Submission

No 20

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

Organisation:

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The Parliamentary Select Committee Of Investigation Into Royal North Shore Hospital

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NORTH SHORE NEAR FATALITIES -

MEAL IMMEDIATELY BEFORE ANAESTHETIFC -

FAILURE TO REPORT SERIOUS BLOOD DISORDER

AND

ENTIRE EMERGENCY WARD COSED FOR SEVERAL HOURS WHILE WAITING FOR JUST ONE PORTER TO CLEAR OCCUPIED EMERGENCY BEDS ALREADY EXAMINED AND NO LONGER REQUIRED IN EMERGENCY.

To The Chairman,
The Reverend Fred Nile
And All To Whom It May Concern.

Reports about nurses privately attending a public hospital are far from isolated incidents. I had been admitted to Royal North Shore when a male nurse from Westmead came to attend the patient in the bed opposite and sat beside him all afternoon. And it is much more than nurse shortages. Last time I was told patients were encouraged to bring their own meals. They may have to. I was in emergency and they ran out. I was told that there was nothing to eat in the hospital and had to wait more than twelve hours, half a day, for breakfast the following morning.

I do not believe that all this is just a matter of money though. It is the inevitable result of a culture that has been blatant for at least a decade and long ago became very dangerous. This culture continues in the decision by the officials to discourage comment and the provision of information about whether or not the administration of health care at the hospital is conducted according to law. Medicine has been always about investigation, discovery and response. It can have no future if the fundamentals of vigorous inquiry followed by the application of uninhibited imagination are circumvented for political reasons. We may as well return to times before penicillin and breast cancer treatments. What life means in New South Wales, should not be according to secret understandings between civil servants and their darker masters who appoint them to agree.

The current investigation into continuing abominations at Royal North Shore Hospital may involve far more that debate over appropriate allocations of scarce financial resources. The question may be whether or not criminal negligence is involved, whether it is continually involved and who is responsible.

The culture that causes this begins at the front door. I was sent to Emergency at RNS late one afternoon by my doctors, who told me there was no point in trying a private hospital for

which I have private insurance. RNS had the only equipment available, I was told. I arrived in considerable pain to find the entrance empty. Two women behind the thick glass panels that protect admission staff from the sick kept their backs towards me for twenty minutes after I had filled in the questionnaire on my side of the barrier.

I complained when one of the women approached me indifferently, pointing out that I was still the only person there. I was told that I had been assed. Both women agreed that my colour was good, so I could not have had heart problems and my breathing was obviously normal.

Those women may have been trained in distance diagnosis but on this occasion it was not reliable. At the time I must have been already showing advanced signs of the hypertension that later ended in a stroke. I could not have been breathing normally either, I never have. I have been a chronic asthmatic since four years of age and hospitalised many times *in status asthmaticus,* some of which occasions I was lucky to survive.

I was told to wait but the pain became more and more severe. Finally I could no longer sit up and had to lie on the floor of the foyer, for several hours.

As I recall, I arrived around five thirty in the afternoon, was examined around three a.m. and discharged approaching dawn. My admission and examination records will have all details of that and the following terrible episodes.

A far larger and much more important problem, however, lies in the continuing practise of diagnosing the public through the windows of the admissions foyer. The problem is, quite simply, that the general public have no medical training. They can tell the nurses behind the window only what they think is wrong with them. For instance, suppose someone applies for admission because they have increasing abdominal pain and fear they may have an ulcer about to burst. Friends and relations may have helped arrive at this conclusion. How could anyone know if the pain was actually being caused by an ulcer, a heart attack, or anything else. Or, if there was no pain all because the person had a psychiatric disorder and approached hospitals frequently with fantasies of medical conditions.

This entry point seems to be where much of the problems begin.

Why cannot a nurse, a trainee nurse, a trainee doctor, a part time student or any responsible person take the blood pressure, a heart function trace, look at a blow through a peak flow monitor - a simple gadget - and take the temperature of everyone who comes in as they come in. These cheap quick tests would immediately identify most danger signs and avoid potentially life threatening waits for more sophisticated examinations.

My next experience was not merely painful, humiliating and fatiguing, it was life threatening.

It was before seven in the morning at RNS and I was waiting to have part of my bowel removed to stop the possible spread of cancer. I had had the pre prep injections, so I was feeing very confident and relaxed as you are supposed to be before you go in for a very large operation like colon resection. My only discomfort was that I was starving. I had been NIL BY MOUTH since the evening before. There it was at the end of the bed, my name and NIL BY MOUTH. I thought everyone, certainly everyone in surgical wards, knew of the terrible peril from ingesting anything before an anaesthetic. Not the young Asian nurse approaching me with a breakfast tray though, a breakfast tray labelled clearly with my name. She seemed quite confused and upset when I told her it could not be for me, even when I pointed out the NIL BY MOUTH at the foot of my bed. I had the impression that she knew little English. I

wondered what someone who apparently could not read, or even speak, our language was doing in such a critical place. I wondered, also, what would have happened if I had been someone else. Someone in hospital for the first time, perhaps, who had no idea of the dangers of eating before an operation and just did what seemed expected of them

Example number two was recently, this year. I had returned to RNS to see the specialist for my condition. During the review I was asked if I was taking a medication indicated by blood tests at the hospital three months earlier. I had no idea of what was being referred to. Apparently the test had shown that I should have the treatment in question and a letter had been sent to my GP. I said that my GP had not received the letter and asked why I needed the treatment. I was told it was to prevent possible erosion of three blood vessels, the aorta, the carotid artery and an artery to the brain. The specialist repeated the blood tests then and there and prescribed the medication immediately. Now I am on it for life.

