Medicine for Managers

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The Changing Face of Complaints and Claims

We can speculate why there has been an apparent explosion in complaints and claims in healthcare over the last fifty years. In the 70s, complaints were rare and there was generally appreciation of services provided and care given. So why so many expressions of dissatisfaction now? Are the facilities worse, the care given less good or has the threshold for complaining fallen, such that gratitude has given way to opprobrium?

The increasing rate of complaint is not confined to healthcare but seems to be general across the service sector. As far as I can tell, no one is even sure whether the problem is that the service is genuinely declining or the expectations of the population are just increasing inexorably.

Staff in primary and secondary care will all say that, although they sometimes get expressions of gratitude and appreciation for the service, there are increasing occasions where they are greeted with complaints about delays, quality, courtesy and a host of other elements which make up the healthcare/patient interaction.

It may be that it is the sheer workload which has to be managed these days that is so much greater than it was even a few years ago.

Another factor, which has affected management of dissatisfaction, both in the way in which complaints are answered and the way in which claims against providers and staff are litigated, is the large number of cases which are cited when claimant solicitors in particular are trying to prove individual or system failure.

The ***General Medical Council*** influences every aspect of medical practice. The standards which it expects of every registrant are outlined in ***Good Medical Practice (2024)***.

For a long time, the GMC was seen as an organisation, funded by medical professionals, working to provide support for doctors as well as assisting patients. However, over time its remit seems to have changed and many clinicians now feel that it has become a patient's organisation to represent them against doctors when they believe that things have gone wrong.

The professional standards laid out by the GMC might give support and credence to this view. The first section of the guidance points out its functions:

- Protecting, promoting and maintaining health, safety and wellbeing of the public

- Promoting public confidence in the medical professions
- Promoting and maintaining proper standards and conduct

On receipt of a concern, the Council:

- Assesses whether it is poor performance and if isolated or repeated
- Reviews how the medical professional responded to the concern, including evidence of insight and remediation
- It decides whether to act against the doctor according to perceived risk

Under knowledge and skills, it states its role to ensure that doctors:

- Provide a good standard of practice and work within competence
- Respect dignity and treat the patient as an individual
- Protect information
- Serve patient's best interest
- Treat patients with respect
- Protect patient safety and dignity
- Act with integrity
- Do not discriminate
- Do not abuse trust

Other regulators have similar remits.

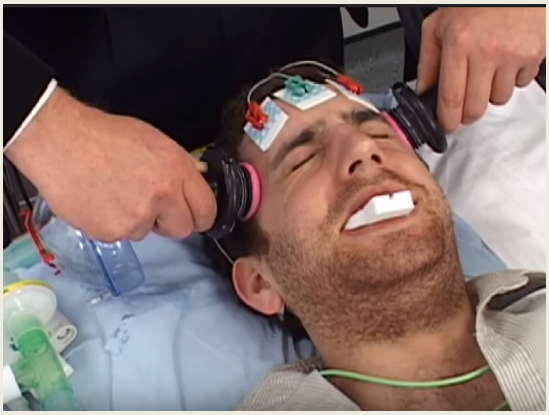
To many clinicians, it appears as though the complainants hold all the cards; that as a result of a complaint or claim the staff member has to prove he or she is not guilty, and that there is no form of redress against patients whose behaviour or actions are wholly unacceptable.

To some extent, claims brought before the court over the last seventy years or so, have influenced the way in which they are formulated and prosecuted and complaint management has changed in parallel.

A number of cases have had profound effects on the manner in which presentations and judgements before the court have proceeded.

The Bolam Case 1957

Mr Bolam suffered from recurrent and severe depression and he had previously attempted suicide. He was admitted to Friern Hospital in North London, which was a large mental health institution. He was assessed by the consultant Dr Allfrey, who decided that, as part of his care he needed electro-convulsive therapy (ECT). In



essence the treatment involved inducing seizures by passing an electric current through electrodes placed on the head. At that time, opinion was divided about the use of muscle relaxants during the procedure and none were used in Mr Bolam's case, although members of the nursing staff were placed on either side of the couch to prevent the patient falling off when the shock was applied.

