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ARTICLE

When things go wrong: a practical guide to dealing with complaints

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SUMMARY

Complaints inevitably accompany clinical care. This article explores complaints primarily in the context of the UK National Health Service complaints system. However, much of the content will apply to other settings, such as the independent sector. The infrequent but serious ramifications of complaints are also considered, including retraining and suspension. The article is written from a medical perspective but considers the roles of other professionals, the organisation and the complainant.

DECLARATION OF INTEREST

None.

The Citizen's Charter Complaints Task Force (1995) has defined a complaint as 'an expression of dissatisfaction requiring a response'.

Changing expectations within society ensure that complaints are an inevitable and usually unwelcome part of clinical practice. Psychiatrists deal with complaints every day and enquiries about a patient's complaints and their history are at the core of clinical history-taking. Usually, practitioners are receptive to complaints about medication side-effects, the weather, the fortunes of the local football team and so on, but are less sanguine about a complaint about their clinical practice.

In 2007, the Medical Protection Society received more than 3000 calls from members about potential complaints (Williams 2008). Issues around diagnosis accounted for 30% of complaints, followed by rudeness (14%), then clinical treatment/management failings (11%). Complaints can also arise from personal misconduct, such as inappropriate relations with patients.

It is difficult to ascertain whether complaints are increasing: some are dealt with informally, and revisions to the UK National Health Service (NHS) complaints procedure complicate year-by-year comparisons. In mental health, for example, in 2004–2005 there were 8542 formal complaints, which increased to 8887 a year later. However, complaint numbers subsequently dropped to 8112 in 2006–2007 and then to 7006 in 2007–2008. In 2008–2009, the number of complaints was 7214. For the whole of the NHS, annual complaints have varied between 86 013 in 1998–1999 and 95 743 in 2000–2001 (all data obtained from the NHS Information Centre: www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/complaints). Unfortunately, available figures do not record outcomes such as the number of complaints upheld.

The NHS complaints procedure

The Healthcare Commission

The NHS covers the whole of the UK and there are significant differences in both the organisation of the health service and the complaints procedure in each of the four countries. The NHS complaints procedure commenced on 1 April 1996 and subsequent amendments have been made (National Health Service (Complaints) Amendment Regulations 2006). From 1 September 2006 a three-stage complaints process operated:

1 local resolution
2 independent review
3 Health Service Commissioner – ombudsman.

The Care Quality Commission

On 1 April 2009, the NHS complaints system in England and that of social care were combined into one system (Local Authority Social Services and National Health Service Complaints (England) Regulations 2009). The main change is that the complaints procedure is now a two-stage process: local resolution and independent review by the Health Service Commissioner (ombudsman). All complainants will have direct access to the ombudsman if they remain dissatisfied with attempts at local resolution. The Healthcare Commission ceased to exist when the Care Quality Commission was formed in 2009.

The Care Quality Commission does not have a role in handling complaints because this might interfere with its function as a regulatory body. This potential conflict of interest is recognised at this level but there is also potential conflict at the local resolution level. This may lead complainants to perceive the system to be less than transparent, even if the complaint is handled by someone independent to the team. In social care, complaints are handled by

an independent team, which should ensure that the process is not swayed by political, organisational or media concerns. Most NHS organisations will have a dedicated complaints manager, but complaints investigators are usually co-opted depending on the nature of the complaint and in some organisations staff receive little training for the role.

Guidance for handling complaints

The Department of Health's website (www.dh.gov.uk) contains formal guidance for NHS organisations on dealing with complaints. It also gives advice on making complaints about the Department. The procedural issues are NHS-specific for England but there is a wealth of information that will be useful to readers who do not work in the NHS. Equivalent structures exist in Scotland (Scottish Public Services Ombudsman: www.spso.org.uk) and Wales (Public Services Ombudsman for Wales: www.ombudsman-wales.org.uk). The site also highlights areas of good practice in relation to complaints-handling and provides links to other resources.

