

**T**RADITIONALLY, patients who, for whatever reason, are dissatisfied with the care their doctor has given them, have had the options of saying nothing or of complaining. Saying nothing may result in resentment and a barrier to subsequent consulting. Complaining is a daunting and inappropriate process for many who, reasonably, are seeking clarification or understanding. A culture, not of complaint, but of feedback and dialogue, is attractive.

As doctors, we can all expect to receive complaints. Often they come from unexpected sources. Usually if we sense a problem we deal with it and try to defuse it. Complaints tend to emerge when a patient perceives that something has been unfairly or negligently done or not done to them by a doctor. The contract between doctor and patient is an intimate one, even when it goes wrong, and the doctor receiving the complaint often goes through a remarkably similar process to that of the patient ... someone is doing something unkindly or unfairly to me. He or she (as tutored by their MDU adviser) tends to respond carefully and defensively. An exchange of letters often leads to surprisingly little shared understanding as both patient and doctor are, in fact, mirroring each other's processes. Substantial hurt may result, but often little light is shed.

These raw but potentially rich experiences can, however, provide an opportunity for both to gain valuable insight, to learn and to avoid future similar situations. There is a more creative and illuminating way to deal with complaints.

We were both recently involved in conciliation procedures and, for both of us and for the patients, they were useful and educational. In both cases, the patients were dissatisfied with the care they had received and were offered, and accepted conciliation as an alternative to lodging a formal complaint. A conciliator, as it happened the same one, was appointed by the complaints officer and she arranged and expertly facilitated the separate conciliation sessions.

For one of us it was the first complaint. A preliminary meeting with the facilitator took place to lay out ground rules and clear boundaries in advance. The session would take up to 2 hours, would involve only doctor, patient and conciliator, there would be no written record and, if either party

indicated that they would be taking matters further, the session would be terminated, the shared goal of conciliation having ceased. Control of time would be in the hands of the conciliator who would also intervene if one party was dominating the conversation. Safety and honesty were the aims.

Shortly thereafter, the session took place. The patient spoke, without interruption, for as long as she needed. The doctor then had the same opportunity. The patient complained that, following a long appointment with her, she had felt judged and, consequently, ashamed. The doctor responded that in no way was she ever judging or dismissing a patient when she listened to them. She had indeed allowed extra time because of the patient's obvious distress, and her own wish to help. Half an hour into the conciliation meeting both parties had simply reiterated their positions, with both feeling deeply 'misjudged' by the other.

The conciliator made some brief, but very acute, observations about the manner in which both had spoken. The patient had repeatedly referred to a past full of 'bad doctors'. The doctor had repeatedly emphasised that she was 'trying' to help the patient. The conciliator pointed out that, if both persisted with these fixed positions, without appreciating the other's position, there would be no congruence or real communication. The doctor's inner reaction to this had been, in retrospect, comical ... 'Of course I appreciate that she lives in the past, that's why she's made such an unfair complaint against me.' But she went on to realise that her aim of being a 'good doctor' for this patient had been unattainable. It was a very helpful lesson to her, as a GP, to move away from 'trying' so hard towards simply 'being'. Trying can be trying for all concerned. Similarly, the patient acknowledged that her past experience of 'bad doctors' now made it difficult for her to relate to any doctor, perhaps especially one who was trying hard to help.

Both parties were a little taken aback and almost united by the facilitator's frank comments. They looked at each other afresh. Defensiveness lessened, as did guardedly correct responses. A new honesty came about which neither would have imagined possible before the session. Much was learned on both sides, not by being angrily spoken to, but by realising their separate inner misunderstandings. The

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mutual sense of personal injustice eased to such an extent that useful communication became possible. They have since met in the street and exchanged wry smiles, the wryness relating more to self than other. A welcome outcome in a small rural practice. All credit to the facilitator. May her tribe increase.

The circumstances of the incident leading to the complaint about the second doctor were different. She had been on call for the town overnight and, at midnight, had been called by a patient of another practice whom she did not know. She was tired and worried about a patient on the ward of the cottage hospital where she was based. The patient had described her problem, an orthopaedic one, and the GP had taken advice from the orthopaedic registrar on call. No immediate action was required and it was confirmed that the patient was due to be seen in clinic the following day. The GP had relayed that information to the patient, had given some pain relieving advice and checked that the patient had analgesia. A visit was not offered and not specifically requested.

The patient's complaint was that the doctor's attitude had been uncaring and inappropriate, and that she would have expected a visit. The opportunity to attend a conciliation process was welcomed by patient and doctor and the same preliminary groundwork was done. In the session, when given the opportunity to describe what had occurred, the doctor started by sincerely apologising for the fact that she had not visited and the air immediately cleared. She acknowledged, as did the patient, that the visit had not been medically required. But she also acknowledged that she had woken up the next morning feeling bad that she had not visited and wishing that she had. The patient explained how, when she was a child, her father had been a GP who cared for his patients day and night. She described how she had been starved of maternal affection. When she had rung and spoken to the doctor, she had wanted to be looked after. The essence of her complaint was that the doctor had not been kind. She had wanted to be mothered and she had been doctored.

By the end of the session, doctor and patient had developed an understanding of each other's position and later exchanged letters acknowledging how useful the process had been.

Inherent in the system are, of course, inequalities. The patient can say anything, the doctor cannot. The rules of professional ethics and confidentiality silence. We all know that medical school admits people and graduates doctors. Along the way is the risk of losing humanity, humanness. The complaints or comments from patients that hurt most are not the ones that criticise the drug prescribed or the medical management, but the ones that cast aspersions on your character, on you as a person. Being accused of being unkind was what hurt most.

There were positive outcomes in both cases: affirmation, from the patient and the conciliator, learning and insight for doctor and patient, opening a two-way exchange, dialogue. The conciliator acknowledged that often complaints are directed at doctors who patients consider to be more accessible and more receptive. For female patients especially this may be more likely to be female doctors. How different are patient expectations of male and female doctors? How different are the roles? The boundaries between doctor and mother may be harder to draw than between doctor and father. How do we best deal with unrealistic expectations?

It is interesting to ponder how this will be affected by the loss of out-of-hours commitment. Will patients be more or less likely to complain about doctors with whom they are not familiar and perhaps have lower expectations? Does familiarity breed an unrealistically high expectation of what can be provided?

In a climate of change and potential blaming, there is even more need for dialogue and honesty. Conciliation can provide such a route and it is important that we promote it in our practice leaflets and in the overall culture of the NHS. There is, of course, the potential risk of opening the floodgates and conciliation is undoubtedly time- and resource-consuming. But offering it as an option will serve to defuse many problems and reduce formal complaints; to encourage, not only complaints and criticisms, but comments and compliments.

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