MANAGEMENT ISSUES

Complaints—and how to deal with them

One of the most commonly discussed features of current medical practice is the growing number of complaints. These vary from an individual's dislike of the colour scheme and companions in the waiting room to genuine serious claims of medical negligence. Dealing with them all requires a considerable amount of time, effort, and paperwork. Over the last decade there has been a 70–80% rise in the number of complaints in most hospitals. Over the past 12–18 months there are signs that this exponential rise has slowed and the numbers are beginning to stabilise. Accident and emergency (A&E) departments are the source of perhaps the largest number of complaints. The greatest cost falls to obstetrics. The NHS now pays more than £160 million in out of court settlements of negligence claims. Increasing litigation is not unique to the practice of medicine but a feature of current attitudes in society largely adopted from the other side of the Atlantic. Attempts have been made to sue doctors in the USA merely on the principle that they work in the hospital where the patient was treated, even though they have never been involved in the patient's care.

There is no evidence to suggest that today's doctors make more mistakes than formerly; what has changed is patients' expectations and acceptance.

Complaints can be divided into two main groups. The first involves cases in which compensation is sought and litigation threatened. These usually involve alleged medical negligence. Secondly, and more frequent, are those in which the patient or relative wishes to raise a concern or grievance for a variety of reasons but often genuinely to ensure that no-one else has a similar unpleasant experience. The patient who complained that the anaesthetist was whistling while preparing the anaesthetic and was thus obviously not taking the procedure seriously presumably falls into the latter category.

Managing complaints is a growth industry involving increasing amounts of medical, nursing, management, secretarial, and legal time. Hospitals now have one or more members of the management team specifically appointed and trained to deal with complaints. The Patients' Charter encourages patients to complain if they are dissatisfied, in theory to encourage improvements in the service. It also states that it is the patient's "right" to have that complaint investigated and a written reply sent.

April 1996 saw the introduction of the new NHS complaints procedure, designed to make things easier for patients, more open and straightforward, and to accelerate the process. Fairness for both patients and staff alike, in addition to an investigation separate from any subsequent disciplinary proceedings, are also key objectives of the new procedure. It is divided into three clearly defined steps.

(1) *Local resolution*—The initial complaint will be investigated by the hospital complaints manager or quality assurance officer on behalf of the chief executive and a written reply sent, ideally within a period of four weeks. The most recent *Journal of the Medical Defence Union* states that anecdotal evidence suggests that 75% of grievances will be resolved if properly handled. If the complainant remains dissatisfied with the initial

reply, further attempts can be made at conciliation. If this is unsuccessful there is a four week period during which time the complainant can request an "independent review". This is not an automatic right and will not be recommended if legal proceedings are pending.

- (2) *Independent review*—A panel will be set up by a convenor who is a non-executive member of the Trust board, and who will in turn contact an independent chairman. The latter will be nominated by the secretary of state for health from a regional list. The third member of the independent review panel will represent the purchaser, be they general practitioner or health authority. After consultation with the rest of the panel, if the convenor decides the matter is clinical, two independent clinical assessors will be appointed from outside the area to advise the panel. The complainant may be accompanied by an advisor during this stage but if that advisor is legally qualified they may not act as an advocate. The review panel will produce a final written report within three months of the original complaint, stating whether or not it was upheld. This is sent to the patient/complainant, the practitioners involved, and the chief executive of the health body concerned. Any resulting action or change in practice will then be circulated to the complainant.
- (3) *Ombudsman*—If the complainant still remains unsatisfied the matter can be taken to the health service commissioner (the Ombudsman). This is the third and last step in the procedure, the decision of the Ombudsman being final. An additional change in the new procedure is that the Ombudsman now also has jurisdiction to investigate clinical malpractice. This procedure in general will only be followed if there is no threat of litigation; however, there is nothing to prevent the complainant seeking legal advice at the conclusion of the procedure.

In cases where litigation is threatened from the outset the patient usually involves their solicitor at an early stage in the proceedings. Doctors are best advised to do likewise, informing the hospital management and solicitors as well as their defence body as early as possible. It is wise to check on a regular basis that one has the appropriate level of cover, remembering that work outside the hospital at sports events and some medicolegal reporting requires increased insurance premiums.

