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Learning from complaints about general practitioners

Clinical governance means handling complaints better—for both parties

General practice
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Those who worry about improving quality claim that "every defect is a treasure," but for the patient who is the victim defects can be disasters, not treasures. Patients who experience defects in care therefore need a complaints system that allows them to express their concerns, undertakes an investigation, provides an appropriate apology, and takes action to reduce the risk of harm to other patients. If such a complaints system is also to provide a supportive environment to doctors who are the subject of complaints it needs to be part of a wider set of systems that are concerned with improving quality overall.

Dissatisfaction with the previous system of handling complaints in the NHS led to the introduction of a new system in April 1996.[1] Since then the complaints system has been separated from disciplinary procedures, and the new system for general practice divided into three levels. At the first level practices are required to have practice based complaints systems organised to comply with national criteria. The second level involves arrangements for health authorities to undertake independent review of complaints that are not resolved satisfactorily by the practice based procedure. At the third level, complaints still not resolved are referred to the health service commissioner (ombudsman), who was also given new powers to consider clinical matters.

The commissioner's annual report for 1997-98 provides some preliminary information about the impact of the new complaints procedure in general practice,[2] although a complete judgment of the success of the scheme will have to await the findings of detailed research. In 1997-98 there were 38 093 written complaints received about general medical and dental services and family health services administration in England, but only 331 complaints were referred to an independent review panel.[3] During the year 27 investigations into complaints about general practitioners were begun by the commissioner, and in reviewing these cases the commissioner noted the readiness of some general practitioners to remove patients from their registered lists once a complaint had been made.

In this week's issue Jain and Ogden show how general practitioners receiving a complaint can find the experience devastating (p 1596).[4] In some cases punishment may be the necessary response to a practitioner's failure of care, but for most general practitioners who receive a complaint the experience appears to be a punishment in itself, regardless of the eventual decision after review of the complaint.

If the number of complaints is to be reduced, it will be necessary to do more than intimidate those general practitioners who make mistakes. They will need help in confronting their failure and correcting any deficiencies in their skills or attitudes. They will also need support to avoid depression or disillusionment with general practice as a career. The systems that contributed to or did not prevent the defect in care will also need to be corrected.[5] Such systems might involve almost any activity of the practice or primary care group, including, for example, protocols of care, routine patterns of work, allocation of staff, or routes of communication.

If the failures of people and systems are to be corrected, a complaints system alone will not be sufficient. From April 1999 clinical governance was introduced to account for and improve the quality of care in the NHS, and complaints systems have been classified as only one component of clinical governance.[6] If complaints systems are linked to other strategies for improving the quality of care—such as continuing professional development, audit, risk management, and critical incident reporting—the possibility of learning from complaints and reducing the number of failures in care will be increased.

However, although this is an advance, it will still not be enough. If practices and primary care groups are to support practitioners who receive a complaint, rebuild systems of work that are failing, and at the same time respond openly and honestly to complainants then clinical governance must become more than a list of loosely related activities. Effective clinical governance also demands a transformed culture.[7]

In primary care groups that have undergone this transformation the various activities of clinical governance will have become integrated with the general management of the primary care group. Concern about the quality of care will be the driving force that determines the short and long term objectives of the group, and patients' experiences of care will have a leading role in defining quality. But practitioners who listen are essential if the group or practice is to understand fully patients' experiences.

Therefore, one element of the new culture is the high value placed on practitioners. They should know that they are part of a health service that values them and operates systems that help them avoid failures in care. Should a failure occur, the service will not shun

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them but will help them cope with a complaint. In consequence, they and the practice or group will be able to continue to listen to the complaining patient or relative, rather than become defensive and allow communication to break down. Even then, a defect will not be a treasure, but if defects have become less common, they may have some rarity value.

