

Report for the Chief Medical Officer's Advisory Group on Complaints and Clinical Negligence, Department of Health, February 2002

Not for citation

Adverse Events, Complaints and Clinical Negligence Claims: What do we know?

**Professor Judith Allsop
Department of Public Policy, De Montfort University,
Leicester.**

**Dr Linda Mulcahy
Department of Law, Birkbeck College, University of
London.**

Address for correspondence:

Professor Judith Allsop
Health Policy Research Unit
De Montfort University
Bosworth House
The Gateway
Leicester
LE1 9BH
Tel: 0116 257 8749
Email: allsopj@dmu.ac.uk

Dr Linda Mulcahy
School of Law
Birkbeck College
University of London
Malet Street
London
Tel: 020 7631 6500
Email: l.mulcahy@bbk.ac.uk

Table of Contents

	Page
List of Tables and Figures	iii
Acknowledgements	iv
Introduction	1
Section One: Conceptual frameworks	3
The relationship between adverse events, complaints and claims	3
The significance of adverse events, complaints and claims	5
Systems and their function	7
The discrete case approach	8
The public interest model	8
Section Two: Adverse events	10
The size of the problem	10
What are the barriers to reporting adverse events	11
Truth telling and honesty: Should patients and relatives be told about adverse events?	11
Honesty in prognosis	13
Section Three: Experiences of complaints and claims for clinical negligence	14
The experiences of patients and relatives	14
Under-voicing and under-reporting	14
Barriers to voicing about health services	14
The presumption of trust and expertise	14
The unequal relationship between patients/relatives and providers	14
Lack of information about how to complain	15
Why do patients/relatives pursue complaints and claims?	16
Barriers to making a claim	16
What do people want when they make a complaint or pursue a claim	18
Doctors' and complaint handlers' response to adverse events, complaints and claims	21
How do doctors respond to complaints and claims?	21
Supportive networks for doctors	23
Do complaints and claims lead to defensive practice?	24
The similarities and differences of complainants' and doctors' perspectives in complaints and claims	24

Section Four: Current systems for dealing with complaints and claims	26
Complainants' views of the 1996 complaint procedures	26
Local resolution	26
Independent Review Panels	28
Doctors' views of the 1996 complaint procedures	28
Complaint handlers' views of the 1996 complaint procedures	28
Differences in dissatisfaction with existing complaint systems	29
The views of the Health Service Commissioner (HSC)	30
The importance of learning from complaints	31
The weaknesses of the 1996 complaint system	31
General criticisms of the clinical negligence system	32
Section Five: Alternatives to existing systems	34
Introduction	34
Reforms to the medical negligence system in the United States	34
Arbitration	35
Mediation	36
The medical negligence mediation pilot scheme	38
Conciliation	40
A no-fault scheme	40
Criticisms of no-fault programmes	42
Conclusions	43
Section Six: Policy implications	44
Systems for handling complaints	44
The particular problems of independent review	45
Integrating systems for managing complaints and claims	46
The importance of learning from adverse events, complaints and claims	47
Bibliography	48

List of Tables and Figures

	Page
Figures	
Figure 1: The relationship between adverse events, complaints and clinical negligence claims	3
Figure 2: Journeys to complaints and medical negligence claims	4
Figure 3: The progress of medical negligence actions	6
Figure 4: Models for managing information about adverse events, complaints and claims	7
Figure 5: What plaintiffs wanted over time	21
Figure 6: Conveners' reasons for sending complaints back for local resolution	27
Figure 7: A dispute resolution spectrum	35
Tables	
Table 1: The action that people wanted when making a Complaint against their GP : 1976-86	18
Table 2: Requests from complainants in letters to hospitals	19
Table 3: Complaints to two hospital trusts: Why did you complain?	19
Table 4: Why do people sue doctors? A study of patients and relatives taking legal action	20
Table 5: What claimants wanted at the start of their claims	20
Table 6: To show respondents' beliefs about what most complainants are looking for when they make a complaint	23

Acknowledgements

The authors would like to thank Julia Eisner for her research assistance and willingness to work to tight deadlines, Marie Selwood for the work she did in bringing the bibliography together and Jennifer Spiegel for all her efforts in typing and sub-editing the final report.

Introduction

1. Calls for reform of the systems for handling clinical negligence claims and complaints are nothing new, but the incentives for change have altered quite considerably over the last two decades. Traditionally, concerns amongst policy makers have focused on the *increasing incidence* of clinical negligence actions and the resulting *cost to the public purse*. These concerns have been exacerbated by suggestions that a far greater number of patients than those who bring a complaint or claim are the victims of adverse events. This suggests that the potential cost to the public purse is even greater. But research into the incidence of adverse events has also invoked intense debate about the wider implications for quality management. As the language and culture of quality and risk management has been introduced into the NHS, policy makers have become increasingly keen to ensure that lessons are learnt from adverse events, complaints and claims.

2. Criticisms of the *processes* by which complaints and claims have been managed in the NHS have been well documented. Critics have come from a number of different quarters including the consumer lobby, the legal and medical professions and academics. They have focused on a number of issues including: overly defensive and reactive approaches to dispute management; the competitive nature of the British litigation system; the effect of complaints and claims on staff and recruitment; the inaccessibility and complexity of dispute resolution systems; the inadequacy of much legal advice; delays in the processing of disputes and the inappropriateness of the remedies available.

3. Recent policy initiatives have attempted to address some of these problems and in doing so have served to challenge the role of self-regulation in the management of disputes between the NHS and its patients. The last decade has seen the reform and partial rationalisation of the NHS complaints system; attempts by policy makers to encourage better dispute resolution practice at service level; the abolition of a clinical complaints appeal structure managed by the medical profession; significant reform of procedures operated by the GMC; and the expansion of the Health Service Commissioner's remit to include clinical complaints.

4. The Woolf reforms to the civil justice system and the introduction of the pre-action clinical protocol have speeded up the settlement process for medical actions and made information about claims more readily available at an earlier stage of proceedings. There has also been a closer regulation of the lawyers who undertake clinical negligence work, by the NHS Litigation Authority and Legal Services Commission, in an attempt to ensure that only specialists practice in the field. In parallel with these developments the Department of Health introduced a mediation pilot scheme in order to test the case for the use of mediation in the management of clinical negligence claims (Mulcahy *et al.*, 2000).

5. Whilst these reforms have addressed some of the concerns of critics, consumer groups and professional associations have continued to lobby the government for change. Research by the Public Law Project (PLP) (Wallace and Mulcahy, 1999), the Department of Health's (DH, 2001c) official evaluation of the new complaints procedure and the reports of the House of Commons Select Committee on Health (Health Committee, 1999) all suggest that

Introduction

there continues to be considerable dissatisfaction about the operation of the reformed procedures and ongoing concern about the ways in which process failures continue to repeat themselves across the country and within the same units. Further impetus for change has come from a number of high profile public investigations of particular incidents and circumstances of poorly managed care such as the Bristol Royal Infirmary Inquiry (Bristol Inquiry, 2001). Such investigations have focused the attention of policy makers, researchers, the media, pressure groups and the general public on the problems caused by systemic failures in the provision of care and redress of the grievances that might arise as a result. It is against this backdrop that this review aims to inform the authors of the forthcoming White paper.

6. The review draws attention to the full range of research which has been undertaken on the handling of complaints and clinical negligence claims in the UK and other jurisdictions. It brings together disparate literatures in order to construct conceptual models that challenge the tendency of existing systems to treat adverse events, complaints and clinical negligence claims as discrete phenomena. It draws attention to the lessons to be learnt from previous research and reviews the characteristics of existing and potential systems that are most likely to lead to credible new procedures.

Section One: Conceptual frameworks

1.1 This section provides an outline of the key concepts in debate about adverse events, complaints and clinical negligence claims. It seeks to clarify the relationship between clinical mishaps and the expression of grievances. It goes on to discuss the key characteristics of grievance systems designed to handle complaints and claims and the ideologies that underpin them. The next section discusses whether there is a duty of disclosure to patients when adverse events occur.

The relationship between adverse events, complaints and claims

1.2 The relationship between adverse events, complaints and claims is not as straightforward as is often assumed. Figure 1 expresses the relationship between the three.

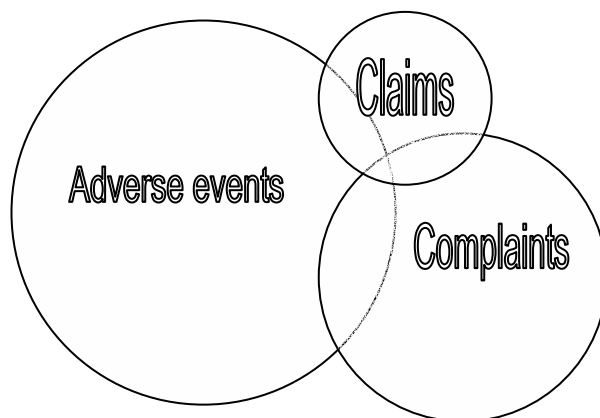


Figure 1: The relationship between adverse events, complaints and clinical negligence claims

1.3 The figure suggests that:

- Adverse events, complaints and claims are distinct but related concepts. Whilst the occurrence of an adverse event may lead to a complaint it is clear from research that the vast majority do not. The Harvard Medical Practice study's review of medical records found that there were seven times as many adverse events as claims for compensation (Leape *et al.*, 1991).
- Conversely, complaints and claims may arise where no medical error has occurred. This is because complaints and clinical negligence claims are accounts of treatment from the perspective of claimants and may subsequently be shown to be erroneous. They relate to *perceived* injurious experiences (PIEs). They may have come about as a result of a

Section One: Conceptual frameworks

misunderstanding or competent clinical care may have resulted in an unusual or unexpected outcome. One of the tasks of complaints and clinical negligence systems is to investigate whether voiced grievances stem from an adverse event or some other failure in the delivery of care that is worthy of a remedy.

- Another reason why there is not a direct causal link between adverse events and complaints. Complaints may contain allegations about mismanagement of clinical care, but they are just as likely to contain allegations that relate to non-clinical aspects of care such as rudeness or waiting times. In turn, a high proportion of clinical negligence claims may relate to the communication of advice about risks and treatment rather than the actual clinical care provided. For example, they may be claims about a lack of informed consent.
- Even when an adverse event has occurred it may not have come about as a result of negligence. The standard of negligence imposed by the British courts operates on two principles: that the patient must agree to treatment; and that treatment must be carried out with proper skill by the clinicians involved. But it holds doctors and other healthcare professionals liable only for that subset of iatrogenic injury that occurs when there is a breach of the legal duty to use reasonable care and, as a consequence, the patient suffers an injury. The law does not expect doctors to be miracle workers. In principle, adverse outcomes which are consistent with 'normal' risk must be borne by the patient. Lindgren *et al.* (1991) found that only 17% of adverse outcomes came about as a result of negligence. This compares with 20% in the Harvard Medical Practice study (Leape *et al.*, 1991).

1.4 The various pathways between adverse events and voiced grievances are illustrated in Figure 2 below.

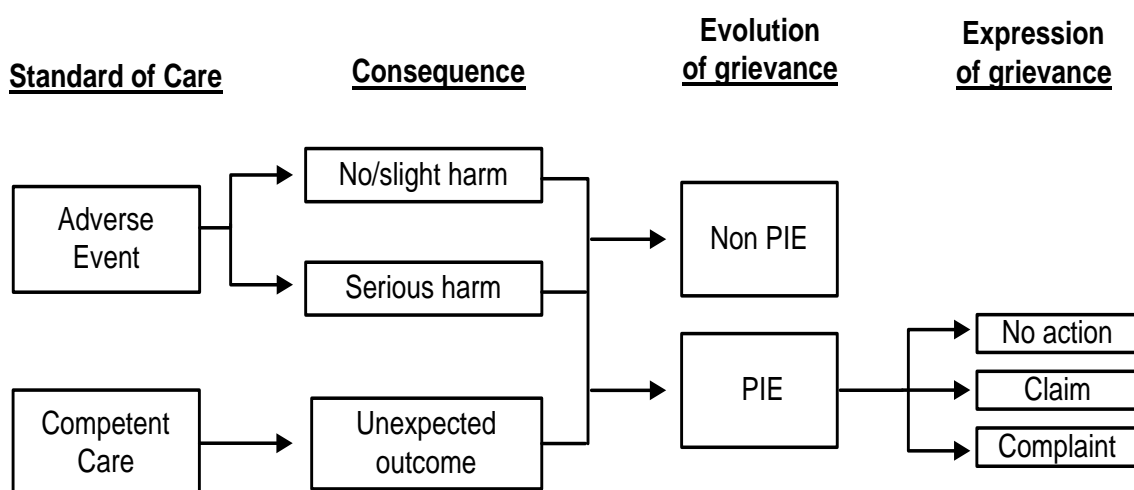


Figure Two: Journeys to complaints and medical negligence claims (After Felstiner, Abel and Sarat 1980-81)

Section One: Conceptual frameworks

1.5 This figure demonstrates that:

- Many adverse events do not lead to injury and when they do it is often minor. Hiatt *et al.* (1989) found that 70% of instances in which there was evidence of an adverse event led to slight or short term injury. Schimmel's study (1964) found that only 20% of iatrogenic injury to hospital patients were serious or fatal.
- Even where serious harm results from an iatrogenic injury, patients do not necessarily *blame* this on the failure of the clinical care. They may believe that their condition is attributable to bad luck or a failure to look after themselves.
- Even where patients believe there has been iatrogenic injury they may *choose* not to make a complaint or clinical negligence claim. In their study of the link between dissatisfaction and voiced grievances Mulcahy and Tritter (1998) found that a significant proportion of dissatisfied patients decided not to pursue their grievance.
- The grievances which are voiced in complaints and claims are not necessarily representative of the medical mishaps which occur. Certain types of grievance are less likely than others to be voiced. Mulcahy and Tritter's study (1998) of 860 dissatisfied patients suggests that certain types of grievance such as those relating to management issues are less likely to be voiced as a formal complaint. Other studies have highlighted the difficulties that patients face in making complaints about technical aspects of care. They prefer to focus instead on aspects of care over which they could claim knowledge e.g., hotel services (Lloyd-Bostock and Mulcahy, 1994)

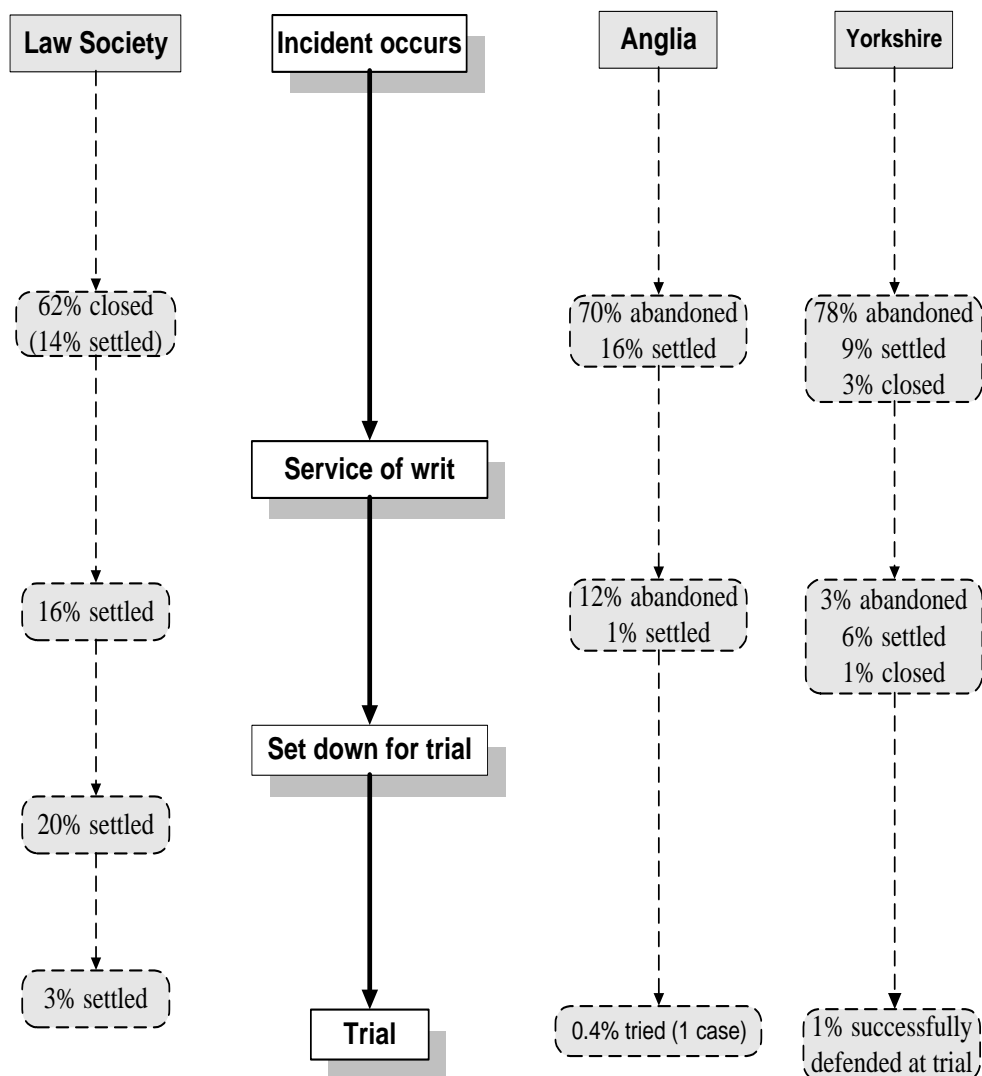
1.6 Figure 3, taken from Mulcahy *et al's* (2000) evaluation of the mediation pilot scheme, shows that in the subset of cases in which clinical negligence claims are made only a small proportion of claimants succeed. Their review of just under 4,000 closed claims files in two health regions found that less than half a percent of cases in the former Anglian region proceeded to trial and one per cent in the former Yorkshire region. Between 70% and 78% of cases respectively were abandoned before the issue of formal legal proceedings.

