# LETTERS

The Spectre of Bristol

The Bristol Royal Infirmary Inquiry

## The Spectre of Bristol

***Gordon Stirrat,*** *Professor of Obstetrics and Gynaecology in Bristol, responds to Michael Keighley.*

Having been Dean of the Faculty of Medicine in the University of Bristol from 1990 to 1993 and a member of both the South-Western Regional and then Avon Area Health Authority over the crucial period, I have direct knowledge of the issues surrounding paediatric cardiac surgery in Bristol Royal Infirmary shared by very few not directly involved. There is much in Professor Keighley's article (*Triple Helix* 2001; Autumn:2-13) with which I find myself in total agreement. For example, I would highlight his sense that it could all happen (is happening?) again elsewhere and the failure to acknowledge fully the consequences of a chronically under-resourced NHS. I also fully endorse his suggested Christian response. But, in what was otherwise a reasonable and balanced article from someone obtaining his information second-hand from the Kennedy Report and the medical and other media, I felt that the table entitled 'Bristol's catalogue of failure' with its final and unanswerable 'Many, many more', was inappropriate. While accepting from my first hand knowledge that there is truth in some of the bullet points as they relate to Bristol, I also know that many of them also apply equally elsewhere. Can Professor Keighley assure me that the hospitals in the city in which he works are free from the criticisms attributed to Bristol? I doubt it.

More importantly his article contains several factual errors. He states, 'Excess mortality in paediatric cardiac surgery (PCS) at Bristol seems undeniable'. The authors of the analysis have subsequently described their *modus operandi* and findings in more detail.[1] They accept that 'excess mortality' is an unsuitable term but could think of no other. The comparator against which the mortality is deemed to be excess is itself unreliable, leaving a question mark at the size and significance of the finding. What was the cause for the 'excess mortality?' The surgeon's defence was that it lay in the unusually high level of risk factors in the small groups of patients which were the focus of the controversy, and which constituted just 3% of their paediatric workload. This judgement can neither be confirmed nor refuted because as Spiegelhalter states, 'there is no recognised procedure for adjusting for clinical risk factors in paediatric cardiac surgery'. They concluded that the excess mortality was 'in open-heart operations in children under one year of age' and not for PCS in general. Neither the GMC nor the Inquiry found that any of these excess deaths were due to surgical errors.

He also writes, 'for me the most frightening statement was that the surgeons just kept going, hoping that things would improve (that a paediatric surgeon, an ITU and a children's hospital and a children's hospital would materialise) rather than stopping so that the politicians and the health economists would do something. Nobody did anything.' Nothing could be further from the truth! To believe that, by stopping, the powers that be would 'do something' is naïve. In addition the record shows that the two surgeons constantly worked for the enlargement of, and the commitment of increased resources to, the PCS Unit. Indeed, together with the whole team, they worked for the transfer of PCS to the Bristol Children's Hospital from as early as 1990. During my time as Dean, James Wisheart obtained funding for a Chair in PCS and a potential candidate was identified only to be lost when the Trust felt that they could not fund the necessary capital works. The decisions to appoint a new paediatric cardiac surgeon and transfer the work to the Children's Hospital were ultimately taken in the summer of 1994. In light of what has happened subsequently it is important to note that this was *before* Steven Bolsin leaked the findings of his 'secret audit' in January 1995. The surgeons and cardiologists saw Bolsin's data for the first time only after he was required to provide it to the Trust in May 1995. This enabled its serious errors to be identified and subsequently acknowledged by him in September 1995.

Finally, Professor Keighley's insight into what James Wisheart and his colleagues were trying to do by 'keeping on going to try to make it work' is absolutely right. As a result of this, two surgeons of the highest personal integrity have been made scapegoats for an NHS that failed them and, even more importantly, the children and families so tragically affected.

1. Spiegelhalter DJ, Aylin P, Best NG et al. Commissioned analysis of surgical performance by using routine data: lessons from the Bristol Inquiry. *Journal of the Royal Statistical Society* 2002;165:1-31.

## Africa's Church Hospitals

***Angus Grant****, working at Chogoria Hospital in Kenya, makes a good suggestion we intend to take up in subsequent issues. Any offers from potential authors?*

I enjoyed reading Gordon MacFarlane's article on Africa's Church Hospitals and the comments from others (*Triple Helix* 2001; Summer:12-14 and Autumn:20-21).

While every country, indeed every church and institution's situation is different, the issues raised are major challenges that we wrestle with: Health care funding, resource allocation, equity of access to care, the place of church-run health care, relationships with other providers, changing health needs, corruption, upholding standards of care, putting health on the political agenda (and keeping it there) etc.

These issues are not limited to the developing world. For example politicians of all nations tacitly recognise that health care funding cannot be limitless, but publicly try to avoid the issue. These are issues where Christians and in particular Christian health professionals must have a voice - we are at one of those turning points in history where everything is up for grabs and where concerted efforts could result in huge improvements in the health of millions. Even if we are working in a system which is relatively equitable, such as the NHS (UK), there is much that can be done to reduce global inequalities. I would welcome more articles looking at these issues - perhaps a series taking each one in turn.