2016

Complaints

PG CERT DENTAL LAW AND ETHICS READING

Chapter Six

Complaints in general dental practice

This chapter will cover the definition of a complaint, managing them in general dental practice and the legal structures that impact upon them

It will look at the role of the GDC in dealing with complaints and the fitness to practice procedures

Everyone one of us has been on the receiving end of unsatisfactory service. Whether it is a restaurant, a hotel , a shop or other business, we have all experienced irritation or annoyance about some aspect of the service we have received but in may cases we do not actually complain either formally in writing or even verbally to a senior member of staff in that organisation[1]. Why is that?

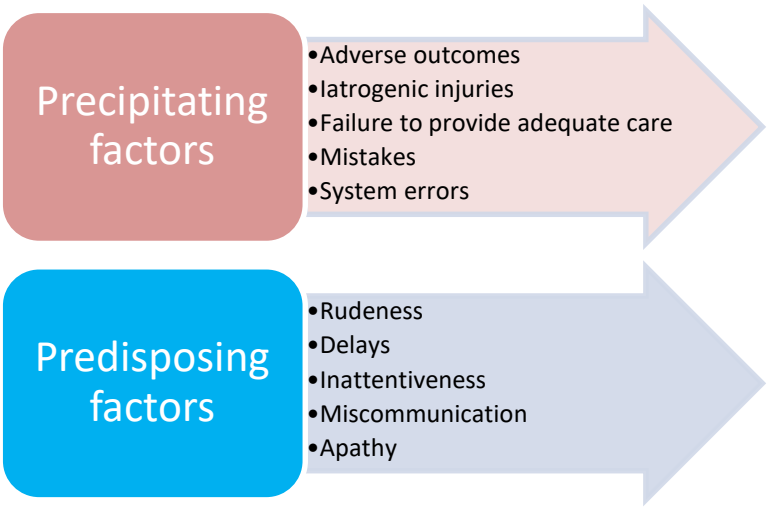
It has been suggested by Oppenheim[2] that patients satisfaction can be conceptualised as a continuum starting with positive thoughts through neutral to negative and that is often the way satisfaction surveys are carried out when using linear scales. This however fails to take into account what Newsome[3] calls the process of "naming, blaming and claiming" in which expressions of dissatisfaction only tend to arise when patients feels the dentist or staff are to blame for the service failure that led to the bad experience. Only when this blame is attributable does the patient register dissatisfaction. Often this blame comes in the absence of any information to the contrary. Thus for example where a dentist failed to explain the possibility of post-operative pain after a procedure the patient may well feel that any pain they do experience may be the result of poor treatment.

What this demonstrates is that complaints occur when precipitating and predisposing factors occur simultaneously[4]

Precipitating factors are those that actually give rise to the complaint such as an adverse outcome, providing incorrect care and system errors and mistakes. This could range from the lab work not being delivered in time for the patient's appointment to an anaphylactic reaction to the administration of a local anaesthetic.

A predisposing factor on its own does not result in a complaint but increases the chance of it such as rudeness, delays, lack of attention, apathy or poor communication.

It is when the precipitating factors are overlaid with the predisposing factors the patient can direct the blame at a series of individuals and a complaint crystallises.



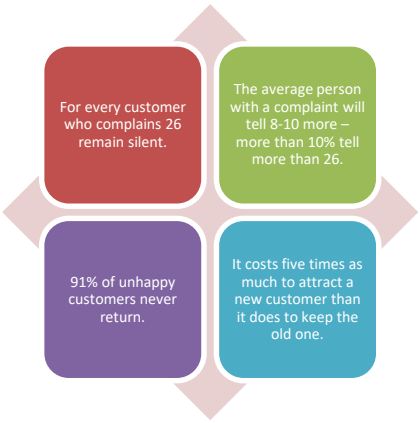
A complaint can be defined as “an expression of dissatisfaction with the practice’s procedures, charges, personnel or quality of service”[5]

For the reasons outlined above it is clear that not every dissatisfied patient complains. A degree of motivation is required for any patient to register dissatisfaction. The greater the gap between expectations and outcome, the higher the level of motivation to complain[6].