The significance of adverse events, complaints and claims

1.7 It would seem from this analysis that complaints and claims are very blunt tools by which to identify and respond to adverse events and to compensate victims. The same point has been made by evaluators of risk management systems and has led some to argue that the expense of setting up a sophisticated incident reporting system is disproportionate to the amount of money likely to be saved as a result of an unpredictable reduction in the number of complaints or claims. However, it could also be argued that complaints and claims are significant sources of data about the mishaps that can arise in the provision of medical care

1.8 As was pointed out in *Organisation with a Memory* (DH, 2001b), adverse events have been estimated to occur in 10% of admissions, or 850,000 adverse events a year. This has a cost in terms of additional hospital days and in the settlement of claims. Considerable staff time is also spent in dealing with the aftermath of adverse events and with complaints and claims when they arise. The National Patient Safety Agency was set up in 2001 and will have the responsibility for developing an improved system for reporting, analysing and acting on these phenomena so as to develop systems to prevent them arising in the first place.

Figure 2.5 Summary of Outcomes



1.9 Complaints and claims are unique because they are patient-initiated attempts to reveal mishap. As such they are an atypical form of regulation fuelled by users which provide an important antidote to internal complacency and defensiveness. Many of the recent exposures of poor care which have been debated in the public domain may not have come to light if it were not for the tenacity of patients and their carers. Although risk management systems originally evolved as a result of increases in the number of clinical negligence cases being brought by patients, there is now more widespread acceptance of their value in improving standards more generally. In this model, complaints and claims still have an important role to play in the myriad of data sources available to help track down instances of poor care.

Systems and their function

1.10 It is important to recognise that all grievance systems, no matter what form they take, can have a number of goals. Not all of these are compatible. They can be used:

- For early identification and management of risk,
- As managerial tools in the assessment of quality,
- As instigators of disciplinary action,
- As an opportunity to improve the reputation of a trust or practice,
- As a formal mechanism for patients to discover more about the care they received, or
- As way to resolve disputes.

1.11 A system that aims to limit the financial liability of a trust by early suppression of dissatisfaction may not, for example, serve to publicise bad practice or encourage a full disclosure of mistakes which have been made.

1.12 Two main models for handling information about adverse events, complaints and claims can be identified. These can be labelled the ‘discrete case’ approach and the ‘public interest’ approach. They are ideal types and in reality there are many hybrid models which exist between the two extremes represented by them. Figure 4 below identifies examples of existing systems which fit into each category.

Figure 4: Models for managing information about adverse events, complaints and claims

Discrete case	Hybrid systems	Public interest
Civil justice system United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) General Medical Council NHS Disciplinary procedures Arbitration	NHS complaints system Health Services Commissioner Mediation pilot scheme	A. National learning Commission for Health Improvement (CHI) National Clinical Assessment Authority Patient Safety Agency Council of Health Regulators B. Local learning Risk management Quality management Clinical and medical audit Patient satisfaction surveys

1.13 In the UK, clinical negligence is an good example of a system which individualises blame. Until recently, mechanisms for complaint handling also tended towards the fault-based model and those operated by professional bodies such as the General Medical Council

Section One: Conceptual frameworks

(GMC), General Dental Council and UKCC still do. However, the introduction of the new NHS complaints procedures from April 1996 began to place more emphasis on responding to the needs of disputants, the aftermath of complaints and the lessons which could be learnt from them. Moreover, the GMC has recently introduced a new layer to its complaint procedures that is rehabilitative and designed to help doctors improve their performance before referring them to more formal disciplinary processes. In introducing their five year re-accreditation scheme, the GMC is accepting responsibility for generic quality standards instead of focusing solely on the relatively tiny numbers of doctors found guilty of professional misconduct each year.

The discrete case approach

1.14 The discrete case approach individualises grievance resolution and tends to adopt a fault-based standard. Its aim is to identify ‘bad apples’ responsible for poor performance and punish them. The main features of such an approach is that it is *reactive* to those who make complaints or claims.

- It *individualises* blame by placing the emphasis on investigating the activities of individual actors within the NHS. Individuals within the organisation rather than the organisation itself will be held responsible. As a result the organisation can distance itself from culpability.
- Action can only be taken when someone has acted outside of the powers allocated to them or found not to have performed to an acceptable standard. This has the effect of narrowing the scope of what can be complained about, especially when the definition of power or standards are defined by a professional group. A good example is the law of clinical negligence which holds doctors and other health care professionals liable only for that sub-set of iatrogenic injury that occurs when a breach of the duty to use ‘reasonable’ care occurs.
- The finding of fault is likely to be based on lengthy investigations because the reputations and livelihood of individuals are at stake.
- Access to appeal structures is limited because of the intensity of investigation, resulting cost and burden of evidence required.
- Cases that are substantiated are seen as *discrete* acts of poor performance.

1.15 The discrete case approach is more likely to polarise the positions of the parties because the management of the dispute personalises blame by investigating the actions of the person blamed. This inevitably encourages defensiveness.

The public interest model

1.16 By way of contrast the public interest model is one which places emphasis on what can be learnt from adverse events, complaints and claims. The main features of this model are that:

- The system is proactive. Dissatisfaction may be sought out and complaints encouraged (Cabinet Office, Service First Unit, 1999).

Section One: Conceptual frameworks

- Methods of investigation are pervasive and involve a wide range of individuals and systems.
- Emphasis is placed on systemic failures as well as individual responsibility.
- Adversarial situations are avoided and resolution and redress are used as a way of maintaining relationships and organisational loyalty. The introduction of the clinical negligence mediation pilot scheme is an example of this approach. Although issues of fault and individual blame still remained important in the mediations conducted, some of the remedies supplied by trusts to injured patients reflected a recognition that it was important for claimants to understand how their claim has changed the way care is delivered. The introduction of a requirement that certain key actors see the reports of independent review panels at the final stage of the complaints procedure also indicates a shift away from a purely fault-based model, as does the heightened expectations in the 1996 system that information about complaints will be fed into quality management systems.
- In addition to initiatives aimed at the local level, a number of national bodies have been, or will be, established to protect the public interest, such as the Patients Safety Agency (2001), the Council of Health Regulators (2001) and the National Clinical Assessment Authority (2001).

1.17 The relative merits of these two systems will be considered throughout this report.

Section Two: Adverse events

The size of the problem

2.1 In recent years a number of studies, most of which have focused on the hospital sector in the US, have revealed that the incidence of adverse events is sizeable:

- In 1964 Schimmel reported that 20% of patients admitted to hospital suffered iatrogenic injury.
- Steel *et al.* (1981) found that 36% of patients admitted to hospital suffered an iatrogenic event. More than half of the injuries involved medication.
- One study of medical error in an intensive care unit found that an average of 1.7 errors per patient per day occurred of which 29% had the potential to result in serious or fatal injury (Gopher *et al.*, 1989).
- In 1991 the Harvard Medical Practice study (Leape *et al.*, 1991) reported the results of a population based study of patients hospitalised in New York State. This revealed that nearly 4% of patients suffered an injury which prolonged their hospital stay or resulted in a measurable disability. Nearly 14% of these injuries were fatal. If these rates are typical of the US then 18,000 people die each year as a result of iatrogenic injury.
- Still higher figures were obtained in a recent Australian study in which 17% of admissions led to an adverse event, of which half were considered preventable (Wilson *et al.*, 1995).
- In a UK setting Vincent (1995) found in his pilot study on adverse events that 7% of hospital patients were the subject of adverse events. He concluded that this led to a mean of seven extra days in hospital for those involved, at a cost of £67,000 for 500 cases.
- It should also be born in mind that not all adverse events are reported. Andrews *et al.* (1997) undertook a prospective observational study of work rounds and clinical meetings of 1,047 surgery patients in a selection of US hospitals. At least one error was identified in the care of 44% of the patients.

2.2 These rates are much higher than would be tolerated in hazardous industries such as aviation and nuclear power. Moreover, a large proportion of iatrogenic injuries are due to error and are therefore preventable. Clinical and corporate governance is increasingly providing a framework for ensuring high standards across the NHS and the reduction of error. The efforts of NICE and CHI are directed at laying down standards and investigating lapses. Despite these initiatives it is important to recognise that human barriers to the revelation of mishap remain. It is essential that these are addressed if a responsive system of regulation is to be implemented.

What are the barriers to reporting adverse events

2.3 The Bristol Inquiry (2001) commented on the barriers to reporting adverse events (ch 25). These were identified as:

- A culture of blame and punishment.
- The assumption of perfectibility.
- The code of silence.
- The system of clinical negligence that is based on establishing blame and fault. It does not hold people accountable, nor does it act as a deterrent. It frustrates monitoring, slows the movement to overcome the incidence of error and feeds the cycle of public anxiety.

2.4 Errors may occur in *diagnosis*, *treatment/therapy*, and *prognosis*. Most studies have concentrated on the former two categories. For example:

- The Harvard study indicated that many adverse events noted on the medical record and deemed by researchers as negligent were not acted upon (Brennan *et al.*, 1991). This was because the patient or carer was unaware of them or that they were slight or short-lived.
- Studies undertaken in the US have shown that untoward events in diagnosis and treatment tend to be re-defined not as mistakes or errors but as part of the risk of undertaking medical treatment (Bosk, 1979; Mirzrahi, 1984).
- Christakis (1999), in a study of prognosis, argues that this is equally important as many people undergoing medical treatment are elderly and/or may have life-threatening conditions. His qualitative study concluded that prognosis poses particular difficulties because of the perceived need to give positive messages to patients and relatives. Doctors tended to be under-prepared for truth-telling in their training and feared a loss of status with colleagues and patients in getting it wrong.

Truth telling and honesty: Should patients and relatives be told about adverse events?

2.5 Recent inquiries (Bristol Inquiry, 2001; Royal Liverpool Children's Inquiry, 2001) into adverse events have underlined the importance of properly informed consent, honesty and candour about procedures and processes in medical care.

2.6 The question is not quite as straightforward as it might seem due to the different degrees of gravity of adverse event, current conflicting advice and the different perspectives of patients and doctors about what should be told.

- There are at least four different scenarios where the question of whether patients/relatives should be informed about adverse events arises. These are where an event:

Section Two: Adverse events

- has not caused damage
 - has caused minor temporary damage
 - has caused major but temporary damage
 - has caused permanent damage
- Doctors receive conflicting advice from different sources. NHS employers do not have a legal duty to disclose information about an adverse event. There is no clear guidance to NHS staff about what they should tell patients and their representatives even when they have been harmed through negligence so practice differs (National Audit Office (NAO), 2001). However, the Litigation Authority encourages the NHS to provide patients with factual explanations of, and apologies for, adverse events and to offer remedial health care. It says they should explain fully to the patient what has happened, the likely effects and, where appropriate, offer an apology. Admitting to an adverse event is not same as admitting liability. Advice from the GMC is that if a patient under care has suffered serious harm through serious misadventure and/or other reasons, the doctors should act to put things right (GMC, 1998).
 - The views of doctors may differ from those of patients/relatives on the matter. In a study cited by Williamson (1999) of 246 patients and 48 ophthalmologists there were differences between the two groups. Both groups were asked whether patients should always be told of complications occurring during cataract surgery. Most patients (92%) said yes, but a smaller proportion of the ophthalmologists (60%) said so. Asked whether detailed information on possible adverse outcomes should be given, 81% of the patients and 33% of doctors said yes they should.

2.7 There are a number of arguments in favour of candour in relation to *all* adverse events, whether major or minor.

- The evidence from inquiries and CHI investigations that have related to adverse events, and from the complaints and claims, is that patients and relatives want to be told what happened.
- Patients and relatives should be treated as autonomous moral agents in relation to what is done to their body or that of a loved one.
- What has happened may affect their future decisions about health care in terms of opportunities, constraints and choices, so they should be told.
- They may hear of an adverse event from someone else and as a consequence believe that they have not been told the things they want to know.
- If they are not told, they may use the litigation system to find out what has happened and this could be avoided (Harper Mills and von Bolschwing, 1995).
- Serious and meritorious claims could be resolved without entering into formal litigation (Harper Mills and von Bolschwing, 1995).

Section Two: Adverse events

2.8 The Bristol Inquiry drew on evidence from parents and patients' groups and the Report (2001) makes a strong argument for honesty and candour as part of building a more equal partnership between health care professionals and patients in terms of sharing information and arriving at decisions. Overwhelmingly, those giving evidence wished to be given the doctors' candid assessment of the risks and benefits of treatment. The Report outlined the fundamental principles of a partnership saying that trust could only be sustained by openness; openness meant that information should be given freely, honestly and, above all, regularly. It should be regarded as a process, not a one off event.

2.9 In this spirit, the Report recommends that patients should be informed of adverse events which result in harm and informed of mistakes that are not immediately apparent both where these have occurred as an accident or due to an error by staff within a hospital or family practice (see also Wu *et al.*, 1991).

Honesty in prognosis

2.10 Cases involving the death of a relative or friend engender particularly strong reactions. However, apart from a small scale study by Allsop (1994), and impressions from the content of recent public inquiries, it is not known how often complaints that are not satisfied at the local resolution stage or claims involve a death.

- A large scale US study of 9,105 patients hospitalised in five hospitals showed that physicians' prognosis and end of life care was poor and also that giving physicians prognostic statistics did not change whether they communicated a prognosis to patients or what decisions they made (Christakis , 1999).
- In 1999, the House of Commons Health Committee, in its report on adverse events, recommended that information and support for people who were bereaved should be improved. In its reply the Department of Health (2000) gave assurances that it provided guidance on these matters (HCG(92)8). It also said that the Cabinet Office was leading a group to improve bereavement services.

2.11 Welcome as these may be, they do not address the question of the expectations of patients and preparation for what may be poor outcomes.

Section Three: Experiences of complaints and claims for clinical negligence

The experiences of patients and relatives

3.1 Some of the barriers that patients or their relatives face are similar, whether they want to express dissatisfaction, make a complaint or wish to pursue a claim.

Under-voicing and under-reporting

3.2 Evidence from empirical studies indicates that the majority of potential and actual dissatisfaction with medical services goes unvoiced. Only a minority of those who are dissatisfied, voice a grievance.

- In a large scale survey of households (860) in England, Mulcahy and Tritter (1998) found that about 52% of respondents expressed general or specific dissatisfaction with the NHS. Dissatisfaction was mainly about clinical care, management, access to treatment and the attitudes of, and communication with, providers. However, only 38% of those who were dissatisfied expressed their dissatisfaction orally or in writing to health providers, and then mostly to their doctor. Asked why they had not expressed dissatisfaction, respondents said they had other priorities, wished to put negative experiences behind them or avoid confrontation.
- A MORI survey (MORI, 1997) found that 32% of those who were dissatisfied with the health services complained. The main reason for not doing so was that they thought it would not do any good. This was particularly the case for young men and older women.

Barriers to voicing about health services

The presumption of trust and expertise

3.3 In general there is a presumption of trust between people. This is particularly the case with professionals. Recent investigations have shown that the presumption of trust is strongly embedded in people's perceptions of clinical acts. It can take a considerable time for a person to interpret the behaviour of a health professional as potentially injurious. This has been vividly portrayed in the Bristol Inquiry (2001) and in the CHI (2001) report on the Loughborough GP, Peter Green.

The unequal relationship between patients/relatives and providers

3.4 The relationship between professionals and patients suffers from information asymmetry. Patients are also more dependent on health care professionals than professionals in a public health system are on them. People who are ill are doubly vulnerable; their well-being and even life is in the hands of the health profession.

Section Three: Experiences of complaints and claims for clinical negligence

- In an analysis of Scottish data, patients tended not to make formal complaints when they have a long term relationship with a service provider to preserve, particularly where there is no alternative provider (Annandale and Hunt, 1998).
- On the basis of evidence from complainants and health councils, both the Public Law Project (PLP) Report (Wallace and Mulcahy, 1999) and the Complaints System Evaluation Study (DH, 2001c) reported that people found it particularly difficult to make a complaint about their GP, or GP practice, because of fear that they might be removed from the practice list.
- A national MORI survey undertaken in 1995 on attitudes to complaints about public services found that more people feared recrimination in the health services than in other services (except the police). However, only a small minority (8%) said they were put off complaining for this reason.
- Mulcahy and Tritter (1998) found that people did not complain because:
 - They did not know how to complain,
 - They feared retribution;
 - They anticipated defensive responses;
 - They did not consider the matter important enough;
 - They had consideration for others and could understand the problems faced by staff;
 - They had overcome their anxiety;
 - They did not think about it at the time;
 - They did not believe that it would make a difference or did not want to cause trouble.

