THE HEALTH REVIEW
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Regional Visit: Cocos Islands

In late October Team Leader Harley White visited the Cocos Islands as part of OHR's service commitment to the Indian Ocean Territories. The Cocos (Keeling) Islands are a group of 27 islands situated in the Indian Ocean, southwest of Indonesia and approximately halfway between Australia and Sri Lanka.

Only two of the islands are inhabited (West Island and Home Island) by a population of around 600 people. Approximately 80% of the population is of Malay descent, the remainder being of European descent.

The islands were discovered in 1609 by Captain William Keeling (and visited by Charles Darwin on the Beagle in 1836). Granted to the pioneering Clunies-Ross family in perpetuity in 1886 by Queen Victoria, the islands became a protectorate of Singapore in 1903 (Singapore then being part of the Commonwealth). A fairly turbulent history followed, including bombing by the Japanese in 1942 and 1944.

In 1978, the Australian Government purchased Home Island. The island group is now classified as a non-self governing territory of Australia, and they are administered from Canberra by the Federal Attorney-General's Department.

Various government services are provided to the Indian Ocean Territories (which includes Christmas Island). These include services provided by WA agencies such as the Department of Education and Training, the Department of Consumer and Employment Protection and Fire and Emergency Services.

The islands have four nurses, a medical doctor and a visiting dentist who works on both Cocos and Christmas Island. These services to the Territories are funded by the Department of Transport and Regional Services.

Residents and service providers of the Indian Ocean Territories are able to access OHR's services, which OHR provides as part of a service delivery agreement with the Federal Government.

During his visit, Harley met with medical, dental and nursing personnel, and also with consumer representatives and Shire CEO Mick Sims to discuss OHR's role, and what the Office can offer the community.

OHR staff will continue to visit the Indian Ocean Territories as part of our ongoing service commitment to the Islands' populations.

2007/08 OHR Annual Report

The OHR Annual Report for 2007/08 has been published, in a new-look format and with an expanded section on complaint statistics.

The report also features a large number of case studies that highlight OHR's work in resolving disputes between consumers and providers. The Agency Performance section of the report provides information about community out-reach activities, regional visits and important project work being undertaken by OHR staff members.

To view or download a copy of the 2007/08 OHR Annual report, visit the OHR web page here.

Welcome to the fifth edition of the Office of Health Review's newsletter, *The Health Review*.

Any feedback or suggestions are welcome and can be sent to: mail@healthreview.wa.gov.au

Discussion: Not for Resuscitation

The Office of Health Review receives a substantial number of complaints from family members of deceased patients. In the course of conciliating these complaints, the carrying out of NFR (Not for Resuscitation) orders sometimes emerges as an issue in these often complex bereavement-related cases.

A NFR order is a written order stating that resuscitation should not be attempted if a person suffers cardiac or respiratory arrest. An NFR order may be instituted on the basis of an advance health directive from an individual, (see 'Living Will' Legislation, below) or at the request of a physician, if they believe that resuscitation of the patient would not alter the outcome of a terminal disease.

Understandably, the request for and arrangement of an NFR order has a significant impact on the patient, his or her family and the health care provider.

In the case of an advance health directive, an individual can make the decision that they do not wish for their life to be prolonged should disease or trauma lead to their being in an incapacitated state (and therefore not able to make an informed decision regarding their medical care).

Even when the patient is mentally competent, the decision to make an advance health directive should ideally be made with the full informed consent of the patient and the support of health care professionals. In this case, informed consent would include making the individual aware of the procedures involved and what they should tell their family and people close to them.

Careful, considered attention needs to be paid to the wording of an advance health directive, so that as many eventualities are covered as possible, and each step in the process is clear and well-defined.

Some professionals in the field, however, believe that the focus should not exclusively be on the semantics of a directive. In an article in *Australian Doctor*, John Kron quotes Dr Bernadette Tobin, Director of the Plunkett Centre for Ethics in Health Care at Sydney's St Vincent's Hospital: "Advance health directives have limitations. Circumstances change and there's only so much that can be accurately anticipated in writing. What is more important is that patients be encouraged to talk with their family, doctors and other relevant people about their hopes for and fears of treatment, and to communicate … their wishes about treatment should a situation arise in which they are unable to make their wishes known. This enables better decisions to be made when situations occur that hadn't been anticipated when the patient is incompetent."

In the same article, Krun recalls a colleague's experience with one patient with a terminal illness who had presented to an emergency department with pneumonia. Due to his illness, the patient had an advance health directive stating that he was not to be put on mechanical ventilation. In the ED, however, the patient told a doctor that if he lost consciousness, he wanted the written order to be ignored.

This experience shows, quite understandably, that when actually faced with death many people might change their minds about the decisions they have made earlier - the person in question may have wanted to say a final goodbye to family, for example. This experience also stresses the need for people to involve others close to them when they make advance health directives, so they can be better prepared to deal with what will happen.

