CASE STUDIES

Volume 1

HEALTH CARE
COMPLAINTS
COMMISSION

HEALTH CARE COMPLAINTS COMMISSION

Dear Reader

This booklet of case studies is one of several Commission initiatives to share complaint driven insights into the consumer experience, health system weaknesses and examples of how the health system is strengthening the safety of health services.

The case studies amply demonstrate the important role of consumer complaints and feedback to improving health care service in NSW. They also reinforce the benefits to health care consumers, the wider community and health care providers of good complaint management linked to quality improvement.

We welcome your feedback on this booklet and trust you find the information to be of value.

Yours sincerely

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Commissioner

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Continuity of care

Provision of health care is complex and, the more complex a system becomes, the greater the likelihood that gaps in care appear. These gaps pose risks to the provision of safe health care. Continuity of care is therefore a key challenge to health systems throughout the world.

The three case studies illustrate:

- the central role information plays in the provision of health care
- how the involvement of one practitioner at key stages enhances continuity of care
- the importance of involving carers and understanding the totality of patient needs in specialist facilities.

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Multiple communication failures complicate care

Mr J, a teenager, died from Meningococcal disease following a brief history of intermittent headache, fever, vomiting, stiff neck and, in the later stages, sensitivity to light and dizziness. While examined by ten doctors in three hospitals, Mr J's illness was only identified after a post-mortem examination.

Mr J was initially examined by a GP, Dr A, who transferred Mr J to hospital 1 with suspected Meningococcal disease.

Contrary to procedures, hospital 1 did not consider the GP's diagnosis during triage. The hospital incorrectly triaged Mr J and arranged for Dr B a junior medical officer to assess him. Dr B failed to order appropriate examinations such as a CT scan or lumbar puncture to test the fluid around the brain. Mr J was discharged with a viral infection diagnosis, despite blood tests indicating a bacterial infection. Dr B did not ensure that Mr J received adequate written discharge advice, or that Mr J's GP was advised of the intervention.

A few days following discharge, Mr J was examined by his regular GP, Dr C. Dr C was unaware of the tests done during Mr J's hospital admission and Mr J's high white cell count – the increase of a certain type of white blood cell which usually indicates bacterial infection.

Dr C examined Mr J again later and had him transferred to hospital 2 with a diagnosis of viral infection, exhaustion and dehydration. Mr J suffered a cardiac arrest hours after his admission and died the next day.

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On investigation, the Commission could not determine whether, if correct procedures had been followed, a correct diagnosis could have been made earlier. The Commission did however identify the following breakdowns in communication:

- hospital 1 emergency department did not identify, review and communicate information from Dr A
- hospital 1 did not follow triage procedures to ensure appropriately trained and experienced doctors examined Mr J
- Dr B did not seek a second opinion
- Dr B did not provide adequate discharge information to Mr J or his regular GP, Dr C
- Dr C did not seek pathology results from hospital 1
- Dr C referred Mr J to hospital 2 without communicating the full history of Mr J's treatment
- hospital 2 initially assessed and treated Mr J on the basis of Dr C's diagnosis without a full clinical assessment to confirm it.

The Commission made recommendations to hospital 1, which it has since acted on, about recording and processing admission information, adhering to triage protocols and providing appropriate discharge information.

The Commission referred Dr C and Dr B for disciplinary action.

Changes to notification of consultant staff

Mr Z was admitted to hospital for elective surgery under the care of Dr X. Post-operative complications arose and emergency surgery was performed to remove blood clots. Mr Z was transferred to the intensive care unit for respiratory support.

Dr X reviewed Mr Z two days before his death, noting that he was progressing well.

The evening before his death, Mr Z experienced high temperatures and high blood pressure. His blood pressure returned to normal after resuscitation. The next day Mr Z's condition deteriorated rapidly and he died after a cardiac arrest.

Mr Z's family raised a number of concerns:

- the timeliness of investigation of the infection causing fever and its treatment
- staff failure to respond appropriately to family queries
- despite family requests, failure to refer Mr Z to his treating doctor the night before he died.

The Commission referred the complaint for investigation to the Area Health Service (AHS) responsible for the hospital. In the AHS report, the hospital acknowledged that communication with the family was not adequate and the resident medical officer (RMO) should have contacted Dr X when Mr Z's condition deteriorated. The report noted that an apology had been extended to the family and a meeting between the hospital and the family was offered.

After reviewing the report the Commission decided that, while overall care was acceptable, the RMO may not have recognised the possible implications of the sudden change in Mr Z's condition. Notification of the consultant was warranted given the nature of the deterioration and the need for consultation with a practitioner who had good knowledge of the patient throughout the hospitalisation.

As a result of the Commission's feedback, the hospital refined policies requiring notification of consultant staff about unstable patients after-hours, and immediate notification about emergency admission of their patients, performance of surgery, and deterioration in a patient's clinical or behavioural state. The policies were discussed during the orientation of junior medical officers and incorporated in the Medical Officers' Handbook.

