Annual Report 1998-1999

HEALTH SERVICES COMMISSIONER

Health Services Commissioner

Annual Report
1998/99

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STAFF OF THE HEALTH SERVICES COMMISSIONER AT 30 JUNE 1999

Office Manager	Michael McDonald has responsibility for resource management and administration.
Conciliators	Keith Jackson and Teresa Punshon assist parties with a complaint to reach a resolution in a confidential and privileged setting.
Investigators	Orysia Ckuj, Liz Gallois, Pamela Gilbert and Lynn Griffin assess and resolve complaints, which have not been resolved in the initial stages, to determine what is required to bring about a resolution. They also provide policy advice to the Commissioner and assist with promotion of the HSC.
Registrar	Shiranee Sinnathamby is responsible for the case management of all complaints and inquiries and supervises the work of the inquiry officers.
Aboriginal Liaison Officer	Melanie Fraser is the Aboriginal Liaison Officer responsible for supervising and monitoring complaints concerning indigenous Australians, for outreach work and complaint handling.
Inquiry Officers	Heather Andrew, Jill Aitken and Piotr Nyczek are responsible for handling complaints and inquiries and provide advice to health service users and providers during the initial stages of the complaints resolution process.
Systems Administrator	Philip Punshon manages the office computer network and provides statistical information and technological advice.
Executive Assistant	Karen Rapson provides executive, administrative and keyboard support to the Commissioner and handles some casework.
Administrative Officer	This position is vacant.
Receptionist	In the year under review receptionist services were carried out by Melita Powell, Karen Rapson, Naomi Pearson, Nicole Hulme of HSC and Sandra Popovski (Mental Health Review Board).

COMMISSIONER'S SUMMARY

This has been a busy and fruitful year for the Health Services Commissioner (HSC). In October 1998 we relocated to our new premises at 30th Floor, 570 Bourke Street, Melbourne, 3000 Tel: 8601 5200 (complaints line), 8601 5222 (administration), toll free: 1800 136 066, facsimile 8601 5219. The co-location of the HSC with three other independent statutory authorities which have similar functions provided opportunities for sharing of resources between the tenants. Sharing of board rooms, equipment and services has increased overall resources and assistance with reception duties has alleviated some pressures on staff. There are now comfortable interviewing rooms for meetings and teleconferencing facilities that assist in discussions with clients in the regions. The move itself was ably managed by Michael McDonald with the assistance of Philip Punshon and I am grateful to them for their hard work which included supervising the move during the weekend.

I am encouraged by the increased awareness in hospitals about the importance of effective complaints handling. In Victoria there are now approximately 150 complaints liaison officers; most are employed in public hospitals with some in private hospitals and other health services. These people are referred to by a variety of titles and their work is vital to complaints resolution and improvements in quality of services. Anyone experiencing difficulties with hospital services will find it helpful to seek out these staff members. Most public hospitals report to the HSC on the complaints they receive and the HSC provides training and support for health services in the handling of complaints. I also note the emerging appreciation by health service providers of the importance of risk management and clinical governance in improving quality of services. The HSC exists to provide an accessible and independent mechanism to receive and resolve health complaints with a view to improving the quality of health services. I therefore have a strong interest in quality assurance processes and encourage all providers to include the complaints liaison officers on their quality assurance committees to ensure that complaints are used constructively. The importance of including consumer representatives is also being increasingly acknowledged.

The HSC is effective in disputes resolution because it has broad jurisdiction, and is independent, accessible and impartial. Complaints handling is confidential and most complaints are resolved in the early stages through mediation. The excellent relationship that exists between the HSC and all the professional registration boards, including the Medical Practitioners Board and the Dental Board of Victoria, allows referral of complaints to the most appropriate body. Complaints which raise issues of professional standards and allegations of misconduct are usually dealt with by the Boards with the HSC retaining other complaints including those suitable for conciliation where compensation is sought or further information and advice is needed.

As with the establishment of bodies like the mental health review tribunals, the introduction of the HSC was greeted with extreme caution in 1988 by some health service providers. My experience is that there is now a greater acceptance of external scrutiny with many health service providers playing an active role in resolving complaints by providing expert opinions and referring disputes to the HSC. I am most appreciative of this co-operation and thank all those members of the medical, dental and other health professions who assist us so willingly and so ably.

The constructive relationship that has been built up between the medical indemnity funds and my officers has also been in the public interest and is vital to the effective resolution of complaints.

As Commissioner I am fortunate in having access to the advice and assistance of Andrea Coote, the President of the Health Services Review Council and the members of Council. In addition to ensuring accountability they also provide expert advice in areas such as law, medicine, policy and social issues. The HSC thanks them for their assistance.

During 1992 a temporary Aboriginal Liaison Officer, Joan Vickery, assisted the staff of the HSC in recognising the difficulties which indigenous Australians face in accessing mainstream authorities like the HSC. Joan's pioneering work culminated in the appointment of the HSC's first full time Aboriginal Liaison Officer, Melanie Fraser, whose report appears on page 25 of this Annual Report.

The relationship between the HSC and the Department of Human Services has developed into a partnership that is supportive and which respects the independence of the Commissioner. My staff and I have benefited from internal training seminars at which invited guests have presented information and answered questions in an informal setting. The Commissioner thanks the following people:

Professor Paul Mullen, Clinical Director, Victorian Institute of Forensic Mental Health,
Ryanda Mee, For Me and For Us, Stress Management Techniques,
Heather Howard & Graham Schrapnel, Association of Masseurs,
Dr Ruth Vine, Deputy Chief Psychiatrist, Department of Human Services,
Judith Monk and Daphne Milward, Aboriginal Cultural Awareness Training,
Genevieve Ryan, Department of Human Services, Vancomycin Resistant Enterococci.

In conclusion I take this opportunity to thank the hard working staff of the HSC.

Beth Wilson
Health Services Commissioner

HEALTH SERVICES REVIEW COUNCIL PRESIDENT'S REPORT 1998/99

The year under review has been a most positive one for the Council. Meetings have been held monthly and a great deal has been achieved. I congratulate the HSC on its relocation and thank the Minister for Health, The Honourable Robert Knowles and the Parliamentary Secretary, The Honourable Robert Doyle for their support. I am grateful to the Council members for their contribution to policy development, ongoing advice and suggestions for legislative change.

The Health Services Review Council is constituted under section 12 of the Health Services (Conciliation & Review) Act 1987, which provides for nine Council members appointed by the Minister for Health.

MEMBERSHIP

Three members of the Council reflect the interests and experience of providers, three members represent users, and three are independent of either.

The Council members are:

- **reflecting the interests of providers**
  Dr Paul Nisselle
  Mr Neil Wighton Naismith
  Mr Michael Gorton

- **reflecting the interest of users**:
  Ms Andrea Coote (President)
  Ms Pamela Barrand
  Ms Dimity Fifer

- **independent members**
  Dr David Williams
  Mr Anthony Seyfort
  Rev. Father Martin Hislop.

ROLE AND FUNCTIONS

These are set out in s14(1) of the Act. They are:

a) to advise the Minister on the health complaints system and the operations of the Commissioner;

b) to advise the Minister and the Commissioner on issues referred to it by the Commissioner; and

c) with the Minister's approval to refer matters relating to health service complaints to the Commissioner for inquiry.

During the year under review Council members have been involved in promotional, training and advisory activities. The Commissioner has advised me that she sees the Council as playing an important role in ensuring that the HSC is accountable to the Parliament, the Minister for Health and to the users and providers of health services. I welcome this approach and advice has been given to the Minister concerning possible legislative changes and avenues for evaluation of the work of the HSC. I thank Erica Grundell of the Department of Human Services for keeping Council advised of the progress of the legislative review. Together with the Commissioner I advised the Minister about the work of the Office, and regular bulletins on complaint trends have been provided.

Council members bring with them a great deal of expertise and this has been utilised with enthusiasm by myself and by the Commissioner. The multi-disciplinary backgrounds of the Council members make them a most useful resource for advising me and the Commissioner who has told me she intends to continue making full use of their skills.

The health services environment continues to change and is vastly different to that which existed when the HSC was established over a decade ago. The efficient and effective management of complaints plays a positive role in ensuring improved quality of health services. This year has closed with a feeling of progress and enthusiasm. The President, Council members and the Commissioner are delighted to be working together to ensure that the HSC provides the best possible service for the people it was established to serve.

Andrea Coote
President
Health Services Review Council

STATUTORY FUNCTIONS

THE ROLE OF THE COMMISSIONER

The Office of the Health Services Commissioner (HSC) was established in Victoria in 1988. The Commissioner's role is to receive, investigate and resolve complaints from users of health services, to support health care services in providing quality health care and to assist them in resolving complaints. The legislation also requires that information gained from complaints should be used to improve the standards of health care and prevent breaches of these standards.

The Health Services (Conciliation & Review) Act 1987 states that the Commissioner is to:

a) deal with users' complaints; and
b) suggest ways in which the guiding principles may be carried out and help service providers to improve the quality of health care.

The purposes of the Act include

a) to provide an independent and accessible review mechanism for users of health services; and
b) to provide a means for reviewing and improving the quality of health service provision.

GUIDING PRINCIPLES

The guiding principles of the Health Services (Conciliation & Review) Act promote:

a) quality health care given as promptly as circumstances permit; and
b) considerate health care; and
c) respect for privacy and dignity of persons being given health care; and
d) the provision of adequate information on services provided or treatment available in terms which are understandable; and
e) participation in decision making affecting individual health care; and
f) an environment of informed choice in accepting or refusing treatment or participation in education or research programs; and
g) reasonable access to information in records relating to personal use of the health care system except information which is expressly prohibited by law from being disclosed or information contained in personal notes by a person giving health care; and
h) the confidentiality of personal health records.

EXPECTATIONS AND STANDARDS

The guiding principles establish the range of responsibilities for health services and the basis upon which a person might complain that a breach of these responsibilities has occurred. They establish a framework for the HSC to become involved in improving health services and reporting on the problems and the improvements made.

OTHER STATUTORY ROLES

The HSC provides training to a wide range of health service users and providers. This is in accordance with our functions as outlined in section 9 of the Act. A supportive working relationship exists between the HSC and the complaints liaison officers at public hospitals and many other health services in Victoria. Dialogue continues between the HSC, consumer representatives including the Health Issues Centre and health service providers and their associations.

LIAISON, TRAINING & PROMOTION

The HSC consults regularly with registration boards about complaint handling in accordance with section 19(6) of the Act. Regular meetings between the HSC and the Boards are held to determine the most effective and efficient ways of handling complaints about registered practitioners. This process avoids double handling and ensures the legislative requirements are met. The Commissioner also discusses relevant issues with the Ombudsman, the Mental Health Review Board, the Intellectual Disability Review Panel, the Office of the Public Advocate, the Coroner, the Commissioner for Equal Opportunity and other relevant authorities. These links assist our work, especially where the management of complaints involves more than one office. During the year under review consultation with the Victorian Workcover Authority has been held to develop an appropriate protocol for complaints handling between the two agencies.

The Commissioner places strong emphasis on promotion and training to improve accessibility of the HSC to the public and health service providers. During the year under review the HSC has been represented at many conferences and venues to promote the work of the Office. The Commissioner gave addresses, lectures and training at over 40 venues. Consumers of health services from the non metropolitan regions, children and adolescents, Koori and Aboriginal Australians and people from non English speaking backgrounds are under represented as complainants and more work will be done to make the service accessible to them. The employment of a full-time Aboriginal liaison officer will assist with this. Her report appears on page 25.

OVERVIEW OF COMPLAINTS

Throughout this Annual Report anecdotal information has been used to illustrate the types of complaint received. **Details have been altered to protect confidentiality** and, wherever possible, actions taken or resolutions achieved have been indicated. Outcomes cannot be indicated where the matter is still in progress.

PUBLIC INTEREST ISSUES

Complaints can indicate trends within the health care system that have implications for the general public. Public interest is defined by the following criteria:

1. The circumstances outlined in the complaint are likely to affect a significant number of people.

2. These circumstances impact on certain population groups.

3. The complaint is indicative of a systematic flaw, the result of a deficiency in policy or procedures.

4. The complaint raises an issue that is individual in nature but that occurs unreasonably often, suggesting that a systemic problem exists.

These criteria have been used to highlight complaints as they move through the system so that the public interest issue may be given appropriate attention in conjunction with the individual's complaint. A review of complaints so labelled has highlighted a number of issues.

COMMUNICATION BETWEEN DOCTORS AND PATIENTS

Good communication is an important factor in the prevention of complaints and in their resolution. Failures of communication continue to feature strongly in complaints made about health services. While HSC data show that treatment complaints are the most predominant a more detailed analysis reveals that communication failures are a feature of nearly all complaints. This year there was a larger proportion of complaints about the poor attitudes and/or discourtesy of some providers. Examples range from rudeness to unintended misunderstandings.

A patient complained that a general practitioner examined him in what seemed to be a hurry. He was told that there was nothing wrong with him. He subsequently required emergency treatment and when he called the doctor to relate this he was told to stop wasting the doctor's time.

A man attended a general practitioner who belittled him because the appointment was in the context of an insurance claim.

A patient with a back injury complained that a doctor's receptionist implied he was a bludger who made too much work for the doctor.

A person had dentures made by an advanced dental technician but they were uncomfortable. When the patient tried to have this corrected the provider swore at the patient and told them not to come back annoying him.

A patient at a clinic had an appointment but another person was seen first. When the patient complained the doctor became very angry and said patients do not tell him what to do and he would choose who to see. He subsequently offered a sincere apology and the patient accepted this.

Many people who experience an adverse outcome as a result of medical treatment complain that they were not warned of the risks involved. Although they signed a consent form stating that the risks had been explained, they claim that risks were dismissed or minimised by the practitioner.

A patient who had a bad outcome as a result of a medical procedure complained that the doctor had provided a written list of risks but had also said that these should not be taken too seriously as they were only for "legal reasons".

Some practitioners believe that people would refuse treatment if all the risks were explained. This may be so, however if the risks of not proceeding are also outlined then people can decide for themselves which course to take. If the person has made a fully informed decision then the chance of a complaint when a "known risk" occurs would be greatly decreased.

A patient required dental treatment but was not warned of the risks. There was a bad outcome and when the patient sought an explanation the dentist said that what had occurred was a "known risk".

When a treatment has gone wrong and an adverse outcome has occurred then the person should be fully informed as soon as possible. Many complainants say the silence that followed such an event led them to believe a cover up was occurring. This increased their suspicion and made subsequent explanations very difficult for them to accept. Some complainants had waited in vain for a considerable time for an explanation before contacting the HSC.

A woman experienced a very bad outcome after childbirth which caused pain and suffering. The specialists involved refused to speak to her and she was advised through their legal advisers that they had done nothing wrong and it was she who was "in the wrong". When the complaint was finally resolved it was clear that the patient was correct and the complaint could have been finalised much earlier had the specialists been willing to communicate with her.

A study of general practitioners' responses to complaints by HSC investigator Lynn Griffin revealed that they typically followed a general pattern. The initial response pointed out that the adverse outcome was a known risk and the person had signed a consent form. In the process of resolution of the complaint, the practitioner came to accept the person's view that they had not realised the reality of the risk, to acknowledge and, occasionally, to apologise for the distress experienced.

While good communication is a shared responsibility, and, in an ideal world, people would feel able to raise their concerns and discuss them openly, this is not yet the case with most health services. Patients are often vulnerable and this places the onus on service providers to educate and encourage their clients about participation in decision making in matters of health management.

COSMETIC PROCEDURES

During the year under review the New South Wales Parliament initiated an *Inquiry Into Cosmetic Surgery in New South Wales*. The HSC in Victoria was concerned about the disproportionate number of complaints it has received about these procedures. Rather than recommending a similar inquiry in Victoria the HSC provided written and oral evidence to the New South Wales Inquiry and will wait until its the findings are available in October 1999. The HSC will then examine the New South Wales findings and recommendations with a view to advising the Minister for Health about their applicability to Victoria.

The number and type of complaints received about cosmetic procedures, conducted by plastic surgeons and other doctors, is of concern in Victoria. At the time the Commissioner gave her evidence to the New South Wales Inquiry a significant number of complaints had been received concerning a small number of practitioners (4) about whom a total of 89 complaints have been made. While it is acknowledged that some consumers have unrealistic expectations so many complaints against a few practitioners is extraordinary and these concerns have been conveyed to the Medical Practitioners Board of Victoria. Data for complaints about cosmetic and plastic surgery are shown in Table A below.

