Dealing with clinical complaints

Judith Allsop, Linda Mulcahy

Complaints about the National Health Service (NHS) can be viewed as an irritating intrusion. Existing complaints systems are time consuming and stressful. Complaints cause extra work, may provide no visible reward, and can lead to disciplinary action. At worst, they can lead to protracted court actions for negligence against a trust or health agency. Yet, *Being Heard*, the review of complaints systems in the NHS commissioned by the Department of Health[1]; discussion documents published by the Complaints' Task Force[2]; and a growing body of management literature suggest that complaints can provide opportunities for risk managers and quality managers as well as threats.[3] Moreover, the case for including complaints in risk management programmes has been increased by health service reforms, which have left hospital trusts responsible for financing claims made against them and accountable to purchasers for the way in which they handle complaints. In the United Kingdom the NHS Executive has made reference to complaints as one of several indicators of risk due to adverse events.[4]

Complaints can be used positively in several ways. They can provide an opportunity for providers to see themselves and their service as others see them and to identify the issues which concern users. Most importantly, complaints can allow for rectifying a past mistake and enabling services to be put right for the future. A well handled complaint can increase a patient's trust in doctors, nurses, other healthcare staff, and managers. Finally, complaints can enable the identification of adverse events which might otherwise go undetected, and they act as an early warning system for legal claims. Lessons can be learnt from individual complaints, and – if properly categorised, contextualised, recorded, and analysed – complaints can identify areas for action.

But how far are these messages applicable to dealing with clinical complaints in healthcare settings? Are there aspects of doing clinical work – that is, any expert work on the body – which pose special problems? Even if there are, can clinical complaints be used more effectively for clinical risk management programmes?

This paper begins with a brief discussion of the present complaints system and changes proposed in the Wilson report, which form the basis for the government's response, *Acting on Complaints*.[5] It examines the barriers to effective handling of complaints and what complainants and the organisation want from the system. The final section examines the key factors in developing good practice in handling complaints. The focus is on mechanisms internal to the trust or general practice. Whatever the final shape of guidelines developed by the Department of Health, chief executives, clinicians, and managers will need to develop their own approach. We suggest that this will bring benefits for patient care as well as for risk management.

South Bank University, London SE1 0AA
Judith Allsop, professor of health policy and associate director, Social Sciences Research Centre
Linda Mulcahy, senior research fellow, Social Sciences Research Centre

Correspondence to:
Professor J Allsop, LPSS, South Bank University, 103 Borough Road, London SE1 0AA

Handling complaints: current system

A "complaint" may be taken as an expression of dissatisfaction which can be made orally or in writing. The dissatisfaction may be about the patient's own care or that received by someone else – a relative or a close friend. Two main complaints procedures operate in the NHS, one which relates to hospitals and community services, the other to general practitioners (GPs).

In the hospital sector the Hospital Complaints (Procedure) Act 1985 obliges hospitals to respond to complaints according to a set of national procedures. Overall responsibility for the handling of complaints lies with hospital managers, who are required to arrange for investigation and monitoring. However, an arrangement made between the British Medical Association and the Department of Health allows for complaints about clinical treatment to be referred to the consultant responsible. When complainants are not satisfied with the response received they can ask to meet with the relevant clinician and, at the discretion of the regional director of public health, can have the case referred to a peer review panel, known as an independent professional review. Complainants who are still dissatisfied at this stage may be able to refer the matter to the health service commissioner or the courts.

Complaints about GPs may be made through the Family Health Services Authority (FHSA) which is responsible for administering the contract between the Department of Health and these practitioners. An attempt to resolve complaints may be made through offering the services of a lay conciliator. If complaints suggest a breach in the GPs' contract of employment with the NHS they may be adjudicated by a service committee panel with professional and lay members and a lay chair. In essence, the contract requires the doctor to provide a reasonable standard of care for registered patients at their home or in the surgery, referring them for specialist care if necessary. Complainants dissatisfied with the above procedures may also refer the matter on to the health service commissioner or the courts.

THE INCIDENCE OF COMPLAINTS

The table shows that complaints about health care have been rising; complaints about clinical

Complaints from the public received by statutory bodies, England

	1981–2	*1985–6*	*1991–2*	*1992–3*
Complaints received by Health Service Commissioner*	586	807	972	1041
Complaints regarding conduct of doctors**	646	748	1301	1615
Hospital clinical complaints†	7005	10 014	17 991	20 647
Community	331	1419	1419	1246
	7336	10 624	19 410	21 893
Complaints about general medical services††	706	1287	1608	1891

*Health service commissioner's annual reports.
**General Medical Council's annual reports.
†*NHS Complaints Review (1994):* appendix and written complaints by or on behalf of patients, England: financial year 1992–3, Department of Health.
††NHS Executive.