Improved safety for patients who wander

Mrs J was admitted to a metropolitan hospital with breathing difficulties. She had a number of chronic conditions and early stage dementia. Her daughter advised nursing staff that Mrs J was quite mobile and tended to wander in unfamiliar surroundings.

Within hours of admission, Mrs J wandered from the hospital. Family members raised concerns about the need for a safer environment. The family felt their concerns were not taken seriously and nursing staff were rude.

Mrs J wandered from hospital again. Mrs J's family was not advised about the incident and found out only when a family member called to speak to her. The family searched for Mrs J, located her and took her back to hospital.

The Commission assessed the matter for investigation by the AHS. The AHS conducted an investigation and advised the Commission that:

- the coronary care unit was not appropriate for dementia patients
- the purpose-built area for dementia patients could not provide the cardiac monitoring that Mrs J required initially
- staff were aware that Mrs J was mobile and had a tendency to wander and did make every effort to observe her
- with respect to the second incident, Mrs J had been nearer the nurses' station, however, the staff left her unobserved to attend to other patients
- it is standard procedure for staff to notify next of kin about a patient wandering and this was in train when the family arrived.

The AHS apologised to the family for failing to provide comprehensive care to Mrs J. The service gave an undertaking that in-service education on the care of dementia patients would be provided to staff in other wards.

Following a review, the Commission asked the AHS to re-examine the issue and provide a further report addressing:

- Systems in place to trigger awareness of the risk of patients wandering and address this risk in the nursing care plan
- The links between the psycho-geriatric ward and the general wards to access their expertise in caring for patients with dementia

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- Communication with families – families informed of the limited capacity of staff in general wards to monitor patients.

To address the issues the Commission had raised, the AHS advised that:

- hospital nursing services now have a system in place to trigger staff awareness of the risk of patients wandering and strategies to manage the identified risks in the Nursing Care Plan
- staff in the general wards are able to access the expertise of psycho-geriatric ward staff in order to appropriately manage patients with dementia over a 24-hour period
- nursing staff are to discuss with relatives/carers any potential risk for patients with a propensity to wander and how they may assist with supervision. Attempts are now made to locate patients who wander in the most suitable inpatient bed to provide the necessary level of supervision required.

Consumer focussed care

The community has gradually developed greater expectations regarding the role of patients and their family and carers in health care. Medical and health information is becoming more available and there has been a rise in consumerism and associated rights. In response to demand, the health system has acknowledged the importance of providing care in partnership with health consumers.

Although consumer focussed care has been acknowledged as important its implementation varies across the health system. Some people using health services have sought the assistance of consumer health groups, hospital patient liaison officers and patient support officers to help them obtain health care and information that is appropriate to their needs.

The following case studies are about:

- responsiveness to patient concerns on safe procedures
- the right to appropriate care
- involvement of carers in decision making.

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Doctor reviews infection control

After examining Ms Q, who has Hepatitis C, Dr G advised that he would have to charge her an additional amount. When questioned by Ms Q, Dr G said the charge was for "extra" precautions needed because of her Hepatitis C status. Ms G paid the bill and left.

Ms Q rang the Commission who referred her to the Commission's patient support officer (PSO). Ms Q told the PSO that:

- she was not aware of any "extra" precautions that should be used for someone with Hepatitis C, as she believed the same procedures were used for everyone
- if there were no extra precautions, then Dr G had no right to charge her an extra fee
- if Dr G was not using standard precautions, then there was an infection control risk.

Ms Q wanted her concerns acknowledged and Dr G's practices reviewed.

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After discussing the resolution options, Ms Q decided she did not wish to resolve the matter directly with Dr G, but wished to make the complaint formally to the Commission. The PSO assisted Ms Q to prepare her letter of complaint and provided Ms Q with written information and support through contact with the Hepatitis C Council.

The Commission referred the complaint to the NSW Medical Board. Ms Q received a written apology from Dr G, a refund, and an outline of Dr G's review of his infection control procedures.

Ms Q was very satisfied with the outcome and the assistance received during the resolution of her conerns.

A prisoner receives the right medication

Mr J, a prison inmate, contacted a patient support officer (PSO) about the refusal of the Corrections Health Service (CHS) to supply him with further quantities of a cream which he was successfully using to treat a skin disorder.

After contacting the prison clinic, the PSO was informed that one of the ingredients in the cream was very expensive and difficult to obtain. The CHS pharmacist also said that he was concerned about the strength of the particular ingredient and that he would not prepare the cream at that strength again.

The PSO emphasised Mr J's view in further discussions with the CHS that the cream was effective and that he used it judiciously. The matter was resolved satisfactorily for Mr J. The CHS verified the initial prescription with the treating dermatologist and agreed to provide the cream at no cost to Mr J.

