Tasmanian Health Complaints Commissioner

seventh annual report 2002/2003

OFFICE COPY ONLY

Tasmanian Health Complaints Commissioner

Seventh Annual Report 2002 - 2003

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or references contained within, should be directed to:

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To the Honourable the President of the Legislative Council and the Honourable Speaker of the House of Assembly.

I have the honour to submit a report on the exercise of the Health Complaints Commissioner's functions during the year ended 30 June 2003 for presentation to the Parliament pursuant to the provisions of Section 12 of the *Health Complaints Act* 1995.

Jan O' Grady
Health Complaints Commissioner

October 2003

OUR MISSION

The mission of the Health Complaints Commissioner is to serve the Tasmanian community by investigating complaints and addressing issues related to the provision of health services and through the conduct of high quality, independent, objective and impartial assessment and investigation to:

- Promote equity and fairness and bring about improvements in the quality and standard of health care in Tasmania;
- Provide information, education and advice to all stakeholders;
- Promote the principles of the community based Charter of Health Rights;
- Carry out inquiries, interacting professionally with like bodies and promoting better complaint resolution procedures.

OUR VISION

The vision of the Health Complaints Commissioner is:

- to be accepted by stakeholders as an effective and proactive agent for continuous improvement in the delivery of health care services in Tasmania;
- to be recognised as an effective means of communication between the providers and users of health care services;
- to assist affected parties to resolve legitimate grievances and to eliminate the necessity of resorting to expensive litigation;
- to provide an effective mechanism for identifying major systemic issues which involve one or more sectors of public or private health care; and
- to provide a reliable repository for the collection, analysis and dissemination of statistical data relating to the system of health care in Tasmania for interested parties.

OUR VALUES

We are committed to ensuring:

- fair and equitable access for everybody who approaches us;
- high standards of probity, integrity and conduct;
- effective and efficient use of resources;
- accountability for our actions and decisions.

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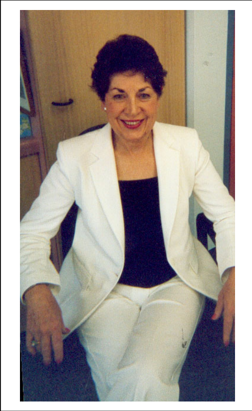
FROM the COMMISSIONER



It is my pleasure to present the seventh Annual Report of the Health Complaints Commissioner.

A highlight of the reporting period was the completion of the first statutory review of the *Health Complaints Act* 1995. In April 2003 the report was presented to the Minister for Justice and Industrial Relations for tabling in Parliament. A copy of the report was also provided to the Minister for Health and Human Services.

The Commissioner is required under section 76 of the Act to undertake a review after the first three years of operation, and this was commenced in December 2000. I am indebted to the members of the expert Advisory Committee for their hard work and dedication:

- Mr Allan Boston, CEO, Calvary Hospital
- Professor Allan Carmichael (Chair), Dean of Health Sciences, University of Tasmania
- Ms Liz de Vries, CEO, Tasmanian Council of Social Service (TASCOSS)
- Mr Ken Hardaker, CEO, Advocacy Tasmania
- Dr Michael Hodgson, President, Medical Council of Tasmania
- Ms Robyn Hopcroft, Director (Health Complaints), Office of Health Complaints
- Mrs Frances Ibbott, Community Representative
- Ms Moira Laverty, CEO, Nursing Board of Tasmania
- Ms Pat J Martin, CEO, Royal Hobart Hospital
- Dr Christopher Newell, School of Medicine, University of Tasmania.

The review process has been lengthy but in retrospect the degree of consensus that has been achieved, particularly given the number of important and contentious issues under debate, is remarkable and is indicative of the high level of goodwill and commitment to positive outcomes shown by members of the Advisory Committee. I am optimistic that once the recommendations have been considered, their implementation will significantly enhance the role of the Commissioner for the benefit of the whole community.

I also wish to acknowledge Health Complaint Commissioners around the country for their support and assistance when required. Also the expressed views of the Tasmanian public have been invaluable to the process and crucial to the development of the recommendations included in the report. (See section on *Review of the Health Complaints Act* 1995.)

In response to resource concerns voiced by the Advisory Committee, staffing for the health complaints function has been strengthened through several new appointments. Ms Robyn Hopcroft has been appointed to the full-time position of Director (Health Complaints); Ms Philippa Whyte has been appointed as a part time Conciliator; Ms Shannon Harwood has been appointed as an Enquiry/Duty Officer and in the coming year, Ms Kim Backhouse will return from a two year secondment to take up a position in the health complaints area. As well, Mr Richard Connock has been engaged as a Consultant to the health complaints area. Mr Connock has undertaken several major investigations, including a major review of a facility for disabled persons in Launceston.

The appointment of an 'in house' Conciliator has been very effective. Conciliation is a core function under the *Health Complaints Act* and one of the primary reasons for the Office being established. Conciliation provides an effective means of dispute resolution and is valuable from the point of view of both the consumer and the provider. Experienced practitioners can make mistakes and may prefer to negotiate resolution through a conciliation process rather than respond to litigation. Quite often there has simply been a misunderstanding and consumers are happy with an apology. In the past year, nine complaints have been put to formal conciliation, compared with three for the previous year.

Complaint numbers have increased in the past year. The increasing complexity of complaints has necessitated the establishment of a database of persons with knowledge in specialist areas. These are practitioners whom we can approach to provide expert opinion when required for more difficult complaints, particularly where professional incompetence or misconduct may be involved. We are most grateful to those specialists who have put themselves forward to assist. Here I wish to pay tribute to the valuable assistance provided by Dr Gerard Flaherty up until his death in late 2002.

I am grateful for a special 'one off' grant provided by the Department of Justice and Industrial Relations to allow a backlog of old complaints to be addressed. Progress in this respect is demonstrated by the fact that this year 349 complaints have been closed compared with 301 last year.

The pending expansion of the Office to include Public Interest Disclosure legislation (effective from 1 January 2004) has meant taking a serious look at the available office space, which already, in addition to the Health Complaints Commissioner, accommodates the Ombudsman, Electricity Ombudsman, the Freedom of Information function and the co-location of the local Commonwealth Ombudsman delegate. Careful consideration and planning is required to maximize the usage of the limited floor area available.

We look forward to the forthcoming year, which again promises to provide many challenges. I take this opportunity to acknowledge and thank my staff for their committed support and hard work throughout 2002-2003.

Jan O'Grady
Health Complaints Commissioner.

October 2003.

ROLE of the HEALTH COMPLAINTS COMMISSIONER

Under the *Health Complaints Act* 1995, the Health Complaints Commissioner is required to receive, assess, investigate and resolve complaints about health services and any service given by a health service provider, both private and public. The Commissioner does not represent the interests of, nor acts as an advocate for, either party in a complaint but must act independently, impartially and in the public interest.

The Health Complaints Commissioner is an independent statutory officer who provides a service to both consumers and providers in an impartial manner. She may give advice, information and assistance to either party in order to expedite a satisfactory resolution; help people make their concerns known to health service providers; assess and clarify problems in health service provision; conciliate formally or informally between users and providers of services; investigate complex or serious complaints; and use the information obtained and lessons learned to recommend improvements to services.

In carrying out these duties, the Health Complaints Commissioner will:

- encourage and assist health service users to resolve complaints directly with health service providers;
- assist health service providers to develop procedures to resolve complaints;
- inquire into and report on any matter relating to health services at her own discretion or at the direction of the Health Minister;
- advise and report to the Ministers for Health and Justice on any matter relating to health services or the administration of the Act;
- provide information, advice and reports to Registration Boards;
- maintain links with health service providers, organisations that have an interest in the provision of health services and organisations that represent the interests of the users of health services;
- consult and co-operate with any public authority that has a function to protect the rights of individuals in Tasmania;
- promote and review the *Charter of Health Rights and Responsibilities*; and
- perform any other functions imposed on the Commissioner by or under this or any other Act.

It is not only the user of a health service who can complain to the Health Complaints Commission. It can also be:

- a person appointed by the user or the parent or guardian of a child under the age of 14 years;
- a person acting under a power of attorney or any other law or order of a court where a person has the care of the affairs of the health service user;
- a person approved by the Commissioner;
- health service providers;
- the Ministers for Health and Justice; and
- the Secretary of the Health Department.

A complaint may be made to the Health Complaints Commissioner where a health service provider has unreasonably:

- failed to provide a service or provided a service that was unnecessary;
- failed to treat a health service user in an appropriate or professional manner;
- failed to exercise due skill;
- denied the health service user dignity or privacy;
- failed to provide:
  - information in language and terms understandable to the health service user;
  - adequate information on the treatment or service received;
  - sufficient information or the opportunity to allow the health service user to make an informed; decision regarding treatment or services available;
  - adequate information on the availability of further advice or relevant education programs;
  - any prognosis that it would have been reasonable to provide to the health service user;
  - denied a health service user access to, or restricted access to, records relating to the user that were in 'the provider's possession;
  - denied information about his or her condition to the health service user;
  - disclosed information in relation to a health service user;
  - failed to take proper action in relation to a complaint made by a health service user; and
  - failed to act in a manner consistent with the *Charter of Health Rights and Responsibilities.*

REVIEW of the HEALTH COMPLAINTS ACT

In April 2003 the Health Complaints Commissioner ("the Commissioner") submitted to the Minister the report of the first review of the health complaints system and sought approval for amendments to the *Health Complaints Act* 1995.

The *Health Complaints Act* 1995 was introduced to give the public access to an independent body to resolve complaints against heath care services and practitioners. The intention was to create an efficient and effective health complaints system, at no cost to the consumer that would take the most appropriate action to resolve the complaint, in the public interest and the interests of the parties involved in the complaint.

The first Commissioner took office in May 1997. Under the Act there was a requirement to review the effectiveness of the health complaints system after the first three years and every five years thereafter. An Advisory Committee chaired by Professor Carmichael, Dean of Health Sciences University of Tasmania, was established in December 2000 and undertook a comprehensive review. The Committee published a discussion paper and consulted statewide, and with key stakeholders.

In April 2003 the Commissioner's Report and the Report of the Advisory Committee were presented to the Minister and subsequently tabled in Parliament. The Commissioner's Report and recommendations are based on the conclusions reached by the Advisory Committee. There was consensus reached on the most appropriate health complaints model for Tasmania and the demarcation of responsibilities and powers between the Commissioner and registration boards so that the most appropriate action would be taken in relation to different aspects of a complaint by the most appropriate body.

The recommendations made arising out of the Review are all part of a carefully crafted statutory scheme to improve the operation of the health complaints system in Tasmania and to ensure its effective operation in consultation with those boards governing registered practitioners. The health complaints system operates on a bi-partite model with each of the eleven [i] registration boards exercising disciplinary powers against practitioners. This model has been retained. The registration bodies retained their role in matters of professional misconduct but all other matters remained with the Commissioner. The health complaints office will continue to assess, conciliate and investigate complaints against health services, unregistered practitioners and matters that fall outside the registration boards' functions.

However, it has been recommended that the Commissioner, after consultation, will have the discretion to decide what complaints should be retained rather than referred to the boards. This will mean that the boards will focus on serious professional misconduct that brings the profession into disrepute or brings into question a practitioner's competence or capacity to practice. The Commissioner will have discretion to deal with those matters that are dismissed by the boards because they do not constitute misconduct but nevertheless may involve a failure to meet an appropriate standard.

The recommendations are designed to create a system where the complaints system and regulatory functions of the registration boards mesh and are complementary. At present matters that do not constitute serious professional misconduct are invariably dismissed as the registration boards do not have clear power to deal with adverse outcomes arising out of negligence or poor standards of care. From the consumer's perspective, these matters are best resolved by conciliation but safety and quality in health should be a shared responsibility involving the complaints and regulatory systems.

The *Health Complaints Act* 1995 deals with complaints against public and private sector health care providers, both individual and institutional. All public and private Hospitals, Nursing Homes, Aged Care, Disability Services, registered practitioners and other health providers come within the ambit of the Act. Under the present Act the definition of what constitutes a health service is very broad but recommendations have been made to expand the scope particularly to encompass a broad range of services to persons with disabilities.

The key recommendations of the Review are summarised in the Commissioner's Report to the Minister, April 2003. The Report can be found on the health complaints website and the recommendations include:

- The appointment of a separate Commissioner to provide a more distinct health focus for health complaints;
- Facilitating the early resolution of complaints;
- Strengthening the conciliation process;
- Improving collaboration between the Commissioner and the boards;
- Increasing the Commissioner's discretionary and investigation powers;

- Improving the accountability of registration boards by providing that their *"administrative actions"* can be reviewed by the Ombudsman;
- Extending the scope of what constitutes a "health service" to include mortuary services and further encompassing the Disability Services sector;
- Strengthening actions against unregistered providers including the publication of reports of an investigation; and
- Various actions to increase the health complaints system's responsiveness to the community's needs.

These recommendations covered almost every aspect of the health complaints system both in administrative, operational and legislative areas and have varying degrees of importance. One of the key amendments recommended involved changing the current arrangements with the registration boards by giving the Commissioner the final say, after consultation, as to whether or not a matter will be referred to a registration board. This was balanced by a requirement to notify boards at the outset of complaints against practitioners. It is expected that there will be closer collaboration between the Commissioner and boards by the introduction of provisions relating to reciprocal reporting, joint investigations, exchange of information, requiring reasons for decisions and consultation as to whether the referral of a matter to conciliation should be concurrent with the board's action or deferred.

There are also recommendations to assist those who have difficulty making written complaints, accepting complaints in a medium other than writing, rendering reasonable assistance to those lodging complaints and broadening the Commissioner's discretion as to who may lodge a complaint. This involves removing the restrictions on third parties who wish to lodge complainants, granting the Commissioner greater discretion to determine who is entitled to lodge a complaint, accepting complaints from persons under the age of 14 years, and accepting anonymous and out-of-time complaints.

There are recommendations to improve the complaints process, to encourage the early resolution of complaints, to provide a power to identify the provider and to access information at the complaint assessment stage and to add new grounds, persons or particulars to a complaint. Recommendations were made for amendments to strengthen the Commissioner's investigative powers under the *Health Complaints Act* 1995 and to publish and table reports in Parliament.

The recommendations propose a number of legislative amendments designed to make the health complaints system more effective and to address flaws in the existing legislation. Additional powers are recommended so that necessary information about a complaint can be obtained at the outset to enable a proper assessment to be undertaken. There was a recommendation that, following an investigation, there should be power to name a recalcitrant provider, whether registered or not, who is not prepared to take a recommended remedial action. This "naming" power would be similar to that under Consumer Affairs legislation and the same rationale would apply to health service providers as to other providers of services.

While the Review Committee did not undertake an in depth analysis of the health complaints system's resource requirements there was a recognition that there was insufficient funding to obtain expert opinions and to make provision for conciliations and that this had compromised a core statutory function and influenced the quality of investigations. The Committee recognised that the resource needs of the health complaints system needed to be addressed and recommended the appointment of a consultant to assist this process.

COMMUNITY OUTREACH

The Commissioner and Health Complaints staff have been involved in the following activities during the reporting year.

July 2002

- Attendance at the 2002 Administrative Law Forum – *Appraising the Performance of Regulatory Agencies* – in Perth, Western Australia;
- Presentation to Rotary Launceston;
- Presentation to the Nursing Board's Professional Conduct Committee in Hobart;
- Attendance at the Nursing Board of Tasmania's website launch in Hobart;
- Presentation to Rotary Newnham-Esk, Launceston;
- Presentation to Community Corrections staff at the Hobart Remand Centre.

August 2002

- Presentation to the Burnie School for Seniors.
- Presentation – *The Health Complaints System and Issues for Patients with Mental Illness* – to the Royal Hobart Hospital Multisciplinary Mental Health weekly lecture series;
- Provision of Complaint Management training module in Hobart.

October 2002

- Attendance at the *Business Planning for the Public Sector* workshop in Melbourne;
- Attendance at the PIAA International Section Conference – *Minimising Medical Error and Limiting Liability* - in Sydney;
- Provision of Investigation Skills training module for Department of Health and Human Services in Hobart;
- Provision of Complaint Management training module in Hobart;
- Presentation on *Conducting Inquiries into Professional Misconduct, Unprofessional Conduct and Breaches of Standards* to the Professional Development Session in Hobart;
- Presentation to Royal Hobart Hospital Social Work Department on *Receiving Health Complaints the Hospital*.

November 2002

- Involvement in the Australasia and Pacific Ombudsman Conference in Sydney;
- Participation in the Investigation Symposium in Manly, NSW;
- Provision of Complaint Management training modules in Hobart and Launceston;
- Provision of Complaint Management training module specifically for Department of Health and Human Services in Launceston;
- Presentation to Soroptomists at George Town.

December 2002

- Attendance at the launch of Human Rights Week in Hobart.

January 2003

- Attendance at farewell function for retiring Commonwealth Ombudsman, Mr Ron McLeod, in Canberra.

March 2003

- Presentation to the 4th National Health Complaints Conference in Canberra;
- Attendance at the National Meeting of Health Complaints Commissioners in Canberra;
- Attendance at the Aboriginal Forum launch in Devonport;
- Presentation to the Tasmanian Association of Vocational Rehabilitation Providers Inc in Hobart;
- Attendance at the International Women's Day Breakfast in Hobart;
- Provision of training session on *Investigation and Disciplinary Processes* for the Pharmacy Board and Optometrists Board in Hobart.

April 2003

- Participation in the Advanced Investigations Course provided by the Commonwealth Ombudsman in Canberra.

May 2003

- Participation in the LEADR Conciliation Training in Melbourne;
- Presentation to Ambulance Services' frontline operational managers in Hobart
- Presentation to Federation of University Women in Hobart;
- Attendance at the 2003 College Ceremony for the Royal Australian and New Zealand College of Psychiatrists in Hobart.

June 2003

- Involvement in the Prison Infrastructure Information Session in Hobart;
- Attendance at the IPPA presentation by the Premier - *Gazing Forward Four Years* – in Hobart;
- Presentation to the Optometrists Registration Board in Hobart;
- Attendance at the Guardianship and Administration Board presentation by Judge Blow on natural justice and how it applies to tribunals in Hobart.

