COMPLAINTS AGAINST DOCTORS, HEALTHCARE WORKERS AND INSTITUTIONS

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Introduction

The well-known maxim reminds us that common things occur commonly and this is not simply in respect to clinical conditions. Whilst there are now a considerable variety of routes of accountability that members of the healthcare professions might face, the most common of these in the UK almost certainly continues to be the National Health Service (NHS) complaints procedure given that the majority of consultations with healthcare workers in the UK will take place in this context.

This article will consider the different ways in which healthcare professionals may have to justify their actions by reference to the systems in place in the UK. Attempts have been made in recent years to reduce the burgeoning use of litigation to call these workers to account as this adversarial approach may not only not have the desired effect, but also result in potential economic disadvantages to society generally in that costs frequently exceed any settlement to the claimant.

The NHS Complaints Procedure

A frequent error amongst these groups continues to be the difference between a complaint and a claim. The generally accepted definition of a complaint within the NHS complaints procedure is "an expression of dissatisfaction that requires a response." Commonly, professionals believe that because there is no "formal" complaint they do not have to furnish a reply. However, if a patient is unhappy with the care he/she has received and wishes to have an explanation, surely by definition the preceding criteria are fulfilled? In contrast, a claim is undertaken through the branch of private law that in England and Wales is known as tort but in Scotland as delict. Here the objective is to obtain financial recompense for harm suffered by a patient. There are three fundamental parts to a medical negligence claim: (1) a duty of care; (2) a breach of that duty; and (3) harm suffered as a consequence (the causative link). Although in England and Wales there has been some moderation of the inherent adversity in the system with the introduction of the new civil procedure rules subsequent to Lord Woolf's reforms, there continues to be a distinctly different approach and the emphasis in the NHS complaints procedure is very much on achieving local resolution.

Of course, it may not simply be double jeopardy that the healthcare worker faces. An adverse event may initially be dealt with through the NHS complaints procedure, then be referred to the Health Service Commissioner (ombudsman) by route of appeal. Thereafter it may be reported to the General Medical Council (GMC) and can even end up in the criminal courts. Ultimately the case may turn to the civil courts in an attempt to obtain restitution. The use of the complaints procedure as a dry run for civil litigation is not unknown despite guidance to the contrary and there appears implicit acceptance of the futility of this in the proposed NHS General Medical Services regulations (the statute governing the provision of general practitioner services in the UK) where there is an acceptance that the two processes can go ahead simultaneously. Even at the present time, there is nothing to stop a solicitor being instructed by a complainant to act for him/her in taking the preliminary steps within the procedure.

Civil actions may ultimately (leaving aside the unifying influence of European law) reach the definitive court of appeal in the House of Lords and, while academics may try and argue on the distinguishing features of cases such as *Hunter* v. *Hanley* ((1955) SC 200, 1955 SLT 213) or *Bolam* v. *Friern HMC* ((1957) 2 All ER 118, [1957] 1 WLR 582, 101 Sol Jo 357, 1 BMLR 1), subsequent case law modifying these principles as found in *Bolitho* v. *City and Hackney Health*

Authority ((1997) 4 All ER 771 HL) has almost certainly affected the way we deal with negligence claims throughout the UK, albeit the new "civil procedure rules" emanating from the Woolf reforms only apply in England and Wales. These new rules came into force in 1999 and represented the greatest change in the civil justice system for over a century. Woolf had concluded that public access to civil justice could only be improved by making litigation simpler, quicker, and cheaper.

After the formal consultation by the Wilson Committee, resulting in the publication *Being Heard*, the new NHS complaints procedure came into effect on April 1, 1996, and thereafter most medical defense organizations found an increase of at least 50% in cases both within the general practitioner sector, which makes up about two-thirds of their workload, and against hospital doctors.

