A TALE OF 2 HOSPITALS

Who Gets The Benefit Of The Doubt?

The Ombudsman for Bermuda's Own Motion Systemic Investigation into Allegations of Discrimination Involving Medical Professionals at King Edward VII Memorial Hospital

BERMUDA OMBUDSMAN

November 2007

November 2, 2007

The Speaker, The House of Assembly
The Hon. Stanley Lowe, OBE, JP, MP
Sessions House
21 Parliament Street
Hamilton HM 12

Dear Honourable Speaker,

I have the honour to present a Special Report of the Ombudsman for Bermuda's Own Motion Systemic Investigation into Allegations of Discrimination Involving Medical Professionals at King Edward VII Memorial Hospital.

This Report is submitted in accordance with Sections 24(2)(a) and (3) of the Ombudsman Act 2004 which provides:-

Annual and special reports

24(2)(a) Where any administrative action that is under investigation is in the opinion of the Ombudsman of public interest; then the Ombudsman may prepare a special report on the investigation.

24(3) The Ombudsman shall address and deliver his annual report and any special report made under this section to the Speaker of the House of Assembly, and send a copy of the report to the Governor and the President of the Senate.

Yours sincerely,

Arlene Brock
Ombudsman for Bermuda

OFFICE OF THE BERMUDA OMBUDSMAN
Suite 102 • 14 Dundonald Street West • Hamilton HM 09 • Bermuda
TEL 441-296-6541 • FAX 441-296-7734 • www.ombudsman.bm • complaint@ombudsman.bm

TABLE OF CONTENTS

1. PROLOGUE 1

a) **The Investigation** 2
b) **Definitions of Success** 4
c) **Principles and Methods** 5

2. FINDINGS 10

a) **Documentary Review** 10
b) **Statistics Derived from Submissions and Interviews** 12
c) **Some Examples** 16

3. SYSTEMS GOVERNANCE 19

a) **Competition** 19
- The OR Theatre 19
- The Department of Anaesthesia 21

b) **Work Permits** 33
c) **The Political Shadow** 37

4. CLINICAL GOVERNANCE 39

a) **Credentialing** 39
- UK vs US 39
- Differential Hospital Response 50

b) **Critical Incident Reports** 56
c) **Disciplinary Process** 59
d) **Administrative Competence** 71

5. EPILOGUE 74

a) **Conclusion** 74
b) **The Hospital as a Metaphor for Bermuda** 79

6. APPENDICES 82

a) **Recommendations** 82
b) **CURE Definitions** 92
c) **Process** 96
d) **Responses** 106

1. PROLOGUE

"THE" Hospital – collectively:
Bermuda Hospitals Board (BHB); King Edward VII Memorial Hospital (KEMH – medical health care);
Mid-Atlantic Wellness Institute (MWI – mental health care)

At The Hospital:

- *"90% of the doctors are very good, very nice, very collegial, etc. There is a small proportion who behaves badly if they are chastised. They write to the press and they get politicians on their side and they create difficulties and problems. And there are a number who feel that they can behave entirely as they please." [WE]*[1]

- *"I want to believe that there are a large number of people who do not want race to be an issue. Wonder if a lot of problems are as a result of small groups who want to perpetuate the fight because it is to their advantage." [WB]*

- *"If you're going to rant and rave and accuse people of discrimination and jump up and down, you won't get very far." [WB]*

- *"The hospital is in danger of lodging itself into two sections: the non-Bermudians and the Bermudians." [WB]*

- *"I hate rumour and innuendo. I hate hints that racism exists and that it has affected decisions at the hospital." [WE]*

- *"There are some doctors whose primary focus is medicine and providing quality care – they wear blinders to what's going on around them." [WB]*

- *"This situation has made Black doctors very nervous. They are wondering who the next victim is going to be. It's very easy – in medicine everyone encounters problems. The more cases you do the more likely you will run into issues or complications that raise questions." [BB]*

- *"The hospital is the last bastion of racist institutions in Bermuda." [BB]*

- *"You need to get rid of people who promote racism, actively or passively, consciously or unconsciously, expressed or unexpressed. We need to get rid of them." [BB]*

- *"There's a notorious but untouchable group of doctors who make routine attacks on black doctors…who's next?" [BB]*

- *"The hospital has to first of all recognize itself that racism does exist. It's not a question of what degree it is, it does exist. Sit down and say we're not going to hold you responsible for anything that may have happened in the past, but we can collectively just move forward." [BB]*

- *"On a scale of 1-10 (with 10 being the highest possible polarization), the entire hospital is a 6; the operating room is a 9." [BE]*

- *"Blacks always have to prove themselves." [BB]*

- *"It's a Tower of Babel." [BB]*

[1] **[BB]** = black Bermudian; **[WB]** = white Bermudian; **[WE]** = white expatriate; **[BE]** = black expatriate; **[EA]** = expert advisor

THIS IS...A TALE OF TWO HOSPITALS

Note: This Report is structured a bit differently than the norm. It is written in two columns. The column on the right presents analysis and commentary. The column on the left allows readers to 'hear' people's perceptions – in their own words. Boxes throughout the Report detail examples or research.

1.a) The Investigation

"We all use the hospital – either on the way in or on the way out." [BB]

"There are many deficiencies here. There is a general lack of collegiality – committees are disappointing." [WB]

"I get a sense that there are two camps – when you challenge us, we will use the race card." [WB]

"We try our best to work together because we're small. We may not like what the other may say about us, but in general we tend to work together and help each other if there's problems. We can call on each other, there aren't any real obstacles to us working together." [BB]

1 Young or old, black or white, expatriate, Bermudian, male, female, rich or poor – almost all of us have used or visited the hospital. Its mission, location, capacity and culture have immediate meaning to us all.

2 Therefore, repeated rumblings, rumours and negative media over the years cause real concern. The tensions seem at odds with and detract from the mission of the BHB to act as *"a committed team of professionals working in partnership with patients, their families, clients and the community to provide high quality health care services that meet their needs and expectations".*

3 Last year, three complaints alleging racism amongst medical practitioners (clinicians, physicians) at KEMH were lodged with our office. Complainants were adamant that the issues were not limited to themselves. Rather, they insisted that their complaints represented systemic, long-standing problems that spawned and perpetuated toxic relationships amongst physicians. Moreover, they alleged that the BHB had neglected to address these issues adequately.

4 Although discriminatory actions and procedures are forms of "maladministration" as defined by the Ombudsman Act 2004, racial discrimination is a protected category under s.2(2)(a)(i) of the Human Rights Act 1981. I therefore first contacted the Human Rights Commission ("HRC") to see if it was able to conduct a systemic investigation. It was not possible. One of the complainants was referred to the Ombudsman by the HRC.

5 Accordingly, I launched this investigation to find out whether there is evidence of "maladministration". That is, were any administrative actions of the hospital:

- inefficient, improper, negligent, unreasonable;
- based wholly or partly on a mistake of law or fact or irrelevant grounds;
- unfair, oppressive or improperly discriminatory; or
- based on procedures that are unfair, oppressive, arbitrary, unreasonable or improperly discriminatory.

6 As Bermuda's single medical facility for acute care, the hospital serves the entire population of almost 65,000 people. It is also one of the largest employers on the island with a diverse staff of 1,200 (spanning both KEMH and MWI). KEMH sees some 30,000 emergency visits per year, 7,000 elective surgery procedures a year in the Operating Room ("OR") and over 6,000 Outpatient visits.

"People tell others and the distrust just grows." [BB]

7 Issues affecting the hospital quickly reach the ears of the entire community. As has been acknowledged in other jurisdictions, the ability to work harmoniously is essential if patients are to be cared for properly. A failure of collegiality, as expressed in tensions based on race, origin or other status, denigrates the partnership that is so fundamental to the BHB's Mission.

"Bermudians don't embrace other cultures easily." [WE]

8 That Mission – to provide high quality health care services – cannot be achieved optimally when public needs are high but internal expectations (of each other) are low. Accordingly, our press release of 1st September 2006 announced that this systemic investigation would focus on whether or not there is a basis for these allegations, including any response to such allegations and, if so, whether there is an impact on patient care.

"Nurses feel rushed, hopeless and powerless. Nurses are dismissed and their concerns made to seem silly." [BB]

9 This investigation focused on relationships amongst KEMH administration and physicians (in particular those granted privileges to attend to their patients in the hospital). There are allegations and concerns about discrimination amongst nursing staff throughout the hospital, particularly between the 30% Bermudian and 70% work permit staff. These issues do warrant closer review. However, an in-depth investigation of these challenges would have broadened and prolonged the scope of this inquiry well beyond the original complaints.

"Nurses should feel free to raise issues with doctors." [WE]

"I don't think that the residents of Bermuda appreciate the service they have in comparison with the UK, US and the Caribbean." [BE]

10 At the outset, it must be noted that the issues forming the complaints to this office and that generate the most angst arise primarily in the Departments of Surgery and Anaesthesia. Other services and professionals used by the public appear to work well with reasonable collegiality. Interviewees did not reveal major tensions amongst physicians and other medical practitioners on the Wards, in the Emergency or Obstetrics Departments or at MWI. There are some concerns about the clinical decisions of MWI doctors being overruled or discounted by doctors practicing at KEMH. This could be rectified by Recommendation IV (p. 84).

"The emergency room works well." [BB]

11 Our professional advisors indicate that the medical community provides a sophisticated level of health care considering Bermuda's size and isolated location in the middle of the Atlantic Ocean. Indeed, its capacity and resources surpass many similar sized and/or remote communities in both Europe and North America.

"We have a good hospital here, we have a lot of facilities." [BB]

12 For example, further to the UK Specialist Register, Bermuda compares very well in the number of specialist surgeons per population. In fact, there may be 'over-provision' in some specialties:

	No. of surgeons : population	
Specialist	**UK Goal** [2]	**Bermuda**
General Surgery	1:25,000	5:65,000
Trauma / Orthopaedics	1:25,000	6:65,000
Urology	1:50,000	1:65,000
ENT (ear, nose, throat)	1:50,000	2:65,000

1.b) Definitions of Success

"Success would be putting an end to some of the misconceptions and misperceptions. You're never going to get rid of all of them." [WB]

13 We asked interviewees what they thought success would look like for this investigation. Almost everyone expressed the hope that the air would be cleared, the facts would come out and recommendations would show a way forward.

14 A few interviewees sought confirmation of their own firmly-held views – that discrimination did or did not exist or that particular doctors were or were not competent.

[2] UK Surgical Specialist Association, 2005 Workforce Report

"Success would be a real change with the way the hospital functions in terms of the way doctors are treated – so that what applies to one will apply for all." [BB]

15 Almost all interviewees defined success as me making recommendations that would help the hospital to develop transparent, clear processes and protocols that would work equitably regardless of whether a medical practitioner is black or white, Bermudian or not.

16 This is where I found common ground, indeed – hope. However defined by each interviewee, they all wanted the hospital to be a place of excellence and harmony where collegiality flourishes and patient care is the primary focus.

"Success would look like widespread understanding, appreciation and celebration of cultural diversity." [BB]

17 Medical practitioners wished that their practices and relationships with colleagues and the public would reflect the ideals that called them into health care in the first place.

1.c) Principles and Methods

"We don't need Bermuda losing confidence in the hospital because of anything – racial / gender discrimination – whatever. That's the only hospital we've got." [BB]

18 Clearly, this investigation is highly sensitive, not only because of the possible ramifications for individual physicians, but also because of the risk of undermining public confidence in **the** hospital. It is not an easy or reasonable option to get on a plane for every health care concern. Therefore, I am mindful of the need to preserve patient confidence.

"I don't know if we're prepared for the diversity issues that are likely to come up." [BB]

19 Nevertheless, to the extent that this investigation has uncovered debilitating fissures, it is my responsibility to expose them and offer recommendations. A Report that merely states: "there are problems" and suggests "there should be changes" is of minimal value.

"If we don't talk about it and don't investigate it then you can never hope for a remedy." [WB]

20 My goal is not to castigate doctors for wrongdoing, but rather to help identify what the BHB might do to develop a fair, transparent administrative process that minimizes opportunities for maladministration on the basis of inefficiency, unfairness and discrimination.

"You've opened up a can of worms." [BB]

21 A few of the matters raised during the investigation have already reached the media; therefore, it may be possible to identify certain persons' experiences that are on the public record. Otherwise, I caution readers that attempts to identify who said what will be a futile use of

"I'm glad you're doing it and not me." [WB]

time. Hopefully, the depth and breadth of the spotlight that I shine on these matters will correct some of the misinformation in the public domain.

"It's all very complex, so good luck." [WE]

22 Soon after the press release announced this inquiry, one person marched into the office to chastise me for using the word "discrimination" rather than "racism". At the other end of the spectrum, one person of influence attempted – gently but persistently – to dissuade me from this investigation.

23 These responses illustrate the emotionalism, fears and unease that attend the allegations of discrimination amongst medical professionals. Some people were eager and supportive to expose and espouse their version of the issues. Others were clearly more comfortable keeping a lid on the tensions.

"I think the very fact that they have to be questioned about things is positive. I think that in itself will change attitudes but hopefully there can be some way for us to move forward as a result of your findings." [WB]

24 The attached Process Appendix describes the investigation. I thank the BHB and some 120 interviewees for their cooperation. At first, some were nervous and wary. The interviews may have seemed interminable (often lasting two or even three hours). Ultimately many interviewees expressed relief at being able to talk candidly and confidentially and several even felt that the process was cathartic.

25 I encouraged interviewees to express their feelings in addition to verifiable observations. Too often, emotion is dismissed as a measure of truth. However, as sentient human beings, we must realize that our feelings define our humanity at least as much as our intellect does. Feelings and intuition inform our reactions to situations and people just as surely as what we can see and touch.

"Success would be if you are fair in your conclusion. But you can only be that if you have all the information. But I think it's difficult to get all of the relevant information because people – we still in a sense, are suspicious of non-medical people. That's meant in the nicest way." [BB]

26 My staff and expert advisors brought fresh eyes to my evolving comprehension and conclusions about this complex terrain. Their multi-competencies and comparative insights were invaluable. Criticisms of this Report, however, should be directed to me alone.

27 I believe that the findings and recommendations of this investigation are limited only to the extent that

"In order to have any credibility your Report needs to deal with facts and not as much the views and opinions. And mostly the facts that are non-controversial. If you can get enough evidence that you feel very clearly are instances of institutional racism then I think you have to say that somehow, name names – open up a can of worms." [WB]

- interviewees failed to be honest and forthcoming; and
- I have not been able to portray the complexities of the details captured in over 45, three-inch thick binders.

28 As with any report that delivers bad news, it is likely that this Report (and I) will be pilloried by people with their own agendas on all sides of the issues. As they pick at, deny or bluster over any particular point, I do hope that the urgency for cultural and institutional changes at KEMH will not be lost.

29 One of the more challenging aspects of this investigation was the exercise of trying to distinguish between fact and perception. The expectation that facts could be extracted with an analytical pipette belies the deep, emotional complexities and reality of racial and other forms of discrimination.

"I hope that if you find that there is no evidence of racial discrimination that you'll actually say that loud and clearly for all to hear…and if you do find evidence again that you say that loud and clear and people recognize that that's not acceptable behavior." [WB]

30 Interviewers were diligent, often ponderous, about cross-checking and reality-testing the various assertions and perceptions that arose in the interviews. Yet, life is so much more nuanced than it seems. To the extent that perceptions inform and guide our actions and reactions; then perceptions matter as much as facts.

"Find out the facts, one way or the other." [WB]

31 The investigation revealed many layers of the dynamics that describe and proscribe relationships within the medical community. It is important to reiterate that whites and blacks are not monolithic groups. Whilst there were clear trends in thinking within each group, there was also significant independence of views. Opinions and observations did not always or unequivocally muster along racial lines.

"I don't see racism." [BB]

32 For instance, a few blacks felt that race was the least of the problems at the hospital – often used as an excuse or veil for issues involving personality, competition and competence. A few whites were sanguine and reflective about the persistence of discrimination with a depth that might surprise many blacks in our race conscious Bermuda.

"People do get treated differently." [WB]

33 There was also a divide along national lines. That is, black and white expatriates sometimes espoused perspectives that were discernibly dif-

ferent from the views held in common by white and black Bermudians.

"If it exists, show the evidence." [WE]

34 Generally, whites demanded factual proof – putting the onus on blacks to prove that discrimination (in particular, racism) exists. When searching their memories for examples of when race might have been a factor, whites thought in terms of personal, one-on-one situations. They had more difficulty than blacks did in grappling with the concept and reach of institutional racism (see CURE Definitions Appendix, p. 92). Whites tended to believe that their observations were always fact based and were somewhat disconcerted when closer examination proved that their assertions were unsubstantiated.

"There is a general environment of unfairness, you can't always put your hands on it." [BE]

35 The "facts" – conclusively asserted – often proved to be twice or thrice baked rumours. Perceptions easily masqueraded as facts and at other times vacillated between intuition and filtered experience. In almost all instances – whether the interviewee was black or white – perceptions truly became reality by defining attitudes, informing actions, hardening stereotypes.

"I think it's good already – that they are being checked. I think that they are too blasé." [WB]

36 During the interviews, blacks tended to proclaim readily and adamantly that racism existed, but when pressed, were often unable to point to clear concrete examples. Many were reluctant to name an action as racist unless they felt 100% sure. This is a criminal burden of proof – very difficult to prove.

"Racism absolutely exists – the OR is where you feel it most." [BB]

37 The Ombudsman standard of proof is civil: that is, on the balance of probabilities – is it more likely than not that an action constitutes maladministration? Even this civil standard of proof is daunting. The common law has long accepted that there is rarely direct evidence of discrimination. Evidence normally consists of inferences drawn from primary facts. Once there are primary facts (a *prima facie* case), then the burden is no longer on the accuser to prove discrimination, but rather shifts to the person accused to prove that there is a clear and credible alternate explanation.

"If someone thinks there is racism, then the discussion must be had." [BB]

"Some black doctors have a lot of influence." [WB]

38 There is no concrete evidence that can penetrate the hearts, minds, motivations and intents of medical practitioners at the hospital. Therefore, we look for indicia of discrimination such as legacy systems

"It would be favourable for most people if a conclusion of this investigation said that we find no evidence of racism." [WB]

and examples that may demonstrate patterns of an inconsistent application of policies. We look also for disparate impact on a group as a result of actions or decisions that may appear to be biased. We seek to understand the extent to which perceptions indeed shape reality.

39 Some believe that this situation is all about incompetent doctors "playing the race card". Others believe that anything less than a denounciation of rampant racism would be inadequate. Both camps will be disappointed in this Report. The complex affairs of human beings – in an institution of over 1,200 persons – cannot be placed neatly into caricatured boxes.

"There have been rumblings of racial tensions, racial preferences for years." [BB]

40 It is useful at this juncture to note the analytical distinction between intent and impact. This is well-articulated in discrimination law (particularly employment and human rights). In essence, a situation or action that results in a disparate impact on a particular group may be deemed discriminatory even if this was not intended.

"I wonder if a lot of our problem is a desire to perpetuate the fight because it is to their advantage." [WB]

41 A negative impact does not necessarily mean that there was a racist or otherwise nefarious intent.

42 On the other hand, a neutral or benign intent does not sanitize an inequitable or offensive impact.

"People with longevity and who are well connected and their protégées – get the benefit of the doubt." [BB]

43 The path in the quest for truth at the hospital was uncharted, rugged, and beset by fear, anger, rumour and agendas on all sides. Proving racism is not as clear-cut as many blacks believe and disproving racism is not as easy as many whites would want. I did not undertake to surmount impossible hurdles – only to survey the terrain.

"Bring all the writhing unpleasantness out into the open. Put it in the sunlight." [WE]

44 That terrain includes issues of competition, competence, personality and power. If race is not the issue, what else could it be? What I discovered are layers and shrouds of all of these issues – sometimes intertwined, other times at tangents.

Each Recommendation is summarized in bold type in the body of this Report. The full rationales for recommendations are fleshed out in the Recommendations Appendix, p. 82.

2. FINDINGS

2.a) Documentary Review

"The entrenched mistrust and animosity is so deep and painful and long-standing. For a hospital to be effective, you cannot have personal and cultural issues getting in the way." [WE]

45 During the course of this investigation, we trolled through almost two thousand pages of documents. We looked at previous reports and at the Minutes of the BHB and several of its Sub-Committees from January 2000 through November 2006.

46 From time to time the Minutes of various Sub-Committees revealed concerns about collegiality and tensions between Bermudian and non-Bermudian anaesthetists as well as between senior and junior doctors.

"The issues are not changing – it's just that the black doctors are speaking up more." [BB]

47 We reviewed the:

- 1992, 2002 and 2006 reviews of the Department of Anaesthesia
- 2003 Kurron Operational Review
- 2003 Critical Care Morale Survey
- 2005 CCHSA[3] Survey

"The Kurron Report had useful things to say regarding Human Resources and IT, but then lost credibility because they recommended themselves to manage the hospital." [WE]

48 The Kurron Review aimed at identifying opportunities to improve efficiency and reduce costs. It considered finance, organizational structure and management, materials management, information systems, quality of care, productivity and clinical/ancillary departments. This entailed site visits, interviews and discussions with more than 100 persons, attendance at committee meetings, documentary and best practices review.

49 This 260-page report recommended a number of cost reduction methods, technology improvements and the need for systematic performance reviews of nursing and medical staff. One sentence alluded to the issues at hand: *"there have also been intermittent tensions around qualification for eligibility for specialty privileges."*

"It's not a morale problem; there is no morale. People hate it. They do their jobs to get their pay." [WB]

50 The hospital's Office of Quality and Risk Management ("OQRM") conducted the Critical Care Staff Morale Survey but only 39% of relevant staff responded. The majority of responders rated the Orthopaedics Department as 'Excellent' to 'Good' for both qualifications and relationship factors (attitudes, communication, participation in decision making, recognition, consistency in treatment of employees).

[3] Canadian Council on Health Services Accreditation

51 The majority of responders rated the Intensive Care Unit ("ICU") and Emergency Departments as 'Excellent' to 'Good' in qualifications but only 'Fair' to 'Poor' in relationship factors. Racism and management style were named the major system problems in the ICU (but this was not raised in our interviews).

"Hospital has lay people sitting on committees to give balance if hospital does not raise issues they should." [WE]

52 The CCHSA process entailed a self-assessment tool, focus group interviews and on-site visits and observations. The Survey looked at the adequacy of facilities, technology and support services such as diagnostic imaging. Beyond the publication of the Survey, the CCHSA does not engage in further feedback or consultation with BHB for system improvement.

53 The Survey was intended to lead the BHB to think of ways to improve how the various elements of the organization work together to deliver quality patient care. There is no review of physician competence and institutional climate nor is there a methodology to surface deficiencies not raised by responders.

54 The 176-page Survey is a snapshot intended to assess progress from the previous Survey. It is not an audit or inspection and is only as adequate as the organization's responders are honest and transparent.

55 Based on the hospital's self-assessment, the Survey identified managing risk as one of KEMH's strengths: *"There is evidence of a good risk management programme and review of incidents and risk issues is occurring. There is a sentinel event policy, which is called the major incident policy. There is good awareness of the policy throughout the organization."*

56 However, as it is not an audit, the Survey did not canvass the implementation or effectiveness of the policy. Notwithstanding its conclusions about the adequacy of governance, the Survey did recommend that the Bye-Laws (not reviewed since 1995) be reviewed *"for currency"*.

Recommendation I: The BHB / KEMH should change its accreditation body to the US Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) which, as our research indicates, offers more robust methods for data collection and iterative, ongoing follow-up.

2.b) Statistics Derived from Submissions and Interviews

Interviewees included physicians, nurses, other medical, auxiliary and administrative staff, relevant experts, BHB members and members of the public. The views of the 120 interviewees are summarized below.

Total number of interviewees: 120 **Believe that some form of discrimination exists: 102** **No opinion: 8**

# of group with an opinion (organizations & expert advisors not incl.)	**Black** 56/59	**White** 41/45	**Asian** 5/6	**Bermudian** 72/79	**Work Permit** 28/31
% of group who believe discrimination is based on:					
White against Black	83%	29%	67%	70%	35%
Black against White	7%	27%	17%	14%	23%
Bermudian against Expat	27%	51%	17%	28%	58%
Country of Training	14%	18%	0%	16%	10%
Language/Cultural	10%	9%	17%	8%	16%
Political Interference	12%	22%	17%	13%	10%
Internal Power Struggle	5%	7%	0%	6%	6%
Gender	3%	4%	0%	3%	6%

"I'd like everybody to feel that they were being treated fairly and if they're not, perhaps some recompense to be made, some changes to be made. I'm not sure how that's going to happen." [WB]

57 These statistics clearly reveal that race, whether white against black or black against white, is the dominant and most divisive issue affecting perceptions and relationships amongst medical practitioners.