In A&E medicine the range of presenting complaints is limitless. This adds to the interest but also to the difficulty of diagnosis. The number of patients presenting to A&E departments continues to increase every year. As the throughput of patients is large and rapid, the time available for each consultation is necessarily short. One of the difficulties in A&E is that the majority of patients are treated by relatively inexperienced doctors under senior supervision, but without direct senior involvement in each individual case. In the vast majority of cases this system is adequate and extremely efficient. Increasing consultant presence on the shop floor to provide 24 hour cover in all A&E departments will be extremely expensive and in the foreseeable

future there will be an insufficient number of appropriately trained people to allow this to happen. Appointing more middle grade staff is another possible solution, but such doctors are also difficult to fund and to find. Senior doctors are also capable of making mistakes, after all "to err is human".

The best way to deal with complaints is to avoid them happening. It is therefore important to ensure adequate staffing numbers of both medical and nursing staff of sufficient seniority and skill. Use of locum doctors is particularly hazardous. Appropriate training and teaching are essential, repeating the lessons with every new six month intake of juniors. The majority of negligence claims in A&E are the things we all know about, for example missed glass in wounds, severed nerves and tendons in hand injuries, scaphoid fractures, and so on. Injuries and illness tend to follow specific patterns and it is important that juniors are made aware of these. The axiom "to forewarn is to forearm" was never more appropriate.

Guidelines and protocols of recommended clinical management and policies pertaining to the individual department and hospital should be available at all times. Senior staff on call should also be contactable for advice whenever necessary.

Regular review and audit of records is vital, as errors may be picked up earlier and good quality notes are essential if any form of defence is to be mounted. Recording A&E notes is an art different from a full admission clerking. It is important in many cases that negative as well as positive findings are documented. The notes must be contemporaneous and not subject to later additions or alterations. The defence bodies are repeatedly having to settle cases largely because the records are inadequate. In cases where future litigation or complaints can be anticipated it is important that the relevant staff make a note of the details as soon as possible and keep them as long as necessary as litigation can take many years to settle once the courts become involved.

All radiographs should be formally checked and reported by a radiologist. It is also important to have a fail-safe system for recalling patients in whom there is a missed fracture or some other doubt. Failure to spot a subtle fracture on a film may not be classed as negligence, but failure to recall the patient once the fracture has been diagnosed most certainly is.

Review clinics provide a safety net for the A&E staff to reassess a patient where there is any lingering concern.

These must be staffed by seniors with experience, but can be useful feedback opportunities for the junior staff. It is important for all patients, particularly the vulnerable young and old, that appropriate follow up is arranged, recorded, and the general practitioner informed.

Most complaints are the result of failure of communication between doctor and patient. Gone are the days when the medical profession was universally revered and honoured. It is vital that patients and relatives are treated in a professional, courteous manner at all times. Some doctors find this understandably difficult when dealing with aggressive, rude, verbally abusive, and violent patients. Arrogance and rudeness on the part of a doctor or nurse is certain to increase the number of complaints.

If a genuine mistake has occurred it is important to apologise sincerely. Saying sorry does not admit liability. Apologising for what has happened does not result in the same problems as with car insurance. A large number of complaints can be dealt with by an adequate explanation and an apology. This role ideally should be undertaken by the consultant after consultation with the staff involved and hearing their side of the story. Meeting with the complainant and direct contact is often more satisfactory than written correspondence. It is surprising how many complainants just want someone to say they were sorry. Failure to do so at an early stage fuels suspicion and distrust.

Consultants have a duty to ensure that the patients treated in their department receive a reasonable standard of care. If this is lacking due to inadequate staffing or lack of other resources, it is important that the hospital trust and health authority are informed. The onus is then upon them to improve the situation. Maintenance of standards of clinical practice within the department is the responsibility of the consultant concerned, and the importance of training is now recognised by risk assessors. Insurance cover may not be available to hospitals without adequate training programmes in the future.

There is no doubt that dealing with complaints will continue to be one of the important tasks of A&E management in the future. They are easier to handle if regarded not as a hassle and nuisance but a "learning opportunity" and possibly the chance to "put right a wrong."

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