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2 Health Services Commissioner. *Annual report 1997-98*. London: Department of Health, 1999.
3 Government Statistical Service. *Handling complaints: monitoring the NHS complaints procedure, England, Financial Year 1997-98*. London: Department of Health, 1998.
4 Jain A, Ogden J. A qualitative study of general practitioners' experiences of a patient complaint. *BMJ* 1999;318:1596-9.
5 Berwick D. Heal thyself or heal thy system: can doctors help to improve medical care? *Quality in Health Care* 1992;1 (suppl):s2-8.
6 Baker R, Lakhani M, Fraser R, Cheater F. A model of clinical governance in primary care groups. *BMJ* 1999;318:779-83.
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Free the slaves

Debt relief for the world's poorest is feasible but may not happen

For the world's poorest countries debt burden is "the new slavery." Jubilee 2000, a coalition of over 90 organisations including Oxfam, Christian Aid, and the British Medical Association, is demanding that those financial chains are broken as a celebration of the new millennium. By clamouring for the cancellation of the "unpayable" debt of the world's poorest countries,[1] Jubilee 2000 has focused the spotlight firmly on the creditors: the world's richest countries, the International Monetary Fund, and the World Bank.

Jubilee 2000's campaign was officially launched in 1996 and gained prominence in 1998 when 70 000 supporters formed a human chain in Birmingham, UK, around the summit meeting of the G8 leaders—representing the world's richest nations. Later that year representatives of 39 national Jubilee 2000 campaigns gathered in Rome and called for cancellation, by the year 2000, of certain forms of debt: unpayable debt, which cannot be serviced without placing an undue burden on impoverished people; debt where the principal has already been repaid and only the interest remains; debt for improperly designed policies and projects; and debt incurred by repressive regimes.[2]

The campaign has gathered an irresistible momentum, with support from a mixed bag of international celebrities. Rock stars Bono and Annie Lennox, former boxer Muhammad Ali, writer Harold Pinter, actor Ewan McGregor, Nobel Prize winners Adolfo Perez Esquivel and Amartya Sen, and the Pope are among the many public figures who have voiced support.

Jubilee 2000 estimates that there are 52 heavily indebted countries that need urgent debt relief, and most of these are in sub-Saharan Africa, Latin America, and Asia. Their total debt burden amounts to around $371bn, of which Jubilee 2000 wants $160bn-300bn cancelled now. If, for example, Britain were to cancel the debts owed to it by the poorest countries, British taxpayers would be worse off by just £2 ($3) a year each. Cancelling all the debts from these countries would still only amount to a cost, from creditor countries, of £12 ($20) per taxpayer.

Shifting the burden of debt may make little difference to the lives of people in richer countries, but it would emancipate the world's poor. The World Bank estimates that 1.3 billion people live in absolute poverty, earning less than $1 a day.[3] For the poorest countries debt repayments are mostly double the amount of earnings from exports, far exceed expenditure on health care, and outstrip what is received in aid or loans.[4] For example, Uganda spends $2.50 per head annually on health, while $15 per head is spent on debt servicing.[5] The net drain from the poorest countries to the richest countries is around $150bn a year (for every £1 sent in grants to developing countries, £9 come back in debt repayments, claims Jubilee 2000). The poverty gap has also widened by 30% over the past decade. Many experts argue that this disparity has accentuated the scarcity of resources, hunger, and death rates in the poorest countries—described as the "pathology of poverty."[6]

Irresponsible lending, structural adjustment policies,[7] providing insufficient aid (less than the UN target of 0.7% of gross national product), and support of regional wars are ways in which the richer countries have nurtured the debt crisis. The poorer countries too have contributed through poor governance, corruption, ethnic conflicts, underinvestment in health care, and neglect of women's rights. None the less, precedents do exist to support the cancellation of debt: in the 1930s the United States turned a blind eye when Britain, France, and Italy defaulted on US debts; in the last century the United States took over Cuba and promptly cancelled Cuba's debt to Spain; and after the second world war Germany was the recipient of generous debt relief.

Over the past decade the World Bank has attempted to ease the debt burden by launching its heavily indebted poor countries initiative.[8] Critics argue that the criteria to qualify for this initiative are too stringent and take too long, effectively imposing six years of strict structural adjustment policies before debt relief is available, in which time poverty can deepen. So far seven countries have qualified for debt relief packages, and three more are expected to qualify soon, with the amount of debt relief for these 10 being estimated at $4.3bn.[9] Only Bolivia and Uganda, however, have actually received debt relief so far, and the World Bank and International Monetary Fund have admitted that the countries who qualify are likely

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