A carer resolves issues about his mother's treatment

Mr S approached the Commission's patient support officer (PSO) after his elderly mother, Ms S, had sustained a minor fracture to her hip after a domestic fall and had been admitted to hospital X. Up to this time, Ms S had been active and had received care at home from Mr S.

The issues Mr S raised were:

- the finalisation of an assessment of Ms S only a few days after her admission, which found her to be unsuitable for rehabilitation, Mr S considered it was too early to forecast her prognosis for recovery
- the lack of an interpreter at the assessment as Ms S has poor English language skills
- Ms S's rapid loss of confidence in hospital
- staff commitment to finding a culturally appropriate nursing home, should one be needed
- the hospital's refusal to provide a copy of Ms S's X-ray report to her general practitioner.

The relationship between the hospital and Mr S deteriorated further when he learned that the hospital planned to seek a guardianship order to facilitate Ms S's transfer to a nursing home.

The PSO arranged a resolution meeting with key members of the treatment team and Mr S. The treating team agreed to a trial to see if Ms S responded to rehabilitation. The team also agreed to release the X-ray report.

Ms S was transferred to the rehabilitation unit and successfully undertook therapy. She was later discharged home to Mr S's care with community-based support.

Aboriginal health care

In general, Aboriginal culture does not promote the making of complaints, particularly written complaints. Health services need to ensure that verbal complaints are taken seriously and appropriate action is taken when problems have been identified. Feedback needs to be provided in a form that is understandable by the complainant and also given, where appropriate, to family members.

The case studies have a common theme of supporting solutions that work for an Aboriginal person or community. They also illustrate how the Commission's Aboriginal liaison officer (ALO) contributes to complaint resolution for Aboriginal people and communities by providing information and support, advice on resolving complaints and health concerns to Aboriginal people and communities, mainstream health providers and Commission staff, brokering local resolution and providing valuable input into Commission investigations.

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Lack of respect in an emergency department

Ms A called the Commission's ALO after an incident in the emergency department of a local hospital. Ms A had asked the nurse taking her blood pressure to remove the cuff as it was causing pain and was on the same arm as an intravenous drip. The nurse reportedly walked away after stating, "well sue me". Ms A felt shocked at the lack of respect.

The ALO discussed options for resolution with Ms A over the telephone and posted out an information kit to assist her to resolve her concerns locally. Ms A felt confident to pursue her concerns directly with the hospital with assistance from her family.

Community finds health service inadequate

Mr W, who lives in a remote community, contacted the ALO about the reduction in local health care services. Mr W advised that the community has a first aid centre which provides limited services. There are no on-site after-hours staff, which causes treatment delays and Mr W had queries about the standard of care provided.

With Mr W's consent, the ALO contacted the manager of the health service to convey these issues. The manager advised he was aware of the community's dissatisfaction with the change in local health services. A community meeting had been held but the resulting options paper had not received community support. The manager offered to meet Mr W and discuss the issues further. The ALO conveyed this information to Mr W who was receptive to the suggested meeting. Mr W felt comfortable about contacting the ALO in the future if needed.

Country doctors build a better relationship with an Aboriginal community

The CEO of an Aboriginal Medical Service, Ms P, contacted the ALO about the decision of local doctors not to treat some young people in a country town. The doctors believed the young people were involved in vandalism and theft.

Ms P asked that the ALO contact one of the doctors to see if they would change their decision. After discussion, the doctor agreed with the ALO's suggestion for a meeting with Aboriginal community members. At the doctor's request, the ALO advised on culturally appropriate ways for the medical team to develop a working relationship with the local Aboriginal community. The doctor, an elder, Ms P and members of the Aboriginal Medical Service Board met and developed plans for providing a service to the youths.

After the meeting the doctor contacted the ALO and expressed his gratitude for helping him understand a process of doing Aboriginal business and felt that, due to this process, a positive outcome resulted and that the future working relationship would only get better.

A local hospital improves services for young children

Mr O, an Aboriginal community member, wrote to the Commission on behalf of a young mother whose child had died following discharge from the emergency department of the local hospital.

Mr O complained that staff had treated the mother and child dismissively and that the child's death from pneumonia could be directly linked to his early discharge. Mr O considered that the staff had displayed racist attitudes.

During its investigation the Commission identified the following factors that impacted on the quality of care provided to the child:

- An inadequate system for managing medical records meant that the child's chest x-ray was not available to the emergency department doctor
- There was no medical co-ordinator in the emergency department to monitor the quality of treatment provided by the department
- Staff had not received adequate training in paediatric health
- There was only one Aboriginal health liaison officer available for all inpatients and outpatients at the hospital
- There was no system to ensure the identification and recording of Aboriginal and Torres Strait Islander patients
- There was no system to ensure that the Aboriginal health liaison officer was made aware of the presentation of young mothers or carers, or to ensure that patients were made aware of the availability of an Aboriginal support person.