My next example did not affect me, other than to keep me awake, but it does paint a picture of what goes on in that hospital.

It was after midnight when I was with a two rows of patients with cardio vascular disorders, all hooked up via the veins to various drips and big black monitors recording our heart functions.

An elderly lady, more than half out of it, announced substantially coherently and very loudly that she must go to the lavatory. She awoke everyone and, trashing her arms about, started trying to get out of bed. I immediately thought of the intravenous needles being ripped out as she crashed onto the floor. Obviously she could not move unaided. I could not help, I was wired up too. So I pressed the nurse call button. So did everyone. We all lay there watching the woman struggling, all unable to do anything except listen to all the nurse call bells clamouring and watch all the call lights flashing. Finally the woman ran out of energy, she could not pull herself to the bed edge, you could hear her piddling. A nurse appeared about twenty minutes afterwards and turned of the bells and lights. Some time later she came back, changed the woman and told her in that future that she was to use the napkin that has been put on for her to relieve herself in.

As I said culture is much of the problem, culture and committee control. No one is in charge, if there was they could find out all this, any day, just by walking through the wards and asking a few simple questions like:

Hullo there, at problems at admission?

What are you in for?

Enjoy your lunch?

Anything you would like to tell me, I am in charge here, I like to know everything that is going on.

I think that this is far from a simplistic view. In principle, it seems to be supported by senior medical staff. Within the last two years the views of a senior nurse were published in the Sydney Morning Herald to this effect. It compared the fundamentally nine to five approach of hospital administrators with twenty four hour a day, seven day a week, actual hospital demand.

I saw an example of this, last time I was in the Royal North Shore emergency ward with cardiovascular insufficiency.

I had been examined and was waiting transfer to a ward. So were many others but none could be moved. Doctors and then The Registrar, began calling for a porter to remove the beds of those examined and treated, so others waiting outside could come in.

I think this went on for three hours; three hours while emergency patients waited for a porter to arrive and clear the emergency ward filled with those no longer emergencies, just lying there taking the places of those waiting to be seen urgently.

Why was there no administrator available to immediately take charge and see that the patients who were no longer emergencies were removed?

If senior medical consultants and surgeons can make themselves available at all hours of the day or night why cannot the administrators?

I have spent weeks altogether in RNS, often wandering around pushing my drip, but never once have I spoken to, or even sited, anyone who looked like an administrator.

The point of this is that there is no attempt to obtain opinion from patients or the public. The reverse is the case, the administration is indifferent and hostile, there is and has been for a long time a deliberate and robust rejection of question.

No one is in charge, no one is allowed to be in charge and no one wants to know.

On this last point there has been public allegation to the effect that funding has been denied Royal North Shore Hospital for political reasons, that share is asserted to have been spent elsewhere.

In rejecting this allegation, reference has been made to socio economic models upon which hospital funding is applied in this State.

The model, to the very limited extent that it has been revealed without any demonstration of how it is applied in practise, seems dependent on subjective interpretation and entirely open to easily concealed interference and influence.

There is, however, a very simple way of calculating how evenly or not public funds are dispersed among hospitals in New South Wales. The method is used all the time commercially to appraise the performances of hotels, ships, airlines, and any facility that involves people going in and coming out.

It removes the confusion and potential problems in trying to agree what are, or should be, representative pattens of community health requirements just by totalling up what actually occurs.

It assumes that each hospital puts through very large numbers of people. So over every few years each will show an intake and output sample of very similar overall community health service requirements. As well, each hospital will reflect a similar sample of costs. This allows apples to be compared with apples, whether the apples come for the North Shore or Western suburbs.

In short the maths involve admissions compared to capital and operating costs in each case. How many patients are put through a hospital for how much in fixed expenditures amortised with continuing charges?

These calculations can be applied over any convenient period, and compared between hospitals, all hospitals, city and regional hospitals etc.

In short, what does each sick person admitted get from the government depending on where they are admitted?

Last point: I noticed this morning that a special clean up crew had been sent to Royal North Shore before The Committee arrived.

I was in emergency there with a suspected blood clot in my heart and wanted to use the lavatory. The blood clot was presumed to have come from an ankle operation that left me able to stand only on my left foot. I was in bare feet. I hopped painfully along to find the lavatory was so filthy you could not approach it to use it. It was in the centre of a four foot diameter moat of urine that must have been there for hours.

They may have cleaned these obvious places but have a look in the cupboards where they keep the cups and saucers, etc for nurses and patients wanting a coffee or tea during the reduced periods when it is being served now. Interesting to know if any have been washed since I was last there. They used to be returned used and just left until there were no clean ones.

Should you require any further information, I shall be pleased to respond.