TABLE A: Cosmetic/plastic surgery complaints received by the Health Services Commissioner (Victoria), 1988- March 1999

Year	Case	Inquiry Only	Total
1988	7	0	7
1989	26	0	26
1990	22	0	22
1991	42	0	42
1992	35	0	35
1993	33	0	33
1994	18	6	24
1995	10	6	16
1996	11	6	17
1997	22	11	33
1998	16	20	36
1999	6	9	15
Total	**248**	**58**	**306**

The HSC is aware that many practitioners are providing skilful services and engaging in best practice. Where complaints occur some have been willing to bear the cost of remedial work themselves and have been co-operative in the disputes resolution process. The HSC has met with relevant professional associations to consider how practices may be improved. These discussions have been most constructive.

The HSC remains concerned about the aggressive promotion of cosmetic procedures and, while consumers of health services are autonomous individuals free to choose or reject medical procedures, there are profound social pressures which women, in particular, face. These pressures include coercion by certain industries and employers who demand that women confirm to stereotypes. This, coupled with aggressive, possibly misleading and seductive advertising by some practitioners who carry out cosmetic procedures has persuaded many to undergo procedures which have resulted in very bad outcomes, physically, emotionally and financially. Poor outcomes include scarring, disfigurement and infection.

The HSC acknowledges that State and Commonwealth trade practices and fair trading legislation have a role to play in dealing with these problems. The HSC, however, agrees with Merrilyn Walton, the New South Wales Health Complaints Commissioner, that trade practices and fair trading mechanisms are generally inaccessible to health service consumers and accordingly are insufficient to protect the public and ensure that professional standards are maintained. In June 1999 the HSC joined with all other health complaints commissioners in nominating Merrilyn Walton to develop a *Guide to the Promotion of Cosmetic Surgery*.

The HSC considers that it is in the public interest for medical boards to regulate advertising by medical practitioners. These restrictions, in the opinion of the HSC, should not be removed as part of competition policy review but should be retained and strengthened to deal with the problems being experienced. Advertisements should not abuse the trust, or exploit a lack of knowledge, of members of the public. The power to regulate advertising needs to include control of advertising by owners of practices where the ownership is held by someone other than a registered practitioner. Another dilemma arises where only a minority of providers use aggressive advertising. The HSC has been told by complainants that they chose a particular provider because advertisements led them to believe that this was the only one practitioner providing the procedure. Accordingly, other well qualified practitioners may remain unknown to consumers.

Complaints have come to the attention of the HSC indicating that information given to consumers by some practitioners is far from adequate. While informed consent should be given before any procedure this is not always adhered to. As acknowledged by Professor Donald Marshall in his book, *Your Face in Their Hands* (1998):

"A fundamental problem in all cosmetic surgery is that despite the most meticulous and skilful surgery in the hands of the most experienced surgeons, there is still an element of uncertainty in the end result".

Many consumers are unaware of this. Commercial pressures on individual doctors may also influence some to ignore the uncertain outcomes of cosmetic procedures by proceeding with surgery which is unwise. Practitioners undertaking cosmetic procedures need to be aware of the vulnerability's of certain patients, particularly those with delusional disorders or unrealistic concerns about their appearance. Although plastic surgeons are not psychiatrically trained and cannot legitimately make such a diagnosis themselves some patients should be referred for expert assessment. Complaints have also been received which indicate that a few practitioners have represented themselves as having expertise or qualifications which they do not.
The HSC evidence to the New South Wales Inquiry recommended that the extent and nature of the current problems require national leadership and innovative programs. It also recommended that:

1. There should be national leadership in improving the standards and quality of consumer information about plastic and cosmetic surgery.

2. Regulations concerning advertising should be retained and strengthened within the Medical Practice Act. In Victoria the Medical Practitioners Board is responsible for regulating advertising by medical practitioners. This function is currently under review as part of competition policy implementation. The HSC has recommended the retention and strengthening of the regulations and the provision of additional powers and resources to the Medical Practitioners Board of Victoria.

3. There is a need for a public strategy that emphasises the pitfalls/fallibility's of plastic/cosmetic surgery. This should be aimed specifically at population groups which are particularly vulnerable, for example, young women. This would be the responsibility of joint agencies including the medical practitioners boards, health departments, health complaints commissioners, consumers and doctors.

4. Brochures outlining risks should be provided to all consumers to take away and read before giving consent.

5. A public health campaign on self acceptance/healthy ageing is required to combat the deluge of "beauty" propaganda.

6. Discussions should be held with the relevant professional organisations with a view to obtaining a commitment from practitioners that they will bear the costs of any repair work that is required as a consequence of plastic and/or cosmetic surgery.

SUMMARIES OF COMPLAINTS RECEIVED ABOUT COSMETIC PROCEDURES

The summaries below are of complaints received over a number of years. Details have been altered to protect confidentiality.

Scarring from laser resurfacing

A patient had laser resurfacing for facial acne scarring. The doctor suggested a medium to deep procedure because it would be the most effective and the patient was told this would clear all the scars and sun damaged skin. The patient paid almost $1000 for the procedure and was told to take two weeks off work as the skin would remain red for some time. The outcome was poor as the patient's skin was burned producing worse scarring. The patient could not return to work and required many additional treatments. The patient complained of not being given information about risks prior to the treatment. A subsequent expert opinion indicated that the scarring was permanent.

Eye surgeon performed plastic surgery

A patient was referred to an eye specialist for problems with eye spots and droopy eyelids. The doctor offered to operate and the patient agreed to the surgery. However, the surgeon cut off too much skin on one eyelid and because of this the patient cannot close the eye fully. The patient subsequently consulted a plastic surgeon who expressed concern that any doctor would perform procedures which were outside their field of expertise.

Unsuccessful eye operation by unqualified plastic surgeon

A patient consulted a doctor seeking the removal of fatty deposits under both eyes. The patient inquired whether the doctor was a qualified plastic surgeon and was assured by a non-medically trained employee that this was so. The doctor examined the patient and performed the surgery at the doctor's private rooms not in a hospital. After the operation, the patient noticed the right eye had good results but the left eye looked unsightly. The doctor offered to re-operate on the left eye free of charge, but the patient refused the offer. The patient rang the College of Plastic Surgeons and was shocked to discover the doctor was not a registered plastic surgeon.

Unsuccessful cosmetic surgery

A patient attended a cosmetic surgeon for collagen injections to the face. As they only lasted a few months the patient returned to the surgeon who suggested a new method of silicon injections. Following the procedure the patient developed a face sore which would not heal and grew bigger. The sore was surgically removed but after a few months another developed in the same place and had to be removed. A biopsy of the sore showed it contained silicon. The patient developed yet another sore under one of the scars. The doctor tried cortisone injections which did not work. The doctor then recommended not touching the injury because the only treatment available would result in the removal of half of the patient's chin. The patient was subsequently advised that silicon should not be inserted straight into the skin. The doctor denied that the problems were caused by the silicone.

Inadequate diagnosis/hard selling

A patient complained about the lack of adequate attention a doctor gave to a facial mark. The patient said the doctor did not conduct a proper examination and therefore did not correctly diagnose it. Three doctors later confirmed that it was a basal cell carcinoma. The complainant says that the doctor was more interested in selling laser therapy and aesthetic nose surgery.

Adverse outcome - laser surgery

A patient attended a doctor for a skin disorder. The patient stated that the doctor's advice was that laser surgery could cure the skin disorder and would make the patient look years younger. The patient decided to proceed with the treatment because the doctor was so persuasive. The patient was shown pictures of other patients who had undergone laser surgery with great success. The patient complained of facial burning and is now too embarrassed to leave the house. A further consultation with a similarly qualified doctor resulted in advice that the skin disorder is a simple form of eczema and could have been cleared with the application of topical creams.

Unsuccessful liposuction and laser treatment

A patient had stomach liposuction. This was performed by a doctor described as a cosmetic surgeon. The operation was unsuccessful and the patient returned four times without a positive result. The patient also complained that laser treatment to remove lines on the side of the forehead were unsuccessful and left unsightly hollow dents.

Dissatisfied with liposuction results

A patient had liposuction to the legs and was left with an unsightly ripply appearance which despite subsequent treatment could not be remedied.

Rhinoplasty - unhappy with results

A 16 year old consulted a doctor about rhinoplasty. They discussed the treatment and the patient paid $4000 "up front". The operation was performed at a day procedure centre as a private patient. The patient was very disappointed with the results saying that the surgeon filed away too much cartilage leaving the nose too thin and making the nostrils appear large. The tip of the nose looked bigger and was turned upwards.

Liposuction

A patient who had stomach liposuction complained to the doctor several times over the next 3 months, about pain and inadequate healing of the area. The doctor assured the patient that the pain would settle down in 6 months and that the stomach would look beautiful. The patient remained in pain and after consulting two other doctors was told by both that the liposuction was not correctly performed.

Alleged incompetent treatment

A woman underwent breast implant surgery. She was not satisfied with the result and discussed it with the surgeon who, she said, seemed uninterested in helping her. She went to two other surgeons for an opinion. Both said the surgery had not been done to an acceptable standard. She has had the operation again and sought compensation from the initial surgeon.

Liposuction performed on unsuitable candidate

A young person consulted a general practitioner who tried to correct facial acne scars. The patient inquired about laser treatment to reduce the scarring. The doctor said laser treatment was not recommended, but offered to perform liposuction on the patient's thighs to improve the contour. The doctor assured the patient that a maximum of 10 incisions to the thighs would be made and the incisions would be in places that could not be seen once scars formed. The patient agreed to the treatment but was distressed after counting many incisions had been made in areas that were visible. After complaining to the doctor the patient was told it would take several months for the scars to fade. The patient lost faith in the doctor and consulted a plastic surgeon who said the liposuction should not have been done in the first place as it would not make any difference to the contour. The patient was angry as she had paid several thousand dollars and was left with scarring.

Unsuccessful breast reduction - pain and scarring

A woman had breast reduction surgery, recommended to ease the heavy weight thought to be causing headaches, migraines and back troubles. The left breast developed an infection and the scars on each breast split open. Despite ten months of regular visits to her doctor and other surgeons, she has not been able to remedy the problem.

ANALYSIS OF COMPLAINT TRENDS

1998/99 SUMMARY

Complaints and inquiries are received on the telephone, by mail and in person. Some of these can be handled immediately and are recorded as inquiries. About one quarter of these initial contacts go on to become managed complaints (cases). This year the overall number of inquiries increased but the number which were accepted as cases decreased. The total number of inquiries and cases for 1998/99 is 9484.

Table 1 below shows the complaints and inquiries received by the Commissioner for the past three years.

TABLE 1

	1996/97	**1997/8**	**1998/9**
New cases lodged	1857	2497	2357
Cases brought forward from previous year	598	658	752
Total cases managed	2455	3155	3109
Inquiries	6288	6773	7127
Cases closed in year	1656	2198	2280
Cases carried forward to next year	658	752	798

In 1998/99 the total number of inquiries received rose by 5% to 7127. Of these 2357 were accepted as new cases lodged representing a decrease of 140 or 5% over the previous year. As in previous years approximately half of the complaints received by the HSC are resolved by a single contact. The other half go on to be accepted cases.

INQUIRIES

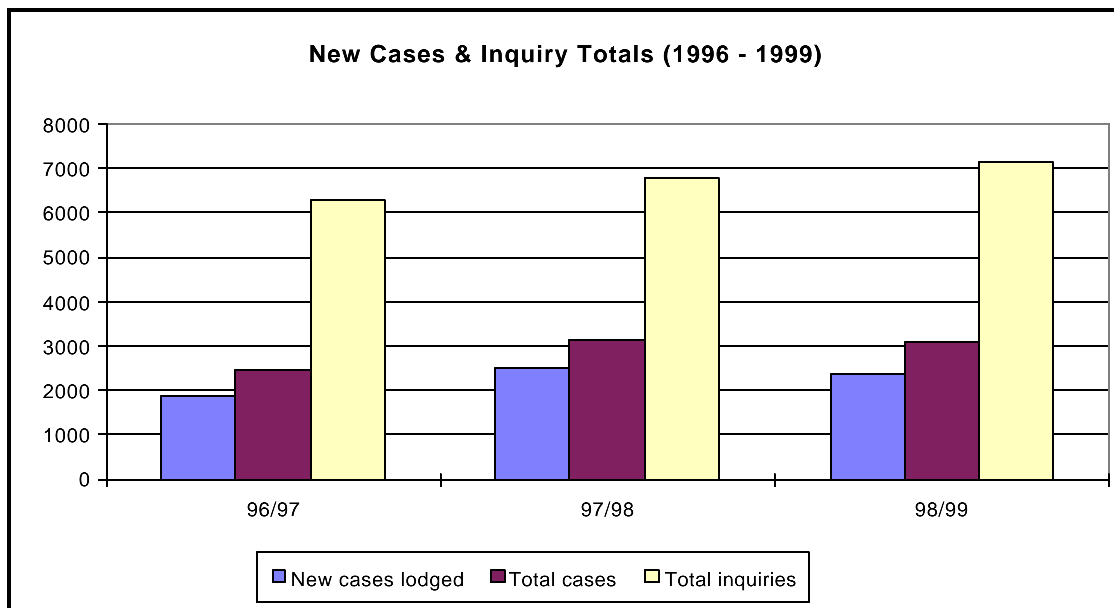
An inquiry is defined as a contact with the Office that does not develop into a complaint case. A telephone inquiry can often be resolved immediately. The caller is given advice or referred appropriately. Table 2 indicates a total of 7127 inquiries in 1998/99 a 5% increase over the previous year. Potential complaints where the caller makes initial contact to receive advice or information about a health complaint but makes no further contact accounted for 5593 of these inquiry calls handled in the year under review, in 97/98, 5040 and 96/97, 5007.

The types of advice and information sought are recorded under five main categories shown in Table 2 below.

TABLE 2

Inquiry	
Fees charged	18%
Health insurance	4%
Waiting lists	3%
Food, environment, health issues	11%
Other inquiries	41%
Access to records (recorded from April 99)	1%
Potential (Could be) Cases	22%

Figure 1



Of the 7127 inquiries in 1998/99, about a quarter developed into accepted complaint cases. The total caseload managed by the Office in the year under review is 3109 compared with 3155 in the previous year and 2455 in 1996/97. Although there has been a high demand for assistance, waiting lists within the office have been considerably reduced because of improved management techniques and increased resources.

SERIOUSNESS

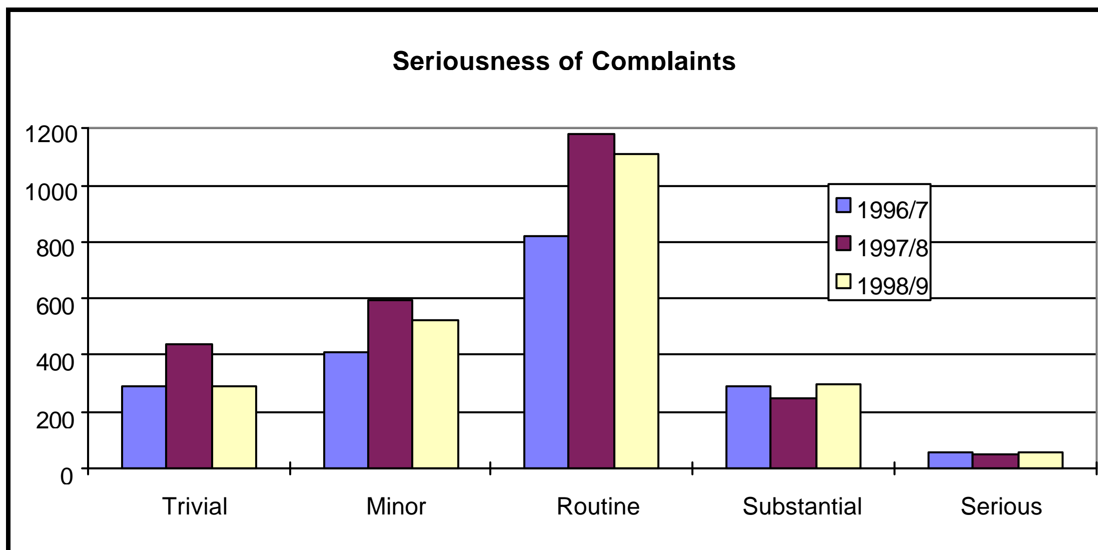
Although all complaints are serious to the individuals concerned, and all are handled with diligence, for management purposes complaints are rated on a scale for seriousness when they are first accepted by the Commissioner and again when they are closed. It is often difficult to assess seriousness at the start of a complaint. This practice of revising the rating at the time of closure has led to fewer complaints being rated as serious or substantial and to more being rated downwards as minor.