The Commission investigated the complaint and an investigator and ALO visited the hospital where management demonstrated the new system of medical records and retrieval already in place. In addressing the problems identified in the quality of care, management also proposed to:

- establish beds for observation of children not well enough for immediate discharge home
- employ a medical coordinator in the emergency department
- develop clinical guidelines for the management of specific paediatric conditions.

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The Commission's Aboriginal Liaison Officer and the Medical Adviser reviewed the proposed changes and, made additional recommendations for:

- regular paediatric in-services and staff training
- a review of services available to Aboriginal and Torres Strait Islanders
- improved identification of Aboriginal and Torres Strait Islanders
- an increase in the number of people referred to the hospital's Aboriginal Health Liaison Officer.

A copy of the proposed changes was provided to Mr O. The investigator then telephoned Mr O to seek his opinion on the matter. Mr O supported the proposed changes. He was particularly keen for a review of the support services available to Aboriginal and Torres Strait Islanders in the area.

The Commission met with senior management from the Area Health Service who supported the recommendations. It was agreed that the Area Health Service and hospital would provide a report on the progress of the changes after six months.

The Commission contacted a relative of the young mother to discuss the investigation. It was agreed that the Commission would send a letter to the young mother outlining the changes which were taking place as a result of the incident involving her child.

Open disclosure

There is always a risk of harm in providing health care. When harm occurs, it is often distressing for the person receiving care, the family and for the care team.

Open disclosure involves truthful discussion of incidents that result in harm.

The elements of open disclosure include a factual explanation of what happened, why it happened, what is being done to prevent recurrence, and an appropriate expression of regret.

The Commission looks forward to the implementation of the Australian Council on Safety and Quality in Health Care national standards for open disclosure which will promote a clear and consistent approach to communication following adverse events.

The case studies below illustrate how open disclosure:

- benefits the patient, carers and the health team
- improves patient care.

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Hospital initially dismissive of mother's concerns

Ms P took her baby to the emergency department of hospital X after the baby had hit her head in a fall. On arrival, a nurse briefly assessed baby P. After 20 minutes, Dr A assessed the distressed baby, commenting that she was difficult to examine. He then walked away.

Ms P approached the doctor, requesting a CT scan and that a paediatrician be called. Dr A said that neither was indicated. When Ms P said that she wanted to see someone else or go elsewhere, Dr A handed her the phone to call an ambulance.

Ms P then drove to another emergency department at hospital Y, where Ms P and the baby were immediately taken to a resuscitation room and a head CT scan and other X-rays were ordered (without Ms P's request). A paediatrician was called, and the nursing staff assisted her and helped to comfort the baby.

Baby P had suffered a fractured thigh bone and a fracture of her arm. She was admitted to hospital and recovered well.

Ms P sent a letter of complaint to the director of hospital X about the communication and attitude of Dr A, and the inadequate assessment of baby P at hospital X in comparison to hospital Y.

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On receiving a written reply, which she felt dismissed her concerns, Ms P contacted a patient support officer (PSO). The response from hospital X stated that Dr A was unable to treat the baby because Ms P took her away. It also mentioned that Dr A's proposed management plan was to observe the baby for four hours and to give Panadol. Ms P was most distressed by a statement that hospital X was sorry for any "perception" that she had that the service was not satisfactory.

Ms P wanted an explanation for the different approaches by the two hospitals and acknowledgement of her concerns. She also wanted some action to be taken about Dr A's manner and inadequate assessment skills. After meeting with Ms P and her husband, the PSO arranged a meeting with the emergency department director of hospital X.

The director immediately acknowledged the concerns of Ms P and offered an apology. She then explained that the matter had been taken up with Dr A, and that his communication skills in an emergency situation were being monitored. The director also explained that Dr A's country of training did not encourage CT scans for younger children.

Ms P was very satisfied with the resolution of her complaint.

Positive results from acknowledgement of medication error

Nurse W, a registered nurse working at an aged care facility, mistakenly gave insulin to facility resident Mr O, who did not have diabetes. Nurse W immediately recognised his error and brought it to the attention of other staff. The facility took immediate action to help Mr O and arranged his transfer to a hospital, where he was admitted and observed, before being returned to the aged care facility.

The Department of Health referred the complaint concerning nurse W's error to the Commission.

In its investigation, the Commission found that nurse W fully and immediately admitted to the incorrect administration of the insulin. Following this critical event, Nurse W had undertaken further training in medications, and had taken a range of other measures to minimise the possibility of a similar error recurring.

The Commission also noted that the aged care facility, after examining the incident, identified and implemented systems improvements. In view of this, the Commission terminated the investigation and took no further action.

Meeting with key personnel answers queries on surgery

Ms L contacted a patient support officer (PSO) concerning her daughter Ms T's treatment at a public hospital after she had cut off her finger.

A surgeon assessed Ms T and it was decided that she required surgery to re-attach the finger. Approximately four to five hours later Ms T was taken to surgery. The re-attachment was not successful and Ms T had to return to hospital to have the top of her finger amputated.