58 Over 80% of black interviewees tended to perceive the hospital as a hotbed of racism that is oppressive and pervasive. Many spoke in terms of a 'cabal' of influential 'untouchable' white doctors who run the hospital and target anyone, particularly blacks, who compete for a market share of medical practice.

"Whites think that this is a way of getting back at them." [WB]

59 Two-thirds of white interviewees believe that claims of racism are overblown. Several felt that the allegations are manipulative attempts to secure retribution for past hurts or to provide excuses for incompetence. A few felt that allegations are intended – strategically – to

"It's a small group who makes trouble." [WB]

"There is just a small group who want to make trouble." [WE]

"If you say there is racism in favour of the blacks, I think they will become more aggressive. If it's in favour of the whites, it will be 'I told you so'." [BB]

"There is no better bus to catch if people tell you that something is about race." [BB]

"There is reverse racism against expatriate nurses who cannot become charge nurses but less qualified Bermudians can." [BB]

"There are two or three people who are overtly anti-white. They have even said in meetings: 'There are too many white faces in this room. I don't want to be told what to do by white doctors. You should have your work permits removed.'" [WE]

undermine the hospital and thereby create a platform to launch private hospitals.

60 A significant percentage of blacks and whites, Bermudian and guest workers recognized that other factors contribute to reciprocal suspicion and mistrust. Close to one-third of blacks and more than 50% of whites believe that there is discrimination by Bermudians against guest workers. Other factors include financial competition, power, perceptions of competence, personality and politics.

61 Generally, if there were possible explanations for an issue other than race, then whites almost always preferred to believe those other explanations and discount race as a possible cause.

62 On the other hand, as between two possible explanations for an issue, blacks almost always identified race. Even when acknowledging other factors, they saw race as the omnipresent and omnipotent source of tension.

63 Close to one third of whites but only 7% of blacks believe that "reverse racism" exists at the hospital. Whites claim that racism and xenophobia is exhibited by black Bermudians against whites and Asians – particularly amongst nurses. Although the handful of Asians interviewed denied that they experienced such xenophobia, a broader inquiry into relationships amongst nurses may reveal deeper problems.

64 The statement most often used to illustrate such xenophobia was *"if you don't like the way we do things here, you can get on the next plane out"*. Several interviewees thought that this was a common statement made by Bermudians to work permit staff. However, upon probing, this statement always seemed to trace back to one particular nurse.

65 This example illustrates the challenges of investigating an institution with such an efficient and pervasive grapevine. One statement made by one person can reverberate to such an extent that listeners may genuinely believe that the sentiment is of epidemic proportions.

"There's a clear difference between the two groups – how they're treated and how they work and what they feel they can say and what they feel they can't say." [WE]

"We ought to hold on to our medical profession until we come up with a better management scheme. I warn you, they will threaten you by not bringing anybody in and you'll have these shortages if you're not careful." [BB]

66 Investigations of this complexity and magnitude invariably elicit personal agendas and partisan perceptions. It is important to be aware of the different interpretations that could be placed on seemingly offensive, or equally, seemingly innocuous statements, reactions and situations.

67 For example, if a report about an incident is met with the words *"don't worry about it"*, does that mean *"keep your nose out of this"* or could it really mean *"don't let this get you down"*? Too often, the problems at the hospital escalate through poor communication. Much too often, people do not give each other the benefit of the doubt.

68 Partisan perceptions notoriously lead people to false conclusions as they often anchor onto interpretations that conform to their previously held views. It is an axiom of cognitive psychology that, in the process of forming new conclusions about something, human beings usually choose new data that fits in with what they already understand and believe.

"Finding out the facts and publicizing them one way or the other. I really don't care which it comes out as long as there's good evidence and then we can get on with it and fix it." [WB]

69 This is certainly evident in the minefield of race. With their vast history of personal experiences and analysis of race issues, blacks feel more qualified than whites to identify when race is at issue or not. Whites, on the other hand, will often characterize those references to race that **they** do not understand or believe in as blacks cynically "playing the race card".

"It's more about personality than race – the older black doctors were respected." [WB]

70 The very first example that most interviewees point to as symptomatic of the racial divisions in the medical community is the fact that there are two professional groups: the older Bermuda Medical Society ("BMS") and the newer Bermuda Medical Association ("BMA")[4].

"It's a ridiculous situation that we should have two societies – mainly because black members were aggrieved about how the BMS did their business." [WB]

71 The BMS, with approximately 25 members, has mixed white and black members. Significantly, work permit whites may hold executive positions in the BMS. Traditionally, the BMS was the voice of the profession. For example, the Department of Immigration consulted with the BMS to determine whether there was a need for a work permit applicant's specialty and services in Bermuda. BMS members note that

[4] There are black medical associations in the US which focus on redressing (a) the (still increasing) gap in medical services for minority populations and (b) the under-representation of minorities in the profession.

"The fact that there are two societies says it all." [BB]

the Department now seems to give more credence to the views of the newer BMA, the majority of whose 20 members are black.

"You have these two organizations that don't communicate – they take sides." [WE]

72 The BMA was formed to give voice to black Bermudians who felt that their concerns and initiatives were discounted by whites in the BMS. They believed that expatriate leadership in the BMS was not capable of or too conflicted to advocate effectively for Bermudian issues. Black interviewees believed that the BMS forms views against black initiatives (e.g. private MRI) but endorses white initiatives (e.g. echo cardiogram and outpatient plastic surgery clinic).

"There was a group of BMA physicians who were unhappy with the way the BMS was being run – it did not address the concerns of all of the doctors." [BB]

73 The BMS and BMA represent two camps that seem to have different interests and constituencies. Yet, the two groups do come together for the common purpose of negotiating pay rates with the insurers. While the existence of the two medical groups may illustrate race divisions generally, the effect on processes, decision-making and patient care at the hospital appears to be tangential.

"Similar incidents by different people have generated different responses." [BE]

74 There is so much mutual suspicion. Memorably, one interviewee repeated a refrain that encompassed every possibility – whether the underlying issue is about professional groupings, wrong-doing, competence, competition or personalities – *"it always fractures along racial lines"*.

2.c) Is this true? The devil is in the details and *The Examples:*

Example 1

A 70 year-old Bermudian doctor retires to Bermuda after a career abroad. He is offered a position of Chief of a department. This is purely administrative. He has no clinical duties. There is no test or other criteria to determine his ability to undertake these administrative duties.

Upon reaching the age of 70, a Bermudian doctor who mentored many careers whilst running a department was required to retire from clinical practice because of his age. He could not continue in the administrative post. An expatriate was brought in to become the Chief of the department.

[The BHB (Medical Staff) Regulations were amended June 2006 to permit appointments extending beyond 70 years of age.]

Example 2

Although credentialed to do thyroidectomy surgeries, an expatriate doctor had not done one in his five years in Bermuda. When he scheduled it, colleagues questioned his ability and considered stopping him from doing it. The operation was a success and uneventful.

Although not credentialed to perform radical breast mastectomies and plastic surgery, an expatriate surgeon was scheduled to do so as one of his very first operations in Bermuda. There were no questions. The operation was a success and uneventful.

Example 3

A doctor is described as rude, crude, imperious to colleagues. He is divisive and arrogant. He is widely thought to be motivated primarily by money. He is sometimes indifferent to patients. Nursing colleagues tolerate him. *"Everything must be his way. He thinks he's a king."* His name is not known to the media.

A doctor is described as rude, imperious, histrionic, pot-stirring, belittling of colleagues; reduced at least two nurses to tears. He is known to be helpful to and caring of patients. He craves attention and drops names of politically influential friends. Nurses mount a petition against him. His personal life is splayed in the media. Everyone knows his name.

Example 4

Before coming to Bermuda, a doctor was controversially married to a girl under the age of consent. They had the consent of her parents. Overseas authorities determined not to prosecute. In Bermuda, the matter is leaked to the media.

In Bermuda, a doctor sexually assaults a nurse. She is traumatized. Although he will not be permitted to return to work at the hospital, his license is not revoked. He suffered a heart attack and is quietly airlifted out of Bermuda.

Example 5

In the mid-60s when the Indigent Clinic was established, two doctors were exempt from the service rota because they lived at the extremities of the island (St. George's and Somerset).

Another doctor was not exempt from the rota for the Indigent Clinic despite the fact that he lived in Somerset.

Which of these doctors are black; which are white?
Who got the benefit of the doubt?

"If it can be proven that there are definite differences between the way black physicians and white physicians are held accountable for what they do, that would be a tremendous success." [BB]

75 These and other examples raise critical questions

- If racism can explain a situation, is it necessarily **the** explanation?
- Even when there are explanations possible other than race, could an action or situation still be due to racism?
- Do whites always enjoy the benefit of the doubt?
- Do blacks ever enjoy the benefit of the doubt?

76 In the right-hand column of **Example 3**, whites and blacks were unanimous that the complaints against the black doctor are about personality, not race. Even those who lauded his caring for patients and professional skills were in accord that his condescension toward colleagues is in "a class of its own".

"There were complaints about a white doctor that he was a pit bull and attacks people. Years ago it was recommended that he receive counseling. Nothing was done." [BB]

77 However, several blacks did charge that the administration colluded in a revolt by the nurses against him. The failure of the hospital to insist on adherence to a proper complaints process was cited as part of a pattern of bias against black doctors. The participation of a physician leader (Chief of Department) in a meeting of the nurses (which one nurse felt manipulated into joining) was considered egregious. He felt a responsibility to attend such an unprecedented meeting about widespread concerns in the department.

"There were questions about how it got to the media, but nobody knows." [WB]

78 Some black interviewees questioned how the media obtained confidential information about the black doctor. Several pointed fingers of suspicion at one (white) practitioner's personal connections to the media. The hospital appears reluctant to inquire without proof. The dilemma is that it cannot get proof without questions.

"There are definitely tensions amongst colleagues. This must happen in every institution and that's why there are rules and regulations to play by." [WB]

79 This issue buttresses black opinion that not only white colleagues, but hospital administration itself will always – and blithely – give whites the benefit of the doubt. The inevitable question is: if the suspected source of the leak were black, would the hospital be as restrained in trying to determine if that person were the source of the leak?

80 In another instance where the details of a confidential management meeting seemed to have been quoted in the media word for word, the hospital's response was merely to ask if anyone was responsible and to remind attendees that it is not acceptable to leak information.

"The rules are simply not applied fairly." [BB]

"There are jealousies and rivalries that lead to things becoming more momentous." [WB]

81 There is a media policy. However, a policy is not an action. The failure of the hospital to thoroughly investigate leaks is viewed by some as a form of intentional acquiescence in the agenda of whoever is leaking information. Policies must be transparent and evenly applied. If not, the administrative decisions and actions of the hospital will always be perceived as arbitrary and without moral authority.

Recommendation II: The hospital should review and follow its Bye Laws and Regulations to ensure clarity, transparency and equitable implementation.

3. SYSTEMS GOVERNANCE

3.a) Is it about race or is it really about...Competition?

- The OR Theatre

"OR time has become a proxy for influence." [WE]

"In the Operating Room there is a lot of adrenaline. The environment is different from the rest of the hospital. In the OR, everyone is focused on the patient." [WE]

"The OR is more of a money making arena than anywhere else in the hospital." [BB]

"The phrase 'you don't have to be a brain surgeon to know…' shows the pedestal that surgeons are placed on." [BE]

"I think surgeons must have a lesson in school, because they are the rudest people, I think, they have no respect. To be honest, it's like a dysfunctional family, the whole place lacks respect in one form or another." [WE]

"The older doctors are controlling. There is lots of rolling over people black and white. They bring in people to do their calls." [WB]

"Old money will win over new money." [BB]

82 The original complaints to our office were all with respect to the Department of Surgery. This department encompasses approximately 11 units, three of which are the operating theater, Post-Operative Care Unit (recovery room) and the ICU. It is not surprising that serious tensions arise in this arena which is one of the most high stress environments in the hospital (other than the Emergency Department).

83 Surgery is also one of the highest income earning departments at the hospital. A majority of interviewees – black, white, expatriate, Bermudian – felt that the competition for practice in our small community is as divisive as race. This is particularly felt to be the case in the concerns surrounding the allocation of time for use of the OR.

84 Surgeons around the world are referred to as the 'prima donnas' of the medical profession. They command specialty resources and awe. In *How Doctors Think* [5], a recent book that is attracting much acclaim and media in the US, Dr. Jerome Groopman notes that it takes a *"high level of audacity and confidence to take a knife to another human being".*

85 Prime time television has conditioned us to expect miraculous feats and intimate drama. However, real life at KEMH is more sobering and less collegial. Just 20 years ago there were two black surgeons and four white surgeons in Bermuda. They seem to have agreed a formula to allocate OR times to meet both the acute and elective needs of their specialties.

86 Black interviewees claim that the allocation necessarily meant that the prime blocks of OR time (specifically mornings) fell within the control of white doctors. Black doctors strongly believe there is a continued racial disparity in OR blocks.

87 This allocation of OR time may be defined as a 'legacy system'. A legacy system is an accustomed organization or way of doing things that

[5] Groopman, Jerome, *How Doctors Think*, p.169, Houghton Mifflin Co., 2007

"There are inherited systems of set blocks for individual surgeons." [WB]

"I think scheduling you'll find in every hospital in the world is also an issue and it can be open to abuse. Again this is my personal opinion as I think in our hospital it really is laid open to abuse and we have the most bizarre way of scheduling that I've ever seen in my life." [WB]

"When a new surgeon comes to work here they don't have block time during the day when they first start." [WE]

"It's not that frequently that surgeries get cancelled. Certain surgeries like colonoscopy prep, breast lumps and tumours would never get cancelled." [WE]

"Black doctors also manipulate OR time by booking for one procedure but then doing two or three." [WE]

"The problem is 70% finances and only 30% racism." [BE]

"Medicine in Bermuda is spelled d-o-l-l-a-r." [BB]

reflects the social structure of the time. Legacy systems persist even when the contexts that created them change.

88 We did a meticulous analysis of six months of the daily OR Schedule from 1st September 2005 to 31st March 2006. Although four of the legacy doctors (older, established) did most of their operations in the mornings and only a few in the afternoons, there was no significant overall pattern of racial disparity amongst white and black surgeons.

89 Notwithstanding the data, blacks insist that they are disproportionally assigned afternoon slots. Time equals money. Morning time slots are at a premium. Delays in the pace of morning procedures often dictate whether surgeons in the afternoon will be able to complete their lists or have to postpone their patients to another time.

90 Further, interviewees said that new surgeons – whether white or black, Bermudian or work permit – have challenges getting OR time. Some work permit surgeons may have an edge because they are attached to the practices of established surgeons. Therefore, they may be able to carve out, cover for or inherit OR time from their host doctors who control time.

91 New surgeons who are not attached to established surgical practices tell stories of being relegated to the shortest periods and least favourable slots. They usually gain additional time only if someone leaves, or after considerable advocacy.

92 Black interviewees (whether surgeons or not) believe that after being allocated OR time, the schedules of black surgeons are cancelled more arbitrarily and frequently for emergencies or to facilitate visiting surgeons. The daily OR schedule submitted to me did not list cancellations.

93 With the introduction of ORSIS (Office of Recovery Services Information System) software in 2001 (properly operational by 2006), the scheduling and matching of OR times and specialties appears to be more fair and rational (although still based on legacy allocations). Scheduling is now less open to arbitrary changes. However, there is still a view that there are ways for anaesthetists to cherrypick OR lists when procedures on their own lists are cancelled.

94 KEMH must review the allocations periodically as new surgeons and health trends emerge. The criteria for allocating OR time should not be in deference to inherited legacy systems but rather by objective criteria such as annual utilization, urgency of clinical volumes and waiting lists. Complaints will persist if the system is not widely viewed as fair.

Recommendation III: The hospital should analyze legacy blocks and cancellations to ensure best practice in allocation of OR time (and by analogy to zero-based budgeting principles).

- The Department of Anaesthesia

Example 6

A majority of the anaesthetists expressed concerns that a particular doctor's skills were deficient or outdated and announced that they would no longer work with him. The Chief of Surgery had to call them in.

Within ten days of the arrival of the new Chief of Anaesthesia, they had bombarded him "unprompted" with their complaints. Two months later, the Chief conducted his own (unasked for) review of the prior seven months of laparoscopy cases. By the following month, he, too, had concluded that this doctor was incompetent.

The anaesthetists questioned this surgeon's decisions to operate. Most often, they complained that he is slow – painfully slow. He is meticulous. *"They are comparing apples and oranges. He does very good things."* He always injects the area of cut with local anaesthesia which the literature shows reduces post-operative pain. Perhaps the other surgeons were not taught about this. His notes are meticulous. *"At least one other doctor is as slow, but they don't target him."*

Many of his patients are older or have co-morbid conditions. He often goes in to do one thing but finds lesions and other conditions that should be corrected first. Other surgeons might skim over them, but he fixes them. He has few return surgeries or complications. He has excellent relations with the patients.

There are some concerns with laparoscopic

They claim that he takes two, three, four times as long as other surgeons do for the same procedures. *"He takes a long time to shave the cut area, fiddles with the drapes and is not at ease with the tools."*

Further, he strains the hospital's resources by operating at night.

procedures – he takes longer. For open procedures, his speed is in the normal range. Perhaps this is generational – e.g. young people are more at ease than their parents with new technologies.

There is never a problem getting him to come to the hospital as it sometimes is for others. He is very responsive.

He has good outcomes.

These are two (composite) views of the same surgeon. Is he black or white? Which views are stated by blacks, which by whites? Who gives this surgeon the benefit of the doubt?

"The anaesthetists refused to work with him because they think he's not competent. That is based only on their observations." [WB]

95 Black interviewees frequently pointed to the above example as a clear instance of racism. They are alarmed that anaesthetists were so powerful that they threatened to refuse services to a surgeon. The hospital did not discipline the anaesthetists in accordance with the Non-Collegiality policy of the BHB Regulations (Appendix 8).

"There is sometimes almost internecine warfare between the surgeons and anaesthetists." [WB]

96 Black interviewees protest that they have to negotiate with anaesthetists who, on occasion, decide that a surgery is not an emergency. The anaesthetists note that this happens with white surgeons also. Although there should be some consultation between the surgeon and the anaesthetist, it is the norm elsewhere that it is the substantive physician – not the anaesthetist – who always has the final say in whether an operation is an emergency, if the issues are purely surgical. Certainly, if patient safety is at issue in regard to the administration of an anaesthetic, then the anaesthetist must make the final decision.

"I don't think that quality is honestly looked at when it comes to the OR – if the emphasis is on speed and quotas, common mistakes can happen." [BB]

97 The anaesthetists also note that they are castigated when they decline to work at the end of an exhausting shift. Moreover, when two surgeons are competing for the same OR time, the anaesthetists are saddled with deciding priorities as surgeons don't consult adequately with each other.

"There are some people who are very good emergency surgeons and there are others who are better suited to elective work." [BB]

98 Questions were raised about the apparent arrogance of one specialty to presume themselves qualified to judge another. Expert clinical reviewers brought in by KEMH asserted that only clinical peers are qualified to evaluate specialties (that is, only anaesthetists can evaluate anaesthetists, only nurses can assess nurses).

"There has been a long-term struggle between those who feel they should control the OR – that has to do with income. Certain surgeons like to work with certain anaesthetists because they are quick and can get lists done. Certain anaesthetists like to work with certain surgeons because they have big lists and you can get paid a lot." [WB]

99 Yet, given their vantage point of observing different surgeons performing similar operations, it is not surprising that anaesthetists form a comparative view (if not a professional specialty view) of the skills of the various surgeons that they have the opportunity to observe. The anaesthetists claim that their reluctance to service the doctor in **Example 6** was solely about competence (most often defined in this instance as "excessive slowness").

100 Others believe that it was really about the business of medicine. This surgeon has consistently charged that the anaesthetists are so bent on making more money that they perform unnecessary epidural and central line procedures that are not justified by evidence-based medicine.

"Anaesthetists should be on salary carefully designed with specific hours. The hospital would be safer if anaesthetists were hired by the hospital, same as pathology and the emergency room." [WE]

101 In particular, he has questioned the practice of anaesthetists in Bermuda to routinely do epidurals for laparoscopic surgeries (televised scope rather than open cut procedures). His concern in this instance is consistent with clinical practice in major, reputable centres in the US – epidurals are almost never done for laparoscopic surgeries.

102 Insurers pay anaesthetists by a formula that combines procedure and time. Today, there is a base unit fee per procedure that is set by the US national fee analyzer Ingenix. In addition, anaesthetists are paid for the number of minutes that they attend to each patient. It is not a straight line formula. Generally, a single procedure that takes a long time will be less lucrative than several procedures in the same amount of time.

103 Surgeons bill once for the entire pre-, intra-, and post-operative care of the patient. Anaesthetists bill separately for pre-operative assessment, administration of anaesthesia during the surgery, and post-operative care. The explanation is that different anaesthetists may be involved in the management of the patient at different stages of care.

Does 'slow' necessarily mean incompetence, or could it mean great care? *"It could indeed mean both." [WB]*

"It would be wrong to say they're not money orientated to the same extent that a Barrister is or a Bus Driver or everybody else. I think to suggest that they are wholly motivated by money is wrong." [WE]

104 'Slow' does not equal incompetence. There are world-renowned surgeons who are reputed to be 'slow'. However, a 'slow' surgeon on the roster in the OR in Bermuda is likely to complete fewer procedures each day. 'Slow' may equal a less lucrative day in the OR for an anaesthetist.

105 Accordingly, a surgeon who is both slow and who insists on questioning certain procedures (such as epidurals for laparascopic surgeries) may be detrimental to the bottom lines of the anaesthetists. It is not a stretch to see that he could be a likely target.

106 While problems between anaesthetists and surgeons are not unknown in other jurisdictions, in Bermuda, rifts seem to morph inexorably into issues of race, origin, stereotype of training and possibly gender by virtue of the composition of the groups involved.

107 In **Example 6**, the hospital seemed to agree solidly with the anaesthetists without adequate inquiry. Maladministration on the part of the hospital is evidenced by its willingness to predicate administrative responses on individual pre-judgments that are not corroborated by reliable data or that may be coloured by financial interests. Patient care cannot be served well by a hospital that allows clinical decisions to be based on data that is arbitrary, unsubstantiated, self-serving or biased by personal friendships.

108 Given differences in training and the fact that there are low volumes of certain procedures in Bermuda, a system must be instituted to ensure access to data about best practices in order to mediate between differences of opinion about clinical decisions and protocols. This would be germane also to the issue of MWI doctors being overruled by KEMH doctors with respect to the need for treatment for MWI patients.

Recommendation IV: The BHB/KEMH should immediately engage information databases, specialist retainers and other relevant resources that doctors would be required to consult in arbitrating between different views on clinical care. This information should also be used to analyze disputed anaesthetic and surgical procedures and to establish standard protocols for pre-, intra- and post-operative practices.

The following Note sets out an historical review of the provision of anaesthesia services to the hospital including expatriate/ Bermudian tensions.

Anaesthesia is not a mere sub-specialty within the practice of medicine. This is a growing specialty with its own critical sub-specialties. Anaesthesia is required, not only for general surgery and dental surgery, but also for post-operative care, intensive care, trauma and resuscitation management, diagnostic testing, acute and chronic pain management and obstetrics. Clinically, the anaesthetist is responsible for the patient from the moment the patient is put to sleep, until s/he wakes up.

A 1999 internal memo to the BHB summarized: *"since the 1950s two UK Fellowship qualified anaesthetists began to offer services to KEMH. As surgical offerings broadened and cases increased, other anaesthetists joined the practice. This organization, Anaesthetiic Associates ("AA"), ran the business affairs of all of the island's anaesthetists.*

For many years there was a close link between the Department of Anaesthesia and AA and the dividing line between the affairs of one and the affairs of the other may have seemed a bit gray as the principals for each organization were the same. The senior anaesthetists were principals in AA and junior members would become partners over time… (but) *would not at first be entitled to a full share in the equity accorded to the more senior anaesthetists."*

At first, all of the anaesthetists were UK trained and most began their service in Bermuda on work permits. The business arrangement of AA began to fracture when two Bermudian status, North American trained anaesthetists started practicing on the island. They challenged the established business organization and remuneration scheme. There were also differences in approaches to the practice of anaesthesia.

