen as an Orthopaedic Surgeon with an excellent clinical reputation. It was for this reason that the District sought to maximise Dr Mullen's time in the public sector. The District went out of its way to support and accommodate the requests of Dr Mullen.

4.17 Dr Mullen indicated that his withdrawal of services was for family reasons and the impending birth of his child. At no stage has Dr Mullen either advised me formally or informally that he withdrew his services for reasons of concern for patient safety. If Dr Mullen had withdrawn his services for reasons of patient safety it would be unlikely that he would recommence those services unless there was a service change. Dr Mullen returned to work with the District after his break and also performed intermittent on call work during the period of that service break. If Dr Mullen had advised that he had concerns in relation to patient safety then those concerns would have been referred to the Surgical Services Management Advisory Group for review.

4.18 The "problem" articulated to the AOA investigators was to deal with the changing circumstances and availability of Dr Mullen and communications with his Practice Manager, Joanne Kelly, being at variance to the undertaking for return to work given by Dr Mullen. These variances had a consequential impact on public sector service planning and rostering. In bringing the issue to the attention of the investigators it was hoped that they would be able to assist Dr Mullen and his practice in understanding the impact that such changed arrangements had on the

public sector rosters and service delivery with a view to improvement. The following correspondence list highlights those variances:

- Fax on 22 March 2002 from Joanne Kelly advising multiple dates that Dr Mullen was unavailable to do work or on-call (attached and marked **MA6**);
- Fax on 27 June 2002 from Dr Mullen's practice advising of unavailability for clinics and theatre sessions during August 2002 (attached and marked **MA7**);
- On 4 September 2002 Dr Mullen wrote stating that due to family reasons he would be withdrawing his services for elective work from Hervey Bay Hospital from 30 September 2002 and that he would be happy to return once demands on his time decreased. He also stated he would remain available for on-call coverage (attached and marked **MA8**);
- On 6 September 2002, Dr Hanelt responded to Dr Mullen stating this was acceptable on a trial basis for a period of six months. Dr Mullen accepted this dated 12 September 2002 (attached and marked **MA9**);
- On 19 December 2002 a fax was received from Dr Mullen's practice advising he would be unavailable for on-call on Wednesday 29 January 2003, on the weekend of 8 and 9 February 2003 and for the month of March 2003. The fax stated he was available for the weekend of 22 and 23 February 2003 (attached and marked **MA10**); and
- Letter dated 12 February 2004 from Joanne Kelly negotiating available times for resumption of clinics and operating time (attached and marked **MA11**).

4.19 Dr Mullen resumed clinics and elective theatre work in February 2004. Dr Mullen then worked four sessions per month after his resumption instead of the previous commitment of eight sessions per month.

4.20 The vision of Dr Mullen for orthopaedic health care for the Fraser Coast is consistent with that of the District. From a District perspective this vision does not only apply to orthopaedics but to all medical specialties. The District

recognises that Dr Mullen is committed to the Fraser Coast and would seek to work with him in realising that vision for orthopaedic services.

4.21 The District is a growth area in terms of population and as such it is essential that we nurture service growth to meet that need. This means that as a District we catered to the needs of the orthopaedic surgeons to ensure service provision while seeking to recruit additional orthopaedic surgeons to ensure service sustainability. However, in no way was safety compromised to achieve that end. It was also for this reason that the District requested the review to ensure safe provision of service in that growth journey.

4.22 The strategic plan for the District in relation to orthopaedic services was not canvassed with me by the investigators. If that had been done there would have been a clear understanding of our vision and the congruence with that of Dr Mullen.

4.23 The Review states that Dr Mullen is "frustrated in his endeavours to improve the standard of orthopaedic care in the District". However, I can find no documentation or proposal by Dr Mullen for service change received during my period of employment as District Manager other than those detailed above in relation to his availability to provide services. It is difficult to understand what endeavours that have been frustrated. It is more difficult to understand the evidence upon which the AOA investigators made this claim. The investigators did not raise these issues with me during my interview or after.