care have risen faster than those about non-clinical matters. Medicolegal claims are also increasing. Payments to victims of medical negligence have risen by a staggering 56% in the past two years and are currently costing the NHS £125m.[6]

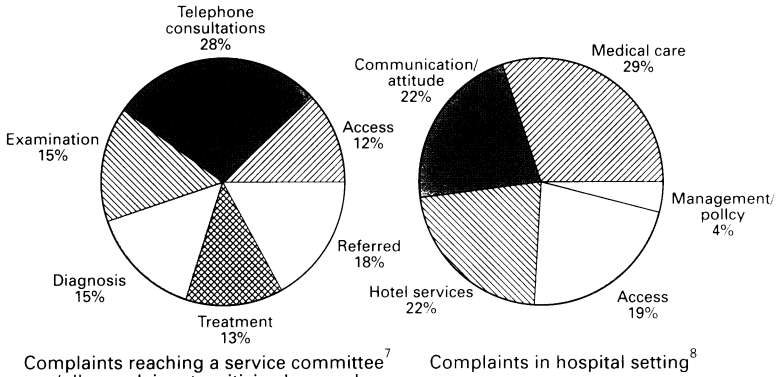
The subject of complaints varies according to the service being complained about and the jurisdiction of the particular system. The figure shows the allegations made in three studies of complaints in healthcare settings.[7–9]

NEED FOR CHANGE

During the 1990s criticisms of existing complaints procedures mounted, and in 1993 the Wilson committee was set up to review current arrangements. Reporting in 1994, it proposed a simplified two stage structure for trusts and general practices. At stage one, complaints could be handled in several ways – informally by front line staff or, if the complainant remained dissatisfied, by a complaints officer, manager or senior clinician, and, finally, the chief executive. Conciliators could also be asked to mediate in certain cases. The committee was not prescriptive about the structure to be adopted but emphasised the importance of listening, investigating, and resolving the complaint to the satisfaction of the complainant. It suggested that responsibility for all complaints, including those relating to clinical matters, should rest with management. To encourage an ethos that did not apportion blame the committee recommended that disciplinary action should be separated from complaints procedures. A second stage was proposed for complainants who remained dissatisfied, whereby a panel with a lay chair and a majority of lay members could be set up to review the complaint afresh.

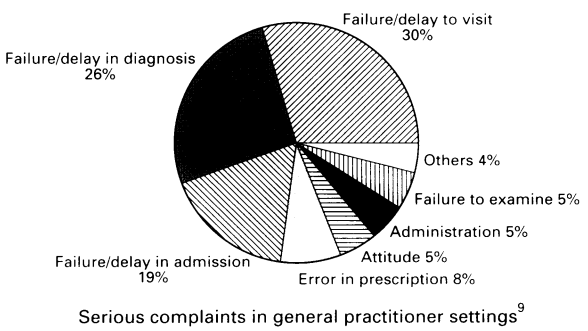
Although the Department of Health's proposals have not yet been implemented, many trusts and general practices have begun to develop new systems. It is in their interest to do so. The case is increasingly strong for identifying and dealing with dissatisfaction early in order to prevent complaints escalating. The resources needed to handle complaints formally are high, although the exact costs have proved difficult to calculate.[1] Even if complaints do not proceed to litigation – and very few do – the costs of investigations and meetings in terms of time and staff can be considerable. In FHSAs, where formal procedures involve lay panels, one study showed that complaints can take on average between 18 months to two years from the receipt of the complaint to a service committee decision.[7] Independent professional reviews may take even longer.[7 10]

The 1990 health service reforms in the UK brought further incentives for change. Trusts and general practices now have greater financial autonomy and more competition exists between them. Additionally, the loss of crown indemnity has made trusts financially responsible for meeting the costs of legal claims. Maintaining good standards of care and managing risk more efficiently is therefore even more important. Finally, the government's citizen's charter initiative has led to widespread discussion of the use of complaints throughout the public sector. In 1993 the Complaints Task Force, set up by the Charter Unit, published a list of principles to guide the operation of complaints systems (box).[11]



Complaints reaching a service committee[7] (all complainants criticised general practitioners' attitude)

Complaints in hospital setting[8]



Serious complaints in general practitioner settings[9]

Substance of complaints: findings of three studies

Principles for operating complaints systems

Complaints systems should:

Be easily *accessible* and well publicised

Be *simple* to understand and use

Allow *speedy* handling, with established time limits for action, and keep people informed of progress

Ensure a full and *fair* investigation

Respect people's desire for *confidentiality*

Address all the points at issue and provide an *effective* response and appropriate redress

