Formal complaints against general practitioners: a study of 1000 cases

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SUMMARY. This study was carried out to determine the reasons given by patients in making formal complaints against general practitioners. A sample of 1000 complaints made by UK patients about general practitioner principals over the period 1982–89 was randomly selected from the computer database of the Medical Protection Society and retrospectively analysed. Thirteen categories of criticism were identified. The most common circumstance in which patients complained was when they believed there had been failure to visit. In nearly one third of cases the complaints were associated with the death of a patient. In a quarter of the letters it was clear that the patient's motive for complaining was concern to protect other patients. General practitioners should bear in mind that in declining to visit they could be inviting criticism, particularly if the patient dies.

Introduction

IN 1987 the population of the United Kingdom was 56.8 million people.[1] As a representative figure the mean number of general practitioner contacts in a year for each patient in the UK has been taken to be 4.4,[2] giving 250 million of such contacts every year.

Most complaints against general practitioners are first notified not to the doctor's practice but to the family health services authorities (formerly family practitioner committees) in England and Wales or health boards in Scotland and Northern Ireland. The family health services authorities have a statutory obligation to investigate complaints.[3-6] If the complaint gives reasons why the general practitioner may have been in breach of his or her terms of service and if it has been brought within the specified time period, the family health services authority is bound to investigate. The general practitioner gives a written reply which is shown to the complainant, who has the opportunity to comment further. This may resolve matters but, if not, a service committee hearing is convened. Here complainant and doctor will address the complaint, usually for one to three hours, answering questions from the lay and general practitioner members of the service committee. Through its service committee the family health services authority has the power to dismiss the complaint or apply a number of sanctions which most commonly include a finding of breach of terms of service with a possibility of withholding money from the general practitioner's remuneration. Up to 1989 the amounts of money withheld have been in the range of £50–£2500 (personal observations).[7,8] Both sides have a right of appeal, determined by the secretary of state, though this option is exercised for less than a quarter of decisions.[7,8] Owen[9] has illustrated the possible outcomes of an investigation by describing five actual cases, all of which were concluded in different ways.

This paper reports the analysis of a large sample of formal complaints made in an eight year period throughout the UK before the introduction of the new contract in April 1990. The merits of these complaints have not been questioned nor have the eventual outcomes been determined. Interesting as these aspects might have been it was not possible with the data available. Rather, the complaints have been classified to see if there were consistent reasons why patients became dissatisfied with their family doctors.

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Method

The computer database of the Medical Protection Society, one of the large defence organizations, was used to generate a record of every complaint in the United Kingdom notified to the society between 1982 and 1989, inclusive. These complaints had been notified by general practitioners requesting assistance in responding to their family health services authorities. The fact that the doctors had involved the Medical Protection Society does not imply that the complaints were unusual or specially selected; help in replying to complaints is simply part of the service offered by defence organizations. Informal complaints and those made direct to practices were excluded from the search.

In the resulting computer list of chronologically notified formal complaints there was no bias in terms of geography, practice profile or type of complainant. From this list, in which complaint files were identified simply by a case number, 1000 cases were randomly selected. The files for each case were retrieved from storage.

Using the letter of complaint as source material the complaints were classified according to the dominant criticism made by the complainant. Formal content analysis was not applied. The classification was surprisingly straightforward because the overwhelming majority of complainants had one dominant dissatisfaction. In a small number of letters several criticisms appeared to have been given equal weight by the complainant; these complaints were classified as miscellaneous.

The letters were also searched for the complainant's motive in making the complaint.

Results

Table 1 is derived from Department of Health statistics[7,8] and shows the number of formal complaints against general practitioners investigated over the period 1976–88 and the outcome of the complaints.

The classification of the 1000 complaints notified between 1982 and 1989 is presented in Table 2. The results show that 24.8% of formal complaints arose as a result of what the complainants perceived as a failure to visit. Commonly this was not an outright refusal to visit but the receptionist or general practitioner persuading the caller to bring the patient to the surgery instead. In other complaints in this category telephone advice was given instead of a visit. In addition, 4.9% of the complaints concerned a delay in visiting. In these cases a visit was made but, in the opinion of the complainant, it was too late so that the patient had either died or suffered an outcome which might have been prevented had the request been attended to more promptly.

The second commonest criticism was failure to diagnose (20.4% of all formal complaints). Complainants became aware of what they believed to be the correct diagnosis through seeing another doctor or from the postmortem. The 'missed'

Table 1. Formal complaints against general medical practitioners for all family practitioner committees in England.

	Total no. of complaints investigated	% of complaints upheld
1976	587	*14.8*
1981	706	*18.8*
1982	989	*27.3*
1983	914	*20.6*
1984	952	*20.2*
1985	1286	*26.5*
1986	1138	*29.5*
1987	1027	*23.2*
1988	1162	*21.7*

Table 2. Classification of patient criticisms in 1000 formal complaints made in the UK over the period 1982–89.