PROFESSIONAL DEVELOPMENT

As with last year, this year has seen a downturn in the number of courses we have been able to offer as part of the Ombudsman and Health Complaints Commissioner's Professional Development Program. Again this has been due to stretched resources within the office, particularly in relation to staff.

Complaint management

Complaint management training specifically geared for those working in the front line of their organization has been provided, and well attended, in the north and south of the State. Ryanda Mee, who facilitates the training in the form of a highly interactive one-day workshop, encourages participants to share their experiences and the effect managing aggravated people and situations has on them as individuals. Participants come away from the day feeling comforted by the fact that they are not alone in this respect and equipped with new strategies and a renewed sense of self-confidence for communicating with difficult people, for managing difficult situations and for stress management.

We are indeed fortunate to retain Ryanda Mee's involvement with the Professional Development Program. She has extensive experience in service delivery, staff training and development, human resource management and corporate communications, and is also a qualified mediator and conciliator. Ryanda has evolved a unique approach to integrated customer service and complaints' management training, which has received widespread support nationally and is acclaimed locally.

Besides the general courses offered across health services and Government agencies, which notably have been well attended by Royal Hobart Hospital and Housing Tasmania personnel, the following specific training in complaints management and strengthened communication skills was provided, by request, to:-

☺ The Department of Health and Human Services in the form of two half-day sessions, held at the McHugh Medical Centre in Launceston;
☺ The University of Tasmania for their general and academic staff, with a total of 70 participants over four sessions;
☺ Prison Services as part of the induction program for over 30 new custodial recruits.

The complaint management training aims to assist participants to:

- identify the differences between consumers' needs and expectations, and how to manage same;
- develop and enhance skills and techniques needed to effectively handle complaints whether in writing, in person or on the telephone;
- develop and enhance communication skills central to each stage in resolving a complaint;
- identify individual techniques which can be used to minimise the negative affects that handling difficult people can have on you.

Investigation skills

In October 2002 we provided investigation skills' training for the Department of Health and Human Services, particularly for their human resources personnel. This two-day course module has been designed for those involved in disciplinary, investigatory and fact-finding positions, ranging from relatively informal investigations intended to support policy or decision making, through to formal investigations which may culminate in prosecutions. For State government departments, the new requirements under the *State Services Act* 2000 Code of Conduct, has been the catalyst for accessing this training.

The training includes:-

☺ techniques and strategies for conducting high quality investigations;
☺ gathering evidence and how to use it;
☺ analysis of professional interviewing skills;
☺ theoretical perspectives of good investigative practice.

This training is always well received by participants, and without the involvement of our esteemed expert presenters it would be difficult to achieve the same standard of training. We take this opportunity to gratefully acknowledge the involvement of the following:-

- Mr Rick Snell, Senior Lecturer, University of Tasmania Law School;
- Associate Professor Margaret Otlowski, University of Tasmania Law School;
- Dr Barry O'Grady;
- Mr Iain Frawley, Evaluation and Review Unit, Office of the State Service Commissioner;
- Inspector Laurie Oakes, Internal Investigations Unit, Department of Police and Public Safety;
- Mr Terry McCully, Senior Investigation Officer (FOI), Office of the Ombudsman;
- Ms Robyn Hopcroft, Director Health Complaints, Office of the Health Complaints Commissioner;
- Mr Geoff Storr, Senior Investigation Officer, Office of the Ombudsman;
- Mr Tony Allingham, Principal Investigation Officer, Office of the Ombudsman.

In March 2003 a training session on *Investigation and Disciplinary Processes* was provided for the Pharmacy Registration Board and Optometrists Registration Board. This session was intended to not only provide valuable information but also the opportunity for open discussion on issues that affect members of a health registration board or investigation/disciplinary committee. Mr Rick Snell, Senior Lecturer at the University of Tasmania Law School, presented on good administrative practice, procedural fairness and the principles of natural justice. Ms Jan O'Grady, Health Complaints Commissioner, covered good investigative practices, personal privacy and information disclosure, and ethics. The Commissioner and Director Health Complaints were happy to provide a further session, as follow up, to the Optometrists Board meeting, at the request of the Board.

Handling Difficult Complaints and Advanced Communication Skills for Managers

We are currently looking at reworking this (previously two-day) course module to provide a concise one-day session. This is in response to inquiries from individuals working at manager/supervisor level who are seeking this type of training but find it difficult to take two days out of their workplace. We hope to be able to offer this in the first half of 2004.

ISSUES ARISING DURING THE YEAR

Can a Complaint Dismissed by a Board then be Referred to Conciliation to Negotiate Compensation

In the following complaint an opinion was sought from the Solicitor General as to whether a matter dismissed by a registration board could then be referred to conciliation to negotiate compensation. In this instance the Medical Council had, in addition to dismissing the complaint, expressed an opinion that there had been no breach of clinical standards. In accordance with the opinion provided by the Office of Solicitor General, the complainant was provided with an opportunity to make submissions as to why the matter should not be dismissed under s.25(g) of the *Health Complaints Act* 1995.

What constitutes "professional misconduct"

In this instance a complaint was lodged against a hospital and a medical practitioner. A section of bowel had been stitched into the lower uterus during the caesarean section. The patient became ill, was readmitted to hospital and the same doctor failed to identify the problem in a second operation. A specialist rectified the problem the following day. The complaint was referred to the Medical Council, which dismissed the complaint under s.48 of the Medical Practitioners Registration Act 1996 and also expressed a view that there was no breach of clinical standards. The Hospital refused to discuss monetary compensation.

While the registrar's action in both stitching a section of bowel into the lower uterus and then failing to identify the problem ought not be regarded as "professional misconduct" arguably it might constitute negligence.

However, in the absence of an independent medical opinion from a specialist having reviewed her surgery and subsequent management, the complainant was advised that, there was no persuasive evidence of negligence or a breach of an acceptable standard of care to justify the Commissioner referring the complaint to conciliation for the purpose of negotiating compensation. Having regard to the opinion from the Office of Solicitor General the complainant's solicitors were invited to make submissions supporting the referral of the matter to conciliation, as was the complainant, but no submissions were made and the file was closed**. Case Summary 1**

Limitation Periods

The *Limitation Act* 1974 sets time limits within which a person is able to commence proceedings in a court of law in respect of certain matters including an action for damages for personal injuries caused by negligence, nuisance or breach of duty. It is not for the conciliator or officers of this Office to provide advice on the limitation periods set by that Act but consumers should be made aware of the existence of these time limits in order to take steps to preserve their right to resort to common law litigation in the event no agreement is reached at conciliation. Under s.25(5)(f) of the *Health Complaints Act* 1995 the Commissioner must dismiss a complaint if a court has commenced to hear proceedings that relate to the subject matter of the complaint, but until that time, the Commissioner may accept and act on a complaint.

It is of concern to this Office that those who have suffered loss or damage as a consequence of negligence may inadvertently go beyond the limitation period and lose their right to initiate a common law damages claim in the belief that their matter will be resolved through the conciliation process. The fact is that although enforceable agreements to pay compensation can be, and frequently are, successfully negotiated between the parties during conciliation, in the event that no such agreement is reached, the Commissioner does not have the power to make a binding award.

While it would seem to defeat the purpose of conciliation as an alternative to litigation, it may need to be made clear to complainants at the outset that if they are seeking compensation they may need to initiate common law proceedings to protect them from being out of time should they subsequently need to resort to litigation to satisfy their claim. These proceedings could then be held in abeyance so that conciliation, as an alternative dispute resolution process can at least be attempted.

In the last reporting year the potential for exceeding limitation periods has been of concern as there have been unacceptable delays in public hospitals responding to requests for advice by the Commissioner as to whether the hospital is prepared to enter into conciliation to discuss compensation. The response to repeated requests, sometimes over many months, is that the hospital is awaiting legal advice from the Crown. While it is proper for the hospitals to obtain legal advice and for the Crown to rely on the periods set by the *Limitation Act* 1974, the Health Complaints Office needs to ensure that complainants are aware of these issues and have sufficient information to enable them to ascertain when they may need to seek their own independent legal advice.

Access to third party medical records

During the reporting year an issue arose as to whether the Commissioner could access the medical records of a third party having issued a notice under s.45(2) of the *Health Complaints Act* 1995. The Commonwealth *Privacy Act* does not apply to State instrumentalities and a public hospital is a State instrumentality. There is, at this time, no State privacy legislation and the question was whether the provisions of Part 6 of the *Health Complaints Act* 1995 enabled the Commissioner in this instance to access third party records. Rather than apply to the Supreme Court for a determination the Commissioner and the Hospital agreed to accept the opinion of the Solicitor General.

The issue arose out of a complaint alleging that a patient in a public hospital had been assaulted twice during the night by another patient whom he did not know and without provocation. On both occasions the victim of the assault had been asleep. From the outset the complainant made it clear that he accepted that the other patient was impaired as a consequence of a medical condition. The incident form recorded the admission diagnosis as "Acute Confusional State" and the medical assessment following the incident was "Patient remains disinhibited and inappropriate. Aggressive towards staff".

The complainant's grievance was the decision by hospital or medical staff to transfer the other patient from a ward in the Department of Psychological Medicine to a general ward, knowing that there had been assaults in the week or so immediately preceding the transfer. Following the second assault the patient was put into a single room and a security guard placed outside due to the risk to other patients including the complainant. The purpose of seeking the third party patient records was to ascertain the decision making process to determine whether the transfer to a general ward was appropriate. The third party did not consent to the release of the records.

The Chief Executive Officer (CEO) initially refused to release the records without the patient's consent, on the basis that the records contained private and confidential information. Later the CEO claimed that the records were privileged from production on the basis of public interest immunity, with the result that s.52(1) of the Act applied. [ii] The CEO also claimed that the release of the patient's records fell within s.53(1) of the Act, whereby a person is not required to provide or produce any information or document under Part 6 of the Act if –

> *"…the Supreme Court determines that the purpose for which the information or document was required to be provided or produced does not justify ... the intrusion on the privacy of an individual by disclosure of private or confidential matters relating to an individual ... that would likely result from the provision or production of the information or document".*

The opinion examined whether, if the Commissioner were to formally require the Acting Chief Executive Officer of the Hospital to produce the records under s.45(2) of the Act, production might successfully be resisted in reliance upon s.52 or s.53 of the Act.

The opinion was that the law of the State in respect of public interest immunity is now to be found in s.130 of the *Evidence Act* 2001[iii] and concerns the admission into evidence of information or a document that *"relates to matters of state."* The *"public interest",* to which this immunity refers, requires a dimension that is governmental in character.[iv] Nothing in s.130(4) embraces the delivery of health services to an individual in a public hospital, and this could not properly be described in common speech as a *"matter of state."* The conclusion was that, if the Hospital was to persist in the claim of privilege; and if the claim were referred to the Supreme Court under s.52(3) of the Act, the Court would surely determine that the claim was unsound.

The Hospital could apply to the Court for a determination under s.53 that the purpose for which the information or document was required to be provided or produced does not justify *"the intrusion on the privacy of an individual by disclosure of private or confidential matters relating to the individual".* Section.53(1) gives the Court an open discretion, requiring it to balance the Commissioner's purpose against the intrusion into the privacy of the individual concerned. The preliminary view was that the balance lies in favour of giving the Commissioner access to the records. Having considered the Solicitor General's opinion the Hospital provided the records and the investigation proceeded.

Is counselling a health service?

During the reporting year a jurisdictional issue arose as to whether counselling, provided to a widow following the death of he husband, fell within the definition of a "health service" as defined in the *Health Complaints Act* 1995 and therefore within jurisdiction. Section 3 of the Act defines a "health service" as, amongst other things, "a service provided to a person for, or purportedly for, the benefit of human health" and includes services provided by a "therapeutic counsellor".

An opinion was sought from the Solicitor-General. The opinion from the Office of Solicitor General referred to the ACT decision of *Hanna v The Commissioner Community and Health Services Complaints Australian Capital Territory* [2002] ACTSC 11, in which the Acting Chief Justice concluded that the *Community and Health Services Complaints Act 1993* (ACT), (which in relevant respects is similar to the *Health Complaints Act* 1995) was concerned with *"services provided for the treatment and care of physical or mental illness or injury"* and noted that the term *"for, or purportedly for, the benefit of human health"* in the definition of *"health service"* should be given a purposive interpretation.

In essence the opinion was that, in order to fall within the ambit of the *Health Complaints Act* 1995 the counselling involved needs to be *"therapeutic counselling"* (the term *"therapeutic"* being defined as *"relating to the curing or treatment of disease; or curative"),* and to be *"for, or purportedly for, the benefit of human health".*

The view was that where the counsellor's duties, as set out in the job description, were limited to providing counselling for the purpose of reducing reliance on welfare support and encouraging self reliance and a reduction in long term dependency and did not specifically include counselling of a therapeutic nature, in terms of being for the purpose of curing a physical or mental illness, in the absence of any evidence as to the counselling in fact being for that purpose it did not fall within the jurisdiction of this office under the *Health Complaints Act* 1995.

Child Protection, expunging records

With recent changes to the Federal *Privacy Act* there is now a provision in that Act which entitles patients to be able to access their medical records. If a patient believes that there is information on the record that contains inaccurate information, the record-keeper shall, if requested by the patient, take such steps as are reasonable in the circumstances to attach to the record any statement provided by the patient for the correction of the record. In general it is not advisable to alter or erase the original entries in a medical record and in some circumstances it may be illegal. In some instances there is a statutory obligation on health practitioners and others to report suspected child abuse.

Expunging records

The complainant lodged a complaint against a medical practitioner at a Hospital. The complaint was lodged on behalf of her daughter who had taken her one month old son to the hospital. On presentation, the doctor who examined the infant questioned the daughter and considered it appropriate to make a report to the Division of Child and Family Services (DHHS) as she suspected that the child had been mistreated. The complainant believed that the report was not warranted and believed that the doctor jumped to an unfounded conclusion. Subsequently, the infant was transferred to Hobart for examination and assessment after an ultra-sound report had indicated that the infant had a large right subdural haematoma or possibly a subarachnoid cyst. The diagnosis was of a *"large right cerebral hemisphere arachnoid cyst with marked compression of the right cerebral hemisphere."* There was no evidence of trauma.

The issue of whether the report made by the medical practitioner should be removed from the file was taken up with the Department of Health and Human Services (Children and Families).[v]

Case Summary 2

COMPLAINT RESOLUTION

Conciliation of complaints

Conciliation, under Part 5 of the *Health Complaints Act* 1995*,* is an important and central function within the health complaints system. It is privileged and confidential. It allows redress for those who have suffered an adverse outcome as a consequence of a failure to meet an acceptable standard of health care and it provides an opportunity for those responsible to provide apologies, explanations and information. The conciliation is held in private and admissions made cannot be used as evidence in subsequent court proceedings. It is an alternative to litigation and binding agreements can be entered into. As a means of alternative dispute resolution, it has many advantages not the least of which is that the relationship between the patient and the provider has a greater chance of surviving than if the parties are adversaries involved in litigation.

No costs are involved, inasmuch as the Commissioner appoints an independent, qualified and experienced conciliator and no charge is made to the parties to the complaint. The conciliator operates in accordance with the provisions in the *Health Complaints Act* 1995 and Guidelines issued by the Commissioner. In order to fulfil the conciliation function properly the conciliator must be qualified and experienced, trained and supported both by a mentor appointed under the Act and in terms of resource allocation. From the consumer's perspective, resolution may mean recompense as well as an acknowledgment and apology. This requires access to an appropriate venue, and an accurate assessment of the issues to be discussed at conciliation, prepared by someone other than the conciliator.

While conciliation has many advantages, the informality of the process can mean that the parties lack an understanding of the principles that guide claims for compensation and are unrealistic in their expectations - the same principles that apply in common law to compensation cases guide negotiations under the *Health Complaints Act* 1995. The parties to conciliation need accurate information and guidance as to this. Providing advice as to a reasonable amount of compensation would compromise the impartiality and independence of the Office. The conciliator however needs to recognise when and if the conciliation ought to be adjourned or deferred to enable the parties to obtain independent expert advice.

In the provider's case this may need to be from a professional indemnity insurer if the complainant seeks compensation. In the consumer's case they need to obtain advice not only as to an appropriate settlement but also as to any requirement to reimburse the Health Insurance Commission and/or private health funds and as to the impact any compensation received may have on the receipt of statutory benefits (such as Centrelink benefits) where preclusion periods may be imposed. Parents also need to be aware that any settlement reached in conciliation involving compensation for a child requires the approval of Supreme Court under rule 299(2) of the *Supreme Court Rules* 2000.

It is not the role of the Health Complaints Office (HCO) to advise, advocate or act for complainants. It is however intended in the next reporting year to establish a register of legal practitioners who might be prepared to include a significant pro bono element in their advice to complainants negotiating compensation through the conciliation process.

Early Resolution

While formal conciliation is central to the *Health Complaints Act* 1995, the most effective resolution is often undertaken early on in the complaints process, before the parties to the complaint become too firmly entrenched in their positions. Facilitating the early resolution of a complaint can be of benefit to all concerned and opportunities need to be created to encourage this. This is recognised by the Act and indeed under s.25 (5)(d) the Commissioner must dismiss a complaint if satisfied that the complainant has failed to take reasonable steps to resolve their grievance with health service providers. Other strategies are being developed by the HCO to give effect to the early resolution of complaints, one of which is to encourage health service providers to communicate directly with the complainant upon receiving notification of a complaint.

The five complaints discussed below which relate to the question of whether charges are appropriate, provide examples of the benefit of early resolution of complaints lodged with this office.

Charges relating to postponed operation resolved by agreement

The complainant was admitted to hospital for elective surgery in July 2002. However the procedure had been postponed as the complainant had just been diagnosed with type two diabetes and the surgeon and the anaesthetist considered it inappropriate to proceed with the surgery. The surgeon had spent about ten minutes with the patient to explain the operation procedure and the anaesthetist's visit was no more than five minutes.