Local resolution in England and Wales

As mentioned, the first stage of the NHS complaints procedure is local resolution. The aim is to take action proportionate to the issues being raised. Therefore, each case should be judged on its own merits and a timescale and outcome agreed, depending on the issues raised. However, a patient's concerns could be expressed by speaking to a staff member and each member of staff should be empowered to respond to the best of their ability or refer to their manager or the trust's patient advocacy and liaison service or complaints manager for further advice and support.

Patient advocacy and liaison services

A patient advocacy and liaison service has been established in every NHS trust and can help to resolve issues or concerns before they escalate to a formal complaint. The service can give information about the complaints procedure and the independent complaints advocacy service. Psychiatrists should make themselves aware of their local complaints procedure and the advice and support available to them in responding to complaints. A complaint that is resolved no later than the next working day after the day on which it was made is not required to be dealt with under the 2009 Regulations.

The complaints manager

Under the new complaints procedure there is no set timescale for the trust's response to complaints, given that each case should be reviewed on its own merits. However, complainants will have the right to refer their complaint to the ombudsman if they have not received a response within 6 months. The emphasis is on working early and closely with the complainant to understand the issues raised and what actions can be taken to satisfactorily resolve matters. The complaints manager will work closely with the complainant and the staff involved in the complaint and will use a toolkit of options to help explore and resolve matters at a local level.

Options to consider will include, for example, facilitating a second opinion or arranging a medication review, conciliation or a local external review of the complaint. The last does not preclude the right of the complainant to take their case to the ombudsman. Every effort must be taken to exhaust local resolution before review by the ombudsman. The new procedure emphasises learning from the complaint and undertaking appropriate actions arising from this learning. Trusts should be more transparent and have monitoring systems that will be open to scrutiny by the Care Quality Commission. Trusts are also required to share complaints activity with the local commissioners of services to help further improve services.

Complaints in Scotland

The complaints system for NHS Scotland is similar (Scottish Executive 2005). Local resolution is the main focus but the complainant can appeal to the Scottish Public Services Ombudsman if dissatisfied with the local response. The complaints procedure of NHS Scotland acknowledges that staff can find being the subject of a complaint stressful and, under certain circumstances, allow the subject of a complaint to request a review by the ombudsman. Research carried out in developing the Scottish guidance demonstrated that a common weakness of many local procedures was investigating and responding to a complaint without first establishing the outcome that the person making the complaint was expecting (Scottish Executive 2005). As a result, if the expectations are entirely unrealistic, then the complainant should be informed ('gently but firmly') of this at the outset.

The complainant's perspective

There are many motives for making a complaint but it is likely that the majority arise when a service user or carer is unhappy about the treatment or care that they have received. Some will be vexatious but most will relate to genuine concerns. Medical errors can have serious consequences so tolerance of mistakes is low. However, the link between whether a patient sues and complains and their standard of care is not straightforward. In a US study (Thomas 2010) only 3% of patients seen as being negligently harmed

started litigation and only a fifth of cases brought to lawyers were for clearly negligent harms.

The true rate of medical errors may never be known (Alberti 2001) but it is likely that only a minority result in a complaint and even fewer in litigation. Patients' expectations may have been formed by watching medical soap operas, political rhetoric and media stories of medical breakthroughs. When confronted with the realities of medical practice it is perhaps surprising that there are so few formal complaints. The sometimes differing perspectives on medical errors between the public and doctors are described by Blendon *et al* (2002). In this survey of clinician and public views on medical errors the public attributed 81% of the main responsibility for a medical error to the doctor, whereas doctors reported a figure of 70%. Complainants may also suspect that doctors will collude with each other in investigating a complaint and that the process will be a whitewash.