Many simply decide not to return to the practice and some of these will tell others. 9 out of 10 dissatisfied patients do not usually give the practice a chance to put things right and leave without raising their concerns[7]. This is double edged sword. It might save you from a complaint and the attendant problems but it also denies you the opportunity of preventing a similar situation occurring again. It also means that the dissatisfied patient never experiences the “recovery” that a practice can utilise to win the patient over again.

In the reception area of a busy practice, it can be hard to view complaining patients in a positive way. Everyone present will be watching the interchange between the patient and the receptionist. The encounter could, understandably, generate a feeling of embarrassment rather than be regarded as an opportunity to improve.[8]

We live in a very customer and consumer orientated world so it is important to remember that receiving a complaint does not necessarily make you a bad dentist,. Sometimes it may just be bad luck, but frequently there has been a breakdown in the relationship between the patients and the team or a member of that team. The breakdown in communication may not rest entirely with the treating clinician and can involve any other individual that the patient considers to be a representative of the practice.[9] Intriguingly Mangels discovered that more than 50% of patients wanted to sue the doctor even before the negligent act took place.[10]



Why patients complain

So why do patients complain? What actually motivates them to put pen to paper or pick up the phone or speak to a receptionist or manager or indeed other third parties?. Contrary to a deeply held suspicion it is not those who are awkward and difficult that are the most likely to complain and complaints are seldom vexatious or mischievous. In every complaint there is always something that can be learnt even if it is simply the manner in which something is said or done.

The most common reasons for making a complaint are[11]:

An outlet

An apology

An explanation

Appropriate remedial action

Redress/recompense/refund

Other sources of information cite other different reasons for complaining

The top 5 issues raised in complaints against dental practices as reported by the Healthcare commission are[12]:

Quality of care

Cost of treatment or challenge in the way in which costs are determined

Removal of patients from practice list

Poor communication with patients

Problems with availability of dentists in the NHS

How do dentists react to complaints?

The instinctive answer to to this is –badly

The effect of complaints on practitioners should not be underestimated as they can be quite significant. In a study conducted amongst a group of medical general practitioners[13] the clinicians described their experiences of patients' complaints in three stages:

Initial impact

Conflict

Resolution

The first stage described being out of control, feelings of shock and panic and a sense of indignation towards patients generally. The second stage described the many conflicts generated by the complaint: emotional conflicts such as feelings of anger, depression, even suicide, conflicts around aspects of professional identity including doubts about clinical competence, conflicts with family and colleagues and conflicts arising from the management of the complaint.

The third stage described a sense of resolution. For many this meant practising defensively, for others it meant planning to leave general practice and, for a minority, no resolution was achieved. Some described becoming immune to complaints as a self-protective mechanism and a small minority described the complaint as a learning experience.

Generally speaking, healthcare staff gives more of themselves emotionally than other workers in service industries, are invariably in a one-to-one close relationship and are therefore much more vulnerable to criticism.

There are short term immediate effects on receiving a complaint, relating to self-doubt and self-confidence, with the result that there is a reduced ability to work confidently and decisively[14]

These go beyond the original complaint and cloud interactions with other patients. In dentistry, where much of the work is of a similar nature, a lack of confidence may affect a significant proportion of the work if, for example, the complaint relates to the

diagnosis of caries or the performance of root canal therapy.

In this study clinicians also reported altered practice in the long-term in the direction of defensive medicine, by withdrawing from providing some services and avoiding perceived at-risk activities.

Patient Complaints in dental practice

A dissatisfied patient in general dental practice has a number of options open to them. They can simply vote with their feet and find themselves another practice perhaps leaving a parting message on a public feedback website such as NHS choices.

They may wish to complain to the practice themselves or the commissioners if the complaint is to do with the provision of services under an NHS contract or the Dental Complaints service if it relates to private care .They may complain to the General Dental Council or raise their concerns via a solicitor and turn their dissatisfaction into a legal claim for negligence. Or they might, in certain cases, do all five.

The response to complaints should be a team effort and all members of the team should receive training in managing a patient's expectation and understanding the practice protocols and policies.[15]

There will always be patients who are dissatisfied with their treatment, or whose expectations are not met in some way and, unless the opportunity is grasped to address and resolve these complaints quickly and effectively within the practice, there will be a likelihood that the patient will take the complaint to another, perhaps to a higher, authority outside the practice.