Lack of information about how to complain

3.5 The Wilson Committee (DH, 1994) placed considerable emphasis on improving access to complaints systems in the NHS. Since 1996, the information on how to complain has become more extensive, but the balance of evidence suggests that lack of knowledge still may be a problem for some groups.

- When asked about their general knowledge of how to complain, the 1995 MORI survey found that one in three surveyed said they did not know how to do so. Lack of knowledge was a particular problem for those on low incomes and the less well educated. Focus group findings indicated that ethnic minority women also had particular difficulties.
- A follow up study in 1997 (MORI, 1997) found that views of complaining about public services had changed little in the NHS, although the existence of charters had made some difference.
- The Complaints System Evaluation Study (DH, 2001c) did not indicate that access to information was a problem. However, their sample was taken from people who had complained.

Why do patients/relatives pursue complaints and claims?

3.6 If most people do not pursue their concerns, what motivates those who do complain to do so? A complaint may be made by an patient, or by someone else if the patient is not able to do so themselves, or they have died. Depending on the particular data set, complaints have been shown to relate to the patient feeling they had been demeaned; to anger about what was considered to be 'near miss'; to a continuing health problem attributed to care or treatment, or to a more catastrophic injury; or to the death of a loved one (Allsop, 1994). Thus, from the complainant's perspective, complaints are about issues where there is a strong emotional overlay.

- Aharony and Strasser (1992) have argued that relatives may experience dissatisfaction more keenly than the patients themselves. This has been borne out in studies of hospital complaints (Lloyd-Bostock and Mulcahy, 1994) and GP complaints (Allsop, 1994; Mulcahy, Allsop and Shirley, 1996). Deaths seem to invoke particularly strong reactions to PIEs. In Allsop's (1994) sample of complaints to medical service committees, a death had occurred in almost half of the cases. There are no data available from complaints/claims in other settings (but see evidence given by patients to the Health Committee (1999)).
- The social network of contacts that people have exerts an influence on whether they decide to voice their complaint to a health care provider or whether they decide to make a claim. For example, Mulcahy, Allsop and Shirley (1996) found that a number of complainants in their study in Oxfordshire had acquaintances who were health professionals and from whom they had sought advice about whether to complain and how to do so. May and Stengel (1990) in their US study of negligence claims found that people who talked to lawyers, as opposed to family and friends, were more likely to go on to make a legal claim.
- Confirmation that others have experienced the same dissatisfaction with a particular practitioner/practice/hospital can confirm a sense of grievance. There is evidence that people both seek this and may use it to justify their complaint (Allsop, 1994; Mulcahy and Lloyd Bostock, 1994; Bristol Inquiry, 2001).
- Professionals may also act as whistle blowers. Though sometimes thwarted, other experts have played a role in bringing matters to the attention of managers, patients, and the public (Bristol Inquiry, 2001; CHI, 2001).

Barriers to making a claim

3.7 Despite concerns within government about the rising bill for clinical negligence claims, there are considerable barriers to people pursuing a claim for compensation for injuries that they believe are the consequence of clinical negligence. In the subset of cases in which clinical negligence claims are made only a small proportion of claimants succeed. Mulcahy *et al's* (2000) review of just under 4,000 clinical negligence claims files in two health regions found that less than 0.5% of cases in the former Anglian region proceeded to trial and 1% in the former Yorkshire region. Between 70% and 78% of cases respectively were abandoned before the issue of formal legal proceedings.

Section Three: Experiences of complaints and claims for clinical negligence

3.8 Researchers have identified a number of reasons why dissatisfied, or injured, patients do not initiate claims. These relate to the disposition of the claimant, the information they possess and the organisational, financial and structural constraints on the expression of grievances in the NHS and civil justice system. Research suggests that dissatisfaction about clinical care is the product of a complex interaction between patients' perceptions, expectations, history of care and emotional state.

3.9 Patients face a number of difficulties in mounting a claim:

- It can be difficult for participants in the process to distinguish negligent harm from the unavoidable outcomes of medical care (NAO, 2001). Patients and their relatives are often not in a position to know that an adverse event has occurred because they were too ill to know, were unconscious at the time or if the relative bringing the claim was not present.
- Whether there has been negligence requires an expert opinion. This has proved to be a problem in clinical negligence actions as doctors have proved reluctant to criticise the work of others in the profession. The nature of medical work is such that it is unusual for expert witnesses to give an unambiguous opinion as to whether there was negligence.
- The standard of proof required is very high. Recent studies have put the success rates for medical negligence claims at around 25% (Hawkins *et al*, 1987) or 30% (Fenn *et al*, 2000). The problems of fault are such that in some countries the burden of proof is reversed and it rests on the defendant to prove that there was no negligence where a *prima facie* case has been made.
- Significant resources are necessary to mount a claim and the costs of pursuing a claim are often disproportionate to the damages awarded (Lord Chancellor's Department, 1996). In order to obtain legal aid, a claimant is subject to income tests and under new rules a case must be judged by the Legal Services Commission to have merit. This effectively rules out smaller claims for under £10K. Under £5K damages must exceed costs where there is 80% likelihood of success with a sliding scale. The Legal Services Commission supports 74% of claims coming to it, but only 48% of the population is eligible for legal aid (NAO, 2001). The fact that 92% of clinical negligence claimants receive legal aid suggests that those who are ineligible for such assistance find the financial risks of mounting a claim too great (Lord Chancellor's Department, 1996). Conditional fee agreements have been introduced for other litigants, but it is still unclear what part these new arrangements play in facilitating the pursuit of meritorious claims.
- People may lack information about how to pursue a claim and on how to seek legal and clinical advice and there are disincentives for staff to help them. Department of Health guidance requires that liability should not be admitted on the basis of an internal investigation, as managers and clinicians are not able to make this judgement on this information alone. The argument has been that claims take resources away from patient care and informing patients of problems in their care would encourage speculative claims.

Section Three: Experiences of complaints and claims for clinical negligence

- Problems have been compounded by the inadequacy of much legal advice. Although this situation has improved since the Legal Services Commission and NHS Litigation Authority have taken a more proactive role in accrediting solicitors.

What do people want when they make a complaint or pursue a claim

3.10 Complaints and claims cover a wide range of concerns from the minor and relatively trivial to life threatening events, permanent disability or death. Despite this range of events, there is some overlap in terms of what people say they want when they make a complaint or pursue a claim.

3.11 Even when there have been poor outcomes, a number of research studies across the different settings of family practice and hospitals, and using different methodologies, have shown that most people place an emphasis on non-financial remedies. These include: to be taken seriously; to be given sympathy and reassurance; to make an explanation or apology; to have a decision reversed, something done more quickly, a loss made good, or something put right; a waiver or reduction of fees; the payment of monies due; the restoration of possessions; or remedial treatment. Very few complainants said they wanted someone punished or that they wanted compensation.

3.12 Those who initiate claims may want compensation but they also want non-financial remedies as well. Many claimants say that they are complaining or claiming to prevent the same thing happening to someone else and that they want lessons to be learnt as a result of the complaint. Studies indicate that these attitudes have been consistent over the last two decades. This indicates that the needs of complainants and claimants often coincide with those of quality managers and policy makers. The tables below present data from a number of UK studies. Table 1 relates to general practice.

Table 1
The action that people wanted when making a complaint against their GP : 1976-86

Type of action wanted	Number of references	Percentage
Sue for negligence	1	1%
Consider suing for negligence	6	5%
Prevent the doctor from practising	3	2%
Punish the doctor	11	9%
Stop a poor standard of practice	28	22%
Hold the doctor accountable	16	12%
Get an investigation and an explanation	37	29%
Voice a complaint	25	20%
Total number of references in 107 letters	127	100%

Source: Letters of complaint to Medical Service Committee Hearings 1976-86 (Allsop, 1994)

Section Three: Experiences of complaints and claims for clinical negligence

3.13 Table 2 presents data from a study also based on an analysis of letters from complainants.

Table 2
Requests from complainants in letters to hospitals

Request	Percentage
Requests to put matters right for the complainant [arrange help/treatment; pay expenses/compensate apologise/arrange a meeting; discipline the doctor]	15%
Make changes to put matters right for others	20%
Carry out an investigation/provide information	21%
General request to take action	21%
No specific request	20 %

Source: Adapted from Lloyd Bostock and Mulcahy (1994)

3.14 Table 3 presents data from a study of two hospital trusts in the Northwest. It is interesting to note that in the case of the hospital complaints there was no mention of negligence.

Table 3
Complaints to two hospital trusts: Why did you complain?

Objective	No of times mentioned	% of respondents
Prevent a recurrence	126	74%
Make dissatisfaction known	112	66%
Explanation	83	49%
Apology	48	28%
Admission of responsibility	35	21%
Get better treatment	45	26%
Have a disciplinary action	6	4%
Other	3	2%

Source: Kyffin et al., 1998

3.15 The remedies that people want when they pursue a claim reflect some of the same needs. As Table 4 shows, an apology, explanations and the desire to improve services figure

Section Three: Experiences of complaints and claims for clinical negligence

strongly in what claimants say they want in addition to an admission of fault or compensation.

Table 4
Why do people sue doctors? A study of patients and relatives taking legal action

One or more of the following	Percentage
An admission of fault, to prevent a recurrence, an investigation	50 %
An apology, to make health providers understand what had happened	40-49 %
To be told what happened, the defence to show they cared, to achieve changes to improve quality of services, to receive compensation, to hear the other side	30-39%

Source: Vincent, C., Young, M. and Phillips, A. (1994)

3.16 Respondents in Vincent *et al's* (1994) study were also asked what would have prevented them from taking legal action. They said that one or more of the following would have provided adequate redress at an earlier stage: an explanation and an apology; the correction of the mistake; the payment of compensation and the admission of negligence.

3.17 More recently, Mulcahy *et al's* (2000) survey of 117 claimants showed that at the outset of their claim, claimants had an extensive range of aims. Table 5 shows the categories of remedies they cited. When asked to prioritise their aims, over a third cited compensation as their first priority, this was followed by a desire to prevent a recurrence (27%).

Table 5
What claimants wanted at the start of their claims

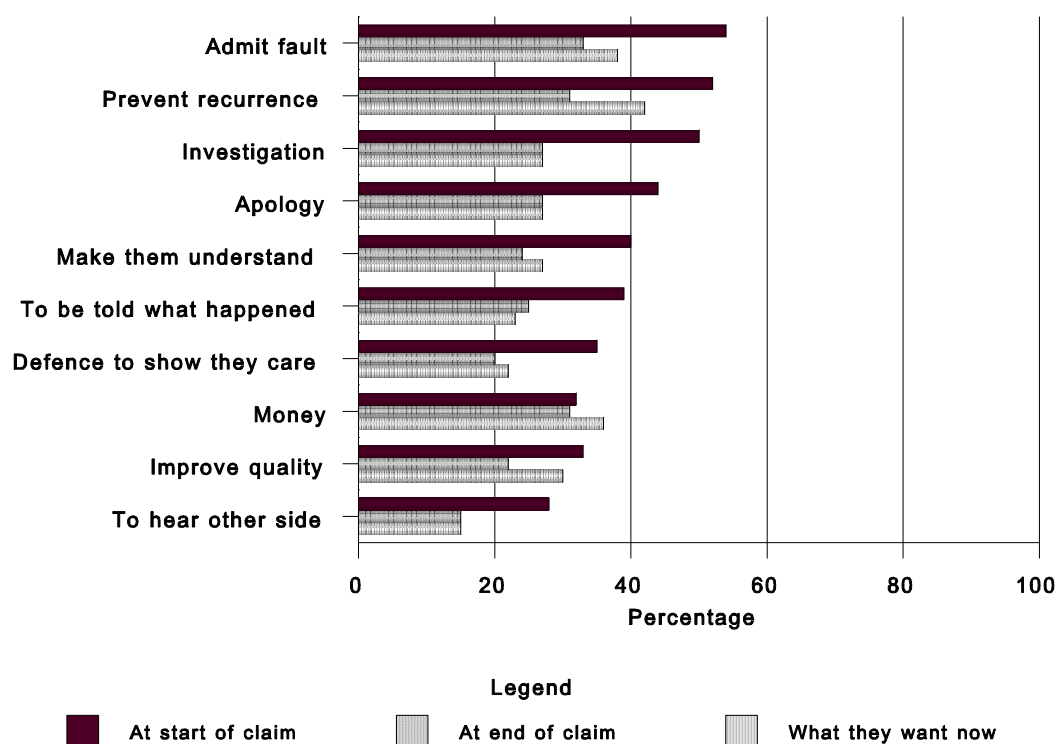
Remedy	Percentage
To stop the same thing happening to someone else	52%
The provision of an apology	44%
The opportunity for the other side to understand their concerns	40%
For someone to show they cared	35%
An opportunity to hear the other side	28%
To talk through the issues	27%
Arrangements to be made for treatment	27%
The opportunity to meet the other side face-to-face	25%

Section Three: Experiences of complaints and claims for clinical negligence

Source: Mulcahy *et al.*, (2000), p 12

3.18 This same study demonstrated that when claimants' goals were charted over time, and they were given the opportunity to reflect on the handling of their claim, many of claimants' needs remained unmet. Indeed, by the end of their claim, their needs for a range of remedies actually increased. This suggests that the process had exacerbated their concerns.

Figure 5: What plaintiffs wanted over time



Doctors' and complaint handlers' response to adverse events, complaints and claims

How do doctors respond to complaints and claims?

3.19 Adverse events, complaints and claims pose a threat for a number of reasons. Physicians are trained to operate at a high level of efficiency and to strive for error free practice as the consequences of error are serious. On the one hand this can lead to psychological defences against admitting errors and on the other an anxiety about dealing with them when they occur or when allegations of poor practice are made through complaints and claims. For example, observational and interview studies undertaken in the US have shown that untoward events tend to be redefined not as mistakes or errors but part of the risk of medical practice (Bosk, 1979; Mirzrahi, 1984).

3.20 A number of UK studies across both the general practice and hospital setting (Allsop, 1994; Mulcahy, Allsop and Shirley, 1996; Allsop and Mulcahy, 1998) have demonstrated the anxiety caused by complaints. Complaints and claims have been explained as due to the uncertainty of disease and the medical process and the different perceptions of the

Section Three: Experiences of complaints and claims for clinical negligence

complainant or claimant. Sometimes, they are attributed to the lack of resources within the NHS and the constraints on practice.

3.21 The UK studies cited above suggest that a complaint is interpreted as a challenge to expertise and authority that goes to the heart of doctors' sense of identity. The findings indicate that doctors thought that most complaints were unjustified. Moreover, they had had a significant emotional impact on the doctors concerned.

- Allsop and Mulcahy's (1998) study, based on a questionnaire to 848 hospital consultants in the Oxford region found that the ten most frequently mentioned responses to a complaint were all negative. These were irritation (52%); worry (42%); concern (38%); surprise (38%); annoyance (37%); anger (33%); distress (32%); disappointment (31%); anxiety (28%) and vulnerability (28%). Interviews indicated that consultants found complaints upsetting and hurtful because they indicated that a patient had questioned their competence and commitment, and this in turn had affected their perception of themselves as competent professionals.
- The emotional impact and fear of the repercussions could prevent a doctor from giving an appropriate response to the complainant. It could also be a barrier to reflecting on whether the complaint indicated a poor standard of practice and whether any lessons could be learnt from it.
- Some doctors in the study dealt with complaints themselves and did not report them to managers as the regulations required.
- Yet others felt disempowered because the complaint handling process was taken out of their hands and they did not have the opportunity to put their point of view forward. Some expressed the opinion that doctors also had a right to be heard.

3.22 Prior to the 1996 complaint system GPs could be subject to service committee proceedings if a breach of their terms of service with the NHS was indicated in a complaint. If found to have breached their terms of service, a warning or a withholding of remuneration could follow. The disciplinary aspect of this system was criticised by bodies representing GPs as being counter-productive and stressful. In the Oxford GP study (Mulcahy, Allsop and Shirley, 1996) Local Medical Committee secretaries reported that some GPs became extremely anxious and sometimes seriously depressed by complaints. In a more recent study that spanned the new and old complaint systems, Jain and Ogden (1999) analysed 288 questionnaires from GPs in one area of London. They also found that complaints initially had a major emotional impact, although this resolved over time.

3.23 The strength of doctors' reaction to being complained about partly relate to a loss of control over a process that might eventually expose them to disciplinary systems such as that operated by the GMC and the courts. Again, although relatively rarely used, the threat of formal sanctions throws a shadow over those who receive complaints. There may also be consequences for the doctor's reputation and status. Their expertise and personal autonomy are also questioned. These may be much more important than an actual court appearance.

3.24 However, it is worth noting that when doctors were asked in the Oxford consultant and GP studies what they thought complainants wanted, most recognised that they wanted

Section Three: Experiences of complaints and claims for clinical negligence

an explanation, an apology or an investigation. More GPs said that the complainant wanted a ‘reprimand’, and more hospital consultants said complainants wanted compensation, than complainants themselves. Table 6 below presents the data.

