

Qualitative Review of Complaints
Received by the Medical Council 2008-2012
and Doctors' Responses

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Chapter One - Executive Summary

1. Outline of project

This project undertook to describe key learning for good professional practice arising from complaints received by the Medical Council between 2008 and 2012. The methodology adopted by the researchers is outlined in Chapter Two.

A very important component of this research project was to carry out a content analysis of selected complaints submitted during the relevant time period. This content analysis is described in considerable detail in Chapter Three. In addition, the content analysis is complemented by detailed narrative analysis of selected cases to demonstrate key themes and recommendations for learning. This analysis is described in Chapter Four. The themes and recommendations highlighted by our research are described in Chapter Five.

2. Key themes

The analysis of complaints undertaken in this project generated many themes underlying the causes of complaint, the motivation for making complaints, and the effect of the incidents complained of on the complainants and their families. To ensure the perspectives of both complainants and doctors were explored, we also carried out an analysis of the responses from doctors, their style and content, and the effect of complaints on doctors and their families.

Key themes that emerge from our analysis include the importance of acknowledging and managing different components of competency of medical practitioners. Our research demonstrates that the traditional distinction between 'hard' and 'soft' competencies, e.g. clinical knowledge and skills on the one hand, and interpersonal skills on the other, is an invalid distinction from the perspective of patients. In many of the complaints reviewed, complainants perceived competences such as diagnostic and listening skills as strongly intertwined. The public expect that doctors will not only be clinically proficient but that they will also have and demonstrate good listening skills, compassion and other interpersonal skills. At times of great distress, such as when a patient is dying, doctors are expected to perform "emotional labour".¹ These different aspects of competency are highly regarded and sought by patients and their families and failures in all aspects of competency can

¹ Hochschild, A. 1983. *The Managed Heart*. Berkeley: University of California Press

generate complaints. Therefore it is very important that this be integrated into medical education and training as well as continuing professional development.

Good communication is an aspect of professional practice that emerges as a key factor in the causes of complaints against doctors. Assessment of the needs of patients requires active listening to the patient's concerns, description of symptoms and expectations of treatment as well as clear communication by the doctor of the diagnosis, treatment options and risks and benefits of treatment. Crucially, from the perspective of many complainants, assessment of the medical needs of patients also requires recognition and valuing of patients' "experiential and embodied knowledge"² and "lay expertise"³ of their health. Our research shows that patients expect to be kept informed of the progression of their illness and the range of options available to them on an on-going basis. They expect to be communicated with honestly, respectfully and sensitively. Doctors need to adopt a repertoire of communication styles to adapt to the individual needs of different patients and the contexts in which they are dealing with the patient.

Another key theme to emerge from our research is the challenges that may arise for doctors in dealing with the families of patients. Many of the complaints analysed in this study were submitted by family members of a patient in circumstances where the patient was a child or an elderly or otherwise incapacitated person. In many ways a patient's family can be of critical importance and value to the doctor in describing symptoms, explaining concerns, acting as carer and advocate for the patient. The challenge for doctors is often how to manage those legitimate concerns borne from experience and knowledge of the patient, with respect for the autonomy and confidentiality of the patient. This challenge is exacerbated when the family is not unified in its concerns or where there is hostility or breakdown of relationships within the family dynamic. Further consideration should be given to the provision of additional guidance and training to doctors in this context.

3. Opportunities for learning

In addition to the themes highlighted above and the commentary contained in the content and narrative analyses chapters of this project report, there are a number of over-arching opportunities for learning that also emerged from our research. These include the recognition that there is a degree of misunderstanding amongst the general public about the role and function of the Medical

² Potts L. "Mapping citizen expertise about environmental risk of breast cancer" *Critical Social Policy* November 2004 vol. 24 no. 4 550-574

³ Epstein. S. 1995. "The construction of lay expertise: AIDS activism and the forging of credibility in the reform of clinical trials", *Science, Technology and Human Values*, 20, 4, 4-8-437.

Council, which should be addressed by greater public awareness initiatives. Many of the complaints show that members of the public perceive the Council to offer a system of individual conflict resolution whereby the complaint will be investigated and an apology provided. Although some complainants state that their motivation in making a complaint is to ensure that the event will not happen again, in general there is little understanding of the statutory function of the Council which is to investigate complaints and promote the highest professional standards in order to protect the public interest. Although information to this effect is available on the Council's website, our research shows that this is not well understood by complainants.

