How To Do It

Deal with a complaint by a patient

KATHLEEN M ALLSOPP

A complaint represents a perceived failure of a doctor to deliver the expected standard of care. This may be due to a failure of communication so that the patient's expectations are unrealistic, but a complaint may be indicative of a much more serious problem.

From *How To Do It: 2*, a new collection of useful advice on topics that doctors need to know about but won't find in the medical textbooks. Just published, price £6.95, this is a companion volume to the popular *How To Do It: 1*, also published by the *BMJ*.

Complaint or claim?

A complaint is not a claim but may lead to a claim. A claim that a doctor has been negligent, if substantiated, may lead to the payment of damages. A complaint only leads to the provision of an explanation for the patient. Nevertheless, it is important that even a trivial complaint should be given proper consideration. Advice on the handling of a complaint is always available from a doctor's defence organisation.

When a mishap befalls a patient he or, if appropriate, his relatives should receive a prompt explanation of the incident. The information should be given sympathetically by someone of sufficient seniority to deal with a potentially difficult situation. There is no reason why an apology should not be made. Apologising should not be confused with the admission of legal liability.

Complaints about hospital doctors

A government circular, HC(81)5, gives guidance on which health authorities are advised to base their arrangements for dealing with complaints.

MINOR MATTERS

It is usually best for criticism of such matters as waiting time in outpatient departments or hospital meals to be dealt with immediately. Every effort should be made to allay a patient's concern. Conciliation not confrontation should be the aim, however trivial the criticism.

MORE SERIOUS COMPLAINTS

When a serious complaint is received the consultant should be informed. All complaints should be investigated as promptly as possible. Most complaints concerning doctors relate to the exercise of clinical judgment.

A complaint may centre on a single consultation:

A child of 10 attends an accident and emergency department after a fall. He has cut his hand. On arrival the nurse cleans the wound. A brief history is taken and the senior house officer sutures the cuts. A week later the hand is suppurating and painful. Several large pieces of glass are removed. They came from the window through which the child fell. Subsequently the mother writes to ask why no one listened to the history and why no one took a radiograph.

On receipt of such a letter the consultant needs to ask the senior house officer for his comments. The senior house officer's notes are sketchy. He does not recall anything about a broken window. Now of course he wishes he had asked more. The child was nervous of needles so perhaps on reflection he had not examined the wound carefully enough. It had never occurred to him to have a radiograph taken. He writes down his recollection.

Having sought the senior house officer's comments the consultant needs to draft a response so that the administrator can reply to the complainant. The letter should contain an expression of regret that a complaint has been made. There should then be a factual resumé of what happened and why. In the case outlined above an apology that the glass was not found on the first occasion could be made. The consultant may consider that it would be wise to offer to see the complainant himself for discussion.

In many cases an explanation is all that is needed. If it is both informative and sympathetic the complainant may well be satisfied. The complainant may nevertheless persist with his complaint.

WHEN A COMPLAINT BECOMES A CLAIM

In the relatively simple sequence described above the family may believe that compensation should be payable for the unnecessary second procedure to remove the glass, and for the unsightly scar caused by infection. The doctors should consult their defence organisation if it is not already concerned. What was a complaint has become a potential claim.

SECOND AND THIRD STAGE OF COMPLAINTS PROCEDURE

Some complaints that do not become claims are less straightforward. The patient may have suffered a series of complications related to his condition. It may be difficult for the patient and his relatives to follow the sequence without believing that something must have gone wrong. On such an occasion an explanatory letter may need to be long, and may meet with further dissatisfaction however sympathetically and carefully it is worded. Such a complaint may be regarded as having reached the second stage in accordance with the provisions of the circular HC(81)5. The consultant should inform the regional medical officer so that

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discussion may take place. Sometimes it is still possible that further discussion between consultant and complainant may resolve the issue, but not always.

If the complainant persists, the regional medical officer may use the third stage of the complaints procedure whereby arrangements are made for two independent consultants to see the complainant and the consultant. This is intended for complaints which are said to be substantial but which are not at first sight likely to be the subject of formal legal action.

Complaints about general practitioners

Complaints about general practitioners are made to the family practitioner committee with whom the practitioner is in contract. The regulations for complaints are laid out in a statutory instrument, and strictly the complaint should be limited to allegations of a failure to comply with the terms of service, which are set out in another statutory instrument.

INFORMAL COMPLAINTS

These are complaints which are deemed not to show prima facie evidence of a breach of the terms of service. Many family practitioner committees use a conciliatory process, often in the form of a meeting between the parties with a lay person nominated by the family practitioner committee present. This system may work very well but it is not suitable for serious complaints.

