Dear Lesley,

After many months of consideration, it is with overwhelming despair, that I write to resign as the Medical Lead for Acute and Urgent Care at the Royal Adelaide Hospital.

In the nearly 10 years I have been employed as a Consultant Emergency Physician in CALHN, I have tried to lead the development of processes and systems to support clinicians to provide safe, timely care to our patients whilst articulating risks and wherever possible strategies to mitigate harm to patients.

Having trained at FMC I knew all too well the dangers of an overcrowded ED and ambulance 'ramping'.

In the 12 months before the RAH ED 'ramped' it's first patient, I worked to develop an escalation plan that supported the ED to communicate it's status to the wider organisation, clearly define the actions required, and how we would attempt to minimise patient risk when large numbers of access blocked patients rendered us unable to provide care for newly arriving patients.

Sadly, nine years later, the ED's commitment to avoiding delays to patient care, including ambulance ramping, have never been met with the required actions from the wider organisation.

The ED clinicians are as horrified as I am by our daily inability to provide care to patients when they need it.

It offends our very humanity, and flies in the face of all that we are trained to do.

What is not understood by those outside the ED is that we have looked every one of those patients in the eye and been forced to decide that another human being needs care before them.

The assertions by many in the organisation (whose only experience of this is through a text message from SAAS or a name on a computer screen) that the ED Clinicians want to deny patients care and 'like', or indeed are 'addicted' to ramping, 'don't understand the risks to the community', or that clinicians in ED and inpatient teams 'just aren't working hard enough' and 'want to keep patients in hospital' could not be further from the truth, or indeed more offensive.

I am appalled that we have a situation where ED Clinicians have felt compelled to take industrial action.

Our failure to act as an organisation to ensure that all our clinical teams have appropriate resources to provide timely and safe patient care reflects our collective failure of leadership and governance.

Our patients, deserve so much better.

Professor Ian Sturgess could not have been clearer: we need to focus our efforts on improving the care delivery processes, and the executive and senior leadership teams need to listen to those providing direct patient care, seek to understand, and then act.

Furthermore, support services like finance, IT, planning and HR need to work with the clinical teams to ensure that they align with the clinical or business needs.

The reality of our situation could not be further from this.

I am an Emergency Physician, not an Accountant.

But I know that accrual accounting methodology fundamentally requires that costs incurred to deliver activity are as closely aligned with activity as possible.

Only when this is accurately done, can the true cost to serve, or any determination about the financial efficiency of that service be derived.

As a clinical leader I am accountable for ensuring that the revenue generated by clinical services is accurately recorded, and costs incurred correctly align to the activity.

Where there is a mismatch between costs and activity: I must understand why this has occurred, assess whether this reflects acceptable clinical practice/service provision and articulate a plan to address.

The organisation has not provided the program leadership with the tools and information to undertake this task.

It holds us accountable to a budgeting process using activity and costing methodologies, and an RVU model that are best described as delusional.

Enormous errors, that Finance themselves admit reflect their lack of consultation, go uncorrected year on year.

Similarly, we are held to account over performance metrics which are deeply flawed, with no attempt made to support IT improvements, or adopt policy and business rules that are commonplace interstate.

Put in simple terms: in health an ‘outlier’ for clinical care is the result of something ‘odd’ about a patient cohort, or ‘odd’ about the care, or it’s not being counted/recorded properly.

We place undue emphasis on the first two elements and neglect the third.

The recurrent organisational narrative that Acute and Urgent Care’s performance is due to poor clinical decisions (that we are just ‘bad/lazy/risk averse doctors’), has stymied any effort to meaningfully examine whether we are ‘counting’ the activity correctly, or correctly recording performance.

There may well be scope for us to change how we practice – but how can we possibly know? Clinical leaders have a deep understanding of our services, and want to be held accountable for performance, including financial.

CALHN has no chance of financial solvency until such time as the Executive and Board compel the Finance and Service Planning leadership to do their jobs properly.

If the clinical teams conducted our work with the same flagrant disregard for basic governance processes and professionalism, we would be at risk of being barred from clinical practice.

For years I have stated, on every possible occasion, that we are not recording our activity correctly.

This means we don’t calculate our NEP accurately.

When combined with Finance’s lack of alignment of cost with activity – it means we have no reliable measures of financial efficiency.

We have then compounded these two egregious errors with an RVU model that bears no relationship to how the business delivers care.

This would not be accepted anywhere in the private sector, and given that we are spending from the public purse our level of accountability should be even higher.

These issues have been raised for many years by the Division of Critical Care and subsequently the Acute and Urgent Care program, with repeated commitments from the Executive that it would be resolved.

This has never occurred, and the same errors were again repeated in 2022.

At Executive direction, with medical leads support, I have led work to ensure we accurately report Radiology use by clinical service, to support financial and more importantly clinical practice improvement (eg. ‘Choosing Wisely’).

Yet when we show that half of the costs attributed to the ED for medical imaging are not due to ED/AUC activity (and this is the third biggest cost in our program) we are informed that this will not be addressed as there is ‘no interest in cross-program recharges’.

