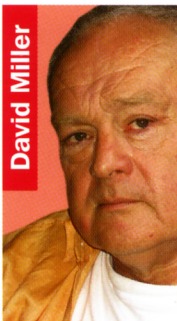


# Patients in peril – who's responsible?

LIGHT AIRS



David Miller

## David Miller looks at the role of regulatory bodies in the cases of 'Dr Death' and 'the Butcher of Bega'

ON THE DAY THE POPE left Sydney in triumph, a surgeon flew to Brisbane in handcuffs. So excited was the media that they filmed his aircraft circling the airport, perhaps they thought he would jump out and escape.

This was the notorious 'Dr Death', previously resident surgeon of Bundaberg, a north Queensland provincial town.

At around the same time he had been operating, another surgeon far away to the south in a provincial town of NSW, Dr Reeves, later known as 'the Butcher of Bega' was also doing strange things in theatre, in effect, female mutilations.

Because they were both sole surgeons working in smaller centres within the Australian health system, it is interesting to compare and contrast their situations.

In both cases, these specialists were valued by the community, because patients were saved the

inconvenience of travel to larger centres, a process involving de-personalisation and family separation.

An article in *The Australian* reports a former editor of the Bega District News as saying, when Dr Reeves (the butcher) arrived to replace a burnt out retiring gynaecologist, "so when we heard that we'd finally found another specialist to take over, he was welcomed with open arms. I mean, there is a philosophy in this town that if we get a specialist, we use him. And we do. We stay loyal."

This is big pressure. Investigative journalist Drewe Warne Smith's article (*The Weekend Australian Magazine* 26 April 2008) continues, "that as long ago as 1997 the medical board found him guilty of 'serious unsatisfactory professional misconduct' after investigating nine out of 14 obstetric complaints, placed some restrictions and allowed him to continue as a gynaecological surgeon."

The water is muddied because in a busy theatre, it's one case after the other and in real life, most of the cases handled by these surgeons had satisfactory outcomes. It's easy through the 'retrospectroscope' to see the litany of blunders.

Many in the community, including local doctors, defended the specialists because even in the best hands things can go wrong from time to time. The 'doctors closing ranks' argument is an oversimplification.

By all accounts, both men were skilled operators, which may explain delays in decisive action by regulating authorities. Also it would account for the lack of clamour from others in theatre during lists, anaesthetists, scrub nurses, students, radiologists and the surgical assistants, also doctors. There was no shortage of first hand

witnesses. In Bega, for example, the wife of a GP who had worked with Reeves in theatre is reported to have said that her husband "had no inkling of Reeves' misconduct. My husband isn't a gynaecologist, he doesn't look over (Reeves') shoulder, and if he did he wouldn't know what to look for."

Thinking about airline pilots for comparison, between one and two million persons are in the air at any moment and

three in the same speciality to share responsibility and allow for time off is a stretch on any human.

In reaction to these incidents, the regulatory authorities have recently decreed for mandatory reporting of possible dodgy doctoring by suspicious colleagues. What a great opportunity to deal with unwanted opposition under protected whistleblower status. It's so easy to accuse.

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aircrew manage thousands of safe landings including some near misses. Do we hear of this in the news or just the relatively few disasters? Successful outcomes are not newsworthy.

Like any other person, the surgeon is a human being and some days are better than others. It seems that 'the Butcher' may have been a bit on the bipolar side, such that when he was good he was very good, but when he was bad he was horrid. Dr 'Death' was different but similar, a skilled operator working under intense conditions, sometimes overstepping his capabilities.

Without peer group support and feedback, judgement may suffer. A decision to not operate is a vital skill, just as important as technical prowess. His professional development in Third World conditions may have taken him to choices not appropriate in the Australian environment. Who knows?

Hubris can be dangerous in a doctor. In a group of medical proceduralists, 'one of a kind' is not usually viable. Less than

On the other hand, doctors by nature exercise confidentiality as an ingrained habit. Most just quietly vote with their referral pads if there is a worry.

It is commonly admitted that anyone who has never made a mistake is either lying, deluded or hasn't practised enough medicine. When it comes to accusing, let the innocent person cast the first stone.

Considering the raft of checks and balances imposed on doctors, including police checks, quality assurance, practice accreditation, continuing professional development, IMS's, medical registration and insurance, AMC and the powers of the medical complaints tribunal, it is hard to understand how slow to action the regulators were in these cases.

Innocent people have been maimed and killed in theatre and the pendulum now is likely to swing far the other way to prevent similar situations in the future. So who should be responsible, the regulators whose job it is – or the doctors?