4.24 An error of fact occurs on page 11 of the Review where it indicates that VMO specialists undertake out of hours (14 hrs) on call during weekdays. Weekend on call work is not divided between the two specialists (it is presumed VMO as it referred to them in the prior sentence). Only Dr Mullen provided weekend on call

of one in every four weeks. Dr Khursandi provides no on call service to the District at either Hervey Bay or Maryborough Hospitals (pages 11 and 13 of the Review). The remaining three weekends of on call are covered by the SMO's and in the past six months by the locum Orthopaedic Surgeon.

Dr Morgan Naidoo - Director of Orthopaedics at Hervey Bay Hospital

4.25 The majority of adverse comments made in the Review in relation to Dr Naidoo require objective substantiation by clinical and audit staff. Dr Naidoo and Dr Hanelt are better able to comment on these issues. Dr Naidoo reports directly to Dr Hanelt.

4.26 With regard to the conditions of employment and leave taken, Dr Naidoo had the same entitlements to leave and other conditions as other Staff Specialists. These entitlements are in accordance with the relevant award. No special conditions were applicable to Dr Naidoo.

4.27 In terms of prosthetics, the Orthopaedic Surgeons have their preferred product and argue that decision on a clinical basis. Accordingly, all arrangements between each Orthopaedic Surgeon and their preferred product supplier should be investigated if one is to be investigated to ensure that inappropriate inducements have not been offered. It is noted that since the review Queensland Health have sought to regulate this area by the introduction of Standard Offer Arrangements for a range of prosthetics and suppliers.

Dr Dinesh Sharma and Dr Damodaran Krishna - SMO's at Hervey Bay Hospital

4.28 Drs Sharma, Krishna and Hanelt are better able to comment on the issues raised.

Dr H ("Jim") Khursandi - VMO at Maryborough Hospital

4.29 It is acknowledged that Dr Khursandi has provided excellent service to the community over an extended period of time.

4.30 The Review states that the Emergency Department moved from Maryborough to Hervey Bay Hospital and that Dr Khursandi felt that he could not offer emergency department cover at Hervey Bay. This is incorrect as the Emergency Department has not moved from Maryborough to Hervey Bay. Maryborough Hospital still retains an Accident and Emergency Department.

4.31 The Review states that Dr Khursandi has been the lone on call specialist for many years. While that may have been the case pre 2003, Dr Khursandi has not provided on call services since 2003 and was not providing those services at the time of the investigation. In 2003 the District centred after hours Emergency Surgery at Hervey Bay Hospital. Dr Khursandi was not prepared to participate in the after hours emergency on call roster at Hervey Bay. While this situation has increased the on call requirement on the other orthopaedic medical staff, from my perspective as District Manager it has not resulted in antagonism between Dr Khursandi and the District administration. The District was prepared to accommodate Dr Khursandi's requirements as we did not wish to lose his services for elective work at Maryborough Hospital. No issues of antagonism were raised with me by the AOA investigators during the interview or after.

4.32 Given the limited number of Orthopaedic Surgeons in the District the sharing of the on call roster, particularly on weekends by Dr Khursandi, would have reduced the on call requirements of the other orthopaedic medical staff as well as increasing the available expertise. Accordingly, the District was seeking the

AOA to assist in negotiating an arrangement with Dr Khursandi to participate in the on call roster, particularly for the weekend on call.

Dr Padayachey - SMO at Maryborough Hospital

4.33 It is acknowledged that Dr Padayachey is a respected member of staff who over many years has provided excellent service to the community particularly in Maryborough.

Nursing Staff

4.34 The Hervey Bay Hospital does not have a separate orthopaedic unit. Orthopaedic patients utilise beds in the Surgical Ward.

4.35 I am not privy to complaints made to the Director and the SMO's by nursing staff. I endeavoured to either respond directly or refer through the governance structure for resolution complaints that may have been referred to me directly.