The anaesthetists (one born Bermudian; one spouse of) offered their services to KEMH privately, but outside of the AA contract. Their resignations from AA produced what the memo termed as *"a dichotomy between the group of British trained, non-Bermudian, and generally more senior Anaesthetists, and the smaller group of relatively junior North American trained anaesthetists with Bermuda connections…This situation has led to some unhappiness within the Department of Anaesthesia…this has not led to a spirit of mutual respect, collaboration and collegiality within the Department."*

Recently, apparently for business reasons, the AA company has broken into two.

109 The above characterization of UK anaesthetists as "senior" and North American anaesthetists as "junior" is somewhat contentious given the actual equivalencies in their training. These descriptions may be based on length of time rather than training levels. Therefore, I am not prepared to find that the above memo was a deliberate attempt to mislead the BHB at the time.

110 Pursuant to repeated concerns about the provision of anaesthesia services and the relative power of AA, three in-depth reports regarding the structure and operation of the Department of Anaesthesia have been conducted over the years.

111 The 1992 Review of Department of Anaesthesia ("1992 Review") was conducted by a single Canadian evaluator, Dr. Bevan. Thereafter, a Working Party of five practitioners and administrators within KEMH analyzed the 1992 Review and produced a "Consensus Statement" of the recommendations acceptable to them.

"The 2002 Anaesthetist Report recommended that the hospital should hire the anaesthetists. That was unpopular with them and was therefore sidelined." [BB]

112 The 2002 Anaesthesia Services Review ("2002 Review") was conducted by an internal KEMH ad hoc committee comprised of ten doctors and administrators. A wide range of interviewees included surgeons, anaesthetists, internists, obstetricians, gynecologists, nurses, physicians and the OR scheduler.

113 The 2006 Appraisal and Inspection ("2006 Review") was conducted by a three person external review team. The report entailed both an overview and individual confidential feedback to the anaesthetists.

"That Report caused the medical community concerns." [WB]

114 All reviews applauded the anaesthetists generally for their high level of clinical competence and hard work. None of the reviews audited specific clinical decision-making regarding the appropriateness of the procedures in contention (mentioned above).

"Anaesthetists are like OPEC. They are true parasites." [BB]

115 Each report also noted the inadequacy of policies as well as the persistent failure of collegiality, described by the 2006 Report as *"highly variable loyalties and attitudes".*

The following Note summarizes each report's process, mandate and recommendations.

1992 Review	2002 Review	2006 Review
Process Dr. Bevan conducted two full days of interviews in addition to review of background material.	**Process** The KEMH Review Committee held bi-weekly meetings and conducted 30 interviews over six months.	**Process** A week-long study with interviews, 360-degree appraisal and direct observations of practice.
Mandate To review anaesthetic policies, service volumes, organization and standards.	**Mandate** To examine the Operational Functioning of Anaesthesia Services, including the Staffing of the Service and the Functional and Financial Relationships between anaesthetists and the Bermuda Hospitals Board and to make Recommendations directed at improving the service to the Board.	**Mandate** To conduct individual appraisals and make recommendations as a whole to the Department of Anaesthesia.
	Matters Reviewed • Which recommendations of the 1992 Review had been implemented • Operating Room capacity and scheduling • On-call procedures and ICU coverage • Quality improvement and procedures • Staffing and Chief of Anaesthesia role • Issues of collegiality and communication • Financial ramifications • Hospital hire of anaesthetists	**Matters Reviewed** • Audit and data analysis • Morbidity and Mortality • Clinical Governance • Educational meetings • Anaesthetic practice • Staff retention • Quality improvement • Intensive care unit
Recommendations Implemented • Create an autonomous Department of Anaesthesia separate	**Recommendations Implemented** • A Chief of Anaesthesia with a job description in accordance	**Recommendations** *(made in the fall of 2006 – no audit of implementation to date)* • Data should be collected on

1992 Review

from the Department of Surgery *(done by 1998)*
- Improve equipment audits and practice Guidelines *(done by 2000)*
- Redesign the Anaesthetic Record
- Increase the number of anaesthetists
- Department be reviewed every five years *(2002, 2006 as reactions to complaints rather than as a planned strategy)*

Recommendations Not Implemented
- Develop acute and chronic pain services *(patient control analegesia introduced; not a full-fledged acute and chronic pain service)*
- A formal organizational structure *(partially done 2005)*
- A risk management protocol for critical incidents and anaesthesia outcomes
- Anaesthetists be hired by the hospital

2002 Review

with the Canadian Standards of Anaesthesia Practice
- An equitable OR scheduling process (as the then existing process was reported by some interviewees as resembling "a consortium of guest worker Anaesthetists actively arrayed against Bermudian Anaesthetists") *(ORSIS software introduced in 2001, realistic scheduling by 2006)*

Recommendations Not Implemented
- Appointment of a Director of ICU to ensure adequate coverage and 'on-call' procedures *(an anaesthetist was appointed in that position but he was not specialist qualified)*
- Extension of Operating Room and staffing capacity
- Addressing the failure of communication and collegiality which *"had resulted at times in distrust and undermining and even in verbal arguments in the presence of staff and patients"*
- A succession strategy for the Chief of Service
- Improvement in quality management, outcome audits *(statistics capability of ORSIS not used properly)*

2006 Review

number of patients anaesthetized, health rated group, pre-operative status and outcomes
- Quality assurance department should audit charts to ensure compliance with standards for accuracy and completion
- Re-start of Morbidity and Mortality meetings with a regular schedule
- Professional presentation of case studies with powerpoint, review of recent research and options to improve practice
- Document action points and feedback changes
- Transparent system for reporting, assessment and action on patient episodes
- Annual appraisals
- Improve pre-operative assessment and records
- Keep pre-operative findings readily accessible in OR theatre
- Use the North American trolley system or some hybrid thereof for ready access to equipment
- Formal patient-focused handover
- Locate blood gas machine in ICU
- Separate Department of Intensive (Critical) Care
- Chief of ICU: fellowship or Board trained
- Seamless coverage in ICU
- Web-based x-ray display

2002 Review Committee: *"when reviews are conducted and recommendations made and agreed upon, then someone is given the responsibility of initiating, monitoring and reporting on their implementation."*

116 Ten years after the 1992 Review, the 2002 Review Committee lamented that some of Dr. Bevan's important recommendations had not yet been implemented. At 2006, there were still serious gaps.

117 In 2001, the BHB considered hiring its own anaesthetists rather than continuing with the existing contracts for individual and group anaesthetic services. The anaesthetists wrote a strong letter of protest and were supported by a group of surgeons who presented their opposition to the Board. Given the fact that the private arrangement had worked very well for many years, the surgeons were concerned about a slippery slope should the hospital get the notion of putting surgeons on salary as well (and charging them for the cost of supplies).

118 The 2002 Review Committee also analyzed this *"major issue"* with an extensive comparison of the two options:

Option	# Pro reasons	# Con reasons
Hire anaesthetists	16	5
Existing contracts	4	13

119 Despite an overwhelming number of reasons favouring the hiring of anaesthetists, the 2002 Review recommended that the hospital **not** hire its own.

120 There were fears about the calibre, recruitment challenges and availability of anaesthetists if the positions became salaried. There were suggestions that the BHB would incur far more costs as salaried anaesthetists are unlikely to agree to work the number of hours that the private anaesthetists do.

"The power has to be taken away from the anaesthesiology staff. They get the run of it and use all of the facilities without paying for that. The few that do try to step out of the box are usually penalized from the insurance company." [BB]

121 The comment about availability caused concern. *"In the mind of some of the* (2002 Review) *Committee* (this was) *a thinly veiled threat"* that the current anaesthetists would leave if the hospital decided to hire its own. This "thinly veiled threat" seems to have been extremely effective.

122 Had it been a heavily veiled threat or even a vague suspicion, it would have warranted at least a watchful attitude. However, a **thinly** veiled threat should have elicited a far more robust administrative and

strategic response.

123 It is a sad commentary on the level of commitment to Bermuda that any threat at all could have been made (denied by anaesthetists) or even perceived to have been made by a group of practitioners who have earned a decent living from their service to Bermuda for many years.

124 It is an even sadder indictment against the quality of its strategic vision and pragmatic capacity that the BHB did not respond immediately and firmly. Bermuda's single medical facility should not be held hostage to the possibility of such a threat being exercised.

In the UK, all National Health Services Trust ("NHS") hospitals employ their own salaried anaesthetists, surgeons and other sub-specialities who, since 1948, have been paid on the same salary scale. Consultant anaesthetists are allowed to be hired by the private sector for a certain number of days, however their primary employment relationship is with the NHS.
(publication of the Association of Anaesthetists of Great Britain and Ireland)

125 A Sub-Committee of the 2002 Review which submitted a brief analysis of anaesthetists' billing practices asserted that *"like other jurisdictions anaesthesiologists are private consultants in the same vein as surgeons".*

126 On the contrary, our research has found no public hospitals that rely exclusively on private anaesthetists. In the public systems that we canvassed in the UK, Canada and the US, the provision of anaesthesia services is considered a central function. Like radiologists and pathologists, anaesthetists are usually hired by hospitals as employees.

127 Some jurisdictions do have a mix of arrangements. That is, public hospitals will hire their own anaesthetists but may also augment their staff with private contracts for anaesthesia services for emergencies or times of staff shortages.

128 Private hospitals tend to either employ their own anaesthetists or contract for private anaesthesia services (often by anaesthetists from the public sector). In this regard, KEMH is organized more like a private hospital than a public facility. Bermuda relies on a legacy business model for the provision of anaesthesia services. This model did not develop from any deliberate strategic plan by the hospital.

129 The hospital should not have accepted without question unsubstantiated opinions about service models from doctors with arguable conflicts of interest. The fact that there are challenges with an idea does

"They get a lot more money being stuck here than they would anywhere else. So they essentially will do – it would appear to me in my experience – will do anything to consolidate their position here. They'll lie, they'll make up stories and the one thing that they will always do is back each other up." [WB]

not mean that it must be summarily dispensed with. Given the "thinly-veiled threat", at the very least, BHB should have researched best practices elsewhere and made some attempt to think about how to structure a system that would balance doctors' earnings with the emergency needs of Bermuda's population.

130 There are several models in other jurisdictions that are reasonable, transparent and provide opportunities for employed doctors to have a substantial guaranteed income in addition to incentives that allow them to earn more upon meeting agreed objectives.

131 Given their work permit status, non-Bermudian anaesthetists are attached to private practice. For some time, this inherited business arrangement had been internally collegial. When the two Bermudians decided to work on their own, a new and inflammable level of competition began. This seems to have cemented the chasm and failure of collegiality.

132 The hospital's attempt to remedy this by recruiting a Chief of Anaesthesia backfired. The idea of the role of Chief of Anaesthesia remains valid and essential, but the credibility of this particular individual diminished in the 2 ¼ years that he was in Bermuda. Although he appears to have strengthened certain procedures, he was perceived (by most blacks and a few whites) as having serious conflicts of interest.

133 This may be due in part to his contract that provided for a mixed administrative and clinical workload. He aggressively sought to expand the scope of his employment. The hospital's evidence is that he requested permission to work outside of the hospital only after a colleague reported him for doing so. He believed he then received tacit approval.

134 Administration, however, concedes that it merely agreed to make an application to the Department of Immigration. Moreover, as a physician leader, he should have known of Bermuda's strict immigration rules and should not have worked without clear approval.

135 In the absence of respected leadership, the Department's climate continued to foster stereotypes and tensions. The 2006 Review

"revealed serious flaws in the interpersonal relationships within the Department. This is producing an inhibitory effect on the learning of the Department and…defensive anaesthesia is being practiced in order to avoid criticism by colleagues."

136 The recently announced training of anaesthetist nurses is an excellent step. Care must be taken, however, to ensure that this does not encourage continued or even more aggressive anaesthetic practice. The volume and protocols should be carefully reviewed and monitored to ensure best practices and that the nurses are not blamed unfairly for any breaches.

Recommendation V: The hospital should reconsider implementing outstanding recommendations from previous reports regarding the Department of Anaesthesia and revisit the idea of hiring its own anaesthetists – at least to cover Bermuda's emergency needs.

The following Note contrasts how anaesthesia service is provided in the UK.

The 2003 National Health Service ("NHS") Contract and Job Planning for Consultant Anaesthetists stipulates that negotiations to vary the basic Contract in order to accommodate private practice and fee-paying services (e.g. coroner's witness work) must adhere to certain proscribed conditions:

"A principle of the Contract is that there should be no detriment to the NHS from any private practice. The job plan should include references to any regular private work you do. Regular private commitments should be recorded with details of location, timing and the general type of work you will be doing. Provision of services for private patients should not prejudice the interest of NHS patients.

Private commitments should not be scheduled during times when you are scheduled to be working in the NHS. Private commitments should not prevent you from being able to attend an NHS emergency while you are on-call for the NHS. The flexibility within the contract allows for private work to be done in your own time – on leave (not study leave) or when not otherwise scheduled to the NHS, by time shifting and where it causes minimal disruption to your NHS duties. There is no specific limit on the amount of private practice that can be undertaken as long as the above principles and the agreed job plan are adhered to."

Private hospitals, which do about 15% of the elective surgery in the UK normally employ middle-grade trainee doctors as Resident Medical Officers but do not often employ consultant anaesthetists. In smaller localities, private hospitals often have a similar arrangement to Bermuda by hiring the services of a group of anaesthetists to work together to cover the work and divide the fees on a basis agreed by themselves.

Up to about one year ago, there was a shortage of consultants in the UK but the situation is changing dramatically. In order to comply with trainee working hour decreases mandated by the European Working Time Directive, training programmes were expanded and a large number of new consultant posts were created. These have now been filled. With the large number of trainees about to complete their training, it is expected that unemployment amongst trained anaesthetists will shortly be an issue.

3.b) Work Permits

"People on work permits feel that their jobs would be in jeopardy if they speak up." [WE]

137 Non-Bermudian physicians (black and white) tend to view the work permit system as oppressive. While Bermuda affords them a desirable lifestyle, there is a range of financial arrangements. At one end of the spectrum, expatriate specialists earn relatively modest salaries with billings in excess of their salaries going into the coffers of employer/host work permit holders.

"You get people who hold other's work permits but they can also control how much work they get in the hospital."[BB]

138 At the other end of the spectrum, expatriate doctors pay nominal amounts to the office of work permit holders (10%-20% of billings) as fair compensation for sharing in administrative or overhead expenses. Less reasonable are reports of up to 70% of their billings paid to work permit holders.

"They usually treat the people they bring in for the work permit – I'll just say it – like slaves. They want you to start a new practice, pay the expenses, then give them 40% of the income." [BE]

139 Although these are private arrangements, they do affect issues of collegiality within KEMH to the extent that there are suspicions and accusations of alliances and economic interests in certain decision-making within KEMH. Real or perceived conflicts of interest inevitably arise. Moreover, the hospital should be very concerned that several expatriate medical professionals (doctors and nurses) say that they are

"It's been intimated to Members of the Medical Staff Committee who are on work permits that they won't get their permits renewed if they make decisions that are against the political flavour of the day." [WE]

less inclined to raise their voices when they see something untoward.

140 Whether under private or hospital work permits, the workplace for these medical practitioners is Bermuda's only – public – hospital. If the work permit system conduces silence by intimidating doctors from advocating for patients, then transparency and ultimately patient care may be compromised.

141 Non-Bermudians, especially those from large countries where protectionism appears less severe find Bermuda's work permit system stifling. Bermuda is typical of other small jurisdictions that are limited in strength and range of local expertise. Opportunity must be reserved for qualified locals to make a living in their own country.

"You have two classes of doctors and nurses – those on work permits and those not – and there is a clear difference between the two groups, how they're treated and how they work and what they feel they can say and what they feel they can't say." [WE]

142 Bermuda will always be dependent on foreign talent, yet section 6(9) of Bermuda's Human Rights Act 1981 provides that it is not discriminatory to give a preference to the employment of a Bermudian.

143 The controversy within the medical community is less with respect to protectionism and more with respect to who should have the right to hold the competing work permits of specialists.

144 Several interviewees as well as our expert advisors felt strongly that either the hospital or an independent entity such as the Bermuda Medical Council ("BMC") should hold all work permits. They felt that, in the absence of a competitive market in the form of another hospital, the resources available to our single medical facility should not be subject to the whims of private practitioner work permit holders.

"That's a real money thing. He wanted to bring a specialist in on a work permit so that he would get a cut out of it. Who is he to delve into our field? I think this is a very contentious issue, cuts across colour and everything. It happened a couple of times, it just opens up the whole Pandora's box, greed, anger, people don't talk to each other." [BB]

145 The ongoing divide on this issue is in the domain of private medical practice and is beyond the focus of this Report. Certainly, there is a spill-over effect to the hospital with the apparent breakdown in the legacy system of decision rights. Differences within the medical community seem to have become a proxy for a broader political debate.

146 Most white doctors were quite vocal against general practitioners holding the work permits of specialists (such as surgeons). They argued that

"The question is – who should hold work permits. Should a generalist be allowed to hold the permit of a specialist? Or should specialists hold only the permits of like specialists." [WB]

"Non-Bermudians should be here only because we have a need and cannot fill the gap". [WB]

"Only a specialist should employ a specialist. If you are responsible for their practice, you should know enough to supervise them." [WB]

"Doctors are bringing in other specialties that have nothing to do with them. It has snowballed into lots of competition." [WB]

"If you take out the incentive for doctors to hire other doctors, then a certain process would go away. By having the doctors that work for you work in the hospital instead of having their very existence in Bermuda dependent upon another individual who's making money on them would probably foster more participation." [BE]

each work permit holder should ultimately be responsible for and therefore be able to supervise the guest worker.

147 Moreover, there is widespread suspicion amongst white interviewees that certain black doctors aim to create private medical facilities to compete with the hospital. They view the trend of generalists holding specialist work permits as a first step toward that goal.

148 One question that arose is whether Bermuda has a market large enough to sustain competition with KEMH from a private hospital in the same way that private schools and private health insurers compete with respective public schemes. The statistics in paragraph 12 show that there is already a healthy (some have said, unhealthy) competition in certain surgical specialties.

149 Several black interviewees felt that Bermuda was overdue for competition with respect to who may bring in medical specialties. One person pointedly said: *"to control the flow of money, you have to control the flow of providers"*. The control of the provision of specialist physicians has been dominated by legacy doctors in the past.

150 Three interviewees (two clinical and one patient) expressed the view that black specialists should be welcomed to offer a choice for Bermuda's 60% black population. Some patients and their families may feel that racial affinity makes black doctors more caring and respectful in consulting with them on clinical matters.

151 It is not just a matter of skin colour but rather a matter of what race has meant in Bermuda. Many senior patients still remember and smart from the indignity of having to sit in separate waiting areas in the offices of white doctors. Today, they relish having a choice of black doctors.

152 The implications of this debate extend beyond the hospital to other sectors and professions. The professional association for dentists, for example, encourages generalists to bring specialists in to enhance the range of services offered to the public. Likewise, the legal, engineering,

reinsurance and accounting professions would be constrained if they could not import specialty skills. In these cases, the competition of the market seems to correct inefficiencies and oppressive arrangements.

153 To the extent that this debate casts light on the BHB's administrative failure to develop a strategy to meet its emergency needs, then it must be noted. Clearly there is a need for systemic analysis and deliberate planning with regard to health trends, and training priorities.

"You call and you have a kid with a tremendous ear abscess and you can't be seen for 6 weeks – you tell me any mother's going to accept that. You take him to the Emergency Room – it's now being used as a primary care physician practice. People are going in there because they can't get appointments with GPs because everybody is booked up to here." [BB]

154 Unlike small communities in Europe, North America and the Caribbean that have some ready access to resources in neighbouring areas, our isolation in the middle of the Atlantic demands that we think specifically and perhaps differently about how to manage our medical needs. A strategy could avoid both over and under provision in some specialties.

155 It should be noted that there is a relative over-supply of doctors in general practice and in the specialty of obstetrics/gynecology. Yet, there does not appear to be the same kinds of competitive tensions as in surgery. This was explained as an acceptance by these doctors that they are all Bermudians with a right to practice and that the pool of patients gives each an adequate level of practice.

Recommendation VI: The BHB, in conjunction with relevant internal committees, the Ministry of Health, the Bermuda Medical Council ("BMC") and the Bermuda Health Council, should engage in a strategic review of Bermuda's clinical manpower needs, including whether the BHB, the BMC or other entity should hold the work permits of the specialists who practice only at KEMH.

3.c) The Political Shadow

"In Bermuda – white Bermudians are top dog. The white man from any other place in the world is next, then comes the black Bermudian, then comes the black man from any other place in the world." [BE]

156 As illustrated by the BMS/BMA divide and the statistical summary on page 12, the two racial camps also reflect a new dynamic in Bermuda as a whole. Nine years ago, there was a seismic shift in who holds the reins of political power. Although whites still dominate the larger economy, Bermudian whites in particular seem to be experiencing some dislocation – described as an "identity crisis" – with respect to influence and decision rights.

"We have a hospital which, whether you like it or not is a government institution. It is a very specific business but is run by lay people who have no idea of health care. It should be a private institution with government having some say." [WB]

157 This has reverberated throughout the island and the hospital is not immune. Many white interviewees complain that the problems are really not about race, but rather about an insidious, growing, political interference with the BHB that seeps throughout the hospital. They believe that, although the Board is supposed to be a relatively independent quango, it has become merely a rubber-stamp for decisions imposed on it.

"The Board is run autocratically – there is a dramatic change in the way the Board was run." [BB]

158 Too often with controversial matters, people try to avoid mentioning the obvious. This is known in communication consulting circles as "tiptoeing around the elephant on the table". Several interviewees specifically pointed to a powerful black doctor as the instigator of complaints.

"The old boys school is not as strong today." [BB]

159 Many white interviewees believe that he is targeting the white power elite who it is widely believed (by blacks and whites) to have unfairly denied him entry into the profession in Bermuda years ago. There is no evidence that his keen interest in matters involving the hospital stem from such motives.

"He is so angry at the way he was treated that he thinks the hospital is an enemy." [WB]

160 On the other hand, some of the black interviewees suspect that work permit black doctors who are his friends may be targeted by the same white medical elite – not because they are black, but because of their association. That is, these doctors are little more than pawns or more accurately, proxies in a battle between the old and new Bermudas.

"The political influence is greater now than ever before." [BB]

161 Several black interviewees believe that there were many instances in the past when the previous political regimes exerted influence on the

"Ministers in Bermuda have no fear of their actions." [WE]

"Medicine by its very nature is a defensive environment because you are basically called to be perfect and you pretty much get by doing a very good job as long as there is not undue scrutiny. If you become excessively scrutinized then you're working more defensively." [BB]

"The hospital is run by the doctors and they make the rules up. There is too much ad hoc." [WB]

"The hospital was told to implement the Report. The Kurron folks recommended that everyone at the top be fired and they be hired." [BB]

operations and services of KEMH. Indeed, there were at one point three physicians in Cabinet in addition to other powerful doctors in the upper echelons of the then governing party. Examples given of political interference were not clear-cut.

162 There is documentary or admitted evidence of political pressure on hospital administration to:

- reinstate privileges for a black doctor until the disciplinary process of the hospital's by-laws were complied with
- grant privileges to a new Bermudian doctor
- investigate cases that may constitute medical errors or complications by white doctors with the same fervor that black doctors are investigated.

163 This issue presents an excellent illustration of how different lenses colour and shape reality. Whites tend to feel such direct political input as extreme harrassment. Blacks expressed relief that – finally – persons with clout have acted on their perceptions of differential treatment.

164 They add that if the hospital had followed a rigorous, transparent, fair and credible system for addressing clinical concerns, then it is unlikely that such pressure would have been felt necessary.

165 Lamentably, the intimidation effect (of persistent emails sent to a relatively new Chief of Staff by a powerful black doctor) overshadowed their important message that all incidents should be treated equally.

166 The goal should not be to replicate the existing culture (by targeting all doctors equally). Rather, the goal should be to transform KEMH into a learning institution.

167 A few members of the BHB have also expressed discomfort with the amount of current political influence. They question what the role of the Board should be if it can be readily overruled by the Ministry.

Recommendation VII: The hospital's Board should review and rationalize its own structures and operations in accordance with best practices in order to strengthen its independence and leadership.

4. CLINICAL GOVERNANCE

4.a) Credentialing

- UK vs. US

Is it about Race or Competition or really about … Competence?