The ratings of closed complaints over the past three years are shown in Table 3 and Figure 2 below.

TABLE 3

	1996/97	1997/98	1998/99
Trivial	287	433	291
Minor	408	589	523
Routine	820	1179	1110
Substantial	288	247	297
Serious	54	49	59
Total	**1857**	**2497**	**2357**

Figure 2



Seriousness Rating

1. Trivial: frivolous, vexatious, obviously misconceived or where an investigation is unwarranted.
2. Minor: the problem is easily resolved by a phone call or letter and an explanation is sufficient
3. Routine: there has been a misunderstanding; issues frequently involve access to records, disputes about costs, discourtesy, diagnostic or treatment errors without serious sequel.
4. Substantial: there are significant quality assurance implications, changes in practice are needed to avoid a recurrence or there is a need for policy development.
5. Serious: usually associated with personal injury, professional misconduct, unlawful or unethical acts, lack of informed consent with adverse outcomes

In 1998/99 only 59 or 3% of managed cases were classed as serious. Not surprisingly complaints classed as "routine" account for the largest number; 47% in 1998/99, 47% in 1997/98 and 44% in 1996/97. Nevertheless these complaints may take time and perseverance to achieve resolution as often records need to be obtained and opinions sought to satisfy the complainant that their concerns have been addressed and to provide the explanations they seek.

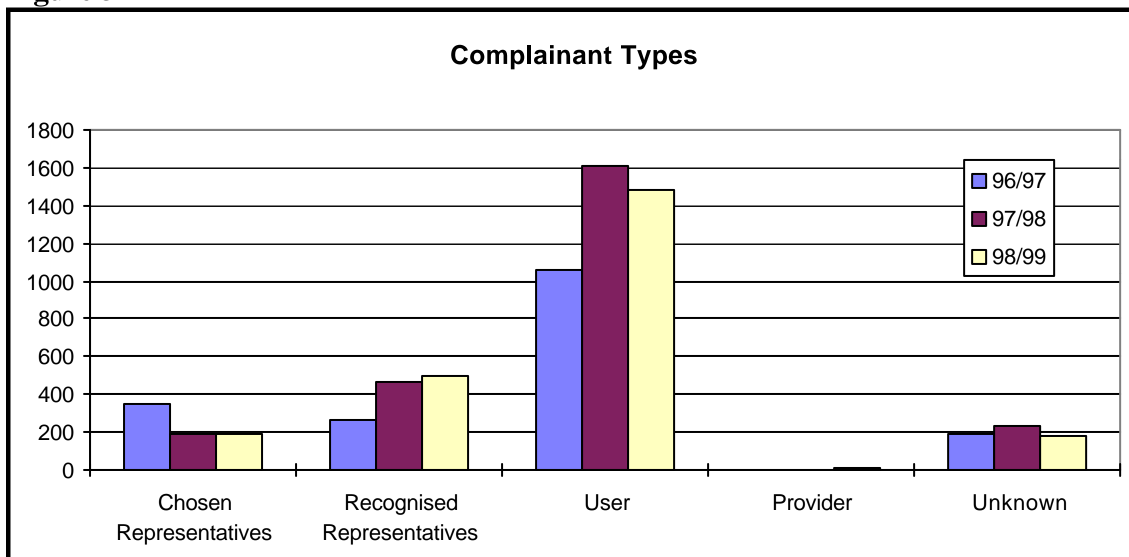
WHO COMPLAINS?

A complainant is defined as the person who makes the complaint. This is most often the patient or client, ie. the person who has used the service. Exceptions include where the service user is a minor, or is disabled and has a legal guardian (called a recognised representative), or where the user is unable to make the complaint and authorises another person to complain on their behalf (a chosen representative). The authority to complain is very important because of confidentiality requirements. Table 4 and Figure 3 below show the types of complainants for the last three years. The proportions remain reasonably constant with around 63% being made by the service user. In 1998/99 there was a slight increase in the number of chosen and recognised representatives making complaints.

TABLE 4

	96/97	**97/98**	**98/99**
Chosen Representatives	353	187	192
Recognised Representatives	260	464	493
User	1058	1613	1481
Provider	0	2	14
Unknown	186	231	177
Total	**1857**	**2437**	**2357**

Figure 3



COMPLAINANT DEMOGRAPHICS

Each year, approximately 60% of complaints are from women, probably related to the observation that women use health services more frequently than men do. People living in the metropolitan area make most complaints (53%). This reflects both the distributions of populations and health services. The 21% "not specified" are single contact calls where the complainant has not provided an address.

Figure 4 below shows the distribution of complaints within regions. There are fewer complaints from the rural regions of Victoria and this reflects past trends in the data. The sixty five years old and over group are well represented among those who make complaints.

Figure 4

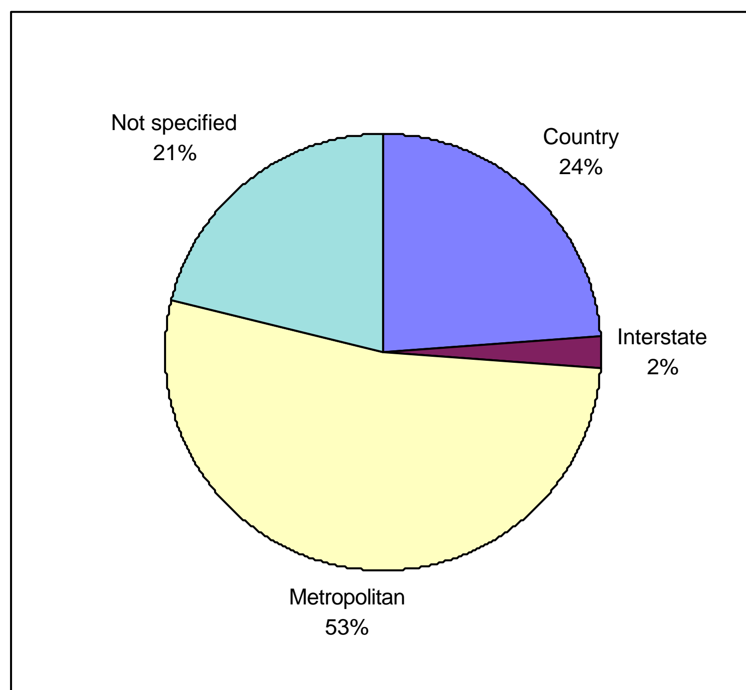


TABLE 4A

	Female	Male	Not Specified	Total
Under one	13	10	0	23
1 - 4	6	18	3	27
5 - 14	18	22	2	42
15 - 24	64	34	2	100
25 - 34	96	28	3	127
35 - 44	69	27	1	97
45 - 54	75	38	3	114
55 - 64	44	29	0	73
65+	93	64	2	159
Not specified	858	483	254	1595
Total	**1336**	**753**	**268**	**2357**

HOW COMPLAINTS ARE MANAGED

The Act requires that complaints made on the telephone or in person be confirmed in writing. Assistance is offered to people needing it, however many preliminary complaints are not confirmed in writing. The legislation anticipates that consumers will attempt to resolve issues themselves wherever possible and staff advise complainants, where appropriate, to make direct contact with the service provider. It is hoped that many of the unconfirmed complaints are resolved in this way.

RESOLUTION BY INQUIRY OFFICERS

Inquiry officers assist complainants to bring their concerns to the attention of the health service and to seek a response. They also help complainants to set their complaints out clearly explaining why they are unhappy with the service and what they hope to achieve in making the complaint. They also advise health services about complaints handling and resolution.

In 1998/99, 2461 complaints were managed and 1919 closed by the inquiry officers. Table 5 below shows the broad resolution categories for these complaints.

TABLE 5
Resolution by Inquiry Officers

Outcome	1996/97	1997/98	1998/99
Declined	14%	23%	23%
Referred elsewhere	4%	7%	5%
Withdrawn by user	10%	9%	9%
Investigation unwarranted	4%	2%	3%
Unsubstantiated	3%	1%	1%
Remedial action	3%	3%	1%
Fee waived/reduced	5%	6%	1%
Procedural change	2%	1%	1%
Explanation offered	50%	45%	54%
Apology	5%	3%	2%

The outcomes are reasonably consistent from year to year and most are resolved when reasonable explanations are provided. This is important because it indicates the role communication plays in both the cause and the resolution of complaints. The resolutions for this year suggest that half of the complaints received might never have been made if full and detailed explanations of procedures, risks, outcomes and costs had been offered sooner. Similarly, when the unexpected occurs, it is much better to explain this to patients as soon as possible rather than waiting for them to ask or to complain.

RESOLUTION BY INVESTIGATORS

A complaint that is not resolved by an inquiry officer may be referred on to an investigator for assessment. The investigator will assess the complaint and try to resolve it by facilitating communication between the parties, obtaining independent advice, and medical reports. Most will be resolved by this process with those that remain unresolved being referred to conciliation or to a registration board.

In the year under review there were 477 complaints managed and 299 closed by the investigators. These complaints can be complex and some assessments can be completed quickly while others require much longer because they may involve many providers or because of the individual characteristics of the complaint. In general complaints involving grief cannot be resolved quickly. The response time of some providers remains a concern but most are diligent and the HSC is grateful to all the providers and provider organisations who support the work of this office as being in the public interest as well as beneficial to their own professions. Table 6 below shows the broad resolution categories for these complaints.

TABLE 6
Resolution by Investigators

Outcome	1996/97	1997/98	1998/99
Declined	7%	12%	12%
Referred elsewhere	3%	6%	2%
Withdrawn by user	10%	14%	12%
Investigation unwarranted	0%	1%	5%
Unsubstantiated	20%	20%	20%
Remedial action	3%	5%	5%
Fee waived/reduced	3%	4%	4%
Procedural change	7%	5%	4%
Explanation offered	45%	29%	31%
Apology	2%	4%	5%

Investigators collect further information about complaints such as medical records, reports and opinions, so complaints are more frequently closed as unsubstantiated at this stage (20% in comparison with 1% at the inquiry stage). The closure rate has remained consistent over the last three years. Once again, explanations offered, by the provider or an independent expert, close the major proportion of all complaints.

CONCILIATION REPORT

The process of conciliation continues to be a successful mechanism for the resolution of complaints. There is little doubt that conciliation is perceived as an effective alternative to litigation by those who participate in it. It would also appear that there is a greater understanding of the way in which complaints can be resolved and, where appropriate, settlements negotiated.
The willingness of private and public hospital staff to participate fully in the conciliation process assists the timely resolution of hospital complaints to the satisfaction of all parties. This co-operative approach was not restricted to metropolitan hospitals, as the country hospitals have also been willing to conciliate.

As in previous years, communication problems have been a common cause of friction between health service providers and patients. The open and honest communication which is encouraged during the conciliation process has overcome much of this. The experience of the conciliators is that good communication is essential in the provision of all health services but it is even more significant “after the event” for consumers with grievances.

The conciliators’ use of independent consultants is also vital in the resolution of many complaints. This input to the conciliation process from all specialities, and also the non-medical fields, is invariably provided willingly and is much appreciated.

The independent consultants have on occasion also agreed to participate in conciliation meetings so that they can explain their thinking in arriving at their opinion on the complaint. In such meetings the complainant is able to ask questions and can receive a more detailed explanation of the issues involved. This process is seen by all parties as more productive than only receiving the formal written opinion.

The conciliation process may involve close liaison with lawyers for all parties and generally relations with the legal firms have been excellent. The number of law firms which refer clients to the Commission has increased and there appears to be a growth in the level of trust existing between some law firms and the conciliators.

The conciliators continue to act as mentors to the equivalent organisations interstate and this has resulted in a consistent approach to conciliation of health complaints throughout Australia. These relationships contribute to the strong links which have been established between the various “health ombudsman” offices and the HSC.

In 1998/99, 217 complaints were managed and 62 complaints were closed by the conciliators. Eighty seven per cent of the complaints closed involved serious issues concerning treatment, and involved claims for compensation, required meetings between the parties and dealt with serious issues involving changes of policy. Table 7 below shows the broad resolution categories for these complaints.

TABLE 7
Resolution by Conciliators

Outcome	1996/97	1997/98	1998/99
Agreement reached	56%	81%	66%
Withdrawn by user	27%	9%	23%
Withdrawn to go to law	7%	6%	8%
No agreement reached	10%	4%	3%
Total closed	**100%**	**100%**	**100%**

REGISTRAR'S REPORT

The Registrar's functions include consulting with the Registration Boards to determine how best to manage complaints received by HSC and the Boards, internal case management, overseeing the inquiry function, responding to Freedom of Information requests and supporting the functions of the Health Services Review Council.

Registration boards

Regular discussions are held with 12 Boards. As a large portion of complaints received by HSC are about medical practitioners, meetings are held fortnightly with the Registrar of the Medical Practitioners Board to discuss these and decide how they should be handled. In 1998/99, 90 complaints were referred to Registration Boards by HSC and the office received 19 referrals from Boards. Complaints against dentists were the second highest of all complaints about individual practitioners and consultations take place as required between HSC and the Dental Board of Victoria (DPBV). The following table contains information on complaints referred to Registration Boards over the past three years.

TABLE 8
Referrals from HSC to Registration Boards

Board	1996/97	1997/98	1998/99
MPBV	85%	84%	78%
DBV	9%	5%	11%
Other	6%	11%	11%

Under the auspices of the HSC, the Registrars of all the Boards met in December 1998 for the first time since the inception of this office. This meeting provided a venue for a valuable exchange of information and meetings of the Registrars are now held bi-monthly. The meetings are also attended by the Registrar of the Veterinary Practitioners Registration Board of Victoria and the Executive Officer of the Mental Health Review Board who asked to be allowed to attend to raise issues of concern and relevance to them. The Registrars meetings were timely considering the review by the Department of Human Services of legislation pertaining to all health registration boards.

Case management

Case management is an important function in ensuring that complaints move through the various stages of resolution. The Registrar is responsible for this as well as managing the inquiry process which is the first stage of complaint handling. During the past year waiting lists were kept at manageable levels. Files on the inquiry waiting list, in the case of routine complaints, are assigned within two to four weeks of the complaint being received while complaints requiring attention without delay are assigned immediately following acceptance. Waiting times on files which require assessment by an investigator, which is the second stage of the complaint process, are necessarily longer because they are more complex.

Freedom of information

There was an increase in the number of Freedom of Information requests this year. In 1998/99, 11 requests pertaining to 22 files were received. Ten of these were processed (21 files). One applicant failed to meet the requirements of the legislation and, therefore, it was not possible to proceed further with that request.

ABORIGINAL LIAISON OFFICER'S REPORT

It is widely recognised that Aboriginal people suffer the worst health of any identifiable group in Australia. The evidence clearly confirms that the burden of chronic ill health and mortality of Aboriginal people is grossly disproportionate to that of the mainstream population.

Between September and December 1992, the HSC was able to employ a Koori Health Rights Officer for a Pilot Program with the assistance of the Koori Health Unit and the then Health Department Victoria. The purpose of the Program was to establish if there was a need for a Koori Health Rights Officer to work specifically with the Aboriginal community in defining health services complaints and to improve their accessibility to services provided by the Commission.

During 1992 Joan Vickery of the Koori Health Unit visited a number of Aboriginal communities where it became clear that Aboriginal people were experiencing a distinct disadvantage in the provision of health services and were highly under represented in the number of complaints lodged with the Commission. It was found that there was a genuine need for the position of a Koori Health Rights Officer within the HSC to:

- assist Koori people in defining their complaints and to ;
- provide support during the complaints process;
- advise the Commissioner and staff at each stage of the complaint;
- educate the Koori community about their rights under the Act; and
- analyse the causes of complaints and make suggestions to remove or minimise them.

Funding became available in late 1998 and the Aboriginal Liaison Officer (ALO) was appointed, commencing on 15 February 1999.

