



OHR staff member Caroline Heffer with NDS' Monique Williamson

OHR and NDS Collaborate on Training

OHR and National Disability Services (NDS) are continuing to collaborate on providing training opportunities for workers in disability services.

In the last issue of Health Review, we announced that the Disability Services Commission had provided a grant to NDS of more than \$20 000 to fund training for people working in the disability sector, following a submission for funding that was supported by OHR.

Since then, NDS Policy Manager Monique Williamson has been talking to staff from various disability support services to

determine what kind of training they think would help them in their jobs.

Ms Williamson noted that the responses she has received have been positive and staff are keen to improve their skills in a number of areas.

"There are a whole range of issues that people want to look at," said Ms Williamson. "Most of the training areas that we have defined can be put into two main categories - preventing complaints and managing complaints. Some of the key topics that have been suggested for inclusion in the training are managing expectations for clients, working with people with cognitive impairments and finding the root cause of complaints."

Ms Williamson said that training in areas like managing difficult behaviour, cross-cultural issues and turning complaints into positive learning experiences could also benefit staff.

"At the moment we are looking at making the training a series of four half-day sessions, but that may change depending on what training we actually go ahead with. We really want to make sure we fulfil the training needs of people working across disability services."

At this stage, NDS is hoping to schedule the training around February/March next year. While the training will be held in Perth initially, some opportunities for regional training may arise later in the year.



The Edmund Rice Centre in Fremantle

OHR Staff Bridge the Cultural Divide

OHR staff members recently attended a cultural awareness training seminar titled 'Working with Aboriginal Communities' at the Edmund Rice Centre for Social Justice in Fremantle.

The seminar was a full-day program that focused on traditional indigenous customs, beliefs and history. The seminar also provided information on dealing with sensitive issues and cross cultural communication.

The seminar gave a valuable insight into indigenous history, family relationships and the importance of 'yarning' with a client, rather than trying to rush through multiple issues.

Many of the seminar attendees appreciated the importance placed by indigenous people on 'yarning' and sharing hospitality when having a discussion.

The seminar was attended by a number of people from a variety of work backgrounds, including the WA Health Department, the Aboriginal Legal Service and the WA Education Department.

Health Commissioner's Conference

On 25 and 26 October this year Brisbane will play host to the Australasian Health Commissioner's conference.

The conference, which is held on a six-monthly basis, gives representatives of Australia's health complaints bodies the opportunity to network and discuss shared challenges and common objectives.

At October's event representatives will discuss topics such as information privacy, unreasonable complainant conduct and open disclosure. A case scenario will also see the attendees "workshop" a customer complaint based on a real-life event.

The next edition of *The Health Review* will provide a briefing on the conference.

Welcome to the second edition of *The Health Review*, the newsletter from the Office of Health Review.

In this publication we hope to keep you informed of developments within the Office, in touch with the work that we do and provide information on some of the collaborative efforts that we have achieved with other organisations.

Any feedback or suggestions are welcome - please send them to mail@healthreview.wa.gov.au. For further information about OHR, please visit our web site at: www.healthreview.wa.gov.au



Feature Article: Informed Consent

Informed consent refers to the consent or agreement made by a patient to a medical treatment or procedure. The use of the first word in the term - informed - is important because it suggests that the patient has agreed to a treatment or procedure with knowledge of not only exactly what will occur but also the reason it is being performed, the desired outcome, any risks and the consequences of inaction.

The health professions and services comprise highly specialised and technical fields, ranging across treatments as simple and non-invasive as therapeutic massage through to surgery and drug therapy.

The WA Department of Health publication *Consent to Treatment Policy for the Western Australian Health System* notes that "...a patient's consent to medical treatment is meaningless unless it is made on the basis of relevant information and advice."

Any procedure or treatment that a patient agrees to undergo carries with it a body of knowledge known to the practitioner. The person receiving the treatment is unlikely to have anywhere near the same level of knowledge as the practitioner. However, it is important that in order for the patient to make an informed decision to undergo a treatment or procedure that they have as much information as possible on which to base that decision.

The provider therefore faces multiple responsibilities of not only conveying their knowledge of the procedure or treatment to the patient, but also of doing so using plain language, and ensuring that the patient understands.

The individual also needs to be in possession of their reasoning faculties when they give consent to treatment. This means that they should not be suffering from an impairment of judgment at the time of consenting. Such impairments might include illness, intoxication, insufficient sleep or other health problems.

In cases where an individual is considered unable to give informed consent, another person is generally authorised to give consent on their behalf. Examples of this include the parents or legal guardians of a child.

In cases where an individual is provided with limited facts, or is suffering from an impairment of judgement, serious ethical issues may arise.