	Percentage of complaints (n = 1000)
Failure to visit	*24.8*
Failure to diagnose	*20.4*
Error in prescription	*8.3*
Failure to arrange emergency admission	*6.1*
Delay in diagnosis	*5.4*
Failure to examine	*5.1*
Delay in visiting	*4.9*
Unsatisfactory attitude of general practitioner	*4.8*
Failure to refer for investigation or opinion	*4.7*
Poor administration	*4.6*
Delay in arranging emergency admission	*4.3*
Delay in referral for investigation or opinion	*2.7*
Miscellaneous	*3.9*

n = total number of complaints.

diagnoses covered a wide range of clinical conditions but the most common were appendicitis, ectopic pregnancy, perforated peptic ulcer, early pregnancy and myocardial infarction. In an additional 5.4% of complaints the complainant reported that the general practitioner made the diagnosis only after a number of contacts and therefore late, so as to prejudice the outcome. An example which appeared a number of times in this category was delay in diagnosing carcinoma of the breast.

The 46 complaints concerning administration all arose from the organization of the practice. They concerned such problems as patients having to wait a week to be seen for a perceived acute condition, lack of privacy, telephones not working, cancelled surgeries and messages left for patients telling them to go to hospital because the doctor was not available.

Of all the complaints 10.4% had, as the single essential criticism, either failure (6.1%) or delay (4.3%) on the part of the general practitioner to admit the patient for emergency treatment. The 'failures' of admission usually concerned patients who later self-referred to hospital or emergency ambulance services. It is difficult to know if these complaints were fuelled by a chance remark made in hospital but certainly a number of letters referred to the hospital doctor expressing surprise that the patient had not been admitted earlier.

Prescription errors accounted for 8.3% of complaints. Some of these were wrongly written prescriptions which could not be dispensed. Other examples were errors of dosage or drug and allergic reactions when the patient had apparently previously given a history of sensitivity to the drug prescribed.

Doctors' attitudes are generally considered peripheral to the terms of service and complaints about manner are usually investigated by the informal procedure. However, in this study of formal complaints 4.8% of letters had, as the essential criticism, a dissatisfaction with the general practitioner's attitude. The adjectives most commonly used by the complainant were 'rude', 'offhand', 'unprofessional' and 'careless'. Not surprisingly, many of the complaints were accompanied by a re-registration.

The complaints commonly centred around a patient's death. In 31.7% of all 1000 letters the death of the subject patient was an important feature of the complaint.

Twenty six per cent of letters said that the complainant's purpose in bringing the complaint was to prevent the same thing happening to other people. For example 'I apologize this is such a lengthy letter and realize nothing can be done to erase our memories of the 18 May. However, if this letter prevents someone else suffering in the hands of this doctor it will have been worthwhile.'

Discussion

This study shows that the predominant criticism about general practitioners is failure to visit. Only slightly less common is failure to make a correct diagnosis. In both these areas it seems that patients will more readily tolerate a delay than what they perceive as a failure.

The outcome of these 1000 complaints has not been determined but Department of Health statistics (Table 1) indicate that only 14.8–29.5% of complaints are upheld. On this basis one would expect approximately three quarters of the complaints in this study to have been dismissed with a finding of no breach of the general practitioner's terms of service.

Klein[10] has described the subjects of complaints in 488 cases for which the clerks of the executive councils (the forerunners of family practitioner committees) provided details in 1970–71. His figure for failure to visit or delay in visiting is 28% which is very close to the figure of 29.7% found in this study. Klein found that failure to refer to hospital or specialist services represented 17% of complaints while in this study failure or delay in arranging emergency admission or in referral for investigation totalled 17.8% of complaints. Despite major evolution in general practice and over a decade of social change it seems that patients are still complaining about the same things.

The number of complaints investigated in the UK is very small in the context of the annual number of contacts between general practitioners and patients and in comparison with the experience in other countries. In Israel, for example, primary care generates 104 complaints per 10 000 registered patients annually.[11] Given the low rate of complaints among UK patients it would be easy to be complacent. However, it is likely that those people whose complaints are investigated are the visible part of a larger number who are dissatisfied with the service they receive but who do not have the patience, nerve and determination to sustain them through the complaints procedures. If a complaint is investigated formally and if the matter proceeds as far as a secretary of state appeal, both complainant and general practitioner may be involved with a complaint for up to two years (personal observations). In areas where patients have no choice of doctor they have the added disincentive of not wishing to prejudice their future care.

Fry has observed an annual death rate in general practice of 11 per 1000 patients[12] but in the present study 317 of the 1000 patients had died during the incidents which formed the basis of the complaints. This supports the belief that the patient's death may precipitate a complaint if there is a background of dissatisfaction. Relatives may complain to assuage feelings of

guilt about not having done more for the patient during life. Equally, bereaved people sometimes blame others for their loss as a way of coping with their own feelings.[13]

There is no means of knowing from the data used in this study exactly how many of the letters of complaint were written with the assistance of the community health council secretaries. Certainly some complainants were helped in this way. Nor did the data permit an analysis of the age and background of the complainant or of the relationship between the complainant and patient. These influences could form the basis of further studies.

If motives, as opposed to precipitant circumstances, are considered then one reason for complaining emerges forcefully. Twenty six per cent of complainants clearly say that they want to complain about the general practitioner to stop the same thing happening to other people.

It is neither feasible nor appropriate for general practitioners to visit every patient who contacts them with a problem and doctors will use their skill, experience and intuition to make a professional judgement of who to visit and when. They may, however, like to bear in mind that in declining a request for a visit they could be inviting criticism particularly when repeated requests are made. If the patient dies in this situation there is the clear possibility of a complaint. Many general practitioners try to keep in contact with bereaved relatives as a matter of caring practice but, aside from this, time seeing the bereaved may be well spent in forestalling a lengthy and stressful complaint investigation.

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