Provide *information* to management so that services can be improved

Barriers to effective handling of complaints

To be sure they are providing good care, health providers need to know what patients and their relatives think of services and, particularly, what causes dissatisfaction and can lead to complaints. Patients and their relatives have a unique view of their medical care. For example, only they may know the intensity of a pain or that there is a mistake in a prescription. Yet there are several barriers to people expressing their concerns. The Wilson committee commented: "Complainants can face an uphill struggle when using NHS complaints procedures. Firstly, in making their views known and, secondly, in receiving the sort of response they would wish for."[1]

WHY PEOPLE DON'T COMPLAIN

Despite the rising incidence of complaints much of the dissatisfaction experienced does not result in a complaint because the level of knowledge of how to complain remains low[12] and people find the various systems confusing. The Wilson committee identified at least nine separate procedures for handling complaints in the NHS. In a study of 1640 householders by Mulcahy and Tritter in 1993, 60% of those who said they were dissatisfied did not discuss their dissatisfaction outside their immediate network of family and friends, and 18% of these blamed their failure to complain on a lack of knowledge.[13] Low expectations, feelings of gratitude, fear of retribution, and deference to health professionals also cause dissatisfaction to remain unvoiced; however, personal circumstances, life events at the time, and general attitudes were also given as reasons for not taking the matter further. The box below gives examples of people's reasons for not complaining despite being dissatisfied.

Reasons for non-complaint*

My mother did not want me to complain because she felt that she would be victimised and it would affect her treatment

If you take them on, you may suddenly find you cannot get a doctor locally

I don't see any point. You'll never prove anything against doctors. They just club together. I just moan

When I came out [of hospital] I was glad to be alive. It seemed trivial. It was just a relief I hadn't got cancer, I thought that was enough

I just thought I'd try to keep clear of NHS people – I dreaded the fact I may get old and may have to use them more frequently

I'm afraid of making a fool of myself

And you're not going to complain about the nurses because you know they're under pressure

*Quotations taken from the following:
L Mulcahy, J Tritter, Dissatisfaction, Grievances and Complaints in the NHS, a report to the Department of Health, 1993.
J Allsop, *et al*, High Hopes, Complaints and Charters, report for North West Thames Regional Health Authority, 1993.

COMPLAINANT'S VIEWS OF COMPLAINTS PROCESS

If people do decide to raise their concerns research suggests that staff are not always willing or able to help them and that people often feel "fobbed off."[14] Some who want to make complaints over the telephone report a lack of response and follow up to their calls. Indeed, some trusts will not accept complaints over the telephone. Written responses can also fail to satisfy a complainant. Here there are several common concerns. Letters of reply are too brusque and impersonal; the process is too slow; people are not kept informed of progress and when an investigation does take place and the complainant receives a response he or she may feel this is inadequate. All these factors can increase the anger and frustration of a dissatisfied person. In certain cases it may harden the complainant's resolve to pursue the complaint and change what he or she wants as an outcome. The box gives some examples of complainants' comments about the complaints process.

What is wrong with complaints process*

Difficulty in getting information about how to complain

A lot of people in the public service are not trained to deal with the public. You have to say things in a calm manner and try to calm the person down. It is the front line staff who should be most helpful. They should be able to tell you who to complain to in writing, or give you the address, to save you going to someone else which gets you more irate

Difficulty in making complaints over the telephone

"We'll look into it." Then you ring again and hear the same thing

Lack of personal response

Instead of a written letter you get something duplicated. It's senseless

Length of time taken to respond initially

They could give a time even if it's on a postcard saying we will deal with this in one month, that would keep you going

If people keep you informed, that's fine: it means that people are listening to you

I think the thing should be speeded up ... if you can do it when its fresh in your mind, you might get upset about it, but its clean and fresh ... if it's looming in the background, you've got to start reliving it again. It stops you grieving

Length of time to investigate and report back

The main problem was the length of time it all took ... [to about what anaesthetics were used]. The actual date I received that information was the 6 August, which seemed a very long time indeed, from May until August, just to find out what to me seem the answers to an easy question

Inadequate responses

What shook me most of all, by the sort of terseness of the reply ... I suppose I wanted to feel a sense of apology and I didn't get it

*Quotations taken from the following:
J Allsop, *et al*, High Hopes, Complaints and Charters, report for North West Thames Regional Health Authority, 1993.
Market Opinion and Research Institute.[14]

RESPONSES OF THOSE HANDLING COMPLAINTS: ATTITUDINAL AND ORGANISATIONAL BARRIERS TO LEARNING

The survey by Mulcahy and Tritter found that when people did voice a complaint, it tended to be to the person they held to be responsible for their care – that is, doctors and nurses.[13] This suggests that clinicians' responses are critical in the process of establishing the nature of, and responding to, the grievance. Despite this, a recent Market Opinion and Research Institute (MORI) survey of public attitudes to complaints systems indicated that many NHS users perceived medical staff to be hostile to complaints and to fear recrimination.[14]

It is in the interest of patients, hospitals, and GPs to create an ethos in which dissatisfactions can be raised. If a complaint is made then it should be dealt with efficiently and fairly. The case study (box) illustrates concerns which were not adequately addressed at the time. A complaint was made, but matters were not finally resolved until nine months later.