Table 6
To show respondents' beliefs about what most complainants are looking for when they make a complaint

What most complainants seek when they make a complaint	General Practitioners (n = 58)		Hospital Consultants† (n = 443)	
	Total	%	Total	%
An explanation	40	26	201	31
An apology	34	22	157	24
An investigation	32	21	81	13
A reprimand for the person being complained about	26	17	54	8
Something to be done more quickly	6	4	48	7
A decision to be reversed	5	3	21	3
Compensation to be given	3	2	82	13
Further investigation / 2nd opinion	3	2	-	-
Other eg. trouble, to displace their anger	5	3	-	-
None of the above	1	0.6	-	-
Total	155	99.6	644	99.6

† Mulcahy, L. and Selwood, M. (1995)

Source: Mulcahy, Allsop and Shirley, 1996

3.25 A number of studies (Charles, 1982; Charles and Kennedy, 1988; Ennis *et al.*, 1991; Ennis and Vincent, 1994) have found that claims are also stressful for doctors. Doctors reported a number of signs of physical illness: insomnia, irritability, headaches, and other stress symptoms as responses to having made mistakes. In the context of clinical negligence, Lavery (1988) argues:

“By bringing a legal action, the patient also assaults the physician’s credibility, insinuating faulty judgement or treatment. Self esteem and status as a successful practitioner in the community or member of an academic environment are suddenly jeopardised. A malpractice suit challenges professional credibility and authority”.
 (p. 139)

Supportive networks for doctors

3.26 While research indicates that doctors feel threatened by complaints and claims, most doctors use both informal and formal networks of support to help them through the

process. Mulcahy (1996) and Mulcahy, Allsop and Shirley (1996) showed that both GPs and hospital consultants turned to colleagues for support more than family, friends and managers. However, Local Medical Committee secretaries in the latter study suggested that a small minority did not. The secretaries believed that these doctors were particularly vulnerable to anxiety and depression. The medical defence organisations provide more formal networks of support and many doctors also used this source for information and help.

Do complaints and claims lead to defensive practice?

3.27 There has been extensive discussion in both medical and legal journals of the problems of defensive medicine as a result of negligence claims. It is said to occur when specific procedures, tests or treatment are employed or withheld, expressly for the purpose of averting a possible lawsuit (Ennis and Vincent, 1994 and see also Ennis *et al.*, 1991; Macfarlane and Chamberlain, 1993; Summerton, 1995). However, Ham *et al.* (1988) suggest that there is little hard evidence that defensive medicine is on the increase. Despite this, the courts appear to have acknowledged the existence of the phenomenon and many commentators assume this effect. Brown and Simanovitz (1995) suggest that the 'mere hint of negligence may lead to a knee jerk reaction of determined defence' (p. 488). Similarly, in an American context McQuade (1991) comments that the perceived threat of litigation has almost as much impact on clinical practice as an actual lawsuit. Empirical research indicates that fears of defensive medicine can have an impact on practice:

- It may be one factor contributing to the rise in caesarean rates (Macfarlane and Chamberlain, 1993).
- In his survey of GPs, Summerton (1995) found that doctors made significant changes to their practice to avert complaints. Common practices were an increase in diagnostic testing, an increased referral rate and follow up, more detailed patient explanations, and more detailed note-taking. Some of these practices could lead to benefits for patients, leading him to the terms positive and negative defensive medicine to describe these practices.
- Mulcahy, Allsop and Shirley (1996) and Jain and Ogden (1999) both found that doctors changed their practice to avert complaints. In former study, doctors reported changes were made to increase the amount of information in record keeping, liaison with other agencies and staff training; and to review out-of hours cover and appointment systems.

The similarities and differences of complainants' and doctors' perspectives in complaints and claims

3.28 The review of existing research has revealed both similarities and differences in complainants' and doctors' perspectives of complaint and claim systems. There are some shared understandings and goals. For example there is a measure of agreement that:

- For both parties, the emotional impact of complaints is high and the process of resolving differences stressful.

Section Three: Experiences of complaints and claims for clinical negligence

- Complainants and claimants want explanations and to be told what happened, as well as other remedies, which is accepted by doctors.
- Data from complaints and claims should be used to prevent events recurring and to improve services.

3.29 However, there are also differences in how complainants and doctors perceive each other:

- A number of studies (Allsop, 1994; Mulcahy, Allsop and Shirley, 1996; Allsop and Mulcahy, 1998) show that complainants perceive doctors as defensive and as closing ranks (see also Health Committee, 1999). Doctors on the other hand sometimes see complainants as ‘moaners’ and as wanting revenge. Complaints are difficult and intrusive and take them away from patient care.
- The Complaints System Evaluation Study (DH, 2001c) indicates that these attitudes have persisted into the new complaints system. Complainants tend to see NHS staff as disinterested, defensive and arrogant while staff consider some complaints as ‘vexatious’. This is discussed further in the following section.

3.30 These attitudes reflect stereotypes of the two parties to a dispute and are not easy to reconcile without a shift in perceptions and in the systems for service delivery that have helped to create an adversarial culture. Managers have to deal with a complex interface between different actors: consultants, medical and nursing staff, and chief executives. In addition, they have to deal with conflicting expectations. Sometimes, their position within the organisation gives them limited authority to act.

Section Four: Current systems for dealing with complaints and claims

4.1 Once patients/relatives have voiced a grievance, dispute resolution systems may either assist them to articulate their concerns and resolve the issue, or leave them dissatisfied. A grievance can be escalated and a critical position entrenched by poor handling so that a patient/relative may take their concerns to a higher level. Alternatively, they may withdraw because they have been defeated by the process. Neither of these outcomes is satisfactory. The longer a grievance continues and the higher the level to which it is taken, the more costly it is to deal with in terms of time and resources. If the patient/relative withdraws, then confidence in the NHS is undermined. Research for private sector companies indicates that dealing with complaints is an important aspect of customer care and seen as essential to maintaining profit share. (Cabinet Office, 1995). The maintenance of public confidence is just as important in public services. It is essential to the integrity of current system for handling complaints that concerns are addressed. It is also important to ensure that as few complaints as possible ‘progress’ to the civil justice system.

Complainants’ views of the 1996 complaint procedures

4.2 Three research studies, PLP (Wallace and Mulcahy, 1999), Kyffin *et al.* (1999) and the Complaints System Evaluation Study (DH, 2001c), have investigated the post-1996 complaint system. Evidence from all three studies indicates a number of sources of dissatisfaction with both the local resolution stage and the Independent Review Panel (IRP) process. Despite the different methodologies and methods adopted, the findings of the studies are broadly in agreement about the reasons for dissatisfaction.

Local resolution

4.3 Most complaints (94%) do not progress beyond the local resolution stage. On the basis of evidence from complainants, health councils and patients’ organisations a number of sources of dissatisfaction have been identified.

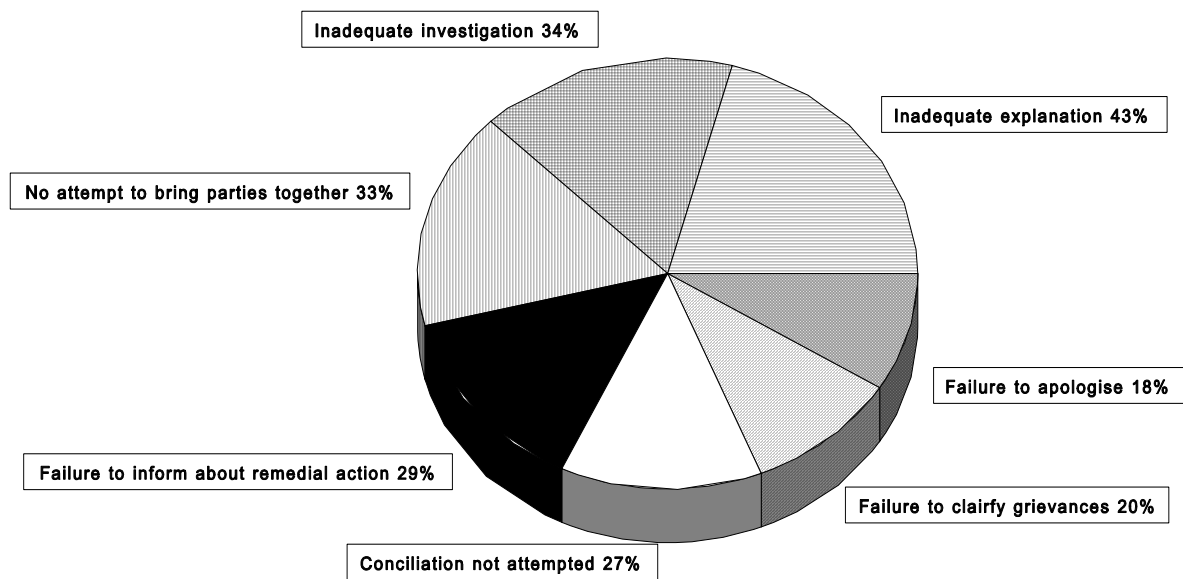
- In the Complaints System Evaluation Study (DH, 2001c), around two thirds of respondents were dissatisfied with:
 - the handling of complaints and the time taken (too many people handling; a failure to take responsibility; persistent questions about taking legal action)
 - the fairness and impartiality of the process (biased in favour of staff)
 - the attitudes of staff (lack of respect/sympathy; patronising/arrogant)
 - the outcome of complaints (didn’t give them explanations/apologies)

Three quarters of the respondents found the process stressful and distressing.

Section Four: Current systems for dealing with complaints and claims

- In the Complaints System Evaluation Study (DH, 2001c), health councils also thought that procedures were daunting for complainants. They believed that the flexibility of the arrangements brought unpredictability. This was particularly so within the family practitioner sector where the requirements are minimal. In particular, people found it difficult to complain about their GP. Furthermore, the family practitioner process did not ensure accountability. This point was endorsed by associations representing patients.
- In their study of two hospital trusts in the north west, Kyffin *et al.* (1999) found that over 75% of complainants said that they were dissatisfied with the response of the trust. In particular, formal response letters failed to address all their concerns. Only 27% of complainants contacted the trust again following their initial letter, suggesting that they had given up.
- Another measure of inadequacy of the initial stage of complaint handling is demonstrated by the PLP (Wallace and Mulcahy, 1999) study in its analysis of why conveners sent back requests for further local resolution. Of the 102 cases identified, conveners sent back almost half (47%). The reasons are shown in the diagram below.

Figure 6
Conveners' reasons for sending complaints back for local resolution*



Source: adapted from Wallace, H. and Mulcahy, L. (1999)

4.4 In both the Complaints System Evaluation (DH, 2001c) and the PLP (Wallace and Mulcahy, 1999) studies, the convening process drew particular criticism from complainants, health councils and conveners. The position of the convener as a member of the Board of the organisation complained about was the reason why the process was seen as unfair and biased. Conveners felt that this jeopardised their position as they knew the staff being complained against.

Independent Review Panels

4.5 Both the Complaints System Evaluation (DH, 2001c) and PLP (Wallace and Mulcahy, 1999) studies found very high levels of dissatisfaction with IRPs. Over two thirds of those interviewed did not think that complaints were handled well at this stage.

- The major criticisms related to the length of time the process took (many took two or three years to process), the lack of fairness and impartiality; the lack of thoroughness of the investigation; and the lack of feedback on action. Almost all the respondents (90%) thought that the process was stressful and distressing.
- Health councils and patients' groups with wider experience of the operation of panels were concerned about the variability of the panel process; the quality of panel reports; inadequacies of the investigations; the lack of feedback on action taken and the failure of organisations to learn from complaints.
- It was also believed that holding the IRP on NHS premises coloured the perception of complainants. Moreover, the PLP (Wallace and Mulcahy, 1999) research demonstrated that there was extensive concern that many IRPs saw the disputants separately and did not bring them together so they could hear each other's point of view.

Doctors' views of the 1996 complaint procedures

4.6 There has been no recent qualitative study of doctors' views of the new complaint system. Staff, including doctors, and their professional associations were included in the Complaints System Evaluation Study (DH, 2001c), but the opinions of doctors were not disaggregated from other staff.

4.7 In contrast to complainants, a much larger proportion of NHS staff were satisfied with the new procedures. Around two thirds thought that the complaint was handled well and that it was dealt with within the time limits. Staff found that their colleagues had been supportive through the process and that the process was fair and unbiased. However, more than half of the respondents were not satisfied with the way they were kept informed of the progress of the complaint and almost three quarters said they found the process stressful.

4.8 Although undertaken at a time when a previous complaint system was in place, Mulcahy's (1996) Oxford consultant study showed that doctors involved in complaints wished to be heard and to be able to defend themselves, particularly in relation to what they considered unjustified or frivolous complaints.

Complaint handlers' views of the 1996 complaint procedures

4.9 Despite the fact that they are intermediaries in disputes between complainants and doctors, there have been few studies of managers. Mulcahy and Lloyd Bostock (1994), in their study of hospital complaints, investigated managers' role in complaint handling through an analysis of letters sent to complainants and interviews with managers.. Some had undertaken an investigation and attempted to resolve the issue at hand, but most had acted

Section Four: Current systems for dealing with complaints and claims

as doctors' agents, simply copying large parts of doctors' responses to the complainant with little attempt to translate issues into lay language and to meet the complainants' concerns.

4.10 In the Complaints System Evaluation Study (DH, 2001c), complaint managers and Chief Executives were interviewed for their views on the current system. There was strong support for local resolution from these groups.

- Complaint managers said they thought the new process was more impartial, more flexible and encouraged learning from complaints compared to the system prior to 1996. However, they also thought that changes were needed to make the system easier to operate.
- The Chief Executives believed that local resolution was more cost effective. A large majority (85%) said that they had met face-to-face with complainants; a finding that contradicts that of complainants who felt there were too few meetings. Chief Executives were most critical of the performance targets set and particularly the time limits, which were seen as most unrealistic.

4.11 Among NHS staff generally, there was a concern with 'vexatious' complainants. They suggested that protocols were needed to deal with these.

4.12 Complaint handlers were particularly critical of the IRP system and the role of the convener, which they believed complainants saw as biased in favour of the organisation complained against. Many also said there was too little evaluation of the different stages of the process and too little monitoring of the action plans drawn up to implement the findings from complaints. This is somewhat paradoxical given their pivotal role in the system.

Differences in dissatisfaction with existing complaint systems

4.13 Complainants were much more dissatisfied than doctors and managers with the local resolution stage:

- They did not think it provided a sympathetic response or the remedies that people wanted in a timely manner.
- There was a failure to use informal means of communication through the telephone or face-to-face meetings or to use conciliation
- In particular, barriers were perceived in relation to complaints about family doctors.
- Complainants often felt that complaints had not been investigated properly and fully.

4.14 Both doctors and their representative organisations and managers were much more satisfied with the new procedures for local resolution than complainants. Although doctors found the process stressful, they said they had access to support networks.

Section Four: Current systems for dealing with complaints and claims

- Complaint managers said the new system was difficult to manage. Time scales and the difficulty in meeting the requirements of the system within the resources available were identified as key problems.
- The lack of training for staff in general, and for complaint handlers were key problems.

4.15 There was widespread dissatisfaction with the IRP procedure. Complainants, patients' organisations, NHS staff and their organisations all were dissatisfied. Common criticisms were:

- The lack of independence of the convener as a member of the Board of the organisation complained about.
- The length of time taken to process complaints that progress to the IRP stage and the impossibility of meeting the time-scales.
- The bias and lack of independence of the IRP process.
- Variations in the process between different trusts and health authorities.

The views of the Health Service Commissioner (HSC)

4.16 As the only public window of review on the operation of the complaint system, the HSC plays a vital role in identifying issues where there have been inadequacies in service and in monitoring the operation of the system. Regional monitoring of the complaint system is minimal and varies between areas. The HSC only investigates a small proportion of complaints referred to him as the remit is to investigate cases where something has gone wrong. These cases are not therefore representative. However, many of the issues pinpointed by the HSC (HSC, 1996/7, 1997/8, 1998/9, 1999/0, 2000/1) have been confirmed by the PLP (Wallace and Mulcahy, 1999) and Complaints System Evaluation (2001c) studies.

- Some complaints take a long time to process and this limits complainants' access to redress.
- GPs have removed patients from their lists after a complaint without giving a reason, causing further distress.
- Lack of understanding of the complaint system within the Family Practitioner Services.

4.17 The HSC has identified the following problems with the operation of the convening role.:

- The perceived lack of independence and partiality in carrying out the role
- Delays in the process
- A failure to refer cases to an IRP

Section Four: Current systems for dealing with complaints and claims

- Investigating a case rather than referring it
- Failure to obtain clinical advice
- Failure to give reasons for decisions
- Assumptions about recourse to law

In relation to IRPs the HSC has drawn attention to the failure to take sufficient evidence and to produce adequate reports.

4.18 The HSC is investigating more cases with a clinical content, including dental and other family practitioner complaints. He has also commented that the cases he receives are at the more 'serious' end of the spectrum where a range of remedies, including financial compensation may be appropriate.

The importance of learning from complaints

4.19 Despite recommendations from various committees and enquiries (DH, 1994; Cabinet Office, 1995; Health Committee, 1999; DH, 2000), all of which called for better systems for recording and analysing adverse events, complaints and claims, these remain poorly developed. Yet, in terms of quality management, recording and monitoring the incidence and type of these phenomena is vital so that action can be taken and things put right.

- Kyffin (1997) in an investigation into twelve northern trusts found limited recording and monitoring. In the absence of central guidance there were different systems in use, categories were not broken down to reveal discrete problems that were common across different sources of information. They recommend a tiered recording framework for complaints/claims.