Within the new procedure there were a number of key objectives, including ease of access and simplification, plus common features for complaints about services provided within the NHS. The intention here was that all healthcare workers would be accountable through the same process. Importantly, there was a separation of complaints from disciplinary procedures and the hope was to avoid apportionment of blame, making it easier to differentiate lessons on management and service delivery from complaints in order to achieve improvement. It is easy to see where the concept of clinical governance emanated from within this process. The hope was that there would be fairness to staff and complainants alike, with more rapid, open procedures and a degree of honesty and thoroughness where the prime intention was not only to resolve the problem, but also to satisfy the concerns raised by the complainant.

Rather than a confrontational, adversarial approach the process envisaged was much more of an investigative one. The overall concept was of the type found within alternative dispute resolution that has attracted considerable interest within the legal profession who had become increasingly aware of the disadvantages of formal litigation.

Accountability for healthcare workers may arise through a number of routes:

- NHS hospital complaint
- NHS family health services complaint
- ombudsman
- civil litigation
- GMC
- General Dental Council
- National Council for Nursing and Midwifery
- criminal prosecution
- fatal accident inquiry/coroner's inquest.

Of course, not only may that professional be required to submit to one of these processes but, if unlucky, the practitioner can end up going through all of these, either simultaneously or sequentially.

Medical defense organizations will look after the professional interests of doctors and dentists, whereas the British Medical Association (BMA) will assist with issues of personal conduct, although it is quite possible that there is overlap. It is not unknown for a doctor's medical defense organization to exercise its discretionary function by helping in this area in cases where a doctor is not, perhaps, a member of the BMA. Likewise, the Royal College of Nursing will cater for a nurse's professional interests and in primary care may also have responsibility for indemnity.

With the separation of complaints from discipline since the inception of the NHS complaints procedure, the number of disciplinary hearings has fallen dramatically, certainly compared to the previous terms of service hearings where general practitioners were often involved in an acrimonious exchange with complainants who were present at the same time in a quasilegal setting. Fewer than 1% of NHS complaints are dealt with through the disciplinary process, although this is still available for certain allegations.

Where a complaint is made on behalf of a patient who has not specifically authorized another individual to act for him/her, care should be taken not to disclose personal data to the complainant. The advice given by medical defense organizations is that one should not be deemed obstructive, although it may be valid to "flag up" this particular issue.

The healthcare worker should avoid disclosing any incidental information and in the case of a medical practitioner should ensure that there is compliance with the GMC guidance contained within its booklet *Confidentiality: Protecting and Providing Information*. Similar obligations apply to the other professions, although the doctors' national regulatory body has increasingly refined its advice in recent years.

Increasing use has been made of private healthcare, especially in England and Wales, and although the complaints procedure will cover any complaint made about a trust staff or facilities relating to that trust's private pay beds, this does not extend to the private medical care provided by the consultant outwith his/her NHS contract.

At the time of writing, there is a time limit on initiating complaints and a complaint should normally be made within six months of the incident resulting in the dissatisfaction, or within six months of the date of becoming aware of that problem, provided that is within 12 months of the problem. However, there is discretion that, more often than not, can be invoked

to extend this time limit and there are proposals within the new family health services regulations to extend the primary limitation period to one year. *Prima facie,* this may appear unfair on the doctor but one has to contrast this with the GMC's ability to look into complaints within a five-year period, although this may be extended if the gravity of the offense merits it.

There is a recognized philosophy that, if a personal response is in order, then a simple explanation may often resolve that patient's concern, but if the preliminary response does not address the complaint to the complainant's satisfaction, there is a route of appeal. To that end, trusts are required to appoint at least one person to act in the role of the convenor to whom such requests are made.

Conciliation

Conciliation is considered to be a voluntary process where both parties agree to participate with the intention and hope of resolving the complaint at a local level.

Lay conciliators are required to be made available by trusts in order to optimize the conditions to achieve resolution. The purpose of this process is to permit the complainant and respondent to address the relevant outstanding issues in a nonconfrontational manner so that an acceptable agreement may be reached but not to impose a solution upon the parties concerned.