Case study

A 48 year old woman had a hysterectomy but subsequently experienced two adverse events. A student nurse cut a vein when removing a catheter, which caused heavy bleeding. The vein was stitched but there was a setback in her recovery. Two days later, a heavy metal box placed on a side cupboard had fallen; in avoiding it, the patient had moved quickly, pulling on the wound. The events caused considerable distress to the patient and her relatives. At the time they were not acknowledged by the staff, let alone discussed with the patient. Indeed, her daughter later said: "the staff involved stayed away from mum ... and she said there was a lack of eye contact and they weren't dealing with it any more."

On discharge, the patient was very weak, and months afterwards she had failed to recover. She had a deep pain in her side and could walk only slowly with the aid of a stick. She could not take paid work. Her daughter, who lived with her, was distressed with her poor health, blamed the hospital but did not know what to do about it. They found the GP unhelpful and unwilling to arrange a further appointment. Eventually, an appointment was made for a hospital check up eight months ahead.

The patient's daughter became unemployed and also became increasingly depressed. She blamed herself for not being able to pay for better care for her monther. Months after her mother's discharge, on a visit to the town hall, she began talking to a woman at a health stall about her mother and said that she had wished to complain. She was given the address of the Community Health Council, which gave her support. An exchange of letters with the hospital ensued. Eventually, at an interview with a senior consultant the patient and her daughter related the events. The consultant had no idea what had occurred. As the incidents had not been recorded at the time the investigation was considerably prolonged. However, a resolution was finally reached. The hospital appointment was brought forward and physiotherapy offered.

From J Allsop, *et al*, High Hopes, Complaints and Charters, report for North West Thames Regional Health Authority, 1993.

Health professionals are commonly perceived to be defensive. This may arise from the uncertainties of medical knowledge and the uncertainties of the course of an illness for a particular person. Yet, having made a decision, a clinician must proceed with certainty, on the basis of probabilities. Adverse outcomes are endemic. Also, a gap may exist between what is theoretically possible in terms of treatment, given ample resources, and what is possible in the circumstances.

If complaints about clinical care are taken as an attack on the professional judgement and the personal integrity of a clinician then it is not surprising that strong feelings are aroused. As a consequence, defensive strategies, such as denial or even a counter attack, may be adopted, rather than a more detached attempt to discover the complainant's problem. Another reason for defensiveness is the costs to the person concerned if a complaint escalates. This may lead to inquiries by senior colleagues and the possibility of disciplinary action, both of which threaten reputation, promotion, and livelihood. However, although it is important to understand the reasons for these responses, they cannot justify overtly defensive reactions to complaints.[15]

Negative responses tend to exacerbate complaints rather than resolve them. One study of GPs showed that if after a complaint a GP removed a patient from the practice list, showed a lack of sympathy, or was hostile, or failed to address the issues raised, these then became issues in the dispute.[7] Similarly, an analysis of letters of response to hospital complaints showed that incomplete explanations, dismissive letters, "pseudo-apologies," technical language, and defensive responses played a part in hardening the complainants' attitudes.[16] The length of time taken to deal with a complaint, a lack of openness and not informing the complainant of progress, and an unwillingness to take action when incompetence has been disclosed can also induce disillusionment and a determination to pursue the complaint.[7]

MANAGERIAL RESPONSES TO COMPLAINTS

The responses of managers to complaints can also be unsatisfactory. Mulcahy and Lloyd-Bostock found that in some trusts managers tended to act merely as clinicians' agents whereas in others they failed to involve clinicians at all.[17] Sometimes, although they began an inquiry process, managers did not undertake a systematic investigation but simply copied the complainant's letter to the people concerned and asked for a response. In other instances, little attempt was made to translate technical or defensive material taken from medical statements into simpler language. Significantly, investigating officers did not always ask the complainant for additional details of their criticisms, despite the fact that many accounts were insufficiently detailed to be useful for either investigation or risk management.

DESIRED OUTCOMES OF COMPLAINTS

Failure to respond to peoples' expectations when they complain brings with it the risk of continuing dissatisfaction. Studies suggest a variety of motives for complaining. A complaint may be an end in itself, or complainants may want an apology or an answer to a question. Many complainants say they want to prevent a recurrence of an event for the sake of others. They may want a decision or procedure reversed; something done more quickly; a loss made good or something put right; a waiver or reduction in a fee; the payment of monies due; the restoration of possessions; or remedial treatment. A few want compensation or someone punished.[7 15 18 19] Particularly if something has gone wrong, many patients and families want a full and clear explanation. Vincent *et al* showed that in surgical accidents poor communication about what went on may increase distress.[20] If several agencies and people are involved in care, no single person may have responsibility for giving information in a way which is understood to the lay person. The box illustrates what people interviewed in the course of these research studies wanted.