Section 4 - Investigators report on the administration of orthopaedic services in the District

Administration of the orthopaedic department

4.36 The need to improve the management of the orthopaedic service in the District are acknowledged and accepted. However, the conclusion that the orthopaedic unit at Hervey Bay Hospital is inherently unsafe in terms of patient care and safety requires further objective review in terms of patient outcomes before one could consider such an assessment being valid. It is understood that this audit is currently being undertaken.

4.37 As previously mentioned, there is no separate orthopaedic unit at either District hospital. It is not clear whether the investigators are referring to the ward area and the treatment provided, the surgical component or both. Again there needs to be objective criteria applied to test the validity of this assessment.

4.38 The limitations of a Director that has a primary residence in Brisbane are recognised. Similar to the VMO's who have the concessions of one in four weeks and no on call, this concession to Dr Naidoo was accommodated on the basis that the elective and on call service that is provided during the week is of value to the community and exceeds the dysfunction of distance. Without that coverage during the week days, there would have been no orthopaedic service at Hervey Bay.

4.39 It is noted that Dr Mullen sought to do two week days per week on call. The reasonable response by the Director was that as he was in Hervey Bay for the week days then the on call of a second Orthopaedic Surgeon was not necessary. This option needs to be re-evaluated. However, the pro bono services offered by Dr Mullen are not within policy guidelines.

4.40 Issues of the transit service between Maryborough and Hervey Bay have previously not been raised as an issue by nursing staff. This is a Queensland Ambulance Service responsibility.

4.41 The limited support for nursing staff in emergency at Hervey Bay has been addressed by duty changes since the investigation.

4.42 The recommendation of the four or five Orthopaedic Surgeons is consistent with the District view and an admirable vision. However, recruiting just one additional Orthopaedic Surgeon has proved a fruitless task over the past two years even with the added incentive of shared work and access to private patients through St Stephen's Private Hospital in Maryborough.

Hospital and District health service administration

4.43 Contrary to the assessment by the investigators the District administration has great respect for all District medical staff including the orthopaedic medical staff. The commitment demonstrated by medical staff in the District to providing services is exceptional and well deserving of respect not only by the District administration but also the community. The basis of the investigators arriving at the conclusion that there is a lack of respect requires evidence.

4.44 As District Manager I was aware of several tensions between the orthopaedic medical staff. These type of tensions exist in various hospitals and departments to differing levels. However, these tensions were not to the extent that any of the parties sought mediation or lodged grievances. As there were no major complaints from the key stakeholders mentioned earlier, intervention was not undertaken to resolve these issues at an executive level. The limited hours of attendance of the VMO's and the site differences gave little opportunity for major confrontation. My assessment was that the disagreements were not at a sufficient threshold level to warrant intervention.

4.45 My experience of Dr Hanelt is that rather than being critical of the orthopaedic medical staff he would have been most probably highlighting areas where there could be opportunity for improvement facilitated by the review process.

4.46 I have always found that I have been treated with respect by the medical staff. An open letter to the Chronicle newspaper by medical staff in May 2005 indicated full support for the administration, attached and marked **MA12**. A similar letter was also presented by nursing staff, attached and marked **MA13**.

4.47 The comment that I lack in creative management skills is a perception that I will seek to improve. However there have been many initiatives achieved in the

District that have not been achieved in others. Some of the initiatives that I have led are at the strategic rather than operational level and include:

- Development through Community and Stakeholder consultation of a District Services Plan;
- Agreement with the St Stephen's Private Hospital to share Medical Specialists;
- Transfer of Bayhaven Nursing Home to the Private Sector to fund increased services in Renal and Rehabilitation Services;
- Substantial improvement in the efficiency and throughput of the organisation since being appointed District Manager (attached and marked **MA14**)

4.48 In terms of the addressing of problems in orthopaedic services, these reached the threshold level for intervention with the publication in the Courier Mail of the concerns of the AOA in late 2003. The threshold being that there were claims of adverse events affecting patient safety. The District responded quickly and transparently to enlist the support of the AOA in identifying and making recommendations in relation to the totality of orthopaedic services within the District.