The ALO organised an Aboriginal Cultural Awareness Training day for HSC staff which was conducted by Judith Monk and Daphne Milward and was very successful. In addition to her work with Aboriginal people the ALO has also undertaken the role of Inquiry Officer dealing with mainstream complaints.

It was recognised that until an ALO was appointed the services of the HSC would remain inaccessible to Aboriginal people. The ALO will therefore promote the services of the HSC to Aboriginal health service users and providers. In the year under review she visited many Koori Communities in Victoria and commenced work with them in dealing with complaints about health services. A strong emphasis will be placed on outreach work with the ALO liaising with both Aboriginal and mainstream health service providers to assist and recommend ways in which the provision of health services to Aboriginal People can be improved and to use the information gained from complaints constructively.

REASONS FOR COMPLAINTS

Complaints received by the Commissioner are classified according to their underlying issues. The broad categories are as follows:

Access, refers to availability of services in terms of location, waiting times and other constraints that limit use of the service;

Treatment, refers to diagnosis, testing, medication and other therapies provided;

Communication, refers to manner of communication such as rudeness, disinterest, quality and quantity of information provided about treatment, risks and outcomes and prognosis;

Cost, refers to information about costs and fees, discrepancies between advertised and actual costs, charges and rebates;

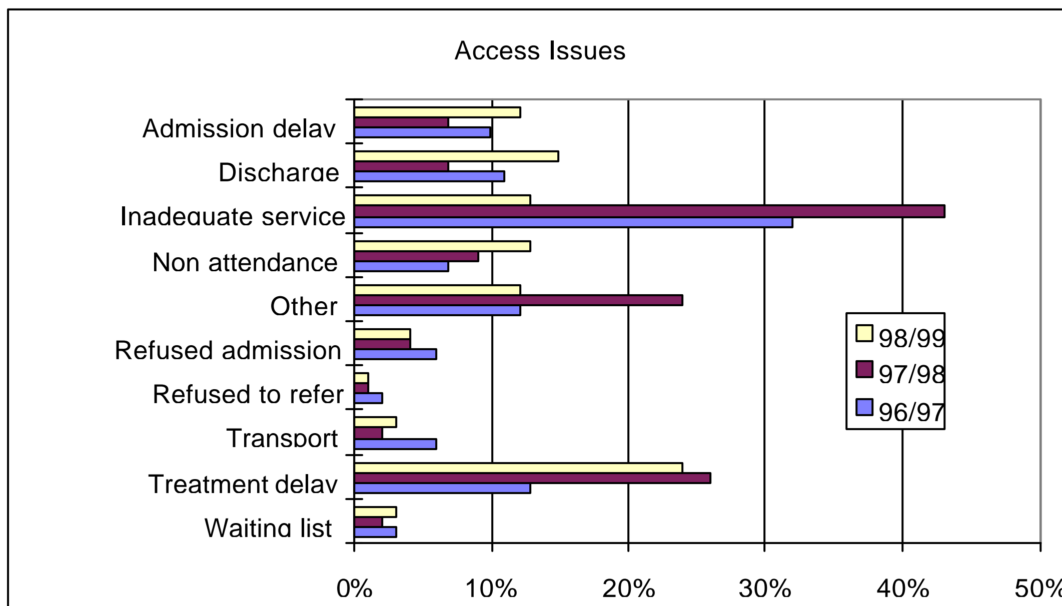
Rights, refers to rights to privacy and dignity, consent to treatment, reasonable access to records; and

Administration, refers to support services for providers such as reception, waiting lists, cleaning services, etc.

Most complaints identify only one of these as an issue but approximately one in three raises concerns about more than one issue.

Figures 5 through to 10 below show the numbers of complaints within each issue.

Figure 5



The most frequently nominated access issue for this year was treatment delay. There was a slight decrease in the number compared with last year. In 1998/99 there were 160 compared with 176 in 1997/98 and 143 in 1996/97. Many consumer complaints in this category could have been avoided had explanations been given at the time.

A man with chest pain attended an emergency department at a major hospital. He was kept waiting for five hours during which he could gain no information about when he might be seen. This caused considerable additional distress.

A person suffered an asthma attack and was refused treatment at a medical clinic. The patient went to another service and was told that a long wait would ensue. By this time the person was suffering considerable distress and had to be taken by a family member to a hospital emergency department.

The family of an elderly person complained that the patient had to wait two hours in emergency before being seen by a doctor even though the patient was experiencing severe pain. Following examination by a doctor the patient was placed in a cubicle and waited for several more hours. Eventually the family were told to take the patient home as no beds were available. The family protested saying the patient was far too ill to be taken home. The Hospital finally agreed to allow the patient to remain in emergency until a bed was available.

A person suffering a bone fracture was taken to a regional hospital. The general practitioner was contacted but refused to attend. The patient had to be transferred by ambulance to another hospital.

A person who had acid splashed in their eye attended a doctor's surgery and while waiting for a doctor had to keep bathing water in the eye. When finally told the doctors were too busy the patient was taken to a public hospital and treated as an emergency.

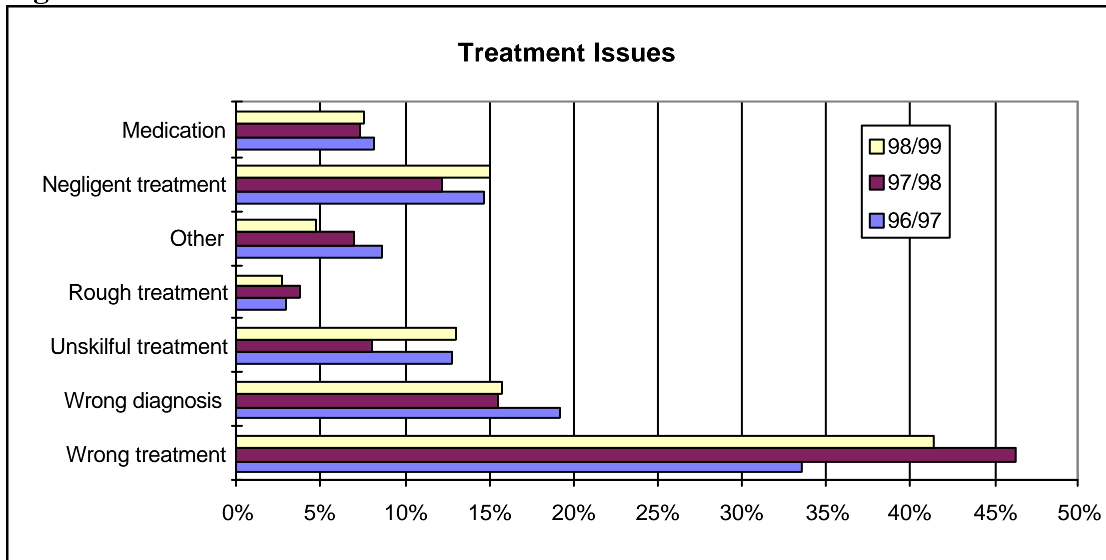
The family of a psychiatrically ill patient complained that their attempts to receive assistance were not responded to by a psychiatrist in private practice. They then contacted a public service but were unable to obtain assistance because the patient was not "sick enough". In the meantime the patient was badly injured in a suicide attempt.

A mother took a toddler to a regional hospital following a fall. She was advised her child required tests and would have to go to Melbourne. The mother and child arrived in Melbourne early in the morning and waited most of the day before the toddler was admitted to the ward. The mother was told that a general anaesthetic could not be administered because of a shortage of nurses. During the scan the toddler became restless and distressed and the process had to be ceased. A further wait ensued until an anaesthetic was possible.

A psychiatrically ill person was experiencing ideas of violence against a health service provider. She sought help from a community based health service which advised her that a crisis assessment and treatment team would see her. No-one had come by the next day and the patient telephoned HSC very unwell and afraid.

Figure 6 below sets out the treatment issues for the past three years

Figure 6



Complaints about treatment follow a similar pattern to other complaints with an increase in 1997/98 (1444) and a reduction to numbers more consistent with 1996/97 (1194) occurring in 1998/99 (1240). The most frequent treatment issue was that the complainants believed they had received the wrong treatment. Not surprisingly, this issue is often accompanied by the complaint that the wrong diagnosis was made.

A patient with breathing difficulties attended a hospital. The patient was examined, told there was a virus and sent home. Still having problems breathing the patient had to be taken by ambulance to another hospital where asthma was diagnosed and an in-patient stay required.

A person had been consulting a general practitioner for years. The patient had a number of troublesome symptoms but tests revealed no particular condition. The doctor told the person that old age was responsible. The patient collapsed and died at home and the family was distressed and upset as they believed more tests should have been performed.

Complaints continue to be received from patients who are given diagnoses of cancer or tumours who believe that earlier diagnoses should have been made. Sometimes these complaints are substantiated, sometimes not. Where patients have such diagnoses sensitivity and careful explanations are required because these conditions can be life threatening. Complaints have also been received about diagnoses of cancer where it has subsequently been found that the person did not have cancer. Where medical practitioners are prepared to discuss the issues with the patients, resolution of the complaints can be achieved, however, over defensiveness and a failure to provide reasonable access to information in records continues to be a problem with some doctors.

A person with back pain visited three doctors. Eventually an advanced tumour was diagnosed. The patient believed an earlier diagnosis should have been made.

A person with cancer believes the general practitioner should have made a more timely referral to a specialist.

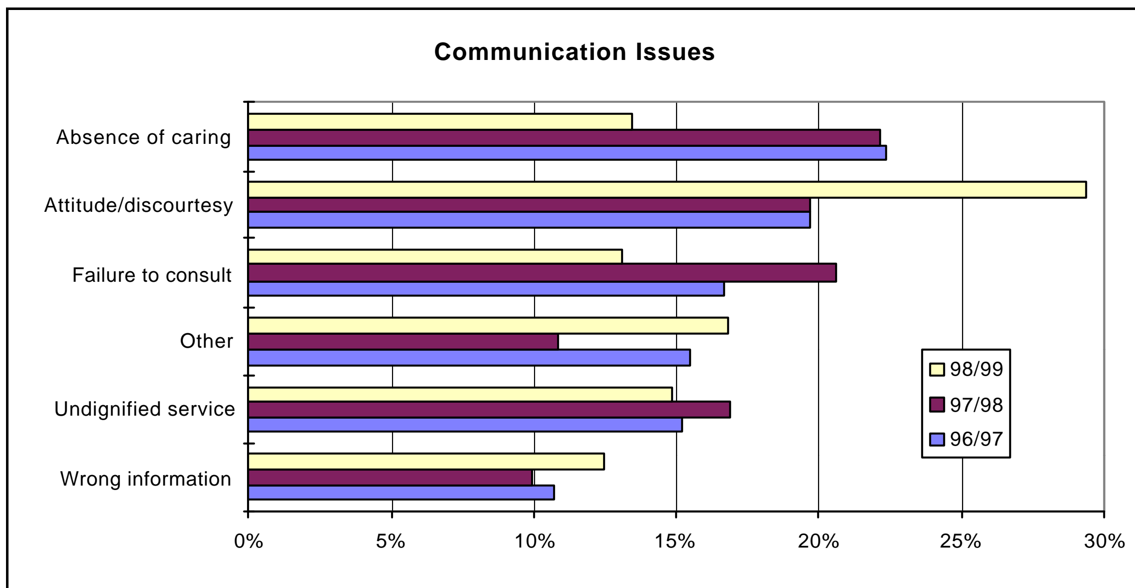
A patient suffering pain had seen three specialists who failed to diagnose her cancer. A correct diagnosis was made by a senior specialist several years later. The patient believes that the failure to diagnose caused years of unnecessary pain and distress and a shortened life expectancy.

A person noticed blood when passing urine. The patient consulted a general practitioner who said there was nothing wrong. A few years later the patient had a large malignant tumour removed from the bladder.

A man consulted a Naturopath who diagnosed two malignant tumours. Subsequent medical testing revealed no tumours. The man lodged a complaint because he wanted the Naturopath to be more careful with diagnoses in future and to refund the fees paid for the consultation.

Figure 7 below sets out the communication issues from the past three years.

Figure 7



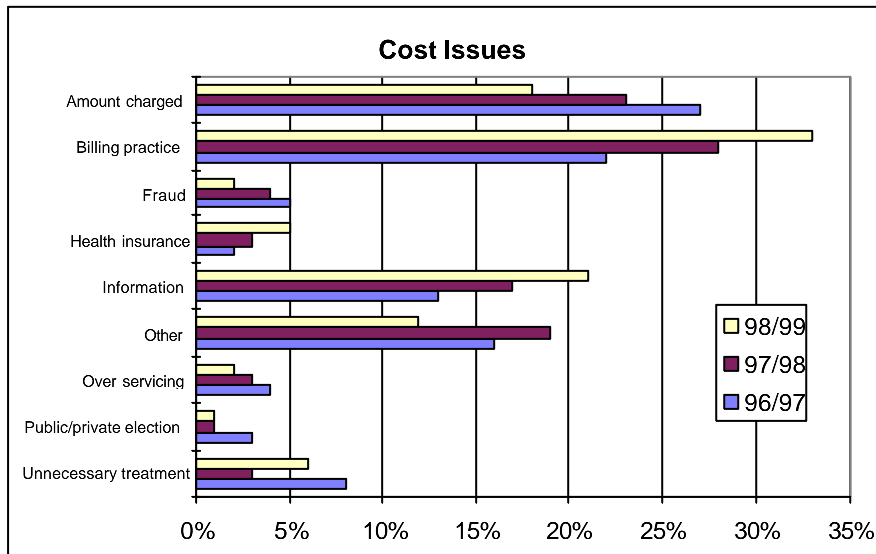
The number of complaints identified as being primarily about communication issues decreased from 462 in 1997/98 to 297 in 1998/99, a 35 % decrease. This is consistent with the overall pattern with an increase in 1997/98 and a return to numbers more consistent with 1996/97 in the year under review. A study by an HSC investigator has established that there are elements of communication problems in every complaint received and this continues to be a problem in the resolution of complaints. Of concern is the fact that most complaints about communication related to many consumers feeling that they were treated with discourtesy because of the attitudes of service providers. Many of these complaints can be settled quickly where genuine explanations and sincere apologies are provided in a timely manner.
In some cases where the complaint contains allegations of such bad behaviour as to amount to possible professional misconduct it will be referred to the relevant registration board.

A parent took a young child to a dentist. The child had a history of medical interventions which caused anxiety. During the consultation the child became distressed and the dentist's response was to attempt to restrain the child physically. The dentist also blamed the mother and recommended physical disciplinary measures. The complaint was referred to the Dental Board of Victoria.

Further anecdotes illustrating these types of complaints appear in the Public Interest section of this Report at page 10.

Figure 8 below sets out the cost issues raised in complaints over the past three years.

Figure 8



There were 129 complaints about costs in 1998/99, compared with 240 in 1997/98 and 159 in 1996/97. Complaints about costs are not accepted unless the complaint raises issues in addition to costs. Once again, communication is important. As noted in last year's Annual Report it would be helpful if health service providers posted lists of charges in waiting areas. Members of the public also have a responsibility to ask about costs before agreeing to a service, although this is not possible in emergency situations. The predominant complaints about costs were billing practices and amounts charged.