What people want to happen as a result of complaining*

An apology
There is a lack of being able to say I'm sorry, we've done it wrong, we will get it right next time

An explanation or answer to a question
First of all I wanted answers to questions concerning things going wrong. Up to this point there seemed to be nothing in the way of information coming forward

Accountability
I wanted some form of justice that this sort of man can't treat people like that ... some form of authority should know how he behaved and stop him behaving like that in the future

Prevention of the same thing in others
Because you should not let anyone be in such pain ... Because I don't know how many people before this has happened to and nobody has done anything about it. That's why I decided to complain

Immediate or additional treatment or an admission of error, or both
I wanted some form of physiotherapy and I wanted her to be thoroughly checked and most of all I wanted them to admit that, yes, that something had gone wrong on their side

Punishment for the person responsible
I wanted him struck off

Something to change as a result of the complaint
If something is wrong then you want to complain about it, and if they get more complaints then they might do something about it

*Quotations taken from the following:
J Allsop, *et al*, High Hopes, Complaints and Charters, report for North West Thames Regional Health Authority, 1993.
Market Opinion and Research Institute.[14]

Verifying the accounts may be necessary in order to give a full explanation. An investigation may suggest that there is a difference between a complainant's account and the information collected from those concerned with the patient's care. In this case a meeting is advisable, at the patient's home or at another neutral place or at the hospital or surgery, in an attempt to clarify issues further. In their interviews with complainants Mulcahy and Lloyd-Bostock found that the criticisms people made in conversation were sometimes appreciably different from those they had made in writing. When this happened more serious allegations of clinical mismanagement were made at interview. This may be due to the difficulties which lay people have in expressing their real concerns in writing.

COMPLAINTS AND FEEDBACK

We have argued above that lessons can be learnt from complaints, but in order to do so, the limitations must also be recognised. Identifying the aspects of complaints which are of use for quality and risk management is not always straightforward.[21]

Firstly, the relationship between dissatisfaction, making a complaint, and adverse events is complex. Adverse events that occur may never become the basis for a complaint either because the patient or carer is unaware of them or because they have been explained by staff and are not considered "complaint worthy." The Harvard study of medical records showed that there were more adverse events than were ever reported through complaints or claims.[22] Conversely, claims were made when no adverse event had occurred.

Secondly, complaints tend to arise in a particular context which needs to be analysed and understood to be useful for risk managers and quality managers. They can provide useful and unique pointers to problems as perceived by patients and their carers. However, the complexity of delivery systems; the variety of tasks to be accomplished for a single patient; the number of care givers involved and their inter-relationships need to be carefully traced. Studies of adverse events show that these are rarely a "one off" event but the result of several small errors by various people.[20] In GP settings complaints were less commonly about a single event and more often arose in the course of several interactions during an episode of longer illness.[7] When there are changes in patterns of healthcare delivery or resources are scarce there may be an absence of clear lines of responsibility, which obstructs good patient care.

Thirdly, both Allsop and Lloyd-Bostock concluded that complaints often tend to be embedded in a narrative account which may contain much information which is not strictly relevant to the healthcare provider.[7 16] Typically, several allegations are made, which relate to both past experiences as well as present care. Accounts tend to focus on the behaviour of healthcare staff and on the outcomes of illness episodes. Moreover, the strength of the emotions felt may get in the way of a precise "naming" of a grievance unless

complainants have had help in talking through their complaint. As lay people, patients and their carers see events from a particular perspective. They may not know precisely what has gone wrong. They tend to have an incomplete picture of certain aspects of care. If they are the patient, they may not be aware of all the stages of treatment. If they are the carer, they may not have been present at all. We do not suggest that this limits the value of cases, but rather it indicates that those investigating should aim to clarify the complainants' account.

Fourthly, the issue of who has ownership of the grievance is also more complex than it might seem. In healthcare settings a significant proportion of complaints, particularly about clinical care, are made not by patients but by family members.[7 16 18] They may be expressing their own dissatisfaction as well as acting on behalf of a patient for whom they have a caring responsibility. Those dealing with clinical complaints need to be sensitive to the fact that criticisms about care do not always come from patients themselves and they should tailor their investigations accordingly. Letters of response should also be written with this in mind, and meetings should offer to include family members or others.