If a patient wishes to pursue a complaint then there are a number of possible avenues open to them. In addition to the NHS complaints procedure they may call NHS Direct, approach their local Citizen's Advice Bureau, consult a solicitor or go to the press. Patients can receive support in making their complaint from their patient advocacy and liaison service and the Independent Complaints Advocacy Service. (In Scotland advocacy is provided by the Advocacy Safeguards Agency and the Scottish Independent Advocacy Alliance.) The patient can also approach the General Medical Council (GMC), which has a web page outlining, depending on the nature of the complaint, the most appropriate place to which to make the complaint (General Medical Council 2010). The GMC receives around 4500–5000 complaints a year, of which a third meet the necessary criteria and are pursued.

The organisation's perspective

Complaints are a quality indicator for trusts and health boards from both an internal and external perspective. The number of complaints received by a trust or board may be seen as a sign of poor standards of care, especially if media attention follows. Complaints lodged by Members of Parliament on behalf of constituents will also cause concern for the organisation. These factors may influence how the organisation responds to a complaint. It might be anticipated that a high-profile complaint that causes the organisation anxiety will be prioritised and the clinicians involved may be encouraged to expedite their responses.

Complaints may also flag internal areas of concern to the organisation, such as poorly performing individuals or clinical areas. Paradoxically, if no complaints are received about individuals or clinical departments, managers may begin to wonder about the clinical throughput. Even if a complaint is not upheld, there still may be an opportunity for the trust or board to improve performance.

As complaints may herald the start of litigation, the organisation may have a financial incentive in managing and resolving the complaint. Organisations in the NHS also have a timeline for responding to complaints. This does not always help in resolving them but there is scope to negotiate with the complainant. This may also indicate to complainants that their concerns are being taken seriously.

The psychiatrist's perspective

Psychiatrists who are made aware that a complaint has been made against them can experience a variety of emotions, including shock, denial, anger and a feeling of being undervalued. These reactions may be modified by their seniority, experience of previous complaints, view of the particular complaint (or complainant) and workload. Other personal issues such as current stress levels and health may also be relevant factors. Psychiatrists' unique training and understanding of transference and psychodynamic defence mechanisms may help mitigate the personal effects of complaints. As complaint is an emotional word with negative connotations, conceptualising a 'complaint' as a 'concern' may reduce this negativity and its accompanying stress.

Doctors in training may feel particularly vulnerable to the complaints system and view a complaint as a serious impediment to their career progression. However, for this group in particular it is important not to view complaints negatively, because they may provide an opportunity for reflection, thereby becoming an invaluable learning experience (Box 1). Trainers may take the view that a doctor in training who never receives a complaint may be achieving this by inappropriately agreeing with patients, thus compromising his or her clinical integrity. Examples include not detaining patients, allowing inappropriate discharge, and inappropriately supporting benefit applications or recommendations regarding driving.

Doctors may be concerned that the number of complaints or claims of clinical negligence may be used as a performance indicator by their employers (British Medical Association 2009). Although complaints may trigger necessary investigations into a clinician's work, they are potentially stigmatising and there may be better ways of evaluating clinical performance. Of course, a number of complaints about a specific area of practice may lead to further action. For example, complaints about poor communication skills could be triangulated with

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BOX 1 Case study: positive results from a complaint

Dr X, a junior trainee, received a complaint about 'being rude' by a patient whom he had seen in clinic. At first he was rather shocked, because he regarded himself as a caring doctor, whose main priority is patient care. This feeling turned to anger and ill-feeling towards the complainant. He discussed it with his clinical supervisor, who then sat in one of Dr X's clinics. His supervisor noted that his non-verbal communication could give the impression of him being dismissive and that he frequently interrupted the patient. His clinical supervisor met with the complainant, who described similar behaviours and also commented on positive aspects of Dr X's consulting style. The patient dropped the complaint when reassured that Dr X had not meant to be rude to her. Dr X reflected on this and attended a communication skills course. His clinical supervisor continued to observe a selection of Dr X's clinics and noted a significant improvement.

the results of 360-degree feedback, appraisals and observing clinical practice to ascertain whether a problem exists. Many complaints are about 'rudeness', which is difficult to investigate as often there is no other party involved (Williams 2008). Complaints about rudeness can also reflect cultural differences and expectations.