An integral part of the process is confidentiality so that the conciliator might encourage both parties to consider the reasons for the complaint in an open way. Whilst neither the conciliator nor the participants should provide information from the process to any other person, it is in order for the conciliator to inform the trust when conciliation has ceased and give an indication of whether or not resolution has been achieved.

Although not strictly forbidden, it is not normal to have a representative from a professional body present or for a solicitor to accompany a complainant, although it would be usual for the complainant to have another person there for support.

The Independent Review Panel (IRP)

There is a route of appeal in that complainants who are dissatisfied with the preliminary response. They may make a request for an IRP to the convenor either orally or in writing within a period of 28 calendar days from completion of the local resolution process.

In deciding whether to convene a panel, the convenor has to consider, in consultation with an independent lay chair from the regional list, whether the trust can take any further action short of establishing a panel to satisfy the complainant and also if establishing a panel would add any further value to the process.

Whilst there was a tendency to grant a request for such a hearing, this is by no means automatically granted and has now decreased, so that only 22% of requests in 2000–2001 resulted in a panel going ahead.

Where clinical issues are involved there is an obligation for the convenor to take appropriate clinical advice in deciding whether to convene such a panel.

As well as informing the complainant in writing of the decision on whether or not a panel should be appointed, the convenor must set out clearly the terms of reference if there is to be a hearing or the reasons for any decision resulting in refusal.

Should the convenor refuse to hold an IRP; there is a further right of appeal to the ombudsman.

It is a decision for the panel how to conduct its proceedings having regard to guidance issued by the NHS within the following rules:

- The panel's proceedings must be held in private.
- The panel must give both parties a reasonable opportunity to express their views.
- Should any of the panel members disagree how the panel should go about its business, the chairperson's decision will be final.
- When being interviewed by the panel, the complainant and any other person interviewed may be accompanied by a person of their choosing who, provided the chairperson agrees, may speak to the panel, except that no one may be accompanied by a legally qualified person acting as an advocate.

Whilst the approach is discretionary, there is normally not an impediment to a professional adviser with a law degree actually assisting a doctor provided the adviser is not acting as a solicitor or advocate/barrister.

Subsequent to receipt of the panel's report, the Chief Executive of the trust must write to the complainant informing him/her of any action the Trust propose to take as a result of the panel's deliberations and of the right of the complainant to take the grievance to the ombudsman if he/she remains dissatisfied.

There are, of course, various time limits set out within the guidance, and it is safe to say there is often difficulty in achieving these targets (only 9% of IRPs were concluded within target in 2000–2001), although with greater familiarity, progress is being made to reach them.

An evaluation of how the new NHS complaints procedure was performing was undertaken, and the

result was a consultation document published in 1993, *NHS Complaints Reform – Making Things Right*. Of the 140 000 people who made a formal complaint the preceding year, only 3500 felt the need to request an independent review. However, the overwhelming consensus was that this stage caused the most dissatisfaction with users of the procedure.

It "is not perceived by complainants to be impartial. Improving this aspect of the current procedure is the single most commonly cited suggestion for reform." The proposal is for Commission for Healthcare Audit and Inspection (CHAI) in England and Wales or an extension of the ombudsman's role in Scotland to permit a more independent and robust review to take place than currently exists.

The Ombudsman

The NHS ombudsman looks into complaints made by or on behalf of people who have suffered because of unsatisfactory treatment or service by the NHS. He/she is completely independent of the NHS and the government. The ombudsman's services are free.

Anybody wishing to complain to the ombudsman must first have put their complaint to the NHS organization or practitioner concerned, such as the hospital trust, health authority, the general practitioner, or the dentist, who should give the complainant full details of the NHS complaints procedure and should try to resolve the complaint. If the complainant is still dissatisfied once the NHS complaints procedure has been exhausted, he/she can then complain to the ombudsman.