In *How Doctors Think*, Dr. Groopman notes a common criticism that doctors have of each other: *"You hear this kind of criticism – that each new generation of young doctors is not as insightful or competent as its forebears – regularly among older physicians, often couched like this: 'When I was in training thirty years ago, there was real rigor and we had to know our stuff. Nowadays, well…' These wistful, aging doctors speak as if some magic that had transformed them into consummate clinicians had disappeared. I suspect each older generation carries with it the notion that its time and place, seen through the distorting lens of nostalgia, were superior to those of today. Until recently, I confess, I shared that nostalgic sensibility. But on reflection I saw that there also were major flaws in my own medical training. What distinguished my learning from the learning of my young trainees was the nature of the deficiency."*

"The old boys are still in control – it's quiet, but you know it's there." [BB]

"There are little alliances – it's kind of like Survivor." [BB]

"Racism is like a dirty word. We don't address it well in the hospital. Sometimes racism is used as an excuse when things don't go right but when you drill down, you find it's something else." [BB]

168 While generational nostalgia undoubtedly persists in Bermuda, black doctors here are focused primarily on the "cabal" that they perceive targets all competition – especially black. They believe that this targeting is cloaked in clinical critique and stalks them throughout their careers, from the credentialing process onwards. They have to practice medicine defensively, always looking over their shoulders, for fear of eagle eyes waiting to pounce in order to discredit them.

169 Within KEMH, there are some legitimate concerns that the considerable variations in practice that result from recruitment of clinicians (including nurses, house officers and paramedical staff) from many different parts of the world could affect patient care.

170 However, black doctors do not feel that they are ever given the benefit of the doubt. They believe that young black doctors are particularly and intentionally discouraged.

Example 7

A young Bermudian doctor completed her year of internship and embarked on specialty training. In the US, Board certification in at least two specialties – OB/GYN and plastic surgery – entails a two part examination interspersed with two periods of practice:

1. The first period of practice is two or more years as a resident in the specialty area.
2. Then the doctor sits the written portion of the Board examination.
3. A second period of practice, after passing the written exam, entails two to five years of additional practice in the specialty in order to compile a list of patient cases.
4. That list is submitted to the Board prior to taking the second part of the Board examination – the oral exam. Part of this exam includes questions on the management of the list of cases submitted.
5. Board certification is granted only after completion of the oral portion of the Board examination.

While the final oral exam is not absolutely mandatory for a doctor who has passed the written exam (Board eligible) to practice, it is very difficult to obtain or maintain hospital credentialing without Board certification.

Non-US citizens are rarely able to obtain placements in hospitals for the second period of practice. Bermudians seek therefore to come home to open their practice and develop the cases necessary for submission to the Board – without which, they cannot take the oral portion of their Board examinations. The Bermuda Medical Council and Privileges Review Committee at the hospital insist that doctors be Board certified before being allowed to practice in their specialty.

In this case, this young doctor was granted privileges only after enormous, persistent advocacy by an influential black doctor.

"Whites always looked for one thing – anything – to disparage a black doctor and then used that one thing to cast them in the worst light." [BB]

171 The reason that black interviewees repeatedly pointed to this situation as another example of racism is that the local medical community is already well aware of the logistics of Board certification and immigration in the US. At least on two earlier occasions, they had to grapple with the concept of credentialing doctors in a specialty before their final oral exam.

172 The hospital's continued failure to clarify and align US training with the UK system and to recognize the need to allow Board eligible Bermud-

"There is always potential for problems if communication is bad." [WE]

"She's fully qualified and this situation (of her not being respected) is not something the country should be proud of." [WB]

"She's a black woman amongst all the white anaesthetists. She is very educated and better experienced than most – but she's given a rough time here. That sums it up right there." [BB]

"This is about qualification, not race…the Chief of Pathology must be able to supervise the medical specialties." [WE]

ian specialists to practice their specialty in Bermuda is viewed by blacks as a matter of intellectual laziness at best or, at worst, a deliberate attempt to frustrate younger black Bermudians who train in the US.

173 The UK, too, has grappled with an influx of medical practitioners from various jurisdictions. According to Article 14 of the *2003 General Medical Practice and Specialist Medical Education Training and Qualifications Order (SI 2003 No. 1250)*, a doctor is eligible to register in the UK if s/he has specialist training **or** qualifications.

174 The BHB likewise must clarify equivalencies between the various jurisdictions so that physicians do not default to misinformation and unfair judgment of each other's training. There is no need to reinvent the wheel. It would be a valuable exercise to determine if US Board eligibility (prior to final qualification after the oral exam) meets the definition of "specialist training" under the UK Specialist Register statute.

175 Part of the problem at KEMH is that medical practitioners do not communicate well with each other. The hospital does not have an induction programme to inform practitioners of each other's skills and interests. KEMH seems to nurture a culture where rumours and stereotypes rather than hard data determine how doctors judge each other, and worse – how the hospital responds.

176 For example, many black interviewees believe that the accomplishments of a Bermudian scientist in the Department of Pathology are being marginalized on the basis of biased or outdated information. There is ongoing debate – that does appear to fracture along racial lines – about whether a Bermudian Ph.D. in Microbiology may be the Chief of the Department and act up in that role in accordance with s. 20(d) of the BHB Regulations.

177 Our research and expert advisors show that the Chiefs of Pathology in most large hospitals in the US and Canada are medical doctors (in addition to their technical specialty). In small hospitals, it is not unknown for a Chief to be a Ph.D. The real issue appears to be whether MD pathologists would balk at taking direction from a non-medical doctor.

"What it really comes down to is competencies of administration and management of a laboratory. There's no way that an histologist can be in charge of, say, a hematologist or a microbiologist in terms of their professional and clinical skills because they can't second guess. They haven't got the knowledge or the training. Histopathologists hardly do any direct activity with patients like clinical rounds whereas a hematologist would. All the Chief can do is act as an administrative manager." [EA]

178 Hospital administration and leadership were not aware that the UK national accreditation body, United Kingdom Accreditation Service had formed a partnership with Clinical Pathology Accreditation Ltd. to develop accreditation policy and standards. In 2004, the two bodies agreed that medical laboratories *"shall be professionally directed by a consultant pathologist **or** clinical scientist of equivalent status"* (who is a member of the Royal College of Pathology).

179 According to our expert advisors, a Ph.D. microbiologist would be considered equivalent in the UK and would therefore qualify as a Chief of the Department of Pathology if s/he is also a member of the Royal College. Black interviewees believe that, if the Bermudian microbiologist were white, then hospital administration would have done the necessary due diligence and found the precedents to justify his appointment as Chief of the Department.

180 Hospital administration has confirmed that the role of Chief of Pathology is *"purely administrative and management and that locums do the service work"*. Inexplicably, one physician leader has asserted that the Bermudian scientist *"has only minimal management skills"*, despite his tenure as the Deputy Director at one of the UK's leading laboratories – the BSE (mad cow) laboratory at King's College. He is also a member of the Royal College of Pathology.

"If he could be the Deputy Director of one of the most prestigious labs in the UK, why can't he manage a small pathology Department like ours – he is widely respected here by the physicians and staff." [BB]

181 Black interviewees see this example amongst others as a perennial fixture of racism, not only in the hospital, but also throughout Bermuda. Students are told to study hard, go abroad and get their 'piece of paper', get top-notch experience if possible, then come back home to contribute. Yet, when they do come back with such training and expertise, it often seems that it is downplayed or ignored, particularly by white Bermudians and expatriate workers.

182 There is no doubt that nostalgia, competition and lack of clarity about training and competence fuel tensions around notions of professional superiority. In Bermuda this is exacerbated by an even more stark distinction – the misinformation and stereotypes pitting US against UK training and practice.

The following Note sets out some stereotypes held by practitioners in Bermuda of US versus UK medical training and practice.

Stereotypes of US Training versus	UK (and South African) Training
"The Privileges Review Committee did not really understand US education." [BB]	*"UK doctors think they are managing patients but they are primarily focused on managing health budgets." [BB]*
"Where do the doctors in Bermuda actually send their own patients and families for health care?" [BE]	*"The US is focused on profit, the UK is socialized." [BB]*
"US trained doctors practice defensive medicine. There is little tolerance for error. For example, if a patient complains of abdominal pain, doctors think of what sort of test they need to do, not what sort of complaint it is." [BE]	*"Doctors in the old Bermuda who trained in the UK trained there years ago. They are paternalistic and not current with the new standards." [WB]*
"The US uses evidence-based medicine and differential analysis. The UK uses presumptive diagnosis techniques." [WB]	*"Diagnosis is based on objective clinical conclusions." [WE]*
"Tests may look unnecessary to the UK but are very important to provide baseline information." [BE]	*"Any doctor who can practice without an MRI is ok in my book." [WB]*
"US doctors are more prudent." [BE]	*"In the UK we do less training as a General Practitioner than a Family Practitioner would do in the US." [WE]*
"In the US, they do unnecessary tests just to show they did it because of litigation." [WB]	*"British training is the best in terms of getting a well-rounded qualification. You become adept at taking history and physical examination. You do not reach for the lab as the first diagnosis." [WE]*

Stereotypes of US Training versus	UK (and South African) Training
"The more experienced you are, the less you would want as many tests and you will bypass tests that less experienced doctors would want." [WB]	*"I think of it as the UK practicing medicine as frugally as possible whereas in the US system it's preventive medicine." [BE]*
"The US is more radical – they operate for everything." [WE]	*"The majority of people here do not think about costs." [BE]*
"People who have problems tend to be US trained." [WB]	*"UK training is better than the US." [WE]*
"In the US, doctors become responsible at an earlier period and there is more consistency in training excellence." [BE]	*If you are comparing someone with British membership* (in a Royal Academy), *they are not necessarily trained to the level of the US Boards." [BE]*
"Nurses have more work to do with more testing. There is definitely an impact on their workload with a more meticulous approach. They may resent this." [BE]	*"The bias in the UK is that you don't waste resources on terminal patients." [WB]*
"US training is more aggressive in trying to save patients." [WB]	*"There's a little bit of bumping of heads between the older doctors who trained in the UK and had control of medicine in Bermuda." [WB]*
"Bermuda's standard of care is abysmal – like the UK in the 1960s. And the UK in 2006 is like Canada in the 1950s. Canada is a few years behind the US." [WE]	*"In the UK there is a 'watch and wait' approach – presumptive diagnosis." [BB]*
"In the US, you almost automatically get an angiogram if you have a heart attack." [WB]	*"In the UK, there is a risk stratification to see who should get an angiogram." [BE]*

"– In the UK, health care is the same for everyone. – In the US, you may have to go to another hospital if you are not insured. – In Canada, doctors require permission to order certain tests. – In Bermuda, no one is turned away because of no insurance." [BB]

183 Conventional wisdom is that medical practice in the UK is more conservative and sensitive to costs as a socialized health system. Despite considerable improvement, the NHS continues to be plagued with months-long waiting lists, delays and claims of patchy care – that is prompting growing numbers of patients to seek private care.

184 There is a controversy in the UK where a few NHS Trusts (those facing financial crunches) have decided not to approve certain surgeries for people who smoke, are obese or have other co-morbid, lifestyle generated conditions. In April 2007 the then Minister of Health was under fire by a skeptical media and even medical experts for her attempt to cast this as a clinical rather than financial decision.

"Bermuda typically follows US standards – supplies and equipment are as up to date as a good US hospital, except for some low volume specialties that cannot be supported in Bermuda." [BE]

185 The practice of medicine in the US is said to be strait-jacketed by excessive litigation that increases malpractice insurance costs. Huge payouts for Court judgments and settlements force doctors to practice defensive medicine. They often order costly tests just to prove that they did so – to confirm rather than enable diagnosis.

186 The fact is that the practices of medicine in the UK and the US are much closer than stereotypes would admit. The UK is becoming more litigious and dependent on evidence-based medicine. Likewise, the managed care system in the US is increasingly imposing fiscal discipline – to the consternation of practitioners who feel that the pendulum has swung in the opposite direction by limiting critical testing.

"The only difference is in diagnostic approach. The US uses high-powered techniques, the UK uses hand to head; listens to the patient, then orders appropriate tests." [WE]

187 Groopman (cited earlier) finds deficiencies in both the UK presumptive diagnostic approach and in the US reliance on tests, and evidence-based and differential analysis. He argues that both forms of analysis are stuck within a proverbial lock-box of statistics and probabilities with limited value when physicians are faced with symptoms that have not previously or easily been categorized.

"There are daily confrontations of the old versus the new." [WB]

188 The insistence of UK trained doctors in Bermuda to assert a superiority over US training is illustrated by the reaction (albeit 15 years ago) of the KEMH Working Party that responded to the 1992 Review of the Department of Anaesthesia.

189 Dr. Bevan had suggested an equivalency between the completion of residency training in the US and HRT training in the UK. This was soundly rejected by the Working Party which asserted in its Consensus Statement to the Board that: *"Dr. Bevan favoured the British trainee anaesthetists obtaining a standard very much higher than those trained in the US and Canada."*

The 2006 Good Practice Guide produced by the Royal College of Anaesthetists (and the Association of Anaesthetists of Great Britain and Ireland) states that physicians *"have a duty to see that public funds are used responsibly. If this is to be reconciled with the duty to bring benefit to individual patients, they must base their clinical practice on the best available evidence and run their departments efficiently."*

190 Remarkably, I could not find any such statement or other language in the 1992 Report or correspondence that would substantiate this portrayal by the Working Party of Dr. Bevan's views. This statement appears to have been an attempt to 'run interference' on this matter in order to protect practitioners of the time.

191 This issue of the equivalence of US and UK anaesthetic training remains a vexing one today. One anaesthetist who is accused of not being collegial insists that some of his UK trained colleagues are not qualified at the level of US Board certification.

"I would never refer my patients to a US trained doctor – I just wouldn't." [WB]

192 The then Chief of Anaesthesia confirmed in 2005 to the Privileges Review Committee that KEMH *"presently has* (expatriate) *anaesthetists who are not certified as* (UK) *consultant anaesthetists who do a fine job and are highly competent".*

"I was told when I first came here that whites would not refer patients to me. Eventually, they did." [BE]

193 This must be sorted out once and for all: what exactly is the equivalence of anaesthetic training; are anaesthetists in Bermuda allowed to practice with a lower level of training than other specialities; and, what should be the level of training required?

"White doctors will refer to white specialists." [BB]

194 There is also the lingering question – is this also about race? If the non-consultant anaesthetists were black and/or Bermudian, would their level of training still be deemed acceptable?

195 The 'cultural' divide that persists in Bermuda affects the credentialing process and referral patterns (from general physicians to specialists). Interviewees admitted that doctors in Bermuda are less inclined to engage in the day-to-day collegial consulting which is common and considered essential elsewhere in the world. Bermuda's medical culture cannot be optimal for patient care.

Recommendation VIII: KEMH should clarify qualification equivalencies between different jurisdictions and establish an adequate induction programme.

"UK doctors have more of an ego about sending patients overseas. They think they can handle the case without doing so." [BB]

196 The difference in UK and US practice not only influences stereotypes about each other's competence in the abstract but also may affect specific decisions about patient management. Several interviewees (black and white) alluded to the practice of US trained doctors being more aggressive about trying to save patients even when the prognosis is very poor. They believe that UK doctors are trained to consider whether it would be a futile use of resources to conduct more tests or procedures when the patient's condition appears terminal.

Example 8

A doctor discusses a 19-year-old patient with neurosurgeons at two US hospitals. Although the prognosis is quite poor, both recommended that the best possible care would be to air ambulance the patient – subject to certain test results. The patient's family understands the poor outlook, but wants the teenager to have "every possible chance." Given the patient's age, the doctor ordered the recommended CT scans.

The patient was in ICU. The anaesthetist, *"based on 20 years of background and training felt that the outcome was certain and the patient was not likely to survive."* He intervened and cancelled the CT scan. He also offered his opinion to the patient's doctor who nevertheless continued with her plan to airlift the patient. The anaesthetist informed the patient's family, without the prior consent of the patient's physician, that the case was terminal. A later review revealed that he also told a nurse, thus undermining the patient's doctor with both family and staff.

As the anaesthetist had no authority to overrule the patient's doctor, the original airlift was executed. However, he wrote a letter to the Chief of Staff disparaging the original plan of care and stating that the patient died abroad without family present. After mediation by the Chief of Medicine, he made a tepid apology in which he admitted to making unfounded and unnecessary allegations.

Just three months later, this time with authority in the role of Acting Chief of Staff, this same anaesthetist intervened and prevented a patient from being sent overseas for treatment (again after the patient's doctor had consulted two specialists abroad). Although aware of the earlier incident, the Chief of Staff did not question whether a training bias played a role in this action.

Were the substantive doctors black or white; US or UK trained?
Was the anaesthetist black or white; US or UK trained?

197 The anaesthetist is white and UK trained. The doctors who wanted the airlifts are black and US trained. It is these kinds of examples that make black doctors think that white Chiefs of Staff and Departments are complicit in the stereotypes and high-handedness that some doctors are perceived to exhibit toward others.

"The melting pot should enrich our medical system – people will begin to think about harnessing our differences to enrich the system of care." [WB]

198 Actually, this might **not** have been a case of high-handedness but rather a consequence of the failure of hospital administration to provide an adequate orientation programme. Both doctors had started to practice here relatively recently. It was the hospital's responsibility to recognize that, given the fact that people from different jurisdictions converge on Bermuda, a clear orientation programme is warranted.

199 In this case, the anaesthetist believed that, as the ICU doctor, the patient was primarily under his care and he was entitled to confer with the patient's family without the prior consent of the patient's specialist. This appears to be in accordance with s. 6(b) of the BHB Regulations: *"patients who are seriously or critically ill, or whose management is complex, should be transferred to the appropriate specialist so that the latter becomes the attending physician."* However at KEMH, the practice was that the internist is deemed to be the specialist, even when a patient is in ICU. Under s. 18(a) of the BHB Regulations an anaesthetist is primarily responsible for respiratory care. This practice was clarified, after much internal discussion, in January 2006. In any event, common courtesy suggests that the patient's own doctor be present or at least consulted about the most appropriate way of delivering such dire news to the family.

"There are 100 doctors in the hospital. They had a leadership seminar but only 26 doctors attended – BHB outnumbered the doctors." [BB]

200 The critical issue issue here is is that both sides rush to denigrate each other's motives and professionalism. The reciprocal disregard even extends to utterly unfounded innuendo – on all sides – about why certain doctors come to Bermuda. A very few whites wondered what might be lurking in their past that black American doctors would leave lucrative practices to come to Bermuda.

201 Equally, a few blacks questioned the influx of South African trained doctors. Two even broached the theory that these doctors wanted to escape the task of servicing black masses in the new South Africa.

"We tried to have a barbeque once. That was the last time anything was done." [BE]

202 Such suspicions are fully in the realm of perceptions rather than facts. The concern is that these suspicions exist at all. Our medical fraternity is clearly not fraternal. Doctors work in a world of 9 a.m. to 5 p.m. integration. They rarely know or socialize with each other. The hospital has done little to introduce new doctors, circulate information about their training and experience or foster a spirit of collegiality.

203 It is typical of a racially dysfunctional institution that people will try to come together as little as possible other than the few critical moments that they need to come together. Instead, hospital leaders should be rearranging the system so that medical practitioners actually interact more so they get to know each other and influence each other. Without lines of real communication, it is possible that when physicians do have to make decisions together, they either wind up with mediocre decisions that represent political compromise because of their inability to have difficult discussions or they make decisions that inflame one side or the other.

204 Often, whichever side wins that discussion will always have a technical argument for why they were right. The other side will often have an argument that is basically about politics and incompetence but underneath, it is usually a racialized attribution. Whites and blacks, US and UK trained, Bermudian and expatriate – all talk past each other and nobody on either side ever says to their group: *"You know, they're right. That was the best decision for the system."*

• Differential Hospital Response

Example 9

During exactly the same two week period of the incident and apology for **Example 8**, another doctor was required to make an apology for his non-collegiality. His apology was similar to the apology of **Example 10** in that he expressed regret that the offended doctor had concerns but then went on at length about why he was right:

"I completely agree with you that it is inappropriate to speak ill of a colleague during a patient interaction, and I have never done so. However I did feel it was appropriate that Mr. __ be aware of the management of his last anaesthetic...The Guidelines of the Association of Anaesthetists of Great Britain and Ireland, published in 2002 state…"

In addition, this doctor wrote an apology to the patient: *"I would like to offer my apology for any distress you suffered during my discussion with you at the pre-operative evaluation…"*

This apology was not accepted. The Medical Staff Committee ("MSC") held an Extraordinary Meeting to review the apology and decided that the doctor *"had not really apologized"*. The MSC then agreed to a course of action that would require the doctor *"to come in and explain himself to the MSC (and bring legal or Active Staff representation). If the MSC is dissatisfied with his responses, the matter will be presented before a disciplinary committee."*

Although an apology to the patient was warranted, the Chief of Staff was informed that the original practice that this doctor had criticized was, indeed, *"unethical, in principle"*.

Example 10

The physician leader in **Example 8** took four months to apologize (after several requests from the patient's doctor). Further, the apology was incomplete in that it did not acknowledge his breach of collegiality in intervening with the tests and plan of care ordered by the patient's doctor, or for speaking without prior consultation to the patient's family:

"I am very sorry that (sic) *hear that you are concerned about our discussions regarding this case. May I say from the outset that I considered our disagreement to be a professional one and I in no way wished to imply that I thought you acted in anything other than what you considered to be the best interest of the patient. I have the highest regard for you as an individual and as a physician and I am very sorry that you have been upset by this matter…with regards* (sic) *the issue of__, I was told by nursing staff that__. I did not, however, check this information for myself. In any event it was an unnecessary comment that should not have been included in a professional letter of this nature and for which I apologize without reservation."*

No further apology was required. This doctor was not required to apologize to the patient's family for remarks made at the bedside. Nor was this matter added to this doctor's file. No MSC meeting was convened for this doctor, nor was there a threat of disciplinary action.

"I was never so aware in my life that I was white until I came to Bermuda." [WE]

205 Both of these doctors are white. This is not a case where differential treatment fractured along racial lines. However, there have been many complaints that the doctor of **Example 9** is surly and always looking for faults in his colleagues. Certainly, he was a competitor who not only questioned the qualifications of his colleagues but also often challenged physician leaders.

206 He has a right to work in Bermuda. Yet, a non-Bermudian physician leader sent an email to the Chief of Staff that urged – with unabashed *noblesse oblige* about his decision rights: *"It is clear that there have been major difficulties in the department for many years. These problems will continue whilst __ continues to work at this Hospital. This is not a problem that is ever going to go away and it will continue to eat at the fabric of the Hospital. I would like to see an urgent meeting to be held between* (yourself, the CEO and the BHB attorney) *with the* ***express purpose of designing a strategy aimed at removing him*** *within a designated timeframe using whatever processes are required."* (emphasis added)

207 One black interviewee noted: *"it is not in the nature of a cabal to announce itself"*. The above email comes very close.

208 It is unlikely that this white non-Bermudian would have felt so emboldened if he did not believe that he was supported by the hospital administration and others with influence. Of course, had the hospital followed his prescription, that would have constituted maladministration on many grounds including biased and arbitrary actions and procedures.

"He (legacy physician leader) *was in her* (former Chief of Staff) *office constantly. It could not have been just for socializing." [BB]*

209 Almost all of the black interviewees and a few whites identified a particular physician leader as the "real" locus of administrative power and influence in the hospital. However, the evidence submitted was not concrete. There are a number of physicians – black and white – who access political and other support to advance their agendas.

210 Instead of facilitating healthy cross-fertilization of various medical traditions, the hospital has stagnated in a collision of medical cultures. There is a disparity in the way that incidents are treated. Each matter should be addressed on its own merits but some doctors do get the benefit of the doubt depending on their relationship to the core circles of influence.

Example 11 (all one doctor)

March 03

Anaesthetist out of room for 12 minutes leaving patient unmonitored. There is no policy in place for OR nurses to monitor patients re anaesthesia.

- **KEMH response:** will be discussed at next Anaesthesia Department meeting.

November 03

Doctor left one patient unmonitored on table in OR to commence anaesthesia in induction room. Could not get the epidural properly sited before having to return to other patient.

- **KEMH response:** will be discussed at the next Anaesthesia Department meeting. Meeting with Chief of Staff – new policies to be written and implemented. Guidelines re monitoring were not adhered to. Doctor agreed to follow guidelines.

December 03 *(2 weeks later)*

All anaesthetists aware that there was no monitoring equipment in Anaesthetic Room. Patient left unattended – went pale and complained of chest pain. *"The problem is arising because some anaesthetists are not following safety precautions and protocol of anaesthesizing only one patient at a time."*

- **KEMH response:** discussed at Anaesthesia

Canadian Guidelines to the Practice of Anaesthesia (quoted in 1992 Review)**:**
The only indispensable monitor is the presence, at all times, of an appropriately trained and experienced physician.