Psychodynamic and other aspects of complaints

We have generally taken a pragmatic view of complaints in this article but we appreciate the myriad interpretations that can be brought to bear on a complaint and the response. Knowledge of psychodynamic defence mechanisms, group and organisational dynamics is undoubtedly useful in clinical work, but refusing to respond to a complaint because it represents a patient's transference issue is unlikely to be an acceptable response to the organisation.

Models developed to describe challenging patients are relevant to understanding and managing complaints (Groves 1978). Patient factors such as certain personality disorders, paranoid traits, egotistical overdevelopment, relationship dysfunction and a critical approach may increase the likelihood of an unsatisfactory consultation and hence a complaint. Of course, doctors may also have these traits, which may predispose them to receive more complaints than average (Steinmetz 2001). Other doctor-related factors that may increase the chances of a complaint include narcissism, poor communication skills, poor psychosocial skills, cultural gaps, lack of experience and stress/overwork (Haas 2005).

The aftermath of a complaint

Psychiatrists need to resist the temptation to project negative feeling onto the complainant and examine countertransference issues. Complaints have a potential to alter the perceived balance of power in the clinical setting, often with the result that both parties feel disempowered. For clinicians this may reflect the NHS complaints system, which allows patients to pursue a complaint further if initial local resolution is unsatisfactory, whereas clinicians effectively have no right of appeal.

Often organisations have no protocol for the practical management of the aftermath of a complaint such as an irretrievable breakdown in the doctor–patient relationship or between the patient and functional/community team. Psychiatrists also have to rely on informal support networks during a complaint investigation, and once the procedure is completed the psychiatrist may not see the final result. Few organisations offer debriefing after complaint investigations.

High expectations: a mixed blessing

Doctors often tend to have high expectations of themselves, a feeling reinforced by the high academic standards required to enter medical school and to complete training. Some of the personality traits associated with these expectations, such as perfectionism and attention to detail, may reduce errors. However, the potential seriousness of what may be an relatively harmless mistake in another profession, such as a misplaced decimal point, further adds to internal expectations of perfection. As a result, doctors may accept personal responsibility for a complaint that actually represents wider organisational failings. This includes the breakdowns in communication that can occur with increased fragmentation of services and multiagency working. Cost pressures, productivity demands, overwork, loss of beds, multisite working and commissioning failures are also relevant.

These high expectations are reinforced by the organisations that set professional standards, for example the GMC and the Royal College of Psychiatrists. Doctors, along with professionals such as pilots, are in a select group who are not generally expected by the public to make mistakes (Wu 2000).

Misdirected focus

Complaint investigations tend to focus on individuals rather than systems and could be seen (at least in some cases) as institutional scapegoating. For example, there may be a conscious or unconscious desire to protect the organisation from criticism following the introduction of a shorter clinic slot

to increase productivity by focusing any complaint on the clinician's communication skills. From the clinician's perspective, managers organise the investigation of a complaint and ultimately respond to it, which can appear to combine the role of judge and jury. Root-cause analysis (Andersen 2000) is used often in critical incident reviews but these principles are applied infrequently to complaints handling.

The importance of balance in investigations

Clinicians are also involved in the investigation of complaints and aspire to neutrality in such situations, but there are potential conflicts. The investigator may overidentify with the complainant or their colleague. For example, if investigating a complaint against a disliked colleague there is a danger of being inappropriately condemnatory given the available evidence.

Clinicians may project their feelings in other unconscious ways, such as blaming the patient for bad experiences without examining their own actions. Conversely, clinicians can idealise standards of care to such an extent that they are unattainable, leading to feelings of professional inadequacy and guilt. Some may enjoy their position of apparent power. When discussing a complaint against a junior colleague, senior clinicians should be aware of the power imbalance. Acknowledging past complaints against themselves may prevent the discussion from feeling punitive. Given the wide range of reactions to complaints, clinicians could see themselves as the second victim and debriefing may minimise pathological responses (Wu 2000).