Health professionals also need to prepare themselves for dealing with these situations. Adhering to an NFR order can put doctors and nurses in the difficult position of trying to support their patient's wishes, while at the same time stepping back from the primary aim of their professions: To sustain life. This is balanced by the need to do what is best for the patient, and avoiding "therapeutic nihilism."

OHR recognises that this is a very sensitive and difficult area of medicine, and one that opens up many medico-legal and ethical issues. We are looking to work more closely with stakeholders to explore the issues further to determine what can be done to minimise the incidence of the NFR component of bereavement-related complaints.

Sources:
Kron, J 2003, 'Last Orders' ,*Australian Doctor,* viewed 10 December 2008, <http://www.australiandoctor.com.au/news/38/0c017838.asp>
Lasagna, L. 1964. 'Hippocratic Oath - Modern Version', *Public Broadcasting Service,* viewed 10 December 2008, <http://www.pbs.org/wgbh/nova/doctors/oath_modern.html>

'Living Will' Legislation

The Acts Amendment (Consent to Treatment) Act 2008 became legislation in the WA Parliament in June this year.

Commonly known as the 'living will' legislation, its aim is to support people planning to refuse life-prolonging medical treatment, should they ever be in a position where they are so ill that they may no longer be able to make such decisions.

Some medical and legal practitioners describe living wills as 'advance care directives', a term that has been in use for some time in the U.S. and the U.K.

Now that the legislation has been passed, treating health professionals will be bound to follow the directions of an advance health directive, if they are aware of its existence.

The legislation is likely to have a major impact on the future of caring for people with terminal illnesses, dementia and those in vegetative states or on long-term life support.

The legislation will also have some impact on the issues surrounding NFR orders, as advance care directives inherently set out a plan for reduced medical intervention.

OHR Case Studies

In each edition of *The Health Review*, we like to bring our readers case studies of issues that we have dealt with that show the results we have achieved through conciliating complaints.

Below are two case studies that document disputes related to dental prosthetics (commonly known as dentures), but before that we will look at a relevant excerpt from our Annual Report:

Dentures

A denture is a prosthesis composed of artificial teeth bonded to plastic gumwork, supported in the mouth by a plastic or metal base. It is not a like-for-like replacement for a patient's natural teeth- it is an artificial prosthesis which acts as a substitute to having missing teeth.

Complaints about dentures can be categorised into a number of issues:

- difficulties in adapting to a new prosthesis (restoring function ,appearance and speech),
- emotional and/or psychological issues attached to the loss of teeth and having to wear dentures
- varying ability to manage a denture
- dealing with an elderly and potentially vulnerable demographic
- significant costs involved, and,
- in some cases poorly constructed dentures.

Every mouth is different in shape and function and every patient's ability to manage a denture will vary. For this reason, complaints about dentures must be examined on an individual basis.

Some complaints about the standard of dentures are warranted, but in any event complaints in this area are difficult to deal with because the suitability of a denture can be subjective.

When it comes to dentures, communication is crucial. The provider must clearly define with the patient what can and cannot be achieved at the outset. From there, they must be prepared to be involved in an ongoing process of managing the expectations of the patient.

Case Study 1 - Prosthetics

A consumer attended a dental clinic to repair damage to a fixed partial denture (a fixed partial denture, commonly known as a 'bridge' is a prosthetic replacement of one or more missing teeth cemented or attached to the abutting teeth).

The dentist apparently advised the consumer that the damage to the denture was irreparable and that a complete new denture would have to be fitted. Following the treatment, however, the consumer was not happy with the appearance of the denture, particularly in relation to the size and colour of the tooth.

To resolve her complaint, the consumer asked that the teeth abutting the denture be re-enamelled and that the false tooth be altered to match her other teeth. The consumer also asked that the dentist pay for this treatment to be carried out at another clinic, and that compensation be paid for pain and suffering.

The provider was willing to enter into the conciliation process, however they did not want to meet with the client. OHR therefore coordinated all communications during conciliation. Part of the conciliation process included obtaining an independent opinion from a specialist consultant, who believed that the treatment was above the minimum standard expected from a general practitioner.

During conciliation, the provider offered to refund the cost of the consumer's new bridge, as well as the associated laboratory costs. The consumer accepted this offer, however the consumer had also hoped to have the cost of an initial consultation and temporary bridge refunded, which the provider was unwilling to do.

Case Study 2 - Prosthetics rebate

OHR also receives a high number of complaints relating to denture rebates. Below is a case study of a recent complaint where the provider was not registered as a rebate provider with the consumer's health insurer:

A consumer consulted a dental prosthetist for a replacement upper denture. The customer was a member of a private health fund and she assumed that the provider was registered with her fund, making her eligible for a 60% rebate.