Ms L had contacted the PSO because she did not understand why the surgery was not successful and was concerned that the length of time between the injury and the surgery had contributed to the unsuccessful outcome. Ms L also commented that she had not had the opportunity to discuss her concerns with anyone when Ms T was in the hospital – the surgeon having spoken with her by telephone after the surgery.

Ms L decided that she wanted to meet the appropriate people at the hospital to discuss her concerns. Ms L requested assistance from the PSO. In the first instance the PSO made contact with the patient representative and a meeting was organised with the specialist hand surgeon. In consultation with Ms L, the PSO prepared an issues paper detailing the background and issues that Ms L wanted to discuss.

At the meeting, the surgeon discussed studies that concluded that waiting times of up to six hours for surgery had no influence on the outcome of the surgery. The surgeon also told Ms L that the reason why surgery was unsuccessful was because of the nature of the injury.

Ms L reported that she was glad to have had the chance to clarify that her daughter had not been disadvantaged and had received proper treatment.

Mental health

The Commission considers that the provision of accessible, appropriate and responsive mental health services is vital for the wellbeing of the community as a whole as well as for people with mental illnesses, their families and friends.

In addition to the issues identified in the Commission's annual reports for 2001-02 and 2002-03, the following case studies demonstrate the need for improvements in:

- provision of information on available services and resources
- upholding patient rights
- maintenance of appropriate professional boundaries
- health record management.

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Mental health care in country NSW

Mr P, a resident of remote NSW, was made an involuntary patient under the Mental Health Act 1990 and was transferred from the local country hospital to hospital T which was several hundred kilometres away.

After a few weeks, Mr P discharged himself because he had not seen a psychiatrist since his second day in hospital. Mr P complained that:

- meetings were sometimes held in non-private areas such as the verandah
- staffing levels and patient care were inadequate at hospital T
- overall mental health services were inadequate in country NSW
- he should be reimbursed for the cost of returning home.

The Commission referred Mr P's complaint for investigation by the Area Health Service (AHS). In its report the AHS advised that:

- Mr P had had an initial consultation with a consultant psychiatrist as well as extensive consultations on a daily basis with two psychiatric registrars
- Mr P's situation was reviewed at the weekly multi-disciplinary case review and the care plan had been followed

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- patients leaving hospital generally meet their own transportation costs although assistance could be provided
- the ward did not have an interview room and staff tended to use various quieter parts of the facility if patients requested greater privacy.

In response to issues raised by the Commission in the review, the AHS further advised that the hospital:

- acknowledged that individual health workers may have met Mr P to discuss aspects of his care on the verandah
- offered an apology on behalf of its staff and gave an assurance that the need to respect patient privacy would be reinforced
- planned to examine whether renovations could be carried out to increase privacy for patients and staff discussions
- agreed that funding would be made available to Mr P under the NSW Isolated Patients' Travel and Accommodation Assistance Scheme.

Dissatisfaction with long-term psychotherapy

Ms D, a young woman, complained to the Commission that she had been treated unsuccessfully with psychotherapy for more than a decade by psychiatrist Dr B. Ms D claimed she made a dramatic recovery after she changed to a different psychiatrist who prescribed anti-depressant medication for her.

Dr B's response to the complaint stated:

- for several years at the beginning of his treatment of Ms D he had peer supervision
- Ms D did not meet diagnostic criteria for depression
- Ms D's depression fluctuated in response to traumatic events and responded to psychotherapy
- prescription of medication was risky
- supportive psychotherapy is conventional treatment for a patient with her diagnosis
- Ms D was positive about Dr B's treatment and did not complain.

The Commission obtained two peer reviews by independent psychiatrists experienced in psychotherapy. They agreed that:

- Dr B's failure to make and preserve adequate records was unacceptable – he could only provide one page of notes for 10 years of private consultations
- the standard of informed consent was in line with the standard prevailing at the time Ms D commenced treatment (the current standard is more exacting)
- a small proportion of psychiatrists favour long-term psychotherapy to treat patients with Ms D's problems.

Dr B was counselled by the NSW Medical Board about his grossly inadequate record keeping but given the expert answers it was not appropriate to discuss his treatment.

Inappropriate provider-patient relationship

The Commission received a complaint which alleged that nurse N had formed an inappropriate relationship with a mental health patient, Mr W. The relationship allegedly started when Mr W was under the care of nurse N, and continued when he transferred to another mental health facility.

It was alleged that nurse N visited Mr W when she was off duty, took Mr W on day leave, visited Mr W's family members, attended his Mental Health Review Tribunal hearings, assisted Mr W to take leave from hospital without notice and spent time with him during his absence.

Nurse N's response to the complaint indicated little insight that her contact with Mr W was inappropriate, and showed scant understanding of the boundaries between nurse and patient.