Compared with some other specialists, psychiatrists usually have a greater knowledge of their patient's milieu and may be aware of potential conflicts, especially when the complainant is not the patient (Box 2). The investigation of such a complaint may also be affected by the senior manager's concerns about the financial ramifications and potential adverse publicity to the organisation.

BOX 2 Case study: a third-party complaint

Mr A is admitted informally to an acute psychiatric ward following an overdose. He is in the middle of divorce proceedings and has a highly paid job. He is happy with his care but his estranged wife makes a complaint when she becomes aware that he will soon be discharged. The essence of her complaint is that discharge is inappropriate and that if he takes his own life then she will suffer financially.

His consultant does not wish to respond to the complaint and Mr A reiterates his position that he is happy with his care. However, any persons affected or likely to be affected by the action, omission or decision taken by a trust or board have the right to complain. The wife's complaint is investigated but not upheld. Mr A does not consent to release of his clinical information so the response from the chief executive can only state that the complaint has been investigated and not upheld. It is permissible to share non-patient information such as policy and procedure.

Responding to informal complaints

How an informal complaint is handled will often determine whether a formal procedure is invoked. There is considerable overlap between clinical consultation skills and skills used to resolve complaints. The first step is to recognise and acknowledge the patient's concern. The next is to ascertain their perception of what happened and why they are concerned. For example, a patient who has been waiting for an hour in clinic may be agitated when seen because the receptionist has been rude to them and not because of the wait. Reassurance, an explanation and, where appropriate, an apology may resolve the issue there and then. If immediate resolution cannot be achieved, a follow-up meeting or correspondence may help. If the complainant is not satisfied by an informal response, they should be given information on the formal complaints system.

Saying sorry

Doctors are often concerned that saying sorry may be seen as an admission of liability and will have potential consequences if litigation is pursued by the complainant. However, Holden (2009) observes that 'saying sorry and providing an explanation to a patient or relative seldom does any harm and can often avoid a complaint'.

This observation is supported by Section 2 of the Compensation Act 2006, which states: 'An apology, offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty.' According to the GMC, a doctor should offer 'an apology and explain fully and promptly to the patient what has happened, and the likely short and long term effects' (General Medical Council 2006).

The complaints process in practice

Trusts and boards have formal complaints mechanisms in place, and practitioners will be asked for their response in order to facilitate local resolution (Box 3). They will need to review the case notes and respond fully to every point outlined in the complaint, acknowledging with regret any shortcomings and giving explanations. If matters are more complicated, the complaint may require detailed investigation. This investigation may range from checking details to formal interview. A meeting with the complainant, the complaints manager and medical manager may also be necessary.

Appeals are not unusual, and may be sent for local independent review and then to the Health Service Ombudsman, depending on the jurisdiction. Appeal processes may not confine themselves to the complaint and may also evaluate and comment on clinical practice.

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BOX 3 Six principles of good complaint-handling

1 Getting the process right (following Department of Health guidance)
2 Being customer-focused
3 Being open and accountable
4 Acting fairly and proportionately
5 Correcting poor practice/systems identified from complaints
6 Seeking continuous improvement from analysis of complaints

Practical tips on responding to formal complaints

Some complaints may be anticipated by the clinician and the basic groundwork already done in anticipation. However, some will come out of the blue, usually when practitioners are at their most busy (or so it seems). The following tips are addressed to any professional against whom a complaint has been made.

When dealing with a complaint, treat it as important, but try not to get too distressed or annoyed (Box 4). Read through it at least twice. Unless an immediate response is required, reread it the next day. Hopefully, by this time you will be able to read it in a more reflective manner. Do not respond until you feel that you are calm and collected.

Discussing the complaint with colleagues even in abstract terms may help, but be aware of confidentiality issues.