2006 Good Practice Guide, Royal College of Anaesthetists & AAGBI:
The anaesthetist will have a responsibility to be physically present with the patient, such as whilst administering a general anaesthetic. If in exceptional circumstances the anaesthetist has to leave the patient they must delegate responsibility to another appropriate person in line with General Medical Council guidance on delegation…Typically, the 'episode of care' during which anaesthetists owe a duty of care lasts from the initial pre-operative visit on the day of surgery through to the administration of anaesthesia and ends with the recovery of normal sensation and muscle power.

American Society of Anaesthesiologists, 2005 Standards for Basic Monitoring:
Because of the rapid changes in patient status during anaesthesia, qualified anaesth-

Department meeting. Doctor agreed to follow monitoring guidelines.

January 04 *(one month later)*
10:10 am: anaesthesia commenced on first patient. 10:20 am, doctor left patient unattended to place epidural in second patient.

- **KEMH response:** new policies to be written; verbal warning given.

esia personnel shall be continuously present to monitor the patient…In the event that an emergency requires the temporary absence of the person primarily responsible for the anaesthetic, the best judgment of the anaesthesiologist will be exercised in comparing the emergency with the anaesthetized patient's condition and in the selection of the person left responsible for the anaesthetic during the temporary absence.

If this doctor were black, would he have gotten the benefit of the doubt – once – much less four times?

"The culture in which doctors work is still often not conducive to the admission of deficiencies, which tend to be regarded as a sign of weakness, and ignored or covered up."
2006 Good Practice Guide, Royal College of Anaesthetists & AAGBI

211 This doctor was never disciplined. Interviewees tried to explain this away by noting that these incidents occurred at a time when (black) leadership was reluctant to discipline colleagues. That does not explain why a subsequent Chief of Staff did not even know about these incidents – and therefore did not have a history to compare with when later incident reports were again filed about this doctor.

Example 12

A general surgeon was trained in vascular surgery before this became a specialty. Section 10 of the BHB's General Board Rules (Medical Staff) provides that second opinions should be obtained in cases where there is doubt as to the best therapeutic measure or a surgical patient is not a good operative risk. Although the doctor spoke with two vascular surgeons overseas, he did not seek a second opinion from other general surgeons on the island. He claims he did not know they had any vascular experience. He was severely criticized for not seeking a second opinion. There were a number of other serious charges regarding the management of this patient leading to a drastic reduction in this doctor's privileges.

Example 13

The hospital was so concerned about repeated deaths likely due to punctures (of the pulmonary artery) during the insertion by an anaesthetist of central lines that a new programme, VAMP (Vascular Access Management Program), was implemented. Relevant doctors were retrained and the policy now requires that two doctors (either two anaesthetists or an anaesthetist and a surgeon) must be present in the OR to do this procedure (one to attend to the anaesthesia and the other to put in the catheters). The doctor alleged to have the original problems was never investigated. He left Bermuda but was allowed by the Privileges Review Committee to return as a 4-month locum in 2006. In that short period, another (white) doctor filed a complaint that required the Chief of Anaesthesia to remind this doctor of the standard for responsiveness.

Example 14

During gall bladder surgery, a staple became loose leading to leakage from the common bile duct as well as to collapsed lungs and malfunctioning kidneys. Surgeon misdiagnosed the site of the leak but did respond appropriately by sending patient by air ambulance abroad. Patient later heard him acknowledge that the staple must have fallen off, but his written explanation to the Office of Quality and Risk Management did not mention this. The hospital did not probe any further to learn how the staple became dislodged. There is no indication that the doctor's response was egregious. It is mentioned here simply to ask the question – if this were a black doctor, would there have been more scrutiny?

On the face of the clinical problems – which doctors are black; which are white?
Based on who got the benefit of the doubt – which doctors are black; which are white?

Groopman: *"No one can expect a physician to be infallible. Medicine is, at its core, an uncertain science. Every doctor makes mistakes in diagnosis and treatment. But the frequency of those mistakes and their severity can be reduced by understanding how doctors think and how they can think better…most physicians are not aware of their cognitive mistakes; in addition, the medical system affords only inconsistent feedback to physicians about diagnostic errors and why they occurred".*

"A white doctor who is not competent will have less of a problem." [BE]

212 All doctors have complications. All doctors are capable of misdiagnosing patient symptoms. Groopman cites studies that indicate that as many as 15% of all diagnoses are inaccurate. This is not due to ignorance of clinical facts, but rather to cognitive traps.

"If you are competent then you are accepted and it doesn't matter what colour you are. However, if there are questions about you, then you will have a tough time if you are a person of colour." [BE]

213 The issue is – how does the institution respond to complications and errors? Hospital administration said that the sanction of the doctor in **Example 12** above was due to the fact that he had a "history" of problems over the years. Although he claims that he was not notified of those problems or given the due process at the time to rebut concerns, his past was used against him.

214 The white doctors above do not appear to have a "history". Their complications and errors seem to have no traction – they are either explained away, addressed systemically or not even pursued. The hospital does not require that doctors report to it private settlements of legal and other patient complaints. Surely the hospital should have full information when considering the renewal of privileges.

"Whites perceive that the issue is really about competence." [WE]

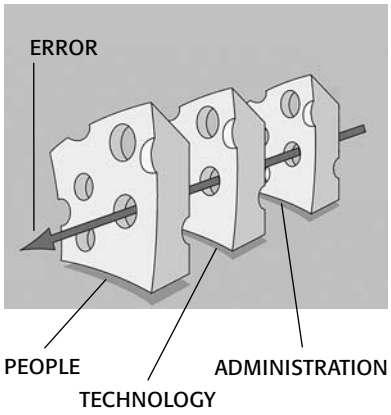
"My fear is that Bermuda will become a dumping ground for people who are not credentialed." [WB]

215 Black doctors believe that, in similar situations, they would not receive the benefit of the doubt – once, much less repeatedly. Colleagues form judgments about each other, which may be based on half truths and innuendo. This problem is particularly acute when the purveyor of the innuendo is a physician leader. The Quality Council and Medical Staff Committee have discussed complaints in this regard, but did not appear to follow them up.

216 Medical practitioners elsewhere say that unfair judgment amongst colleagues is a feature of professional egos and competition. In Bermuda, the problem is magnified because of our size and competition for market share.

Recommendation IX: KEMH must introduce an 'apples to apples' data collection and comparison which is benchmarked to medical literature and includes mandatory reporting by doctors to the Office of Quality and Risk Management and the Privileges Review Committee of all elements of their practice such as lawsuits, insurance settlements and billing anomalies.

4.b) Critical Incident Reports



217 Professor James Reason, arguably the world's leading thinker on managing institutional risk, notes that errors occur when three layers of an organization's defences align and falter: people, technology and administration. His "Swiss Cheese Model" of human error posits that an institution improves only by simultaneously tackling all three layers.

218 Many organizations respond to human error by focusing on the people layer only: *"blaming individuals is emotionally more satisfying than targeting institutions"*. However, there must be a focus also on the context and conditions within which people make errors. That requires "a reporting culture" and a system of rigorous analysis of mishaps, incidents and near misses by the institution.

"I think they need to be very fair in the way they document the incidents and it should be done by an objective group." [BB]

219 Reason continues that *"trust is the key element of a reporting culture and this, in turn, requires the existence of a **just** culture – one possessing a collective understanding of where the line should be drawn between blameless and blameworthy actions."* [6]

"Good training teaches you how to operate, when to operate – and, as important, when not to operate." [WB]

220 The problem at KEMH is that there is no trust. Many blacks would add – there is no justice.

"White doctors do not rush back (for emergencies) *to the hospital – and do not lose their privileges." [BB]*

221 Contrary to the conclusion of the CCHSA Survey (see p. 11), I find that KEMH does not have an effective reporting system for sentinel incidents involving physicians. The Major Clinical Incident Policy is not clear and not followed consistently. Further, the hospital has no mechanism to capture the incidents that are not now reported.

"Some surgeons book the theater without even seeing the patient." [WE]

222 As another example, there is no process for the hospital to learn about billing anomalies that may evidence unsafe practices: for example, anaesthetists billing for two patients during the same time period. A 2005 Yearly Review submitted by the Department of Anaesthesia found "*no evidence or valid complaints relating to 'double billing' or overcharging by anaesthetists.*" This may have been a classic case of the fox guarding the henhouse. The insurance industry continues to have concerns about double-billing.

[6] Reason, J., *Human Error: Models and Management*, British Medical Journal 2000; 320 18 March

"I don't know if it's a black/white issue, I don't know if it's a Bermudian/expat issue, I don't know if it's a male/female issue, but the rules are not applied uniformly." [WB]

223 According to the policy, Occurrence Reports should be made to the CEO, Chief of Staff ("COS") and the Office of Quality and Risk Management ("OQRM"). The relevant physician leader and OQRM must initiate an inquiry within 24 hours. Sometimes reports are made to physician leaders who may decide to address complaints directly and not forward them to the CEO, COS or OQRM. Forms are not always properly filled in either initially or for follow-up actions and notations.

224 As a consequence, the files held by the Chief of Staff may not be complete. Our perusal of KEMH physician files revealed incomplete, almost ad hoc data – making it difficult to analyze individual performance and patterns of physicians over time. Even the hospital's records of its own out of court settlements are not adequate.[7]

"If you are unsuccessful, what do you blame it on?" [BE]

225 If, for personal, ego or competitive reasons, medical practitioners target or identify a particular doctor as incompetent or a threat, they may ensure that s/he has a very full file "history" by reporting each incident, even if suspicions are unfounded (as was the case of the 19 year old patient in **Example 8**).

"That doctor looks out for himself and his white colleagues." [BB]

226 This is not a wild theory. There is documentary evidence of one physician leader who not only pre-judged the validity of a complaint but indeed expunged it from due process altogether: *"I am concerned that if the formal complaint procedure was followed this would give credence to allegations that are likely to turn out to be primarily malicious and largely false."*

"Expat nurses are not heard." [WE]

227 A further problem with the review of critical incidents is that when incidents involve both a doctor and a nurse, it may be reviewed by two separate silos (nursing administration and physician leaders) without adequate communication between the two.

"There are some examples where we self-assess and I wonder how we passed." [WB]

228 Moreover, several medical practitioners – doctors, nurses and others concurred: they do not get any feedback or see obvious consequences for the incidents or doctors that are reported. They feel discouraged and conclude that there is no point in filling out incident reports. The

[7] A list, submitted to me, of payments by the BHB/Underwriters for the period 1/4/00-10/4/07 did not include at least one settlement of $25,000 – minuted by the Patient Safety Committee in 2003.

"People who chose to fight end up being discredited." [BB]

"It is credible that people are saying they're targeted." [WB]

June 2003 Critical Care Morale Survey quotes staff: *"When we submit incident forms, they seem to 'disappear' and the issues don't get addressed".*

229 Even more disturbing, nurses have felt intimidated not to report incidents. One nurse recalled filling out an incident report that reached the hands of the physician leader rather than the Chief of Staff or OQRM. She claims that within two days the anaesthetist about whom she had filed the report accosted her: *"writing incident forms has a habit of coming back to haunt you."* He claims that he was referring to himself. However, most reasonable people would feel that this was a threat.

230 The value of effective critical incident reporting and analysis is severalfold. **1.** the practice of an individual doctor can be remediated. **2.** systemic improvements (to the administration and technology layers of defense) can be made in clinical practice as a whole. **3.** the institution's overall credibility is strengthened (both from within and without). As noted by Dr. Lucian Leape of the Harvard School of Public Health: *"if error analysis leads to systems correction, then internal reporting will skyrocket."* Patient care is affected by the fact that, beyond a basic continuing education requirement, KEMH has not yet instituted formal processes to share and foster learning from critical incidents.

Example 15

A pacemaker was hooked up to the wrong leads. Patient was told that his gasping for breath was due to "over exertion". Within the week, there was a second operation to correct placement of the leads. There was no critical (or sentinel) incident report (see definitions, p. 88).

If this doctor were black, would s/he have been reported and scrutinized?

Recommendation X: The hospital should augment its Major Clinical Incident Policy to ensure a clear, accessible and confidential procedure in a separate complaints department to identify, report, review and respond to sentinel events. There should also be a policy, based on best practices, for disclosing incidents to patients.

4.c) Disciplinary Process

Example 16 – 1996 [8]

A new surgeon came to work in Bermuda. His specialty was spinal surgery and he was able to offer both existing levels of surgery and types of surgery that patients used to have to go abroad for. He was criticized for a "sudden increase in spine surgery."

He was subject to lengthy external investigations. He was accused with not being familiar with the use of tools and equipment – despite the fact that he needed tools which were very different from the existing ones. The established surgeons would not have been familiar with his tools.

He was accused of having an increased infection rate, prolonged operations and excessive blood loss. He disproved the latter two charges with data compared to his colleagues and medical literature.

He was accused of high complication rates. He did have a higher number of complications and return surgeries (especially in the long term) than would have been acceptable for the type of operations that the established doctors did.

He has documented that for the types of operations that **he** did, the rate and date of returns and complications was well within the norms established by the medical literature.

Example 17 – 1999

Within a few years of a doctor entering the island, surgeons and fellow anaesthetists questioned his standard of care with respect to four cases. A lengthy and close scrutiny of his competence ensued. *"This process produced some polarization of opinion, lack of collegiality, and perhaps bitterness."*

Quote from the internal KEMH inquiry: *"In any busy hospital, a certain number of cases will have an unfavourable outcome. When things go wrong it is necessary to consider human factors such as lack of skill, neglect, mistakes, poor communication, etc. The practice of clinical audit to examine these cases, learn from them, and seek remedies for improvement is important and in place."*

The problem is that the default critique and review of that one anaesthetist has resulted in what appears to be an irreparable chasm. In turn, that anaesthetist has leveled serious accusations (some founded and some not) regarding the practice and qualifications of his colleagues.

This inquiry concluded that his standards were satisfactory. *"Over time it became apparent that different Schools* (UK vs. North America) *emphasized different techniques, and that several methods of practice may be acceptable and none were necessarily 'wrong.'"*

Were these doctors black or white?

[8] Curiously, the hospital could not locate this doctor's files anywhere. He kept meticulous copies of all original data.

"People aren't told what other doctors can do. Therefore, they assume things." [BB]

"It's always easy to target someone from another jurisdiction with different training because there are always new ideas and new tools which sometimes take additional time – nurses need to be trained up." [WB]

"They create an environment that allows the matter to grow rather than to be resolved." [BB]

231 The doctor of **Example 16** is black. The doctor of **Example 17** is white. In these cases, the KEMH response to embark on lengthy investigations of the doctors did **not** fracture along racial lines. These doctors are similar, however, in that they both presented competition to the established doctors in the same or related specialties.

232 Although the black doctor was offering different surgeries that hitherto had to be done abroad, he also drew patients away from existing practices. His techniques and instruments necessarily would be different from that of the established surgeons. He kept meticulous records and claims that, during two external reviews against him, he was able to disprove specific criticisms with hard data.

233 Just before the unsubstantiated inquiries were launched against him, the white doctor had resigned from Anaesthetic Associates after disagreements about his remuneration. He would become a direct competitor. The acrimony resulting from the inquiries has not abated.

234 There even seems to be an eerily familiar pattern of critique: first, the targeted doctor is accused of being slow. If that does not stick, then of doing unnecessary procedures…having no insight…being indifferent to complications…manipulated by political interests…

Example 18 – 2005

- Too slow
- Unnecessary operations
- No insight
- Pre-op ill at ease – fiddles with drapes
- Not at ease with tools
- Poor clinical judgment
- Nice fellow – but manipulated
- Did not respond quickly to info about complications
- Excess of postoperative mortalities *(never substantiated)*
- Singled out for external review

Example 19 – 1996

- Prolonged operating time
- Sudden increase in spine surgery
- Does not realize limitations
- No pre-op planning
- Not familiar with use of tools and equipment
- Poor judgment – elective & traumatic
- Weird – egged on by others
- Confrontational approach
- Indifferent to post-op complications
- Excessive blood loss *(disproved)*
- Increased infections *(not proved)*
- Singled out for external reviews

"The review (of the doctor in **Example 19**) *was based totally on hearsay." [WB]*

"People get along much better than the politicians would like to say." [WB]

"The way it runs – everyone scratches everyone else's back." [BB]

"The old guard feels entitled."[BB]

"50-60% of consents are not done properly. Some doctors' witness their own consents." [BB]

"An ethnic minority doctor in a major US hospital has less problems – people want his brain. The last thing they see is his colour." [BB]

"Some doctors are never on the rota for night call." [BB]

"This is a stressful environment." [WE]

235 In both of these cases, the targeted doctors were able to point to white doctors who they felt were slower, performed unnecessary procedures or equally had complications. The only reason that explains why the latter doctors seemed to get the benefit of the doubt is that they are white.

236 In any profession, there are code words that label a person as being at one end of the continuum of competence or the other. If someone is 'in my club', I will give them a little slack – they are not labelled as slow or otherwise incompetent. But if someone is 'not in my club' they can be demonized by the use of all of those code words, starting with: "Dr. X is really slow."

237 One interviewee noted that if one doctor's name keeps coming up in a negative light, then there must be some fire behind the smoke. Certainly, if all incidents and complications were reported for all doctors, then repeat reports for one doctor would be a red flag. However, in a system when reports are made meticulously for one doctor, but not for others, and when competition is a factor, then some scepticism is warranted.

238 This Report does not aim to determine whether a particular doctor is competent or not. However, it is important to identify how standards are set. Standards for judging medical practitioners should be objective and not set merely by the opinion and/or bias of individuals with influence *du jour*.

239 The rumour, innuendo and conjecture that parade as rational, fact-based decision making cannot be allowed to continue to run rampant, destroying relationships and reputations. Properly evidenced and analyzed problems must be addressed. But it is unfair and unreasonable to generalize a whole career from one incident.

240 For example, one physician leader commented that the doctor of **Example 18** was reviewed *"because of his history of higher than acceptable fatalities."* The statistical data simply did not substantiate this assertion – which the interviewee seems genuinely to believe.

"Racism at the hospital has been an issue since we've broken across the colour line and it is a bastion of racism because it is a place of control. It is a place of money you can be victimized; your license can be taken. It is easy to find a mistake on a doctor's chart and then begin to create an atmosphere of incompetence and that is what doctors have to protect." [BB]

241 Similarly, several white doctors heard and circulated the rumour that the black surgeon had "higher than normal" perforations during scope surgeries. Actually, he had the same number as two white doctors. The follow-up to an incident occurrence about one of the latter noted: *"a perforated bowel is a potential complication of a colonoscopy. No further follow-up is required as this is not considered a MCI* (major clinical incident)." The white doctors got the benefit of the doubt. The black doctor did not.

242 The problem is that the system seems to have tolerated a fair amount of incompetence (such as rushed or no pre-operative exams) and policy breaking (such as inadequate operative notes and doctors witnessing the consents of their own patients).

243 One of our expert advisors noted: *"And then suddenly, there's a point when the light goes red and you're black and we deal with it one way. And the light goes red and you're white and we deal with it another way. What moderates that is how you're connected in whatever set of political dynamics are at play at any point in time."*

244 The key recommendation which almost all interviewees recognized is needed – but few could figure out how to implement – is the introduction of systematic, ongoing, in-depth Morbidity and Mortality Rounds ("M&M"). In other jurisdictions, this is considered a basic and critical component for maintaining high standards. It is one of the most useful ways for physicians to improve.

"The key advantage of Root Cause Analysis over traditional clinical case reviews is that it follows a protocol for identifying specific contribution factors in various causal categories (e.g. personnel, training, equipment, scheduling) rather than attributing the incident to the first error one finds or to preconceived notions."
US Dept. of Veterans Affairs (National Center for Patient Safety).

245 M&M Rounds are structured discussions within each clinical department. Doctors take turns presenting current cases to colleagues. The presentation includes clinical details of interest or concern, how the doctor handled the patient, comparisons with current articles or research on the issue and, as a consequence, options for improving care in the future.

246 In the current climate of medical practice in Bermuda, doctors (black and white) fear being targeted and counter-targeted, given:

- prior leaks to the media
- the seeming eagerness of doctors to critique each other
- the intense competition chasing a low amount of business
- racialized attacks on each other's competence.

"Bermuda is not a teaching hospital, therefore certain problems are not discussed. You do not present your complicated cases out of fear that this might not stay in the room. If things got in the media it would be a catastrophe." [WE]

247 Doctors do not trust that M&M discussions will be kept confidential and fear that cases will be twisted and exaggerated in order to prove each other incompetent. Likewise, there has been some reticence in Bermuda about performance appraisals for the purpose of renewing privileges.

248 According to the Medical Protection Society ("MPS", UK based insurer/advocate formerly used by many physicians in Bermuda), there is evidence of a positive association between effective appraisal and better outcomes for patients. Appraisals are primarily an educational process that focus on the development of the practitioner. It is a process that facilitates self-reflection and should allow individuals to review their professional activities comprehensively and to identify areas of strength and areas needing development.

"This is not a teaching hospital, but it should be a learning hospital." [BB]

249 In the US, the evolving scholarship that promotes a culture that examines errors was spurred on by the insurance industry. In the UK, recent professional introspection has been prompted by the ground-breaking Bristol Infirmary and Shipman inquiries. In a recent annual report, the Chief Medical Officer for England noted that the reason why poor performance was not dealt with satisfactorily within the world of medicine was because of three main themes:

- the high tolerance of deviant behaviour amongst doctors
- the fact that whistle blowing could be seen as disloyal
- the ambiguity of where to draw the line between acceptable and unacceptable practice.

"It's daunting and intimidating for blacks where there are not many blacks. Many blacks feel intimidated by white members of staff." [BB]

250 I hope that this Report on discrimination in Bermuda will be the catalyst for the kinds of changes that will lift the layer of race out of the equation. KEMH is in desperate need of change in the institutional culture – in order to break the cycle of blame and attack and to ensure rational practices focused on patient care.

Recommendation XI: The hospital must phase in mandatory, methodical, and regular reviews of adverse events, including Morbidity and Mortality Rounds and analytical tools such as Root Cause Analysis and Evidence Based Practice.

Example 20

The monitor in the OR beeped…and beeped. A nurse rushed in and found the patient on the operating table. The anaesthetist was just sitting there at his trolley. Despite the incessant alarm, he was in a sedated state. The nurse could not rouse him. She had to run around and find another anaesthetist to come in to manage the patient.

Later tests showed that the doctor had taken two drugs that could be obtained only from the OR.

He admitted his problem; his privileges were withdrawn and he was suspended. There was some talk of reporting him to the Bermuda Medical Council ("BMC") for onward reporting to the US practitioners database.

The hospital reported him to the BMC but there was no onward reporting. The public does not know his name. He is said to be practising in the US.

Example 21

Five years earlier, this doctor was arrested in his home jurisdiction for minor possession of illegal substances. The law there allows for re-habilitation and five years of monitoring, after which the matter is expunged from the record.

This doctor's parsing of the application for admission to practice in Bermuda is that, as he had a clean record, he did not need to mention this incident on his application.

KEMH administration confronted him at a public meeting about rumours of drug use. There were no concerns about impairment.

He offered to be tested; there were mixed results (negative urine; positive hair follicle). The MSC accepted his offer to resign. However, a BHB Executive Meeting insisted on a hearing. As his privileges expired, the matter ended.

The matter appeared in the newspaper the next day. Everybody knows his name. He no longer practises medicine.

Which doctor is white? Which is black?

251 If by now, the reader can discern that the doctor of **Example 20** is white and the doctor of **Example 21** is black then it is no longer a guess. It is a pattern.

252 I have met the civil burden of proof.

253 It should be noted that the hospital's 2001 Drug, Alcohol & Substance Abuse Policy signed by the Joint Union / Management Committee (which includes physicians with privileges) sets out the principle that the BHB's commitment to a safe environment is jeopardized *"when any staff member illegally uses drugs, reports to work under the influence of alcohol or controlled substances, or possesses, distributes or sells drugs in the work place."*

254 Further, referral for testing *"must be based on documentation of all information, facts and circumstances which lead to substantiation of the observed impairment of work performance or behavioral change."*

255 Both doctors in the above examples tested positive for drugs, notwithstanding the mixed test results for the black doctor. The white doctor was severely impaired and put a patient directly at risk. Some interviewees believed his prior similar infractions were covered up.