Apologizing is not an admission of guilt or negligence but goes a long way to helping patients feel better when they think they've been wronged. Effective apologies are sincere − mean what you say.

Make the apology personal − speak in the first person and say 'I' not 'we'. Be specific and don't use a bland phrase like 'We're sorry' when something happens to a patient and 'We always try to do our best'. The 'sad but glad' technique[16] for dealing with complaints allows you to recognize a patient's feelings and motives for complaining − 'I can understand your frustration about your problem' – whilst acknowledging the positive benefit of the person making the complaint both for his/her own benefit and for others using the practice − 'I'm

glad you have brought this to my attention' − which means 'I can try and sort this out'. Being defensive is our natural reaction as clinicians when we try so hard to get things right but, in order to deal effectively with complaints and turn them to our future advantage from which lessons can be learnt, we need to counter that basic instinct of self-preservation.

This section gives a broad outline of the stages of the NHS system of complaints. It then goes on to describe briefly what happens at the GDC if a patient writes directly to complain about a dentist.

Some general practitioners treat patients either under an insurance type scheme such as Denplan or as part of a quality assurance scheme such as the BDA Good Practice Scheme. Both these schemes have procedures in operation if a patient should make a complaint about the services they have received.

From the introduction of the National Health Service in 1948, until 1990 there was no official separate procedure for complaints and they were dealt with under the service committee procedures as set out in the regulations. Thus complaints and discipline cases were inextricably linked to the detriment of both patients and practitioners.

Fundamental to the progress of the complaint was the identification of a breach of one or more of the practitioners Terms of Service. Without this there was no complaint to answer and the patient was left with no further options under the NHS.

Pre-1996 The 'old system'

Criticism of the NHS complaints system in the 1980's and 90's centred on three issues a) it was biased towards dentists b) the procedures were opaque and c) it focussed too much on disciplining rather than resolution of the patient's complaint.

In 1993, in response to the disquiet amongst professionals, academics and patient interest groups, the Wilson Committee was asked by the Government to review the NHS complaints procedure. They reported their findings in *Being Heard-The Report of the Committee on NHS Complaints Procedures (1994).*

The Committee identified nine principles that should be introduced into any NHS complaints procedure: responsiveness, quality enhancement, cost effectiveness, accessibility, impartiality, simplicity, speed, confidentiality and accountability.[1]

Their conclusions ran to over 60 recommendations but fundamental to it was the a) introduction of a single procedure applicable throughout the NHS b) a three-stage process involving "local resolution", "independent review" and the Health Service Commissioner

[1] para 161 Being Heard-The Report of the Committee on NHS Complaints Procedures (1994)

(HSC) and c) an extension of the HSC's jurisdiction to GDP's (and other Part II practitioners) so as to cover "clinical judgement" complaints [2]

The government accepted the Wilson Committee's recommendations in *Acting on Complaints* in March 1995 and on April 1 1996 the "new complaints" procedure was introduced into the NHS for doctors and dentists. The most significant change was the separation of the complaints procedure from disciplinary procedures thus allowing a wider range of issues to be addressed within the complaints procedure. It also meant that practitioners would be more likely to engage fully with the process knowing that disciplinary issues were not the usual end point to the investigations.

The complaints procedure after 1996 was a three level process.

Stage One was local resolution and was the first part of a three-stage process that was common to all parts of the NHS. The intention was to make this part of the process responsiveness enough to deal with the majority of the complaints received by a general dental practitioner, the aim being that the practice itself dealt with the problem quickly and efficiently.

Stage Two of the process kicked off if complainants were not happy with the practice based response and sought an independent review of the matter. Up until 2004 the Independent Review stage was carried out by the Health Authority who via a Screener reviewed the complainants request to establish an Independent Review Panel (IRP). There was no absolute right to an independent review and it was a matter for the convenors discretion.

