

EDITORIAL

Complaints, doctors and older people

Complaints about patient care take up much time and may still not be satisfactorily resolved [1]. Complaints may have different meanings to different people: employers have business and clinical governance objectives, and may perceive things differently from the clinician and the person making the complaint.

The quality of service in hospitals is subjective, personal and intangible, yet there is a tendency to manage service organizations by focusing on what is most tangible, such as numbers of patients served, the cost of providing the service and the revenues generated [2]. These indicators of performance provide evidence of activity, not quality. By focusing on what is measurable, they may lead to incentives for steadily poorer standards of quality by staff, who are increasingly overworked, underpaid and under-appreciated [2]. This tendency towards mediocrity changes in the business world only when a new competitor enters the market place; competition in health is unlikely in those countries where health care is mainly provided by the state. In a genuinely competitive environment, complaints must be taken seriously: 91% of customers who have had a bad experience do not return and, on average, tell 10 acquaintances of their experience [3]. On the other hand, when complaints have been handled well, the customer is more likely to return for repeat business than if there had been no problem in the first place [3].

Clinical governance

If the incentives (particularly in the UK and other centralized health-care systems) worked against dealing well with complaints in the past, the introduction of clinical governance may alter the organizational perspective. Clinical governance is a term invented in the UK [4] to ensure that: (i) systems are in place to monitor quality of clinical practice and ensure that these are functioning properly, (ii) clinical practice is improved as a result, and (iii) clinical practitioners meet standards such as those set by national professional regulatory bodies.

In interpreting this national programme for UK geriatricians, the British Geriatrics Society and Royal College of Physicians of London set out the questions and processes required by organizations in developing a systematic approach to clinical governance (Figure 1). Complaints within the clinical governance cycle form one part of the monitoring process (asking 'Am I doing it correctly?'). Systematic monitoring of clinical

care and performance involves bringing together all the evidence—including audit, critical incidents, independent professional reviews, risk assessments and external peer review visits as well as complaints [5]. Organizations must develop systems to pull out consistent messages from the monitoring process, use that information systematically to improve services and make organizational changes through business planning and through personal development plans for individuals. Whether clinical governance can act as a counterweight to other pressures within organizations is not yet clear.

Effects of complaints

Complaints have a direct effect on the clinician. Their impact has been studied in general practitioners [6]. Three stages of complaint experience are described: initial impact, conflict and resolution. The first phase describes being out of control, feelings of shock and panic and a sense of indignation towards the patient. The second stage encompasses the many conflicts generated by the complaint: emotional conflict (such as feelings of anger, depression and even suicide), conflicts around aspects of professional identity (including doubts about clinical competence, conflicts with family and colleagues) and those arising from the management of the complaint. In the third stage there is some sort of resolution. For many, this means practising defensively. A few may even plan to leave clinical practice. Very few doctors saw complaints as a learning experience [6]. Other health-care professionals report anger, guilt, isolation, worry and symptoms of depression after receiving a complaint [7, 8].

The patient perspective is most important. The principal goals of complainants are usually to have their grievance acknowledged, obtain an explanation, receive an apology and ensure steps are taken to prevent recurrence [9]. In this issue of *Age and Ageing*, Anderson *et al.* [10] describe the number, instigators, nature and outcome of complaints concerning elderly patients treated at an Australian hospital over 1 year. The main findings are that the complaint rate for older patients was similar to that for younger patients, that most complaints relate to communication, and that analysis of complaints may provide pointers for improvement in quality of care. This can be compared with a UK study [11] which found that older patients were twice as likely to complain as younger patients. Again,

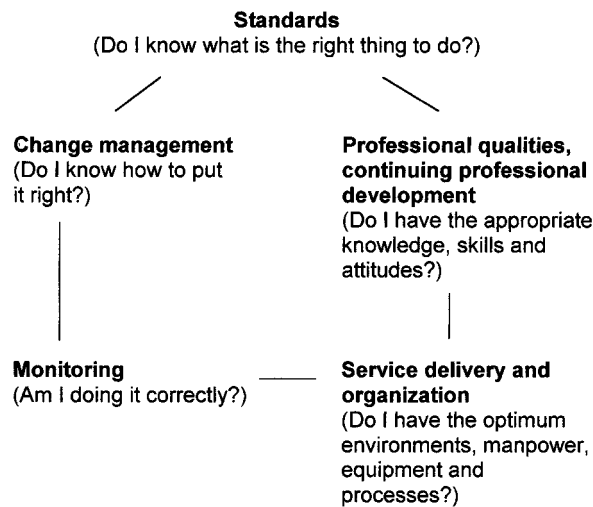


Figure 1. The clinical governance cycle.

most complaints were about poor attitudes of and communication by staff.

The General Medical Council has reported that 70% of complaints against doctors relate to communication problems. It is not clear whether these are more likely in older than younger patients but there are distinctive features that affect communications between older patients and physicians [12]. Ageism can occur in medical encounters with older people: physicians may trivialize older peoples' medical problems, they may spend less time with them or they may consider older patients to be more difficult to deal with than younger patients. Geriatric medicine is complex: patients often have co-existing multiple problems, many of which may not be soluble. Sensory deficits may not be recognized or overcome successfully, while cognitive impairment may be either missed or cause inappropriate stereotyped behaviour. Clinical discussions with older people are unusual in that a third person is often present (usually a friend or relative), which complicates the communication process. Three major roles for this third person have been described: as an advocate (supportive), as a passive participant (minimally involved and generally disengaged) or as an antagonist (working against the patient either openly or covertly) [13]. Each of these may require time, experience and understanding if they are to be handled successfully.

The specific problems of communication in managing older patients complicate the generic issue of how to improve communication between all doctors and patients. Doctors use different distinct styles: the paternalistic, the shared and the informed. Each has advantages and disadvantages and most doctor-patient encounters combine approaches from different models [14].

The possibilities for misunderstanding are enormous. For example, in a study of prescribing in general

practice, 14 different categories of misunderstanding between doctors and patients were identified, each of which had potential or possible adverse consequences for medicine-taking [15]. Perhaps medicine has become too preoccupied with the technical side of care rather than personal or human aspects [10, 14]. Rising numbers of complaints reflect changes in society. They also emphasize the need to get the physical and the psycho-social elements of care in balance.

In the UK, the care of older people is becoming a key measure of satisfaction with the National Health Service. The increasing number of complaints and some high-profile cases have raised elderly care higher up the consumer agenda. Currently, there is little evidence here of a change to an open, 'no blame' culture [16]. Yet, doctors must understand and learn from the messages being given by patients. Organizations should take complaints more seriously as part of clinical governance in the drive to provide continually improving patient care.

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