The surgeon rendered an account for $33.00 and the anaesthetist an account for $184.00. The complainant believed the anaesthetist's account was excessive. The complainant was happy to pay the Medicare rebate but objected to paying any excess because he believed that the anaesthetist had not provided any medical service that warranted a charge for $184.00. He sought an explanation as to the basis for fee. The anaesthetist advised that he had contacted the complainant and had "…resolved the issue regarding the account". The compliant confirmed that the matter had been resolved.

Case Summary 3

Charges reimbursed for a consultation when there is no on-going care

The complainant had moved into the area and was seeking a general practitioner. She believed that a medical practitioner refused to accept her as a patient solely on the grounds of the drugs previously prescribed to her for pain and insomnia and which she might require from time to time. The complainant and her husband had been bulk billed for the consultation but as her husband had walked out with the complainant after she was refused treatment, she considered that there had been no effective consultation. As the complainant and her husband were not accepted as clients of the practice from their perspective the consultation fee should not have been raised and a refund should be made to the Health Insurance Commission.

An explanation was sought from the medical practitioner who addressed the above issues. The medical practitioner noted that his practice was so busy that he had declined over fifty people as permanent patients. While some time had been spent with the complainant he rebated the Health Insurance Commission $48.90.

Case Summary 4

An inappropriate referral to a specialist who did not treat children

The complainant was referred by the hospital to a specialist. When she made an appointment for the consultation with the specialist for her two and a half year old daughter, she made it very clear that the patient was a child. On attending the appointment the specialist advised the complainant that he did not treat children and referred her to another doctor. Subsequently, the specialist charged $67.60. The practitioner's staff advised that the charge was made in error and an undertaking was given to reimburse the Health Insurance Commission. A request was made to reimburse the complainant any amount charged over and above the Health Insurance Commission fee.

Case Summary 5

Reimbursing costs – seeing eye to eye

The complainant collected her prescription glasses in the absence of the optometrist but found that the glasses were unsuitable and returned them. Ten days later she met with the optometrist and adjustments were made to the glasses however the complainant was unable to collect the glasses as the laboratory was closed over Christmas. The glasses were subsequently posted to her. As they were still not suitable she underwent an eye test with another optometrist. She was quoted $480 as the cost of rectifying the glasses so that they were suitable. The complainant sought reimbursement from the first provider who indicated that they wished to undertake the rectification. This matter was resolved and a full refund was provided to the complainant.

Case Summary 6

Compensation as out of court settlement

The complainant underwent an endoscopic carpal tunnel release operation, during which the median nerve was damaged (severed). The complainant was reluctant to take up the matter direct with the surgeon. It was agreed that this office would refer the complaint to the provider for initial response. The complainant accepted an out of court settlement and on that basis the complaint was closed. The medical practitioner would have had an obligation under the *Medical Practitioners Registration Act* 1996 to notify the Medical Council of Tasmania.

Case Summary 7

Compensation Expectations

If seeking compensation under the conciliation provisions of the *Health Complaints Act* 1995, complainants need to have some understanding of the principles underlying the question of liability for payment of compensation in order to decide whether monetary compensation is appropriate and if so what constitutes appropriate compensation, taking into account any reimbursements they may be required to make.

In complaints lodged under the *Health Complaints Act* 1995, it is often very clear that a person making a complaint has suffered an adverse outcome and may have serious and significant disabilities. The person making the complaint genuinely believes that the harm they suffered was a consequence of negligence and that they are therefore entitled to compensation. However the complainants often fail to distinguish between three main scenarios:

- A complication arising from a known and material risk about which they were informed,
- A “near miss” or failure to meet an acceptable standard of care where there was no loss or damage suffered, and
- Conduct of which meets the civil standard for Negligence.

In the first instance the complainant, having been informed of the risk and having assumed that risk, is said to have given “informed consent”. Under our legal system once that consent has been given, and in the absence of negligence, the consumer assumes the risks and bears the consequences should a relevant risk materialise. In the second instance liability for compensation is unlikely to arise as no loss or damage has been suffered. It is only in the third instance that the complainant should be entertaining an expectation that they are entitled to receive compensation. In many instances a complainant may genuinely, but mistakenly, believe that the condition from which they are in fact suffering can be attributed to the negligent actions or inactions of a health practitioner.

Although the complainant may not receive compensation, and the complaint is often dismissed, [vi] the complainant has had the benefit of the analysis of their complaint by an independent body, without the costs and stress associated with pursuing a remedy through the court system, which ultimately they might lose. There are other indirect benefits in saving court time by screening out those claims that, although genuine, may lack merit.

ISSUES ARISING OUT OF COMPLAINTS

Who assesses a failure to meet an acceptable standard?

As stated in Halsbury:

The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. It extends to the examination, diagnosis and treatment of a patient, the provision of information and the processes of obtaining the patient's consent to treatment.

The standard of reasonable care and skill required is that of the ordinary skilled practitioner exercising and professing to have the capabilities required in the particular field of medical practice under consideration. In ascertaining what, in a particular case, constitutes reasonable care and ordinary skill in the relevant medical discipline, a court will usually receive evidence of the practice of medical practitioners and the state of medical knowledge at the relevant time.

This evidence is usually given as expert opinion from medical witnesses and is of considerable significance when there are allegations of negligence in diagnosis or treatment. However, evidence of professional practice cannot dictate to a court the standard of care applicable to the clinical facts before it. The court will determine the standard demanded by the law in the practice of medicine (or, indeed, in the practice of any other profession). Having said that, a court must have strong reasons for substituting its judgment where it has been properly arrived at and is supported by a responsible body of medical opinion.

Expert opinion will generally play little or no role in the determination of whether a medical practitioner has complied with the duty of care to provide adequate information to patients contemplating medical treatment. However, expert medical opinion may assist in determining the nature and foresee ability of a risk, which attracts the duty; the assessment of whether there were grounds for withholding information from a patient or the evaluation of a medical emergency which precluded the giving, of information to a patient .[vii]

If there has been a significant breach of standards by a health practitioner, then this needs to be dealt with appropriately. To this end, where it is mandatory that the Health Complaints Commissioner refer complaints to registration boards, the health complaints system and the regulatory system need to mesh to ensure that all aspects of the complaint are fully investigated including a breach of a standard of care even if this might not constitute ‘professional misconduct’.

The registration boards deal with complaints about registered providers and the disciplinary and other regulatory powers apply if a practitioner is incompetent, unfit to practice, engaged in unethical conduct, incapable of practicing due to incapacity or guilty of “professional misconduct”. The registration boards governing health providers have disciplinary powers to deal with *“professional misconduct”* but most do not have a clear statutory scheme to deal with a mistake or a failure to meet an acceptable standard, if this conduct does not comprise ‘professional misconduct’. As stated in the Medical Council 2001 Annual Report:

> *The Medical Council has the responsibility to ensure that medical services in the State are of the highest possible standard and to protect the public from practitioners whose clinical performance or ethical behaviour are not of an acceptable standard. Council’s interest in complaints, therefore, is to determine if they reveal evidence of a breach of acceptable professional standards by the practitioner.*

As explained in letters to complainants: [viii]

> *Council’s investigations are limited to determining if there has been a breach of acceptable clinical standards by the practitioner and if there has been any breach of the Medical Practitioners Registration Act 1996.*

As a result, although it is mandatory [ix] for the Commissioner, after consultation, to refer matters to the registration boards, the boards are obliged to dismiss many complaints on the basis that they are *“trivial, vexatious or unsubstantial”* if the conduct does not comprise ‘professional misconduct’.

In most cases complainants believe their adverse outcome are a consequence of the practitioner’s negligence and they are often deeply aggrieved when a registration board dismisses their complaint. Complainants often confuse complications associated with

medical procedures with negligence and often assume that if the *lack of due skill* constitutes negligence, then the registration board will find the provider guilty of 'professional misconduct' and discipline the provider accordingly. However, although the actions of a *"health service provider who failed to exercise due skill"* is a ground for complaint under the *Health Complaints Act* 1995 it does not necessarily bring into question a practitioner's overall capacity or competence to practice or constitute 'professional misconduct'.

The meaning of 'professional misconduct' has been considered in a number of cases. The Court of Appeal upheld an appeal from the doctor who had been deregistered for 'professional misconduct' by the Medical Tribunal of NSW. In *Pillai v Messiter* (No 2) (1989) 16 NSWLR 197 Justice Kirby said that professional misconduct means more than negligence or professional incompetence:

> *It includes a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges, which accompany registration as a medical practitioner' not 'an isolated error … as might happen even to a careful practitioner.* [x]

While the Solicitor General is of the opinion that all matters not dealt with by a registration board can be dealt with under the *Health Complaints Act* 1995, it is difficult to establish that there has been a failure to meet an acceptable standard and persuade the practitioner to attend conciliation when the complaint has been dismissed by their regulatory body on the basis that the conduct is not 'professional misconduct'. Practitioners sometimes erroneously believe that the finding by the registration board exonerates them.

This creates a "gap" between the health complaints system, which seeks to resolve complaints through conciliation, and the regulatory system. There is not a cohesive system with the power to address issues of poor practice, mistakes or a failure to meet an acceptable standard of health care. This "gap" occurs because a mistake or failure to meet an acceptable standard does not necessarily constitute "professional misconduct". The exception is the legislation governing the Nursing Board of Tasmania as the board, under the *Nursing Act* 1995 can promulgate standards under By-Laws and take action on a failure to meet an acceptable standard.

The Commissioner's view is that registration boards should have legislative power to determine whether there has been a breach or failure to meet an acceptable standard and to empower the boards to enhance standards of health care by clear powers aimed at addressing competencies, guiding, supporting and promoting good health care practice.

Such an approach would better address consumer concerns and would also enable the health complaints system under the *Health Complaints Act* 1995 to be more effective as it would ensure that appropriate matters were referred to conciliation with a clear assessment by the regulatory body as to whether or not the health care provider had met an acceptable standard.

Expert opinions

If it is left to the health complaints system under the *Health Complaints Act* 1995 to assess whether or not the heath care provider has met an acceptable standard then there is a need for the HCO to be adequately resourced when conducting investigations and to obtain expert opinions. These expert opinions would assist in assessing claims where compensation is sought. The Tasmanian branches of the colleges have assisted in nominating specialists who have provided assistance sometimes at no cost or with a significant pro bono element. However as Tasmania is a small state with a small pool of specialists, there have been instances when no one has been available, with sufficient expertise, to comment on a complaint against another specialist who is also a professional colleague. In the last two reporting years the Health Complaints Office has received no allocation in the budget to obtain such opinions either for assessment, investigation or conciliation purposes. Access to this expert clinical advice, and funding for this purpose, is essential.

Whether the standard of care has been met

The standard of care required from a health professional in Australia is one of reasonableness. For professionals who hold themselves out as having particular skills, the standard of care is not that of a reasonable person in the street, but rather a reasonable medical practitioner in that area. In *F v R* (1983) 33 SASR 189 the Chief Justice stated that the standard of care required of medical practitioners was *"that to be expected of an ordinarily careful and competent practitioner of the class to which the practitioner belongs".* Therefore, even an inexperienced health professional will be expected to act as a reasonably competent health professional in that speciality. A failure to meet that standard of care may leave a health professional exposed to legal liability.

Whether there has been a breach of an acceptable clinical standard is the issue that underlies almost every complaint when a lack of due skill is alleged and compensation sought. When an adverse event occurs the patient may suffer a very real detriment and be very ill as a consequence.

Causation, coincidence or complication

When a contemporaneous but unrelated condition occurs it is difficult to ascertain whether this has arisen out of the treatment administered or is simply coincidental. Sometimes a provisional diagnosis or suggestion by another practitioner can “convince” the patient that their present ailment must have arisen from their previous treatment which must have been deficient. Medical causation cases at common law can be extremely complex and can lead to lengthy hearings with a disproportionate amount of costs compared to damages. Causation issues arise in complaints lodged under the *Health Complaints Act* 1995 where compensation is sought and while the Act gives a person a right to information about their medical condition and “open disclosure” is encouraged, it is sometimes prudent for health practitioners to temper comments about what might have gone wrong until there is more certainty about the diagnosis. The HCO receives many complaints arising out of systemic failure in the delivery of health care services by hospitals and other organisations. These factors can include actions of a number of health professionals, or poor communication between different sections of the hospital. Some of the following cases illustrate complaints where the patient has genuinely believed that their condition was caused by a failure by the practitioner to exercise due skill, but in fact the condition they developed is unrelated and a coincidence.

A case of coincidence

The complainant underwent a right stellate ganglion block and about 24 hours later developed right sub-mammary pleuritic chest pain. She was admitted to hospital and it was suggested by a medical practitioner that she may have suffered right phrenic nerve palsy. On this basis she lodged a complaint. A Respiratory Physician provided an opinion that the radiological findings did not support this diagnosis and that it was possible that the apparent right lower lobe pneumonia and pleurisy were coincidental.

The matter was referred to the Medical Council of Tasmania and dismissed under s.48 of the *Medical Practitioners Registration Act* 1996 on the basis that the chest X-ray showed no evidence of phrenic nerve damage; respiratory specialists could find no association between the stellate ganglion block and the complainant’s respiratory problem, which they believe were coincidental and unrelated; the complainant was a heavy smoker and therefore more prone to respiratory problems. Further, the events that occurred following the stellate ganglion block could not be foreseen and therefore could not be foreshadowed when consent was obtained.

Case Summary 8

A complication or natural occurrence

In some instances the complainant may not have experienced any problems prior to medical treatment but subsequently suffers some difficulty. The issue may be whether the treatment has caused a subsequent problem, or whether this is a natural occurrence or complication that can arise without involving a lack of skill or care by the treating practitioners.

The complainant suffered a tear whilst giving birth but had not had an episiotomy or any post-birth stitching or complications after giving birth. The complainant later experienced a great deal of discomfort and painful intercourse. She attended a Health Centre where it was noted in her medical record that her "labia sutured together". She then saw a private Gynaecologist who reported that the complainant had some fusion below the clitoris. The complainant then underwent a procedure to separate her labial adhesions. While there is no doubt that the complainant genuinely believed that she had grounds to make the complaint, it appears, that *"adhesion of the labia"* is fairly common and may be caused by vaginal inflammation or irritation. It was reasonable to assume that the complication was caused by a "natural occurrence" not negligence.

Case Summary 9

A complication or pre-existing condition

In some instances the complainant is aware that a pre-existing condition causes problems but when the patient has an adverse outcome following surgery, it is an issue as to whether the symptoms arise from that condition, are a risk associated with that surgery, or are causally related to the surgeon not have exercised due skill. The complainant in the following case wished the condition to be remedied and, while not seeking monetary compensation, sought an earlier operation by being advanced on the hospital waiting list.

The complainant experienced faecal incontinence after a fistula operation. The complainant had several procedures and investigations done subsequent to the fistula operation but not until some time later was it documented that the complainant had a lax sphincter tone or incontinence. There was some issue as to whether the symptoms were related to Crohn's disease or an outcome of the operation. The matter was referred to the Medical Council and while the Council noted that the adverse outcome was most unfortunate, the Council accepted the doctor's explanation and did not seek a referral of the matter. The complainant was concerned about the waiting list for remedial surgery and this was expedited.
Case Summary 10

Same place, same injury, different time

A complaint having suffered an injury may be vulnerable to future injuries. This does not mean that the remedial surgery or treatment was unsuccessful. A person experiencing a recurrence of their original injury may attribute this to their practitioner failing to exercise due skill and seek compensation.

A complainant suffered an industrial accident and underwent a rotator cuff repair with acromiplasty. After surgery and some months of physiotherapy he still suffered significant pain. A further Magnetic Resonance Imaging (M.R.I) investigation was undertaken and an arthroscopic assessment of the shoulder indicated a rupture of the rotar cuff. The surgeon who performed the initial repair believed that a rotar cuff tear two years after the initial repair is not a disruption of the repair but a new tear of the rotar cuff attributable to a further considerable injury and was not a degenerative-type tear.

The matter was referred to the Medical Council and dismissed under s.48 of the *Medical Practitioners Registration Act* 1996. The Council's view was that there is no evidence of incompetence by the surgeon and that the injury, which had been thoroughly assessed by three orthopaedic surgeons, had been carefully and competently managed.
Case Summary 11

If it's not one thing it's another

The following case illustrates how understandable it is to mistakenly attribute a condition to inadequate service or delays.

The complainant believed that a poor repair to her dentures caused her gum to become sore and as a consequence she developed a dental abscess requiring her tooth to be extracted. The complainant had new dentures made at a cost of about $960 and her overall costs were in the vicinity of about $1,116.00. She sought compensation.

The issues raised by the complaint were whether the denture repair was competent, whether dentists had failed to properly assess the cause of her gum complaint on some three occasions over about eighteen months and whether the abscess had developed as a consequence of the "repair". The opinion of the ENT specialist was that the complainant probably had an apical abscess on the tooth. However, in this case there was no evidence to support a causal relationship between an abscess of this nature and the sore gums the complainant experienced from the uneven pressure of the denture repair and the delay in providing new dentures.

It appears that once the denture chrome bar had broken there was little option other than to grind down the chrome bar as a temporary repair and to place the complainant on the waiting list for a new denture. While there are concerns about the length of the Oral Health Service (OHS) waiting list for new dentures, it appears that this abscess would have arisen regardless.
Case Summary 12

A complaint on behalf of a deceased person

When a complaint is made on behalf of a person who has died, it is sometimes difficult to determine whether the care and management of the patient was adequate. In this regard adequate notes of the advice and warnings given can assist in making this assessment. Complaints where a surviving parent or spouse are grieving are often difficult to assess as the complainant has not usually be present during the consultations where advice was given and the patient may not have recalled or disclosed that advice to their partner. The complainant is often genuinely convinced that the advice was inadequate but this is not necessarily so as indicated in the case below.