This stage, most of all was criticised as lacking any real independence and the decision making process by the panels were inconsistent primarily because they sat so infrequently. Whilst this role was taken over by the Healthcare Commission (formerly known as the Commission for Healthcare Audit and Inspection) in July 2004 there remained some concern about the bureaucracy and slowness of the whole process and the complaints process was slimmed down further to a two stage process in England and Wales and set out in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

Requirement to have a practice based complaints process

Under Part 6 of the National Health Service (General Dental Services Contracts) Regulations 2005, general dental practices providing NHS care must establish and operate a complaints procedure to deal with any complaints in relation to any matter reasonably connected with the provision of services.

The Care Quality commission require a practice based complaints process to have an effective complaints process under Regulation 19 of the Health and Social care Act 2008 (Regulated Activities) 2010

[2] p 212 Kennedy I, Grubb A Medical Law 3rd Edition. 2000 Butterworths

The GDC also require that a complaints system is established by the practice and extends the responsibility to deal with complaints down to the individual professional

5.1.1 It is part of your responsibility as a dental professional to deal with complaints properly and professionally. You must:

• ensure that there is an effective written complaints procedure where you work;

• follow the complaints procedure at all times;

• respond to complaints within the time limits set out in the procedure; and

• provide a constructive response to the complaint

Key points of the process

Who can complain –the patient or a representative can complain on their behalf with the patient's consent

A patient can complain directly to the practice or to the NHS Commissioners. The process and time scales for investigation will be the same. The NHS Commissioners can choose, with the complainant's consent to investigate the matter itself or redirect it back to the practice

The regulations require the appointment of a **responsible person** who is responsible for ensuring compliance and in particular ensuring that action is taken if necessary in the light of the outcome of a complaint. This will normally be the sole proprietor, partner or director of the company.

There should also be a **Complaints manager** who maybe a person who is not an employee of the **responsible body** (the primary care provider or independent provider) but could be the same as the responsible person. The intention of having a complaints manager is to ensure one person has an overview of the whole complaints system and would have the task of co-ordinating the correspondence and replies on a day to day basis. A person must be nominated to administer the complaints procedure and they should be identified as such to patients. In a small practice it is usually the dentist who acts as the complaints manger but would not be the appropriate person if the complaint is about the dentists themselves. In this case another member of staff should act as the co-ordinator.

Time limits –the practice has to acknowledge the complaint within 3 working days in writing or orally. The practice must offer to discuss with the complainant, at a time to be agreed with the complainant:

a) the manner in which the complaint is to be handled

b) the response period within which the investigation of the complaint is likely to be completed and the response is sent

If the complainant does not accept the offer of a discussion, the practice must determine the response period and notify the complainant in writing. The outer limit to make a substantive response after investigation of the issue is six months but in most cases, unless the relevant staff are away the process should be completed in a few days. The regulations require the company to be dealt with speedily and efficiently and to keep the complainant informed if timelines need to altered. It is certainly better to respond quickly though there may be delays if advice from your indemnity organisation or input from different staff or dentists is required. In any case as soon as practicable possible after completing the investigation the response must be sent in writing. This must be signed by the responsible person as this ensure that any learning from the complaint and any changes required will be owned and carried out .

The response letter should have an explanation of how the complaint has been considered, what conclusion was reached in relation to the complaint including any remedial action needed and confirmation that any action proposed has or is proposed to be taken.

An **annual report** should be compiled by the practice and available by 31st March each year to the commissioners covering the;

Number of complaints received

Issues that these complaints raised

Whether the complaints have been upheld

Number of cases referred to Ombudsman

Lessons learnt from complaints

Parliamentary and Health Service Ombudsman (PHSO)

The Health Service Ombudsman is the second and final tier of the complaints system in the NHS in England.

The Health Service Commissioners for England and Wales came into existence as a result of the National Health Service Reorganisation Act 1973 (subsequently Part V of the National

Health Service Act 1977) but whose jurisdiction is now defined by the Health Service Commissioners Act 1993 (as amended).

In accepting the recommendations from the Wilson Committee, the Government extended the jurisdiction of the Health Service Commissioners to complaints against dentists (and other Part II practitioners) and to those involving clinical judgement in Section 6 of Health Service Commissioners (Amendment) Act 1996. This was a new step but recognised by the Health Service Commissioner at the time, William Reid, as being another burden "I well understand the concern of professionals about the potential multiple jeopardy they face-from the courts, the regulatory bodies and now the Ombudsman-when encountering complaints about their practice"[3]

The PHSO can only investigate a dentist where it has received a complaint by or on behalf of a person if they have sustained injustice or hardship in consequence of action taken by the practitioner. Action includes inaction and a failure to provide a service[4].

