UROLOGICAL SOCIETY OF
AUSTRALIA AND NEW ZEALAND
ABN 64 880 438 690

28/4/2009

The Secretary
Senate Community Affairs Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Australian urologists are extremely concerned for the future of Australian urological surgical patients given our appreciation of the scope of changes being proposed by COAG under the guise of a National registration and accreditation scheme.

Current systems for training and accreditation of urological surgeons have evolved continuously over decades of scientific and technological improvement. Our systems allow for highly cost effective output of extremely highly qualified sub-specialists with world best capabilities and international respect. Our organisation, USANZ, is respected amongst Australian urologists as the expert body capable of assessing standards for practising specialists and is empowered to apply these standards across the nation (and internationally to New Zealand). These standards have always had best clinical and social outcomes for our patients as foremost in their application.

If a new standards body is introduced with bureaucratic influence and political control, different objectives for the setting of standards will apply. It is likely that in the interest of workforce and economic pressures, other healthcare groups and healthcare companies will propose alternative standards. Lowering the standards of healthcare providers will result in poorer patient outcomes. If, for example, an overseas company offers to perform cancer checkup procedures with alternatively trained staff, they could conceivably entrench a less rigorous investigation, with failures of early diagnosis more common. When a patient is given the all clear they want to believe it. Subtle changes in cancer detection rates will, in all likelihood, go un-noticed for generations. Only stringent regular universal population wide assessment of emerging mortality rates would alert us to the impact of such a change and this would be entirely too late.

A concerning scenario of a similar ilk occurred in the United Kingdom, after a scientific investigation was implemented to look into the poor survival of British bladder cancer patients compared to all other developed nations. Generations of British bladder cancer patients were treated for severe advanced cases of bladder cancer, far in excess of those seen in other developed countries. It emerged that the implementation of the NHS had restricted access for these patients to timely investigation for symptoms. The delay in diagnosis allowed British bladder cancer patients to develop more advanced cancers that were commonly incurable.

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This information took fifty years to emerge. Hundreds of thousands of gravestones across the UK mark the consequences of the changes to standards brought in by the NHS.

The healthcare bureaucracy in the United Kingdom responded to these damning revelations by implementing a new policy change for bladder cancer diagnosis. The changes were made without consideration for the impact they may have on population survival as a whole. The changes were knee jerk and media friendly. They ignored the wider problem that they might create, by changing resources for one disease, at the certain expense of others. Regrettably, it is likely again to be generations before the outcome of their new model of bladder cancer care is really known, and entirely probable that it will result in more overall population deaths rather than less.

Currently, when an Australian patient has an investigation for possible cancer, they can believe the result they receive. The initial opinion regarding cancer status must be of the highest order of integrity, otherwise the entire process becomes meaningless. Decisions as to who is qualified to make a determination such as a negative cancer investigation must remain the domain of clinicians who advocate for best patient outcomes, not economic or political objectives. Sacrificing quality will lead to patients and their subsequent future clinicians, questioning whether a negative cancer result can be believed. This will begin a cycle of repeat investigations that will ultimately end up costing the health system considerably more. Some unfortunate patients who are discovered to be positive for cancer after a negative primary investigation will pay with their lives. Reassurances that alternative practices can maintain quality are untested and should not be implemented without rigorous assessment.

Recently, urologists in the Illawarra had a major problem calling for a review of cancer diagnoses performed by an under-qualified and under-supervised practitioner employed by the Illawarra Area Health Service. When his work and qualifications were called into doubt, it was clear to all that 700 patients who had undergone cancer diagnosis testing could have been misdiagnosed. Numerous administrators, nurses and healthcare executives all determined to sweep this problem away and bury the mistakes in a quagmire of internal investigation. It was only through the advocacy of independent medical practitioners that these bureaucrats were forced to acquiesce, resulting in a review of all potential cancer diagnoses made by the underperforming staff member. This was not accomplished for any goals other than best patient care standards. It was clear that the priorities of the other healthcare workers were out of step with best clinical care. Australian healthcare must not be entrusted to such groups.

Professionalism is a nebulous concept that is hard to measure and harder to train. It implies altruism and advocacy. Professionalism has been the backbone holding medical standards together in Australia despite the onslaught from public health bureaucracy to reduce standards and increase ‘efficiency’. Where systems seem to oppose common sense clinical judgment and threaten a patient’s outcome, a professional will override and bypass obstacles to redeem a good outcome. This type of action is a daily occurrence in healthcare institutions across the country. Patients are the beneficiaries of this type of advocacy. The new system of accreditation will remove the profession from many clinical frontline services and replace them arbitrarily with employees who work to a roster and go home when their shift finishes. These ‘efficient’ workforces will hold different priorities to those of the current medical professionals.

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Urologists are in agreement with the AMA, the AAS, and numerous other representative bodies that harbour concerns for healthcare standards under the proposed scheme. RACS and other educational organisations and specialist colleges also hold similar concerns. The politicians and bureaucrats that are championing these changes are ignoring our professions concerns completely. It appears that they intend to inflict this new healthcare experiment on the Australian public regardless of the deaths and suffering that will eventuate. We trust that the objectives of these few will be overridden by good political review processes such as your senate committee, and that a better system for National registration can be developed. We would all support changes that improve safety and quality in healthcare, rather than eroding them.

Yours sincerely

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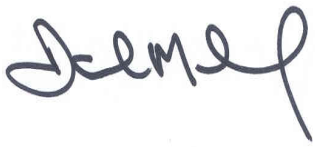

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