EDITORIAL

Trusting the surgeon: A tornado from Bristol

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The latest edition of the *Medical Journal of Australia* presents an article by Stephen Bolsin, a British anaesthetist now working in Australia (Bolsin 1998). He describes how, as early as 1987, there was talk behind closed doors in the United Kingdom Department of Health about worrying results of paediatric cardiac surgery at a large public hospital in southern England, the Bristol Royal Infirmary. In 1988 Bolsin began work there. He had not heard the whispers, but soon became concerned. He noted the long surgery times overall, and the long duration of the period during which the heart was off-line (and hence deprived of oxygen). He suspected this could be associated with higher death rates and injuries (like brain damage).

In 1990 he began asking questions at internal clinical team meetings, but was told that his '… expressions of concern were neither helpful or constructive'. He therefore wrote to senior management at the Bristol Royal Infirmary, stating his view that something was wrong. Nothing happened, and the surgery continued.

Bolsin tried to reduce his involvement in paediatric cardiac surgery. However, he continued to collect data, and presented a detailed analysis to the Bristol Royal Infirmary's senior management in 1993. His data suggested children were three times more likely to die than the national average, and one surgeon had 20 times higher mortality rates for some procedures.

Still nothing was done, and therefore Bolsin approached the Department of Health. This led to an informal agreement in December 1994 that some of the risky procedures would not be performed pending further investigations. However, Bolsin discovered that one of these procedures had been scheduled

anyway, on an 18-month-old child. He urgently began to talk with anyone who would listen about having it moved to another hospital. The Department of Health told the hospital's chief executive to do just this, but he refused.

On the night preceding the operation, there was a meeting of anaesthetists and surgeons at which Bolsin argued the operation should not proceed. He was in a minority of one, and the following day the child died on the operating room table.

Bolsin and his wife were very upset. They had thought of going to talk with the child's parents about the risks (even though this might represent professional misconduct), but had not done so, and felt guilty.

In early 1995 the Department of Health finally did what it should have done at least eight years previously: requested an enquiry by external experts. Their report was highly critical in draft, but they were pressured by the Bristol Royal Infirmary chief executive to eliminate the more negative comments. Their report found its way into the mass media, and the story finally broke on the front page of the *Daily Telegraph* in April 1995.

Bolsin received few kind words as a result. He had 'let the side down' and 'brought medicine into disrepute'. Bristol Royal Infirmary managers threatened him with dismissal and changed his duties to his disadvantage. This contributed to his decision to move to The Geelong Hospital in February 1996.

In April 1996 he wrote to the General Medical Council, asking that an enquiry be conducted. Bolsin believes he is the only doctor ever to have taken such action.

The enquiry started in 1997 and ended in June 1998. The General Medical Council found three paediatric cardiac surgeons guilty of serious professional misconduct. Families of children who died or who were seriously disabled requested a full independent public enquiry, and the government has agreed. Local police are considering criminal charges, and there are likely to be multi-million dollar compensation claims.

Could this unfortunate process happen in Australia? Bolsin believes there may be cultural differences between the United Kingdom and Australia that make questioning of authority more acceptable and commonplace here than in the United Kingdom.

However, we should not be complacent. The editor of the *Medical Journal of Australia* notes that we have similar structural weaknesses (Van Der Weyden 1998). He argues that it is less a matter of human imperfection than of systemic failure, and I agree.

Present arrangements are partly a consequence of genuine and appropriate concern: doctors handle difficult problems, and they need to be protected from unfair criticism. Moreover, doctors cannot work together if they are continually looking over each other's shoulders, and uncontrolled criticism will increase anxiety and pain for patients and their families. There is also the matter of society's expectations of its doctors: for example, that they be single-minded in caring for our parents and children, and should not be constrained by bureaucracy.

However, these factors must be balanced against the broader community interest. There are no easy answers, but three matters should be addressed with increasing vigour. First, medical culture needs to change in some small ways, starting in the medical schools. For example, we need to create the view that it is acceptable to admit error (and indeed a sign of strength and competence). Evaluation based on evidence must play a part, but it is insufficient by itself. Bolsin was involved in the development of tools for the measurement of risk-adjusted outcomes in cardiac surgery, and they served to confirm his concerns about clinical practice at Bristol. However, his scientific analyses failed to persuade senior managers to take action.

Second, we need to change the health system. It is not in the community's best interests to have a conspiracy of silence, and we have been going in the wrong direction recently. For example, most senior managers are now employed under contracts which severely restrict their rights to talk with the mass media and the community at large. We need a balance, but I believe we do not have it yet. Bolsin notes that he tried '.. to stand up for the best interests of the patient and for that I suffered at the hands of a profession that locally was not prepared to stop children from dying unnecessarily in the practice of powerful men'. We need to ask how many health professionals in Australia are as concerned about clinical practice as Bolsin, but have not been as brave (or as foolhardy) to speak out.

Third, and most important, we must renew our commitment to consumerism. This is the best protection of society's interests in the long run. Consumers should not only feel they have a right to know what's going on. They should also be continually advised of matters which might concern them, and be given simple mechanisms for following up their concerns. We have just started the consumer revolution in health. Everyone should be committed to ensuring it takes on some of the attributes of a steamroller.

The General Medical Council enquiry generated much information which is fascinating or frightening (or both), but one small part of the report caught my eye. The Chairman of the Disciplinary Committee asked the last question to Bolsin, which was 'How can we prevent a situation like Bristol from ever

happening again?' Bolsin says he was surprised, given that he had been subjected to two days of detailed questioning about history. However, he found a good response: 'You must never lose sight of the patient.'

References

Bolsin S 1998, 'Professional misconduct: The Bristol case', *Medical Journal of Australia*, vol 169, no 7, pp 369–72.

Van Der Weyden M 1998, 'The Bristol case, the medical profession and trust', *Medical Journal of Australia*, vol 169, no 7, pp 352–3.