An intemperate response may be censored by a complaints manager but may find its way into the final reply, which will not aid resolution. Try to put it into the context of the interview/situation described. Respond quickly and as comprehensively as you can. Try to put your version of events, but do not get overly defensive. For example, if complainants are concerned that their health has not improved, it might be appropriate to remind them that they have failed to take prescribed treatment or attend therapy sessions. Make sure you use jargon-free language that can be understood by the lay person and always explain the reason for taking the decision that led to the complaint. If you feel that an apology is due, make it.

BOX 4 Responding to a formal complaint

1 Think before replying
2 Try to respond in a timely manner
3 Keep your response relevant (reread the complaint)
4 Avoid using medical jargon and provide factual information in your response
5 Respond to further enquiries in a polite and timely manner
6 Apologise when appropriate and offer what can be learnt from this experience
7 Remember that complaints officers are only doing their job

If you are a trainee psychiatrist, discuss the complaint with your educational/clinical supervisor. A formal complaint letter will usually go to your consultant, who can help you to draft an appropriate response and enable you to reflect on aspects of your practice that led to the complaint as well as what has been learnt from this.

Finally, remember that the complaints manager has not made the complaint. Don't shoot the messenger and remember that these individuals have externally imposed deadlines for dealing with complaints. They are a useful resource, especially when responding to your first complaints.

Occasionally complaints may become public and usually the organisation's chief executive, in liaison with the medical director and communications manager, should manage any media interest or adverse publicity. Doctors would be ill-advised to respond directly to media interest. The press can be intrusive, and in a high-profile case the clinician should seek advice from their defence organisation and employers on managing this aspect.

Complaints can be a positive experience

The case study in Box 1 demonstrates how complaints can bring about positive change to a doctor's professional practice and play a vital role in continuing professional development at every stage of a doctor's career. Investigating complaints or sitting on the relevant committee is another way of benefiting from the complaints procedure. Under the 2009 Regulations all trusts and boards must provide reports on complaints statistics and examples of points learnt.

Sometimes it may be problems inherent in the doctor's roles and responsibilities that lead to complaints. For example, a junior doctor who is not provided with sufficient clinical supervision may find himself making decisions that lie beyond the realms of his expertise and may therefore make mistakes that result in complaints. A frequent source of complaints is seeing a different doctor each time, which may prove difficult to address but may lead to staffing changes that benefit everyone. Indeed, doctors may encourage complaints about services as a mechanism for change.

Handling repeated complaints

Doctors in the NHS have an annual appraisal that should involve a review of any complaints, allowing both doctor and appraiser to undertake a trend analysis to identify any recurrent themes. An experienced appraiser will be able to benchmark that doctor against others within the organisation to establish whether the number of complaints received is within the expected range.

The unit in which the doctor works may also have a system in place to identify trends in complaints. Even without the intervention of such a system or appraisal it should be considered good practice to review complaints reflectively. If problems are identified then the trust or board should help with the remedial action to improve performance. Complaint managers can also support the appraisal process by providing information on complaints received, including themes and trends.

A doctor experiencing stress related to their professional as well as private life may be vulnerable to complaints due to underperforming at work. If you think such a description applies to you, you may want to discuss the situation with a trusted colleague. It may be appropriate to see your general practitioner and consider taking a period of sick leave, if deemed appropriate. Other sources of help for sick doctors include staff support schemes run by their trust or board, counselling services offered by the British Medical Association, and the Psychiatrists' Support Service of the Royal College of Psychiatrists.

Negligence

Complaints may herald a clinical negligence claim. More than 70% of claims are settled out of court with no admission of liability (British Medical Association 2009). The NHS Litigation Authority (NHSLA) handles negligence claims on behalf of the NHS but this scheme will not cover private practice and other non-NHS duties. Therefore, all doctors are strongly advised to have independent clinical negligence cover. Psychiatrists are not a high-risk group for negligence claims. Although the NHSLA manages clinical claims for trusts, individual trusts generally have claims or legal services managers who tend to be the local contact for such matters and can be a good source of information and support. Find out who your legal service manager is within your organisation.