The first treatment was uneventful but, during the second induced seizure, Mr Bolam suffered

bilateral hip fractures as a result of the severe muscle spasm.

Subsequently Mr Bolam lodged a claim against the Hospital Management Committee alleging clinical negligence by allowing the consultant to administer the treatment without the use of muscle relaxants.

He also alleged that he was not warned of the risks and that he was not restrained during the treatment. During the trial, experts explained that opinion on the use of muscle relaxants and restraints was divided, some clinicians favouring their use and others indicating that they were not appropriate and restraints actually increased the risk of fracture.

The case was heard by Mr Justice McNair who, in his advice to the jury, made the well known statement that;

"*Where some special skill is exercised, the test for negligence is* ***not the test of the man on the Clapham omnibus****, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising or professing to have that special skill*"

The judgement delivered by the jury was in favour of the hospital and that Dr Allfrey was not negligent.

The test, which has become known as the ***Bolam Test***, held that a doctor is not guilty of negligence if;

"*he has acted in accordance with a practice accepted as proper by a* ***responsible body of medical men*** *skilled in that particular art*".

In other words, ***a doctor is not negligent if he acts in a particular way, simply because there is another body of opinion which takes a contrary view.***

Bolitho v City and Hackney Health 1997.

Bolam stood as the principal yardstick by which negligence was measured, until the Bolitho case. Two year-old Patrick Bolitho was admitted to St Bartholomew's Hospital twice with respiratory distress due to croup.

On the ward, the child had two episodes of respiratory difficulty, during which he became pale and gasped for breath.

A house officer was called but did not respond (the batteries on her bleep were flat) and the senior registrar responded twice but did not come to see the child. Shortly after the second episode, the child stopped breathing and suffered a cardiac arrest which resulted in severe brain damage and subsequently to the child's death.

The child's mother subsequently sued the City and Hackney Health Authority for clinical negligence, on the basis that, if the child had been intubated, he would have survived.

The Health Authority accepted the assertion that the Registrar had not attended but refuted the suggestion that the breach led to the child's death because the registrar would not have intubated the child on the basis that it was not warranted by the condition of the child after the acute episode.

The Authority applied the Bolam test that a

respected body of medical opinion would support the registrar's decision not to intubate.

Five medical experts testified that any competent doctor would have intubated the child. Three experts held the opposite view, stating that the risk of respiratory failure was small and did not justify the invasive process of intubation. The judge was most impressed by the evidence provided by one of the witnesses supporting the doctor's decision not to intubate.

The case went to the House of Lords.

The ruling was that opinion should not only be reasonable and responsible but also capable of logical analysis.

Even though the approach that would have been adopted by the registrar was held to be a minority view, it could be accepted if it was not illogical or irresponsible.

In other words, the Bolam Test stipulated that no doctor can be found guilty of negligence if he or she acted in accordance with a responsible body of medical opinion.

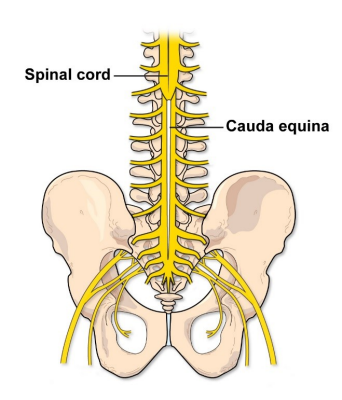
The Bolitho Test clarified what was meant by a 'responsible body', defining it as one whose opinion had a 'logical basis'.

Chester v Afshar 2004

This interesting case further defined the responsibilities of clinicians in cases where there was a breach of duty.