The independent peer who reviewed the matter for the Commission noted that nurse N appeared to have difficulty working within the boundaries set for the safe and therapeutic management of Mr W. The peer reviewer also determined that nurse N had difficulties working within a team approach to care. This not only negatively affected the therapeutic care of Mr W, but also caused problems for nurse N's colleagues. The peer was critical of nurse N's conduct towards Mr W and noted the importance of good clinical supervision as one way of keeping a clear view on boundaries.

The Commission's view was that nurse N's behaviour in establishing a personal relationship with patient W was unacceptable. At a hearing of the Nurses Tribunal, nurse N was found guilty of professional misconduct and deregistered for 18 months.

Disciplinary cases

The following cases are examples of disciplinary matters that the Commission dealt with. The cases contain important statements of legal principles and professional standards.

Professional Standards Committees

Dr A – Sexual harassment of staff

A complaint was made to the Commission that a medical practitioner had sexually harassed Ms Q. Ms Q was working as a receptionist for Dr A when he had inappropriate contact with her including touching her shoulders, tickling her and kissing her on the lips. Dr A was also making inappropriate remarks and showing Ms Q a picture of a naked woman in a seductive pose.

Dr A admitted some of the conduct and accepted in retrospect there may have been a blurring of boundaries between employer and employee. Ms Q had also received a vaccination against the flu from Dr A.

The Professional Standards Committee found that a doctor/patient relationship existed and that Dr A's conduct was inappropriate. It found the employer/employee relationship between Dr A and Ms Q did relate to the practise of medicine.

The Committee also found that giving the vaccination or a similar type of casual treatment to employees is best avoided on the grounds that it is better for a person to have the one medical practitioner; casual ad hoc consultations do not usually lead to the best considered outcomes; and there may be conflicts of interest in treating employees.

The Committee determined that Dr A was guilty of unsatisfactory professional conduct. It reprimanded him and placed conditions on his registration including that he complete courses on harassment and bullying prevention and EEO and harassment prevention for managers.

Dr B – Inappropriate use of intravenous iron

Ms W consulted Dr B, a GP, complaining of tiredness. Dr B took a history and ordered blood tests. The pathology results stated haemoglobin was normal, however, Dr B recorded "Borderline Ferritin level, (?) early iron deficiency." Ms W was young, fit and not a vegetarian.

Dr B suggested injections of iron and explained that the side effects were rare. Ms W agreed. After the first two treatments, despite experiencing some dizziness at the time, Ms W felt improved. On the third occasion the patient developed a severe allergic reaction which can lead to death. Dr B stopped the treatment and administered adrenaline. Ms W recovered.

Ms W discussed the matter with another GP who lodged a complaint with the Commission on her behalf.

The Professional Standards Committee found Dr B guilty of unsatisfactory professional conduct and reprimanded him. The Committee noted that the peers who gave evidence and the Australian Iron Status Advisory Panel recommended that in the case of lowered iron stores, iron depletion and iron deficiency anaemia, treatment should be at first dietary manipulation, then the use of oral supplementation and that injectable iron should rarely be necessary. None of the articles referred to by Dr B in evidence recommended the use of intravenous iron in patients with mild or moderate iron deficiency. The vast majority of the articles referred to patients with renal failure on haemodialysis, not to a 19 year old otherwise healthy female. The Committee also found that the intravenous iron was used contrary to the advice contained in the manufacturer's product information.

The Committee decided that the issues arising in the case warranted bringing to the attention of other general practitioner's to raise awareness and serve as a learning tool. It therefore directed that a de-identified version of its decision be supplied to the Royal Australian College of General Practitioners.

Medical Tribunal

Dr C – Breach of conditions

In 1998 Dr C, a general practitioner anaesthetist, was found guilty of unsatisfactory conduct by a Professional Standards Committee and on appeal by the Medical Tribunal in relation to a complaint where Dr C had administered general anaesthetic.

The Committee expressed great concern as to Dr C's training, experience, continuing medical education and professional review. The Committee imposed conditions on Dr C's registration directed towards these matters. The Medical Tribunal varied the conditions to require Dr C to participate fully in the Maintenance of Professional Standards (MOPS) programme conducted by the Australian and New Zealand College of Anaesthetists (ANZCA) and to report his participation in the programme annually to the Medical Board.

In 2002, the Commission made a complaint under the Medical Practice Act 1992 that Dr C was guilty of professional misconduct and/or unsatisfactory professional conduct for breach of conditions, for failing to participate fully in the MOPS programme and by failing to report his participation annually to the Medical Board by submitting the annual statement of participation issued by the College. The Medical Board had made a complaint to the Commission about the matter.

Dr C admitted the particulars of the complaint and that his conduct amounted to unsatisfactory conduct. By the time of the inquiry it was apparent that Dr C had participated in the programme for most of the relevant years but had not submitted his annual statements for those years to the Board until just prior to the inquiry.