4.20 Learning from complaints can be achieved through better recording and monitoring so that trends can be identified and through analysing and taking action on particular complaints

The weaknesses of the 1996 complaint system

4.21 Currently, NHS complaint systems do not meet either of the criteria set out in chapter One, namely:

- That they should satisfy the needs of the complainant. They do not meet natural justice criteria of accessibility, impartiality, transparency, fairness
- That they should lead to lessons being learnt. Complaints where there were serious implications for the care of others are not being dealt with in an urgent and timely manner

Section Four: Current systems for dealing with complaints and claims

4.22 A number of structural factors contribute to these weaknesses, such as:

- Complaints are not dealt with at a senior enough level. The lines of accountability are not always clear. The complaint management role is not always integrated with quality management and clinical governance.
- There is insufficient training for staff in complaint handling. Complainants would also welcome more telephone contact, face-to-face meetings. Other third party interventions such as conciliation are rarely used, particularly by trusts.
- Opportunities for early resolution are lost. Investigations are often insufficient and responses insufficiently detailed. There is a need for greater creativity in providing remedies.
- Practice-based systems in primary care are diverse and often poorly developed.
- The operation of IRPs pose particular problems as they tend to deal with more serious complaints, some of which raise issues of adverse events and serious injuries. They are discussed further in Section 6

General criticisms of the clinical negligence system

4.23 Claimants, defendants and policy makers have all demonstrated concern about the overly adversarial nature of the litigation system. In his review of the civil litigation systems, Lord Woolf argued that litigation practice in general has ‘degenerated into an environment in which the civil litigation process is too often seen as a battlefield where no rules apply’ (Lord Chancellor's Department, 1996: para. 3.4). In addition, he was concerned that unmeritorious and indefensible claims are pursued for too long.

- Other critics have drawn attention to the impersonality, insensitivity and remoteness of the law, which is perceived as rigid and formal and as forcing the parties into defensive positions. As a result, the system is ill equipped to deliver what research suggests risk managers and claimants want most - an explanation and investigation of what has occurred (Vincent *et al.*, 1994).
- The present system for obtaining compensation destroys the doctor patient relationship. It encourages confrontation and concealment. It has been argued that much of the cost and delay in Anglo-American systems is attributable to the competitiveness and rancour with which modern litigation is conducted (Menkel-Meadow, 1996).
- The stress caused by litigation can be detrimental to the clinical performance of the professional involved. The aftermath of events at Bristol also demonstrates that those involved in giving evidence about poor performance may be shunned by colleagues.
- The National Audit Office (2001) recently found that cases closed in 1999/2000 worth over £10,000 took five years or more to settle. These findings have been confirmed by other studies (Mulcahy 2000)
- The NAO (2001) found in their recent study that 80% of trusts rarely or never offered meetings with clinicians, remedial health care either within or outside, the trust. There is no information on whether, if offered, these would have affected the pursuit of a claim.

Section Four: Current systems for dealing with complaints and claims

The NAO looked at the possibility of offering packages outside a court setting. However, perceptions of participants in current systems created barriers to seeking creative solutions. They argued that when solicitors were involved, they were likely to see the award of compensation as their main goal. Claims managers were also not accustomed to offering creative packages. The NAO suggested they required further training to develop greater expertise.

- The mediation pilot scheme evaluation (Mulcahy *et al*, 2000) suggested that the provision of a wider range of remedies than those available could promote greater satisfaction with process and outcome. However, they also observed that solicitors did not think that it was their job to be creative about remedies.

4.24 In short, it would seem that the tort system is falling short of achieving its three main goals:

- It provides insufficient and inefficient compensation for injuries. Only a small fraction of legitimate claims are pursued and resolution of claims is slow and costly;
- It provides poor incentives for improvement of patient safety;
- There is inadequate accountability. Most problems are never discovered, much less systematically addressed (Cullen 2002).

4.25 Recent changes to the civil litigation system and the introduction of the clinical negligence pre-action protocol have gone some way to encouraging more candour about the relative strengths of the claimants' and clinicians' cases in the early stage of proceedings. These reforms have also attempted to reduce delays in the system, although a certain amount of delay is inevitable in clinical negligence cases because of the need to obtain expert evidence. Judges are also being encouraged to become proactive case managers in the early stage of proceedings. To date there is very little information about the impact of these reforms. If the expected improvements do materialise they should lead to less delay, earlier settlement and the earlier abandonment of cases without merit.

4.26 However, for claimants, even if their case is taken on by a solicitor, civil litigation is still a complicated, lengthy and risky process. The NAO concluded that litigation was a particularly inefficient way of resolving small and medium sized claims.

4.27. In the section which follows we consider the alternatives to current systems for handling complaints and claims and how these might adopt a more integrated approach to the management of adverse events.

Section Five: Alternatives to existing systems

Introduction

5.1 Current systems for redress, and the extent to which they are meeting the needs of complainants and claimants, are a cause for concern. In particular, criticism continues to mount over the ability of the civil litigation system to promote high quality health care and distribute compensation fairly to patients. It has been argued that there is an inappropriate emphasis on the individual clinicians' role in error and iatrogenic injury: a tendency that is reinforced and encouraged by the fault-based civil litigation system.

5.2 The current system rests on the assumption that significant advances in quality are achievable by discovering aberrant behaviour and punishing individuals who are 'guilty' for it. But successive reports have drawn attention to the fact that the civil justice system is having virtually no deterrent effect on poor performance. It has even been suggested that litigation actually stifles efforts to reduce error (Studdert and Brennan, 2001). Most recently, this led the Bristol Inquiry (2001) to argue that the problems caused by medical error should be taken out of the civil litigation system altogether.

5.3 Commentators are now looking to alternative systems to improve current arrangements. In July 2001, the Secretary of State for Health announced plans for reform, commenting that fundamental reform of clinical negligence was long overdue. As a result, the Chief Medical Officer (2001) has proposed options for reform to make clinical negligence compensation 'faster and fairer, cheaper and less bureaucratic'. Calls for reform are nothing new:

- Prior to 1997, a number of private members' bills were introduced into Parliament to promote other systems for handling clinical negligence claims and the Conservative Government agreed to consider some form of alternative dispute resolution. It consulted on the feasibility of a paper-based arbitration scheme (DH, 1991) but this was not received with enthusiasm (Brown and Simanovitz, 1995).
- In 2000 the NHS plan recognised the need for a review and change in the handling of clinical negligence claims and the NHS's report on the need for an organisation with a memory identified a number of serious problems with current systems including delays (Department of Health, 2000)
- More recently, the Woolf reforms of the civil justice system have encouraged the earlier settlement of cases. However, changes have been procedural rather than substantive and little is yet known about the success of this scheme.

Reforms to the clinical negligence systems

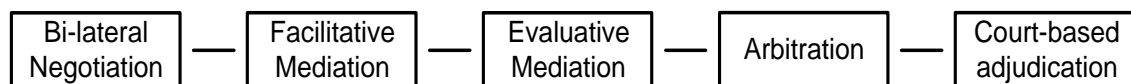
5.4 In the aftermath of the first 'litigation crises' of the 1970s, the majority of states within the US introduced reforms to tort litigation and these affected medical malpractice suits. In the first wave of reforms, procedural changes were introduced to reduce the time available for litigants to bring claims (the limitation period). More substantive reforms attempted to 'chill' the interest of claimants in pursuing their grievance. The courts either introduced special pleading requirements that altered the rules about the revelation of evidence to the

Section Five: Alternatives to existing systems

other side (discovery) or alternatively, they required disputants to have their case subjected to scrutiny by a pre-trial review panel. In the 1980s, a second 'litigation crisis' occurred as it was argued that previous reforms had done little to reduce the incidence and size of awards to victims of medical malpractice. Subsequent reforms shifted the focus towards methods of dispute resolution outside the courts such as arbitration, mediation and no-fault.

5.5 Other countries such as Sweden, Finland and New Zealand also experimented with reform by introducing no-fault systems. In Figure 7, the various alternatives to adjudication are placed along a continuum that reflects the more or less authoritative impositions of judgement about the merits of the case. No-fault compensation schemes can exist at various points on the continuum depending on the characteristics of the scheme and manner in which decision making occurs. But most require some sort of adjudication. These issues will be discussed further below.

Figure 7: A dispute resolution spectrum



Arbitration

5.6 Arbitration, like court handling of disputes, is a form of adjudication in which a third party makes an authoritative judgement that is binding on the parties involved. Arbitration has proved popular in commercial settings and in labour disputes where there is a pre-existing contractual relationship and an interest in having disputes handled in private. Unlike court-based adjudication, arbitration:

- Is not conducted in public. It provides a private forum in which to resolve complex cases and protects the parties from harmful publicity.
- Involves one or more arbitrators. These are selected or approved *by the parties*, rather than the state, to adjudicate on the merits of their claims.
- Usually requires voluntary participation.
- Is relatively informal e.g., the rules relating to the disclosure of deadlines tend to be much less vigorous than those used in the courts.
- Is said to be a relatively quick way of resolving disputes. Heintz (1979a) found in his study of clinical negligence arbitration in California that arbitrated cases took about a 20% less time than litigated cases to reach the same settlement.
- Involves arbitrators who are usually experts in the area. As a result they are likely to spend much less time acclimatising themselves with the context of the dispute. In medico-legal cases there is likely to be both a medical and a lay person involved.

Section Five: Alternatives to existing systems

- Is said to reduce costs. Supporters of arbitration suggest that it can minimise expenditure on lawyers and expert evidence, and reduce the costs associated with case preparation. Research has confirmed this view. In his study of the first hospital based programme, the Southern California Arbitration project, Heintz (1979a) argued that there was a 62% net differential in cost savings in the early years of the scheme. When compared with a control group of litigated cases, it was shown that the same proportion of arbitrated cases closed with a financial settlement, but defence costs were reduced by about one fifth.

5.7 The agreement to arbitrate is a contractual one. Agreements can be signed by the patient prior to undergoing medical treatment or after a malpractice claim has been discovered. In schemes involving a pre-treatment agreement, there can be provision for patients to opt out if, on reflection, they change their minds.

5.8 Empirical research suggests that arbitrators can provide a knowledgeable and equitable forum for resolving malpractice claims. Moreover, physicians support such programmes because the process is expeditious and an expert adjudicator is valued (Heintz, 1979b). But reservations have also been expressed:

- Prior agreements to mediate or arbitrate have themselves been the subject of litigation and may not be upheld by the courts. In the US, compulsory arbitration schemes have been challenged as denying the disputants a right to trial (Saunders, 1986).
- Arbitration has acquired a reputation for involving high costs and producing delays. There has been far more appellate review by the courts than was originally anticipated.
- The privacy of proceedings has been viewed as contrary to the public interest. The instigation of a negligence action is a useful way of making large institutions more publicly accountable for their actions. For example, arbitration forces hospital trusts to come to court to give evidence. This gives the plaintiff or their representatives an opportunity to cross-examine them (Atiyah, 1997). The actions of doctors and other staff are scrutinised in detail and evaluated by independent experts. The process provides a valuable pool of information that can be useful in improving the standard of care (Clements, 1995).
- The public interest is also served by issues of poor care being discussed in the open. Court decisions can have a radiating effect on future activity across the NHS extending beyond a single case. (Galanter, 1983; Fiss, 1984). However, there is a tension between encouraging those cases that can be used to set standards while also at the same time respecting claimants' need for a quality process and outcome.

Mediation

5.9 As a form of facilitated negotiation, mediation shares some of the characteristics of both court and out-of-court dispute resolution and in recent years interest has grown. In the late 1990s, a medical negligence mediation pilot scheme was introduced.

Section Five: Alternatives to existing systems

5.10 There is not one accepted definition of mediation so it can be described as an *approach* to dispute resolution. Ideologies, styles and practices vary according to the scheme being considered, the provider agency concerned and the characteristics of the dispute.

- The approach can be facilitative or evaluative. In the *facilitative* model of mediation mediators seek to remain neutral and to facilitate and referee discussions about what the parties consider to be important. In the *evaluative* model mediators give an opinion on the merits of the dispute. This form of mediation is more likely to involve an expert as mediator and is more widely used in the US.
- Mediators come from different backgrounds and have followed different courses of training. Sole or co-mediators can be used. They may use face-to-face meetings or private caucusing. The use of mediation can be compulsory or voluntary.

5.11 Despite the differences, certain broad principles and frameworks underpin mediation (Black and Baumgartner, 1983; Roberts, 1986; Murray *et al.*, 1989; Brown and Simanovitz, 1995).

- Mediation has been described as an empowering process that enables the parties to explore their mutual interests and differences to arrive at settlement that maximises their joint interests. It is interest-based rather than rights-based. Unlike the litigation system, the parties are encouraged to vent their feelings and explore issues that contribute to the sense of grievance. It replaces adversarial relations with a more co-operative form of negotiation and settlement, termed 'integrative bargaining'. Mediators aim to increase the appreciation of the parties of each other's position, to preserve relationships and not to exacerbate conflict.
- The process has the potential to provide detailed information about mishaps and their causes. It is complementary to other proactive forms of claims management.
- Like arbitration, mediation is conducted in private and is confidential. This holds a special appeal for doctors who are able to provide explanations of treatment without any admission of fault being necessary. However, the very privacy of this form of dispute resolution has been criticised.
- Unlike litigated claims, the majority of which are abandoned or settled by lawyers in the absence of their clients, mediation involves the disputants in the negotiation of settlement. They can thus understand the rationale for the proposals put forward by expert lawyers.
- Mediation allows for 'norm creation' rather than 'norm imposition' through the legal system (Fuller, 1971).
- Mediation can be more flexible than court-based adjudication. Rules of evidence are relaxed or abandoned and the process tends to be more geared to the preferences and needs of the parties.

Section Five: Alternatives to existing systems

- Mediation is a voluntary process that is not binding on the parties. Proponents therefore claim that the parties are more likely to adhere to agreements reached. Mediators cannot impose a judgement, rather they help the parties to reach a settlement acceptable to them¹. They claim to manage process rather than determine an outcome.

The medical negligence mediation pilot scheme

5.12 Increases in the incidence of clinical negligence and the size of claims led to the launch of the medical negligence mediation pilot scheme. Although some have questioned the suitability of mediation in clinical negligence cases, Brown and Simanowitz (1995) argue that it offers an opportunity to incorporate fact finding; explanation and dialogue; assisted negotiation; neutral expert settlement guidance; accountability and other issues of importance for the parties. Settlements can include not only financial aspects but arrive at a form of words that parties find mutually acceptable.

5.13 The pilot scheme aimed to test whether mediation could improve satisfaction with claims management. By the end of a third year of the scheme, 12 cases had been mediated and settlement was reached in 11. The cases covered a range of medical specialities and took an average of seven hours to settle. The average settlement was just over £34,000 although one case settled for £80,000.

5.14 The official evaluation of the scheme conducted by Mulcahy *et al.* (2000) concluded that mediation had considerable potential.

- It proved to be much more sensitive to the non-financial needs of the parties. In addition to compensation a number of additional remedies, not normally associated with legal settlement, were granted. These included apologies, in-depth explanations of medical decisions, new treatment plans and information about the place of burial of a foetus.
- It provided an opportunity for the parties to meet in person, discuss the details of medical treatment and participate in settlement negotiations.
- It provided an explanation for claimants to understand why something had happened. The flexibility of mediation allowed the claimants to fully explore such issues with clinical staff before launching into a discussion of legal precedent and the value of the claim. This was an essential to the success of the scheme for claimants.
- Many claims managers felt that mediation gave them the chance to provide a more satisfactory and speedier outcome for claimants.
- Solicitors who represented the parties had more mixed feelings but recognised that mediation concentrated their efforts on a case, encouraged settlement and allowed greater flexibility than a court timetable.

¹ However, it is important to note that in the wake of the Woolf reforms of the UK civil justice system court annexed mediation schemes and judicial pressure to mediate are becoming more common. Lawyers are being compelled to discuss settlement at an earlier stage of litigation and to consider alternatives to the courts.

Section Five: Alternatives to existing systems

5.15 The problems with the pilot scheme related to design and management. The flow of cases was inhibited by the lack of funding for mediation from the then Legal Aid Board until the third and final year. A number of expert solicitors commented that the NHS Litigation Authority discouraged referrals. Other problems were that:

- Mediated settlement could prove to be costly when compared with like cases managed in more traditional ways.
- Doctors were almost unanimously opposed to the scheme. They felt it exposed them in ways that a settlement negotiated between solicitors did not.
- Expert solicitors were reluctant to refer cases. They felt ill-equipped to adopt more conciliatory approaches to dispute settlement and were not prepared to recommend mediation to their clients.
- Solicitors act as gatekeepers to mediation. It is important that they present mediation to clients in a measured way.

5.16 The evaluation report concluded that mediation has considerable potential and addresses many of the concerns expressed by complainants and claimants referred to above. However, a more integrated approach to dispute resolution in the NHS is required. Mediation should be viewed as just one of a number of ways to approach grievance resolution. It should be considered alongside conciliation, to provide an integrated policy for grievance resolution and meeting patient's concerns. A separate claims system can arrange compensation where appropriate.

