Australia:

Health workers falsely blamed for hospital deaths

Mike Head
6 May 1999

"Hospital fatalities blamed on staff" read a headline in the *Australian* on Monday. The article purported to report on a new study published by the *Medical Journal of Australia* analysing the causes of the estimated 18,000 deaths and 50,000 serious injuries caused by medical mistakes in the country's hospital system each year.

According to the opening paragraph of the *Australian*'s story, "Eight in 10 incidences of needless injury or death among hospital patients have been attributed to human error." It is difficult to imagine a more misleading way of depicting the health study's results.

In fact, the research paper and an accompanying *MJA* editorial specifically warned against simplistic misuse of the term "human error". They pointed to systemic organisational problems, insufficient use of information technology, doctor fatigue and sleep deprivation, and inadequate supervision of junior staff as the most likely primary causes of the shocking death and injury toll.

The study was a follow-up to the 1995 Quality in Australian Health Care Study (QAHCS), which first estimated that 16.6 percent of hospital admissions led to an "adverse event" (an injury or complication caused by the health care received rather than by the disease from which the patient suffered). Apart from those killed or permanently disabled, the 1995 report said about 230,000 patients experienced some degree of hospital negligence annually. Half of these were judged to be preventable.

The latest report presents an intensive analysis of more than 2,000 of the cases identified by the QAHCS. It found that half were highly preventable and 82 percent were associated with one or more "human error" categories. The major categories were "failure in technical performance" (34.6 percent of adverse events); "failure to decide and/or act on available information" (15.8 percent); "failure to investigate or consult" (11.8 percent); and "a lack of care or failure to attend" (10.9 percent).

In addition, delay contributed to 20 percent of the needless injuries, with delays in diagnosis accounting for near 60 percent of such cases and treatment delays for 40 percent.

While finding that human error was a prominent cause, the report's authors, led by Ross Wilson, director of quality assurance at Sydney's Royal North Shore Hospital and co-author of the 1995 study, issued the following caution: "Other studies have noted that the label 'human error' is prejudicial and non-specific; it may retard rather than advance our understanding of how complex systems fail. It is postulated that within complex systems error is a symptom of organisational problems."

The report refers to other studies that provide considerable evidence that junior doctors' hours of work are frequently excessive in Australia, as well as in Europe and the United States. In one often-quoted study of junior doctors with work weeks of 100 hours, "fatigued" was defined as less than four hours' sleep in 24 hours, and "rested" as more than four hours' sleep in 24 hours. Another recent Australian study of 4,000 reports to a voluntary register of adverse incidents in anaesthetic work, showed "fatigue-related" and "stress-related" factors cited in up to 38 percent of the errors.

In their conclusion, the specialists led by Wilson point out that the high rate of human error must represent a failure of the hospital system itself to provide patient protective procedures, "if one accepts that these practitioners are appropriately trained and competent by international standards".

They call for immediate measures such as better information systems and quality control processes, including automated patient-tracking and drug-administering systems. They insist that technological

tools exist to create a more "failsafe" health system.

In the associated *MJA* editorial, Charles Vincent, a reader in psychology at the Clinical Risk Unit at University College in London, criticises the tendency to simply blame doctors and nurses for medical error, emphasising that studies have demonstrated that the causes are more complex. He points to over-reliance on junior staff, unavailability of senior staff, inadequate or haphazard communications systems, and delays in obtaining test results, combined with inexperience and inadequate knowledge.

Vincent suggests that federal and state governments have not urgently addressed the problems revealed by the 1995 study. He welcomes an allocation last year of $658 million over five years for quality improvements within the public health system, but "the pace of change nevertheless seems slow given the stark message of the original QAHCS study four years ago".

"Since then, thousands more Australians have presumably been injured or died through deficiencies in the healthcare system," he says, also noting that the annual cost of the preventable errors has been estimated at $4.17 billion a year. "Achieving change on the required scale will require a specific commitment from all healthcare providers, administrators and consumers, as well as unequivocal, sustained government support. It is hoped that 1999 will see the necessary consensus for urgent action from all the parties involved and the implementation of specific, carefully evaluated safety initiatives."

Vincent concludes as follows: "It would be tragic if the 'lack of care and failure to attend' and 'failure to decide and act', revealed as causes of AEs [adverse events], ultimately also applied to those professional and government bodies responsible for programs of prevention."

There is good reason to doubt that Vincent's impassioned plea will lead to any great shift on the part of the political and medical establishment. Labor and Liberal governments alike have stalled all remedial action. Three years ago the National Taskforce on Quality in Australian Health Care responded to the 1995 QAHCS report by producing a detailed plan to reduce healthcare injuries and deaths. Its recommendations were officially supported but placed in the hands of various working groups. Federal and state health ministers are not due to consider final recommendations until later this year.

The *MJA's* references to fatigue, stress and over-reliance on junior staff provide only a partial view of what is happening in public hospitals. After more than a decade of hospital closures and cost-cutting, not only doctors, but nurses and the entire staff are over-stretched, under-resourced and under continual strain as they make sometimes life and death decisions on patient care. Lack of critical care beds, constantly rushed treatment and use of nurses and trainee doctors as lowly-paid substitutes for medical specialists all contribute to the breakdown of safe procedures.

As for the $658 million set aside for improvements over five years, it is not only a pittance compared to what is needed, it is only a fraction of the $1.4 billion a year now being spent by the Howard government to subsidise and prop up the private health insurance funds. In effect, the federal government is utilising the unsafe conditions in the public hospital system to pressure people into seeking private insurance and private hospital treatment. Simultaneously, the state governments are implementing measures, such as the casemix funding system, to force hospitals to further cut treatment costs and shorten the length of patient stays. By seeking to scapegoat doctors, nurses and other medical workers, headlines such as that in the *Australian* aid these processes.

In the meantime, as Vincent states, thousands more people are dying or being disfigured for life each year. No statistical analysis can convey the human misery involved. The latest study provides a dozen case studies. In one, a 32-year-old woman died of acute peritonitis, an abscess and pneumonia nine days after a failed endoscopic gastric operation that was followed by an open procedure. In another, a 52-year-old man with known asthma was prescribed a beta-blocker for hypertension, resulting in acute respiratory failure. A 75-year-old woman died from acute renal failure after developing toxicity to a drug used to treat an infection, where the drug levels were not measured.