256 There were no allegations that the black doctor had ever been impaired or put patients at risk. Yet, clearly he suffered the more serious consequence. His offer to undergo continual testing was not accepted by the BHB. Was this because he was black? Or was it because he did not go away quietly but protested his innocence? Black interviewees who raised this example are convinced that racism is at issue.

257 These examples feed into the current controversy about the reluctance of some doctors to agree to mandatory, periodic drug testing. It is shocking that the mistrust is so thick, that doctors – black and white – believe that others would falsify test results to target certain doctors.

Example 22 (same case as **Example 12**) is the controversial case that led to the Ombudsman's investigation. The Complainant, a black surgeon, performed the first operation on an elderly patient. There was a complication. The next day, a white surgeon operated on the patient. There was another complication. The patient died on the third day. To preserve patient confidentiality, my in-depth clinical and ethical review was included as a Non-Public Appendix for information to hospital administration.

"When someone's name keeps coming up then you have to ask questions – one can't get away from the fact that a history is built up." [WB]

258 In this case, there were two surgeons, two nurses, two anaesthetists and two Chiefs of Service all involved in the management of this patient. Yet, within a week, without any tested evidence, one surgeon was faced with the ultimate sanction – severe reduction of his privileges.

"He is slow and gets in the way – this leads to cancellations of other doctors. But he has good outcomes." [BB]

259 This was not in compliance with the disciplinary procedure set out in Appendix 7 of the BHB Regulations. The procedure requires that: If neither the Departmental Chief nor the Chief of Staff are able to resolve a complaint, then the Chief of Staff refers the matter to the Medical Staff Committee ("MSC"). Only after an inquiry and hearing of the parties may the MSC make a recommendation for disciplinary action.

"I don't think he's incompetent – he's just slow and relies on technology." [BB]

260 In this case, the Chief of Staff believed that general patient safety was at such great risk that the reduction of privileges of the one surgeon was warranted. However, there was not, at that stage, adequate evidence that it was the one doctor rather than any of the other seven medical practitioners who put that particular patient at risk.

"He's not one to communicate and he doesn't like to be challenged". [WE]

261 Although both the External Review and the MSC noted concerns about other medical practitioners, this was as an aside. None of the anaesthetists or nurses underwent a similarly in-depth review of their management of this patient.

"He's ok with lumps and bumps and slicing and dicing – but in a life-threatening situation, he does not have the pace to deal with it." [WE]

262 On the face of it this situation warrants inquiry as there appears to be the possibility of maladministration in the form of arbitrary, prejudicial actions and procedures. This case was the lightning rod, indeed the battlefield, around which the racially divisive alliances amongst physicians coalesced and jousted. Almost everyone had an opinion.

263 Due process demands that KEMH also take into account data that does not conform to pre-judgments. Little consideration was given to this doctor's meticulous notes, good history of responsiveness whenever called to the hospital by nursing staff, consistent rounds after each surgery, and excellent relationships with patients and their families.

"He's fine with people he thinks are respectful, but clams up with people who he feels are targeting him." [BB]

"The Chief of Staff was process and quality driven but she aligned with a circle of influence." [BB]

"His method is the differential method of diagnosis rather then the UK presumptive diagnosing. His documentation is meticulous – so why would it have failed this one time – if he really knew?" [BE]

"I don't think that case is about race and I think that things weren't done more quickly because people were afraid to do it earlier because they thought that they would be accused of racism." [WB]

264 Critical evidence of people with potential conflicts of interest was not corroborated or reality-checked. A Chief of a Department:

- within two months of being in Bermuda, wrote a letter to the Chief of Staff about the time this surgeon takes to complete certain operations. Without being asked to do so, he *"took the liberty"* of reviewing the previous seven months of that doctor's operations. He concluded that the anaesthetists would no longer service one type of operation performed by this surgeon until more literature on the range of time was available
- by the next month, he had formed a view that this surgeon is incompetent
- was the Acting Chief of Staff who intervened in the doctor's plan of care for the complication after the first operation and requested another surgeon to conduct the second operation
- decided that the black surgeon's plan to send the patient abroad was a *"crazy decision"*. This was just three months after he had protested against another doctor's decision to send a patient abroad – and had to apologize for making unfounded allegations (**Example 10**)
- called the Coroner to demand an autopsy
- typed the witness statement of the nurse who said she had notified the surgeon of problems after the first operation
- advised in the decision to severely reduce the surgeon's privileges within one week of the first operation.

265 Hospital administration did not see conflicts of interest where the same person plays multiple roles. However, blacks were fully suspicious. It would have been advisable and far more credible had the Acting Chief removed himself from any involvement, after inserting the surgeon for the second operation. Certainly, as a matter of integrity and leadership, he should not have participated in any evidence gathering or decision-making.

266 By and large, black interviewees felt that the black surgeon was targeted and held to a standard of care that other doctors are not. At least four white doctors concurred during the interviews.

"Sounds like a failure of justice – there were no grounds for the hospital to have reacted this way." [EA]

267 Whenever I presented scenarios that might tend to exonerate the black surgeon, most of the white doctors quickly searched for ways to turn those explanations against him. He never received the benefit of the doubt and was castigated for doing what he was supposed to do.

"Maybe the BMC should take on disciplinary matters to keep the hospital honest." [BB]

268 For example, the surgeon reported the death to the Coroner as required by Appendix 5 of the BHB Regulations. He was appropriately questioned by the Coroner's Assistant. However, without checking the facts, hospital administration (and External Reviewers) determined that he had not done so and had, in fact, attempted to thwart an autopsy.

"We made it clear to the reviewers that they could review anyone." [WE]

269 I find maladministration in that the disciplinary process is inadequate and poorly implemented. There was a rush to judgment and poor investigation. This was based on perceptions and pre-judgments rather than on clinical analysis. This prejudiced the rest of the disciplinary process. The information given by hospital administration to the External Review Panel and the Medical Staff Committee was skewed against the surgeon and certain evidence was not properly tested. The Non-Public Appendix, based on all evidence and clinical reviews by leading specialists experienced in disciplining other doctors, shows that KEMH had valid evidence for only one of seven statements against the black doctor.

"There is no such thing as an error free hospital. What's important is the response. The community should expect that errors will be addressed." [BB]

270 The UK Medical Protection Society sets out a better process: *"If a hospital learns of allegations of poor performance, it should conduct a fair investigation into these allegations to determine which of the three elements (health, lack of clinical skills, or poor professional behaviour) predominately is responsible for any poor performance found. The outcome should be rehabilitative for the doctor and not punitive whenever possible. Occasionally, however, any poor performance may be because of unacceptable professional behaviour by the individual clinician. The latter may ultimately lead to a disciplinary inquiry."*

"In medicine there are always complications. If there's no fair system of reviewing them, then black doctors could be unfairly targeted." [BB]

Recommendation XII: The hospital must revamp entirely its disciplinary process, including training in tribunal process. Consideration should be given to appointing lay arbitrators to any disciplinary review panel.

The way an investigation is launched and framed can colour and entrench conclusions:

Example 23

BHB direction of External Review Panel and Medical Staff Committee

- Told from very first contact that there were concerns about the competency of this particular doctor
- Remit was to review his management of a particular patient
- Told they could look at other medical involvement but panel did not as this was not their specialty
- Commented as an aside that other doctors could be reviewed
- Hospital did not commission an external review of other doctors with respect to their management of this patient (although a general practice review was later commissioned)

Ombudsman's 'blind' direction of three expert clinical evaluators

- In the first instance, not directed to any particular doctor or concerns
- Presented with a number of cases and requested to comment on any issues of concern in the management of patient and / or in the hospital's response to the incident
- None of the experts singled out this case as one for concern. One asked why it was included in the list
- Context and history of charges and conclusions of prior reviews explained. Experts requested to review case again
- Again, they found no problem warranting a reduction of privileges (even taking into account historical cases reviewed by External Panel)
- Individually and independently concluded that the withdrawal of privileges was excessive

"There's need for more communication. I don't know why they see each other competitively instead of working together. Because in every jurisdiction you're going to have people who are highly skilled in one area and not another." [BB]

271 The process in **Example 22** entailed: an initial failure of due process, conflicts of interest of decision-makers, pre-judgments, gaps in the investigation, and failure to equally review all clinicians in depth. The directions to the External Review Panel and the MSC were skewed almost to the point of inherent bias.

272 I cannot say whether this doctor is competent or not. I do know that the process was fatally flawed. It is apparent that with this one incident, the system was mobilized in an aggressive way to create a racialized narrative about his incompetence.

"Doctors don't like to be questioned about anything: they feel that you are doubting their competence so you have to keep everything to yourself." [WE]

"You can't reprimand somebody if you don't find them guilty. If you don't have proof of what the pathological event was, then it's just conjecture." [WB] (speaking of allegations against a white doctor)

"There is a lot of sniping and sabotage. Doctors talk about each other in front of patients." [BB]

"Doctors don't want to discipline other doctors because they have to work with each other – there is poor leadership." [BB]

"It is not a place where you can learn, it's not a place where you can be nurtured. It is almost as if you have to prepare for war all around the world before coming to your country to work and so, it undermines your confidence, it destroys your sense of optimism, it certainly kills any spirit of wholeness for patients because the doctor then becomes very defensive." [BB]

273 Currently, the conversation seems to go like this:

- there is a problem – this doctor did something wrong
- s/he's incompetent / slow / ill at ease / difficult
- anaesthetists don't want to work with her / him
- how can we get rid of her / him?

274 The conversation needs to be more like this:

- there may be a problem with patient management
- is this a known complication or error
- is this sub-standard performance or negligence
- let's get all the facts from all relevant sources
- is the doctor's explanation plausible
- are there any hidden agendas amongst his detractors
- could race / competition / ego be at issue – real or perceived
- what does the medical literature say
- how is this handled elsewhere
- how could this have been avoided
- how could the situation be improved
- what is the likely impact of our response – for individuals, the hospital, the patients.

275 It is a much longer conversation. Ultimately, it is the only kind of conversation that will engender trust, credibility and a level playing ground.

276 The hospital needs a:

- fair, consistent and accurate system for reporting incidents
- protocol by which all incidents are investigated in the same way
- data collection capacity to compare apples with apples that can analyze individual performance over time
- culture that seeks to learn rather than blame
- resource base to anticipate complications for co-morbid patients
- practice of measuring complication types and rates with reference to current medical literature
- clear understanding of what is sub-standard for specific patient characteristics and procedures.

277 Then, judgments can be made – fairly, without conjecture.

278 In the famous quote: *"It is not merely of some importance but is of fundamental importance that justice should not only be done, but should manifestly and undoubtedly be seen to be done."* [9]

[9] Lord Chief Justice Hewart, *R. v. Sussex Justices*, 1924

4.d) Administrative Competence

"The hospital desperately needs strong leadership and accountability." [WB]

279 Given clear maladministration in the hospital's complicity in inefficient and negligent implementation of policies as well as the failure to correct biased decisions and procedures, the BHB must be accountable for creating a new, more fair institutional climate.

"They find it difficult to deal with non-Bermudians who do a good job because these non-Bermudians come in and make them look bad." [WE]

280 Accordingly, hospital administration cannot meet mere clinical and managerial qualifications. They must also be leaders. In Bermuda, that means having: the insight and sophistication to navigate racial and other dynamics; the acumen and skills to facilitate equity; and a commitment to due process and fair play.

"People have a very blurred line of being a superior versus a subordinate and they have a very difficult time disciplining people that they're friends with." [BB]

281 Physician leaders and other administrators recruited to Bermuda who are not alert to race relations challenges in their home environments simply do not have the full range of competencies necessary to assume the responsibility of leadership in our hospital. You cannot lead people when you do not understand their issues.

282 At least three physician leader interviewees asserted that there were no racial problems in the hospitals they had worked in elsewhere in the world. These comments seemed disturbingly naïve at best or willfully blind at worst.

"There's a lot of back-stabbing instead of approaching the person." [WE]

283 In the UK, for example, a 2004 report exposed an "abscess" of institutional racism in the NHS. Further, a Handbook of the Association of Anaesthetists of Great Britain and Ireland notes a 2001 survey that stated the 37% of doctors who felt bullied were more likely to be black and Asian.

"The fact that whites are chiefs of service has nothing to do with race – that's just the amount of time that they have been here – and their interest. Most of the younger doctors want to build their practices rather than siphon time off to do administrative work – and who would want it?" [WB]

284 Similarly, the Ontario Human Rights Commission has conducted two important investigations into allegations of discrimination within the medical community, including one about the discounting of UK nurse training and consequent disparate impact on senior Caribbean nurses.

285 In Bermuda, the 2004 and 2005 CURE reviews of the workforce noted: *"lack of a representative workforce is a social problem, stemming in*

part from institutionalized racism. These challenges may in part, explain the inequities that continue to be so highly pervasive in the upper employment levels…representation and the racial demographics of the workforce are partial indicators of equality". [10]

"Less than 30% of the (800) *nurses are Bermudian but they have more of the management positions." [BB]*

286 Institutionally, KEMH cannot continue to act as the proverbial ostrich with its head stuck in the sand. Hospital administration has a responsibility to analyze and address imbalance. The CURE report notes that *"equality of opportunity"* entails policies, creative recruitment, development and retention and implementing tracking and mentoring systems.

"You need to be recruiting the best person for the job. Not giving the job necessarily to a Bermudian person. I completely understand why the immigration rules are as they are – and I think for working in ships and restaurants and gas stations, I completely 100% support that. But I think in something critical like health care, you should get the best person that you can to fill those jobs. And I have not yet met anyone from middle or upper management who would have that job in the UK." [WE]

287 For example, with respect to the fact that of the 12 Chiefs of Departments at the hospital, nine are white, one is Asian and only two are black: white interviewees tended to shrug their shoulders noting this is just a matter of history. Black interviewees tended to think that accepting legacy is to acquiesce with it.

288 A more proactive stance is warranted. Leadership at the hospital must be more attuned to issues that may hamper their ability to lead. Often these are intangibles that are not located in the bye-laws or policy shelves. Issues such as race (whether real or perceived), in a country as divided as Bermuda, will necessarily have implications for the management of an institution as important and large as the hospital.

289 If the people at the top are essentially not a group that reflects the real population that one must lead, then it is not useful to focus exclusively on them. Competent leaders must figure out how to break the hierarchy. For example, if a policy group is put into place, that group cannot be just the Chiefs of Departments because they are not diverse enough to reflect the system.

290 The Board and hospital administration must realize that it has to be explicit in addressing the issue of discrimination. They must be able to understand this issue and integrate it into how they think about making decisions and selecting leaders. Diversity training is necessary but not sufficient.

[10] CURE, *Annual Review of the Workforce Survey Report 2004 & 2005*, pp. 69-70, 186

"Diversity training just to train is not enough. You have to have accountability at the top…(this) *requires a substantial commitment of time, staff and money…In practice, a multipronged approach leads to results. General Electric initiated an aggressive diversity strategy that included employee networks, regular planning forums, formal mentoring and targeted recruitment. Perhaps most significantly, GE appointed a Chief Diversity Officer."*

Dobbin et al, *Best Practices or Best Guesses? Assessing the Efficacy of Corporate Affirmative Action and Diversity Policies*, Amer. Sociological Rev., 2006 (Aug.), Vol. 71: 589.

291 Even when the quality of diversity training is good, what many institutions fail to do is to differentiate what the leaders, in particular, need to know. There is a generic level of knowledge about diversity that everybody needs. In addition, there are also structures and perspectives that hospital administration must have in order to operate better as managers of a diverse system.

292 The key to change at the hospital is in whether or not leadership is credible and capable of mediating the various fissures in the medical community. Leadership must understand the role and limits of policies as well as the extent to which perception is reality for people in the system.

293 Simply being good at governance is not enough. Unfortunately, leaders often tend to focus only on the technical side of governance and not deal with all the emotions and politics underneath. It is apparently a classic pattern – by ignoring nuance and institutional culture, leaders wind up in a position of having to defend themselves as being biased.

294 Any new leadership in the hospital – whether Bermudian or expatriate – must quickly begin to build a very diverse network of personal relationships with people on multiple sides of the racial and other divides and enlist them in trying to make the system technically better governed and more rational. A leader who is viewed as being in one camp or the other will be neither credible nor effective.

295 In a context where: there are two professional organizations grouped along racial lines; charges of discrimination that have raged for years; and race is a pivotal part of the daily lexicon of life in Bermuda; it would be negligent of the hospital to remain passive on the issue. Institutional change requires a strategy founded on best current practices of institutional diversity management.

Recommendation XIII: The hospital should require recruitment criteria for leadership positions to include training in conflict management, diversity and administrative due process. Physician leaders should have clear job descriptions, which include a credible commitment to equality. Each Department should submit annual reports.

5. EPILOGUE

5.a) Conclusion

"First, do the patient no harm."
Florence Nightingale

296 At the outset, I emphasized that I had no preconceived notions as to whether or not there is discrimination at KEMH. The investigation revealed a clear basis for perceptions of discrimination.

"The issues are really about money, plus control, plus race." [BB]

297 Because of the persistence of this charge throughout the decades, it would have been irresponsible of me to reach a facile conclusion. The devil was always in the details. The challenge was to pick at and peel away all of the various agendas and cognitive dissonance presented.

"This whole issue of race and money and power and turf deflects all of us from patient care which should be the priority." [WE]

298 I determined to investigate whether there was evidence of discrimination and if so what is the impact on patient care. It was difficult to draw a direct line of causation from the tensions described in this Report to negative impacts on patient care. Clearly, however, the rumours, whisperings and other ways that doctors have undermined each other – especially in the presence of nurses, other staff and even the public – does not engender confidence.

"The Report needs to come out and say: racism in this society has not escaped the hospital. And it shows up in economics, referral patterns, disciplining actions, hiring practices and delivery of equal care." [BB]

299 Based on all I had seen and heard so far, I was prepared to conclude that tensions at KEMH are not always and only about race. I was inclined to believe that issues are really motivated more by competition and control although they too often play out in or are clouded by racial themes.

"You have a big job trying to winnow out what is racism and what is not." [WB]

300 For example, whenever it appears that blacks will gain some advantage (through entrepreneurship, political influence, superior skills or otherwise), whites seem to be quick to draw out their swords – questions and innuendo. On the other hand, whenever they are challenged, blacks have a knee-jerk, defensive belief that race must be involved.

"Get to the root of it through a Bermudian perspective." [BB]

301 Yet, over and over, it appeared that the primary factor driving behaviour is competition for market share of patients. Established doctors seemed to go for the weakest link – if they can spot anyone who is not up to snuff and is actually coining some of the business, then they will try and limit the competition by discrediting that individual.

"There have been reports before but we don't have access to them. I think if we got feedback and there would be discussion of issues – that alone would solve many of these problems. That would be success." [BE]

302 This is a classic case of economic protectionism. In a legacy system, the tendency is for legacy doctors to protect their position and market share from the new doctors. Competition ignites potential prejudice in the system and results in disparate treatment of doctors. I was tempted to title this Report: *"The Colour of Money"*.

303 During the interviews, I learned that the Privileges Review (then Credentialing) Committee had taken an extraordinary step in the case of two black doctors. Contrary to its normal acceptance of the documentation from the Bermuda Medical Council, the hospital's Privileges Review Committee actually telephoned the California State Board to verify the credentials of the two black doctors. The explanation was that one of them had requested a wide range of privileges (for which he was qualified).

"Race is overplayed. It's not quite the issue always." [BE]

"In the 1980s a couple of white Bermudians were also failed – there was all kinds of nasty stuff – resentment for fear of people coming to take market share and potential clients." [WB]

304 The Privileges Review Committee did not do this for any of the white doctors to whom it routinely grants privileges. Indeed, in one case, it had to rescind privileges to a white doctor who had actually not submitted adequate documentation. The white doctor received the benefit of the doubt. The black doctors received extra scrutiny. It is very hard to convince black interviewees that there is any credible explanation other than race.

"I have never worked in a place where people argued so much and were so hostile to each other." [WE]

305 When we look at comparative cases, there is clear evidence of disparity in the way in which the system responds to either perceived or actual transgressions by doctors. The disparity is fueled by other forces that have to do with governance and competition. However, the pattern became too predictable. Whether intended as racial slights or not, black physicians did not seem to enjoy the benefit of the doubt.

306 On the balance of probabilities, it became clear that the default position of hospital administration seems to privilege the views, versions of events and interests of white doctors. Moreover, the administration appeared to tolerate a troubling level of "non-collegiality" against black doctors by white physicians and nurses. However, "non-collegiality" by black physicians was immediately addressed. Note that "non-collegiality" is defined by Appendix 8 of the BHB Regulations as *"the failure to*

"The only reason why we're having this discussion is because it's money, and who's going to control the money, the slave master or the slaves. Because, if the slaves have money, then they can speak out and have revolts. That's the psychological war that's going on... They just say that people who express what I'm expressing are incredibly defensive, very angry, paranoid; therefore they're unconscious of the fact that we have a battle over money." [BB]

work well with others, and where uncooperative, uncivil, abusive and disruptive conduct is judged to adversely affect patient care."

307 The examples described in this Report were repeatedly raised by interviewees as instances poisoned by race. I cannot say to what extent these examples characterize an epidemic; but it is clear that these incidents are representative of some of the pathology that exists amongst medical practitioners at the hospital.

308 Racism has been described as a "disease". Many blacks in the medical community believe that it is a chronic, almost terminal disease. They believe that the more things change, the more things remain the same. In part, this cynicism is due to the fact that the issue has languished for so very long.

309 In 1954, for the first time in its history, the Parliament of Bermuda commissioned an ad-hoc Inter-Racial Select Committee to consider *"the vital matter of race relations"*. In addition to general problems of segregation, immigration and political representation, the Committee looked at occupational opportunities for black people. In this regard, the Committee focused on the administration of KEMH.

"I find it very alarming that Black doctors in Bermuda do not meet together and the common discussion is that there is always the threat that White doctors will perceive you as racist." [BB]

310 The Committee considered the procedure under which doctors are admitted to the staff at the hospital, the differential treatment of black patients and the exclusion of black student and graduate nurses from the hospital. Interestingly, *"although the Committee realize that under their terms of reference their attention should be restricted to the racial aspects of this matter, it became apparent to the Committee, after cursory examination, that rather wider treatment was essential if the problem was to be considered intelligently."*

311 With respect to the admission of doctors to the staff of the hospital, both the concerns expressed by black doctors today as well as the response of hospital administration echo those of 53 years ago: *"The Committee fully concurred in the views of the hospital Trustees that there should be no relaxation of existing standards. It is*

imperative, however, that present standards, or those which might be adopted in the future, should not be utilized so as to discriminate against medical practitioners on the basis of race. Some members of the Committee believe that such discrimination has existed in the past although this is strenuously denied by the Trustees. The Committee feel that it is unnecessary and inadvisable to dwell on past procedures in any event, and are content to recommend, that whatever may or may not have happened in the past, discrimination on grounds of race should not be permitted."

312 It is ironic that, some 53 years later, the same issues persist.

"This is not an account of bad people. Nor is it an account of people who did not care, nor of people who willfully harmed patients. It is an account of people who cared greatly about human suffering and were dedicated and well motivated. Sadly, some lacked insight and their behaviour was flawed. Many failed to communicate with each other, and to work together effectively for the interest of their patients. There was a lack of leadership, and of teamwork. It is an account of a time when there was no agreed means of assessing the quality of care. There were no standards for evaluating performance. It is an account of a hospital where there was a 'club culture'; an imbalance of power with too much control in the hands of a few individuals. And it is an account of a system of hospital care which was poorly organized. It was beset with uncertainty as to how to get things done."

"People who come in from abroad at first they're friendly and open, then they learn the lay of the land, then they change." [BB]

313 This could be an accurate description of KEMH.

314 Actually, this note is in the synopsis of the Bristol Royal Infirmary Inquiry that set new standards for hospital reviews in the UK and elsewhere.

315 I am told that competition, ego and stereotypes are rife within medical communities throughout the world, from Hong Kong to the British Virgin Islands and throughout continents in between. I asked our expert advisors and others – what works well in other jurisdictions?

The following Note summarizes some of their observations:

What Works Well?

"While structures, processes, clear job descriptions and operational policies can all help, in the end it is down to the leadership who must combine to motivate and lead the staff. The avoidance of 'blame cultures' and the adoption of clear standards and transparent processes can all help. Making people happy in their work and proud of the institution should be the aim."