The Tribunal found that Dr C encountered difficulties in facing up to the obligations imposed upon him by the conditions. The Tribunal found that he had received a number of reminders from the Board and the Commission and had made some incorrect representations to the Commission during the investigation of the complaint. The Tribunal observed that Dr C had apologized for his failure to comply and recently enlisted the support of another practitioner to assist him in dealing with his obligations as well as undertaking to comply scrupulously in the future.

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The Tribunal found that Dr C's conduct amounted to unsatisfactory professional conduct of a very serious nature. The Tribunal stated it was charged with exercising powers to sanction members of the medical profession for the purpose of protecting the community. The principal consideration in the exercise of these powers is the maintenance of the standards of the medical profession and maintaining the confidence of the public in the profession. The public is entitled to the assurance that measures will be taken to address breaches of acceptable standards of practice.

The Tribunal ordered that Dr C be severely reprimanded, fined the sum of $7,500 and ordered to pay the Commission's costs of the proceedings. The Tribunal placed further conditions on Dr C's registration directed towards the reporting and monitoring of his compliance with the condition to participate fully in the MOPS programme.

Psychologist Tribunal

Mr D – Lack of good character

A complaint alleging that Mr D, a psychologist, was not of good character was heard by the Psychologists Tribunal in February 2003. Under the Psychologists Act 2001, good character is an essential pre-requisite for registration as a psychologist.

The complaint alleged that Mr D had engaged in conduct of a sexual nature with two young girls, who were not known to each other, in 1993 and 1996. The girls were aged 11 and 13 respectively at the time of the incidents, and were the daughters of women with whom Mr D had relationships. The conduct occurred prior to Mr D obtaining registration as a psychologist.

Mr D denied any sexual impropriety in relation to the young girls. The Tribunal found the particulars of the complaint proved and stated that *"such behaviour in relation to each of the children individually can only be characterised as sexual".*

Having found the factual allegations proved, the Tribunal then considered the question of Mr D's good character. In its judgement it stated *"the repeated breaches of appropriate boundaries in relation to each case…over a number of years as well as the degree of conscious actions on the part of the Psychologist and his efforts to conceal and minimise his conduct clearly demonstrate that the behaviour, rather than being an error of judgement, was inappropriate and impinges on his character to the extent that it shows a defect in his character."*

The Tribunal found that Mr D had not overcome the defect of character which led to the conduct, and held that he is not of good character and that his registration should be cancelled and his name removed from the Register of Psychologists. It ordered that he cannot make an application for review for a period of two years. The Tribunal recommended any application for re-registration be considered with a report by a psychiatrist or psychologist outlining treatment, progress and Mr D's suitability to practice as a registered psychologist given the findings of the Tribunal.

Nurses Tribunal

Ms E – Fraudulent misappropriation and convictions

The Commission made a complaint under the Nurses Act that Ms E, a registered nurse, was guilty of unsatisfactory professional conduct and professional misconduct; had been convicted of three counts of fraudulent misappropriation; and was not of good character. At the time of the alleged incidents, Ms E was employed at a retirement village. Ms E was fined by a Court for the criminal offences.

The Commission alleged that Ms E misappropriated sums of money of between $50 and $5,000 on eight separate occasions from four different residents in a retirement village, over a two-year period between 1996 and 1998. The residents were dependent upon Ms E. Three residents were mentally incapacitated, suffering from dementia and schizophrenia and the fourth resident was incapacitated from breathing problems. It was also alleged that Ms E failed to disclose to residents of the retirement village that she would receive commissions from a private company for sale of clothing to them; inappropriately completed and signed a form giving herself authority to operate the personal bank account of one of the four residents; and that she employed her sister at the retirement village after she had been told by her employer not to employ relatives.

The misconduct ceased when Ms E was discovered making a withdrawal of $5,000 from one of the resident's bank accounts.

Ms E admitted the particulars of the complaint but denied that the circumstances of the offences meant that she was unfit to practise in the public interest or that the behaviour outlined in the particulars meant that she was not of good character. Ms E did not give oral evidence to the Nurses Tribunal. The Tribunal consequently relied on documentary evidence, which set out her view of events.

In relation to the question of character, the Tribunal stated *"These are serious matters which involve dishonesty by the respondent who took advantage of her position of trust, exploiting relationships of dependence and breaching trust with residents in the hostel of which she was the manager. Increasing large amounts of money were taken by the respondent. One event involved the respondent obtaining a signed authority for her to operate the bank account of a resident suffering from schizophrenia. In the absence of hearing from the respondent in the absence of having substantial evidence of a possible change of character, we are left with the conclusion that the respondent is not of good character."*

The Tribunal found that Ms E was guilty of professional misconduct and that she was not of good character. She was de-registered and cannot apply for re-registration for one year.

Dr F – Stay of proceedings

Dr F had been the subject of a complaint to the Commission by Ms Z concerning an inappropriate sexual relationship over a 20-year period. The Commission made a complaint under the Medical Practice Act. The complaint was heard by the Medical Tribunal in 2001. The Tribunal found Dr F guilty of professional misconduct and de-registered him. Dr F successfully appealed the decision and the Court of Appeal ordered that the complaint against Dr F be reheard.