Our research also indicates that some complaints could be better resolved at local level rather than through investigation by the Council. In a number of instances, complainants indicate that they have raised their concerns with the relevant doctor but have been ignored or dismissed. This results in further frustration and escalation of the complaint to the Council, which in some cases could be avoided by a more open and effective response by the doctor. Complainants are more likely to proceed to making a complaint if they feel disrespected or ignored by the doctor and therefore doctors should be advised that it is in their interests as well as the interests of their patients, to respond quickly and effectively to any concerns or complaints made. There is of course a balance to be struck here between these complaints and those that the Council would prefer not to be resolved locally or privately as they may raise significant issues relating to the doctor's fitness to practise or professional competence. This is a matter for further consideration by the Council in relation to the advice it provides on websites and other public media for those who are considering making a complaint.

4. The key recommendations arising from this project are:

- i. Listening and communication skills are central to the establishment and maintenance of good relationships with patients and to good medical practice. Different styles of communication should be adapted to meet the needs of individual patients, particularly those who need additional support in understanding their condition and treatment.
- ii. Patients have an understanding and expectation of professional competence that encompasses not only clinical or technical knowledge and skills but also inter-personal skills such as verbal and non-verbal communication, listening, empathy, diplomacy and courtesy. Additional education and training on these aspects of professional

competence should be enhanced by medical schools and through professional competence schemes.

- iii. In seeking medical attention patients and their family members place a value on medical professional knowledge. However, they also expect that their experiential knowledge will be recognised and valued by medical professionals and taken into consideration in the decisions about medical treatment. The importance of recognising the 'knowledgeable patient' is now widely recognised in health policy and is regarded as best medical practice internationally.⁴
- iv. The role of the patient's family is very important in providing information which may assist the doctor in reaching a diagnosis, and also in providing daily care for the patient. However, the role of the family is also potentially very challenging as it may involve the doctor in conflict resolution, dilemmas regarding confidentiality, and patient advocacy. The patient's family does not always understand that they do not have a decision-making role in relation to the patient, particularly where the patient is elderly or otherwise lacking capacity. The role of the doctor in such circumstances is to listen and try to communicate with the family as sensitively and carefully as possible, while being conscious of the patient's confidentiality. Additional guidance should be provided in the Guide to Professional Conduct and Ethics on this issue.
- v. Complainants have varying levels of communicative capacity, formal education, and "medical and regulatory literacy". Efforts should be made to avoid privileging complaints that "speak the language" of the Council, such as those submitted by solicitors or other health professionals, over those that use a more informal style of communication. Consideration might be given by the Council to whether complainants might be offered additional assistance and support in making a complaint, either in-house from the Council itself or by referral to a patient advocacy group.
- vi. Our research provides evidence that complaints may be more likely to arise in certain medical contexts more than others, and that certain types of complaint may be more likely to arise within the context of certain medical specialities. This suggests that

⁴ E.g. In 2011 the Cochrane Collaboration published a book entitled *The Knowledgeable Patient: Communication and Participation in Health*, <http://consumers.cochrane.org/news/knowledgeable-patient-communication-and-participation-health-cochrane-handbook-sophie-hill>

context-specific guidance to doctors may be required in areas such as psychiatry, cosmetic surgery and obstetrics. Concerns about the provision of care in locum and out-of-hours contexts also featured strongly in the complaints.

- vii. Patients diagnosed with psychiatric conditions may present additional challenges not only to doctors but also to the Medical Council in circumstances where a complaint is made in relation to their diagnosis and treatment. There may be inherent difficulties in understanding the perspective of someone who “may often respond to the world in ways that mystify and perplex the “normal” persons observing them.”⁵ There is a risk that the “inaudible voices” of people will either be ignored or, that observers will hear what they want to hear rather than what the patient is really saying.⁶ It is critically important that such complainants are treated with dignity and respect and there is no inherent bias against the legitimacy of their complaints on the basis of their psychiatric illness. The Council should consider providing additional training to members of the PPC and FTFC in relation to assessing and hearing such complaints, in collaboration with specialised patient advocacy groups and the Mental Health Commission who have experience in this area.

- viii. The Council could consider providing general advice to doctors who are the subject of a complaint in relation to how they might respond. Both the substance and style of the doctor’s response are significant to the resolution of the matter from the complainant’s perspective. Complainants are more likely to be satisfied with a prompt, comprehensive, open and honest response than one that is delayed, incomplete or hostile. The latter may only serve to exacerbate the situation further.