Dealing with underperforming NHS doctors

Rarely, a complaint or series of complaints may lead to questions about a psychiatrist's performance. These concerns may be reinforced by evidence from other sources such as appraisal, audit or complaints by staff. All NHS organisations are required to have in place procedures for handling concerns about a doctor's conduct, clinical performance and health (Department of Health 2003). Some groups of doctors, such as those involved in child protection, can be subjected to orchestrated campaigns and this should be remembered when assessing multiple complaints.

The responsibility for disciplining medical staff lies with the employing trust or board, but where issues about the practitioner's competence arise, the assistance of the National Clinical Assessment Service (NCAS), as discussed in the pages of this journal (Margerison 2008), can be sought for doctors in the UK. The service (which also accepts self-referrals) aims to work with all parties to improve the practitioner's performance. It does not act as a regulator and the referring authority has final responsibility for the case. A disproportionate number of referrals to NCAS are for psychiatrists and obstetricians (National Clinical Assessment Service 2006). Out of the new referrals, NCAS provided an alternative to exclusion in more than 80% of cases.

Dealing with concerns about a psychiatrist

When a concern arises, it is first and foremost important to clarify precisely what the issue is. The involvement of NCAS should be seriously considered. It may be helpful to discuss with them the appropriate action that needs to be taken. If it is deemed that the concern is not too serious, it should be dealt with informally without resort to formal disciplinary procedures. Sometimes allegations arise that are totally unfounded and malicious – it is important to identify these because they can have a lasting adverse effect on a professional's mental health.

Where the problem is serious and can adversely affect patient care it must be registered with the chief executive, who must then appoint a case manager. If a concern relates to the practice of a consultant or clinical director, the medical director should act as case manager and then appoint a case investigator to be responsible for leading the investigation and establishing the facts. A written record of the investigation should be kept and patient confidentiality respected at all times. The practitioner needs to be made aware of the allegations, be given the name of the case investigator and should be given the opportunity to see any correspondence relating to the case. They should also be given the chance to put their views and version of events across, and should be given a list of the names of individuals that the case investigator will interview. The practitioner

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is entitled to bring along a companion, who may or may not be legally qualified.

Should there be concerns about the safety of patients, it may be appropriate to consider restricting the doctor's performance. This may vary from restricting clinical duties to excluding the doctor from the workplace. If restrictions are put in place, the doctor must not undertake similar work with any other organisation. If it is suspected that a doctor is undertaking such work, the issuing of an alert letter needs to be discussed with the professional regulatory body, the Director of Public Health or Medical Director of the Strategic Health Authority.

In all instances where a serious danger to staff or patients is identified, the doctor must be referred to the regulatory body, irrespective of whether or not the case has been referred to NCAS. When exclusion is considered, it is important for NCAS to be made aware of this at an early stage so that alternatives are considered.

The case investigator should complete the investigation within 4 weeks of appointment and submit the report to the case manager within a further 5 days.

Exclusion

Exclusion may be necessary following a critical incident when serious allegations have been made or where the presence of the doctor is likely to hamper the investigation. The chief executive has overall responsibility for managing the exclusion procedure. Exclusion should last for the minimum necessary time and can continue for up to, but no more than, 4 weeks at a time. The justification for continued exclusion must be reviewed on a regular basis and should be discussed with NCAS. Any extensions need to be considered seriously and not be used as punitive measures. Consideration should be given as to whether the practitioner could return to work in a limited capacity or even in a non-clinical role.

Exclusion should usually be on full pay and the doctor must be available for work with the organisation during normal working hours.

Capability issues

A failure to deliver an adequate standard of care is described as a capability issue. In such instances advice from NCAS must be sought. The trust or board should try to identify issues early as well as providing support and opportunities for further training. As far as possible, mitigating factors need to be taken into account.