Advice to a patient with a heart condition

The deceased had been a regular patient of a medical practitioner for over a decade and his widow alleged that his medical practitioner should have diagnosed the heart condition earlier. Further that the practitioner failed to instigate preventative measures and did not adequately explain the serious nature of his condition to her husband. As a result her husband continued to over exert himself. Consequently, he had a heart attack and died.

This matter was referred to Medical Council and dismissed the complaint under s.48 of the Medical Practitioners Registration Act *1996. The Council's decision was made based on the following reasons: there were no pointers to an underlying heart condition; advice had been ignored about his hypercholestreolaemia; highlighting that the medical practitioner had instigated preventative measures and a high level of care had been provided to his patient. The practitioner's response to the complaint was totally satisfactory. The Council recommended conciliation. Neither party was interested in pursuing that course.*

Whether the complainant could have been better reconciled to the outcome if their had been an independent specialist report and early resolution by the office is an issue in a number of these serious complaints where it transpires that there has been no breach of a standard of care.

Case Summary 13

The need to have risks identified and strategies in place

The use of due care when treating patients is also important. A hospital may be negligent if they do not properly assess patients and have a safe system in place to prevent accidents. A patient who suffers an injury could claim for damages. The following complaint against a public hospital concerned the care and treatment of the complainant's mother and relates to whether a fall contributed to her death.

The complainant's mother had been admitted into hospital with serious respiratory problems. Her condition worsened and she was admitted to Intensive Care Unit where she had responded to treatment and was to be discharged. Prior to discharge the deceased got out of bed and slipped on some urine and as she fell hit her head on the floor. Several patients on the ward witnessed this.

The nurses found her conscious and treated her by placing a pressure bandage to her head. After being moved to her bed she became unconscious and a decision was taken by the doctor not to operate due to the respiratory condition. Morphine was administered and she died several hours later with family present.

The circumstances of her death were reported to the Coroners Office and a post mortem was requested and carried out. The pathologist report to the Coroner stated that the cause of death was due to Cor Pulmonalae due to Emphysema Chronic Bronchitis. Consequently, the Coroner handed down a decision that there was no need to conduct further investigations as it was determined that she had died of natural causes rather than any injury that she may have sustained in the fall she had in the hospital immediately prior to her death.

In addition to the coronial inquiry the Nursing Board of Tasmania also investigated the matters relating to the nursing care during her stay in hospital. The board dismissed the matter on the grounds that the evidence gathered revealed that the nursing care did not contribute to the deterioration of her condition and subsequent death.

Accordingly, the complaint could not be substantiated.

Case Summary 14

For better or worse

In many cases it is clear that the complainant has suffered some loss and damage, in the case below the complainant suffered a herniated disc. The complainant believed that chiropractic treatment caused his disc to herniate and he requires surgery in an attempt to address this problem. He refused to accept a reimbursement of fees. The question is whether the injury that is the subject of the complaint was a consequence of the treatment given and whether it was foreseeable that this injury was likely to arise from such treatment.

The complainant believed that the nature of his chiropractic treatment was ill advised given the condition of his spine as indicated by his description of his symptoms. X-rays, MRI scans and other documentation was provided. The matter was referred to Osteopaths and Chiropractors Board who resolved that there was no evidence to support a finding that the chiropractor had either incorrectly diagnosed condition; commenced a course of treatment that caused a herniated disc, or exacerbated a pre-existing condition, and thus dismissed the complaint.

Case Summary 15

Cause and effect

In some instances treatment for one condition may exacerbate another dormant or pre-existing condition. As the complainant suffers this condition post operatively it is understandable that they believe that their pain and disability is causally related to the operation.

The complainant suffered significant pain and permanent impairment following a bone graft operation on her right foot. She believed that the orthopaedic surgeon had damaged or cut a nerve during the operation and sought compensation. The issue was whether the pain and disability following surgery was a consequence of the procedure having being performed negligently. Reports from specialist indicated that the complainant had arthritis in her talonavicular joint.

The matter was referred to the Medical Council pursuant to s.25(1)(a) who dismissed the complaint under s.48 *Medical Practitioners Registration Act* 1996. The Council considered that there was no evidence to support nerve damage nor any other surgical misadventure or incompetence and that, according to the specialist reports, the surgery was performed in accordance with reasonable standards. On this basis the matter was not referred to conciliation to discuss compensation.

Case Summary 16

An excision in time

A complainant may receive an accurate diagnosis of a condition that requires prompt surgical intervention in circumstances where a delay could cause the condition to worsen. This might be the basis of a substantiated complaint if that delay is unreasonable.

The complainant in this case presented with a large keratocanthoma on the left side of her nose (approximately 75mm in diameter). The referring doctor had made an accurate diagnosis on that same day, faxed an immediate referral to the surgeon, provided the patient with his contact details, gave appropriate warnings about scarring and in all respects had acted appropriately. The complainant returned to the Clinic as the lesion had grown (approximately 1cm in diameter) and was advised by a second doctor to wait for her appointment with the specialist scheduled one week later.

The complainant sought compensation as she believed that had she been encouraged to expedite her appointment with the specialist, the scarring would not have been as extensive. She maintained that the surgeon said she ought to have been referred at an earlier date however the lesion was not removed until a week after the consultation with the surgeon. At the consultation the surgeon reported a 1 cm nodular lesion on the left side of the mid portion of the complainant's nose - clearly suspicious for skin malignancy, either a keratocanthoma or a rapidly growing basal cell carcinoma – which needed to be excised.

He explained to the complainant that it *"would leave a defect that will require a small VY advancement flap to fill it."*

The Medical Council considered that the explanation provided by the general practitioner was entirely satisfactory. The HCO considered that there was no clear case for compensation however the parties agreed to attend conciliation.

Case Summary 17

Cardiac tamponade and the death of a newborn

Patients can experience adverse outcomes of care. For example, unintentional harm may come to the patient as a result of a clinical decision or a clinical procedure. This is illustrated in the following case.

Baby A was born on 20 September 1999 and died on 26 September 1999. At birth he was electively intubated and ventilated. There were difficulties in accessing veins to administer drugs and fluids and an attempt to insert a long line used for nutrition on 21 September 1999 failed. The medical practitioner successfully inserted a long line in the right leg the following evening. Following insertion, an x-ray was taken indicating that the line was too far in and it was withdrawn 1.5 cm into the right atrium (chamber of the heart). Baby A progressed satisfactorily until 0015 hours on 26 September 1999 when he suddenly deteriorated and he died at 0400 hrs. At the time the cause for the deterioration was unknown. At post mortem the totally unexpected presence of cardiac tamponade was discovered and was the cause of the infant's death.

The decision to insert a long line is made by the consultant paediatrician. Where the registrar is considered experienced, as in this case, they are left to perform the procedure themselves and a consultant is available if there are any problems. The hospital reported that virtually all babies in neo natal intensive care with a weight of less than 1000 gm have a long line and that it is a routine procedure.

The matter was referred to the Medical Council who dismissed the complaint against the registrar under s.48 of the *Medical Practitioners Registration Act*. 1996. Council indicated that in order to prove professional misconduct, it is necessary to show that the practitioner has departed from accepted rules, standards or practices within the profession and that the doctor was in breach of those accepted rules, standards or practices or that the conduct would reasonably incur the strong disapproval of fellow practitioners of good repute and competence. Council could not find that the medical practitioner had departed from accepted standards or procedures and therefore could not refer the matter to the Medical Complaints Tribunal.

At the time there were no written guidelines for the insertion of long lines at the hospital. Since the death of baby A the Hospital has instituted the following a written protocol for the insertion of long lines and the procedure for inserting a long line has been changed and the tip of the catheter is left in the superior vena cava (that is outside the chamber of the heart).
Case Summary 18

SYSTEMIC FAILURES

Failure to advise of test results

Diagnostic tests are an extension of a physical examination and medical history. The information gained from the different diagnostic techniques is used as part of the overall assessment and from the results obtained, a doctor can make a diagnosis and recommend appropriate therapy if necessary. Therefore, the creation and reporting of diagnostic and other medical tests are one of the most important pre-cursors to accurately diagnosing a patient's medical condition that cannot otherwise be diagnosed by means of a physical examination. Diagnostic film images created by radiographers are provided to the radiologist who then report their findings to the referring doctor. Consequently, from the time the film image is created, it passes from the radiographer to the radiologist, to the referring doctor and then to the patient for safe-keeping and future reference. In some cases, the radiologist rooms may hand the films and report direct to the patient who in turn delivers them to their referring doctor.

Failure to provide x-ray report to a general practitioner

The complainant believed that due to failure on the part of a practitioner at the hospital to advise him or his general practitioner of the radiologist's recommendation that he undergo a further Computed Tomography (CT) scan, he engaged in work activities for a period of three months and in doing so exacerbated a pre-existing back injury. The complainant failed to seek further advice on the management of and treatment for his back condition until his level of pain and impairment caused him to return to his general practitioner who sought the records from the Hospital and arranged the CT scan which revealed the extent of the patient's injury. Compensation was sought however an independent specialist's assessment, carried out at request of the Hospital with the complainant's agreement, could not conclusively support his claims that his level of injury had increased during this period. While the conciliation ended and the complaint was dismissed, the hospital put in place a proper reporting system to advise outpatients or their general practitioner about the results of diagnostic reports.

Case Summary 19

Failure to advise Hepatitis status

The complainant alleged that after a blood specimen test in May 1998 had revealed that she was Hepatitis C positive, the hospital failed to inform her for a period of almost three years. Further tests done in January 2002 discovered that the complainant was Hepatitis C positive however she became extremely distressed when she was told that her Hepatitis C status was known by the hospital as far back as 1998 but she had not been informed. The Hospital responded that the complainant had not been denied treatment and that on-going treatment was still available. The matter was dismissed on the basis that an adequate explanation had been provided by the hospital.

Case Summary 20

Lost records

Given the clinical importance to patient care of the film images and the accompanying diagnostic reports and the associated costs, it is vitally important that those handling these records have in place a reliable and effective tracking system. In part this is to ensure that if and when the "old images" are required for future comparison with subsequent test results, there is a readily available audit trail to go back to, to trace the whereabouts of the information.

Lost X-Rays

A number of complaints received by the Health Complaints Office concern lost x-rays. It appears that the documentation recording the receipt and dispatching of x-rays is inadequate and there are systemic issues relating to the transfer and safe handling of these records. These records are frequently critical to the patients on-going care and while such records are ultimately returned to the patient for their safekeeping, systems need to be put in place to ensure that all records are returned either directly to the patient or when being couriered to a referring doctor.

A recommendation has been made that a receipt should be given itemising all records received with identifying data such as number and date. Similarly the referring specialist or practitioner to whom records are transmitted or the patient should acknowledge receipt in writing. While it is understandable that records if couriered are forwarded in one package, the records should not be removed from their original envelope and collated in one bag as this can potentially lead to records being mislaid or confusion as to whether all records are returned as illustrated by the following case.

Lost MRI Scans

A complaint was made against a magnetic imaging provider on behalf of a complainant who spoke very little English. The complainant had been referred by her general practitioner for Magnetic Resonance Imaging (MRI) scans and took with her, as requested, previous x-rays. The complaint was that some of these previous x-rays handed to the provider had been lost.

The complainant handed three separate x-ray bags containing old films to the front counter staff. On completion the staff forwarded the MRI results to her referring doctor and the issue is whether they forward all the old x-rays at the same time. The provider acknowledged that they re-packaged the old x-rays into one bag and say this is normal practice. Some time later the complainant's son attended the referring doctor's rooms and collected a single envelope purportedly containing all his mother's x-ray films, both the new and the old images. Enquiries were made with the referring doctors staff and the advice given was that it was usual practice for the doctor to hand all x-rays back to the patient after they have been viewed. This suggests that all the x-rays received by the referring doctor were handed back to the patient.

The complainant had been required to make a second appointment for a further scan some two days after the initial appointment as a scan needed to be repeated. On this occasion, she had taken some other films that were handed back to her at the end of the appointment. These scans do not form part of the complaint but illustrate that a number of images may be handed over and it is necessary to have a safe system in place for recording the scans received, returned and transferred between health care providers. The provider's records showed that a courier delivered the films to the referring doctor however the quantity and type were not recorded.

Whilst the missing x-rays were not found the provider acknowledged that their system for receiving and dispatching x-rays either directly back to patients or delivery by courier to referring doctors does not involve these records being formally recorded or receipted and therefore if films are *"lost in the system"* there are no ways of checking what films were received or dispatched by their organisation.

The provider offered an apology and was willing to reimburse the complainant any out-of-pocket expenses and, should any future examinations be required, they were prepared to do these at no costs. The provider agreed to review their collection and delivery system and, if a better system was identified, they would implement it and advise the Commissioner. However it was also stated that it was difficult to put in place a system to avoid this occurrence "*as operationally recording all films received and delivered is an extremely difficult process as this would effect all referring doctors in the region".*

Case Summary 21

Lost CT Scans

Another complaint related to missing CT scans following a liver biopsy. The complainant suffered a rare but recognised complication namely bile peritonitis. She believed that the liver biopsy was not performed with due skill and care and in the process of seeking legal advice became aware that the relevant CT scans were missing.

The complainant was referred to the Radiology Clinic for a liver biopsy. She experienced pain (incorrectly diagnosed as angina pain) and subsequently required emergency surgery. The specialist's report indicated that it was likely that bile had leaked into the peritoneal cavity during or shortly after the liver biopsy, causing the pain that the patient experienced, and leading to a rare but recognised complication, namely bile peritonitis. The relevant CT scans of the biopsy were "lost". The CT scans were not amongst the records provided to the complainant on her discharge from the Hospital and had not been documented in the 'document record book' however, staff recalled the doctor who performed the biopsy delivering these records to the Hospital personally.

It was accepted that the complainant had not lost the scans, the practitioner had delivered the scans to the hospital when the patient was transferred and that, on balance, they were not returned to the patient when she was discharged from the hospital after a lengthy admission.
Case Summary 22

Records not missing but can't be found

The system for storing records is sometimes inadequate particularly if the records are voluminous. Other problems can arise if a health service provider in a sole practice dies, retires or transfers interstate and no provision or system is in place to enable patients to access their medical records, as illustrated by the following complaint.

A complainant was aggrieved because he has been unable to access the results of a test he had some years ago. He had phoned the medical practice on numerous occasions and written a letter, but he did not receive a response of any kind.

The Medical Centre where the test results were originally held did advise him that that particular practice had amalgamated with the current medical practice and that all medical records were merged to allow the "new" amalgamated practice to use a computerised program known as the "Medical Doctor". Prior to that both practices had separately used what was known as the "RACGP Health Record". The doctor who had requested the "tests" and held the results and report of the tests, had archived and catalogued all of his "old active files" but did not catalogue any of his inactive files.

Because of on-going work demands, personal illness as well as storage difficulties, the situation became very difficult for the doctor concerned and the files remained stored in boxes. The complainant was provided with an opportunity to indicate whether he accepted the response but did not reply and the complaint was dismissed. **Case Summary 23**

Risk Management

Given that mishaps can happen it is prudent to develop risk management strategies. In some instances a consumer's actions may have contributed to a potential mishap and the "near miss" can cause these strategies to be reviewed. While not every contingency can be covered, every strategy has to consider that the consumer may not be aware of the risk as indicated in the following case:

Risk management and the human element

A complaint related to the purchase of an Epi-Pen device (an auto-injector device used to treat people with allergies) for the complainant's sixteen year old son. While in the pharmacy her son "pulled the top of the device to open the container, the trigger fired and her son was stabbed". He was taken to hospital for treatment. The owner of the pharmacy wrote to the complainant and stated that, in his view, the attending pharmacist and dispensary staff had acted appropriately and complied with all professional requirements in the sale of the Epi-pen device. The pharmacist offered an ex-gratia payment of $104.80 but made it clear that this payment was made solely as a gesture of goodwill and without admission of liability. The complainant was not satisfied with the ex-gratia payment and stated that she would "not cash the cheque without an appropriate apology".
Case Summary 24

Unacceptable Delays

The next complaint relates to a failure by the prison staff to respond to requests for treatment and highlights that some patients may experience a standard of care that is less than satisfactory under the circumstances.

Watching the watchers

The complainant alleged a failure by the Prison to provide timely medical care. A period of thirteen days elapsed before a nurse attended to a prisoner who had requested medical care. Information was sought about nurse-initiated medication, the referral system between the main Prison and the Prison Hospital and whether the referral system was operating as intended. It was said that there was a need to clarify the legislation and policy on nurse-initiated medication in a custodial setting.

Subsequently, the Clinical Nurse Manager conducted an audit of the request system and reported that most requests were at that time being dealt with the same day they were received. It was stated that where a request cannot be addressed the same day, a system is being devised so that inmates are informed that they are on a waiting list for medical or nursing attention. An apology was conveyed to the prisoner and it was acknowledged that there were delays in the prisoner receiving attention. **Case Summary 25**

The Oral Health Service (OHS)

As noted in the Auditor-General's Special Report (November 2002):

> *the waiting times for general care in the Tasmanian Public Dental Service are at unacceptably high levels, with no reasonable chance of an adult obtaining general care in Tasmania's public oral health system. Waiting times for prosthetic services are considered reasonable, albeit longer waiting times in the North West region need to be monitored.*

Such comments are consistent with a significant proportion of all telephone inquiries received by the HCO during this reporting year and previous years. A number of complaints concern the OHS waiting list which complainant's consider unacceptable. In view of the OHS response citing lack of financial and human resources it does not appear that the matter will be resolved in the immediate future.

The Auditor-General made a number of significant recommendations in his report, however, it would appear that unless there is a significant increase in funding to secure the appointment of more OHS dentists, many of the Attorney General's recommendations will be difficult to achieve and those lodging complaints under the *Health Complaints Act* 1995 will continued to be dissatisfied with the outcome.

Six year wait for a denture repair and still waiting

In 1996 the complainant developed a crack in his denture and attended the OHS for treatment. He was told that his name had to be put on a waiting list, which provided for free repair or replacement and was informed that the waiting time was about two years. No offer was made at the time to do a temporary repair.