4.49 Unfortunately the Review did not address the agreed Terms of Reference. However, work has commenced on examining the validity of all recommendations of the Review with a view to constructively addressing those recommendations and their implementation.

4.50 The comment that my approach to problem solving was seen as "shooting the messenger" rather than listening to the message and taking constructive action is rejected. The investigators should be required to present evidence of such incidences.

4.51 Issues raised with me relating to patient care are referred through the clinical governance structure of the District for review by clinical staff to investigate and determine solutions and propose policy. In the case of orthopaedics it is the

Surgical Services Management Advisory Group. Solutions to clinical problems are developed and responded to by clinical staff with a recommendation to the District Executive. While I lead the District Executive it includes both administrative and clinical staff. I do not recall any occasion where the recommendation of the clinical staff through that governance structure has been overruled by the District Executive.

4.52 I reject the comments in relation to Dr Hanelt being out of his depth and showing no leadership skills and consider these unfair. The investigators have made a general assessment based on a very limited sample of opinion and subject area. Dr Hanelt as Director of Medical Services reports directly to me. He has a substantial workload with equivalent responsibility. His priority is to ensure quality service in the clinical areas and the provision of advice through the clinical governance structure. He undertakes both an administrative and clinical role, regularly filling in for clinical shifts where we are unable to recruit or re-allocate staff to provide service continuity. He is well respected clinically and thorough in his approach to the performance of his administrative role. He provides advice to me in relation to clinical issues and again this advice is thoroughly researched and practical. Dr Hanelt performs his role to a very high standard and has my confidence as a Director of Medical Services. I have also found that he is responsive to service complaints and is prepared to tackle issues head on that affect patient safety. No evidence to the contrary was presented or discussed with me during the review process.

4.53 It also should be noted that in a hospital, staff and middle management regularly push decisions up the line to the executive rather than accepting responsibility for making decisions within their areas. It would be necessary to ascertain whether the decision making responsibility for those alleged areas of non-responsiveness should have in fact been addressed by staff or middle management. Also it would be necessary to ascertain whether or not the complaints were formalised, i.e. did the relevant individuals follow the relevant policies in relation to critical

incident reporting and complaints management. I do not consider passing comment in a corridor to be an appropriate advice to the executive for a formal response.

4.54 The issue of the SMO's being portrayed in the media as being Consultant Surgeons has not been the intent of the District administration. Such a claim has not been presented in any media releases that I am aware. However, I am aware that Dr Mullen did raise his concerns with Dr Hanelt after a particular article appeared in the local paper that could have construed that the SMO's were accredited Orthopaedic Surgeons (attached and marked **MA15**). Dr Hanelt advised me of Dr Mullen's concern and advised me that to portray an SMO as a Specialist Surgeon was illegal. I considered that the comments did not portray the SMO's as Australian Accredited Specialist Orthopaedic Surgeons and nor was this the intent. There was no advantage for the District to portray the SMO's as accredited Orthopaedic Surgeons either internally or within the community. The differentiation in the work actually performed by the SMO's compared to that performed by the Orthopaedic Surgeons makes that distinction obvious. For example all joint replacements (arthroplasty) are performed by the Orthopaedic Surgeons. In mentioning the SMO's in future media I was very conscious of the need to portray them as SMO's and not as Consultants or Specialists. I am not aware of any articles that have since compromised that position.

4.55 The mentioning of the reduction in waiting lists was not fully articulated in the newspaper article. The strategy was that the SMO's would be able to provide minor orthopaedic services within their scope of practice. This action would free up the Orthopaedic Surgeons to concentrate on joint replacements where the greatest demand for service existed.