This reflects a woefully inadequate understanding of contemporary health performance reporting and clinical practice improvement requirements.

Dr Paul Tridgell’s recent report confirms what AUC and many other programs have stated for years.

“The Linkage between the reporting and CALHN operations and clinical areas shows significant areas for improvement.

This is perhaps best outlined with a few examples: The Medical Director of Acute and Urgent Care described a number of significant issues.

As outlined in my report these are significant issues impacting on LHN activity reporting but the significance was apparently not recognized” “preparation of a bed plan with unrealistic assumptions on the length of stay for Acute and Urgent Care also shows a disconnect between analysis of data and operational management requirements for realistic projections.

There is currently a capacity gap with the linkage between information analysis and its interpretation and alignment with operational requirements.

Some of the gaps in reporting compared to the national definitions are very large and I would have expected them to have been identified already given the amount of external scrutiny CALHN has been under.

“This fundamentally means that South Australia has not been seeking an appropriate allocation of federal health spending for years.

The recent South Australian Health Performance Council report clearly showed that SA was “falling behind the rest of the nation”, we must urgent examine why this is.

Whilst it is gratifying to have someone of Dr Tridgell’s eminence confirm what I have long contended, we cannot possibly address these issues unless we have genuine dialogue.

This requires the Executive and Board to listen without judgement to the clinical and program leadership.

Not to conduct forums where we are berated like naughty children and then limited to one question each.

The level of disrespect and outright disdain we experience at our Performance meetings from some of the few members of the Executive who bother to attend should not be accepted in any forum.

In the recent ICAC report, 7% of our 18,000 staff took the time to give us feedback.

I was dismayed at the SLT meeting to hear this dismissed this as ‘only 7%’ and not reflective of what our workforce really experience.

Over 1200 members of our workforce took the time to give us feedback.

Diminishing the value of this is just wrong and speaks to a culture that treats harshly, or overtly dismisses any who dare to speak up.

As a doctor I experience privileges not shared by my Nursing colleagues, who form the back-bone of the organisation.

They are marginalised, disrespected, and excluded from forum after forum in our organisation.

We talk about a Clinical Council, where nursing, medical and allied health leaders, can work together – yet this forum has not met in well over a year despite a chair being selected many months ago.

We committed to Demand Management meetings led by the NOC.

Facilitating cross program leadership collaboration to design operational management systems.

These were repeatedly cancelled by Executive “because of demand”.

Irony notwithstanding, we cannot achieve any improvement in our operational processes when the mechanism to do so is not representative, or simply non-existent.

Taskforces with short term agendas focused on “quick wins”, with inadequate representation are not the solution.

Putting the word ‘empower’ in the title is pointless unless the Executive and Board are willing to listen to, and act, on the actual barriers the programs face that they cannot resolve internally.

Taskforces are not a substitute for clearly defined governance structures underpinned by rigorous clinical and financial risk and audit functions, and adequately resourced implementation.

I can no longer play a leadership role in an organisation which has so little respect for its workforce, no capacity to reflect, which characterises clear and present dangers to patient safety as ‘clinicians making a fuss again’; perpetuates financial mis-management, poor governance, risk and compliance practice; and whilst espousing the values of respectful workplaces, patient centred care and responsibility to our community, demonstrates the polar opposite in its words and actions.

On a nearly daily basis having to insist (and therefore be labelled as ‘difficult’) that appropriate governance processes are complied with by the Executive and the teams they lead is manifestly unacceptable and untenable.

I am deeply saddened, as I believe that CALHN’s clinical workforce is extremely dedicated to excellence in patient care, and many individuals within the finance, HR and service planning teams are highly skilled, and dedicated to support the health needs of our community.

However, I can no longer be complicit in the continuing lack of action by the CALHN Executive and Board.

Clinicians must be supported to provide safe patient care; clinical leaders with the tools and information to manage their services.

The business of the organisation must be transacted in a respectful and professional manner that complies with basic governance principles, commensurate with the stature of the organisation and significance of our responsibility to our community.

In choosing to detail the reasons for my resignation, I am cognisant of the resulting professional/career ramifications which may well preclude me from any future leadership role.

For the past six years, I have made significant personal and professional sacrifices to undertake leadership roles in the ED and AUC.

Whilst being profoundly distressed that I am abandoning my colleagues and our patients, I am grateful for the opportunity to have served in this role, and the support of my family and colleagues to do so.

However, I simply cannot continue as a Medical Lead in the face of all that I have described above, and my inability, despite considerable effort, to change the risks to patients, our staff and our community.

Lesley: I implore you, the executive and the board to listen, reflect and act.

With great sadness, but no regret, I give six weeks notice of my resignation as the Medical Lead for Acute and Urgent Care, Royal Adelaide Hospital effective from today, and intent to return to my substantive position as a Consultant Emergency Physician at the RAH.

Yours sincerely,

Dr Megan Brooks,

MBBS FACEM