5.17 There have been few other evaluations of the use of mediation in clinical negligence actions. However:

- A study of the *mandatory* system of mediation/pre-screening panels introduced in Wisconsin was pessimistic about the ability of mediation to resolve cases or divert them away from the courts (Meschievitz, 1991). It found that 96% of cases referred to mediation panels were either abandoned, or they progressed to court based adjudication. However, the study suggests that mediation served to narrow down the issues in dispute. Cases with no merit had been filtered out at an earlier stage.²
- A pilot study of doctor patient mediation at the early stages of disputes in St. Louis found that settlement was reached in 80 per cent of cases referred. Mediation avoided structuring the dispute in terms of rights and wrongs and had encouraged the parties to reach a mutually satisfactory solution that balanced emotional and financial needs. The scheme allowed cases that did not mediate to proceed to arbitration: a system which is known to commentators as med-arb (Reeves, 1994).

² Although such schemes appear revolutionary, the notion of no-fault is in fact nothing new. Until the nineteenth century common law jurisdictions held a person liable for the harm they caused by accidents whether or not they were at fault (Posner, 1992).

Conciliation

5.18 Like mediation, conciliation is a form of intervention that allows the parties to resolve their differences with the help of a third party. In the field of family law conciliation was once used interchangeably with reconciliation and tended to focus on bringing those in a relationship back together rather than resolving their differences on the break-up of a relationship (Eekelaar, J., and Dingwall, R, 1988). Today, conciliation tends to be used co-terminously with mediation. A form of conciliation appeared in the 1996 NHS complaints system, and was used in the pre-1996 procedure in a general practice setting. Mulcahy *et al.* (2000) argue that the potential for conciliation in the early and later stages of the complaint procedure has been under-developed and under-explored. This point has also been made by the Health Committee (1999). Wallace and Mulcahy (1999) found that practice up and down the country and within districts varied considerably and was approached in an uncoordinated way. They discovered a haphazard approach to training and expressed concern that poorly trained conciliators might do more to polarise the parties that reconcile them.

A no-fault scheme

5.19 Neither arbitration nor mediation do much to change the existing substantive rules which govern clinical negligence actions. They merely allow for settlement to occur according to a different process. No-fault systems involve much more radical changes. They require a significant overhaul of the rules governing the circumstances in which an individual will be awarded compensation by the state. No-fault schemes are based on a *distributive justice* model. Whilst court-based adjudication, arbitration and mediation seek to identify individuals who are at fault and liable to pay damages as a result, no-fault schemes attempt to spread the losses for medical accidents over entire populations of consumers of medical services and taxpayers. Moreover, because of their compatibility with a patient-safety agenda, no-fault approaches have been cited by leading commentators as presenting ‘the most intriguing possibility from within the list of alternatives’ (Studdert and Brennan, 2001)

5.20 A key rationale for the introduction of such schemes is that they ensure greater parity amongst those who are in need of support and assistance in society. After all, victims of road accidents are able to obtain compensation under the criminal injuries compensation scheme without having to prove fault. No-fault systems are also expected to compensate more cases than the tort system including many which could not meet the liability standards of medical negligence. Its delivery of compensation is expected to be less formal.

5.21 The Pearson Commission which reported in 1978 considered and rejected a no-fault compensation schemes but the case for such reform has also been made by the British Medical Association (1999) and the Royal College of Physicians. The Select Committee on Health discussed the possibility of a no-fault scheme for adverse clinical incidents and poor outcomes and recommended that the Department of Health seriously consider the proposal. The Bristol Royal Infirmary Report (2001) suggested the introduction of a no-fault scheme be considered in order to persuade healthcare workers to volunteer their mistakes.

5.22 The term ‘no-fault compensation’ refers to a range of schemes that abandon the rule that an injured patient has to show that someone was negligent in order to obtain compensation. They must prove only that they have suffered an injury; that it was caused by

Section Five: Alternatives to existing systems

medical care and that it meets whatever other threshold criteria that are in place. When they opt to have their claim settled under a no-fault scheme, patients generally forego their right to litigate their claim. In a medical context, no-fault schemes exist in various forms:

- Sweden introduced a Patient Insurance Scheme in 1975 as a result of complaints that few victims of medical mishaps were getting compensation because of the difficulties of proving fault and finding experts to support a claim as well as the expense and delay involved.
- The Treatment Injury Insurance Scheme introduced in Finland in 1987 provides a similar scheme.
- A no-fault scheme was introduced in New Zealand in 1971 which covered all disabilities resulting from accidents and not just injuries caused by medical negligence
- In the USA the States of Virginia (1988) and Florida (1989) have introduced schemes covering birth injuries
- In a UK setting the industrial injuries scheme, vaccine damage scheme and vCJD compensation system are based on no-fault principle.

5.23 An important distinction must be made between those schemes that require patients to identify an individual who is responsible for their condition, and those that do not. The former has the advantage of being able to make constructive use of the desire of injured patients to obtain redress in a similar way to the clinical negligence system. Adverse outcomes can be attributed to individual doctors and can be used to contribute to quality agendas. The doctors involved can be asked to provide information about the treatment given to the claimant so that the quality of their care can be assessed. They may also be asked to cooperate with reviews of their licence to practice. Those schemes that sever the link between victims and the agents of their injuries must find alternative ways of achieving this objective.

5.24 The extent to which this is a serious problem depends on the ability of individual doctors to avoid accidents. If accidents are better understood as a product of organisational failure and not personal mistakes, then the attribution of responsibility to individuals is unnecessary. All that is needed is sufficient information to demonstrate that the patient's injury arose from medical treatment. Information on claims for compensation can be fed back to those responsible for service delivery and used in national reviews to alert all care providers to common problems.

5.25 A number of advantages of no-fault schemes have been cited:

- Empirical evidence suggests that providers are less willing to disclose information about errors they make or observe when a punitive atmosphere prevails. Fear of blame poses a major obstacle to the design and implementation of patient safety initiatives (Bristol Inquiry, 2001; Studdert and Brennan, 2001). For example, physicians in the Swedish no-fault compensation scheme actively participate in the filing of 60% of claims (Studdert and Brennan, 2001)
- Because fault and blame are not major issues, the parties are better able to cooperate in resolving their differences. Whetten-Goldstein *et al's* (1999) study of the Florida scheme found that individuals filing claims with the programme were significantly less likely to be seeking retribution than those filing legal claims. Moreover, those who claimed under the scheme reported higher level of satisfaction than tort claimants.

Section Five: Alternatives to existing systems

- Some schemes are designed to include cases that cannot meet the liability standards of negligence and so increase the large number of victims of medical mishap who are compensated. Evaluations of the Danish Patient Insurance systems show that many more claims were instigated under the no-fault compensation scheme introduced in 1999 (2700 cases per year) than was previously the case in the fault-based systems (250 per year). In 1999, the Patient Insurance scheme made 2530 decisions and 1125 (44%) of patients were found to be entitled to damages. Erichsen (2001) argues that this finding demonstrates that the fault-based system was failing to compensate a large number of victims of medical mishap. He also claims that the fault system failed to have a deterrent effect on practitioners because compensation was paid for by the hospital insurance scheme.
- It is argued that if fault does not have to be determined, time and money are saved and stress reduced. Evidence from the Florida and Virginia schemes, which cover neonatal injuries, suggests that decisions are quicker and more efficient in providing compensation (Bovbjerg *et al.*, 1997; Ridgway, 1999; Studdert, 2000). In the Florida scheme, claims are decided in months rather than years (Whetten-Goldstein *et al.*, 1999). The two most experienced no-fault schemes, those operating in New Zealand and Sweden, are particularly well known for their simple administration systems and streamlined adjudication pathways. Both schemes function with relatively little attorney involvement. Available evidence on administrative costs suggests that they have dramatically lower administrative costs than their tort counterparts.
- No-fault schemes allow the issue of damages to be separated from a complaint system.
- No-fault programmes typically restrict payment for non-pecuniary loss and reduce the role of lawyers, thus allowing the compensation budget to focus on paying for injuries rather than advice.
- Despite the rise in costs incurred under many no-fault schemes, the amount of money spent on such programmes continues to be a very small percentage of the health care budget.
- In no-fault schemes, there is little evidence to show that resources were restricted by the administrators of the scheme. For example, in the Florida system, levels of compensation were comparable with those who had pursued their case in the courts although the latter were compensated more for medical expenses and income loss (Whetten-Goldstein *et al.*, 1999).

Criticisms of no-fault programmes

5.26 Criticisms of no-fault systems have also been made. Fears have been expressed that the emphasis on distributive justice will lead to the loss of any form of corrective justice., that no-fault systems are contrary to natural justice and place barriers in the way of the human right to have access to redress in public courts. Critics have been sceptical of the ability of such schemes to achieve professional accountability, a blame-free culture and a reduction in the overall cost of dealing with medical accidents. Empirical evidence from an evaluation of the Florida scheme suggests that:

Section Five: Alternatives to existing systems

- Although there is no necessity to seek the advice of a lawyer, 93 per cent of clients still do so.
- The tort process allows families a better opportunity to learn about the events that led to the injury.
- There was no evidence that no-fault schemes had any impact on the likelihood of defensive medicine.
- Half of the respondents were dissatisfied with the level of premium that they had to pay to join the schemes (Sloan *et al*, 1998).

5.27 Others argue that in no-fault schemes:

- The eligibility criteria for compensation of injuries are overly restrictive.
- Medical care compensated under such schemes may be inadequate if those administering them have an interest in conserving resources.
- A compensable event has to be defined. They do not remove the burden, currently carried by the courts, of having to determine causation and the remoteness of damage.

5.28 The experience of those who work on compensation schemes suggests that such issues have generated as much doctrinal and administrative complexity as the system of common law actions they seek to improve. As long as there are limits to the scope of coverage there will always be a need for case by case adjudication.

Conclusions

5.29 The reform of current arrangements should be able to:

- Channel compensation to eligible patients in a manner that is predictable, timely and fair.
- Be compatible with systems that generate detailed information about error.
- Provide incentives for health care professionals and organisations to work towards improving the quality of care.
- Recognise that most preventable injuries in hospitals are not due to incompetent professionals but the imperfect systems within which professionals work.

Section Six: Policy Implications

6.1 In the final section of this report, we identify what constitutes good practice in the handling of adverse events, complaints and claims. We argue that systems should work together to satisfy the needs of patients, their relatives, health care professionals and managers. Managing adverse events, complaints and claims as though they are unrelated problems is no longer tenable. Information gleaned from complaints and claims should be an integral part of the quality agenda. Moreover, when things go wrong with clinical care, health care professionals have a duty to patients and their relatives that continues beyond the usual treatment period.

Systems for handling complaints

6.2 Complaints systems are an ideal place in which to satisfy the non-pecuniary and minor financial needs of aggrieved patients and their relatives. The complaints procedure introduced in 1996 went some way to empowering front line staff to take part in putting matters right. When handled well at this stage there is less likely to be an escalation of the grievance. However, there is evidence that complainants are less satisfied with the way the current system operates than NHS staff.

6.3 The introduction of Patient Advice and Liaison Services (PALs) should assist in developing a culture of customer care within trusts. However, monitoring will be required to gauge the public's satisfaction with the process.

6.4 Complaint systems should:

- Treat complaints and complainants seriously
- Identify complainants questions and needs and give a response that addresses these
- Satisfy the complainant that a fair, thorough and prompt investigation has taken place
- Inform complainants of the form the investigation will take
- Use informal means of communication through the telephone and meetings
- Have key staff present at these meetings so they can explain what happened
- Inform complainants and others about the process and outcome of the investigation, and what changes have been introduced
- Consider using conciliation where a relationship may be restored
- Treat complaints as important sources of information
- Provide an audit loop back into quality management systems.
- Support staff in responding to complaints
- Place complaint management at the centre of clinical governance with a leading position for the complaint manager

Section Six: Policy Implications

6.5 Good communication of treatment risks, treatment processes and communication of appropriate information about prognosis is essential. Many of the responses to the Department of Health's call for ideas on complaints and clinical negligence referred to the need for more extensive training in dealing with patients concerns - a point also made by the Bristol Inquiry.

The particular problems of independent review

6.6 Good practice guides on complaint handling suggest that a second or review stage in the procedure is important (Cabinet Office, 1999). It can provide an end point for the internal process as well as another chance to satisfy the complainant and provide an external check on internal procedures.

6.7 The independent panel review stage is the aspect of the 1996 complaint system most heavily criticised by both staff and complainants. This is not surprising.

- The complainant has already been disappointed by the previous stage.
- Research by the PLP (Wallace and Mulcahy, 1999) made clear that complainants were bothered by the lack of transparency in review panel proceedings.
- The HSC reports show that some of the cases referred to IRPs are at the more serious end of the spectrum and a wider range of remedies may need to be offered at this stage.

6.8 The PLP study (Wallace and Mulcahy, 1999) and Complaints System Evaluation Study (DH, 2001c) both recommended a replacement of the present IRP with a more formal and independent system. Both studies favoured a regional panel of lay chairs, who would also take over responsible for deciding when a panel should be convened, aided by clearer criteria. They also recommended that panels should be carried out in a more structured way, with a clearer purpose and a more developed support system.

6.9 The current role of the IRP is to reconsider whether a complaint should be upheld. If the role of panels is to be investigatory, then they should have the powers to collect evidence. Moreover, if they are to satisfy complainants, it may also be appropriate to recommend the provision of a broader range of remedies. The performance of panels should be monitored to achieve greater consistency. The parties to the process could also be asked for their views on a regular basis.

6.10 It is important the review stage does not seek to be punitive in relation to NHS staff. The research referred to in Section Three indicated that the complaint systems that seek to find fault, can result in defensiveness and denial on the part of professionals. The focus should be on discovering the systemic weaknesses and putting them right. If weaknesses in staff performance are identified, then this is a matter for trusts as employers.

Integrating systems for managing complaints and claims

6.11 Our report has drawn attention to the similarities between the needs of complainants and claimants. The NHS should be able to respond to these needs in exactly the same way regardless of whether a patient has decided to complain or claim. The litigation system encourages the parties to take oppositional stances and this can serve to exacerbate grievances in the early stages of disputes. The Woolf reforms may well encourage earlier settlement of dispute but may not necessarily leave claimants and defendants feeling any more confident that their concerns have been fully aired and taken seriously. Instead of seeing the complaints and clinical negligence systems as discrete entities there is an argument for having an integrated first stage of grievance resolution. This should not serve to increase the time taken to start negligence actions for those who prefer this route. Rather it should serve to narrow the issues in dispute, provide information to patients and their relatives and reduce the points of contention.

6.12 Serious consideration should be given to formalising systems for giving *ex gratia* payments in the first stage of an integrated grievance procedure. Mechanisms for conciliation and mediation should also be available at all stages of the complaint and claims systems. Training should be given to all conciliators and nationally agreed standards put in place to assure the quality of conciliation/mediation.

6.13 Timely explanations of treatment decisions and risk and the process of investigation to be adopted are essential in managing all patient grievances. In many cases face-to-face contact between the patient/relative and those blamed for poor care are necessary for effective resolution. The irony is that when these are not made available through the complaints system, the clinical negligence system is reverted to as a system of last resort.

6.14 Section Five has shown that alternative systems of dispute resolution can be effective in finding solutions for at least some of the people who have suffered an injury. Although these *may* be more costly, they are preferable to current systems for clinical negligence that fail to offer what claimants have said that they want.

6.15 Reform of current arrangements should be led by the following considerations:

- It must be able to channel compensation to eligible patients in a manner that is predictable, timely and fair.
- The system must be able to generate detailed information about error and misunderstandings.
- The system must provide incentives for health care professional and organisations to work towards improving the quality of care.
- The system must recognise that most preventable injuries in hospitals are not due to incompetent professionals but imperfect systems within which professionals work.

Section Six: Policy Implications

6.16 There are a range of mechanisms that can be used for achieving settlements such as conciliation, mediation and arbitration – the relative benefits of which have been discussed. But serious consideration should be given to a no-fault system based on establishing administrative criteria for establishing injury and investigating the factors that have led to that injury.

The importance of learning from adverse events, complaints and claims

6.17 The issue of how complaints and claims can promote organisational learning is an area where policy has still to be developed.

- Despite recommendations from various committees and enquiries which called for better systems for recording and analysing adverse events, complaints and claims, integrated systems remain poorly developed.
- Learning from complaints can be achieved through better recording and monitoring so that trends can be identified and through analysing and taking action on particular complaints.
- Arrangements for reporting and acting upon the recommendations of IRPs are insufficiently systematic and rigorous.

The Patients Safety Agency should take a lead in developing systems and ensuring that they are put into place.

6.18 Finally, as has been apparent from our analysis, complaint and claims systems form arenas in which there is an interplay of interests that may conflict. Changes to existing systems should encourage those involved to act in ways that assist in the resolution of issues for those concerned and in the public interest.