4.56 The view formed by the investigators as to the manifestation of a budget driven organisation for crisis management is incorrect. I note the following:

- SMO's were employed not for budget convenience but due to the fact that we have not been able to attract additional full time or VMO Orthopaedic Surgeons to the District. This is the case despite the assistance of Dr Mullen and St Stephen's Private Hospital;
- The evidence has yet to be validated that the SMO's were unsafe in terms of their level of medical practice;
- The rostering of non-specialists on consultant rosters without supervision was on the basis that they operate within their scope of practice;
- There is no financial advantage to the District to not transfer a patient to a larger institution. Transfers to larger institutions are based on clinical need and patients with conditions outside the scope of practice of the Orthopaedic medical staff and not financial considerations; and
- I reject the allegation that there was a persistent failure of the hospital and District administrators to address serious clinical concerns reported to them by staff associated with the orthopaedic unit. The investigators did not provide evidence of such failure.

4.57 It is acknowledged that the District is required to meet budget. However, that is not the prime driver of health care within the District. Services reduction rather than quality compromise is the strategy necessary to achieve budget if approval is not given to exceed budget. Service reduction for financial reasons requires the approval of Queensland Health Corporate Office. No application has been made during my period of employment as District Manager for a reduction in service based on financial reasons. Queensland Health Corporate Office have accepted the financial performance of the District in prior years albeit that the allocated budget has been exceeded.

4.58 In terms of orthopaedic services budget distribution, this amount is determined by a Finance Committee (attached and marked **MA16**). Activity targets are negotiated through the Surgical Services Management Committee for each surgical discipline including orthopaedics which is represented on that committee

by the Director. Funding is allocated on that basis. Funding for orthopaedic services has increased in each of the past four financial years.

4.59 It should be noted that the orthopaedic service was able to attract additional funding under the Elective Surgery Program for the current financial year to the extent of over $600,000. This would have provided treatment to an additional 40 or more joint replacement patients. However, accessing that funding was not possible by the decision to follow the AOA recommendation to cease all orthopaedic services within the Fraser Coast. Funding was available to supplement the services provided, contrary to the opinion expressed by the investigators in the Review.

4.60 The claim that there exists a culture of criticism and blame within the administrative services of the District requires production of evidence by the investigators. The culture that I have sought to engender in the District is one of transparency and response.

4.61 The message that I give to all managers at all levels within the health service at Department Heads meetings and the Executive is that the role of management is to create an environment for the delivery of quality health care to the community. In addition, all actions that are seen to be outside the realm of acceptable clinical practice should be reported through the incident reporting process so that they may be addressed and rectified.

4.62 While it is not agreed that the administration passed off the two SMO's as specialist orthopaedic surgeons, patients being attended by these medical officers should be informed that they are not Orthopaedic Surgeons. Action will be taken by the District to implement a process for such advice to be given to patients.

4.63 It is agreed that the perception of dysfunction between the medical staff in orthopaedics and the administrators should be addressed. Action should be

initiated to determine what the issues are and to seek solutions to ensure a quality work environment for the clinical staff.

4.64 The investigators state that Dr Hanelt and I have not handled our roles in a competent or professional manner. If evidence can be provided of this then action should be taken to improve our competencies as well as establishing a performance management process in accordance with the relevant IRM procedure.

Section 5 - Investigators' report on the processes related to the provision of orthopaedic services in the District

Staff appointments

4.65 Queensland Health has approved guidelines for recruitment of staff. These need to be re-evaluated in terms of the recommendations of the investigators to determine the legitimacy of the proposed criteria.