SUMMARY

In summary, the way complaints are handled under current NHS procedures has several weaknesses which stem from the nature of complaints; the ambiguities about what they represent; a lack of knowledge about the dynamics of complaints on the part of managers and clinicians; a lack of skill in investigating complaints; and, for the purposes of risk management, the absence of methods for recording, categorising, and analysing complaints so that they can identify user concerns and predict areas of risk. Ideally, to be of use to the organisation, dissatisfactions and complaints need to be noted, recorded, and investigated thoroughly. The outcomes of investigations and feedback are important not only for patients in resolving a complaint for them but also for staff and the organisation concerned.

Key aspects of handling complaints effectively

There are several ways in which effective handling of complaints can be achieved and can contribute to risk management programmes, depending on the ethos of the trust or general practice. Central to this is accepting that complaints reflect users' views, but a low level of complaints does not necessarily indicate good care nor a high level, poor care.

ATTITUDE AND MOTIVATION: A POSITIVE APPROACH

Taking complaints seriously is more critical than having particular structural arrangements. A coherent corporate approach should be developed and the complaints system assessed against three evaluation criteria. Does the system promote good practice and deter poor practice? Are those who use it satisfied? Can the insights gained be used for feedback? The interest, commitment, and cooperation of the chief executive and those in clinical leadership positions is essential to any programme.

Developing a coherent corporate approach

- An ethos of taking complaints seriously
- Commitment of senior managers and clinicians to a multidisciplinary approach
- Clear delineation of staff responsibilities
- Standards for processing and recording complaints
- Assessment of the complaints system against evaluation criteria

Paradoxically, when there is a strong lead from the centre front line staff initially receiving the complaints are able to take responsibility for trying to resolve problems as they arise and exploring what the complaint is about. Given that complaints typically entail a chain of events and several people from different specialties, this requires trust and cooperation between colleagues, which is characteristic of well functioning cross disciplinary teams. The circumstances in which complaints should be referred on for further investigation should be made clear.

WELCOMING COMMENTS AND COMPLAINTS

Patients have made several suggestions about how complaints procedures could be improved; the box opposite illustrates some of these.

Training, support, and publicity

- Staff knowledgeable about complaints systems
- Procedures publicised
- Training for front line staff
- Ease of access to information
- Sensitivity to the needs of minority groups
- Support for complainants

Because a complaint may be made to anyone within a hospital or community trust it is important that everyone knows about the complaints system and is able to give inquirers the name of a contact person or a contact number. Leaflets with this information should be widely displayed. Nurses, receptionists, hospital volunteers, and others in daily contact with patients should have priority for receiving suitable training. Details of how to make a complaint should be part of standard patient information packs and made available to hospital outpatients as well as inpatients. Information about the trust, including its complaints system, should also be made widely available through the community health council, GP surgeries, and other local organisations. Some hospitals use the local press and radio for this purpose.

Research suggests that many people like to convey their dissatisfaction by telephone and indeed some hospitals have freephone lines for complaints. However, take up varies widely, for unknown reasons. Chief executives may need

Patients' suggestions for improvements to complaints procedures*

Some sort of advertising like leaflets: if you can see a sign saying complaints department, you will go there. You don't need anyone else to tell you

They could put up a sticker, saying: complaints, contact such and such

The person you contact should deal with your problem all the way through

*Quotations taken from the following:
J Allsop, *et al*, High Hopes, Complaints and Charters, report for North West Thames Regional Health Authority, 1993.
Market Opinion and Research Institute.[14]

to encourage experimentation to find the right approach for their community. In a large hospital calls may come in at several points, and if the response to the caller is inappropriate or callers are referred repeatedly this can add to anger and frustration. One patient commented: "They say he's tied up, they keep saying that. I say, will you untie him please and bring him to the phone."[14] However, not all callers are so assertive, and for some the cost of "hanging on" is prohibitive.

Lessons can also be learnt from comments about what people see as good practice. When asked about the experience of a service committee procedure, one complainant commented: "I can quite honestly say, having gone right the way through from beginning to end, that I can't think of any way it could be improved. They responded immediately. I remember that day I left a call for X and immediately they gave me the right number to call and he called back in 20 minutes. People had enough time to listen and that helped enormously ... but I think it [the complaints procedure] should be better known."*

In relation to access, the question of whether special efforts should be made to reach particular groups in the population is important. Although systematic evidence is lacking, qualitative research suggests that people in certain social positions – for example, those with a low income or from certain ethnic minority groups and some elderly people feel themselves to be in a weak position in making a complaint. There are also groups whose expectations of services are low. Again, there is some evidence that members of ethnic minorities are reluctant to complain.[14] Health providers can help through translating leaflets into languages relevant to their local community. They should be able to tell people where to get support, to provide help to those making complaints, and to be sensitive to the differing expectations of patients.