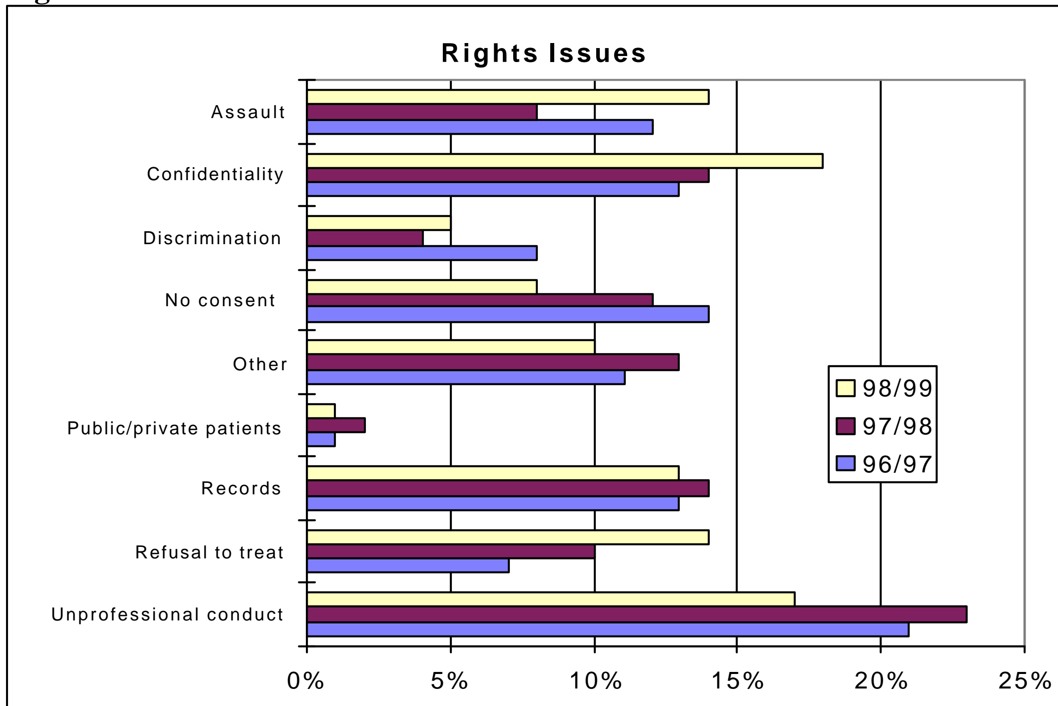
A person had wisdom teeth removed. During the night bleeding occurred and the patient telephoned the dentist who responded angrily. The patient consulted the dentist next day and was later charged for emergency treatment. The patient considered this should not have occurred as there was no information given about costs and, in the patient's opinion, if better care had been taken the bleeding might not have occurred in the first place.
A patient complained that a chiropractor had not told him prior to treatment how much it would cost. The fee was much higher than he had expected.
A solicitor from a community legal service complained on behalf of a NESB man who had received treatment at a specialist public hospital and who received an unexpected large account. When he queried why he had not been previously told of the costs he was told he must pay up regardless. He approached the community legal service when the hospital took legal action against him. The solicitor tried to negotiate but without success, and then complained to the HSC. The file was reviewed by an Investigator. The Hospital subsequently apologised for the way the man had been treated and waived the fee.

A person attended a chiropractor as a result of an advertisement promising an initial free consultation. The chiropractor examined the patient and said a report detailing treatment was required. The patient subsequently received an account for $100.

A patient had an appointment to see a specialist but was kept waiting for 45 minutes. The patient was then advised that there would be at least another half hour wait so cancelled the appointment and left to return to work. Subsequently an invoice charging a cancellation fee was received. The patient objected to this and when the circumstances were explained the specialist apologised and waived the fee.

Figure 9 below shows the types of complaints made in relation to rights.

Figure 9



In 1998/99 there were 220 complaints about rights. In 1997/98 there were 316. This year most (18%) related to issues around confidentiality and there was a decrease in complaints alleging unprofessional conduct but it remains the second most frequent rights issue complained about. The number of complaints alleging assault increased from the previous year from 18 to 29.

In the context of a family planning consultation a woman overheard a staff member discussing details about her in a public area. The matter was investigated by the service, an apology was forthcoming and a change of practice was promised.

A person who had attended a public hospital was contacted by a credit card agency. The patient believes the hospital supplied her name and address to the agency.

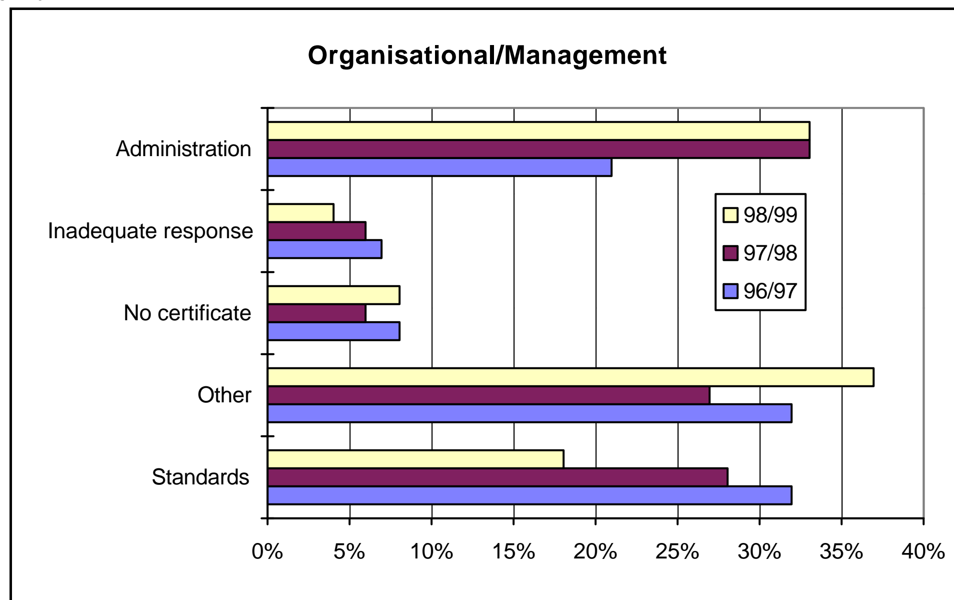
A person who suffered an illness had told a hospital that she did not want her spouse to be involved in any way in her care. She discovered that a social worker had been passing information to her husband without her consent.

A patient who underwent exploratory surgery had told the doctor that no consent was given for any other procedure. During the procedure a polyp was removed. Following a complain to HSC the doctor apologised.

A woman had a laparoscopy. Prior to this she told the doctor she did not want to have her ovary removed. He removed it anyway which has caused early menopause and distress.

Figure 10 shows the administration issues in complaints for the past two years.

Figure 10



There were 49 complaints in 1998/99 about organisational/management issues in health services. In 1997/98 there were 99 and in 1996/97 there were 7. These complaints are about the ways in which services are run rather than the medical or health components of services.

A person was diagnosed with hepatitis. She was advised to contact close friends so they could also be tested. She did so and one of her friends made an appointment at the clinic. The friend saw a doctor who gave him a "lecture" on hepatitis. The doctor then told him he should have seen another doctor at the practice. The man complained that he had made an appointment with the other doctor. He returned to reception to be told that the receptionist had accidentally given his health care card to someone else and insisted he had to pay for the "consultation" with the first doctor because the doctor had provided "counselling".

A woman was a public patient for the birth of her child. She received an on call account from the obstetrician which she considered she should not have to pay. The hospital agreed that she should not be obliged to pay the account but said it was unable to intervene.

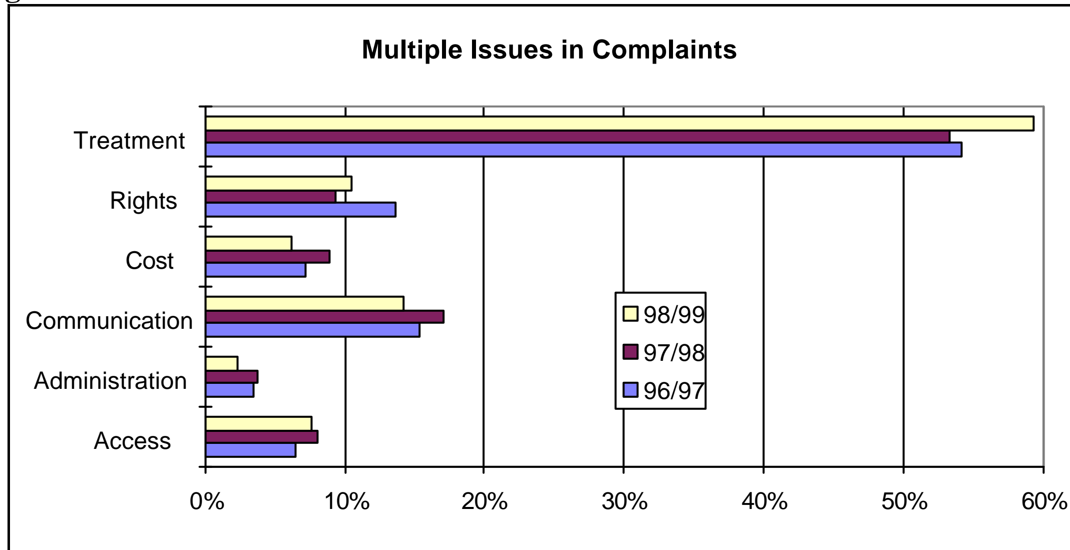
A man was told by a public hospital that he would be placed on a waiting list for by pass surgery for veins in his leg. Six months later he had not been contacted by the hospital so telephoned them and was told he had never been on the waiting list.

A general practitioner arranged for a man to be examined by a respiratory physician. The man had suspected pneumonia. Upon arrival at the clinic he found he had been booked to see a bowel surgeon. He was sent away feeling very ill.

A man travelled from the country to have a test conducted by a specialist in Melbourne. Upon arrival he was told there had accidentally been a double booking and he would have to return the next day. This meant he had to arrange overnight accommodation. The next day he saw the specialist for a three minute consultation.

Figure 11 shows the main issues in multiple complaints for the past three years.

Figure 11



Many complaints contain more than one issue and the data collection processes at HSC allow the recording of up to three issues per complaint. The pattern of complaints remains consistent with that of previous years with treatment, rights and communication being the most common issues.

A man attended a doctor following a car accident. The doctor "bullied" the patient into having a flu injection which he did not want because of religious beliefs. The doctor failed to attend to the injuries received in the accident. The doctor wrote a letter of apology saying that there would be no recurrence.

A woman was angry with the practices of a hospital pharmacy. Mistakes were made with medication and costs seemed excessive. She was charged over two hundred dollars for medication for cancer treatment and contacted her own pharmacist to check the price. She was told the medication should have been only $23. The hospital pharmacy then refunded the money. On a second occasion she was charged an excessive amount and the charge nurse queried this for her, again resulting in a significant price reduction. The woman was concerned that vulnerable patients were being "ripped off". The pharmacy service apologised but said they could do nothing about the pharmacist in question who was no longer employed there. The matter was referred to the registration board.

A man complained about the lack of care provided for his daughter who had been injured in a sporting accident. The daughter subsequently contracted a staph infection while in hospital. She required an operation which was delayed many times. The

matter was further complicated by traffic accident compensation problems and the hospital appeared to be reluctant to treat the girl. The man believed this was because of the staph infection.

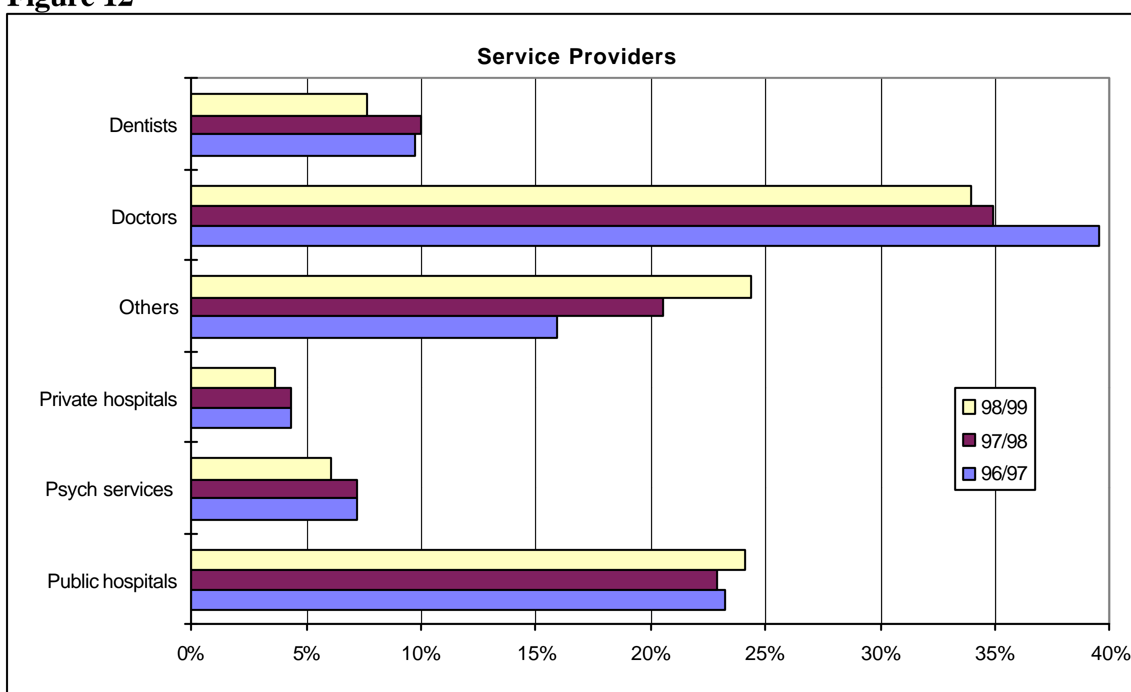
A man's family sought assistance at a regional hospital for a fractured limb. The doctor and a local pharmacy were advised of the man's allergies but medication was supplied to which he was allergic. He was then taken back to hospital by ambulance but was told there were no doctors available. The man believed the ambulance officers had taken him to the wrong hospital and that he should have been taken to the larger regional hospital which had an emergency department. The man's family insisted that his general practitioner be contacted. The doctor refused to attend and the hospital was on "by pass" at the time. The man was not seen by a doctor until the next day and in the meantime his own doctor resigned from his visiting position at the hospital.

CATEGORIES OF COMPLAINTS AGAINST HEALTH SERVICE PROVIDERS

A health service provider includes any person or organisation providing a health service. This covers a wide range of traditional and alternative or complementary services. It also includes support services, such as administration, deemed necessary for the provision of the health service.

Figure 12 below shows the broad groups of health services that have been the subject of complaints in the past three years.

Figure 12



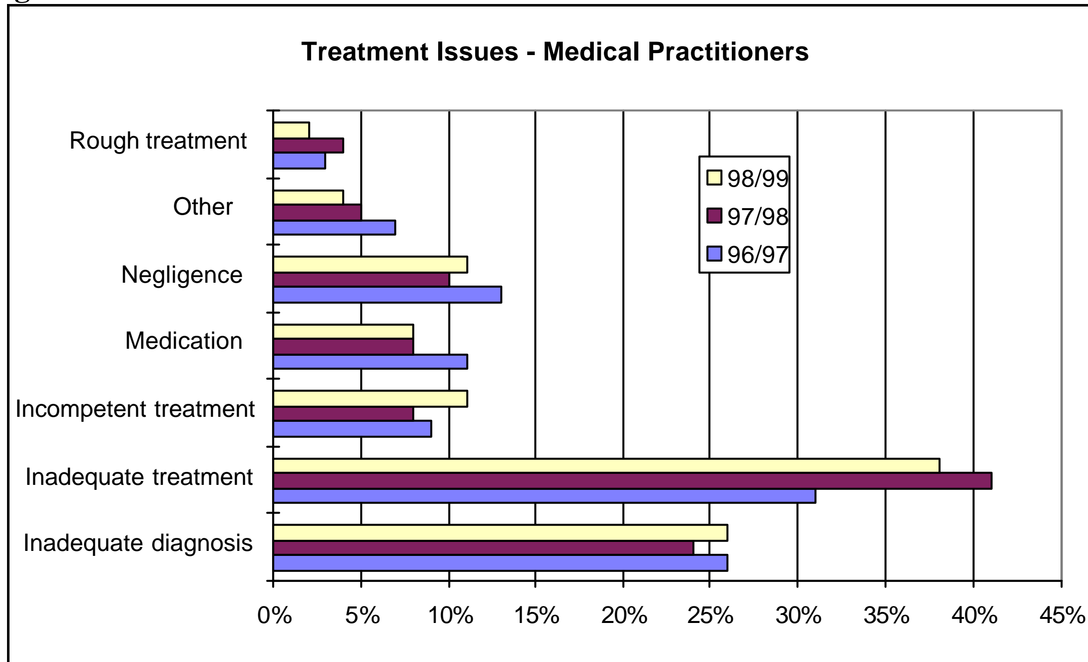
Private medical practitioners continue to be the subject of most complaints however they are, by far, the largest provider group. There was a decrease in the number of complaints about doctors from 851 in 1997/98 to 801 in 1998/99. The percentage of complaints about doctors decreased from around 37% in 1997/98 to 34% in the year under review. Public hospitals are the next largest category and there was a slight increase in the percentage as shown in Figure 13. Complaints about employees of public hospitals are always recorded as a complaint against the institution rather than the individual. Doctors working from private hospitals, however, are considered to be private practitioners. There is often confusion about responsibility, or shared responsibility, when a person complains about the treatment received in a private hospital.