Patient care

4.66 Dr Hanelt is better able to comment on patient care. However, I will comment on a specific case which occurred in August 2004. This was the first and only time that I was required to police a policy developed by clinicians for operation in a clinical area. On weekends, the Operating Theatre at Hervey Bay Hospital is staffed for Emergency admissions only. In the case in question, Dr Mullen sought to operate on a case on the Saturday that did not meet the criteria for Emergency surgery as determined by the nurse in charge of Operating Theatres for that shift. The nurse conveyed her concerns to the Nurse Unit Manager for Operating Theatres. Tying up the Operating Theatre Emergency Nursing team for a case that could be deferred to normal weekday operating times meant that this team would be occupied should an Emergency admission require surgery.

Dr Mullen requested that the procedure proceed. The case was further complicated by the fact that a Senior Medical Officer in Anaesthetics examined the patient and considered the patient inappropriate to operate on due to her medical condition. The Nurse Unit Manager contacted me after being unable to contact Dr Hanelt for a ruling. I advised that the policy determined by the clinical staff should be applied as well as considering the decision by the SMO that the patient was unfit for surgery. The Nurse Unit Manager also advised me that nursing staff were concerned that when on call for weekends Dr Mullen sought to undertake elective procedures during Emergency time. I was subsequently contacted by Dr Mullen requesting that this decision be overruled. I advised him of the concerns. It was agreed then that Dr Meier, VMO Anaesthetist, be contacted to provide a second opinion in relation to the condition of the patient and suitability for surgery and the risk of tying up the emergency team. Dr Meier advised me that the patient was suitable for surgery and agreed with Dr Mullen's assessment that the clinical outcome for the patient may be compromised if the surgery waited until the Monday. On that basis I approved the operation to proceed. The surgery proceeded on the Sunday.

4.67 The recommendation to cease all orthopaedic surgical health care activity in the public sector in the District is difficult to understand for several reasons:

- The investigation and review occurred in July 2004, yet the report was presented in May 2005. No investigation or inquiry was made of the District as to changes implemented in that time period;
- Substantial changes occurred during that time period in relation to both supervision and delineating the surgery to be performed by the SMO's. Whether these changes were adequate should have been reviewed prior to the making the recommendations;
- A Risk Manager had been appointed for the District to establish procedures and protocols for the identification of risk for patients and the follow up and investigation of all clinical incident reports (attached and marked **MA17** is the position description);

- The District had also established an Operating Theatre Review Committee to implement the Queensland Health standards in relation to Operating Theatre Management. This included identification and review of cancellations;
- No practical surgical skill assessment was undertaken in the investigation of the SMO's or the Director of Orthopaedics. All recommendations in this area relied on hearsay or file review;
- The commencement of both Drs Sharma and Krisha in the Australian Medical Council program occurred within this time;
- Introduction of a Rehabilitation service into the District occurred within this time;
- No data was produced by the investigators to demonstrate that the patient outcomes of the service provided through the Fraser Coast Health Service District were inferior to those of comparative Districts within Queensland or Australia;
- The findings of the report principally rely on subjective rather than verified objective data;
- From January 2005 until July 2005 the District had employed an accredited locum Orthopaedic Surgeon who provided service in place of Dr Naidoo who was on approved leave for the majority of that period;
- If the concern was in relation to the SMO's and Dr Naidoo then the restriction of the service should have been for those medical staff only. Pending further investigation of the claims made in the Report, the remaining Orthopaedic Specialists could have continued to provide service as they did in the past;
- Both VMO Orthopaedic Surgeons continue to provide service in the private sector in the Fraser Coast. If they can provide such service in the private sector why should they not continue service to the public sector;
- If there were genuine concerns in relation to patient safety I would have reasonably expected that the investigators raise that issue with either myself or the Director General or the Medical Board immediately after the review in July 2004, and not wait until May 2005; and

- Consideration and negotiation of options should have been pursued by the AOA before they recommended the cessation of services. This is particularly pertinent given the demand for service in the District and the concerns of General Practitioners for the care of their patients.

4.68 Finally, given the issues raised in the report there is an obvious risk of an orthopaedics department or any specialty for that matter in a non metropolitan area not having formal links with a major teaching hospital for the purposes of peer review of the performance of the clinical Director. This link should also include the Quality Assurance programs that should operate within that service.