After not having had any contact from the OHS for four years he contacted the OHS and was given an appointment. He attended the appointment with the expectation that OHS would either repair the damaged denture or that he would be have the preliminary work done so that his new denture could be made as the Clinic had first agreed.

Much to the complainant's disappointment, the only treatment he received was a minor filling and a general clean. Having waited four years to get an appointment for dentures, the complainant expressed his disappointment and dissatisfaction when he was advised that he would have to pay the account for the treatment he had already received, in addition the cost of his denture (when he received it). [xi] He said he could not afford to pay the account and said he did not wish to come back. He subsequently received a bill from OHS for $26.00. The complainant had no further contact from the OHS until some two years later when he received notification that the outstanding account for $26.00 had been placed in the hands of the Tasmanian Collection Service for recovery and or legal action. The placement of the debt by the OHS with the Tasmanian Collection Service formed part of the complaint in that the complainant stated that: *"I was forced to pay the debt, even though I can't afford to pay it out of my $300.00 fortnight pension, yet 6 years I still have that cracked "rattley" denture and no prospects of having it fixed by the OHS".*

The complaint was forwarded to the State Manager of the OHS for a response. The response advised that the complainant's case had been reviewed and it was found that the preliminary treatment provided to him at the first

appointment was standard treatment in order for him to receive a new partial denture because a partial denture is not usually made when adjoining teeth are decayed. It was pointed out to the complainant that if he wanted to get the denture made without the repair to his teeth, he would need to seek that service privately. An appointment was made for him for the new denture, but he failed to attend despite being reminded one month before. In view of the delay, it was stated that it was unlikely that the complainant's oral health status would be the same as it was when he was last seen, and so he may need additional restorative work to his natural teeth before a new partial denture could be made. The response concluded with the statement, "unfortunately, the waiting list for this type of treatment may prevent the complainant from being seen for some time".

During the course of this matter, OHS advised this office that it had received additional funding to improve the waiting list for people requiring dentures. Unfortunately for the complainant this funding was only available to those people who required full upper and lower dentures. We wrote to the OHS and requested the State Manager's advice as to whether the complainant was are eligible for consideration to be placed on the supplementary list for treatment being offered with the additional funding provided to Oral Health Services. Six years after the initial contact with OHS the complainant is still waiting for his denture to be repaired.

Case Summary 26

CONSENT

Informed Consent

A doctor or other health professional must obtain a patient's consent before undertaking a medical procedure. The general principle of informed consent is that patients are entitled to make their own decisions about medical treatments or procedures and should be given adequate information on which to base those decisions. The doctor is also required to inform their patients about his/her proposed treatments and must provide sufficient information to a patient in order for the patient to make an informed decision whether to consent to the procedure in question.

There are issues as to the nature of the consent, the degree to which it was "informed", the capacity of the consumer to comprehend the possible consequences, the capacity of the provider to communicate the information so that the consumer can understand and make an informed choice and the obligation on the provider to provide proper information as to the alternative options.

In the case below the complainant entered hospital in great pain. There was little option other than to consent to the procedure but in the circumstances of an urgent admission neither he or his wife could recall being informed of the risks or complications related to the procedure. Even had they consented to the procedure and informed of the risks they had little concept of what it might mean if that complication arose. The patient was grateful for the care given to him but could not accept that the outcome would be so adverse unless an error had been made.

Consent and illness, a difficult partnership

In this case the complainant alleged that his consent to a medical procedure (ERCP) had not been "informed" because he had not been informed of all the relevant risks. In 5% of cases pancreatitis occurs and in 0.5% severe pancreatitis may occur. It was maintained by the surgeon that these are well-recognised complications and medical articles were submitted in support of this claim. In this case severe pancreatis did occur and the patient almost died, spent approximately two and a half months in intensive care and a subsequent long recovery period. The complainant, who required urgent treatment and may have been told of the risk, may not have appreciated or understood the potential seriousness of the consequences if complications arose.

In this case the surgeon recalls instructing the patient's general practitioner. to outline the risks. Prior to the procedure the resident medical officer explained the risks and obtained a signed consent form. The surgeon also talked to the patient just before the procedure was commenced and states that he made sure that the patient understood the possible complications.

At the time the consent for the ERCP procedure was obtained the complainant was an in-patient in hospital suffering from intermittent severe epigastric pains, vomiting, difficulties with eating, had been prescribed pethidine, and was on a ventilator. In view of the serious nature of his illness it is likely that his recall of conversations pertaining to the possible complications of the ERCP procedure may not be wholly accurate. This is not to say that the complainant did not make this complaint in good faith but simply that there appeared sufficient evidence indicating that an explanation as to the risks had been given by more than one practitioner. The complaint was found to be unsubstantiated and dismissed having been referred to the Medical Council and dismissed pursuant to s.48 of the *Medical Practitioners Registration Act* 1996.

Case Summary 27

Communication

Providers also need to be vigilant regarding matters such as “informed consent” and “substitute consent” in instances where an adult patient is incapable of giving the requested consent. There are other instances where a person’s capacity to consent may be impaired by their illness or fear of the treatment they are undergoing and they seek assistance from family or utilise the complaints system as they feel unable to discuss their unwillingness to undergo the proposed treatment with their treating doctor. The following case illustrates this.

Consent can be given and also withdrawn

The patient in this case was a voluntary patient at a residential facility having regular Electroconvulsive Therapy (ECT) treatments for Bi-Polar Disorder. The complaint was lodged by her son alleging that his mother dreaded this form of treatment and constantly complained about it. He complains that the care facility was resistant to alternative methods, and that although the ECT treatments had been reduced from once a fortnight to once a month the doctor in charge of his mother’s care was reluctant to abandon this particular form of treatment believing it to be of benefit to the patient.

The issue was resolved without further intervention when the patient withdrew her consent ECT treatment. The treating doctor remained open to discussing the issues with the patient and with her consent, members of her family.
Case Summary 28

Cosmetic surgery and realistic expectations – an impossible dream

There are some elective procedures, particularly relating to cosmetic surgery and body image issues, where the provider must endeavour to ensure that a potential patient has realistic expectations about the outcome. Disappointment about the outcome may arise out of the patient’s unrealistic expectations or the provider’s failure to communicate or inform the patient about the likely outcome. This can lead to complaints as to whether the consent was “informed”.

The problem is present in all jurisdictions. In 1998 the New South Wales Minister for Health called for an ‘inquiry’ into cosmetic surgery. The ‘inquiry’ was prompted by complaints from consumers and health professionals and professional bodies concerned about the way that cosmetic surgery procedures were promoted and the quality and safety of those procedures.

Cosmetic surgery is a procedure performed to reshape normal structures of the body with the aim of improving the consumer's appearance and self-esteem. It includes procedures such as breast enlargement, breast reduction and liposuction, as well as non-surgical procedures, such as collagen injections and any cosmetic treatment. The consumer, rather than medical need generally initiates such surgery, and the notion of 'improvement' of appearance is a subjective one, defined by the consumer.

Generally, the consumer will have a definite (and perhaps unrealistic) image of how they see themselves post-surgery however quite often outcomes are poor and do not meet the expectations of the consumer. In some instances, as indicated in the following complaint, what was expected and what occurred are clearly at odds.

Expectations and outcomes

The complainant, a twenty-four year old female, lodged a complaint against a Plastic Surgeon after undergoing a Abdominoplasty. She was very disappointed with the result because one of the main reasons she had the operation was to remove excess abdominal skin. The complainant had had expected that there would be some improvement in the upper abdominal skin but conceded, to the Council, that no guarantee was given about the upper abdominal skin and that the excision of the lower abdominal skin was a big improvement.

The matter was referred to the Medical Council who considered that the central issue of the complaint was “what was agreed pre-operatively and whether or not there was any specific request for, or agreement, that the lax upper abdominal skin would be removed.” The Council dismissed the complaint under s.48 of the *Medical Practitioners Registration Act* 1996 and reported that:

It appears that (the complainant’s) expectations of surgery have not been met. However, Council is not able to reach the conclusion that there was inadequate pre-operative explanation of the proposed surgical procedure. It does appear that the limitations of surgery were explained and that (the complainant) understood that there was no agreement to excise upper abdominal skin although it was her expectation that there would be an improvement.

The Council’s reasons are instructive as they illustrate the importance of good communications and records given the contractual nature and the difficulty of accommodating the expectations that can arise with cosmetic surgery. It appears that the surgeon spent at least half and hour with the complainant discussing the procedure and while he conceded that the possibility of tightening the upper abdominal skin had been discussed, it had been agreed that he would make this judgement at the time of surgery. He stated unequivocally that the agreed procedure was performed with the emphasis on the lower abdominoplasty and that he had not agreed that there would definitely be excision of the upper abdominal skin. The matter was not referred to conciliation. **Case Summary 29**

Informed Financial Consent

As well as receiving complaints relating to the issue of consent, the Commissioner also receives enquiries and complaints that deal with the issue of "informed financial consent". With ever widening "gaps" between Health Fund rebates and medical fees, out-of-pocket expenses for patients can be substantial and in this environment the issue of financial consent is an important one. This is recognised by the Australian Medical Association and to quote from their web-site:

> *In keeping with the Notes for Guidance to the AMA List of Medical Services, Federal Council reaffirms the principle of 'informed financial consent' between the patient and the doctor, i.e. wherever possible, the doctor should give the patient sufficient information regarding his or her likely fees and the associated rebates so that the patient is able to make an informed financial decision prior to the provision of medical services.*

Seeking fully informed financial consent may not be possible in an emergency situation, but in general terms if the consumer has an understanding of the likely costs of a procedure they are then able to make an informed decision as to their treatment options. For example, a consumer may chose to access the public system rather than undergo a private procedure, compare costs between service providers, or seek out a practitioner who is in a registered partnership with a health fund and so lessen their out-of-pocket expenses.

The role of communication in "informed financial consent"

An eighty year old patient, whose sole income was the aged pension, visited a specialist and later underwent a hospital procedure. He complained that he was at no time informed of the cost of this procedure and, when faced with the account, found there was a difference between the Medicare rebate and amount charged which he was unable to pay.

Once made aware of this complaint the specialist agreed to accept only the scheduled fee leaving the complainant with nothing further to pay, and mentioned that he would have preferred the complainant to raise this matter at the time of his consultation. At the time of the initial consultation with the specialist the complainant presented both his Medicare card and his pension card.

This complaint raises the question as to why the costs of the procedure were not discussed initially? Should the presentation of a pension card have been seen as a sufficient indicator of possible financial hardship, prompting the specialist to address the issue of costs? Should the patient have requested information regarding the likely costs of the procedure? In this case adequate communication between patient and practitioner would have obviated the need for intervention on the part of this office.
Case Summary 30

How much Consent is enough?

A complaint was lodged about the fees charged by a surgeon. The complainant believed that the fee charged was "excessive" and in support stated that the fee was substantially above the "scheduled fee". The "scheduled fee" is the fee listed in the Medicare Benefits Schedule (MBS). In his response to this office the surgeon included copies of a consent form that had been signed by the patient prior to surgery that clearly stated that *"the 'gap' (between the Medicare rebate and the Private Health Fund cheque) can be substantial".*

This consent form also asked the patient whether they would like to further discuss their financial situation further with the surgeon. The complainant had not requested such a discussion. In light of this, the complaint was dismissed. While the MBS is set well below the fees routinely charged by medical practitioners this may give rise to false expectations within the community as to the likely costs of any given procedure. A patient entering into a contract also has obligations to enquire as to the likely charge for the services provided.
Case Summary 31

A stitch in time…

A delay in admission procedures left only a short amount of time for the anaesthetist to explain to the patient the risks associated with anaesthesia, post-operative pain relief options and the cost of anaesthetic services. The conversation with the anaesthetist took place in the half-hour before surgery and was conducted whilst the admitting nurse was collecting information from the patient and providing surgical consent forms - a less than ideal situation.

The complainant was aggrieved at the amount charged by the anaesthetist, claiming that they had no fore knowledge of the extent of the charges. The patient was also stressed by having to make difficult decisions in relation to pain management in a very short period of time. The complaint was resolved when the anaesthetist offered an apology for the rushed pre-surgery consultation, and negotiated with the patient a reduced charge for services. The anaesthetist also gave an undertaking that an attempt would be made, wherever possible, to consult with patients on the day preceding surgery**. Case Summary 32**

RESTRICTED MEDICATIONS

Schedule Eight Medications

Complaints and enquires are received on a regular basis in relation to difficulties complainants experience in obtaining narcotic medications – be they analgesics for pain management or methadone for treatment of opiate dependency.

These drugs fall within Schedule 8 of the *Poisons Act* 1971 and as such are subject to restrictions imposed by that Act as to manufacture, supply, distribution, possession and use. The reason for these restrictions is to reduce abuse, misuse and physical or psychological dependence. The *Alcohol and Drug Dependency Act* 1968 places further restrictions on the prescription and supply on the medications that are supervised by the Pharmaceutical Services Branch of the Department of Health and Human Services (DHHS).

Under the *Alcohol and Drug Dependency Act* 1968 these, and certain other medications, cannot be made available for a continuous period of more than two months without special authority of the Secretary of DHHS. In those cases prescribers are required to make an application and to notify if they believe the patient, the subject of the application, is drug dependent. A medically based committee, known as the *Section 22 Committee* then considers the application and in turn provides advise to the Secretary who has the power to specify conditions on the authority to prescribe. These conditions may relate, for example, to having the application supported by specialist reports, particularly where long term prescribing is anticipated, or may be subject to special supply provisions.

Some patients in receipt of narcotic drugs feel aggrieved at having their analgesic needs tested and examined in this way. However, the objective of the Pharmaceutical Services Branch and the legislation is to prevent the serious harm that narcotic drugs cause some individuals and the Tasmanian community generally and therefore scrutiny of the basis for prescribing narcotics should not be anything less than vigorous.

It is accepted by the HCO that it is fundamental to good medical practice that a medical condition is properly investigated and a proper diagnosis made. It is the general practitioner who makes the application to the Department, not the patient, and the prescribing of narcotics is a medical decision with the general practitioner acting as the patient's medical advisor and representative. The general practitioner makes the clinical decision and can refer the patient to a specialist to obtain advice as to appropriate medication prior to making the application for a permit.

At present it is not always clear how the process operates. The Pharmaceutical Services Branch has attempted to rectify this by providing information about the Section 22 Committee and the "Requirements for the on-going prescribing of narcotic analgesics". [xii] This process seeks to support the general practitioner as the central co-ordinator of patient care. The Chief Health Officer provides information to general practitioners. [xiii] An article "*Legal Obligation of Medical Practitioners when Prescribing Schedule 8 (Narcotic) Substances*" [xiv] was published in the Medical Council Newsletter.

The purpose of the patient attending the specialist is to establish the diagnosis, obtain expert advice on the best way to manage it, determine whether opiates are indicated or if unnecessary use of opiates can be avoided, and if necessary identify the appropriate drug, form and route of administration. There are instances where some patients are not supported by specialists in their use of opiates as indicated in the following complaint to the HCO.

Chronic Pain

The complainant was involved in a motor vehicle accident in 2001 following which she complained of persistent back pain. She was prescribed opiate analgesics, namely Oxycontin over a period of some fourteen months, her treating doctor having obtained the necessary authorities from Pharmaceutical Services. In February 2003 she attended another doctor who refused to prescribe further Oxycontin. She complained to this office.

The doctor explained that his refusal to prescribe further Oxycontin was because enquires he made from Pharmaceutical Services had disclosed that in the preceding month she had visited several doctors and had acquired four times the quantity of the drug she was authorised to receive. He said he explained to her that it was not an appropriate treatment for chronic pain because people very quickly become addicted and build up a tolerance to it as a result of which they need larger and larger quantities to ease their pain. He provided her with a prescription for Tramal (a synthetic analgesic not derived from natural sources nor chemically related to opiates) and encouraged her to seek physical treatment for her pain such as physiotherapy or massage. It was considered that the doctor's response in this case was entirely appropriate.

In terms of a patient's condition, given that a patient prescribed with opiates is going to be exposed to the risk of drug dependency (a chronic long term relapsing condition), it is necessary to be sure that the need for treatment is there in the first place. Hence the need for rigorous scrutiny and specialist advice. **Case Summary 33**

The complainant in the following case lodged a complaint against the conditions to be put in place before approval to prescribe was authorised by the *Section 22 Committee*.

The problem for some patients is that often they have been appropriately prescribed with opioid medications for relief of chronic pain, but over time have deviated from the prescribed regimen and have become dependent without intentionally setting out to abuse the drug in the first place. The compulsion for these people to seek drugs to satisfy this addiction, can lead to them feigning illness and/or doctor shopping. The problem of balancing the public safety and public interest with the requirement to supervise and prevent abuse is illustrated in the following case:

A daily dose

The complainant alleged that she suffered chronic pain, and the medication sought required special approval and authorisation under the *Alcohol and Drug Dependency Act* 1968. An application to prescribe was approved and the Secretary issued a permit in accordance with the recommendations of a *Section 22 Committee.* The approval required the complainant to attend a pharmacy *each day,* and the medication had to be taken under the direct supervision of a pharmacist. The complainant considered that these requirements were discriminatory.

In an earlier permit issued in 2003 the patient had been prescribed benzodiazepine Rivotril (Clonazepam) under the same dosing requirements. However more recent specialist advice to the department had indicated that this drug had been ceased during her admission to hospital and on her discharge from hospital was not to be continued. The specialist also confirmed that, in the interests of security and patient safety, the controls under the s.22 permit needed to be continued. If the patient for any reason needed to travel out of the area, arrangements could be made for her to receive sufficient medication for her journey and dosing to occur in the area to which she had gone. In the circumstances the complaint was not substantiated and dismissed on the basis that the complainant had been given a reasonable explanation and information.

Case Summary 34

However, if there is a conflict in expert opinion as to the patient's treatment requirements and it would, in our view, be appropriate to have grievance or appeal procedures in place or opportunities for patients through their general practitioner to be heard in relation to decisions being made about their medication regimes or the nature of the conditions imposed.