MEDICAL PRACTITIONERS

The category Medical Practitioners includes all doctors whether in specialist service provision or general practice. The most common issues in these complaints related to treatment.

Figure 13 below sets out the types of complaints about treatment made against medical practitioners over the past two years.

Figure 13



Most complaints about treatment were related to the complainants' expectations that a doctor will invariably make the correct diagnosis and deliver the appropriate treatment for the condition. This is not always a realistic expectation but when the consequences for the person are significant there is often disappointment and anger expressed.

A youth attended a general practitioner following an accident experiencing sharp pains in his hand. The doctor squeezed the hand tightly causing pain. The youth was then told to go home as there was nothing wrong. Subsequent x rays organised by another practitioner revealed fractures.

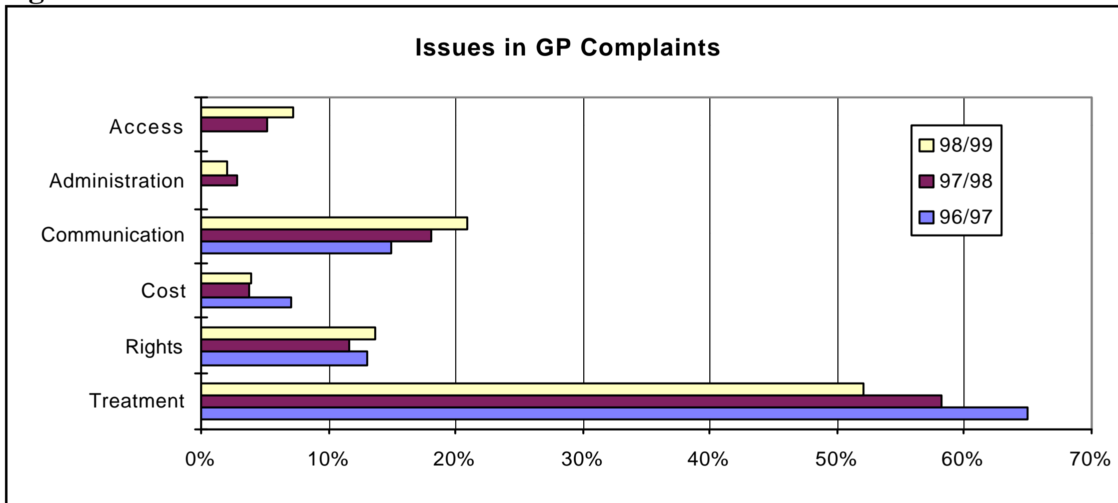
A woman required induction of her pregnancy and there was difficulty in removing the placenta. A manual removal which caused severe pain. She suffered heavy bleeding and was readmitted on several occasions for related procedures. She had an elective tubal ligation but pain and bleeding persisted until it was discovered that some of the placenta remained. She had a hysterectomy.

A man had treatment at a private hospital. Several days later he had a high temperature and contacted his specialist who prescribed antibiotics over the telephone without examining the man. His condition worsened and he presented at the emergency department of the nearest public hospital. The hospital contacted the specialist who refused to allow the man to be admitted. The specialist insisted that treatment could only be given at a private hospital.

GENERAL PRACTITIONERS

The largest group of doctors is the General Practitioners (GPs). In 1998/99 almost half (47% or 400) of all complaints against doctors were made GPs. Figure 14 below shows the categories of complaints made against GPs for the past three years.

Figure 14



Once again the most common issues in complaints about GPs relate to treatment issues, usually inadequate treatment and diagnosis however attitudinal problems and poor communication occur far too often and have a strong potential to undermine the public confidence in the medical profession.

A woman went to a pharmacist for methadone. This required the pharmacist to telephone the woman's general practitioner. The doctor was rude and "ordered" the pharmacist to tell the patient that he (the doctor) was not there. Both pharmacist and patient were upset by the doctor's attitude.

A patient was advised by a general practitioner to stop taking anti-depressants and to stop consulting a psychiatrist. The patient became depressed and attended the psychiatrist who was very angry with the general practitioner.

A woman complained that her father received very poor medical treatment at a nursing home. She said the doctor turned up at times convenient to himself, had a rude manner and the consultations were inadequate and lacking in privacy.

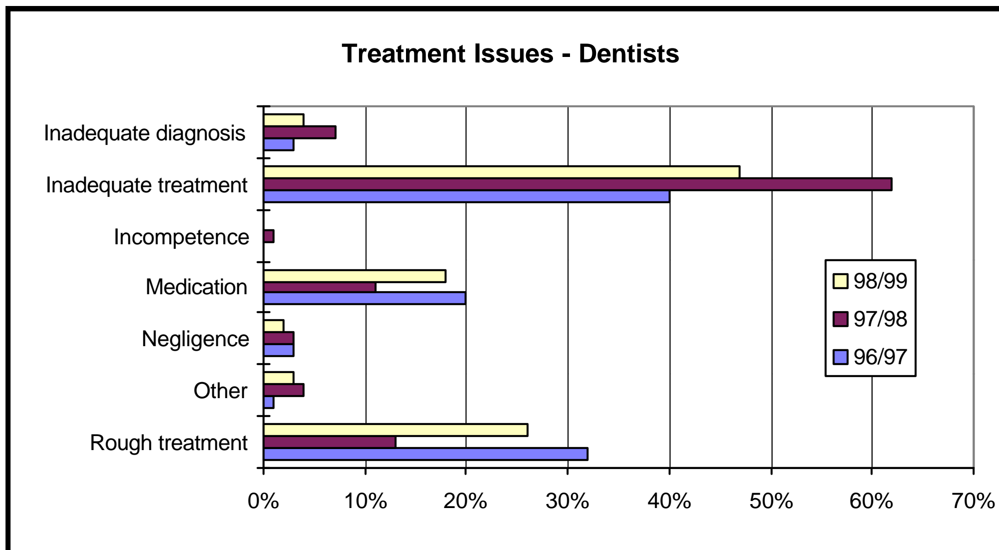
A woman visited a general practitioner for a pap smear test. It took twenty minutes and the woman suffered bleeding for several days. When she contacted the clinic for the results she was told the procedure was unsuccessful and she would need to have it done again. She visited another doctor who performed the test in five minutes without any discomfort or subsequent bleeding.

A man attended a doctor for removal of a bunion. After the operation he could not move his big toe. A second operation was performed. The problem remained and he visited the doctor again. The doctor suggested s second operation which made the man feel the doctor had not consulted the records.

DENTISTS

There were 182 complaints against dentists this year, 61 less than for the previous year. Most of these complaints were resolved with advice given at the inquiry stage. The remaining 65 complaints were the subject of formal assessments by HSC. As in previous years treatment issues account for the largest number of complaints received (48%) with communication often cited as a secondary issue.

Figure 15



Of the 65 complaints formally dealt with by HSC, 32 were closed during the report period. The outcomes reflect the difficulty a service user has in obtaining a refund, ex gratia payment or the waiver of fees in cases where the result of treatment falls short of expectations. In only 8 cases was it possible to obtain such an outcome with the remainder being closed with an explanation offered, or in some cases, the misunderstanding being resolved to the satisfaction of the user. During the report period 3 complaints were referred to the Dental Board of Victoria and 3 complaints were referred to conciliation.

The HSC is assisted by the Dental Board of Victoria and the Australian Dental Association Victorian Branch (ADAVB). Complaint handling mechanisms were the subject of discussions between the ADAVB and HSC and it was decided to document the processes used by each organisation. The development of a protocol has facilitated the faster settlement of some complaints.

Dentures remain the cause of most dissatisfaction with dental services and a problem persists for dentists in explaining adequately why a good fit of denture is difficult to achieve. Ill fitting dentures cause enormous distress. These complaints are difficult to resolve because the dentist believes the denture is appropriate and in most cases many attempts have been made to adjust and reline.

A person had a new denture made on the recommendation of a dentist. Over the next 7 months the person required 10 adjustments and a reline but the fit remained poor. An opinion was obtained which confirmed the denture has several problems, the main one being that the discrepancy between upper and lower dentures is too great to correct. A refund was refused and the complaint was referred to the Dental Board of Victoria.

Root canal therapy and cosmetic dentistry equally account for the next largest number of complaints about dentists. The complexity of root canal treatment is not greatly understood and because the treatment is usually lengthy, expensive and sometimes uncomfortable an adverse outcome needs to be dealt with sensitively.

A woman underwent root canal treatment. After the treatment the pain became worse. After several attempts to diagnose the problem she was referred by her general dentist to an endodontist who found that the root had been perforated and that a piece of amalgam was blocking the canal in the next tooth. The treatment had cost the woman $3000.

As with cosmetic surgery, cosmetic dentistry is now being aggressively marketed. Whilst the outcome of cosmetic dentistry may be more predictable than that of cosmetic surgery, adverse outcomes when they occur are greeted with equal disappointment. Practitioners need to be aware that some patients will have unrealistic expectations.

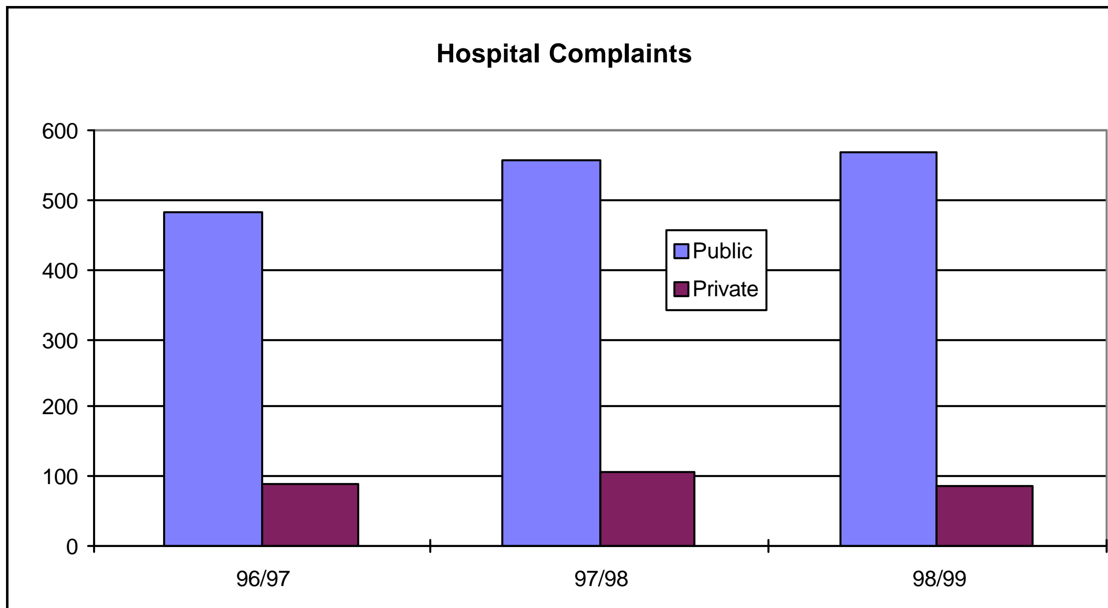
A woman saw a magazine advertisement and made an appointment to have her six front teeth bonded. Within six months some of the veneers had fallen off leaving her teeth sensitive to hot and cold. A second dentist advised that she would need post & core crowns but that he could not guarantee his work. The first dentist agreed to provide a full refund.

HOSPITALS

In 1998/99 there was a slight increase in the number of complaints received against public hospitals and a slight decrease in those against private hospitals. During the year under review there were 570 against public hospitals and 86 against private hospitals.

Figure 16 shows the trends of these complaints from 1997/98 to 1998/99.

Figure 16

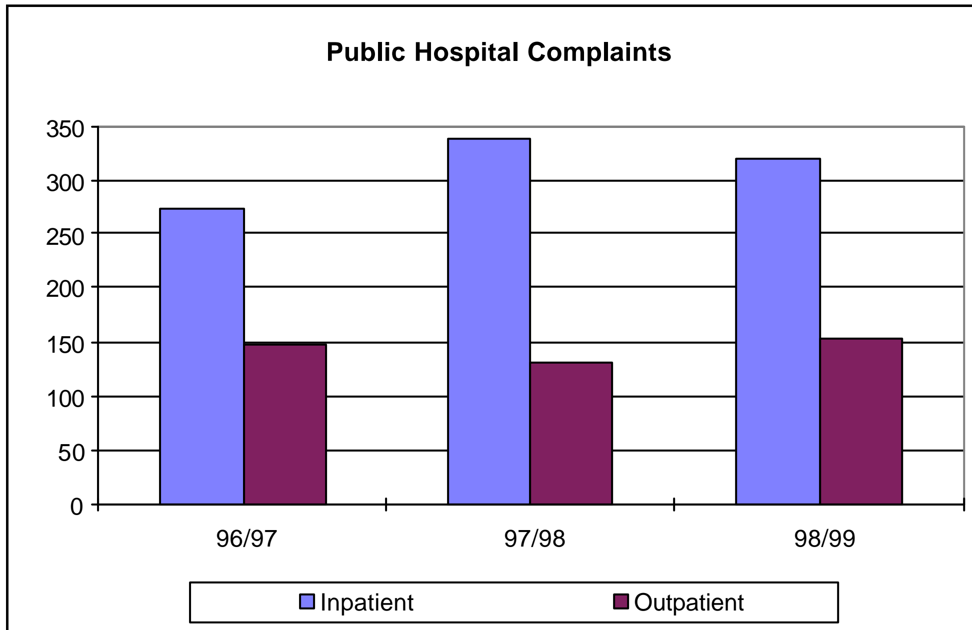


PUBLIC HOSPITALS

All public hospitals are required to have internal complaint handling systems. For this reason a large number of complaints are handled in-house and do not need to be referred to the Commissioner. Public hospitals are required to provide details of complaints to the Commissioner on a regular basis and these figures are reported in the section on the Health Complaints Information Program. The work of complaints liaison officers or patient representatives at the hospital level in complaints resolution is most important. There are approximately 150 of these people working in Victoria in the public and private sectors.

Figure 17 shows the number of complaints made by inpatients and outpatients of public hospitals made directly to the HSC.

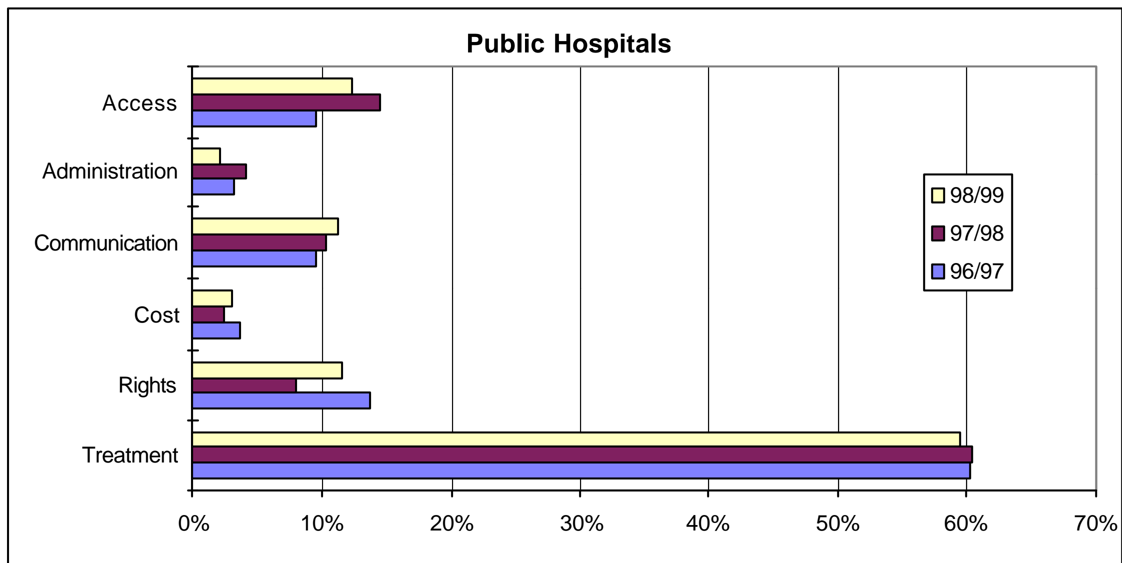
Figure 17



Public Hospital Issues

Figure 18 below shows the types of issues behind complaints about public hospitals.