Bibliography

- Aharony, L and Strasser, S (1992) *Patient Satisfaction – what we know about and what is still unexplored*, College of Medicine, Ohio State University, paper given at Patient Grievances in Health Care, a Research Seminar, 16 November
- Allsop, J (1994) 'Two sides to every story: complainant's and doctor's perspectives in disputes about medical care in a general practice setting', *Law and Policy* 16: 149–84
- Allsop, J and Mulcahy, L (1997) *Regulating Medical Work: Formal and informal controls*, Open University Press, Buckingham
- Allsop, J and Mulcahy, L (1998) 'Maintaining professional identity: doctors' responses to complaints', *Sociology of Health and Illness* 20(6): 847–69
- Allsop, J and Mulcahy, L (2000) 'Dealing with clinical complaints', in C Vincent and R Clements (eds), *Managing Risk in the NHS* (2nd edn), BMA Publications, London
- Andres, LB (1993) *Medical Error and Patient Claiming in a Hospital Setting*, paper presented at the Law and Society Association Annual Meeting, May 30
- Andrews, L, Stocking, C, Krizek, T, Gottlieb, L, Krizek, C, Vargish, T, and Siegler, M (1997) 'An alternative strategy for studying adverse events in medical care' *The Lancet*, 349: 300-304
- Annandale, E (1989) 'The malpractice crisis and the doctor-patient relationship', *Sociology of Health and Illness* 11:1–23
- Annandale, E and Hunt, K (1998) 'Accounts of Disagreements with doctors', *Social Science and Medicine* 1: 119-129
- Atiyah, P (1997) *The Damages Lottery*, Hart Publishing, Oxford
- Audit Commission (1993) *What Seems to be the Matter?: Communication between Hospitals and Patients*, HMSO, London
- Barclay, S (1995) 'Are litigants stupid? The false consciousness debate re-considered', paper presented to the Annual Meeting of the Law and Society Association, University at Albany, State University of New York
- Bark, P, Vincent, C, Jones, A and Savory, J (1994) 'Clinical complaints: a means to improving the quality of care', *Quality in Health Care* 3:123–32
- Bates, DW (2000) 'Using information technology to reduce rates of medication errors in hospitals', *British Medical Journal* 320: 788-791
- Black, N (1990) 'Medical litigation and the quality of care', *The Lancet* 335: 35–37
- Bolt, D (1989) 'No fault compensation – the BMA proposals', in R Mann and J Havard (eds), *No Fault Compensation in Medicine*, Royal Society of Medicine Services Limited, London
- Bosk, C (1979) *Forgive and Remember: Managing medical failure*, Chicago University Press, Chicago
- Bovbjerg, R *et al* (1997) 'Administrative Performance of no-fault compensation for medical injury', *Law and Contemporary Problems* 60: 71-102
- Bowles, R and Jones, P (1990) 'Medical negligence and resource allocation in the NHS', *Social Policy and Administration* 24: 39–51

Bibliography

- Brahams, D (1987) 'No fault compensation based on patient insurance', *The Lancet* 1: 698
- Brahams, D (1989) 'No fault compensation in Finland with an overview of the Scandinavian approach to compensation of medical and drug injuries', in R Mann and J Havard (eds), *No Fault Compensation in Medicine*, Royal Society of Medicine Services Limited, London
- Brennan, T, *et al* (1991) 'Incidence of adverse events and negligence in hospitalised patients: the results of the Harvard Medical Practice Study', *New England Journal of Medicine* 324: 370–76
- Bristol Inquiry (2001) *Learning from Bristol, Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995*, Stationery Office, London
- British Standards Institute (1999) *Complaints management systems - Guide to design and implementation*, BS 8600
- British Medical Association (1999) *No fault compensation for medical mishaps*, BMA, London.
- Brown, H and Simanovitz, A (1995) 'Alternative dispute resolution and mediation', in C Vincent (ed), *Clinical Risk Management*, BMJ Books, London
- Burns, S and Mulcahy, L (1999) 'Civil justice reforms, ADR and mediation', in M Powers and N Harris (eds), *Medical Negligence* (3rd edn), Butterworths, London
- Cabinet Office, Citizen's Charter Complaints Task Force. (1995) *Putting things right*, HMSO, London
- Cabinet Office, Service First Unit (1999) *The Good Practice Guide*, HMSO, London
- Capstick, B, Edwards, P and Mason, D (1991) 'Compensation for medical accidents', *British Medical Journal* 302:230–32
- Carmel, S (1988) 'Hospital patients' responses to dissatisfaction', *Sociology of Health and Illness* 10(3):262–81
- Charatan, F (2000) 'Clinton acts to reduce medical mistakes', *British Medical Journal* 320: 597
- Charles, SC (1984) 'A different view of malpractice', *Chicago Medicine* 87: 338-42
- Charles, SC and Kennedy, E (1988) *Defendant: A psychiatrist on trial for medical malpractice*, Free Press, New York
- Chief Medical Officer (2001) Clinical Negligence: What are the issues and options for reform? www.opengov.doh
- Christakis, N (1999) *Death Foretold: prophecy and prognosis in medical care*, University of Chicago Press, Chicago
- Clarke, SH, Ellen, ED and McCormick, K (1995) 'Court-Ordered civil case mediation in North Carolina: court efficiency and litigant satisfaction', paper prepared for the Annual Meeting of the Law and society Association, Institute of Government, University of North Carolina at Chapel Hill
- Clothier, C (1989) 'Medical negligence and no-fault liability', *The Lancet* 1: 603
- Cobb, S (1994) '“Theories of responsibility”: the social construction of intentions in mediation', *Discourse Processes* 18: 165–86
- Collinge, S (1995) 'Mutual trust', *British Medical Journal* 310:1670

Bibliography

- Commission for Health Improvement (2001) *Investigation into issues arising from the case of Loughborough GP Peter Green*, Commission for Health Improvement, London
- Coombes, S (1994) 'Peace-making process for neighbours at war', *Inside Housing* 4 November: 14–15
- Cullen, J., (2002) Will the introduction of a no-fault compensation scheme remove the social injustices associated with the clinical negligence compensation scheme operating in the UK? Research Proposal, Birkbeck College.
- Danzon, PM (1985) *Medical Malpractice – Theory, evidence, and public policy*, Harvard University Press, Cambridge, USA
- Danzon, PM (1987) 'The effects of tort reforms on the frequency and severity of medical malpractice claims', *Ohio State Law Journal* 48: 413–17
- Davies Committee on Hospital Complaints Procedures (1973) *Report of the Davies Committee on Hospital Complaints Procedures*, chaired by Sir Michael Davies, HMSO, London
- Department of Health (1991) *Arbitration in Respect of Claims for Medical Negligence against the NHS*, Department of Health, London
- Department of Health (1994) *Being Heard: Report of the Review Committee on NHS Complaints Procedures*, chaired by Professor Alan Wilson, HMSO, London
- Department of Health (1995) *Acting on Complaints*, HMSO, London
- Department of Health (2000) *Memorandum responding to the Sixth Report of the Health Select Committee (1998-9) session on Procedures related to adverse clinical incidents and outcomes in medical care CM 4698*, The Stationery Office, London
- Department of Health (2000) *An organisation with a memory*, Department of Health, London
- Department of Health (2001a) *Assuring the Quality of Medical Practice: Implementing Supporting Doctors, Protecting Patients*, The Stationery Office, London
- Department of Health (2001b) *Building a safer NHS for patients: implementing an organisation with a memory*, Department of Health, London
- Department of Health (2001c) *Handling complaints: monitoring the NHS Complaints Procedures, England 2000-01*, <http://www.doh.gov.uk/nhscomplaints>
- Department of Health (2001d) *Modernising Regulation in the Health Professions: Consultation Document*, Department of Health, London
- Department of Health (2001e) *Modernising Regulation – The New Health Professions Council: A Consultation Document*, Department of Health, London
- Department of Health, Education and Welfare (1973) *The Report of the Secretary's Commission on Medical Malpractice*, DHEW, United States, Publication number (OS) 73-88
- Dingwall, R (1994) 'Litigation and the threat to medicine', in J Gabe, D Kelleher and G Williams (eds), *Challenging Medicine*, Routledge, London
- Dingwall, R and Fenn, P (1991) 'Is risk management necessary?', *International Journal of Risk and Safety in Medicine* 2: 91–106

Bibliography

- Dingwall, R and Fenn, P (1995) 'Risk management: financial implications', in C Vincent (ed), *Clinical Risk Management*, BMJ Books, London
- Dingwall, R, Durkin, T and Felstiner, WLF (1992) 'Delay in tort cases: critical reflections on the Civil Justice Review', *Civil Justice Quarterly* 353–65
- Donaldson, L (1994) 'Doctors with problems in the NHS workforce', *British Medical Journal* 308: 1277–82
- Donaldson, LJ and Cavanagh, J (1992) 'Clinical complaints and their handling: a time for change?', *Quality in Health Care* 1:21–25
- Editorial (1989) 'Finding fault with medical negligence', *New Law Journal* 139: 101
- Eekelaar, J., and Dingwall, R., (1988) 'The development of conciliation in England', in *Divorce Mediation and the Legal Process*, edited by Dingwall and Eekelaar, Clarendon, Oxford.
- Ennis, M (1994) 'The effects of medical accidents and litigation on doctors and patients', *Law and Policy* 16(2): 97–121
- Ennis, M and Vincent, C (1994) 'The effects of medical accidents and litigation on doctors and patients', *Law and Policy* 16(2): 97–122
- Ennis, M, Clark, A and Grudzinkas, JG (1991) 'Change in obstetric practice in response to fear of litigation in the British Isles', *The Lancet* 338: 616–18
- Epstein, R (1976) Medical Malpractice: the case for contract, *American Bar Foundation Research Journal*, 87(1): 87-149
- Erichsen, M (2001) 'The Danish Patient Insurance System', *Medicine and Law*, 20: 355-369
- Ervine, C (1993) *Settling Consumer Disputes: A review of alternative dispute resolution*, National Consumer Council
- Espinosa, JA and Nolan, TW (2000) 'Reducing errors made by emergency physicians in interpreting radiographs: longitudinal study', *British Medical Journal* 320: 737-740
- Felstiner, W, Abel, R and Sarat, A (1980–81) 'The emergence and transformation of disputes: naming, blaming, claiming', *Law and Society Review* 15(3–4): 631–54
- Fenn, P, Hermans, D and Dingwall, R (1994) 'Estimating the cost of compensating victims of medical negligence', *British Medical Journal* 309: 389–91
- Fenn, P., Diacon, S., Gray, A., Hodges, R., Rickman, N., (2000) 'Current cost of medical negligence in NHS hospitals: analysis of claims database 320 *BMJ* 1567
- Fitzpatrick, R (1991) 'Surveys of patient satisfaction: I – Important general considerations', *British Medical Journal*, 302: 887–89
- Fitzpatrick, R (1993) 'Scope and measurement of patient satisfaction', in R Fitzpatrick and A Hopkins (eds), *Measurement of Patients' Satisfaction with their Care*, Royal College of Physicians, London
- Fitzpatrick, R and Hopkins, A (1983) 'Problems in the conceptual framework of patients satisfaction research: an empirical exploration', *Sociology of Health and Illness* 5(3):297–311
- Fitzpatrick, R and Hopkins, A (eds) (1993) *Measurement of Patients' Satisfaction with their Care*, Royal College of Physicians, London

Bibliography

- Fox, J and Storms, D (1981) 'A different approach to sociodemographic predictors of satisfaction with health care', *Social Science and Medicine* 15A: 557-64
- Fuller, L (1971) 'Mediation – Its forms and functions', *Southern California Law Review* 44: 305-339
- Gaba, DM (2000) 'Anaesthesiology as a model for patient safety in health care', *British Medical Journal* 320: 785-788
- General Medical Council (1998) *Good Medical Practice*, GMC, London
- Hall, J and Dornan, M (1988) 'What patients like about their medical care and how often they are asked: a meta-analysis of the satisfaction literature', *Social Science and Medicine* 27 (9): 935-39
- Ham, C (1989) 'Should a no fault compensation scheme be introduced and what would it cost?', in R Mann and J Havard (eds), *No Fault Compensation in Medicine*, Royal Society of Medicine Services Limited, London
- Ham, C (1995) (ed) *NHS Handbook*, JMH Publishing, Tunbridge Wells
- Ham, C, Dingwall, R, Fenn, P and Harris, D (1988) *Medical Negligence: Compensation and accountability*, Briefing Paper 6, King's Fund Institute, London/Centre for Socio-Legal Studies, Oxford
- Harper Mills, D and von Bolschwing, G (1995) 'Clinical risk management: experiments from the US', *Quality in Health Care* 4(2): 90-101
- Harris, J (1987) 'Defensive medicine: it costs but does it work?', *Journal of the American Medical Association* 257:2801-02
- Harvard Medical Practice Study (1990) *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York*, HMPS, Cambridge
- Harvey, I and Chadwick, R (1992) 'Compensation for harm: the implications for medical research', *Social Science and Medicine* 34(12):1399-404
- Hawkins, C., and Paterson, I., (1987) 'Medicolegal Audit in the West Midlands: Analysis of 100 cases' 295 *BMJ* 1533
- Health Committee (1999) *Procedures relating to adverse clinical incidents and outcomes in medical care*, Sixth Report 1998-9, (HC 549-1), HMSO, London
- Health Service Commissioner (1996/7 1996/7, 1997/8, 1998/9, 1999/0, 2000/1) *Annual Reports*, The Stationery Office, London
- Heintz, D (1977) 'Arbitration', *Maryland Law Review* 36: 533-552
- Heintz, D (1979a) 'Arbitration of medical Malpractice Claims: Is it cost effective?', *Maryland Law Review* 36: 533- 552
- Heintz, D (1979b) 'Medical Malpractice Arbitration: A Viable Alternative', *Arbitration Journal* 34(4): 12-18
- Helmreich, RL (2000) 'On error management: lessons from aviation', *British Medical Journal* 320: 781-785
- Hensler, DR (1990) 'Assessing claims resolution facilities: what we need to know', *Law and Contemporary Problems* 53(4): 175-88

Bibliography

- Hensler, DR (1991) 'Science in the court: is there a role for alternative dispute resolution?', *Law and Contemporary Problems* 54(3): 171–93
- Hiatt, H, Barnes, B, Brennan, R, Laird, N, Lawthers, A, Leape, L, Localio, R, Newhouse, J, Peterson, L, Thorpe, K, Weiler, P and Johnson, W (1989) 'Special report: a study of medical injury and medical malpractice', *New England Journal of Medicine* 321(7): 480–84
- Hingorani, M, Wong, T and Validis, G (1999) 'Patients' and doctors' attitudes to the amount of information given after unintended injury after treatment: cross sectional questionnaire survey', *British Medical Journal* 311: 640–64
- Hogan, P (1997) 'Claims data reveal true costs of negligence cases against trusts', *CNST Review* (Summer): 9
- Hopkins, A (1993) 'The doctor's perspective', in R Fitzpatrick and A Hopkins (eds), *Measurement of Patients' Satisfaction with their Care*, Royal College of Physicians, London, pp 99–114
- Hoyte, P (1995) 'Unsound practice: the epidemiology of medical negligence', *Medical Law Review* 3: 53–73
- Jain, O and Ogden, J 'GPs' experiences of patients' complaints: qualitative study', *British Medical Journal* 318: 1596
- Jost, T, Mulcahy, L, Strasser, S and Sachs, LA (1993) 'Consumers, complaints, and professional discipline: a look at Medical Licensure Boards', *Health Matrix: Journal of Law-Medicine* 3(2)(Summer): 309–38
- Kohn, LT, Corrigan, JM, and Donaldson, MS (eds) (1999) *To err is human Building a safer health system*, National Academy Press, Washington DC
- Kyffin, R, Cook, G and Jones, M (1997) *Complaints Handling and Monitoring in the NHS: A study of 12 trusts in the North West Region*, Institute of Medicine, Law and Bioethics, University of Liverpool
- Lavery, P (1988) 'The physician's reaction to a malpractice suit', *Obstetrics and Gynaecology* 70: 138–41
- Leape, L, Brennan, T, Laird, N *et al* (1991) 'Incidence of adverse events and negligence in hospitalised patients: the results of the Harvard Medical Practice Study II', *New England Journal of Medicine* 324: 377–94
- Lind, EA, Huo, YJ and Tyler, TR (1989) *And Justice for All: Ethnicity, gender and preferences for dispute resolution procedures*, American Bar Foundation Working Paper 9301, Chicago
- Linder-Pelz, S (1982) 'Social psychological determinants of patient satisfaction: a test of five hypotheses', *Social Science and Medicine* 16: 583–89
- Lindgren, OH, Christensen, R and Harper Mills, D (1991) 'Medical malpractice risk management early warning systems', *Law and Contemporary Problems* 54(2): 23–41
- Lloyd-Bostock, S (1992) 'Attributions and apologies in letters of complaint to hospitals and letters of response', in JH Harvey, TL Orbus and AL Weber (eds), *Attributions, Accounts and Close Relationships*, Springer-Verlag, New York, pp 209–20