The issue of whether or not a patient should have a further avenue of appeal remains unresolved. The Pharmaceutical Services Branch consider that it would not be appropriate for the patient to have an avenue of appeal as, should the general practitioner object to the recommendation of the *Section 22 Committee* and take this objection to the Minister for Health, or raise it through other avenues, then the Department could re-examine the issues. With regard to improving the transparency of the permit authorization process the Pharmacy Services Branch advise that:

The Poisons Act 1971 *is currently being revised and updated with a view to a new Bill being introduced into Parliament in the first half of 2004. The DHHS reports that it is proposed that the narcotic prescribing application and authorisation processes currently found in Part 3 of the Alcohol and Drug Dependency Act 1968 will be transferred to the Poisons Act and regulations. This transfer will provide an opportunity to examine and update the current legislative scheme to better describe the processes for reviewing and approving prescribing applications.*

Access to Methadone Program

Options, such as the Methadone Maintenance Treatment Program (MMTP), for treating addictions to prescription opioids and to help manage the severe withdrawal symptoms that accompany sudden cessation of drug use, also pose problems for some patients and lead to complaints under the *Health Complaints Act* 1995. These problems relate mainly to the accessibility to, and cost of, this medication.

The Pharmaceutical Services Branch of the Department of Health and Human Services is responsible for the issuing of authorities to prescribe methadone in Tasmania pursuant to s.22 of the *Alcohol and Drug Dependency Act* 1969. The Alcohol and Drug Services of the same Department provides related clinical training and manages the methadone program.

In 1992, a generally available methadone treatment program was established in Tasmania. Prior to that, methadone treatment was only available in special circumstances. In August 1995 however, methadone treatment was moved predominantly to the private providers. The reasoning behind this, as advised by the then Chief Medical Officer of the then Department of Community and Health Services, was in an attempt to increase access to those in need of treatment outside centralised locations in Tasmania.

The reality seems to be however that some patients experience difficulty in locating both a doctor to prescribe the medication and a pharmacist to dispense it, as both are required to be trained, as recommended by the Methadone Accreditation and Training Committee, and accredited for these purposes. The conduct of the patient might be a factor in some pharmacists being reluctant to be involved in the program as illustrated in the following complaint.

‘Drug Shop’

The complainant alleged that he had been released from prison without appropriate measures being taken for him to access the Methadone Program (or other appropriate long-term pain relief medication). A medical practitioner noted that in view of the nature of complainant’s past conduct, including the drug related reason why he was imprisoned in the first place, it was highly unlikely that local pharmacies would be prepared to accept him as a recipient under the “Methadone Program”. Fortunately the complainant found a medical practitioner who was prepared to prescribe his medication and a pharmacy who was prepared to dispense his medication.

Case Summary 35

In 1996 a former Minister for Health established an advisory Tribunal known as the Methadone Review Tribunal. It was a function of the Tribunal to hear complaints from patients on methadone treatment and to make recommendations to the Chief Medical Officer after attempts had been made to resolve the complaint with the prescriber, the dispenser or the Regional Coordinator of the Alcohol and Drug Service. The Advisory Tribunal referred to above was an interim measure until the establishment of the Office of the Health Complaints Commissioner. The Tasmanian Methadone Policy 2000 refers to three (3) avenues of complaint.

1. If a patient has a concern about their methadone treatment they should wherever possible take the matter directly to their prescriber or pharmacist. Equally, it is suggested that prescribers or pharmacists with concerns should deal directly with the relevant party in the first instance. This is the most direct and generally quickest approach.

2. A concern about any aspect of the methadone program may be taken by any of the parties involved in the Methadone Program to the relevant officers within the Department of Health and Human Services (DHHS). It is said that this option provides the opportunity to clarify concerns and assist in dealing with complaints in a short time-frame.

3. If the concern still exists, then the Office of the Health Complaints Commissioner has been established under legislation to investigate health complaints.

A large proportion of clients on the Methadone Program attend private Medical Practitioners and Pharmacists. The Alcohol and Drug Service does not have direct control over their prescribing practices although medical practitioners accreditation as prescribers under the Methadone Program would require that they act within the requirements of the Tasmanian Methadone Policy.

In Tasmania the commencement of the *Health Complaints Act* 1995 was regarded as providing a review process for complaints relating to the Methadone Program.

PART 6 INVESTIGATIONS

There were six Part 6 investigations completed during the reporting year and a number of other matters resolved without the necessity of either conciliation or investigation. The investigations related mainly to systemic problems in hospitals but one complaint arose out of allegations relating to an organisation providing support to persons with disabilities, another related to a Health Centre not properly assessing a child who was subsequently hospitalised. A third involved a failure by a medical practitioner to advise a patient about an adverse test result. In the last case although remedial action had been put in place, the Medical Council followed this matter up at the conclusion of the investigation and reinforced the requirements with all practitioners.

One complaint, which is not summarised below, involved an incident that occurred many years earlier and this matter was not dealt with as an investigation. A recommendation was accepted for an *ex gratia* payment to resolve a long-standing dispute involving a complainant and the Sexual Health Unit. While the matter was referred to as an assessment report it in essence was an investigation but was referred to conciliation with a recommendation for an *ex gratia* payment that was accepted by the Department of Health and Human Services.

Investigation Summary 1

Medication management and other issues

A complaint was lodged on behalf of an inpatient against a Private Hospital and a Pharmacy. The complaint against the Pharmacy related to the dispensing of medication in an amount that differed from that which had been prescribed. The complaint against the Hospital related to various aspects of the care and management of the complainant's mother over a period of three months until her mother's death from cancer. The issues arising out of this complaint primarily concerned medication management relating to the manner of dispensing, administering, recording and securing patient's medication. It was also alleged that the patient had fallen out of bed and sustained cuts to her head and arm, that another patient's medication was in the patient's locker at the date of her death, that the oxygen unit provided to the patient to enable her to spend time with her family had a leakage and was known to be faulty and only partly full.

A number of matters were resolved directly between the Hospital and the complainant without the intervention of this office. The Hospital is to be commended for this approach and in this respect demonstrates the benefits of good communication and openness in complaint resolution.

Issue : Medication not dispensed in dosage prescribed
The Pharmacy confirmed that due to a supply problem Oxazepam (Serapax) was dispensed as 30 mg not 15 mg as prescribed. The pharmacist gave directions for half of a 30 mg tablet to be taken as directed, delivered the medication to the ward and spoke to the nurse advising her that if the patient was having 1 x 15 mg then she would be given 1/2 of the 30mg tablet and if having 1/2 of 15mg then she would be given ¼ of the 30mg.

The pharmacist, personally delivered a quantity of 25 Serapax tablets to the ward and alerted the nurse that the medication dispensed and supplied was 30mg, not 15mg tablets and that the dosages to be administered would have to be adjusted accordingly. She requested the nurse to pass the message on to the other nurse(s) at changeover. It was accepted that problems in supply do occur and did so in this instance.

Although no criticism was made of the pharmacist's actions, recommendations were made as to how this information should be communicated and recorded when medication is dispensed in a dose higher than prescribed. It was recommended by the HCO that:

> *The pharmacist endorse medication charts with a warning when a strength other than that prescribed, is the only strength available. In these circumstances the Pharmacy warn the Hospital nursing staff by facsimile to the ward and that this be placed on the patient's medical record.*

Investigation Case Summary 1 continued overleaf -

Issue: Incorrect administration of prescribed medication
It was alleged that an incorrect dose (30mg of Serapax and not 15mg) was administered for eighteen days. Further, it was alleged that there were numerous other incidents with medication not being given and was not recorded on drug sheets. The Hospital responded that a variable dose up to 30mg a day could be administered. The medical records could not establish whether the correct amount had been administered. No determination could be made on this aspect of the complaint.

The Nursing Board's examination of the drug chart highlighted that in most instances the actual dose was not recorded. The Board's view is that the exact dose administered should be recorded. The Hospital accepted this recommendation and requested the Board to draft *"Guidelines in Medication Management for Nurses"* which would be adopted as hospital policy for record keeping purposes.

Issue: Injuries received in a fall
The patient climbed out of the bed without assistance. It is unknown whether she had sought assistance. Consequently, she sustained a cut to her left eye and quite serious injuries to her arm. Two separate incident reports, one related to the fall and one regarding administration of medication were not located during the course of this investigation.

Issue: Other patient's medication being stored in the patient's locker
The Hospital did not dispute that another patient's medication had been stored with the patient's medication in her locked drawer at the time of her death. This established that there had been a major breach of policy in that medicine dispensed for one patient was re-used to treat another patient.

The complainant stated that the Oxygen unit provided by the Hospital had run out of oxygen and therefore it became necessary for "the patient to be taken back to the hospital. The Hospital was aware that the unit was faulty. This part of the complaint was substantiated. It was recommended that regular equipment audits should be undertaken.
Case Summary 36

Investigation Summary 2

Absent without leave
Hospitals have a non-delegable duty of care and in some instances a patient, anxious or confused about their treatment or hospitalisation, may "abscond" or discharge themselves without notice. It is essential to identify and have risk management strategies in place for such patients and to ensure appropriate support and supervision is in place. In the following complaint the Commissioner received a request from the Chief Executive Officer of a private hospital asking that the HCO investigate a complaint given that *"an internal investigation was unlikely to achieve an acceptable outcome to any of the parties involved".*

A Pain Specialist admitted the patient for investigation and management of his condition. The patient's wife was accommodated at a nearby motel so that she could be contacted if required. A short time later the patient discharged himself against medical advice but then agreed to return. Some four days later the patient had a fall; an incident form was completed and his medication was adjusted. His wife left her mobile phone number with the hospital in addition to her motel contact. Either later that night or early on Sunday morning the patient "left" the hospital without being discharged. Some time elapsed before his absence was discovered and there was a further delay in notifying the patient's wife of his absence. He returned on Monday morning for further tests and after a Computed Tomography (CT) myelogram on Monday morning the patient convinced his wife to take him home and was subsequently discharged.

The records noted that the patient was not found in the corridor or his room at 0100hrs and at 0130hrs he was thought to have "absconded". Hospital security was not notified of the patient's absence until 0130hrs although the patient's absence was noted at 0100hrs. The patient was found by hospital security at the nearby motel where his wife was staying. However the patient's wife had not been called on her mobile phone and had not been contacted.

The only recommendation following the investigation was that mobile phone contacts should be readily retrievable if required and that security be promptly notified if a patient is absent from the ward without cause. The Hospital in response to the initial verbal complaint, made the day after this incident, undertook a review of its Complaints Policy. The Director of Medical Services under this policy would be involved in complaints investigations relating to medical issues. Admission process and the formal processes for complicated pain management were also reviewed and the Hospital implemented "care-plans" for complicated pain management cases. The patient had displayed signs of anxiety with each testing procedure and he and his wife appeared concerned regarding the lack of information provided relating to the testing procedures.

There were other aspects of the complaint that were either not substantiated or a reasonable explanation was given. These related to the nurse's assessment that there were no obvious injuries following the patient's fall. There were some other concerns relating to the patient's medication. **Case Summary 37**

Investigation Summary 3

Residential services for persons with disabilities

In November 2002, the Minister for Health and Human Services, requested the Commissioner to investigate a community-based service, providing services to people with disabilities. The Commissioner appointed a consultant to conduct an investigation pursuant to Part 6 of the *Health Complaints Act* 1995. The standards and objects set out in the *Disability Services Act* 1992 were applied to assess the service.

The Association's objectives and the Service Agreement reflected the objectives set out in the *Disability Services Act* 1992. The issue was whether the service met these standards. The investigation arose out of allegations made by parents whose adult daughter with spastic paresis was a client of the Association. Further the Association's staff had raised concerns with their union about employment conditions but also about the management of the Association and the care of clients. Disability Services had conducted an investigation and the Association had initiated their own review.

The Association is a large multi purpose residential, outreach and day service for people with disabilities and for students requiring boarding services. While the parents making the allegations had moved their daughter to another organisation, it was considered warranted to pursue an investigation to determine whether any of the allegations were substantiated and if so to what extent and what action might be required.

The matters of complaint raised by the parents were numerous and ranged from the specific to more general areas of concern and a perceived situation of continued neglect and/or abuse of their daughter. Their daughter had become increasingly unhappy residing at the group home, and became reluctant to return to the home after weekends with them. They had concerns as to the standard and level of care and when they had attempted to raise these concerns, believed that they were not being addressed. The investigation reached the conclusion that the most serious allegations were not substantiated. Some of the less serious allegations indicated that the standards prescribed by the *Disability Services Act* were not met to the extent that would have been desirable.

It was considered that by implementing all the recommendations contained in the 'Internal Review Report' commissioned by the Association, that the Association would address the issues raised in this investigation. Therefore the only additional recommendations made by the HCO were that the procedure whereby all clients on day programs outside the Association are collected from and returned to the Hostel be reviewed in order to ensure that clients with severe mobility difficulties are not disadvantaged. It was also recommended that there be a system for the formal and comprehensive exchange of medical and other information affecting individual clients between the Association and day support workers and other service providers be developed. Further that the Association adopt a form of regular accounting to clients and their families in relation to the expenses and general financial position of clients.

Case Summary 38

Investigation Summary 4

The doctor's duty to provide information to patients

The High Court in *Rogers v Whitaker* (1992) 175 CLR 479 determined the law on a doctor's duty to provide information to patients. The Court by majority held that it is part of a doctor's general duty of care to inform patients about material risks of a procedure before they agree to undergo the procedure. While the following complaint did not involve a material or adverse harm to the complainant it does highlight a doctor's duty to provide information to patients regarding test results.

A complaint was made that a gynaecologist had failed to communicate the results of a positive Pap smear test which indicated low grade epithelial abnormalities and recommended a colposcopic evaluation. The doctor failed to inform the patient or the referring doctor. There was a further issue and that was whether the gynaecologist had refused or failed when requested to forward the patients medical history to the relevant hospital.

Following the investigation under Part 6 of the *Health Complaints Act* 1995, the report was forwarded to the Medical Council of Tasmania who requested a referral. The Council accepted the gynaecologist's admission of guilt in respect of the allegation that he *did not meet his professional responsibilities in that he failed to follow up an abnormal pap smear* with the complainant. The Council also noted that while patients have rights, they also have responsibilities, this commentary resulted from the complainant's failure to contact the gynaecologist's rooms for the pap smear result as requested. The Council advised that it would remind medical practitioners of their responsibilities to provide patients with test results in its forthcoming *Bulletin.*

The Council referred the issue of compensation back to this office as this issue fell within the powers of the Commissioner. Understandably the complainant feared that the delay may have adversely affected her prognosis. However, in this case it appears that the delay, albeit stressful, did not result in an adverse outcome. The complainant was invited to make submissions in support of matters to be referred to conciliation but did not do so and therefore no further action was taken in relation to the complaint. **Case Summary 39**

Investigation Summary 5

Failure to provide treatment to a seriously ill child

The complainant had sought medical attention for her daughter from a Centre for what she believed was an emergency. The treatment was declined, without a medical practitioner assessing the child, and the complainant then went to her general practitioner who made a diagnosis of bronchopneumonia. The child was immediately admitted to hospital and discharged some four days later. The principal issue was whether the situation was one of clinical urgency warranting prompt attention by a medical practitioner at the Centre rather than refusing treatment.

It was accepted that the Centre does not have any particular status as an emergency centre, but there may be a community perception that it retains that role. The Centre is staffed by the Department of Health and Human Services (DHHS) salaried staff, but in all other respects operates in a similar manner to other private medical practices. The Centre has a policy for limiting new patients and, although the complainant and her daughter had both been past patients of the Centre, they used the Centre only occasionally. In this instance the complainant sought assistance from the Centre rather than her own general practitioner because she was aware that her own general practitioner's surgery would be busy and she believed that her child required urgent medical attention.

The matter was investigated and it was concluded that the practice protocols of the Centre were adequate. However there was no adequate triage assessment of the child by the nurse and as a consequence the doctor on duty did not make any clinical assessment of the child. The Centre accepted the recommendation that the Director re-enforce the practice protocols regarding triage assessment with nursing and reception staff.

Case Summary 40

COMPLAINT STATISTICS

Complaint Activity

Complaint activity for the period 1 July 2002 to 30 June 2003 has slightly increased over the previous year. (refer figure 1). The number of closed cases has increased by 14% in this reporting period, as a direct result of employing additional staff to handle general enquiries.

Figure 1 – Complaint Activity 2001/2002 to 2002/2003

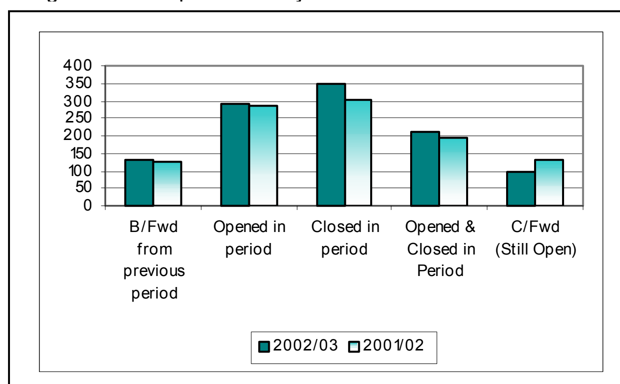


Table 1 – Complaint Activity

Status of Complaints	2001-2002	2002-2003
B/Forward from Previous Period	128	132
Opened in Period	284	292
Closed in Period	301	349
Opened & Closed in Period	194	210
Carried Forward (Still Open)	132	98

Complaint Resolved by Stage

Table 2 – Complaints resolved/dismissed

Stage of Complaint	Complaints
Total Retained by Registration Boards s57 1(c)	81
Total Enquiries	341
Early Resolution s25 5 (j)	42
Total Dismissed (following assessment)	111
Total Referred to Registration Boards s25 1(a)	53
Total Conciliated	9
Total Investigated	6
TOTAL	**643**

Note: Early Resolution

A number of complaints are resolved by the provider reaching an agreement with the person who has made the complaint to the mutual satisfaction of both. These matters are resolved, usually very quickly and through a course of negotiated resolution facilitated by the Health Complaints officer who has carriage of the matter. There is no need to refer the matter to investigation or conciliation or to take any further action on the complaints. Although these complaints are then "dismissed", under s.25(5)(j) of the Health Complaints Act, they represent an important category of complaints where the outcomes sought by the complainant are often achieved. For this reason they have been recorded, for comparative purposes, as a separate category of "dismissed" complaints and are part of the "early resolution" focus of the Health Complaints Office.