During the course of the Tribunal inquiry another former patient of Dr F, Ms Q, became aware of the disciplinary proceedings. Ms Q then made a complaint to the Commission. The patient claimed that Dr F had engaged in an inappropriate sexual relationship with her in 1982 and following a break of treatment further sexual contact occurred during consultations in 1990 and 1992. The Commission sought to proceed on an amended complaint before the Tribunal concerning the allegations made by both patients.

The Tribunal ruled that the amended complaint could be filed and the two complaints could be heard together. Dr F applied to the Court of Appeal for a permanent stay of proceedings in relation to the complaint made by the second patient. In addition, Dr F claimed that the delay by the patient in making her complaint and the fact that his own medical records of the patient, as well as the medical records held by other health care professionals who had treated the patient, had been destroyed, prejudiced him to the extent that he would not have a fair hearing of the matter at the Tribunal inquiry.

The Court of Appeal dismissed the application for a permanent stay. It noted that where the delay in bringing a complaint was caused by the complainant, and not the prosecutor's delay on its own, should not normally lead to a permanent stay order, unless it will result in an unfair trial. The Court noted that in the present case the patient's explanation for the delay was not inadequate or unreasonable. The Court stated that the power of the Court of Appeal to permanently stay proceedings in the Medical Tribunal should only be exercised in very exceptional circumstances and in considering whether to order a stay, consideration must be given to the protective character of the proceedings and the importance of protecting the public from professional misconduct by medical practitioners. It considered that the nature of the patient's complaint and the circumstances of the case were such that the absence of the practitioner's medical records would not make a fair trial impossible.

Mr G – Breach of statutory duty

Mr G brought proceedings against the Commission in the Supreme Court concerning a complaint he had made to the Commission. The case was reported in the Commission's Annual Report of 2000 - 2001. The proceedings in 1999 were dismissed.

In 2002 Mr F brought further Supreme Court proceedings against the Commission. His claim was distinguishable from the one in the first proceedings only by the additional allegation that the Commission had breached a duty to Mr F to act in good faith and that he had a right to damages as a result of the Commission's breach.

Upon the Commission's preliminary application, the Master of the Supreme Court decided that the claim did not disclose a good cause of action and dismissed it. The Master cited with approval the previous judgment and X (Minors) v Bedforshire County Council which was referred to in the previous judgement. The Master did not consider whether or not Mr F's claim might be alleging wrong doing in public office. The Master said:

"the scheme set up by the Health Care Complaints Commission is to investigate complaints. It is not intended to give private rights to individuals. As Sully J held this legislation is not to be treated as being passed for the benefit of individuals, but for the benefit of the society in general. In so far as the statement of claim propounds a claim based upon the defendant's breach of its statutory duties, it does not disclose a good clause [sic] of action."

These two judgments show that although court proceedings can be brought to quash an unlawful decision by the Commission and compel the Commission to carry out its statutory duties and exercise its statutory discretions according to law, a claim must disclose a good cause of action and ultimately the Health Care Complaints Act 1993 is for the benefit of society in general.

Health Care Complaints Commission

Services available:

- Provide information – eg about how to make a complaint to the Commission or your health provider, rights of health consumers, types of complaints received by the Commission. You can look on our website, contact our telephone inquiry staff or a patient support officer.
- Support and advocacy services at a local level for people with health care concerns– you can contact the patient support officer in your area.
- Receive and assess complaints – you can send written complaints to the above address.
- Training sessions – eg about how to resolve complaints, conduct investigations, improve your interviewing skills or consumer advocacy – write or ring the Commission with your request.

Telephone:	(02) 9219 7444
Toll Free in NSW:	1800 043 159
TTY:	(02) 9219 7555
Fax:	(02) 9281 4585
Postal Address:	Locked Mail Bag 18 STRAWBERRY HILLS NSW 2012
Website:	www.hccc.nsw.gov.au
Email:	hccc@hccc.nsw.gov.au

Translating and Interpreting Service (TIS) 131 450, please ask to be put through to the Health Care Complaints Commission on 1800 043 159.

Patient support service contact numbers:

Central Sydney	(02) 9395 2028
Dubbo/Macquarie	(02) 6885 7937
Lismore/Northern Rivers	(02) 6620 7663
Newcastle/Hunter	(02) 4985 3143
Northern Sydney	(02) 9926 8184
Penrith/Blue Mountains	(02) 4734 3870
South Eastern Sydney	(02) 9382 8129
South Western Sydney	(02) 9828 5710
Western Sydney	(02) 9881 1506
Wollongong/Illawarra	(02) 4222 5556
Other Regions in NSW	1800 043 159

If you have difficulty contacting a patient support officer, please call the Health Care Complaints Commission on 1800 043 159.

HEALTH CARE COMPLAINTS COMMISSION

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