The American Medical Association (AMA) notes on its web site

that informed consent is "...more than simply getting a patient to sign a written consent form. It is a process of communication between a patient and physician that results in the patient's authorisation or agreement to undergo a specific medical intervention."

The AMA has highlighted an important component of the 'informed consent' procedure, that being the 'process of communication.' It goes on to list the recommended steps and issues for discussion in the communication process:

- The patient's diagnosis (if available)
- The nature and purpose of the proposed treatment or procedure;
- The risks and benefits of the proposed treatment or procedure;
- Any alternatives
- The risks and benefits of the alternative treatment or procedure
- The risks and benefits of not receiving or undergoing the treatment or procedure.

The AMA goes on to note that the patient should be given the opportunity to ask questions in order to gain a better understanding of the treatment or procedure.

Informed financial consent

Informed financial consent (IFC) is related to the concept of informed consent, however it specifically relates to the client's knowledge of how much they will be charged for a service.

IFC has in particular become an issue for members of private health funds, who may not anticipate a 'gap' payment - the shortfall between the sum they are covered for and the cost charged by the provider - before they undergo treatment.

Statistics provided by the Federal Government show that in 2006 Australia had an IFC rate of 81 per cent for all in-hospital episodes -that is, in 19 per cent of cases patients had to pay a gap fee to make up the shortfall in costs. The surveys have also found that up to 15 percent of patients were not even made aware that they would have to pay any gap fees.

In 2006 the Federal Government launched a campaign in conjunction with the Australian Medical Association to encourage doctors and patients to discuss estimated fees. The campaign, "Let's Talk About Fees", also encouraged patients to confirm the level of cover provided by their health fund, noting the responsibility of the health funds to provide this information to their clients.

Federal Health Minister Tony Abbot even recently suggested the introduction of penalties against doctors who had not ensured their patients had been given IFC before treatment.

While Mr Abbot has not pursued this course of action, he recently announced that patients whose doctors failed to warn them of extra gap charges would be able to take their complaint to the Private Health Insurance Ombudsman.

New brochures launched

OHR recently released an updated series of information brochures designed for both providers and consumers of health and disability services.

The brochures were developed after extensive consultation with a number of OHR's key stakeholders, including the Health Consumers' Council Readers Group and members of the Healthy Publications Committee.

One of the main aims of the new brochures was to make them easy to read, accessible and to use 'plain English.'

The new brochures also reflect some changes to internal procedures that have taken place since our last set of brochures was released, as well as updated contact details for the Office.

The brochures will soon be available for viewing and downloading at OHR's web site. If you or your organisation would like to request multiple copies for distribution, please phone OHR on 9323 0600 or email the Office at mail@healthreview.wa.gov.au.



Left: Star of the HCC infomercial, Mary G, in the studio.



HCC Staff Pass on the Knowledge

The OHR was recently treated to a visit by two members of staff from the Health Consumers Council (HCC), Laura Elkin and Brian Charlie.

Laura and Brian were recently appointed to the HCC as Aboriginal Consumer Participation Project Officers, and they visited OHR during our monthly staff meeting to discuss their roles and how they plan to assist Aboriginal health consumers throughout WA.

The two HCC staff members have been charged with a broad charter that includes recruiting Aboriginal consumer representatives, reviewing current health complaint policies and improving complaints processes for Aboriginal people and their families.

Laura and Brian also screened a promotional film recently produced by the HCC, which features 'The Queen of the Kimberley,' cult comedian and radio show host Mary G, the comic creation and alter-ego of Mark Bin Bakar.

The short film, which is half-comedy, half-advertorial, encourages Aboriginal people to speak up if they have a complaint regarding a health service. The film also features Brian in a leading role, playing a foil to Mary G's dry humour and sharp tongue.

Laura and Brian gave the OHR staff a valuable insight into their work and have provided the OHR with some inspiration and ideas for working more closely with Aboriginal communities.

New Database to Deliver the Numbers

The OHR is currently upgrading and revamping its electronic complaints database.

The current database, known as RAEMOC (Real And Effective Management Of health Complaints) has been in use since 1996, when it was purchased from the Tasmanian Health Complaints Commission.

The aging MS Access - based database, while having served the Office well, has become outdated and cumbersome in comparison to the new breed of databases that use SQL platforms.

The Office has contracted an IT programmer, Mr Martin Gilmore, to convert the old database, remove any 'bugs' and most importantly integrate the ever-increasing list of improvements suggested by our staff.

The new database will not only be easier to use and provide a

greater range of functionality, but will also increase reporting capabilities. This will help the Office to analyse trends and systemic issues more readily, as well as providing 'rapid response' feedback when required.