Complaint Issues

The primary reasons for complaints as stated by consumers are recorded in nine (9) main headings. As illustrated in Figure 2 the issue 'Treatment' subsumes the majority of complaints, 46%.

Figure 2 - Nature of Grievance

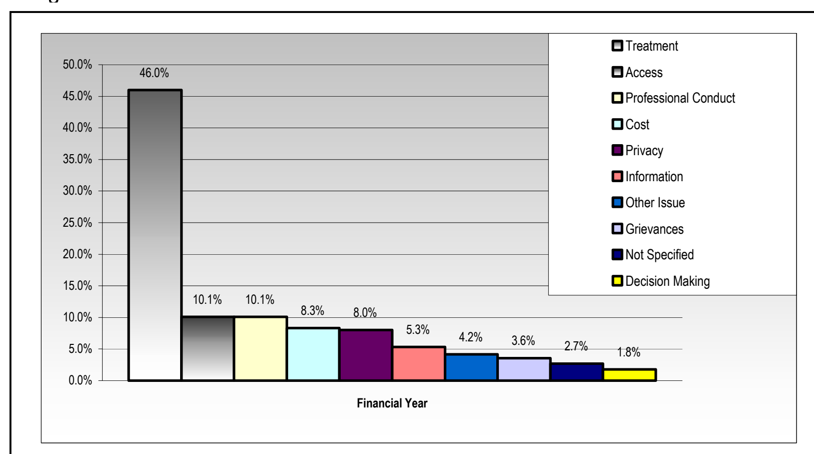


Table 3 - Resolved Complaint Issues

Primary Issue	Secondary Issue	2001/02	2002/03
Access	Access – waiting list for surgery	5	2
	Access discharge/transfer	1	1
	Access to transport	-	2
	Delay in admission	2	-
	Delay in treatment	4	7
	No/inadequate service	6	12
	Non attendance	1	2
	Refusal to refer	1	1
	Refused admission or treatment	7	7
	Sub-total	**27**	**34**
Cost	Inadequate information on costs	7	3
	MEDICARE schedule fee issue	2	-
	Overcharging	4	10
	Private health insurance matter	2	2
	Unsatisfactory billing practices	11	13
	Sub-total	**26**	**28**
Decision Making	Consent not informed	1	1
	Consent not obtained	-	2
	Failure to consult consumer	2	-
	Over-servicing/unnecessary treatment	2	2
	Refusal to treat	4	1
	Sub-total	**9**	**6**
Grievances	Inadequate (or no) response to complaint	8	11
	Retaliation following complaint	1	1
	Sub-total	**9**	**12**
Information	Failure to pass on information	10	8
	Inadequate access to records	3	6
	Inadequate information on diagnosis, prognosis	7	1
	Inadequate information on services available	3	1
	Inadequate records	1	2
	Sub-total	**24**	**18**

Primary Issue	Secondary Issue	2001/02	2002/03
Not Specified	**Sub-total**	**-**	**9**
Other Issue	Administrative practice	13	9
	Illegal practice	5	3
	Policy issue	3	1
	Public health issue	1	1
	Sub-total	**22**	**14**
Privacy	Assault	1	1
	Breach of confidentiality	9	6
	Discrimination	2	1
	Failure to ensure privacy	3	1
	Inconsiderate service	13	9
	Unprofessional conduct	14	9
	Sub-total	**42**	**27**
Professional Conduct	Breach of Standard	-	2
	Competence/impairment	23	30
	Misconduct	-	2
	Sub-total	**23**	**34**
Treatment	Adverse outcome	13	25
	Failure to diagnose	11	15
	Inadequate diagnosis	11	8
	Inadequate treatment	25	34
	Medication	18	16
	Negligent treatment	20	19
	Rough treatment	15	8
	Unskilful/incomplete treatment	22	23
	Wrong diagnosis	1	5
	Wrong treatment	2	2
	Sub-total	**138**	**155**
Total		**320**	**337**

Profile of Health Service Providers - Organisations

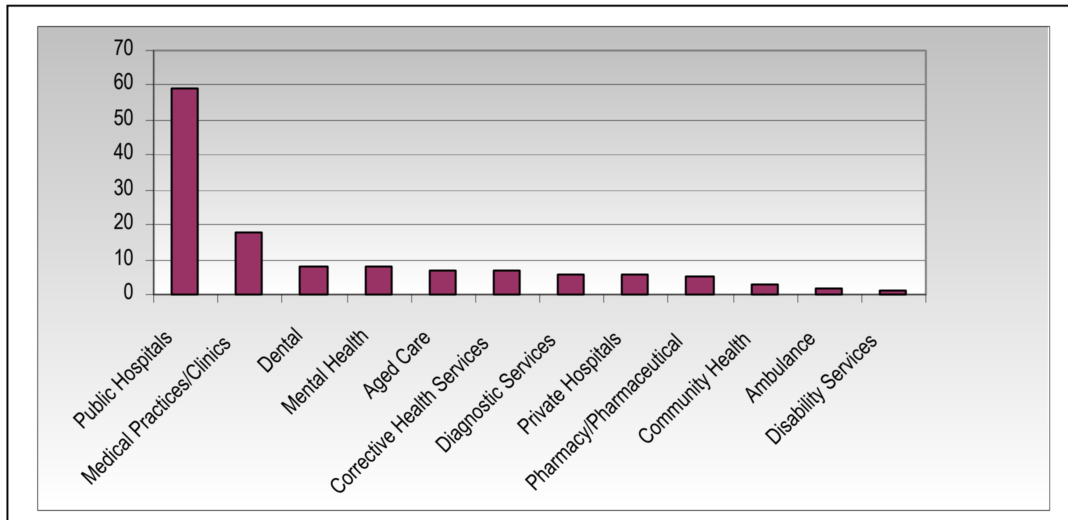
In this reporting period (2002/2003), there was a reduction of 3.7% in the total number of complaints against all Health Service Organisations. Public hospitals still record the greatest number of complaints with 45% in 2002/2003. This result represents an increase of 11% over 2001/02. Refer table 4 for breakdown.

The largest increase in complaints received came from Disability Services with a five fold increase in the number of complaints. Dental Practices, Private Hospitals and Medical Practices/Clinics all recorded a reduction.

Table 4 - Complaints about Health Service Organisations

Health Service Provider - Organisation	**2001/02**	**2002/03**
Aged Care	4	7
Ambulance	3	2
Community Health	1	3
Corrective Health Services	4	7
Dental	15	8
Diagnostic Services	1	6
Disability Services	3	1
Medical Practices/Clinics	25	18
Mental Health	19	8
Pharmacy/Pharmaceutical	2	5
Private Hospitals	5	6
Public Hospital	53	59
Total	**135**	**130**

Figure 3 – Comparison of Health Service Providers by Organisations (130 complaints)



Profile of Health Service Providers – Medical Practitioners

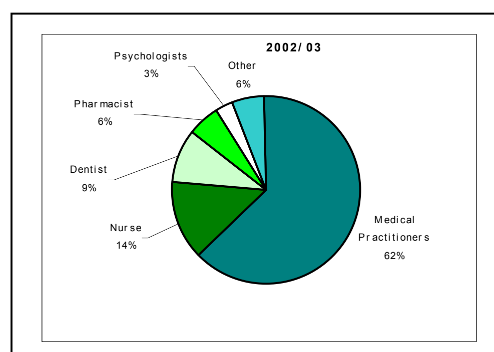
All Health Service Providers recorded increases in the number of complaints except for Chiropractors, Psychologists and Alternative Health Providers.

Medical Practitioners and nurses recorded a total of approximately 76% of all complaints. This represents an average increase of 14% from the previous reporting period 2001/02.

Table 5 - Complaints about medical practitioners

Medical Practitioners - Breakdown	2001/02	2002/03
Anaesthetist		2
General Practitioner	47	52
Gastroenterologist	1	1
Gynaecologist/Obstetricians	4	8
Neurosurgeon	Nil	2
Occupational Practitioner	2	1
Ophthalmologist	1	2
Orthopaedics/Orthotics	2	2
Pain Specialist	3	1
Plastic Surgeon	2	1
Psychiatrist	14	10
Specialist (Other)	5	3
Surgeon	8	13
Urologist	1	1
Total	**90**	**99**

Figure 4 - % Breakdown of Medical practitioners



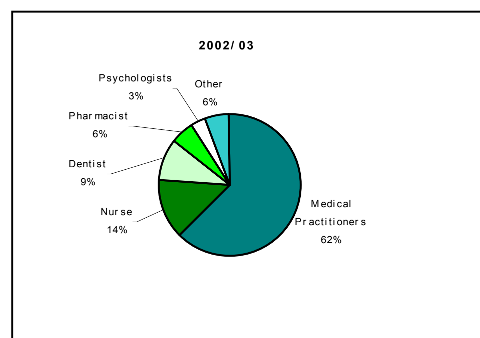
Note: *In figure 4 'Other' includes Optometrists 1.39%, Physiotherapist 1.8%, Podiatrist 1.3%, Radiologist 0.6%, Counsellor 0.6%, Alternative Health 0.6% (chart rounded)*

Profile of Health Service Providers – Individual Health Providers

Table 6 - Complaints about Individual Health Service Providers

Health Provider - Individual	2001/02	2002/03
Medical Practitioners	90	99
Nurse	16	22
Optometrist	2	2
Pharmacist	6	9
Dentist	13	15
Chiropractors/Osteopaths	2	Nil
Psychologists	6	5
Alternative Health	5	1
Counsellor	1	1
Physiotherapist	1	2
Podiatrist	1	2
Radiologist	1	1
Total	**144**	**159**

Figure 5 - % Breakdown of Individual Health Service Providers



Note: *In figure 5 'Other' includes Anaesthetist 2.02%, Gastroenterologist 1.01 %, Neurosurgeon 2.02%, Occupational Practitioner 1.01%, Ophthalmologist 2.02%, Orthotics 1.01%, Orthopaedics 1.01%, Pain Specialist 1.01%, Plastic Surgeon 1.01%, Urologist 1.01 %. (chart rounded)*

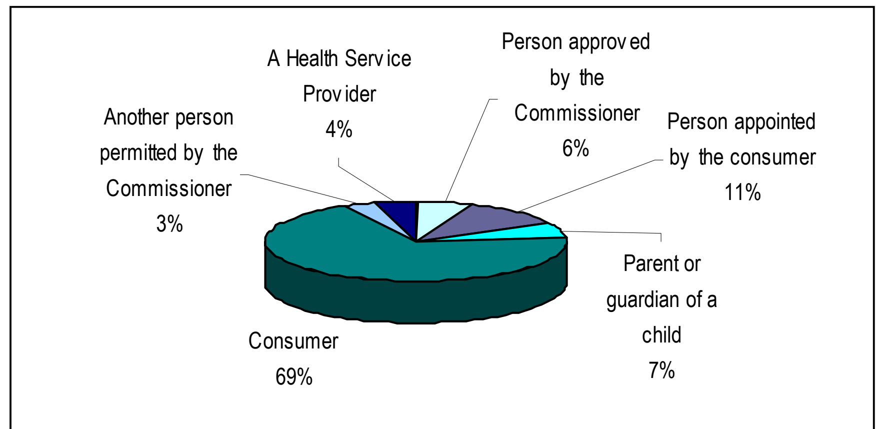
Profile Complainants

Who is complaining?

As in previous years, the majority of health complaints are made by the Consumer.

The *Health Complaints Act* 1995 allows the Commissioner to accept complaints from a person other than the consumer. As indicated in figure 6, 69% of complaints lodged are by the person aggrieved.

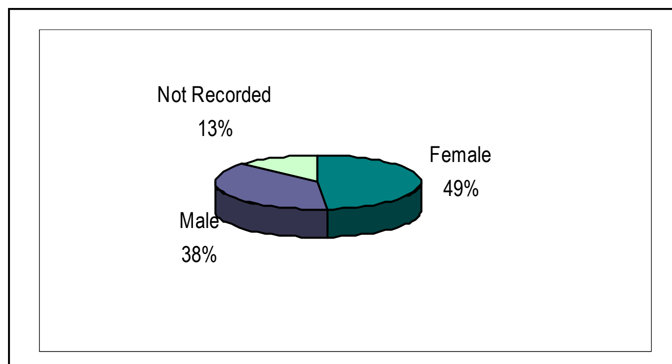
Figure 6 - Who lodges the complaint ?



Complainant Gender

The proportion of complaints by gender is consistent with previous years.

Figure 7 -Complainant/Consumer Gender



Consumer Type

In 2002/2003 95% of complainants were made by individuals.

Figure 8 - Consumer Type

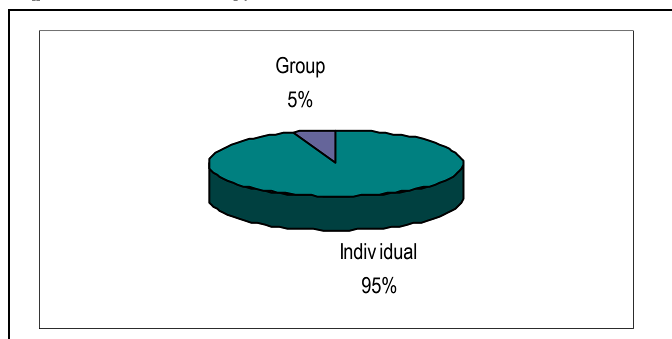
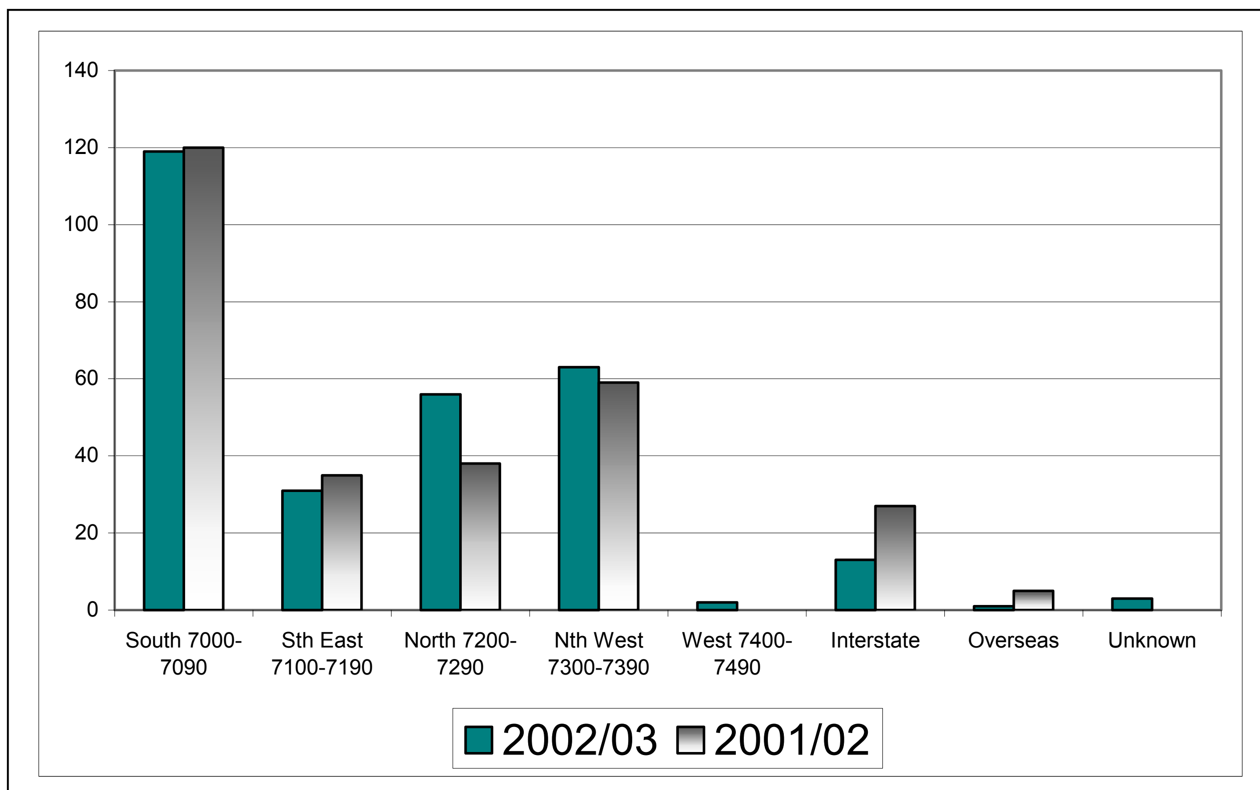


Figure 9 - Distribution of complaints by postcode region



The distribution of complaints by postcode shows a slight increase in number of complaints received in the North of the State, with the South remaining the same. The distribution in the West and East regions of the State suggest that, finance permitting, outreach programs are required in these areas.

Complaint Details

Those complaints closed in the reporting period 2002/03 are allocated a complaint closure reason. Many are recorded as dismissed complaints under s25, although they may have been substantiated in part or resolved.