The ombudsman will not normally become involved unless the complainant has taken up the complaint officially and is still unhappy, for example, because:

- it took too long to deal with the complaint locally
- a panel review was unreasonably refused
- a satisfactory answer to the complaint was not given

The complainant has to send the complaint to the ombudsman no later than a year from the date when he/she became aware of the events that are the subject of complaint. The ombudsman can sometimes extend the time limit, but only if there are special reasons.

Whereas previously, the Health Service Commissioner was predominantly involved in looking at cases of maladministration, often in respect to the handling of a complaint, since March 31, 1996 the ombudsman was also able to investigate complaints about clinical issues in both hospital and general practice.

General Medical Council

Of all the healthcare workers' national regulatory bodies, the best known is almost certainly that of the medical profession, the GMC. There has been a marked growth in GMC complaints and, whereas previously the GMC would write back to the complainant recommending that the NHS complaints procedure had not yet been exhausted, the GMC is now often used as the first stop by a complainant. The GMC will usually take the matter forward if it is felt that there are concerns either about the doctor's conduct, that is, that his/her failing constitutes serious professional misconduct, or that there is significant cause for concern by way of that doctor's performance.

The New Council

The Council is the GMC's governing body, and until 2003 it had 104 members and delegated much of its work, including the consideration of complaints about doctors, to numerous committees.

The new system established a smaller Council on July 1, 2003 consisting of 35 members, 40% of whom were lay people. It is now made up of 19 elected medical members, two appointed medical members, and 14 lay members appointed by the government. This reflects the principle of professionally led regulation in partnership with the public.

The reason for this fundamental change was to produce a council capable of acting more quickly and effectively that included more lay members than before.

By 2002, a record 72 doctors had been erased or suspended from practice and a further 62 had conditions imposed or were reprimanded (previously given an admonishment) by the GMC. The GMC also investigated a record number of 5539 doctors that year, an increase of 4% from the previous year. However, for the first time in seven years the number of complaints made fell, which suggested that there might be a return of public confidence in the profession.

If a doctor is found guilty of a criminal offense within the UK, there is an automatic referral to the GMC. The findings of the court are taken as proved and the case will not be re-heard by the Professional Conduct Committee, although they will allow representation to be made on behalf of the medical practitioner and reach a decision as to whether any additional sanction should be taken against the individual concerned.

Since the inception of the NHS complaints procedure, there has been an increasing tendency for such cases simply to be referred to the GMC as a first stop.

The GMC has legal powers through the Medical Act 1983 (as amended) to act against problem doctors. Until 2004 a decision was taken at an early stage to stream a complaint into one of the three procedures: (1) health; (2) performance; or (3) conduct. Each has, potentially, different possible outcomes and not all can lead to being erased (struck off) from the GMC's register. At that time the cases were heard by members of the GMC Council.

The new system was introduced from 2004, together with a new single complaints process. All complaints now go through the same process; this means that a doctor's fitness to practice will be considered in the round, rather than being "labeled" early on as a health, performance, or conduct case. The same outcomes and sanctions are now available to apply to every case as appropriate. No council members will sit on the panels that decide the case against a doctor and all panelists will be appropriately assessed for suitability.

The reason for this change is to produce a new system to streamline the previous processes and ensure that complaints are processed as promptly as is consistent with achieving fairness.

Not only are doctors personally accountable by way of their medical practice, but they also have certain obligations set out in the GMC document *Management in Health Care: The Role of Doctors*, published in December 1999 that the first consideration for all managers must be the interests and safety of patients. Doctors must take action if they believe that patients are at risk of serious harm by way of a colleague's conduct, performance, or health and it explicitly states in this document that concerns about a patient may arise from critical incident reporting or complaints from patients, and doctors who receive such information have a duty to act on it.

In addition there will now be a license to practice and revalidate. In the old system the GMC's register of doctors was traditionally dependent on a once-only check on a doctor's qualifications. However, in the new system, commencing in 2005, every doctor who wants to practice medicine must not only be registered, but also hold a license to practice from the GMC.