Sometimes a panel hearing may be necessary once the case has been considered by NCAS if the doctor's practice is such that no proposed action is thought to have a chance of success. The panel should be aware of the typical standard of competence. A capability panel can provide a written warning that an improvement in clinical performance is needed or it may even consider a termination of contract. Given the nature of the decisions, a robust appeal procedure must be in place.

Handling health issues

Professionals experiencing ill health should be offered treatment and as far as possible kept in employment, as long as they do not pose a risk to other parties. Adjustments to their clinical duties or workplace should be given consideration or a period of sick leave may be required. At all times, input from the occupational health service should be offered. If a practitioner's ill health poses a danger to patients and the individual is unwilling to recognise this or to cooperate with the proposed measures, exclusion should be considered.

Suspension

The GMC has powers to suspend doctors for matters in relation to discipline, health, personal misconduct and performance. It also has powers to suspend a doctor during investigation of allegations when it is believed that it is in the best interests of the doctor or the general public to do so. Suspension can occur in two ways: it can occur while an investigation takes place in relation to the performance of a doctor; or as the result of a final decision by the Fitness to Practise Panel, which could also result in erasure from the Medical Register.

Emotional and other reactions to suspension

Practitioners faced with the news that they have been suspended may encounter a number of emotions. These may include a sense of shame, a loss of self-worth and confidence, paranoia and a feeling of powerlessness to challenge a large organisation. They may feel marginalised, isolated and stigmatised by the rest of the community, especially if the media are involved, and this may have repercussions for family members.

The Society of Clinical Psychiatrists' Doctors Suspension Study Group collected information on 351 senior hospital doctors in the UK over a 16-year period (see www.scpnet.com for further details and advice on managing suspension). The study identified two patterns of illnesses: depression and stress-induced myocardial infarction. Half of all the suspended doctors had to be treated for their depression. Myocardial infarction was four times more common among suspended doctors

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than other doctors of the same age and gender. Morbidity was also higher in the suspended doctor's spouse.

Conclusions

Complaints are often viewed negatively by practitioners. However, they can bring to light both strengths and weaknesses and therefore may be viewed more positively. They potentially inform continuing professional development and should be viewed accordingly by the practitioner and the employing organisation.

Every organisation has a duty to ensure that staff members are given the opportunity to develop their potential in the context of a 'fair-blame' culture. When concerns arise, they should be dealt with promptly and in an unbiased manner. The aim of ensuing investigations should be to establish the facts rather than to build a case against a particular doctor. Patient safety issues should be given utmost consideration. The exclusion of the practitioner should be avoided at all reasonable cost, for (as highlighted above) the detrimental effects of such action on the individual concerned are only too apparent by reading the Society of Clinical Psychiatrists' study (Tomlin 2003).

Acknowledgments

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MCQs

Select the single best option for each question stem

1 When replying to a complaint:
- a use as much medical terminology as possible
- b never apologise
- c never discuss your response with the complaints manager
- d always read the letter at least twice
- e aim to ignore the complainant's main concerns.

2 The National Clinical Assessment Service:
- a receives fewer referrals about psychiatrists than would be expected
- b will accept self-referrals
- c has the power to erase doctors from the Medical Register
- d is part of the General Medical Council
- e advises exclusion for the majority of referrals.

3 Suspended doctors:
- a subsequently have low rates of depression
- b have low rates of cardiovascular disease
- c find that their spouses are more likely to experience ill health
- d should never discuss their case with their defence organisation
- e should not consult their general practitioner.

4 The NHS complaints system:
- a is due to change in 2010
- b will continue as a three-tier system
- c only deals with complaints about doctors
- d was first set up in 2002
- e emphasises local resolution as a first step.

5 With regard to complaints:
- a all complainants are vexatious
- b they never benefit the psychiatrist
- c they result in disciplinary action in the majority of cases
- d trusts have to produce figures on complaints
- e the practitioner will not have to be interviewed regarding the complaint.