Figure 18



There were far more complaints about treatment than other issues. Many complaints arise from the failure of hospitals to provide prompt and sufficient information where poor outcomes have occurred.

A woman attended a public hospital for a check up when her pregnancy was overdue. It was decided she should be delivered that day. Complications occurred and an emergency caesarean section was attempted. The baby died during this procedure. The woman was very upset at the subsequent attitude of the hospital staff. She felt she was being fobbed off and no one would tell her what had happened.

A woman gave birth to a baby. The baby appeared to be well. It was taken to a nursery and the next morning was returned to the mother floppy and very sleepy. The baby has subsequently failed to thrive and the mother became very frustrated with the hospital's failure to tell her what happened.

A man was admitted to a public hospital with breathing problems. Over the next fortnight he was given diagnoses ranging from heart failure to chest infection. This confusion made him very anxious as he thought he was being diagnosed with a life threatening condition which was not the case.

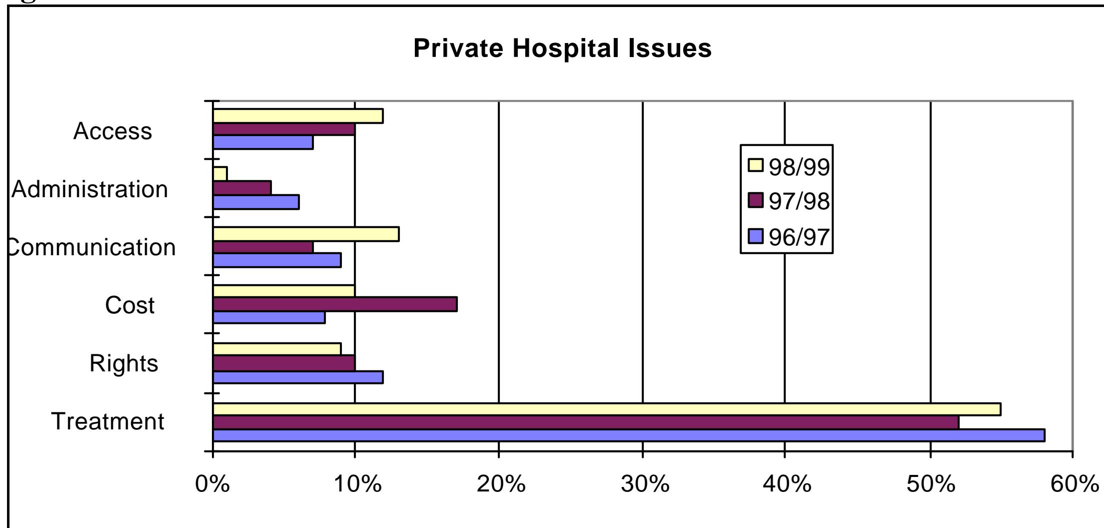
A family complained that their mother, who had cancer, was inappropriately discharged from a public hospital. Despite concerns about their ability to cope they were told they would have no trouble. The mother experienced severe pain and emotional distress. The hospital failed to provide the follow up care that had been promised. Following the mother's death the family were extremely distressed by the suffering they had witnessed and their inability to alleviate it.

PRIVATE HOSPITALS

In 199/8/99 there were 86 complaints against private hospitals compared with 105 in 1997/98. As with previous years treatment issues remain the most common. In the case of private hospitals the treatment issues relate to staff other than doctors because these hospitals do not employ their own doctors.

Figure 19 below shows the main issues in complaints against private hospitals over the past three years.

Figure 19



A woman died in a private hospital. Her family complained that the doctors had failed to provide reasonable care. A chest infection had not been diagnosed. The woman was administered a drug to which she was allergic even though this was clearly marked on her records.

A man attended a private hospital because of complications following a dental procedure. He was concerned about standards of hygiene. A doctor examined a patient and then entered a sterile operating theatre without scrubbing up.

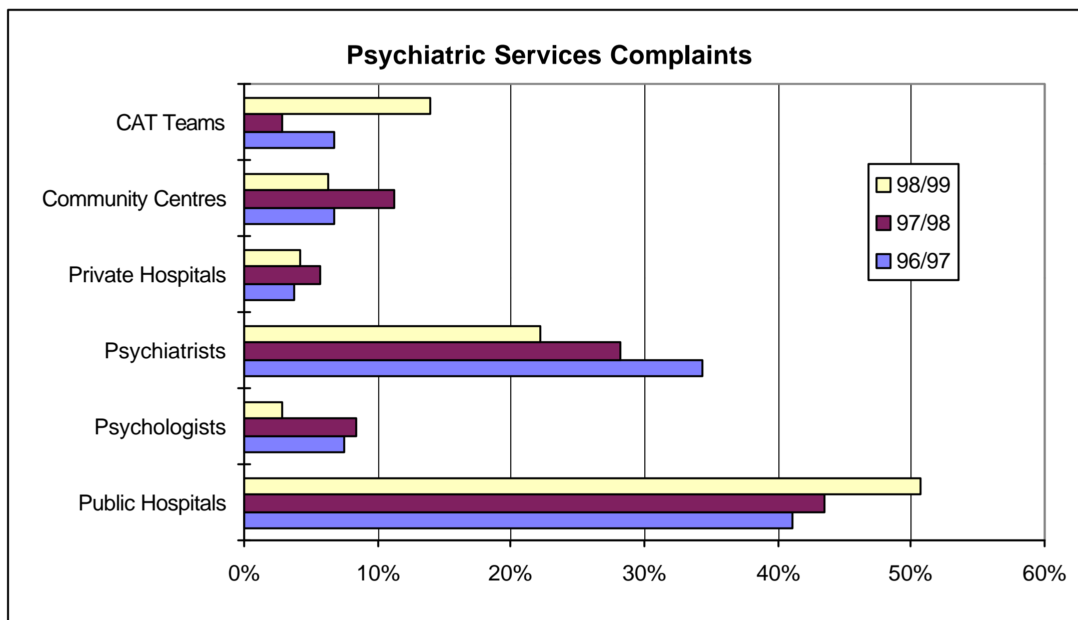
A woman discharged herself from a private hospital following a procedure which left her in pain. She was unable to receive adequate advice on pain management at the hospital. Upon discharge she was readmitted to a public hospital.

PSYCHIATRIC SERVICES

Inpatient psychiatric treatment is now provided through public hospital networks and in the community. The total number of complaints against psychiatric services for 1998/99 was 144, in 1997/98 it was 177 and in 1996/97, 134.

Figure 20 below shows the numbers of complaints received against each type of service.

Figure 20



It was anticipated in last year's report that there may be an increase in complaints made against Community Assessment and Treatment Teams as more community facilities came into use. That did not occur last year but has eventuated in 1998/99. Whereas there were 20 complaints against the teams in 1998/99, there were 5 in 1997/98 and 9 in 1996/97

A woman complained that she had tried to get psychiatric help without success. When her condition deteriorated a family member called the CATteam. There was a long delay and when the team finally arrived they realised the woman could not care for her children and required hospital admission. The woman feels that the psychiatrist who examined her did so cursorily and she was made an involuntary patient. Following discharge from hospital and from involuntary status four weeks later she sought information from the service about what had happened. Despite leaving many phone messages no response was forthcoming.

The family of a patient who subsequently attempted suicide are upset that a CATteam told them their child was not "sick enough" to be admitted for psychiatric treatment.

Complaints about psychiatric services in public hospitals numbered 73 in 1998/99, 77 in 1997/98 and 55 in 1996/97. Private psychiatric hospital complaints were 5,10 and 6 complaints respectively in the last three financial years. Complaints against psychiatrists were 32 in 1998/99, 50 in 1997/98 and 46 in 1996/97. There were 4 complaints against psychologists in 1998/99, 15 in 1997/98 and 10 in 1996/97.

A patient complained that during a Mental Health Review Board hearing serious issues were raised about the appropriateness of the medication being given. The psychiatrist told the Board that these issues would be discussed with the patient following the hearing but this was not done. The patient continued to suffer unpleasant side effects.

A patient complained that a psychiatrist doubled the dose of medication without examining the patient and this is causing unpleasant side effects including stiffness.
A family complained that they had taken their daughter to a public hospital when she suffering severe depression. After a long wait the hospital refused to admit her. The depression worsened and the patient became suicidal. The family believe that had treatment been available earlier much suffering and stress for the patient and the family could have been avoided.

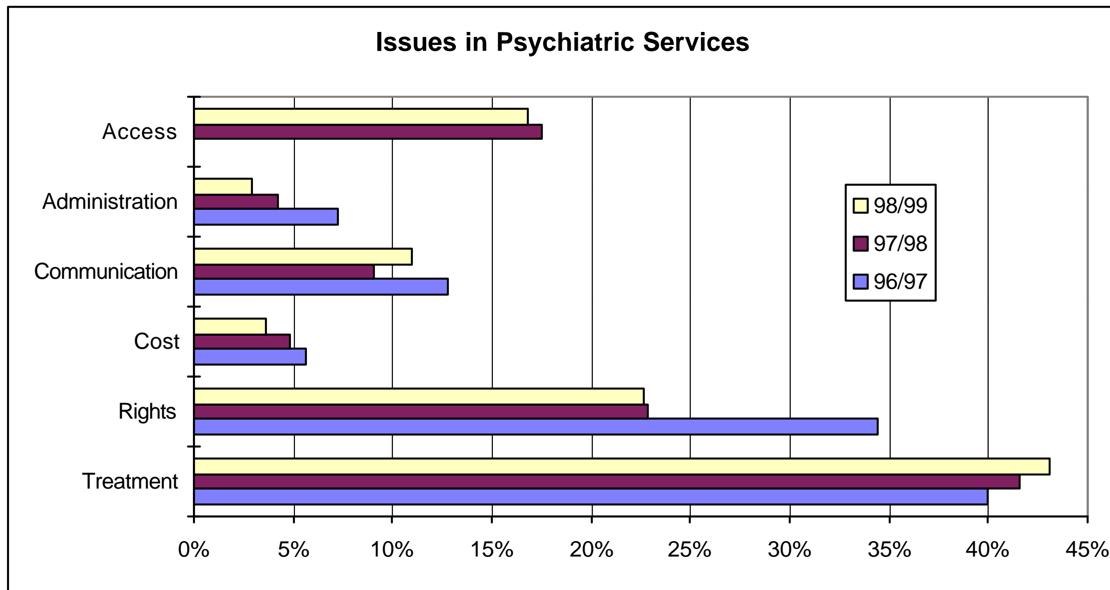
A family complained that their child, an involuntary patient, had been able to leave a hospital without permission. The patient later committed suicide and the matter was referred to the Coroner.

Issues in Psychiatric Service Complaints

Complaints about psychiatric services of all kinds refer mostly to access, administration and treatment.

Figure 21 below shows the types of complaints made by users of these services.

Figure 21



The major treatment issues were about perceived inadequate treatment and medication (50 in 1996/97, 69 in 1997/98 and 59 in 1998/99). The number of complaints about rights violations decreased in the year under review from 38 in 1997/98 to 31 in 1998/99. Rights issues included lack of privacy, unprofessional conduct and assault. The most frequent complaint about rights is that the treatment is given without the consent of the person. When a complaint about a person's involuntary status under the mental health legislation is received patients are advised of their right of appeal to the Mental Health Review Board. As the anecdotes above indicate complaints were received from parents and/or carers of people with mental illness about their inability to gain access to inpatient care for their family member.

HEALTH COMPLAINTS INFORMATION PROGRAM

The Health Complaints Information Program (HCIP) is a complaints management software program developed by the HSC and public hospitals with the support of the Department of Human Services. It assists hospitals with efficient complaints management and allows them to report complaints data to the HSC as anticipated by section 32 of the Health Services (Conciliation and Review) Act 1987.

During the period of this report, a total of 32 public hospitals, Victoria wide, provided returns to the Commissioner. They reported 3540 complaints with 4671 issues.

TABLE 9
Number of weeks in which complaints are closed

Area	Metropolitan	Country
closed within 1 week	40%	22%
closed within 4 weeks	31%	34%
other closed	29%	44%
Total	**100%**	**100%**

Table 9 shows the number of weeks to closure as a percentage for metropolitan and country hospitals. Some large metropolitan hospitals report median days to closure of 17 to 20 days. There is a significant difference between metropolitan and country based hospitals in closed complaints within one week. However, there are inherent dangers and weaknesses in using statistical information which does not inform quality or reflect the diversity of issues involved in complaints, for example, grieving, where an early closure of the complaint is not appropriate. Or, similarly, a complaint involving a single issue compared with complex multi-issue complaint.

TABLE 10
Who complains?

	96/97	**%**	**97/98**	**%**	**98/99**	**%**
Patient	1464	47%	1472	46%	1600	45%
Other	1621	53%	1731	54%	940	55%
Total	**3085**	**100%**	**3203**	**100%**	**3540**	**100%**

Table 10 shows that 45% of complaints are made by the user of the service with 55% made by other interested parties, including a parent, child or spouse. Interestingly, complaints made by staff on behalf of a user were only 1%. In hospitals where management supports staff who identify potential problems and/or complaints on behalf of their patients complaints can provide a powerful tool for quality improvements. Management support for nursing staff, and others, who have contact with patients is important as they can observe potential difficulties in the system. Hospitals which support an accessible complaints system may have a higher number of complaints but they may also be the ones who use complaints most constructively in the interests of patient safety and clinical best practice.

Figure 22

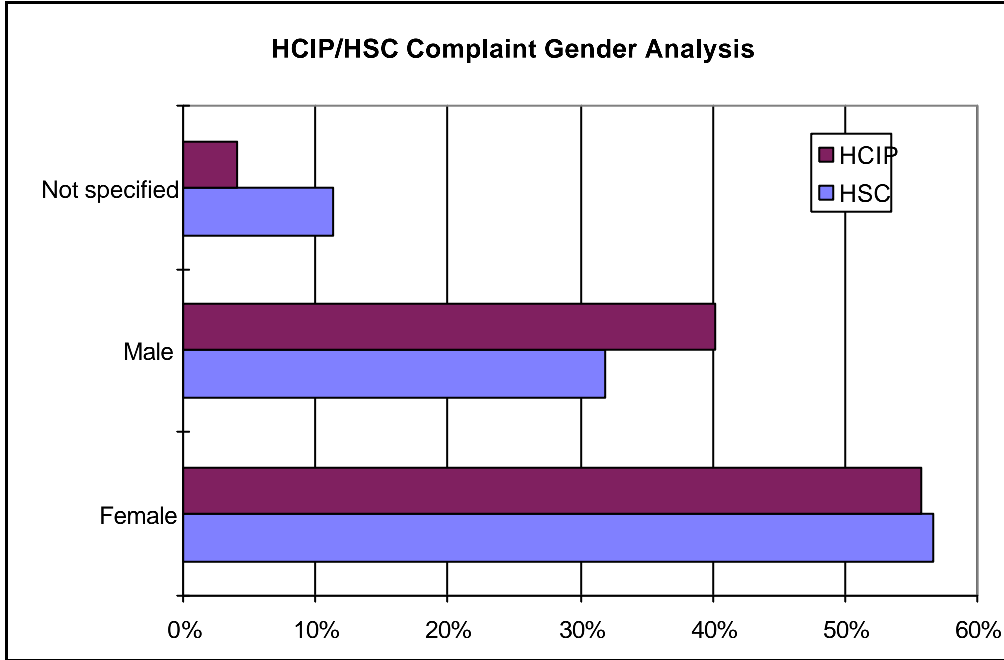


Figure 22 shows a comparison between the HCIP and HSC data in respect of gender of the complainant. Both data sets indicate that most complaints are received from females. Compared with the HSC data for the same period, it appears more males have made complaints (40%) direct to hospitals as opposed to 32% to the HSC.

TABLE 11
Category of patient

	96/97	**%**	**97/98**	**%**	**98/99**	**%**
Public Patient	2572	84%	2769	86%	3177	90%
Private Patient	282	9%	241	7%	173	5%
Dept of Veterans Affairs	125	4%	86	3%	98	3%
Other	106	3%	117	4%	92	2%
Total	**3085**	**100%**	**3203**	**100%**	**3540**	**100%**

Table 11 shows that of the total complaints reported via HCIP, 90% are from, or about, public patients. This is not surprising given that the data are supplied by public hospitals most of whose admitted patients are "public". Public hospitals do, however, treat some private patients and Veterans.