Bibliography

- Lloyd-Bostock, S (1993) 'Attributions of cause and responsibility as social phenomena', in J Jaspars, F Fincham and M Hewstone (eds), *Attribution Theory and Research: Conceptual developmental and social dimensions*, Academic Press, New York
- Lloyd-Bostock, S and Mulcahy, L (1994) 'The social psychology of making and responding to hospital complaints: an account model of complaint processes', *Law and Policy* 16: 123-47
- Locker, D and Dunt, D (1978) 'Theoretical and methodological issues in sociological studies of consumer satisfaction with medical care', *Social Science and Medicine* 12: 283-92
- Lord Chancellor's Department, (1996) *Access to Justice*, HMSO, London
- Macfarlane, A and Chamberlain, G (1993) 'What is happening to caesarean section rates?', *The Lancet* 342: 1005-6
- Mann, R (1989) 'No fault compensation – a discussion paper', in R Mann and J Havard (eds), *No Fault Compensation in Medicine*, Royal Society of Medicine Services Limited, London
- May, ML and Stengel, DB (1990) 'Who sues their doctors?', *Law and Society Review* 24(1): 104-20
- McGregor Vennel, M (1989) 'Medical misfortune in a no fault society', in R Mann and J Havard (eds), *No Fault Compensation in Medicine*, Royal Society of Medicine Services Limited, London
- McIntosh, D (1989) 'A prescription for medical negligence', in R Mann and J Havard (eds), *No Fault Compensation in Medicine*, Royal Society of Medicine Services Limited, London
- McLean, SAM (1985) 'Accident compensation liability without fault – the New Zealand experience', *Journal of Social Welfare Law*, 6: 31-45
- McQuade, JS (1991) 'The medical malpractice crisis – reflections on the alleged causes and proposed cures: discussion paper', *Journal of the Royal Society of Medicine* 84: 408-11
- Menkel-Meadow, C (1996) 'Will managed care give us access to justice?', in R Smith (ed) *Achieving Civil Justice: Appropriate Dispute Resolution for the 1990s*, Legal Action Group, London
- Meschievitz, C (1991) 'Mediation and Medical Malpractice: Problems with definition and implementation', *Law and Contemporary Problems* 54(1): 195-215
- Meyer, A (1987) '“Lumping it”: the hidden denominator of the medical malpractice crisis', *American Journal of Public Health* 77(12): 1544-8
- Mills, S (ed) (1977) *Report on the Medical Insurance Feasibility Study*, Sutter Publications
- Mizrahi, T (1984) 'Managing medical mistakes: ideology, insularity and accountability among internists in training', *Social Science and Medicine* 19: 135-46
- MORI (1994) *Attitudes Towards and Experience of Complaints Systems*, research conducted for the Citizen's Charter Complaints Task Force, MORI, London
- MORI (1995) *Complaints Handling in the Public Sector*, Citizen's Charter Unit Complaints Task Force, HMSO, London
- MORI (1997) *Complaint Handling 1997 Report*, MORI, London

Bibliography

- Mulcahy, L (1996a) 'From fear to fraternity: doctors' construction of rational identities in response to complaints', *Journal of Social Welfare and Family Law* 18(4): 397–412
- Mulcahy, L (1996b) *Putting it Right for Consumers: Complaints and redress procedures in public services*, National Consumer Council, London
- Mulcahy, L (1999a) 'Being seen to be heard: reflections of a researcher on practice level handling of complaints', *Clinical Risk* 5: 77–82
- Mulcahy, L (1999b) 'Patient orientated approaches to dealing with medical negligence claims', in M Rosenthal, S Lloyd-Bostock and L Mulcahy (eds), *Medical Mishaps*, Open University Press, Buckingham
- Mulcahy, L (1999c) 'Sliding scales of justice – a cause for complaint?', in Michael Harris and Martin Partington (eds), *Administrative Justice in the 21st Century*, Hart Publishing, Oxford
- Mulcahy, L (2000) 'Threatening behaviour: the challenge posed by medical negligence claims', in M Freeman and R Lewis (eds), *Current Legal Problems*, Oxford University Press, Oxford
- Mulcahy, L and Allsop, J (1995) 'Dealing with clinical complaints', *Quality in Health Care* 4: 135–43
- Mulcahy, L and Allsop, J (1997) 'A Woolf in sheep's clothing? – The move to informalism in NHS tribunals', in Leyland and Woods (eds), *Administrative Law: Facing the future*, Blackstone, London
- Mulcahy, L and Allsop, J (1997) 'Deconstructing professional identity: doctors' responses to complaints', in V Oligatti, L Orzack and M Saks (eds), *The Sociology of the Professions*, Institute of Sociology of Law, Onati
- Mulcahy, L and Allsop, J (1999) 'How doctors react to complaints – coping strategies and identities in crisis', in M Rosenthal, S Lloyd-Bostock and L Mulcahy (eds), *Medical Mishaps*, Open University Press, Buckingham
- Mulcahy, L and Lloyd-Bostock, S (1992) 'Complaining – what's the use?', in R Dingwall and P Fenn (eds), *Quality and Regulation in Health Care*, Routledge, pp 51–68
- Mulcahy, L and Lloyd-Bostock, S (1994) 'Managers as third-party dispute handlers in complaints about hospitals' *Law and Policy* 16(2): 185–208
- Mulcahy, L and Lloyd-Bostock, S (1996) 'NHS complaints procedures and patient centred care – the connection', in B Fulford, S Ersser and T Hope (eds), *Essential Practice in Patient Centred Health Care*, Blackwell Science
- Mulcahy, L and Tritter, J (1996) 'Rhetoric or redress', in M McConville (ed), *The Citizen's Charter*, Blackstone Press, London
- Mulcahy, L and Tritter, J (1998) 'Pyramids, pathways, and icebergs – understanding the relationship between dissatisfaction, complaints and disputes', *Sociology of Health and Illness* 20(6): 825–47
- Mulcahy, L with Selwood, M, Summerfield, L and Netten, A (2000) *Mediating Medical Negligence Claims – an option for the future? An evaluation of the Department of Health's Mediation Pilot Scheme*, The Stationery Office, Norwich
- Mulcahy, L, Allsop, J and Shirley C (1996) *The Voices of Complainants and General Practitioners in Complaints about Health Care*, Social Science Research Monographs, No 3, South Bank University, London

Bibliography

- Mulcahy, L, Jost, T, Strasser, S and Sachs, L (1993) 'Consumers, complaints and professional discipline: a look at Medical Licensure Boards', *Health Matrix: Case Western Reserve University Journal of Law and Medicine* (Winter): 309
- Mulcahy, L, Lickiss, R, Allsop, J and Karn, V (1996) *Small Voices, Big Issues – An annotated bibliography of the literature on public sector complaints*, University of North London Press, London
- National Audit Office (2001) *Handling clinical negligence claims in England*, The Stationery Office, Norwich
- National Health Service Executive (1994) *Being Heard*, Department of Health, Leeds
- Nau, J-Y (1994) 'No-fault compensation in France', *The Lancet* 344: 676
- Nightingale, PG, Adu, D, Richards, NT and Peters, M (2000) 'Implementation of rules based computerised bedside prescribing and administration: intervention study' *British Medical Journal* 320: 750-753
- Nolan, TW (2000) 'System changes to improve patient safety', *British Medical Journal* 320: 771-773
- Oldertz, C (1989) 'Compensation for personal injuries – the Swedish patient and pharmaceutical scheme insurance', in R Mann and J Havard (eds), *No Fault Compensation in Medicine*, Royal Society of Medicine Services Limited, London
- Ossyra, JD (1998) 'The Massachusetts malpractice plaintiff's new hurdles: the expanding role of the medical malpractice screening tribunal', *American Journal of Law and Medicine* 8(4): 481-508
- Owen, C (1991) 'Formal complaints against general practitioners: a study of a thousand cases', *British Journal of General Practice*, March
- Pascoe, G (1983) 'Patients satisfaction in primary health care: a literature review and analysis', *Evaluation and Program Planning* 6: 185-210
- Peterson, MA (1990) 'Giving away money: comparative comments on claims resolution facilities', *Law and Contemporary Problems* 53(4): 113-36
- Perason Commission (1978) otherwise known as *Royal Commission on Civil Liability and Compensation for Personal Injury*, (1978) Cmnd. 7054 HMSO, London.
- Pietroni, P and de Uray-Ura, B (1994) 'Informal complaints procedure in general practice: first year's experience', *British Medical Journal* 308:1546-48
- Posner, R (1992) 'A Theory of Negligence', *The Journal of Legal Studies* 2: 29-96
- Prescott Clarke, P, Brooks, T and Machray, C (1988) *Focus on Health Care: surveying the public in four health districts*, Vol 1, SCPR and RIPA, London
- Quam, L, Dingwall, R and Fenn, P (1987) 'Medical malpractice in perspective: I – the American experience', *British Medical Journal* 294:1529-32
- Quam, L, Dingwall, R and Fenn, P (1987) 'Medical malpractice in perspective: II – the implications for Britain', *British Medical Journal* 294:1597-1600

Bibliography

- Reason, J (2000) Human error: models and management, *British Medical Association* 7237: 768-770
- Reichl, M and Sleet, R (1990) 'Complaints against accident and emergency departments: current trends', *Archives of Emergency Medicine* 246-48
- Reinertsen, JL (2000) 'Let's talk about error', *British Medical Journal* 320: 730
- Ridgway, D (1999) 'No fault vaccine insurance: Lesson from the National Vaccine Compensation Program', *Journal of Health Policy and Law* 24: 59-86
- Roberts, R, Pascoe, G and Attkisson, C (1983) 'Relationship of service satisfaction to life satisfaction and perceived well-being', *Evaluation and Program Planning* 6: 373-83
- Roghaman, K, Hengst, A and Zastowny, T (1979) 'Satisfaction with medical care: its measurement and relation to utilization', *Medical Care* 17(5)(May): 461-76
- Rosenthal, M (1987) *Dealing with Medical Malpractice: The British and Swedish experience*, Tavistock, London
- Rosenthal, M (1992) 'Medical discipline in cross-cultural perspective: the US, Britain and Sweden', in R Dingwall and P Fenn (eds), *Quality and Regulation in Health Care*, Routledge, London
- Rosenthal, M, Mulcahy, L and Lloyd-Bostock, S (eds) (1999) *Medical Mishaps*, Open University Press, Buckingham
- Royal Liverpool Children's Inquiry (2001) *Summary and Recommendations*, House of Commons, London
- Saunders, L, (1986) 'The Quest for Balance: Public Policy and Due Process in Medical Malpractice Arbitration Agreements', *Harvard Journal on Legislation* 23: 267-85
- Savage, R and Armstrong, D (1990) 'Effect of general practitioner's consulting style on patients' satisfaction: a controlled study', *British Medical Journal* 301: 968-70
- Seelos, L and Adamson, C (1994) 'Redefining NHS complaint handling – the real challenge', *International Journal of Health Care Quality Assurance* 7(6):26-31
- Select Committee on Health (1999) *6th Report*, House of Commons, London.
- Shirley, C, Mulcahy, L with Allsop, J (1994) *Family Health Service Authority, Complaints Research Project*, Report to the Anglia and Oxford Regional Health Authority FHSA Complaints Consortium
- Silvester, S, Allen, H, Withey, C, Morgan, M and Holland, W (1994) *The Provision of Medical Services for Sick Doctors: A conspiracy of friendliness?*, Nuffield Provincial Hospitals Trust, London
- Simanowitz, A (1987) 'Medical accidents: the problem and the challenge', in P Byrne (ed), *Medicine in Contemporary Society*, King Edward's Hospital Fund, London/Oxford University Press, Oxford
- Simanowitz, A (1989) 'No-fault compensation – short term panacea or long term goal?', in R Mann and J Harvard (eds), *No-Fault Compensation in Medicine*, Royal Society of Medicine Services Limited, London
- Sloan, F, Whetten-Goldstein, K, and Hickson, G, (1998) 'The influence of obstetric no fault on obstetrics practice patterns', *American Journal of Obstetrics and Gynaecology* 179(3): 671-676

Bibliography

- Sloan, FA (1985) 'State responses to the malpractice insurance "crisis" of the 1970s: an empirical assessment', *Journal of Health Politics* 9(4): 629–46
- Smith, R (1992) 'Fiddling with medical negligence: forget arbitration and go for no fault', *British Medical Journal* 304: 198
- Smith, R (1994) *Medical Discipline: the professional conduct of the GMC 1958–1990*, Oxford University Press, Oxford
- Strasser, S and Davis, R (1991) *Measuring Patient Satisfaction for Improved Patient Services*, The Health Administration Press, Ann Arbor, Michigan
- Studdert, D, (2000) 'The jury is still in: Florida's birth related neurological injury compensation association after a decade', *Journal of Health Policy and Law* 25: 499-526
- Studdert, D, and Brennan, T (2001) 'Toward a workable model of 'no fault' compensation for medical injury in the United States', *American Journal of Law and Medicine* 27: 225-252
- Summerton, N (1995) 'Positive and negative factors in defensive medicine: a questionnaire study of general practitioners', *British Medical Journal* 310: 27–29
- SUPPORT principal investigators (1995) 'A controlled trial to improve care for seriously ill hospitalized patients: a study to understand prognoses and preferences in outcomes and risks of treatment (SUPPORT)', *Journal of the American Medical Association* 274: 591-98
- Susman, J (1994) 'Resolving hospital conflicts: a study of therapeutic jurisprudence', *Journal of Psychiatry and Law* 22(1): 107–33
- Thompson, A (1993) 'Inpatients: opinions of the quality of acute hospital care: discrimination as the key to measurement validity', in R Fitzpatrick and A Hopkins, (eds), *Measurement of Patients' Satisfaction with their Care*, Royal College of Physicians, London, pp 19–32
- Vincent, C (1995) 'Introduction', *Clinical Risk Management*, BMJ, London
- Vincent, C, Neale, N, Woloshynowych, M, Moore, J (1999) 'Adverse events in hospitalised patients: proposal for a national study' (unpublished)
- Vincent, C, Pincus, T and Scurr, J (1993) 'Patients' experience of surgical accidents', *Quality in Health Care* 2: 77–82
- Vincent, C, Taylor-Adams, F, Chapman, J, Hewett, D, Prior, S, Strange, P and Tizzard, A (1996) 'How to investigate and analyse clinical incidents: Clinical Risk Unit and Association of Litigation and Risk Management protocol', *British Medical Association* 7237: 777-780
- Vincent, C, Young, M and Phillips, A (1994) 'Why do people sue doctors? A study of patients and relatives taking legal action', *The Lancet* 343: 1609–13
- Wallace, H and Mulcahy, L (1999) *Cause for Complaint? An evaluation of the effectiveness of the NHS complaints procedure*, The Public Law Project, London

Bibliography

- Ware, J and Hays, R (1988) 'Methods for measuring patient satisfaction with specific medical encounters', *Medical Care* 26(4)(April): 393–402
- Whetten-Goldstein, K, Kulas, E, Sloan, F, Hickson, G and Entman, S (1999) 'Compensation for birth related injury – No fault programs compared with tort', *Archive of Pediatric and Adolescent Medicine* 153: 41-48
- Williamson, C (1999) 'Critical incidents and candour', *Royal College of Anaesthetists Newsletter* May 46: 113-4
- Wilson, DG, Runciman, WB, Gibberd, RW, Harrison, BT, Newby, L and Hamilton, JD (1995) 'The Quality in Australian Health Care study', *Medical Journal of Australia* 163: 485-471
- Woolley, F, Kane, R, Hughes, C and Wright, D (1978) 'The effects of doctor-patient communication on satisfaction and outcome of care', *Social Science and Medicine* 12: 123–28
- Wu, A (2000) 'Medical error: the second victim', *British Medical Journal* 320: 726-727
- Wu, A (2000) 'The doctor who makes mistakes needs help too', *British Medical Journal* 320: 726-7
- Wu, A, Folkman, S, Mcphee, J and Lo, B (1991) 'Do house officers learn from their mistakes?', *The Journal of the American Medical Association* 265: 16-24

Appendix: Data collection and methods of analysis in complaint studies

Name of study	Source of data	Data collection period	Time span covered by data	Sample size and response rate	Method of analysis
GP Tribunal Study (Allsop)	Letters of response to formal complaints to one English FHSA	1976-1990	1976-1987	All formal cases during period - 110 cases and 122 doctors.	Content analysis of accounts and defence strategies.
Consultant Study (Mulcahy)	a) Postal questionnaire to consultants in one English RHA	1993-1996	Experience of complaints over whole professional career of doctors involved	a) All consultants in one RHA (848). Response rate 52%.	a) Use of SPSS to generate frequencies and cross tabs
	b) Exploratory face to face interviews with consultants			b) Sample of 35 consultants by specialty, gender and workplace	b) Grounded analysis of key themes.
GP Study (Mulcahy, Allsop and Shirley)	a) Postal questionnaire to GPs in one English FHSA	1993-1995	a) Experience of complaints in last five years of professional career	a) All GPs in one FHSA (363). Response rate 56%.	a) Use of SPSS to generate frequencies and cross tabs
	b) Exploratory face-to-face interviews with LMC secretaries		b) Experience of complaints over whole professional career	b) All LMC secretaries in Region (4)	b) Ground analysis of key themes
PLP Study (Wallace and Mulcahy)	a) Postal questionnaire to health councils, conveners, IRP chairs - UK	1998	1996-1999	a) Health councils - 146 Response rate 65%. Trusts - 169 Response rate 58% IRP Chairs - 191 Response rate 52%	a) SPSS
	b) Interviews with health councils, NHS staff, complainants			b) 72 interviews	b) content analysis
Complaints System Evaluation Study (DH)	a) Postal questionnaire to NHS complaints handlers	1999	1996-2000	a) Complaints handlers - 1454 Response rate 62%	NA
	b) UK-wide survey of Health Councils			b) Health Councils - 130 Response rate 58%	NA
	c) Questionnaire to complainants, NHS staff who have received complaints			c) Complainants - 271 Response rate 31% Staff - 144 Response rate 25%	NA
	d) Workshops				
Complaints to Hospital trusts N.W England (Kyffin, Cook and Jones)	a) Postal questionnaire to complainants in 3 trusts	1998	1998	a) Questionnaire - 175 Response rate 50%	NA
	b) Complainants letters and trust responses			b) Letters - 63	Content analysis