Record keeping

4.69 Dr Hanelt is better able to respond to the record keeping issue. However, it is noted that the District established a Medical Records Committee subsequent to the review to improve the standard of medical record keeping (attached and marked **MA18** are the committee terms of reference).

Quality assurance procedures

4.70 The District has a comprehensive Quality Assurance program that meets the standards of the Australian Council of Healthcare Standards.

STRATEGIC DIRECTION

5.1 As previously mentioned the District has an elderly population skew which creates an increased demand for orthopaedic services. The strategic direction of the District is to have a sufficient number of Orthopaedic Surgeons to meet that demand. The ideal number would be four or five depending on their private

practice and public sector workload. This number is required to provide a reasonable on call lifestyle for the participating practitioners.

5.2 Currently the District has three accredited Orthopaedic Surgeons and has been recruiting for at least the last two years in conjunction with St Stephen's Private Hospital to increase that number to four. Unfortunately the District has not been able to recruit due to the nationwide shortage of Orthopaedic Surgeons.

5.3 Succession planning is required for the replacement of both Drs Naidoo, Khursandi and the SMO Dr Padayachey who are nearing the retirement phase of their careers. Dr Naidoo indicated to me his plan to retire in 2006 but that he would not do so until we had a replacement Orthopaedic Surgeon to provide the necessary supervision required to sustain the service.

5.4 The employment of SMO's was a support strategy to provide an infrastructure that would allow the Orthopaedic Surgeons to concentrate on joint replacements while the SMO's performed the minor orthopaedic work within their scope of practice.

5.5 The District is currently in the transition stage of building a service while not having the necessary critical mass of Orthopaedic Surgeons to take it to the next level. This would include training positions to ensure the future sustainability of a quality service.

5.6 A hospital cannot go from having no service to a full service in an instant with all risks managed. The building of a service requires time and evolution. Hospitals need to start with the medical staffing resources that are available. During that evolution period, many concessions have to be made for the work and private lifestyles of the Orthopaedic Surgeons to maintain them and their service within the District. This District has accommodated various concessions to each of the Orthopaedic Surgeons to ensure their continued contribution to the service during

this evolution period. These concessions also realised the length of time that the Specialists planned to stay with the health service prior to retirement. Patient safety has not been one of those concessions. The District has in the growth period sought to increase its resources in the area of clinical risk management to provide improved safety of service to the community.

5.7 The Review indicates that substantial bridge building is required if we are to work together with the Orthopaedic Surgeons to improve the service in the best interest of the community.

5.8 The overall longer term strategic direction for the District was to become the major orthopaedic service centre between Rockhampton and the Sunshine Coast with a sufficient catchment to provide a sustainable workload for the four or five recruited Orthopaedic Surgeons. Maryborough Hospital would be the major elective site with Hervey Bay being the Emergency Service site.

5.9 Rehabilitation services have also been introduced into the District since the visit by the AOA investigators to complement that service evolution.

5.10 At any point in time along that continuum of growth there would be many aspects identified for improvement. However, as time progresses each of those aspects become less until the critical mass is reached to achieve sustainable service to the local community through a fully integrated service. The District is on that journey and a review of the improvements made since the review visit hopefully demonstrate that commitment.

5.11 The District has sought to put patient safety as a priority in that evolution and as such invited the AOA in good faith to provide advice on our areas of needed improvement. Unfortunately, their report has resulted in the cessation of those services rather than their development.

5.12 Orthopaedic services should be available in non-metropolitan areas like the Fraser Coast where there is an elderly population. Restricting orthopaedic services to metropolitan areas cause significant social cost and disruption to patients. The District and its Executive have worked hard and in a professional manner to seek to achieve this objective for the community.

Signed at Aceh on 27th July 2005

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Mike Allsopp
District Manager
Fraser Coast Health Service District.