FORMAL COMPLAINTS

For a complaint to be deemed suitable for investigation under the formal regulations there must be allegation of a prima facie breach of the terms of service. Such a complaint must be made within eight weeks.

A patient's wife telephones the doctor at 1 00 am and demands an immediate visit: her husband is unwell. She claims he has pain in his side and his arms, and a cough. The doctor, after questioning the caller, decides that influenza is the likely diagnosis. In any case he knows of old that this particular woman is likely to panic. There is a further call at 6 00 am to say that the man is pale and sweating and losing consciousness. The doctor visits immediately but the patient has already gone to hospital by ambulance.

Some weeks later the administrator of the family practitioner committee sends the doctor a copy of the complaint from the widow. She tells the story of having impressed on the doctor the seriousness of the patient's chest pain increasing over the past six weeks and culminating in crushing chest pain radiating to the throat and down the left arm. The patient's widow is understandably bitter: when they got to hospital the nice young doctor there said that if only the patient had been admitted earlier of course he would have been alive now. Instead he died of a myocardial infarct within hours of admission.

On receipt of the administrator's letter the doctor should acknowledge it promptly promising a detailed reply within the 28 days allowed by the regulations. He may need to consult the patient's records, practice and personal diaries, telephone records, and visit books to check the facts. If a colleague or deputising doctor is involved in the complaint he should be informed. The respondent doctor may also be responsible for the comments from his deputies. The reply should pick out each comment in the complaint and answer it. It is acceptable to start with an expression of regret that a complaint has been made and to offer sympathy to the relatives if there has been a bereavement. It is appropriate to indicate how long the patient has been on the doctor's list and to give a brief outline of the relevant previous history including the rate of surgery attendance. Defamatory or critical remarks about the patient or his family must be avoided. It is important to try to achieve an air of calm authority and concern for the patient's well being.

In the case outlined above it would be important for the doctor to explain how he came to the decision not to visit and confirm that indeed he did put himself in a position to make a reasoned judgment, and that he had impressed upon the wife to call again immediately if there was any change or if she was anxious. However irritating it may be to hear that a junior doctor has been critical the reply to the complaint is not the place to criticise a hospital colleague. With a complaint to the family practitioner committee it is important to remember the question asked is not "Was the doctor negligent?" but "Was he in breach of his terms of service?"

The regulations provide for further exchange of correspondence and the complaint can be concluded after correspondence, but it may go on to an oral hearing at the direction of the chairman of the medical services committee. Doctors may obtain assistance from the defence organisations with both the written response and an oral hearing.

Complaints to the Health Service Commissioner

The function of the Health Service Commissioner is to investigate written complaints from members of the public about the provision of services or maladministration by a health authority.

The commission has powers to examine a health authority's internal papers and this includes the clinical records. A doctor faced with such an investigation would be prudent to take advice before giving a written report or oral evidence.

After investigation a report of the commissioner's findings goes to the complainant and to the health authority.

Complaints arising from private practice

A patient receiving private treatment will normally address his complaints to the practitioner himself. A patient who is declining to pay a bill because of alleged deficiencies in his care presents a difficult problem. To withdraw an account may be interpreted as an admission of fault, to persist after complaint as hardheadededly bluffing it out. Professional help may be advisable. Other complaints should always be answered. It may be appropriate to spend extra time—not necessarily at the patient's expense—to explain or inform.

Complaints to the General Medical Council

The idea of a letter from the General Medical Council strikes terror in most medical hearts. No letter from the GMC indicating that a complaint is being investigated should be regarded lightly. The temptation is to put the letter out of sight, but the proper course of action is to obtain the assistance of the defence organisation immediately; it is not wise to try and deal with such a communication without guidance.

Conclusion

However irritating it is to a doctor to be the subject of a complaint, a patient is entitled to a proper response. A lovable cartoon character is said to believe that a kiss on the nose turneth away much anger, but it would be prudent not to take the advice too literally for fear of complaints of another nature entirely.

Is household bleach safe to use for sterilising baby feeding equipment?

Household bleach has a normal strength of 1 000 000 parts available chlorine per million. We have tested bottles—purchased and hospital stocks. The concentrations varied from 150 000 parts per million to almost none. This is because household bleach is not very stable, particularly after it has been opened. The strength normally used for baby feeding equipment is 120 parts available chlorine per million. Unless the strength could be accurately titrated before dilution there would be a danger that it would be either too low, and therefore inadequate, or too high and potentially toxic. A stabilised product such as Milton or one of the many alternatives on the market intended for this purpose would be safer and more reliable.—B J COLLINS, chief medical laboratory scientific officer, Birmingham.

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