In addition, licenced doctors must be revalidated by the GMC every 5 years. This means that they will be asked to show the GMC that they have been practicing medicine in line with the principles set out in their guidance booklet, *Good Medical Practice*. If they do this, the regulator will confirm that their license will continue.

The changes aim to ensure that doctors are up to date and fit to practice medicine throughout their careers. It also aims to modernize regulation and increase public confidence in doctors.

Council for Healthcare Regulatory Excellence (CHRE)

There is now a statutory overarching body overseeing all the healthcare regulatory bodies, covering all of the UK and separate from government, established in April 2003. Its function is to promote best practice and consistency in the regulation of healthcare professionals by the following nine regulatory bodies:

1. GMC
2. General Dental Council
3. General Optical Council
4. General Osteopathic Council
5. General Chiropractic Council
6. Health Professions Council
7. Nursing and Midwifery Council
8. Royal Pharmaceutical Society of Great Britain
9. Pharmaceutical Society of Northern Ireland.

This body came into being as a consequence of the report of the Bristol Royal Infirmary Inquiry (*Learning from Bristol*, July 2001), chaired by Sir Ian Kennedy, which recommended the establishment of the CHRE (formerly CRHP).

This was implemented in the NHS Reform and Healthcare Professions Act 2002, which was also informed by the NHS Plan for England and the consultation document *Modernizing Regulation in the Health Professions*.

Its functions are to promote the interests of the public and patients in the field of the regulation of health professionals. Another stated aim is to promote best practice in professionally led regulation. An annual report goes to parliament on the CHRE's work, with discretion to report on the performance of individual regulatory bodies and to compare their performance of similar functions. A further role is to promote cooperation and consistency across the regulation of all the healthcare professions, in the interest of patients. In addition, it should develop principles of good regulation and advise ministers across the UK on professional regulation issues in healthcare.

It may also refer a regulator's final decision on a fitness-to-practice case to the High Court (or its equivalent throughout the UK) for the protection of the public. Even in cases where the regulator finds there are insufficient grounds to constitute serious professional misconduct, the CHRE will examine this verdict and consider whether it needs to take action. As a last resort it can order a regulator to change its rules to protection the public (this requires the permission of both Houses of Parliament).

The CHRE is answerable to the Westminster parliament and is independent of the UK Department of Health.

Conclusion

A variety of routes of accountability have been set out but the one that a healthcare worker practicing within the UK is most likely to face is the NHS complaints procedure. As from April 1996 this has almost certainly achieved the purpose of providing a thorough investigation of the issues raised, albeit not always to the complete satisfaction of the complainant. However, the new proposed changes are intended to address reservations expressed by complainants, especially about the independent review process.

The previous confrontational and legalistic process has by and large been dispensed with and, although there are still inherent delays in the system, particularly in the hospital sector, the complainant is usually able to obtain a better understanding of the medical management of his/her care that is within the ethos of clinical governance, allowing doctors to learn from adverse events in order that their practice might subsequently be improved.

Of course, there continue to be safeguards for society, generally where that healthcare worker's conduct may be so serious that regulatory body intervention is justified or his/her performance is so seriously deficient that it is necessary for this to be examined. The system has now been underpinned by the CHRE in order to retain public confidence.

There is no doubt that self-regulation is one of the hallmarks of a profession but the emphasis now is very much that of professionally led regulation, but with a significant lay input, in order to avoid the all-too-prevalent criticism that culminated in an exponential rise in complaints. It appears that the new changes are starting to work in that complaints are no longer rising but society does require an effective legislative backstop to maintain progress in the face of public concern.

See Also

Medical Malpractice: General Practice; **Medical Malpractice – Medico-legal Perspectives:** Negligence, Duty of Care; Negligence, Causation; Negligence Quantum

Further Reading

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