

Submission to the Australian Commission on Quality and Safety in Healthcare

Regarding the
Draft National Patient Charter of Rights

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Introduction

The Australian Psychological Society (APS) has long held the issue of patient rights as fundamental to good patient care. It has encouraged its members to provide their clients with a copy of a patient rights document – a version of which can be found on our web site (http://www.psychology.org.au/community/client_charter/). This version of patients' right was influenced by earlier documents published by the health privacy commissioners and as such focuses considerably on the rights to confidentiality and information protection. This document affirms our commitment to patient rights and provides a context from which to support the National Patient Charter of Rights.

In commenting on issues raised in the consultation paper, the APS applauds the work of the ACS&QHC. It is no simple task to create a national document which blends the best aspects of all previous work while avoiding the pitfalls or possible conflicts that surround such a process. The eight Rights identified are both appropriate and reasonably comprehensive and certainly form a good basis for ongoing development and review - particularly by the States and Territories as well as by clinical speciality areas such as mental health, palliative care and aged care.

We offer the following comments in response to the consultation questions.

1. National Patient Charter of Rights and National Patient Charter Principles

While the intention of the Commission is clear in delineating the Rights from the Principles in the consultation paper, it does look confusing and repetitive to the casual observer. Conventionally "principles" stand above the details, driving and defending the rights. In this context, they seem subordinate. It is also unclear who the Charter's target audiences are: the patients, health care providers, or health care administrators. The table on page 5, for example, talks about Rights in the first person, whereas subsequent pages refer to patients in the third person.

A more meaningful way of presenting the Charter would be a series of documents outlining the Rights, the Principles and their application to specific audience groups. The usage of language and their expression would change depending on the target audience, while retaining the essential features of the right and their underlying principles. For example, the right of Access can be expressed from a patient's perspective as illustrated below

Rights	Underlying Principle	What does this mean to me?
Access	I have the right to access public health care	I can get help from public health services when I am not well without being asked if I can pay for their services first.

Similarly, the right of Privacy can be expressed from a provider's perspective

The development of audience specific versions of the Charter would also take into consideration allowances for subtle changes of presentation, wording and structure of the Charter.

2. Rights included in the Charter

The current set of the 8 patient rights is a combination of desired outcomes, such as Access and Safety, and tools to achieve such outcomes, such as Communication, Information and Participation. In other words, Safety can be achieved using clear communication, current information and facilitated participation. It might be useful, therefore, for the Commission to reconsider if the purpose of the patient rights is about seeking specific outcomes (high level) or to provide patients and health care providers with the tools to do so (low level).

The issue of safety requires a much more robust discussion in the Charter. Safety is an absolute fundamental in health care and has moved beyond “do no harm”. Additions to this principle and its implementation might include topics like: evidenced based practice, appropriate levels of expertise to deliver health care and ongoing professional competence underpinned by continuing professional development.

Similarly, the Commission should consider the inclusion of the following as rights, which, in line with earlier suggestions, are desired outcomes and can be supported by appropriate tools such as communication and information:

- a. Efficiency: patients should have services that are not duplicative, cost effective and within the same physical location where possible.
- b. Effectiveness: patients should have services that are proven to be effective, by appropriate providers using up-to-date technology.
- c. Continuity: Patients should have seamless transition between services and between health care settings.

3. Points included in the Principles

Notwithstanding the fact that the Charter aims to set out minimum standards upon which health care services and specific provider settings can be built, there was no attempt to address the very vexed question of to what extent the patient’s rights include their right to refuse active treatment, or for the document to make passing references to euthanasia. It would seem necessary for some reference to be made to the former issue at least, as the community is not silent on these issues, and are ones which our health care providers, particularly in aged care and palliative care are facing on a daily basis.

4. Rights and responsibilities

The document makes a number of references to what the patient is entitled to expect as well as for what the patient needs to take responsibility. This is a very important principle and certainly deserves the iteration that you gave it. However, the only reference made to patient responsibilities is outlined in the explanatory notes under Information on page 7. There should be greater emphasis on patient responsibilities in the Charter. This is particularly so in light of work places of high incidence of violence and stress such as emergency departments and acute mental health facilities. The following are some of possible additions to the Charter in order to fully reflect those important responsibilities.

- a. Exercise the same respect for the rights of other patients as you would wish for yourself.
- b. Communicate about yourself, including any concerns and questions about your treatment, with your treating health professional in an open and honest manner so as to facilitate your care and treatment.
- c. Communicate with your treating health professional and other patients in a non-abusive and non-threatening manner.

Alternatively, if the purpose of this Charter is to set out patients’ rights, the Commission may wish to produce a separate document that focuses on patients’ responsibilities. However, this approach would be regretted as the two need to be viewed simultaneously so as not to lessen their impact and undermine their co-dependent relationships.

5. Existing charters

It is not clear what relationship this new Charter will have with those currently enunciated by various State and other bodies. It is assumed by the reader that this new Charter will have priority and dominance, but this is not explicitly stated in the document. It is also unclear to the reader as to what extent this Charter will be enforceable, and by which authority.

It would also be useful for the Charter to include an explanatory note to health care providers commenting on the relationship of this new Charter and existing Charters of Rights. It should state the aim and objectives of the new Charter and whether it serves as the minimum benchmark or foundation on which existing charters of rights are reviewed and realigned in order to reflect jurisdictional or treatment setting specific issues.

The Council of Australian Governments (CoAG) has already agreed to schemes for national registration and accreditation of health care providers. It would seem necessary to include in this Charter a reference to pathway(s) of national complaints process(es) available for patients, so as to minimise any confusion and frustration.

6. Possible uses of the charter

It is possible for this new Charter to be used as a minimum framework by which existing Charters are realigned and/or for new Charters to be developed, such as for specific treatments settings of palliative care and emergency departments. If that is the object of the new Charter, then the rights should be phrased in terms of desired outcomes as suggested above. This will encourage meaningful interpretation and adaptation of such rights by local and specific end users.

The phrasing of patients' right in terms of desired outcomes also means that local and specific end users will be able to demonstrate their ability and achievement of these rights in the new Charter should accreditation be articulated at a later stage. For example, a dialysis provider may interpret Safety in terms of infection control whereas an emergency department would interpret this as safety of staff and other patients as equally important. Therefore, any policies and procedures developed as a result of such interpretations would allow the providers to demonstrate in a clear manner how they are meeting their patients' rights, and therefore worthy of accreditation and/or re-accreditation.

7. How the charter applies in different sectors and settings

This question has already been answered to a large extent by previous comments. Specific health care settings with high risk populations should be encouraged to develop their own specific charter of rights, if they have not done so already, or review and revise their existing charters, based on this new Charter.

It should also be pointed while the new Charter is set out to cover health services, at no stage was health service defined in the Charter. Many health professionals work outside of traditional "health" settings, such as in correctional facilities or refugee detention centres, where their clients have limited ability to exercise their rights. Similarly, there are many "health" professionals, including a significant number of psychologists, working in places such as schools, family courts and non-government organisations. It might be useful therefore, for the Commission to at least outline the limitation of the new Charter in certain settings so as not to create false expectations for patients.