*Quotations taken from the following:
L Mulcahy, J Tritter, Dissatisfaction, Grievances and Complaints in the NHS, a report to the Department of Health, 1993.
J Allsop, *et al*, High Hopes, Complaints and Charters, report for North West Thames Regional Health Authority, 1993.
Market Opinion and Research Institute.[14]

Once someone has decided to complain, he or she may need support to continue. Some hospitals have funded a patient's advocate post, which can also be used as a first point of access. Other trusts and general practices have found it helpful to consult with user groups about how their handling of complaints is perceived and to survey complainants. Pietroni and Uray-Ura described the establishment of a user group in their general practice and its use in dealing with complaints.[23]

ELICITING COMMENTS, LISTENING, AND INVESTIGATION

Some trusts and general practices have found eliciting comments helpful as a way of identifying and dealing with problems early. This may be done spontaneously as part of patient care. For example, in one trust, a sister in the eye clinic routinely asked patients how long they had been waiting. Patients were given the option of continuing to wait or of seeing another doctor. Patient's advocates may also help in finding out patients' views.[24]

Once a complaint has been made, the likelihood of resolution is greater if it can be dealt with at the time by the person receiving the complaint. This means making sure that he or she understands what the complaint is about and what the concerns of the complainant are. As indicated above, this may not be straightforward. It may be necessary to inquire into the circumstances which gave rise to the complaint or to refer the complaint to a senior clinician, a manager, or a complaints' officer. It is important to inform the complainant of what has been done and what the next steps are.

Responsive handlers of complaints should:

- Elicit comments
- Understand what a complaint is about
- Find out what the complainant wants
- Be investigative not adversarial
- Acknowledge the complainant's feelings
- Address *all* concerns
- Act on the issues raised

Perhaps the most crucial skills are listening to what the complainant has to say, clarifying the issues, finding out what the person wants, and attempting to find a solution. In healthcare settings complainants lack knowledge and, above all, may fear a rebuff. They may find it difficult to raise their concerns; they often feel frightened and unwell and do not know what to expect. If all staff members are to respond appropriately then training is essential. Some trusts have introduced focus group discussions which involve patients or user groups, or both, in training sessions. In this way, the staff of the trusts are able to see themselves as others see them. Ideally, the informal complaints made to first line staff should be recorded or reported so that they can be used for feedback and to identify trends in a way which fits with work routines, such as at a weekly staff meeting, a case conference, or in the notes made when shifts change.

For some complaints a fuller investigation will be necessary. This should involve a senior clinician or a complaints' officer, or both. Those undertaking investigations should be trained and follow similar procedures. The objective should be seen as establishing what happened rather than attributing fault. An offer to meet at the complainant's home or another location of his or her choice may be helpful. The box shows the general principles of investigation.

Principles of investigation

The person investigating should:

- Not have a direct interest in the complaint
- Keep notes on the information collected and from whom
- Identify conflicts in accounts and attempt to resolve them, if this is not possible, stating why not
- Be open about the information collected and what has been said
- Reach a view and have reasons for that view
- Report the findings to a senior person who is responsible for action

Responses to complaints, whatever form they take, should recognise the complainant's concerns and outline the process of any investigation, the main findings, what action has been taken, and what further steps will be taken. For example, a letter might begin by acknowledging the complainant's feelings by saying: "I was very sorry to hear of the unhappiness caused when. ..." It should then address *all* the issues raised by the complainant. In some trusts the standard practice is to thank the person for bringing matters to light and to say what lessons have been learnt and what changes will be made as a result of the complaint. This type of response acknowledges that many people find it difficult to complain and do so because they want to improve the service for others.

Most trusts have a specialised complaints department. This can set standards for handling complaints – for procedures, time limits, data collection, and analysis of complaints – and carry out surveys to assess satisfaction with process. Some trusts have found it useful to set up audits of complaint procedures which involve user groups. In one trust, for example, response letters are discussed with the Community Health Council and other user groups.

If complaints are to be encouraged then it is important for team leaders to support staff who raise issues and who have tried to resolve complaints. It is also essential not to attribute blame before investigation. If people have made mistakes accident analysis suggests that these are rarely due to a single event. In most situations joint responsibility should be assumed. The tension between supporting staff when an honest error has occurred and dealing with poor performance and incompetence is a challenge for leaders in all organisations. Occasionally action must be taken in the interests of the service as a whole, but only after a full inquiry.

OUTCOMES OF COMPLAINTS

The outcome of complaints can be seen at two levels, firstly, for the complainant and, secondly, for the organisation. Firstly, if investigations show that things have gone wrong some form of redress may be needed. The general purpose of redress is to put things right if possible. It can also reinforce an entitlement to a service or can be used to restore a person to the position he or she would have been had the problem not arisen. It may also compensate people for inconvenience or suffering. As mentioned, complainants may have various concerns, and each should be identified and responded to. Secondly, for an organisation to learn from complaints there should be clear leadership from senior management. This means not only having systems in place to set standards and check on their maintenance but also encouraging an ethos of reflection on the results of investigations. In 1995 the Health Service Commissioner commented on the lack of learning from complaints, that he was "...getting rather fed up with seeing the same mistakes made again and again and the trend of handling local complaints getting worse."[25] Ultimately, it is the responsibility of the chief executive to see that this does not occur.

