The Patel case and its consequences for health workforce governance in Australia

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Bob Burton [1] reports on one reason that 1 July 2010 was a historic day in Australian health workforce governance. Jayant Patel, former head of surgery at the Bundaberg hospital in Queensland, was sentenced to seven years in gaol following a guilty verdict on three counts of manslaughter and one of grievous bodily harm. This was the very same day that a new national agency commenced operation across Australia. Some ascribed its creation to the regulatory failure the Patel case demonstrated.

The Australian Health Practitioner Regulation Agency (AHPRA) constitutes a new national approach to health workforce governance. Following an inquiry by the Productivity Commission (an independent government agency) into Australia's health workforce in 2006 [2] the Prime Minister and heads of state and territory governments decided to adopt a national approach to health professional regulation. This single organisation replaces an array of bodies across the country. We now have legislation in each of our states and territories that rests authority in the national body. This will now overcome some procedural issues within a single country that also present challenges across national borders. [3]

AHPRA's structure brings together health professions under the one body. Ten professions are included - chiropractic, dental, medical, nursing and midwifery, optometry, osteopathy, pharmacy, physiotherapy, podiatry, and psychology. On 1 July 2012, the next tranche of professions (Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners, and occupational therapists) is set to join the new national structure.

AHPRA brings together the responsibility for two distinct elements of regulation: registration and accreditation. Registration focuses on the expectations and obligations of individual practitioners, and accreditation focuses on the educational requirements of each profession. For each profession there is a single board (e.g. Medical Board of Australia), which has responsibility for both these elements, but all 10 boards operate under standard AHPRA measures. [4]

Australia has opted for a streamlined, centralised model of health profession regulation that is distinctive on the international scene. The United Kingdom comparatively has nine regulatory bodies that operate under separate legislation. These govern 30 professions with a separate Council for Healthcare Regulatory Excellence having oversight of the system. In New Zealand profession specific bodies operate as responsible authorities under a single piece of legislation. In the United States of America and Canada the bulk of regulation is managed at a state/provincial level. In establishing AHPRA Australia has made significant progress in reformulating arrangements governing accreditation and registration of its health workforce. [5] But what led to this reform?

The circumstances that led to the conviction of Jayant Patel provide a tangible demonstration of the implications of regulatory failure. The reliance of the Australian health system on doctors educated
outside of Australia was not news. However, a journalist using a simple Google search to uncover the fact that a rogue practitioner did not disclose previous disciplinary actions from the United States certainly was.

General media coverage and specialist commentators have explicitly linked the establishment of the new scheme with the incidents in Bundaberg. The Queensland Health Minister and Premier reportedly went further. They claimed that the new national regulatory system was introduced because of the lessons learnt and that this, together with additional changes at state level, has drastically curtailed the likelihood of a recurrence.

There is certainly a precedent for crises delivering change in the regulatory circumstances of health workforce governance. In the UK the cases of Harold Shipman (the general practitioner convicted in 2000 of the murder of 15 patients) and of the Bristol Infirmary (high death rate of paediatrics cardiac patients) highlighted regulatory problems and that led to substantive reform. In Australia, events at Bundaberg have similarly been described as the "catalyst for long overdue reform." But do these linkages provide only an expedient but incomplete explanation? It is more likely that the brave new world of health workforce governance under AHPRA comes in response to a complex web of problems and challenges beyond the experience now synonymous with Patel and Bundaberg. This is the subject of our ongoing research; exploring the ways in which this particular regulatory development has been shaped by a myriad of individual events and crises, various agendas, deliberative policies, and other factors requiring further exploration and explanation.

References


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