Ms Chester had suffered back pain for six years. The severity resulted in episodes where she could not walk or control her bladder. She had a disc protrusion into her spinal column and surgery was advised.

Mr Afshar, a reputable and competent surgeon, undertook the surgery but did not warn Ms Chester of a 1-2% chance of damage to the cauda equina (a system of nerve roots which leave the spinal cord between the bones at the base of the spine to supply the legs and bladder).



The result of the operation was that the symptoms unfortunately worsened.

In evidence it was shown that Mr Afshar had undertaken the operation skilfully and without negligence. However, Ms Chester argued that, had she been warned of the risks, she would have delayed the operation to obtain a second opinion, although she might well have ultimately proceeded with the surgery.

The judge found for Ms Chester. The defendant appealed but the Court of Appeal dismissed the appeal.

The defendant then appealed to the House of Lords. Five Law Lords found, by a majority of three to two, in favour of Ms Chester.

The basis of the judgement was that;

the claimant had a right to be informed of any small serious risk and the law protected that right.

Lord Bingham said "the existence of the duty is not in doubt. Nor is its rationale – to enable patients of sound mind to make for themselves intimate decisions affecting their own lives".

Lord Steyn said "*in modern law medical paternalism no longer rules. . . The patient has the right to be informed of a small but well established risk".*

Montgomery v Lanarkshire Health Board 2015

After the clarification of valid consent in the Afshar case, the Montgomery case further affected ***material risks*.**

The issue revolved around ***shoulder dystocia***, which occurs during the delivery of a baby if the infant's shoulder becomes stuck against the maternal pubic bone at the outlet of the pelvis, thereby delaying the delivery.

Mrs Montgomery was only 5 feet tall and was diabetic, which often results in a big baby. The clinician had discussed the risks for a diabetic woman during delivery but had not mentioned shoulder dystocia which, under normal circumstances, is a risk in 9-10% of pregnancies.

The obstetrician did not believe that a Caesarian section was in the patient's best interests. They proceeded with an attempted vaginal delivery, shoulder dystocia occurred and the shoulders could not be released for a prolonged period during which the umbilical cord was trapped between the pelvis and the baby's shoulder cutting off the blood supply and resulting in an infant with cerebral palsy. The risk of cerebral palsy was estimated at less than 0.1%.

The claim was successful on the basis that that the doctor should have provided information about ***all risks***. The court decided that the assessment of whether consent was adequate would be assessed by;

whether the patient had received information about all material risks, including disclosure of any risk to which a reasonable person in the patient's position would attach significance.

Doctors must now be ***guided by what matters to the patient.***

Mrs Montgomery was awarded more than £5 million in damages.

Although these four cases related to medical treatment, the principles were all rolled out across all areas of healthcare.

So, at the time of ***Bolam***, all that a doctor needed to show was that a reasonable body of medical opinion shared his or her view.

As a result of ***Bolitho***, scrutiny of an action and the application of logical analysis became an extra test.

Afshar added to the consent process ensuring that any material risk should be told to the patient, and…

Montgomery incorporated the additional requirement of placing on the doctor the responsibility of telling the patient what he or she would have wanted to know.

Life has changed in my time as a doctor, in terms of how care is delivered.

The bond between doctor and patient was much closer. In the 70s, the degree of trust between patients and doctors could be

witnessed by patients being largely disinterested in being given options for care. “Whatever you think is best” was the standard answer and I would reassure the patient “not to worry; I’ll do the best I can”.

I don’t honestly know whether telling a patient all the risks makes it easier or more difficult for the patient.

Not mentioning risks may give them a sense of false security in terms of the success of a particular treatment.

Telling them all the risks might result in patients declining treatment that might have been very beneficial. Patients often say “what would you do, doctor”.

I guess that just re-introduces the bias that the lawyers have tried so hard to crush, and that we must keep our own counsel.

I am not sure that makes us the patient’s friend!

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