"If the hospital has a management culture, endorsed by staff, that focuses on excellence of care and service to the community, then openness and accountability follow quite naturally. Many hospitals, though, have a pathological corporate culture, in which the first priority is the interest of the staff, with the public interest a distant second. It is exemplified when processes – put into place to protect the public interest – are used to forward private gain. Some physicians will naturally try to do this – the test is whether the hospital tolerates, or reviles the attempt. This pathological culture is tragically common. Corporate culture does not happen by accident – it requires proactive, visionary leadership. Pathological corporate culture thrives in a passive management style. Hospital corporate culture starts at the top, not at the staff level. The culture is self-perpetuating, and will firmly resist reform efforts from within, by punishing middle managers and staff that question it. It is interesting that, in the pathological corporate culture, workers are primarily motivated by fear – in a healthy one, their motivation is the common good."

"What makes our place work well involves several factors. First, we all work for the same employer. Second we have great transparency regarding the finances of the Department and we pay people well. They have a guaranteed income with an incentive piece that allows them to make more money based on meeting agreed upon objectives. All of this is very transparent. We also are very busy and most of the surgeons enjoy a high volume of the cases that they like to do."

"Very robust incident reports do a world of difference. In smaller jurisdictions, there is a strong blame culture. The doctors are afraid to say, 'We have doctors behaving poorly'. The approach should not be punitive."

"The most effective way for institutions to tackle problems of diversity is by creating structures that embed accountability, authority and expertise" (affirmative action plans, diversity committees, task forces, and diversity managers).

5.b) The Hospital as a Metaphor for Bermuda

"These problems do not stop at the hospital." [BB]

316 One value of the institution of the Ombudsman is to shine light in the crevices and illuminate possibilities for resolution. The prominence of race as a major divisive force in the hospital parallels race as a focus of daily life throughout Bermuda. Race is both a measure and an illustration of Bermuda's failure to come to terms with itself.

"It's a microcosm of the inherent conflict that's happening in Bermuda." [BB]

317 Bermuda is unusual in that approximately 60% of its population is black and 40% is white. However, 250 years of slavery and effective dominance by a white mercantile oligarchy for much of the 20th century has meant that blacks tend to experience themselves as a minority. Many of the inevitable themes of stereotype and stereotype threat, low expectations and racial supremacy that prevail in the United States are also characteristic of racial relations in Bermuda.

"Tension amongst doctors was thought to be a KEMH issue but really it's a doctor issue and because they meet/ interact at KEMH it seems to be a KEMH issue." [WB]

318 Our population dynamics are changing, especially amongst the youth. For the past four decades Bermuda's teenagers have formed deep friendships in "integrated" schools. There is also a growing (underserved) population of mixed race families whose children learn to accept all of who they are. Further, Bermuda is embracing peoples from far-flung regions and cultures of the world. If we cannot resolve the legacies and tentacles of our own history, we cannot move forward.

"White doctors slink away; black doctors bleat." [WB]

319 The hospital is truly a microcosm of the entire island. The marked differences in the society at large with respect to the experiences and perceptions of most (but not all) blacks and of most (but not all) whites is mirrored in the hospital. The hospital is not 'another world'.

"One thing is for people to get a resolution between what is subtle discrimination or subtle racism or whether you're just looking at favouritism and in some instances, people just don't like one another anyway. You can have five children and you have your favourite – you'll never admit it to your children." [BB]

320 The issues raised in this report, inclusive of the various examples presented, are embedded in the racialized context of the medical system. In turn, the medical system is embedded in the racialized context of Bermuda.

321 A couple of interviewees during the investigation queried why the hospital should be expected to tackle this seemingly intractable and

"I don't want to be distracted by a whole lot of things going on." [WB]

"Patients lose out because people don't get along and there is no focus on medicine." [BE]

"Race is constantly just beneath the surface." [WE]

"Because hospital structures come out of a racist past, if you are doing what was always done, then you are perpetuating the racism." [BB]

"I'm not saying that Bermuda is Iraq but there's some consistencies between what's happening there and it ends up being painful for everybody because the black community is saying – we have certain numbers, how come we don't have certain entitlements?" [BB]

"I want to know what is the meaning of 'going through it' – retribution? Turning the tables? What am I to do as a white person? I want to be on the other side – I don't want to go through it." [WB]

enduring issue when Bermuda as a whole has not done so. The answer lies in the pivotal role that the hospital plays in this island.

322 In order to ensure optimal care for patients, the institutional climate at the hospital must change. Medical practitioners must become more collegial so that they can capitalize on and exemplify an institutional focus on learning. This will require a genuine engagement in the arena of discrimination, particularly discrimination based on race and national origin.

323 Today, in 2007, the hospital has a unique opportunity to be a leader of institutional and cultural change in Bermuda. Of the multi-pronged ongoing strategies that must be employed to address discrimination, this one aspect – development of institutional mechanisms – has the potential to influence change throughout the island.

324 The medical community must make the effort to understand the patterns – whether intentional or not – that produce inequality. For example: seniority systems where there have been historical exclusions and imbalance often produce current inequality where blacks end up at the bottom of authority hierarchies.

325 The logic for overturning an antiquated structure is that there is no evidence that the legacy system is justified for patient care. Further, if the old systems perpetuate inequality and constrict the best use of new entrants into the field, then there is no logic and in fact, this may be detrimental to the best possible patient care.

326 Noted US author Beverly Tatum says *"you cannot live in smog and not breathe some of it in"*. It is naïve and unrealistic at best – willfully blind at worst – to think that the hospital is immune to the persistently vexing issue of racial division.

327 Blacks are often skeptical and pessimistic. However, during the course of this investigation, I found real glimmers of hope and insight amongst some whites. Several acknowledged disparities in the past and present. Several asked how to move forward. A few even wanted to tackle some basic questions during the interviews – such as understanding the

"People who see educated blacks treated badly, lose confidence in the promise of Bermuda." [BB]

"I recognize it as a white male I have the luxury of not having to wonder when I get slighted or when something doesn't go right for me, I generally don't have to wonder whether it was racism or sexism or whatever; that works, because most of the time it isn't. So, I know a black person doesn't have that luxury. That anytime something doesn't go right, that there always is going to be that question." [WB]

definitions and impact of the concepts and practices of racism, discrimination, prejudice, reverse racism, institutional racism and the ground-breaking arena of white privilege (see CURE Definitions Appendix, p. 92).

328 Much of this report has been about determining whether the professional and disciplinary playing field at the hospital is fair and balanced. The report sets out different perceptions on whether all of the players enjoy equal influence and benefit of the doubt. I hope that implementation of the recommendations will ensure at least a procedural level playing field at the hospital.

329 No one can legislate people's hearts, historical references or perceptions. However it is the BHB's responsibility to institute fair, robust and transparent processes that are immunized as much as humanly and institutionally possible from legacy decision rights, agendas and bias. This requires vision and will.

Recommendation XIV: The hospital should designate a person or office with executive level authority to be trained in and conduct ongoing audits and reports on the institutional climate with respect to race, country of origin, language, gender and other diversity areas.

"It was the best of times; it was the worst of times;
it was the age of wisdom, it was the age of foolishness;
it was the epoch of belief, it was the epoch of incredulity;
it was the season of Light, it was the season of Darkness;
it was the spring of hope, it was the winter of despair;
we had everything before us, we had nothing before us;
we were all going directly to Heaven, we were all going the other way." [12]

We all have a choice.

[12] Dickens, Charles, *A Tale of Two Cities*

RECOMMENDATIONS APPENDIX

to the

Ombudsman's Own Motion

SYSTEMIC INVESTIGATION

into

Allegations of Discrimination
Involving Medical Professionals at KEMH

(pursuant to s. 5(2)(b) and s. 24(2)(a) and (3)
of the Ombudsman Act 2004)

The Ministry and BHB are requested to provide an update of progress with respect to these Recommendations by 30th June 2008.

Recommendation I (p. 11): The BHB / KEMH should change its accreditation body to the US Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) which, as our research indicates, offers more robust methods for data collection and iterative, ongoing follow-up.

The hospital lab is already accredited by this group and the Office of Quality & Risk Management already receives monthly email Sentinel Events Alerts from JCAHO International.

Although JCAHO's survey methodology (Periodic Performance Review) is similar to the Canadian Council on Health Services Accreditation ("CCHSA") in that it is a self assessment, JCAHO offers additional services:

- consultation with the organization regarding compliance issues
- interactive "tracer" activities to track actual experiences of selected patients
- on-site review of patient safety (Priority Focus Process)
- after the initial survey, Unannounced Surveys and observation

The next CCHSA accreditation is scheduled for May 2008. Thus, it may not be possible to change accreditation agencies before this time. However, it would be untenable for the BHB to wait until a new hospital is built to move to JCAHO. The current CCHSA relationship does not provide or optimize interactive, ongoing feedback and consultation for improvement measures.

Recommendation II (p. 18): The hospital should review and follow its Bye Laws and Regulations to ensure clarity, transparency and equitable implementation.

Hospital administration must ensure that its actions are based on or consistent with clear policies and rules. Ad hoc or discretionary decisions should be easily explained and justified within the principles of due process and reasonableness.

Clinical governance is weakened by the fact that medical Chiefs of Departments are not aligned with Program Managers. There should be more systematic ways for consultative decision-making.

While it is difficult to thwart someone determined to leak information, the hospital should respond with something more than a cursory inquiry. Generally, institute a zero tolerance policy for rumour and back-biting, especially in front of patients or the public.

Recommendation III (p. 21): The hospital should analyze legacy blocks and cancellations to ensure best practice in allocation of OR time (and by analogy to zero-based budgeting principles).

Allocation of OR time should be based on annual utilization review; urgency of clinical volumes; waiting lists; and equity amongst type of procedure and specialty.

OR times can be allocated by analogy to zero-based budgeting principles.

Recommendation IV (p. 24): The BHB/KEMH should immediately engage information databases, specialist retainers and other relevant resources that doctors would be required to consult in arbitrating between different views on clinical care. This information should also be used to analyze disputed anaesthetic and surgical procedures and to establish standard protocols for pre-, intra- and post-operative practices.

The hospital should negotiate for second opinion retainers with overseas specialties that are not represented in Bermuda so that the burden of emergency decisions is not left to solely to clinicians who are not specialists in those areas.

Note that the General Medical Council in the UK has initiated changes which will result in all doctors having to undergo a process of revalidation. That can include regular appraisals, multi-professional (360 degree) feedback, personal audits and hospital performance figures. Bermuda should give serious consideration to this as well. Respected doctors should be brought in for continuous training (mandatory to maintain privileges).

There should be a system for internet access to current evidence-based medicine data and best clinical practices.

OPERATING ROOM PROTOCOLS

The hospital should institute Standard Operating Procedures, including "Time-Out":

- all patient identification is checked
- surgeon explains procedure including expected duration, complications, anticipated blood needs
- all members of team take opportunity to express any concerns about the operation
- system for examining specimens before team disbands from OR

The hospital should clarify its "Most Responsible Physician" policy (and rationale for variations from the policy) in a way that fosters collegiality for decision making on whether a patient is a candidate for emergency or night surgery, air-ambulance, etc.

Recommendation V (p. 32): The hospital should reconsider implementing outstanding recommendations from previous reports regarding the Department of Anaesthesia and revisit the idea of hiring its own anaesthetists – at least to cover Bermuda's emergency needs.

The hospital should review arrangements regarding staff anaesthetists in other jurisdictions to determine if there are incentives that would be of mutual benefit to the hospital and the existing practicing anaesthetists.

Such review should consider volumes and target goals for saturation of the number of anaesthetists per population.

On-call anaesthetists should be required to remain at the hospital during the on-call period.

The anaesthetic record should be reviewed to ensure recording of pre-induction values, anaesthetic technique, equipment monitoring, patient monitoring and physiological variables and postoperative instructions.

Recommendation VI (p. 36): The BHB, in conjunction with relevant internal committees, the Ministry of Health, the Bermuda Medical Council ("BMC") and the Bermuda Health Council, should engage in a strategic review of Bermuda's clinical manpower needs, including whether the BHB, the BMC or other entity should hold the work permits of the specialists who practice only at KEMH.

In order to allay the many concerns about oppressive contracts and conflicts of interest with respect to physicians holding the work permits of expatriate physicians, consideration should be given to the hospital or the BMC holding these work permits.

This would allow for a rational flexibility in granting and releasing work permit holders depending upon strategic needs.

An open and transparent process should be set for the criteria and recruitment of physicians that responds to the demographics and needs of the population.

Recommendation VII (p. 38): The hospital's Board should review and rationalize its own structures and operations in accordance with best practices in order to strengthen its independence and leadership.

There should be clear avenues of access to the Board from all of the various constituencies within the hospital.

There should be consensus amongst the executive and non-executive members of the Board with respect to rules and committee responsibilities. There should be ongoing training for Board members.

Recommendation VIII (p. 47): KEMH should clarify qualification equivalencies between different jurisdictions and establish an adequate induction program.

Given the stereotypes that have persisted over the years, it would be negligent of KEMH to acquiesce in continued confusion. Equivalencies should take into account years of training and practice as well as examinations.

In particular, the matter of anaesthetist equivalencies and required qualifications should be sorted out.

There is no need to invent the wheel. Equivalencies and guidelines for practice in other jurisdictions have been developed. For example, pursuant to 2003 UK legislation, guidelines are established by the Joint Committee on Higher Surgical Training.

The Privileges Review Committee must be competent to judge specialties and employ a fair, pro-forma assessment process equally applied to all applicants for all levels of privileges.

There should be a formal induction process for new doctors. A biography of their credentials, experience and interests should be circulated. Likewise, they should receive adequate information about the skills of existing practitioners. The formal orientation for all new staff should include adequate introduction to Bermudian history and culture.

A volunteer host program pairing new staff with Bermudians should be considered. There are models for minimum, but invaluable, acculturation programs.

Recommendation IX (p. 55): KEMH must introduce an 'apples to apples' data collection and comparison which is benchmarked to medical literature and includes mandatory reporting by doctors to the Office of Quality and Risk Management and the Privileges Review Committee of all elements of their practice such as lawsuits, insurance settlements and billing anomalies.

It is important that the infection control monitoring system be capable of identifying specific doctors with problems in order to alert them to recurring issues.

Data must be collected on local doctor outcomes compared with the literature identifying expected blood loss, infection rates, sterile field and practice, the way tissues are handled and repeat surgeries.

In order to encourage surgical teams to be on the same page pre-operatively and in the event of intra-or post-operative complications, data on complication rates should be discussed prior to operations and should be correlated with the age, obesity and co-morbidity of patients. To be fair, complication rates must also be compared with peers and with literature of the complication rate accepted for these procedures.

Develop clear guidelines about the volume of procedures necessary for clinicians to keep their skills up to date and maintain credentials in those particular procedures.

Institute a mandatory reporting requirement by doctors to the Privileges Committee of all elements of their practice such as lawsuits, insurance settlements and billing anomalies.

Recommendation X (p. 58): The hospital should augment its Major Clinical Incident Policy to ensure a clear, accessible and confidential procedure in a separate complaints department to identify, report, review and respond to sentinel events. There should also be a policy, based on best practices, for disclosing incidents to patients.

Centralize all incident reporting in one office for triage and allocation to respective departments and relevant leadership.

Separate out a Complaints Office or create a sub-specialty office within the Office of Quality and Risk Management (which would retain the important task of setting standards). The Complaints Office would focus on the equally important function of adequate inquiry and consistent follow-up. If separated, the two offices must have a close relationship.

Introduce a confidential electronic reporting system; require reports to be submitted within two days. Incident reports should not only be about sentinel events but also about breaches of administrative processes such as doctors witnessing their own patient consent forms, cursory pre-operative assessment and post-operative follow-through.

The Complaints handling office must feedback to complainants and departments any disciplinary, remedial or policy steps taken so that the institution as a whole is encouraged to report incidents for the purpose of long-term learning and improvement.

The hospital must respond to incident reports by making the requisite structural and process changes that are indicated by an analysis of the incidents. Otherwise, people will feel that it is futile to report incidents.

There must be formal, well-known, credible whistle-blowing protection.

A general report that categorizes and reviews (a) serious events, (b) efforts to improve patient safety proactively and in response to actual events and (c) mechanisms needed to accomplish this goal, should be produced annually.

There must be a policy to ensure full disclosure to clients or relatives as soon as possible after discovery of critical incidents (also recommended by the CCHSA Survey)

Complication: An additional problem that arises following a procedure, treatment of illness and is secondary to it, that may result from the illness or from independent causes. Postoperative complication may (or may not) be directly related to the disease for which the surgery was done or to the surgery itself.

Error: There is little consistency in definitions for what constitutes "medical error". Some countries use a wider definition that encompasses action and potential harm to patients, whilst others consider only errors that cause actual harm:

- From Australian General Practice: "*An unintended event, no matter how seemingly trivial or commonplace, that could have harmed or did harm a patient*".
- From US Family Physicians: "*An act or omission for which the physician felt responsible and which had serious or potentially serious consequences for the patient*".
- The Department of Health (UK): "*The failure to complete a planned action as intended, or the use of an incorrect plan of action to achieve a given aim*".

Sentinel Event: *"As defined by JCAHO (US), a sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. The term 'sentinel' reflects an event that requires immediate investigation and response"*.
Smith,D., Brennan, PJ, Fleisher, L., *Approaches to Quality Improvement in Anesthesia Care.*

Near Miss: A "Process Variation" that did not affect the outcome, but for which recurrence carries a significant chance of a serious adverse outcome. Should be reviewed and changes made to decrease the risk of the event happening again.

- The Department of Health (UK): "*a healthcare near-miss*" *is a* "*situation in which an event, or omission…arising during clinical care fails to develop further, whether or not as…a result of compensating action thus preventing injury to the patient*".

Substandard Care UK: *"The totality of care – not only failure of clinical care, but also some of the underlying factors which may have produced a low standard of care for the patients. This includes situations produced by the action of the patient or relatives which may be outside of the control of the clinicians. It also takes into account shortage of resources, administrative failures in services and back up facilities such as anaesthetic, radiological and pathology services."*

The OQRM should conduct ongoing educational programs to clarify policies and consequences of breach to staff and to set out clear understanding of relevant terminology.

The main tool used to identify medical error has been incident reporting. It is generally regarded that this underestimates the extent of medical error, since it is opportunistic and medical staff can be reluctant to report mistakes or incidents that occur. However, reporting errors, adverse incidents, unexpected outcomes that are analysed by a Clinical Risk Officer are an extremely useful way to learn lessons about near-misses or mistakes that have happened.

Recommendation XI (p. 64): The hospital must phase in mandatory, methodical, and regular reviews of adverse events, including Morbidity and Mortality Rounds and analytical tools such as Root Cause Analysis and Evidence Based Practice.

Given the current level of distrust, some help will be needed from a medical institution or training organization abroad to phase in M&M rounds gradually.

The hospital should record morbidity and mortality rates and compare it to previous rates at the hospital as well as generally recognized benchmarks from peer hospitals.

Recommendation XII (p. 68): The hospital must revamp entirely its disciplinary process, including training in tribunal process. Consideration should be given to appointing lay arbitrators to any disciplinary review panel.

Disciplinary charges must match and be derived from existing regulations and policies.

Ad hoc committees formed to investigate for the purpose of discipline should have adequate training in tribunal process, investigative techniques and the principles of due process.

The policies for granting, modifying, suspending or withdrawing of privileges must be clear, equitable and well-understood.

Discipline and remedial assistance should be consistent for similar types of incidents and based on clear principles applied equally across the board.

Although the Shipman inquiry reported deficiencies in the system of self-regulation of the medical profession, professionally led regulation is still accepted as the ultimate method for dealing with matters of poor performance. People without a medical training cannot adequately evaluate and regulate physicians. On the other hand, the

importance of the perspective provided by a strong **non-medical** input is now widely recognized[1]. Tribunals should have representation from the public (such as Justices of the Peace).

Recommendation XIII (p. 73): The hospital should require recruitment criteria for leadership positions to include training in conflict management, diversity and administrative due process. Physician leaders should have clear job descriptions, which include a credible commitment to equality. Each Department should submit annual reports.

Physician leaders should have clear job descriptions and responsibilities. Each Department should produce formal, annual reports including complaints, clinical incidents and diversity efforts.

In addition to management and clinical skills, the Chief of Staff, in particular, must have diversity and mediation experience. This position requires a demonstrated ability to listen fairly and parse the text and sub-text of various positions in order to advocate for the best interests of patients as a whole rather than for particular camps. Given the current climate of mistrust, the hospital may have to cast a wide net in order to find this combination of skills-set.

Recommendation XIV (p. 81): The hospital should designate a person or office with executive level authority to be trained in and conduct ongoing audits and reports on the institutional climate with respect to race, country of origin, language, gender and other diversity areas.

Diversity 'awareness' is critically important, but it is not enough. Recent research from the US shows that the most effective way for institutions to tackle problems of discrimination and diversity is by creating structures that embed accountability, authority and expertise (such as affirmative action plans, diversity task forces and/or managers).

Best Practices or Best Guesses? Assessing the Efficacy of Corporate Affirmative and Diversity Policies, Dobbin et al, Amer. Sociological Rev., Aug. 2006, vol. 7, 589

Recommendation XV: For hospital autopsies, the pathologist should confine his or her written opinion to the matters in which the pathologist has appropriate expertise.

Although not expanded in the text of this Report, our clinical advisor expressed concerns that autopsy reports seemed to reach conclusions beyond the expertise of pathologists. There were complaints of two instances in which black interviewees believed that the autopsy attempted to exonerate (white) physician error. There is no evidence of this, but in order to guard against such allegations, written opinions should be limited to the expertise of the pathologist. When an autopsy is performed at the coroner's direction, only persons authorized by the coroner should be allowed to attend, and only for the purposes for which the coroner has approved their attendance.

[1] 2006 Good Practice Guide, Association of Anaesthetists of Great Britain and Ireland (AAGBI)

CURE DEFINITIONS APPENDIX

to the

Ombudsman's Own Motion

SYSTEMIC INVESTIGATION

into

Allegations of Discrimination
Involving Medical Professionals at KEMH

(pursuant to s. 5(2)(b) and s. 24(2)(a) and (3)
of the Ombudsman Act 2004)

Disparate Impact

Any test, job criterion, educational statistic, or crime statistic in which people of colour are rated more poorly than white people.

Institutional racism

A variety of systems operating within an organization that allows for attitudes, behaviours and practices that subordinate persons or groups because of colour. The systems' effect is to perpetuate and maintain the power, influence and well-being of one group over another. Institutional racism can be present in all areas of life (i.e., education, housing, businesses, employment, professional associations, religion, media, criminal justice, etc.) but originates in the operation of established and respected forces in society. Although equally destructive, the practice receives far less public condemnation than does individual racism because it is far more subtle than individual racism. Institutional racism can be documented only with the use of a carefully designed system of statistical inquiry and analysis.

Prejudice

A judgement or opinion about others, made without knowledge, thought or facts. Implies a preconceived idea, judgement, or opinion, usually unfavourable and marked by suspicion, fear, intolerance, or hatred. Prejudice may be directed towards a racial, religious, cultural, or ethnic group.

Racism

Any action or attitude, conscious or unconscious that subordinates an individual or group based on the colour of their skin or race *(Source: U.S.Civil Rights Commission)*. Racism stems from a strongly held belief that human races have distinctive characteristics that determine their respective cultures, and that the white race is superior and has the right to rule others. Racism is a policy of enforcing such asserted rights and implementing a system of government and society based on it. Individually or institutionally, racism is ultimately the misuse of power (social, economic and political) in granting resources, changing structures, rewarding or punishing, deciding what is important and deciding who shall have 'access' – on the basis of race. Racism is not the intent but the effect of attitudes, behaviours, policies, and practices. The equation of *"Prejudice + Power = 'isms'"* applies to race and other grounds of potential discrimination *(Adapted in part from the Random House Dictionary of the English Language)*

White privilege

Often used in 'race' work as a term associated with the advantages of one group over another. In a racialized society, not all white people are well off or particularly powerful, given a class system, a patriarchal system, and other forms of advantage and disadvantage (i.e., rich white people may be more powerful than poor ones; white men may be more powerful than white women; able-bodied whites may be more powerful than those with disabilities…). However, these other forms of privilege may never fully eradicate white privilege. White privilege plays our differently for different people. But, when all other factors are equal, whiteness matters and carries with it certain advantages. For example, although whites are often poor, their poverty does not alter the fact that relative to poor and working class persons of colour, they have an advantage. While many people face obstacles on the basis of nonracial factors, being a member of the white race elevates whites over similarly situated persons of colour *(Source: White Like Me, Wise, Tim. 2005. Soft Skull Press: N.Y.).*

PROCESS APPENDIX

to the

Ombudsman's Own Motion

SYSTEMIC INVESTIGATION

into

Allegations of Discrimination
Involving Medical Professionals at KEMH

This Appendix was submitted to the Speaker of the House of Assembly and was tabled in Parliament at the end of March, 2007.