After having the work completed, the customer's total costs came to $3400.00. While the customer did not have any complaint about the quality of the denture or the service provided, she felt that the provider should have made it known to her that the provider was not registered with her fund during her consultations.

The customer asked that to resolve the complaint, she be refunded $1500.00 (which is approximately what she would have received had she been entitled to a rebate through that provider). The provider made an ex-gratia payment of $1500.00 to resolve the matter.

The provider also agreed to change the printed information regarding health fund subsidies that his clinic provides to customers, making it clear what gap fees they can expect to pay. It was hoped that by taking this action future customers won't find themselves in the same situation.

Complaint Statistics 2007/08

In the 2007/08 reporting year, OHR received 1734 new complaints. This is an increase of 18% from 2006/07, and is close to the all-time high of 1768 that we recorded in 2003/04.

The 2007/08 year was also significant in terms of the number of complaints closed, with 1844 issues being resolved. This is the greatest number of complaints closed over a 12 month period since OHR came into being in 1996.

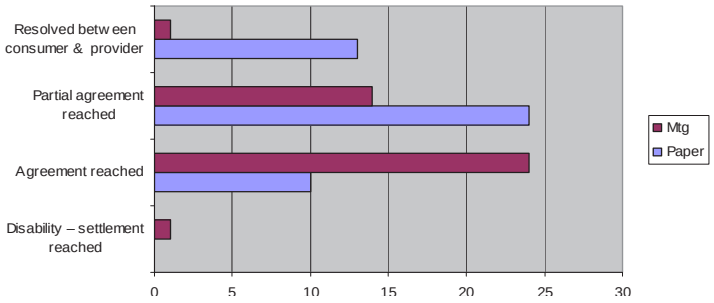
The table below provides some data comparing complaint statistics over the past two reporting periods:

Workload data 2006/07 - 2007/08

	2006/07	2007/08
Active complaints 1 July	268	210
New complaints received during the year	1470	1734
Total complaints handled	1738	1944
Complaints closed during the year	1548	1844
Balance	190	100
Re-opened cases	20	25
Active complaints 30 June	210	125

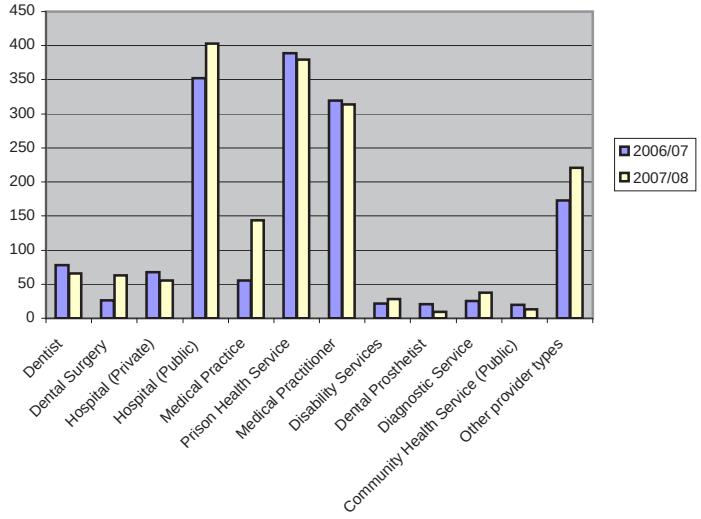
In the 2007/08 reporting year there were significantly more cases where complete agreement was reached through a meeting, than through paper-based conciliation (see table below). This could either indicate meetings are a more effective means of resolving a complaint, or that parties who are willing to meet may be more willing to come to an agreement.

Agreements Reached in Paper and Meeting Based Conciliations



During the year we received complaints about many different types of service providers, the most common categories being public hospitals and prisons (see table next column). These figures are not unexpected, considering the high number of patients treated each year in such facilities.

Complaints by provider 2006/07 - 2007/08



While complaints overall have increased, there was some variation among the trends experienced by service providers. For example, complaints about public hospitals increased 14.5% in the last year, while complaints about private hospitals declined 19%.

There was also a variation in the trend for complaints regarding dental services, but this is most likely due to a change in the way we categorise complaints about dental services.

These process changes could also account for the vast differences in the two-year trend for complaints about dentists (reduced 20%), dental surgeries (increased 142%) and dental prosthetists (reduced 52%).

When we review the complaints over the past two years for these three dental service types, the overall trend in the area is a 10% increase.

The categories of medical practitioner (262% increase) and medical practice (1.6% reduction) are also more meaningful when combined, as together they experienced a 22.4% increase in complaints.

As is always the case with statistics, it is important that the figures in the annual report be considered in context and not as 'stand-alone' figures that reflect the whole.

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

Our mission: To improve health and disability services 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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