Table 6 - Complaint and Enquiry Closure Reasons

Closure Reasons	2001/02	2002/03
Enquiry only	98	47
Schedule 1 part 2 Excluded as is an opinion or decision under Workers Compensation	2	3
Dismiss - Section 25 (1) (a) Complaint referred to the Ombudsman or a relevant Board or another person	73	53
Dismiss - Section 25 (1) (b)(iii) Dismiss the complaint	6	16
Dismiss - Section 25 (5) (a) Complainant not a person entitled under s22	3	Nil
Dismiss - Section 25 (5) (b) Complaint does not disclose a subject matter referred to in s23	1	3
Dismiss - Section 25 (5) (c) Complainant became aware of the circumstance more than 2 years ago	2	9
Dismiss - Section 25 (5) (d) Complainant has not attempted direct resolution	5	Nil
Dismiss - Section 25 (5) (e) Issues adjudicated by court or tribunal	7	6
Dismiss - Section 25 (5) (g) Complainant has been given reasonable explanation and information	69	72
Dismiss - Section 25 (5) (h) The complaint lacks substance	1	1
Dismiss - Section 25 (5) (i) The complaint is frivolous vexatious or was not made in good faith	Nil	1
Dismiss - Section 25 (7) Complainant has failed to provide information under s24	5	Nil
Early Resolution - Section 25 (5) (j)The complaint has been resolved	20	42
Section 30 (1) The complaint has been withdrawn in writing	5	Nil
Section 36 (1) Conciliation Terminated - Unresolved	Nil	3
Section 39 (1) Conciliation Agreed/Resolved	3	6
Section 55 Investigation Report and Recommendation(s)	1	6
Section 57 (1) (c) (ii) Retention by the Registration Board	** Nil	81
Total	**301**	**349**

Note:
1. *** Previously these complaints were incorporated into Section 25 (1) (a)*
2. *In addition to the Enquiry categories shown above, a significant number of enquiries are received during the year, which are not recorded. This represents a significant part of the workload for staff. It is estimated that 30% of all enquiries return as complaints.*

Table 7 - Complaint Outcomes

Outcome	2002/03
Apology given	4.6%
Change in policy/procedure effected	5.1%
Compensation received	2.8%
Concern registered	3.8%
Costs refunded	3.0%
Disciplinary action to be taken against provider	1.5%
Explanation given	19.5%
No Jurisdiction	3.3%
Complaint objective not obtained *	29.7%
Part 6 Investigation - Report recommendations	0.3%
S25(1)(a) Referral for Registration Board action	7.1%
S57(1)(c)(ii) Retention by Board	15.5%
Service obtained	3.8%
Total	100.0%

** Note:*

Many complainants seek outcomes such as compensation in circumstances when this is unwarranted or complainants may have unrealistic expectations

Complaint Complexity and Seriousness

Figure 10 - Complaints by Seriousness

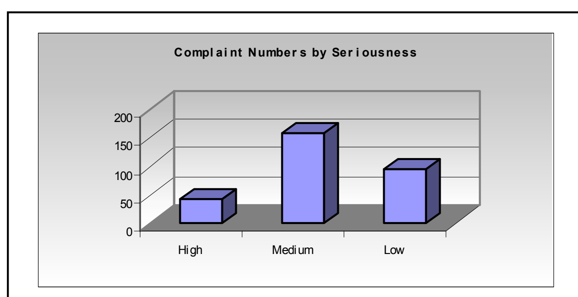
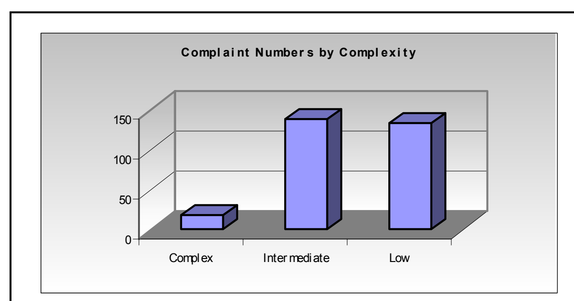


Figure 11 - Complaints by Complexity



Referral of Complaints

Complaints referred to Registration Boards or another body as required under s25 (1)a of the *Health Complaints Act 1995*

Table 8 - Referrals of complaints (opened between 1 Jul and 30 Jun)

Referrals to Other Bodies	**2000/2001**	**2001/2002**	**2002/2003**
Ombudsman	3	Nil	Nil
Medical Council	38	45	63
Psychologists Registration Board	3	Nil	1
Pharmacy Board	1	5	2
Chiropractors Board	Nil	1	1
Nursing Board	18	17	10
Dental Board	Nil	8	14
Optometrist Registration Board	Nil	Nil	1
Physiotherapist Registration Board	1	1	Nil
Podiatrists Board	Nil	Nil	Nil
TOTAL	**64**	**77**	**92**

Retention of Complaints by Registration Boards

Complaints that were retained by a registration board as required under s57 (1)c of the *Health Complaints Act 1995*

Table 9 - Retention of complaints (opened between 1 Jul and 30 Jun)

Complaints Retained by Registration Boards	**2002/2003**
Medical Council	21
Psychologists Registration Board	1
Pharmacy Board	6
Nursing Board	26
Physiotherapist Registration Board	1
Podiatrists Board	1
TOTAL	**56**

Note: Tasmania operates as a bipartite system with the 11 registration boards listed in Schedule 2 of the Health Complaints Act 1995 retaining the registration, regulatory and disciplinary powers over registered health services providers. A number of complaints, referred to in the legislation as grievances, are made directly to the boards who are required to notify and consult with the Commissioner as to whether the complaint will be retained for action by the board or referred to the Commissioner. Those complaints that are retained under s.57(1)(c)(ii) of the Health Complaints Act 1995.

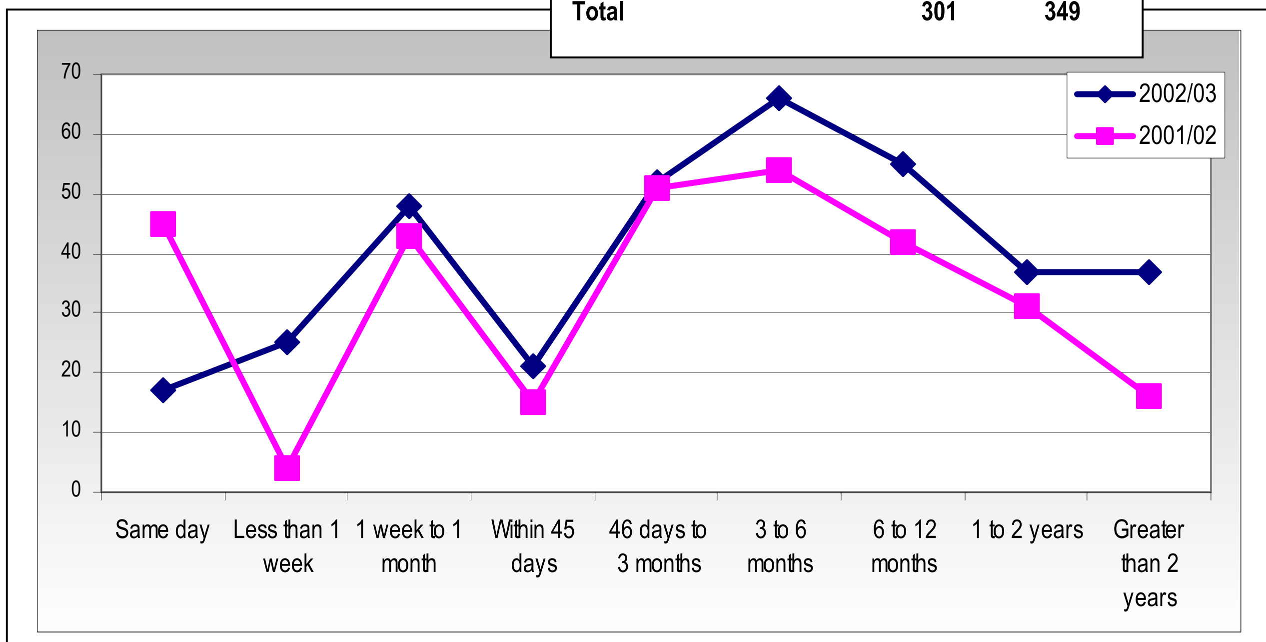
Time to Finalise Complaints

Complaints finalised on the same day they were lodged have decreased (refer figure 12). This can be attributed to an alteration in the manner that enquiries and complaints are recorded. In 2002/03, the time is recorded when the date of the complaint enquiry is made and it may take several weeks before a written complaint is lodged.

Complaints finalised on the same day cannot be compared with 2001/02 figures, as the time did not start to be calculated until the complaint was lodged, whereas in this reporting year the time starts to be calculated from the date of the enquiry. It may be some weeks before a complaint is lodged or an enquiry file is closed for 'no further action' and this time is included when calculating complaint closure. Future recording of enquiries will be registered for recording purposes only.

Time Taken	2001/02	2002/03
Same day	45	17
Less than 1 week	4	25
1 week to 1 month	43	47
Within 45 days	15	21
46 days to 3 months	51	52
3 to 6 months	54	65
6 to 12 months	42	53
1 to 2 years	31	34
Greater than 2 years	16	35
Total	**301**	**349**

Figure 12 – Timeliness of Complaints



FINANCIAL STATEMENT

REVENUE

	2001/02	2002/03
Consolidated Revenue	**$217,229**	**$279,429**

OPERATING EXPENDITURE

	2001/02	2002/03
Salary expenditure	$183,106	$229,061
Employee related	$ 1,231	$ 1,114
Total Salary expenditure	**$183,106**	**$230,175**
General administration	$ 268	$ 920
Information technology	$ 4,985	$ 5,221
Personnel expenses	$ 938	$ 2,786
Travel and transport	$ 2,770	$ 3,965
Property expenses	$ 15,066	$ 17,645
Operating expenses	$ 10,096	$ 18,717
Total Non-salary expenditure	**$ 34,096**	**$ 49,254**
Total Expenditure	**$217,229**	**$279,429**

Note: *The significant variance in salary expenditure between 2001/02 and 2002/03 is mainly due to the appointment of additional staff, (particularly a full-time Director of Health Complaints) and salary increments.*

Non-salary expenditure variance is attributed to a major investigation into a Health Service Organisation undertaken by an external consultant. Funding for this purpose was provided through the Department of Health and Human Services.

COMPLAINT HANDLING PROCESS

In most cases, complaints are initiated by a telephone call to the office. An investigation officer then completes an inquiry form for the purpose of taking personal details about the complainant, the name and address of the health service provider and brief details about the complainant's concerns. A complaint can only be escalated to the next stage once it has been received in writing and registered on the health complaints database. Where a person has a difficulty in completing a complaint form, he/she may request assistance to do so.

Local resolution - at the point of service

When a written complaint is received by the office, or the completed and signed standard complaint form has been returned, the complaint is then registered on the health complaints database. In the first instance, a copy of the complaint is sent to the health service provider with a request that a written response be sent directly to the complainant within 10 days from the date received. The reason that a request is made for a prompt response from the provider is the Act allows only 45 calendar days for the whole of that local resolution to be completed before the Commissioner must formally assess the complaint and:

(a) if of the opinion that the issue relates to a matter that falls within the functions imposed by a law of Tasmania, another State, a Territory or the Commonwealth or the Ombudsman, a relevant Registration Board or any other person, refer it to the Ombudsman, relevant Registration Board or other person as the case requires; or

(b) in any other case
- (i) refer it to a conciliator; or
- (ii) investigate the complaint; or
- (iii) dismiss the complaint.

Conciliation

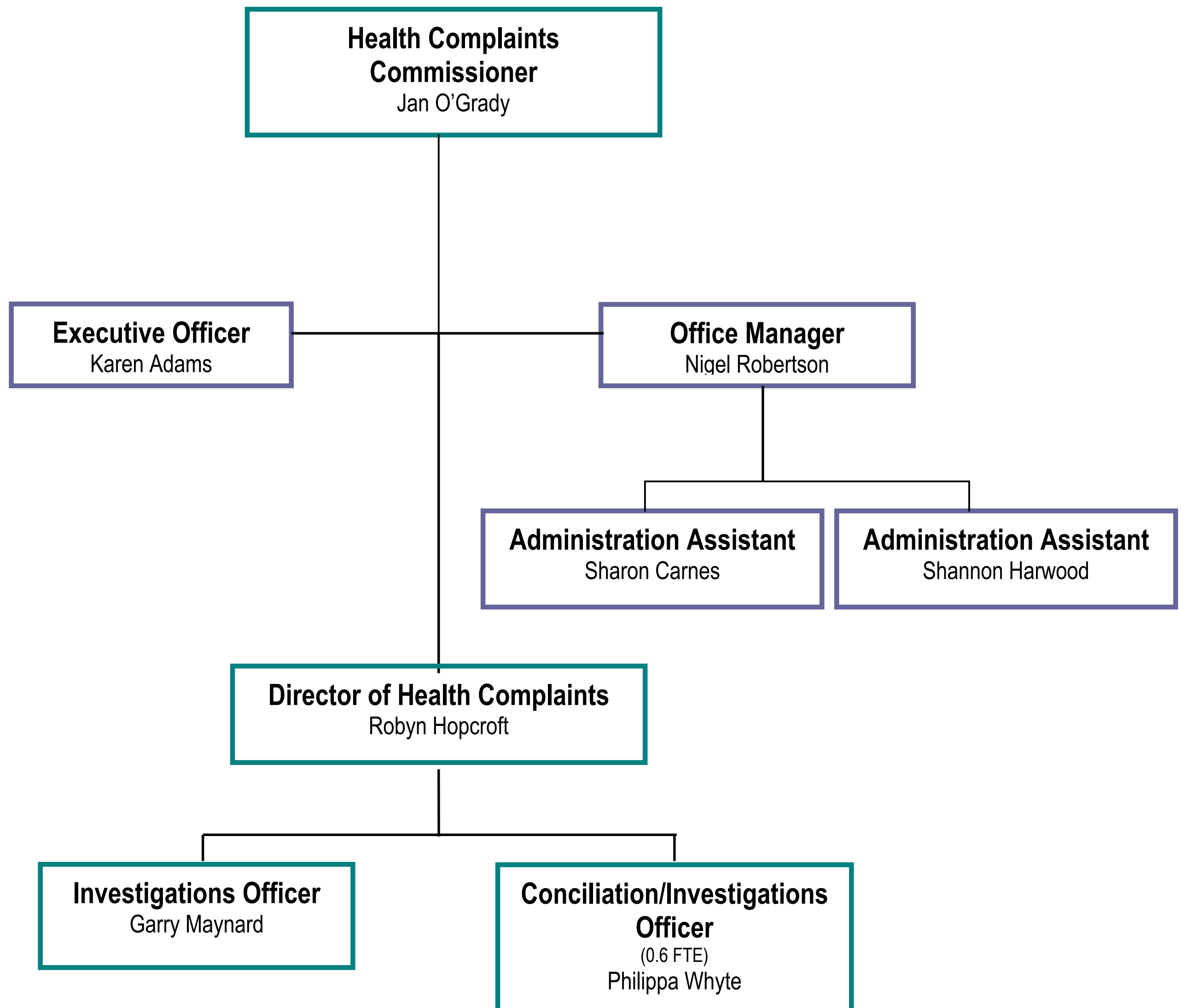
Conciliation is a process which may help people resolve their complaint about a health service provider through discussion and negotiation. Conciliation, to be successful, must be voluntary, and the Commissioner will not refer cases unless the parties agree.

The Act requires conciliation to take place in the strictest confidence. Conciliation is also privileged, which means anything said or admitted during conciliation may not be quoted or used as evidence in any court or tribunal, and may not be used by the Health Complaints Commissioner as a basis for investigation or inquiry.

Conciliators are bound under penalty not to disclose any information gained in the conciliation process to any other person, except for the purposes of reporting to the Commissioner. Both parties are also bound by these provisions. This protection provides the best opportunity for both parties to speak freely and seek an agreeable solution.

APPENDIX B:

ORGANISATIONAL CHART – HEALTH COMPLAINTS COMMISSIONER



Note: The Health Complaints Commissioner, administrative and corporate staff, are allocated on a 0.33 Full-Time Equivalent (FTE) basis. The total FTE for Health is 4.5

End Notes

- i. The Tasmanian Health Complaints Office receives and assesses most of the complaints about health services and providers. There are 11 registration boards and most complaints against registered practitioners come via the Health Complaints Office and, after consultation, are referred to the registration boards
- ii. That provision states that a person -*"…is not required to provide any information or produce any document if the person objects on the ground of a privilege that the person would be entitled to claim against the provision or production of the information or document were the person a witness in a prosecution or an indictable offence.*
- iii. s 130 of the *Evidence Act* 2001 and drafted in such a comprehensive fashion as to provide "by necessary intendment" that the rules of the common law in relation to public interest immunity no longer operate in this State.
- Iv The types of governmental function in view are set out s 130(4), which refers to such circumstances as prejudice to the security, defence and international relations of Australia, damage to relations between the Commonwealth and a State or between States, prejudice to the enforcement of the criminal law, and prejudice to the proper functioning of the government of the Commonwealth or a State etc.
- v The complainant was advised that if the matter remained unresolved and the Department refused to amend the record, she could lodge a separate complaint with the Ombudsman's Office as failure to remove the offending comments off the record was an "administrative" decision.
- vi Under s.25(5)(g) on the basis that they have been "*given reasonable explanations and information and there would be no further benefit in entertaining the complaint".*
- vii Halsbury Laws of Australia
- viii Medical Council letter to [complainant] dated 17-9-2001.
- Ix Under s.25(1) of the Health Complaints Act 1995
- x The doctor had inadvertently transcribed the dosage of a patient's drug, failed to check the 'drug intoxication test' after the patient developed symptoms of an overdose and failed to diagnose or adequately treat those symptoms. Kirby P said (at 200): 'The first error was accidental. The second error may have been careless … [But] in evaluating whether those mistakes amount to 'misconduct in a professional respect' it is necessary to demonstrate something more than mere negligence by the civil standard'.
- xi Which he was advised would probably be somewhere in the order of two to three hundred dollars.
- xii *"Requirements for the ongoing Prescribing of Narcotic Analgesics*", Department of Health and Human Services, Pharmaceutical Services Branch, August 2003
- xiii see pro-forma letter to general practitioners from the Department of Health and Human Services, Chief Health Officer, Pharmaceutical Benefits Branch outlining narcotic prescribing information and the Section 22 Committee
- xiv "*Legal Obligation of Medical Practitioners when Prescribing Schedule 8 (Narcotic) Substances",* Medical Council Newsletter August 2003