Whilst there are a number of complaints made to the PHSO only a small number (6% in 2012) are investigated formally by them with clinical input where necessary from a dentist.

Any complaint about a dentist to the HSC must be about action related to NHS services the provider has undertaken to deliver. This means that dental treatment provided under private contract falls outside the remit of the PHSO though she has conducted investigations where the patient *believed* they were having NHS treatment when in fact it was private.

Before the PHSO can investigate a complaint they must as a general rule ensure that the complainant pursued the matter locally with the practice or the NHS commissioners

There are statutory limits to what can be investigated by the HSC. These include complaints about personnel issues, actions taken by Health Authorities in connection with disciplinary cases (the old Service committees) and commercial or contractual matters.

Remedy

The PHSO HSC does not to have the power to award compensation but they can recommend ex-gratia payments to cover out of pocket expenses. The PHSO can and often do ask for an apology to be made in the report by the PHSO. They can also ask that a review of the procedures can also take place in the practice.

The PHSO also has the power to disclose information about any person discovered in the course of an investigation to the General Dental Council where they consider it necessary in

3 Reid W Introduction in A guide to the work of the health Service Ombudsman 1996. Published by the Office of the Health Service Commissioner for England

[4] Section 3 (1) (1A) Health Service Commissioners Act 1993 (as amended)].

the interests of the protection of the health and safety of patients. In such cases the Ombudsman must inform the individual about whom they have passed information on to.

The PHSO also has the power to “name and shame” clinicians in their report to Parliament with all the attendant bad publicity that would bring

Dental Complaints Service (DCS)

Up until the establishment of the Dental Complaints service, patients receiving private care who had a complaint about a practitioner, had only the GDC or a legal claim as remedy.

This had always been a cause for concern both for dentist and the public. Private patient complaints often did not amount to the suggestion that the registrants conduct would amount to serious professional misconduct and therefore the GDC would have no reason to consider it. The only other route for the patient in the alternative was a civil claim in negligence.

For the dentists themselves, the GDC’s involvement was an unwelcome and unnecessary addition to the stress of receiving a complaint.

The impetus for a private patient’s complaints scheme came also from the Office of Fair Trading (OFT) which had looked at dentistry following a super-complaint from the Consumers Association in 2001.

The DCS , funded by the GDC was established in 2006 to consider complaints from private patients across the UK against dentists or DCPs. Patients are expected to try and resolve the matter with the practice / clinician in the first instance and can act as an intermediary to facilitate this process. Normally the issues are resolved 7-10 days

If there is no resolution at this stage the DCS will arrange a panel meeting with the consent of the practitioner and patient. The panels comprise two lay and one dentist and are held in the vicinity of the practice. There are very few panel hearings as most issues get resolved quite quickly.

Further Reading

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2) The value of Life-an introduction to Medical Ethics Harris J. Routledge 1997

3) The English Legal Sytem –Martin J 3rd Edition Hodder and Stoughton 2002

4) NCAA Handbook Autumn 2004 - www.ncaaa.nhs.uk

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[2] Oppenheim A Questionnaire design, interviewing and attitude measurement. London Pinetr Publishing Ltd 1997

[3] Newsome P The patient centred dental practice-a practical guide to customer care BDJ Books 2001

[4] Bunting R et al Practical risk management principles for physcians J Healthc Risk Manag. 1998 Fall;18(4):29-53

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[7] Managing Service Quality Vol 4 No 6 p25-28

[8] Complaint handling BDA Advice May 2016

[9] Influencing satisfaction What the patient did next Dental Protection Annual review 2006

[10] Tips from doctors who've never been sued Mangels L *Medical Economics* 1991 Vol 68 PT4 pp56-64

[11] Setting up and running in-house complaints procedures Dental Protection Risk Management Pack

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[14] Cunningham W, Dovey S. The effect on medical practice of disciplinary complaints: potentially negative for patient care. *N Z Med J* 2000; **113**(1121): 454−455.

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