THE COMPETENT NOVICE

Dealing with complaints

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This article explores why patients complain and outlines some strategies for reducing the rising number of complaints and for dealing appropriately with any that do occur

One in 10 patients admitted to hospital in the United Kingdom experience an adverse event,¹ and around half of these events are preventable. The number of complaints from National Health Service (NHS) patients is rising in the UK: the Department of Health's Independent Complaints Advocacy Service dealt with 10 422 complaints in 2003-4 but almost 13 000 complaints in 2004-5.²

It is essential that healthcare professionals work together with patients and deal constructively with feedback to reduce adverse events. Evidence shows, however, that doctors find complaints extremely upsetting, feel unsupported in dealing with them, and are fearful of the consequences, including litigation.³⁻⁵ Here we describe how and why patients complain and then suggest some evidence based strategies for reducing complaints and for dealing appropriately and helpfully with any that do occur.

Why do patients complain?

Complaints often follow adverse clinical events, but they can occur even when nothing has "gone wrong." Similarly, not all adverse events result in complaints. Focus group studies show that patients want to be told about events occurring in hospital that have caused them harm. Patients want to receive an apology, a description of what has happened, any consequences, and the medical steps needed to reverse these and/or to prevent further harm.⁴ A survey of 1007 complainants found that their primary motivation was to prevent other patients experiencing the same adverse event in the future.⁶ Only 7% of patients who complain do so because they want financial compensation.⁷

About two thirds of complaints concern clinical judgment or decisions,^{6,7} but it is rare for complaints to occur because of a clinical incident in isolation (11% in one study⁸). Often a series of adverse experiences will eventually motivate a patient to make a formal complaint. Most complaints (72%) involve an element of staff insensitivity or communication breakdown.^{6,7}

Complaints related to communication are usually found to be valid. In a cross sectional study of complaints referred for peer review, the proportions upheld were as follows: complaints about breakdown in communication, 78%; complaints about failure to investigate or treat, 25%; complaints about misapplication of clinical skills, 20%.⁸

How can patients complain?

Patients or relatives in the UK can complain to any member of NHS staff (figure). Only the patient or complainant can decide whether they wish the complaint to be formal, in which case it will be referred to the complaints manager according to the local complaints policy. The complaints manager will try to resolve formal complaints through correspondence and/or face to face meetings. An internal inquiry may also be held.

Ultimately, dissatisfied patients can resort to litigation, although this is rare (fewer than 50 cases a year in the UK); 38% of potential litigation cases are abandoned each year, 43% are settled out of court, and only 4% proceed to court (see the "key points" on the home page of the NHS Litigation Agency, www.nhs.uk/nhsliag/home).

Anyone with a concern about a specific doctor can also complain direct to the General Medical Council. The council will deal with cases where it considers that a doctor has made serious or repeated mistakes; has not examined patients properly or has failed to respond to reasonable requests for treatment; has misused information about patients; has treated patients without consent; has behaved dishonestly; has made sexual advances towards patients; or has misused alcohol or drugs.⁹

How can you prevent complaints from occurring?

To reduce complaints doctors must not only work to reduce adverse events but also strive to improve communication. Complaints about doctors' attitudes fall after doctors attend communication skills workshops,¹⁰ so you should attend all available training courses in communication skills and consider attending commercial courses—for example, in preparation for clinical exams. You can also ask for feedback from colleagues. The Patient Advisory and Liaison Service officer at one local trust had the following advice for medical staff: "If you say you'll get back to someone by the end of the week, then do. Even if you still don't have

This series aims to help junior doctors in their daily tasks and is based on selected topics from the UK core curriculum for foundation years 1 and 2, the first two years after graduation from medical school.

the information they wanted, contact them and explain this. Try to give timescales and stick to them.” Improved written communication may also help: the number of complaints at that trust has not risen since clinic letters have been copied to all patients, contrary to some expectations (personal communication to JC).

When something goes wrong

Patients who have been involved in an adverse incident experience not only the physical effects of the incident but also fear and loss of trust. Doctors should do all they can to reduce this emotional trauma, by apologising for the distress caused (and where appropriate for the error as well), and by being open about exactly what happened.¹¹ If necessary, patients will lodge a formal complaint to obtain information, but patients may forgive medical errors if they are explained promptly, fully, and compassionately. The box gives guidance on effective apologies and on how to act with honesty and sensitivity in a non-confrontational manner¹²; an apology does not represent an admission of liability.¹³

The National Patient Safety Agency (an NHS body set up to identify problems relating to the safety of patients and to find appropriate solutions) has published a policy for adverse healthcare events or outcomes.¹⁴ The agency suggests that if you become aware that a potential incident has been averted—so no harm was caused—there is no requirement to inform the patient (although there may be advantages of doing so). If you become aware of an incident that has led to severe harm or death, you should notify the senior responsible clinician immediately and apologise as soon as possible to the patient and/or the carers. The senior clinician will probably set up a meeting with the patient or the patient’s representative. The National Patient Safety Agency guidelines cover the running of these meetings and the follow-up of such incidents.

What to do when a patient complains

If a patient raises concerns about his or her treatment or care, the correct thing to do is to listen to them, take their concerns seriously, and answer any questions you can. This may provide sufficient reassurance, in which case you should inform the senior responsible clinician and document the discussion in the clinical notes.