(pursuant to s. 5(2)(b) and s. 24(2)(a) and (3) of the Ombudsman Act 2004)

"There is always a flurry of policies; everything changes; and then everything goes back to the way it was." [BB]

Genesis of the Systemic Investigation

1. *"We all use THE hospital – either on the way in or on the way out"* (interviewee). Young or old, black or white, expatriate, Bermudian, tourist – almost all of us have had to use or visit the hospital at some time or other. Its mission, location, capacity and culture have some immediate meaning to us all.

2. Repeated rumblings, rumours and media hype over the years therefore do cause us some concern as they seem at odds with and detract from the mission of the Bermuda Hospitals Board ("BHB") to act as *"a committed team of professionals working in partnership with patients, their families, clients and the community to provide high quality health care services that meet their needs and expectations"*.

3. Between January and June 2006 three complaints alleging racism amongst medical professionals at the King Edward VII Memorial Hospital ("KEMH") were lodged with our office. Complainants were adamant that the issues were not limited to them but rather represented systemic, fundamental problems that spawned and perpetuated toxic relationships amongst medical practitioners. Moreover, they alleged that the issues had not been addressed adequately or fairly by KEMH or the BHB.

4. Before considering whether a systemic investigation would be appropriate, we reviewed media reports and also reality-tested the allegations. It became clear that there are commonly held, long-term perceptions that relationships amongst medical practitioners were less than collegial at best and rife with discrimination at worst.

5. Race was most frequently named as the source of the alleged discrimination. As a protected category under s. 2(2)(i) of the Human Rights Act 1981, we first contacted the then Chairman of the Human Rights Commission ("HRC") in order to refer the matter. The HRC consulted and decided that it was not able to conduct a systemic investigation at that time.

6. Accordingly, we decided that instead of investigating each individual complaint which might entail repetitive lines of questioning, a systemic investigation was warranted as the allegations pertain to Bermuda's single medical hospital. The Northern Ireland Ombudsman, who has a global health administration background, noted: *"the issues are not unique to Bermuda: your investigation will be hugely important to the entire Ombudsman system"*.

7. We consulted with the Special Ombudsman Response Team ("SORT"), a specialized group within Ombudsman Ontario that conducts investigations on high profile issues which can impact a large number of people. This team has galvanized the international Ombudsman community with their successes. SORT's criteria to determine whether an issue warrants a specialized, systemic investigation are:

- serious and sensitive issue having a high public interest component
- broad systemic implications
- facts of the complaint are complex and/or not agreed upon
- there is no likelihood of an informal resolution to the complaint.

8. Our initial contact with the then Chairman of the BHB revealed that the Government had also determined to conduct a wide-ranging inquiry. Our understanding is that the Government decided that its review should be outside of the then Ministry of Health and Social Services in order to ensure credibility and relative independence. Accordingly, carriage of the issue was put within the then Ministry of Labour, Public Safety and Home Affairs which had already scheduled preliminary scope discussions with a labour negotiation/process expert.

9. As many of the medical professionals potentially involved in the review are not employees of the BHB, we suggested to the Chairman that employment parameters might be inadequate. Further, any Government review should have the same investigation powers provided for by the Ombudsman Act 2004 ("Act"). We anticipated that complaints would inevitably be made to this office if that review was not perceived as independent. It is preferable that the Ombudsman conduct an investigation in the first instance – before witnesses become jaded and/or investigation-weary.

10. The Cabinet invited us to set out the Ombudsman's statutory authority for systemic investigations.

S. 5(2)(b) of the Act provides for an investigation by the Ombudsman on her

> *"own motion", notwithstanding that no complaint has been made to her, where she is satisfied that there are reasonable grounds to carry out an investigation in the public interest.*

After consideration, the Cabinet agreed to support – and has cooperated fully with – our investigation.

Pre-Investigation Diagnostics

11. In order to determine the scope and frame of the issues and investigation, we employed the diagnostic methodology of Conflict Management Inc. (corporate arm of the Harvard Negotiation Project). This included meeting with seven key administrators of KEMH and relevant organizations. We canvassed their perceptions of the issues, concerns and possible roadblocks to a systemic investigation as well as their definitions of success.

12. We were assisted in the diagnostic and scoping process by SORT's Director and Lead Investigator. SORT investigations typically include extensive document review and witness interviews which are usually taped and professionally transcribed in order to ensure accuracy. For investigations of the projected issues and magnitude identified during our diagnostic interviews, SORT usually assigns up to ten investigators and twice as many support

staff. We adapted SORT's template to the context of Bermuda as well as to the logistics and schedules of our small office of four people. (We did hire two researchers and an additional administrative assistant for approximately two months each.)

13. While racism was the most frequently named allegation of discrimination, interviewees on all sides of the issue were unanimous in perceiving that a number of other differences similarly impact professional relationships and contribute to an increasing crescendo of tension and mistrust. As a consequence, in our press release of 1st September 2006 we framed the investigation as:

"a major systemic investigation into allegations of discrimination involving medical professionals at KEMH. The investigation will focus on whether or not there is a basis for these allegations, including any response to such allegations and, if so, what is the impact on patient care."

Investigation Scope

14. DOCUMENTARY EVIDENCE

S. 12(2) of the Act provides that the Ombudsman

may obtain information from such persons and in the manner, she considers appropriate.

S. 14(1) of the Act gives the

same privileges in relation to the giving of information to the Ombudsman, the answering of questions put by the Ombudsman, and the production of documents and things to the Ombudsman, as witnesses have in the Court.

Over 1,000 pages of documents were produced and reviewed:

- All BHB/KEMH policies and procedures; risk management reports and Minutes from the year 2000 to date of the BHB and several of its sub-Committees: including Ethics, Privileges, Hospital Management Team, Operating Room, Quality & Risk Management;

- Previous reports: including 1993 'Bevan' Report, 2002 Anesthesia Review, 2003 Kurron Report, and the 2005 Accreditation Survey Report.

We thank the Board, CEO(s), Deputy CEO, Hospital Management Team, Chief of Staff and especially the Office of Quality & Risk Management for their assistance in the production of documents and encouragement of witness interviews.

15. PROFESSIONAL ADVISORS

In addition to SORT, we sourced specialized expertise in hospital management ethics, clinical evaluation, diversity amongst professionals and small jurisdiction dynamics in Ombudsman investigations. A list of our professional advisors who assisted with research abroad as well as interviews in Bermuda, is attached. *We are indebted to them all.*

16. WITNESS INTERVIEWS

S. 13(2) of the Act states that the Ombudsman

shall not be bound by the rules of evidence but shall comply with the rules of natural justice.

S. 14(2) of the Act (2) provides that

Compliance with any requirement of the Ombudsman under section 13

> *(a) is not a breach of any relevant obligation of secrecy or non-disclosure, or of the enactment or provision by which that obligation is imposed; and*
>
> *(b) no person shall be liable to prosecution for an offence against any enactment by reason only of that person's compliance with any requirement of the Ombudsman under that section.*

Confidential interviews were conducted with 113 individuals both in Bermuda and elsewhere. The interviews were led by either A. Brock, Ombudsman or Q. Kumalae, Investigations Officer, (either together or in various combinations with our professional advisors). Our aggressive schedule usually entailed 4 interviews per dedicated day – spread out over:

- *four 1 week intervals*
  (A. Brock and Q. Kumalae 55 interviews)
  (B. Nicholls and K. Addo 22 interviews)
- *one 4 day interval*
  (A. Brock and Q. Kumalae 16 interview)
  (K. Addo and E. Collins 14 interviews)
- *two 3 day intervals*
  (A. Brock and Q. Kumalae 17 interviews)
- *two 2 day intervals*
  (A. Brock and Q. Kumalae 11 interview)
  (Sir F. Blackman and B. Nicholls 6 interviews)

- *September - March interspersed*
  (A. Brock and Q. Kumalae 23 additional interviews)
- *Nov. 16 & 17: analysis meeting*
  (A. Brock, Q. Kumalae, Sir F. Blackman, B. Nicholls, K. Addo, G. Jones; Dr. D. Thomas by telephone)
- *February – March 2007: clinical evaluations*
  (Dr. Lee Fleisher 19)
  (Dr. D. Eden 3)

There were nine repeat interviews. A copy of the generic letter sent to each interviewee to explain the process is attached. Most interviews were taped and professionally transcribed. All interviewees were free to decline being taped. Ten of the 113 interviewees so opted.

The interviews, conducted in almost all instances by two interviewers each, were quite in-depth. Approximately 83 of the interviews lasted one to two hours; and approximately 30 of the interviews lasted between two to three hours or more.

Profile of the interviewees:

Black: **57**	Bermudian, Spouse or PRC: **80**	Local Organizations: **2**
White: **48**	Work Permit: **22**	Overseas Organizations: **2**
Other: **4**	Overseas: **7**	

Although sometimes grueling and uncomfortable, we are informed that at least some interviewees found the process cathartic. *We thank them all for their candour and time.*

Delay in Substantive Report

17. In September 2006, we estimated that the substantive report could be submitted to the Speaker of the House of Assembly by the end of March 2007. That report will be delayed by approximately two months because:

a) there were more interviews than our original estimate of around 80. Unavoidable postponements required that fifteen were conducted in January, eleven in February and three in March. Five remain outstanding and are scheduled for April.

b) We had originally sourced clinical evaluators from the Johns Hopkins Medical Institute ("JHMI"). However, during the course of our investigation, the BHB cemented a relationship with JHMI. After some consultation, JHMI lawyers determined that the evaluators would not be able to assist. Therefore, in December, we had to restart the process of sourcing new clinical evaluators and then schedule them in accordance with their already very challenging diaries.

c) We had initially hoped to utilize a local investigator to assist with the interviews, even during his vacation time if necessary. However, this was not possible. SORT kindly stepped in at quite short notice by providing a lead investigator to fill the gap.

d) In January 2007, we learned that one of the original complainants had reinstituted legal proceedings. A reassessment of our investigation strategy was required in order to ensure that document production and inquiries did not infringe on the judicial process.

e) Critical evidence became available only in mid-March.

18. While I regret that we cannot submit the substantive report by the end of March, I hope that this interim Process Appendix is of interest and provides a glimpse of the complexity and thoroughness of this investigation.

Arlene Brock
Ombudsman for Bermuda

Professional Advisors

Kwame Addo has been with Ombudsman Ontario since 1990 and is a lead investigator for the Special Ombudsman Response Team (SORT). Mr. Addo was the lead investigator in numerous investigations including the provision of pediatric testicular prostheses and newborn screening. Prior to joining Ombudsman Ontario, he was a Senior Claims Officer with the Ministry of Transport and investigated and resolved all claim types against the Crown. He served on the Toronto Mayor's Committee on Race Relations and is the Coordinator of Ombudsman Ontario's Federated Health Campaign. *Mr. Addo assisted with investigation design, analysis of interviews and documents and media reports.*

Sir Frank Blackman was the first Ombudsman for Barbados from 1987-1993. He is a founding member of and consultant to the Caribbean Ombudsman Association. Prior to his appointment as Ombudsman, he served Barbados for over 40 years as the Head of the Civil Service, Cabinet Secretary and Clerk to the Upper House of Parliament. Sir. Frank chaired Bermuda's (Electoral) Boundaries Commission. *Sir Frank assisted with analysis of interviews, complaints handling, discipline and regulation.*

Dr. Malcolm V. Brock, cardiovascular surgeon, assistant professor of Thoracic Surgery at Johns Hopkins Hospital and author of more than 40 scientific papers and one book, also heads a NIH funded laboratory researching lung and esophageal cancers. *Dr. Brock assisted in the **pre-investigation** phase with research on surgical protocols, clinical incident reporting, accreditation and sourcing expert advisors in the US and UK.*

Eric Collins is a Vice-President of Tegic Communications, Inc, a subsidiary of AOL. He manages all partnering, marketing and communications activities globally to Tegic's customers, partners and users and is responsible for worldwide sales for handset OEM and carrier partners. He was a founding managing partner of ThoughtBridge, a negotiation strategy firm spun-off from Conflict Management Inc. (where he led a team conducting a systemic inquiry into race relations at Harvard University). *Mr. Collins assisted with investigation strategy and initial interviews.*

Dr. David Eden is a Regional Supervising Coroner for the Office of the Chief Coroner of Ontario. He chairs the Office's Quality Assurance Committee and is a member of the Best Practices sub-Committee. He is a part of the National Mortality Database Initiative for Health Canada and Statistics Canada. He teaches in a wide variety of fora about processes for dealing with sentinel events, particularly at the Physician Management Institute in Canada. *Dr. Eden assisted with clinical evaluations and process monitoring.*

Dr. Lee Fleisher is the Chair of the Department of Anesthesia and Critical Care at the University of Pennsylvania Health System. He was previously the Director of the Program for Medical Technology Assessment and Practice at the Johns Hopkins University School of Medicine. He is the Chair of the Taskforce for Practical Guidelines for the Society of Cardiovascular Anesthesiologists. He is on the Steering Committee of the national Surgical Care Improvement Project (sponsored for the Centers for Medicare and Medicaid Services, Agency for Healthcare Policy and Research, Centers for Disease Control and 10 other partners) and is a Technical Expert for their Panel on Surgical Site Infection and Cardiovascular Disease. *Dr. Fleisher assisted with clinical evaluations.*

Gareth Jones (SORT) served as a police sergeant with the Metropolitan Police in London, UK before becoming an investigator with the Special Investigations Unit of the Attorney General of Ontario. He was the lead investigator for over 500 cases where police were accused of involvement in deaths, serious injuries and sexual assaults. He was Special Advisor to the Military Ombudsman Office of the Department of National Defense / Canadian Forces and became the Director of their Special Ombudsman Response Team. Mr. Jones was appointed to direct and develop Ombudsman Ontario's Special Ombudsman Response Team which is becoming recognized worldwide as a model of investigative excellence. *Mr. Jones assisted with investigation design, analysis and report structure.*

Dr. Larry Kaiser is a Chaired Professor, Chairman of the Department of Surgery and Surgeon in Chief of the University of Pennsylvania School of Medicine, Medical Center and Health System respectively. He is the Chair of the Credentials Committee of the American Board of Thoracic Surgery and is on the Credentials Committee of the American Board of Surgery. Dr. Kaiser is a noted author in the field of Thoracic Surgery and is on the Editorial Board of several journals including *The American Journal of Surgery* and the *Annals of Surgery*. He is Principal Investigator of several studies funded by the National Institutes of Health and holds patents for the invention of thoracoscopic instruments and methods. *Dr. Kaiser assisted with clinical evaluations.*

Robert Nicholls' career in health care management and ethics includes thirty-five years with the National Health Service as a manager at hospital, district and regional levels and as a member of the NHS Executive. In 1995, he was awarded a CBE (Commander of the British Empire) by Queen Elizabeth II for his services to health care. He is a Fellow and Past President of the Institute of Healthcare Management and is the London Region NHS Appointments Commissioner. He is a member of the Clinical Education Committee of the Oxford University Medical School. From 2003 to 2005 he was Chairman of the National Clinical Assessment Authority which was recommended for key advisory roles by the two most significant investigations into health care issues in the UK (Bristol Infirmary and Shipman). Mr. Nicholls has served on the Royal College of Physicians Working Party on Professionalism. He was appointed to several committees of the General Medical Council including Standards/Ethics, Governance and Fitness to Practice. He has consulted on medical regulation and health care management and reform around the world. *Mr. Nicholls assisted with ethics analysis, hospital management and clinical and corporate governance.*

Dr. David Thomas is Senior Associate Dean, Director of Faculty Recruiting and H. Naylor Fitzhugh Professor of Business Administration at Harvard Graduate School of Business Administration. He is the 1998 recipient of the Executive Development Roundtable's Award for Contributions to Executive Development Theory and Practice. His book *Breaking Through: the Making of Minority Executives in Corporate America* (with John Gabarro) is the recipient of the Academy of Management's Award for outstanding contribution to the advancement of management knowledge. Professor Thomas received his B.A., M.Phil., and Ph.D. degrees from Yale University. He also holds a Master of Arts in Organizational Psychology from Columbia University. He serves on several corporate and Not for Profit Boards, including the Brigham and Women's Hospital in Boston. *Professor Thomas assisted with issues of diversity, strategic human resources management and hospital governance.*

RESPONSES

to the

Ombudsman's Own Motion

SYSTEMIC INVESTIGATION

into

Allegations of Discrimination
Involving Medical Professionals at KEMH

(pursuant to s. 5(2)(b) and s. 24(2)(a) and (3)
of the Ombudsman Act 2004)

Government of Bermuda
Ministry of Health

Ref: MOH-MHQ 138

24th October, 2007

Ms. Arlene Brock
Ombudsman for Bermuda
Office of the Ombudsman
Suite 102
14 Dundonald Street West
Hamilton HM 09

Dear Ms. Brock,

Response to Ombudsman's Report on allegations of discrimination amongst medical practitioners at the King Edward VII Memorial Hospital

Thank you for providing me a preview of your report into allegations of discrimination amongst medical practitioners at the King Edward VII Memorial Hospital. It garners very high marks in my view in setting out the issues clearly. Your methodology was unique and refreshing.

Public confidence in KEMH is a primary goal. In every way KEMH is akin to a centre of medical justice. Patients, practitioners and workers all expect fairness, integrity, medical professionalism and competence to be daily watchwords since decisions taken in this institution often entail life and death.

The issues raised in the report are extremely important and many of them have also been identified by the new management team of the Bermuda Hospitals Board. I am pleased to report that a significant number are already in-train.

I am confident that the Board and management team will take the necessary steps to ensure that our hospitals meet their mandate to be "Centres of Excellence."

Thank you again for this report. You can be sure that the Board will have my full support as they move forward to achieve their goal to provide first class medical care.

Sincerely,

The Hon. Michael J. Scott, JP, MP
Minister of Health

P.O. Box HM 380 • Hamilton HM BX • Bermuda • Telephone: 441.278.4900, Ext. 4901 • Facsimile: 441.292.2622

Bermuda Hospitals Board

CARING FOR OUR COMMUNITY

BY HAND

David W Hill
Chief Executive Officer
7 Point Finger Road
Paget, DV 04
PO Box HM 1023
Hamilton HM DX
(Tel) 441-239-2003
(Fax) 441-239-5908
david.hill@bermudahospitals.bm
www.bermudahospitals.bm

24th October 2007

Ms Arlene Brock
Ombudsman for Bermuda
Office of the Bermuda Ombudsman
Suite 102
14 Dundonald Street West
Hamilton HM 09

Dear Ms Brock

I would like to thank you for allowing us access to your published investigation of discrimination at Bermuda Hospitals Board. The Board welcomes the publication of your report, which reflects the thoroughness and professionalism of the research undertaken through interviews and review of BHB documents.

Board access to the report has to date been restricted in accordance with your governing legislation. I now look forward to sharing the full report with the Board and management of the hospitals so that we can agree how best to implement your recommendations. I am also grateful for the support you have already shown in helping us through the implementation process as we go forward.

Our new Board and management have already recognised the importance of BHB making changes that will make us a fairer, more progressive organisation for physicians and all our employees. It is no small task, but we recognise it is fundamental for us to successfully serve the community of Bermuda with the highest quality of healthcare services going forward.

We are under new leadership, with a new Chairman, Deputy Chairman, Chief Executive Officer and Chief of Staff. There has also been a restructuring of the Senior Management Team at BHB. We are now well advanced in overhauling many of our current by-laws and practices in order to establish a sound and fair structure at our hospitals.

As such, I am pleased to report the progress in addressing concerns raised by medical practitioners at the King Edward VII Memorial Hospital prior to your report's publication. We are already implementing many of your recommendations and are working to introduce international best practices throughout our organisation.

The Board has already discussed the benefits of moving to the Joint Commission (previously called JCAHO) for accreditation *(Recommendation I)*, given our close association with East Coast hospitals. Our Pathology Lab has been accredited by Joint Commission International, the international arm of the Joint Commission, since January 2006. We are, however, currently in the process of completing our tri-annual accreditation with the Canadian Council on Health Service Accreditation (CCHSA).

This still remains an important goal for 2008, especially as the CCHSA has moved much closer to the Joint Commission standards, including constant monitoring, ensuring that the bar is already raised for the delivery of service to the Bermuda community, even as we transition.

The creation of a new position, Director of Physician Relations, in January 2007 and, even more significantly, the appointment of a new, full-time Chief of Staff (COS) in September 2007 have been instrumental to much of our progress towards restructuring our current by-laws and credentialing *(Recommendation II)*. This includes a privileging project that will allow BHB to map equivalencies so that we can recruit and promote on an equivalent basis for physicians trained in different countries. *(Recommendation VIII)*

The COS is already undertaking a detailed analysis of OR useage, and is recruiting a Chief of Surgery and reorganising the OR Committee to oversee a demonstrably fair allocation of surgery time *(Recommendation III)*. To provide better access to evidence-based medical sources and reference materials, and to allow eventual online clinical management for physicians, the COS is working with our Chief Information Officer (CIO) to develop a physician portal. This will be critical in meeting your fourth recommendation.

We are already working towards utilising 'apples to apples' data collection and comparison, and mandatory reporting by physicians of all elements of the practice *(Recommendation IX)*. A policy on mandatory reporting and review of adverse events is already under development, although it may require health privacy type legislature before being completely effective *(Recommendation XI)*. Autopsies at the hospital are now undertaken along standard procedural lines *(Recommendation XV)*. The COS is also working closely with the CIO and Director of Quality & Risk Management to automate the process of reporting sentinel events *(Recommendation X)*.

Work on our disciplinary process *(Recommendation XII)* is being advanced by our COS for physicians, and will also be a key deliverable of the new Director of HR, when appointed, for the rest of the organisation. For physicians, the restructured by-laws will result in a completely new peer review process, which will ensure all errors are reviewed and the most serious are tracked for appropriate actions.

Physician leadership training is planned along with succession planning for medical staff *(Recommendation XIII)*. The Director of Human Resources will review the induction programme and recruitment criteria for administrative leadership positions as well as advise on implementing a person or office with executive level authority to conduct audits and reports on institutional climate with respect to diversity.

Of the remaining recommendations, our Board and Senior Management will consider how best to progress once your full report has been fully disseminated.

With regards to the Department of Anaesthesia *(Recommendation V)*, our ability to consider hiring our own anaesthetists will rely on our ability to charge for anaesthetist physician services. This will allow us to afford the level of anaesthetists your recommendations would require. Clinical manpower needs *(Recommendation VI)* in Bermuda are highly complicated due to the small size and remote location of our community. We will sit down with our local and international partners to discuss the best way forward.

Finally, as already noted by the Minister, our Chairman has proposed a new structure to the Board to ensure it has the right mix of expertise to ensure it can provide sound governance to the BHB.

We are cognisant that the people in the community and our own staff will be looking to us to make effective and lasting changes. Following the full publication of our report we will be actively engaging with all our staff. We want to fully support them through this difficult process and ensure they can raise any issues of concern about discrimination of any kind in an open, supportive environment.

We hope to achieve this through various methods and processes, beginning with:

- Facilitated open forums
- An anonymous, confidential hotline
- Independent advice
- Ongoing open communication

We do not take our duty lightly and look forward to the ongoing support of the Ombudsman's office as we move forward.

Yours sincerely

pp David W Hill
Chief Executive Officer

DWH:jps

During this past summer, the Minister of Health, Chairman of the BHB, Permanent Secretary of Health and BHB Chief Executive Officer had the opportunity to read and comment on the preliminary draft of this Special Report. Further to their reading of the final draft during these past few weeks, I am pleased to report that the Ministry and the Bermuda Hospitals Board were unreserved in their acceptance of my findings.

I commend the Minister's vision that KEMH must be "a centre of medical justice" as well as the BHB's resolute commitment to making "effective and lasting changes". The BHB's analysis of progress to date on each Recommendation is highly encouraging.

Given the pivotal role of the hospital in Bermuda, the public deserves nothing less than all best efforts. I look forward to a progress report on the implementation of the Recommendations at 30 June 2008 and offer my full support in any capacity possible.

Arlene Brock
Ombudsman for Bermuda

OFFICE OF THE BERMUDA OMBUDSMAN
Suite 102 • 14 Dundonald Street West • Hamilton HM 09 • Bermuda
TEL 441-296-6541 • FAX 441-296-7734 • www.ombudsman.bm • complaint@ombudsman.bm