The database, which was named 'CRED' (Complaints Record Electronic Database) by a member of staff following a naming contest, should be operational by early 2008.

Once CRED is working, data from the old database will be cleansed and transferred to CRED. This will aid historical analysis of complaints, while also providing a more secure and stable environment for the large amount of data the Office holds.

Complaints Statistics

During the July - September quarter, the Office received 461 new complaints. Of those, 454 related to health services, while 7 related to disability services. During the same period, the Office closed 431 complaints.

OHR Case Studies

To give our readers some insight into our work, we have provided selected case studies from issues brought to us by our clients. In concert with our confidentiality requirements, we have tried to eliminate all details that would identify any of the parties involved.

Case Study One

A patient underwent emergency surgery at a major teaching hospital for what doctors believed was a potentially fatal aneurism of the aorta (the major blood vessel supplying the heart). A provisional diagnosis was made at another hospital and the patient was referred to the hospital concerned for additional tests.

On arrival at the hospital, the patient was informed there would be no further tests and they would have to undergo immediate surgery to prevent certain death. The risks of surgery included possible stroke or death. If the surgery was successful, the patient was facing up to 10 years of possible infection and rejection risks from the required tissue graft.

The patient went into surgery believing they would not survive the procedure. Fortunately, the actual surgery revealed that the man did not have an aneurism. Potentially, a Magnetic Resonance Imaging (MRI) scan could have established that there was no aneurism, without the patient having to undergo surgery.

The MRI was not done, as the hospital claimed it would take too long to arrange. The reason given for this was that it was New Year's Day and the delay was considered unreasonable, given the potentially fatal condition.

The recovery period from the surgery was extensive, and the patient had to take a considerable amount of time off work. The patient tried to claim income protection from their personal insurance policy, but when the hospital issued a written explanation for the insurance company, they described the surgery as 'exploratory'.

The claim was initially rejected by the insurance company, and the patient began legal proceedings against their own insurers. The insurance company eventually paid out once they changed their classification of the patient's treatment to a 'mistaken diagnosis'. The patient sought compensation from the hospital on the basis that the mistake had cost them financially, physically and emotionally.

More specifically, compensation was sought for the financial loss to the patient's business from three months off work. The patient also claimed to be suffering ongoing pain in the chest, spine and back. The patient had indicated that they wanted compensation as part of their complaint. However, the hospital had advised the patient prior to the matter coming to the OHR that they would not consider compensation.

When the complaint was accepted for conciliation by the OHR, the hospital maintained their stance on compensation and advised

that this meant there was no need to meet. From early 2007 OHR made attempts to set up a conciliation meeting. A conciliation meeting was finally set for mid-2007.

The conciliation meeting was not successful. The hospital's medical representative deferred to the complaints manager when questions were raised regarding the patient's treatment. The hospital staff did not admit that the surgery took place as a result of their inability to obtain an MRI to exclude the aneurism diagnosis. No apology or expression of empathy was made by either of the staff members during the meeting.

When the issue of compensation was raised by the patient the meeting was effectively shut down by the hospital staff. No further discussion either on the medical care or the process of dealing with the complaint was possible.

Unfortunately, the Office was not able to facilitate a successful resolution for the client. The case has, however, highlighted the need for hospitals to use all available resources when making diagnoses, particularly when they can result in such serious consequences.

Case Study Two

A consumer complained to the Office of Health Review about what appeared to be her classification by a regional health service as a mentally ill patient.

The consumer contended that she was not mentally ill but had been "sung" by another Aboriginal person (the practice of 'singing' brings about physical deterioration in the person that has been 'sung' and has been claimed to be responsible for death in some cases).

The consumer claimed that rather than being treated as a mentally ill patient, she should have been treated by a recognised healer, such as an 'Elder Law Man', rather than through the use of Western medical techniques.

This case raises an important issue for health care providers, particularly those working closely with Aboriginal clients, as it highlights the need for cultural sensitivity when providing care.

The consumer stated that a provider at her health service had made enquiries as to whether she had been sung, but was told this was not the case. The consumer believes that a recognised healer should have been consulted to determine her condition, rather than her provider only making verbal enquiries within the community.

It appears that the provider was considerate in their acknowledgement of the patient's condition by making enquiries within the community.

However, by working within culturally-appropriate guidelines the consumer's condition may have been treated successfully without the need for any further intervention.



The **Office of Health Review** is an independent State Government agency established to deal with complaints about health and disability services.

Our mission: To make health and disability services better through the impartial resolution of complaints.

For more information about the Office, please visit our web site at: www.healthreview.wa.gov.au

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