If the patient wishes to make a formal complaint, you should advise them to complain to the complaints manager in the relevant NHS trust at the earliest

The anatomy of a complaint. The coloured box indicates the process covered by a trust's formal complaints procedure

opportunity. You can make the referral to the complaints manager on the patient’s behalf, although most complaints managers will wish to avoid any intermediaries, as this can introduce delays. In fact, you may only become aware of a complaint via the complaints manager, who will usually feed back to the relevant team.

Complainants will often be extremely angry as well as experiencing fear and lack of trust. Their anger may focus on individual healthcare practitioners, including you and/or your colleagues. It may help to acknowledge the complainant’s anger and to try to understand the underlying causes, but do not become distracted from treating the complaint seriously. It may also help to be aware of the effect that the complainant’s anger will be having on you. Many doctors take this anger very personally, when often the cause of the anger is the adverse outcome. There may be significant inaccuracies in the complainant’s perception of the situation. Try to be supportive of colleagues if you can.

If you become aware that a patient has made a complaint about you specifically, then the first thing to do is to discuss the situation with a senior colleague or your educational supervisor. You will probably be feeling upset and guilty, and you may become angry or feel disappointed in yourself even if you haven’t done anything wrong: after all, most of us go into medicine to help people, not to make things worse. Other doctors have reported uncertainty about where to go for support in these situations,⁴ and there is no easy answer. Probably your colleagues, including allied health professionals, will be the most helpful. If necessary,

Patients’ expectations of the conduct of the medical professional who is the subject of the complaint (n=424). * Values are percentages of patients

Expectation of what the professional should do	Degree of importance accorded by patients		
	Very important	Important	Not important
Admit a mistake when it has occurred	84	7	2
Explain how the incident could have happened	65	14	9
Offer an apology	41	22	24
Show sympathy for what I went through	38	21	29
Make an effort to recover our relationship	15	17	53

*From Friel et al⁷

staff counselling will almost certainly be available via your occupational health department. An incident such as this may make you question your choice of career.

The table may be a useful aid if you are deciding how to proceed with respect to a complainant. The data are from an account of a survey (by questionnaire) of 424 patients who had initiated complaints in the Netherlands. These data suggest that the most important thing doctors can do is to admit a mistake when it has occurred.

Challenges for the future

Barriers exist to the adoption of the advice in this article about openness and explanation after adverse incidents and complaints. The advice will probably be familiar to most readers but be difficult to follow as a culture of acceptance of criticism is missing among medical professionals.¹⁵ If we are to foster openness and encourage reporting of adverse events, then support and training for doctors must be increased.

This problem may be tackled by exorcising the myth that doctors should be perfect and by emphasising the importance of teamwork. One example is the administration of intrathecal chemotherapy, which now cannot take place unless a qualified pharmacist, nurse, and physician all complete a formal checking process. Important lessons can also be learnt from the airline industry, where deaths fell by 80% when

KEY POINTS

Try to give patients as much information as they want or need to allow them to navigate through the complexities of their illness and the healthcare system

If things go wrong, offer an explanation and a compassionate apology and explain how you will prevent similar incidents in the future

If a patient or relative expresses concerns about the patient's treatment, then listen to them and answer any questions you can. If the complainant decides to make a formal complaint ask them to contact the complaints manager as soon as possible

teamwork training became mandatory and safety procedures were ritualised.¹⁶

The government is working towards streamlining the complaints process both for patients and for doctors.¹⁷ Reducing the blame culture, training doctors in teamwork, and improving the flow of information is the best way to ensure safety for patients and sanity for doctors.

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Principles and skills for an effective apology*

Firstly decide if you are making an expression of consolation or a true apology.

Expression of consolation

An expression of consolation is appropriate after an unfortunate but recognised complication of a procedure—for example, a postoperative haematoma. Use a phrase such as “I am so sorry for what has happened.” It is helpful to empathise (“It looks very swollen. Is it painful to move your arm?”) and to offer any practical support available (“Would you like some stronger painkillers?”), but it is not necessary to accept blame.

True apology

A true apology is necessary when you wish to acknowledge responsibility for an offence and to express remorse—for example, when an incorrect drug dose has been given. The following four step approach is helpful.

- Step 1: Acknowledge the offence and identify the offender(s) and the details and consequences of the offence. Confirm that the offence was unacceptable—for example, “I need to apologise. I prescribed you 10 mg of warfarin last night instead of 1 mg. I am very sorry—this shouldn't have happened. Your blood is a little too thin today. It shouldn't be dangerous because we are monitoring it, but you are going to need extra blood tests and possibly an injection to reverse the warfarin.”
- Step 2: Explain how it happened—for example, “I was in a hurry because there was a patient with chest pain waiting in casualty, and I didn't look up your latest results on the computer.” If you don't know how it happened, say something like, “We are still trying to find out how this happened, and there will be a thorough investigation. As we find things out, so will you.”
- Step 3: Express remorse, shame, humility, and most importantly forbearance (a commitment not to repeat the offence)—for example, “I feel ashamed to have made such a simple mistake. I have learnt my lesson, I won't be prescribing warfarin again without looking up the results first, and I will ask for help if I am feeling overworked.” It may help to empathise with the patient, showing your awareness of how the mistake made he or she feel.
- Step 4: Ensure that amends are made if possible and appropriate.

*Based on Lazare¹²

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