Figure 23

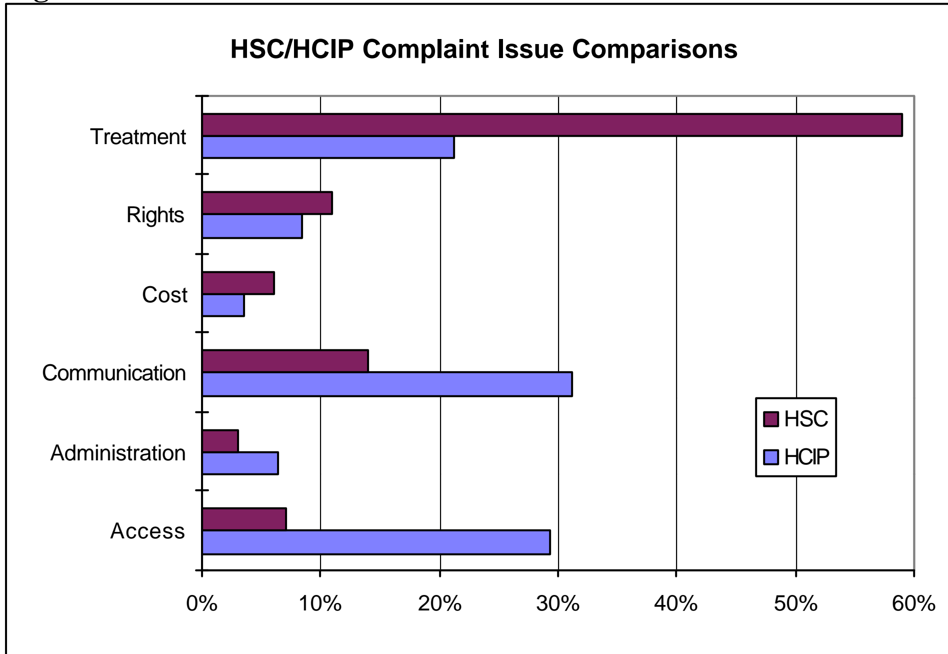


Figure 23 shows a comparison between complaint issues dealt with by CLOs and the HSC. As in previous reports, CLOs received and resolved far more complaints than the HSC. Communication (31%), access (29%) and treatment (21%) are the top complaint issues dealt with by CLOs. This trend is unchanged from the last report period.

Figure 24

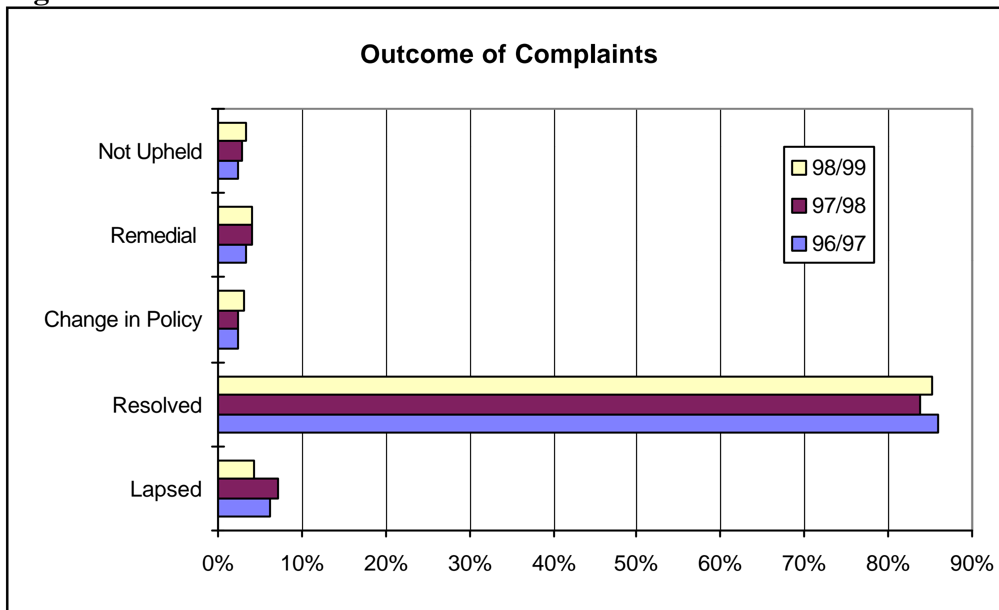


Figure 24 shows the outcomes achieved by CLOs. Data on outcomes is not necessarily exclusive, for example, in the resolved category are included examples of change in policy. This coding issue is currently being reviewed by HSC, in conjunction with the CLOs, as part of the upgrade/rewrite of the HCIP software.

Issues concerning access include -

A patient was distressed about long waiting times in outpatients clinic and was concerned when told that she was ineligible for "shared-care" where she could have visited her GP in his/her rooms in the community. Modified shared-care was arranged and she was satisfied with the outcome.

Issues concerning communication include -

A patient and her partner were distressed to find that pathology tests had been conducted on their baby after foetal death in utero (FDIU). They believed this prevented the discovery of possible causes of the FDIU and their choices for future pregnancies.

The pathology request process was reviewed and identified as the cause of the breakdown in communication. An apology was offered and changes to the system implemented.

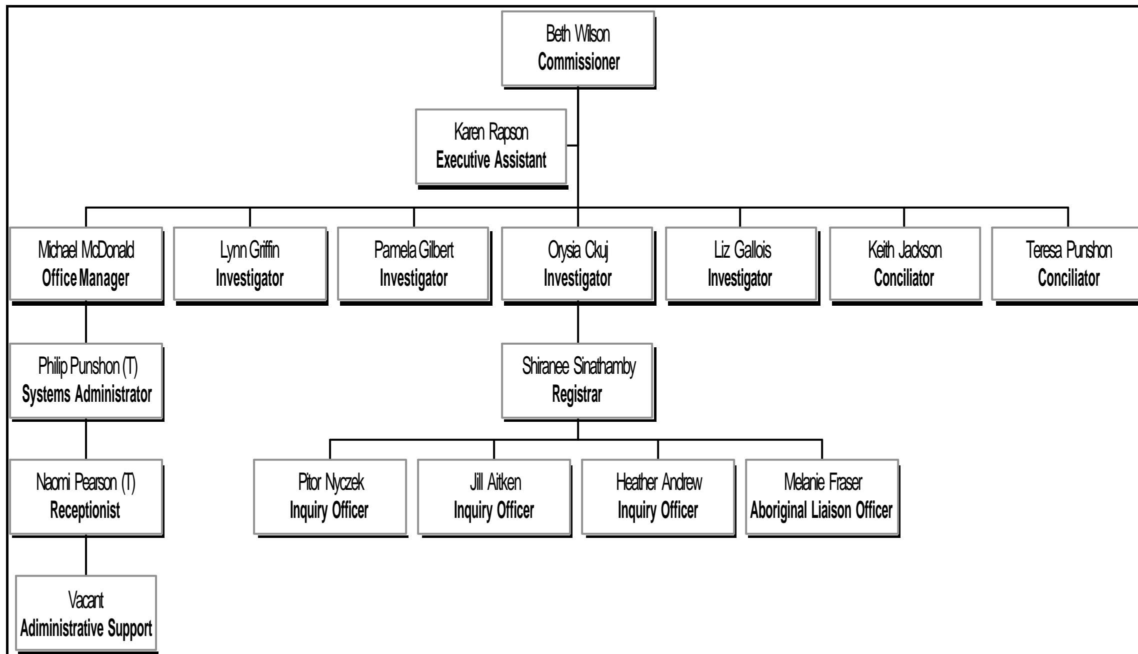
A woman requested information and an explanation about her difficult birthing experience. Her issues were referred to the appropriate doctor who provided a clear and timely explanation.

A woman and her partner were distressed by the loss of an advanced multiple pregnancy. They were distressed by the lack of consistent information from medical staff. A meeting was arranged with the senior consultant who provided a detailed explanation, answered their questions and advised about support and grief counselling.

OFFICE MANAGEMENT

HUMAN RESOURCES

Organisational Structure



Recruitment

The recruitment of appropriate staff is essential for the efficient operation of the office. In 1998/99 an Aboriginal Liaison Officer, a Receptionist and an Executive Assistant were recruited.

Performance Management Program

The OHSC adopted the DHS performance management program in the previous financial year. The program provides a mechanism for evaluating work and rewarding good performance based on outcomes.
Individual work plans are aligned to the organisational directions of the office and encourage staff to work towards a common purpose. Staff have a clear understanding of what is expected of them and have the opportunity to receive regular feedback.

Merit and Equity Employment

The OHSC has supported specific initiatives of the Office of Public Employment Managing Diversity and Employment Equity goals. The office follows equal employment opportunity policies when recruiting.

The composition of staff by gender for 1998/99 was 12 women and 4 men.

INFORMATION TECHNOLOGY

Millennium Bug

The major issue from an IT perspective for the office was to ensure Year 2000 (Y2K) compliance. This process commenced early in 1999 and continues into the next financial year.

It includes:

- Identifying all potential items at risk including hardware, software and business practices
- Assessing the risk and impact these will have on the operations of the office
- Compliance action where possible
- Developing contingency plans if normal operations are not possible

Transfer to DHS Network

In March 1999 the office integrated its IT operations with the DHS computer network. This has resulted in a number of benefits to the office such as enabling access to a large IT infrastructure, improved communications with DHS staff, on line links with DHS Human Resource and Finance administration and access to the Intra and Internet. The appropriate security measures have been put in place to ensure the confidentiality of the complaint data held by the office.

Hardware Improvements

As the IT environment is constantly evolving it is necessary to continually review and improve the office equipment. Improvements made in 1998/99 include:

- All office computers have been replaced with Pentium 3 level 450Mhz machines which are Y2K compliant.
- New laser printer purchased
- Portable projector to aid in presentations
- Additional fax machine for outgoing correspondence

Health Complaints Information Program (HCIP)

HCIP is a software based database used for collecting and analysing aggregate complaints data from hospitals. The software HCIP was developed in became technically obsolete requiring a transfer to MS Access to meet the demands of the hospitals and ensure Y2K compliance.

The transfer of the HCIP data went to tender in May 1999, a successful provider appointed and is scheduled to be completed in September 1999.

ACCOMMODATION

On 12 October, 1998, the OHSC relocated from level 10/55 Swanston Street, Melbourne to Marland House level 30/570 Bourke Street, Melbourne. The relocation brought together four independent statutory authorities, Office of the Health Services Commissioner, Mental Health Review Board, Intellectual Disability Review Board and the Infertility Treatment Authority resulting in rental savings for the Government and efficiencies for the four organisations.

FINANCE

Statement of Understanding

The HSC and the Director, Portfolio Services, DHS have an agreed "Statement of Understanding" which identifies the types and levels of services delivered by the office and the funding allocation necessary to deliver its statutory responsibilities and services. The document identified service improvement initiatives, organisational and business management issues and statutory responsibilities and core business.

This document reflects the Department of Human Services move to an output based funding model which ensures all work units, funded agencies and statutory authorities are more accountable and responsible for their allocated funds.

Budget

For the 1998/99 financial year the OHSC expended 99.21% of its total allocation. Operating expenses exceeded allocation by 25.74% however this was offset by a savings in salaries enabling the office to come in under budget.

Expenditure

Direct Expenses

Salaries		$752,731
Administrative stationery & operating supplies	$7,413	
Advertising	$1,429	
Books/publications/subscriptions/memberships	$6,512	
Computers - purchases	$30,623	
Computer systems - maintenance	$7,773	
HCIP review	$11,555	
Furniture, fittings & equipment	$5,205	
Interpreting	$847	
Medical reports	$8,205	
Meeting expenses	$1,500	
Postal /courier	$2,063	
Printing	$8,799	
Publicity & information	$836	
Solicitors	$10,656	
Staff development & seminars	$9,294	
Telephones	$31,735	
Travel	$9,032	
Trust fund	(6,595)	
Vehicle	$239	
Sub Total		$147,121
Total		$899,852

Financial Statements

	Allocated	Actual
Operating Expenses	$101,400	$147,121
Salaries	$806,500	$752,731
Sub Total	$907,900	$899,852
Indirect Expenses	$269,881	$268,607
Total	$1,177,781	$1,168,459

APPENDIX 1

Complaints by Provider Type

TYPE	1996/97	1997/98	1998/99
Aboriginal Health Worker	0	1	2
Acupuncturist	1	1	0
Alcohol & Drug Service	3	2	1
Alternative Therapist	7	12	21
Ambulance	7	15	10
Appliances & Equipment	3	2	0
Audiologist	1	1	2
Community Health Centre	13	25	25
Chiropodist/Podiatrist	4	6	3
Chiropractor	3	10	10
Corrections, Health	6	17	49
Diagnostic pathology	11	13	6
Dentist	181	243	182
Dental technician	6	22	17
Family planning	1	1	2
Commonwealth Dept	5	6	4
Human Services (Vic)	22	18	11
Health Insurance	5	7	4
Hostel	3	2	1
Infant Welfare	2	1	0
Masseur	4	2	1
Medical Practitioner	736	851	808
Nurse	21	5	5
Nursing Home	17	19	16
Naturopath	2	1	2
Optical dispenser	1	4	2
Optometrist	28	26	9
Osteopath	3	2	0
Pharmacist	8	16	21
Pharmaceutical supplier	3	7	3
Physiotherapist	6	10	8
Private Hospital	88	105	78
Psych CAT team	7	5	12
Psychologist	9	15	4
Public Hospital	473	559	497
Radiographer	12	16	18
Social Worker	3	6	5
Speech Therapist	0	0	2
Specialist Hospital	16	7	6
Supported Residential Service	7	4	8
Not identified	143	416	406

APPENDIX 2

Medical Practitioner Specialties

Specialty	1996/97	1997/98	1998/99
Allergy	1	1	0
Anaesthetist	11	15	14
Cardiologist	2	5	8
Dermatology	8	16	23
Emergency	3	1	0
Ear Nose Throat	6	13	10
General Surgery	29	23	24
GP	496	409	400
Gastroenterology	1	2	3
Neurology	2	2	4
Obs/gynaecology	47	43	47
Oncology	2	3	8
Ophthalmology	15	21	12
Orthopaedics	14	22	27
Paediatrics	6	7	5
Physical Medicine	1	2	5
Plastic Surgery	24	33	49
Psychiatry	44	50	34
Pathology	1	1	0
Radiology	3	3	2
Rehabilitation	1	6	1
Urology	9	3	6
Vascular surgery	4	1	2

APPENDIX 3

Areas within Public Hospitals where complaints are directed

Specialty	**1993/94**	**1994/95**	**1995/96**	**1996/97**	**1997/98**	**1998/99**
Allergy	0	1	0	0	0	0
Anaesthetics	7	4	5	1	2	3
Cardiology	0	3	0	6	5	11
Dentistry	3	19	11	8	10	18
Emergency	54	34	34	51	47	57
ENT	4	6	3	6	5	5
General surgery	16	33	14	20	26	40
GP	3	1	7	3	1	3
Gerontology	7	7	5	2	2	4
Infectious disease	1	1	1	1	0	1
Medical Admin	8	14	7	1	1	2
Neurology	2	1	1	1	4	0
Neurosurgery	2	3	3	2	3	3
Obs/gynaecology	38	37	37	29	67	63
Oncology	5	5	5	9	8	12
Ophthalmology	2	0	3	2	0	7
Orthopaedic surgeon	4	8	10	4	7	11
Outpatients	15	13	10	2	2	0
Paediatrics	7	13	13	4	7	8
Pathology	0	3	1	2	2	1
Podiatry	1	1	0	1	0	0
Pharmacy	0	1	2	0	1	1
Physical Medicine	0	3	4	1	1	2
Plastic surgery	2	1	0	0	1	1
Psychiatry	32	55	39	56	49	77
Radiology	0	2	1	6	5	9
Administration	15	8	4	8	6	8
Rehabilitation	3	1	5	3	2	3
Social work	1	0	3	0	1	2
Urology	2	1	5	3	5	8
Vascular surgery	3	1	3	2	3	0
Wards	44	27	27	61	26	14
General	117	200	198	182	258	196
Total	**398**	**507**	**461**	**481**	**559**	**570**