Conclusion

We have argued that dealing with clinical complaints in an open and sympathetic way is part of good patient care. It is also part of risk management. Through reflecting on individual complaints, health providers can see their service as patients and their carers see it. If something untoward has occurred there is a chance to reflect on the chain of events which led to that poor care and to take the necessary action to address problem areas. Because the frequency with which untoward events occur is also significant, it is necessary to look at trends over time to identify where a more detailed review may be necessary. The Wilson committee and the governments response set the framework for change; implementation of the recommendations will depend on the commitment of individual clinicians and managers. A positive response could lead to stronger partnership between patients, their carers, and health providers. Not only will Chief executives need to set up new systems they will also need to evaluate their implementation.

1 NHS Executive. *Being heard – report of the Review Committee on NHS Complaints Procedures*. Leeds: NHSE, 1994.
2 Complaints Task Force. *Access, Speed and simplicity, Fairness, Information, Attitude and motivation, Redress*. London: HMSO, 1994. (Discussion papers, 1–6.)
3 Seelos L, Adamson C. Redefining NHS complaint handling – the real challenge. *International Journal of Health Care Quality Assurance*, 1994;7:26–31.
4 NHS Executive. *Risk management in the NHS*. London: Department of Health, 1994.
5 Department of Health. *Acting on complaints: the government's proposals*. London: DOH, 1995.
6 House of Commons, Parliamentary Answers, 7 March 1995. Reported in *Guardian*, 8 March, 1995.
7 Allsop J. Two sides to every story: complainants' and doctors' perspectives in disputes about medical care in a general practice setting. *Law and Policy* 1994;**16**: 149–84.

8 Owen C. Formal complaints against general practitioners: a study of a thousand cases. *Br J Gen Practice* 1991; **41**:113–5.
9 Lloyd-Bostock S, Mulcahy L. The social psychology of making and responding to hospital complaints: an account model of complaint processes. *Law and Policy* 1994;**16**:123–47.
10 Donaldson L, Cavanagh J. Clinical complaints and their handling: a time for a change. *Quality in Health Care* 1992;**1**:21–5.
11 Complaints Task Force. *Effective complaint handling: principles and check list.* London: Citizen's Charter Unit, HMSO, 1993.
12 Prescott Clarke P, Brooks T, Machray C. *Focus on health care: surveying the public in four health districts.* Vol 1. London: Social and Community Planning Research and Royal Institute of Public Administration, 1988.
13 Mulcahy L, Tritter J. Hidden Depths. *Health Services Journal* 1994;Jul:24–6.
14 MORI. *Attitudes towards, and experience of, complaints systems.* London: MORI, 1994. (Research conducted for the Citizen's Charter Complaints Task Force.)
15 Donaldson L. Doctors with problems in the NHS workforce. *BMJ* 1994;**308**:1277–82.
16 Lloyd-Bostock S. Attributions of cause and responsibility as social phenomena. In: Jaspars LJ, Fincham LF, Hewstone LM, eds. *Attribution theory and research: conceptual developmental and social dimensions.* New York: Academic Press, 1993:261–90.
17 Mulcahy L, Lloyd-Bostock S. Managers as third party dispute handlers in complaints about hospitals. *Law and Policy* 1994;**16**:185–208.
18 Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. *Lancet* 1994;**343**:1609–13.
19 Bark P, Vincent C, Jones A, Savory J. Clinical complaints: a means to improving the quality of care. *Quality in Health Care* 1994;**3**:123–32.
20 Vincent CA, Pincus T, Scurr JH. Patients' experience of surgical accidents. *Quality in Health Care* 1993;**2**: 77–82.
21 Mulcahy L, Lloyd-Bostock S. Complaining – what's the use. In: Dingwall R, Fenn P, eds. *Quality and regulation in health care.* London: Routledge, 1992:51–68.
22 Brennan TA, Leape LL, Laird NM, Hebert L, Localio AR, Hawthers AR, *et al.* Incidence of adverse events and negligence in hospitalised patients: the results of the Harvard medical practice study. 1. *N Engl J Med* 1991;**324**:370–6.
23 Pietroni P, de Uray-Ura. Informal complaints procedure in general practice: first year's experience. *BMJ* 1994;**308**: 1546–8.
24 Audit Commission. *What seems to be the matter: communication between doctors and patients.* London: HMSO, 1993.
25 Select Committee on the Parliamentary Commissioner for Administration. *6th Report 1994/5 session.* London: HMSO, 1994.