⁵ Rebecca Dresser “Missing Persons: Legal Perceptions of Incompetent Patients” (1994) 46 *Rutgers Law Review* 609 at 666

⁶ Prof Mary Donnelly, UCC School of Law, Seminar presentation on Patients’ Voices and the Law, Cork 6 Oct 2010

Chapter Two - Background and Methodology

1. Background to the project

In December 2013 the Medical Council issued an invitation for proposals to provide evaluation services to describe key learning for good professional practice arising from complaints received by the Medical Council (2008 - 2012). The invitation sought an in-depth, “rich” and “thick” description of this learning to complement quantitative analysis of complaints which was being conducted contemporaneously in-house by the Medical Council.

2. Project goals

The invitation stated that the goal of the project was to provide evidence, based on learning from concerns the Medical Council has received about doctors’ practice that will inform its development of professional guidance to doctors, and other work, such that good practice can be better fostered among doctors.

3. Objectives

The stated objectives of the project as described by the invitation from the Medical Council were

- To identify factors which cause concern among complainants in relation to doctors’ practice;
- To explore how these factors are perceived by complainants;
- To explore how factors vary depending on complainant and doctor characteristics;
- To explore how concerns expressed by complainants are perceived and responded to by doctors who are subject to that complaint;
- To develop a set of concepts about the causes of concern in relation to doctors’ practice received by the Medical Council and compare these to current professional guidance;
- To identify ways in which current Medical Council guidance to doctors can be revised, strengthened and better reflect lessons learned from complaints so as to enable good professional practice. And to identify any other ways in which the Medical Council can apply these lessons to foster good practice.

4. Requirements:

The invitation from the Medical Council set out a number of requirements to be met by applicants

1. A strategic partnership with an individual or organisation with a proven track record for health and/or public services research and evaluation:
2. The analysis of complaints and responses to derive key learning for good professional practice for doctors.
3. The identification of recommendations for revision and strengthening of guidance to doctors on good professional practice to reflect and align with learning from complaints; and any other recommendations for fostering good practice.

5. Access to complaint files

For the purpose of this study, the Medical Council agreed to give researchers access to complaint files which would be limited to the complaint and the doctor's response, and would be fully redacted to remove personal identifiable information. Some non-personal information such as age, gender, country of qualification of the doctor, decision of Preliminary Proceedings Committee etc., was retained within the files to enable analysis.

6. Other matters

The invitation from the Medical Council also set out further information and requirements in relation to cost, assessment criteria, supplier information, timeframes and other matters.

7. Tender

Professor Deirdre Madden, School of Law, University College Cork and Dr Orla O'Donovan, School of Applied Social Studies, University College Cork submitted a tender on 22nd January 2014 which was accepted by the Medical Council on 3rd February 2014.

The researchers undertook to carry out a combination of qualitative content analysis and narrative analysis in order to produce a comprehensive, nuanced and thick description of the content of

complaints and responses from doctors, and generate new learning for the Medical Council which will be helpful in the development of guidance on good professional practice for doctors, educational initiatives and professional competence assessments. The research methods employed are described in detail below.

8. Confidentiality and work plan

The researchers were required to sign a confidentiality agreement with the Medical Council. All data provided to the researchers was redacted of personally identifiable information.

During the lifetime of this project the researchers worked closely with Dr Paul Kavanagh and Simon O'Hare in relation to the sampling methodology, redaction of the files to ensure confidentiality, agreed timeframes, progress reports, and revision of the brief. The redaction of files by the Medical Council and the use of the NVivo technology was resource intensive and more time-consuming than initially anticipated but ultimately proved to be extremely important and useful in the analysis of the data.

The original time-frame could not be met due to some of these issues and extensions of time for submission were agreed between the researchers and Dr Kavanagh. As will be described below and consistent with the iterative nature of qualitative analysis, the research design was revised in light of the researchers' initial immersion in the dataset.

It was originally envisaged that this evaluation would be contained within an internal report for the Medical Council to provide evidence that will inform its development of professional guidance to doctors, and other relevant work. As the secondary analysis for this purpose was to improve the Medical Council's functions, and as the data was anonymised, in general, consent was not sought for content analysis. . However, in the course of the study, consent was sought and secured by the Medical Council from parties involved in a small number of cases to use fully-redacted extracts from their correspondence with the Medical Council in order to carry out a narrative analysis. This was because it was recognised that individuals related to presented narratives could be recognisable despite removal of personally identifiable information. Following presentation of the report to the Medical Council, the significance and value of the findings and analysis for policy makers, other professional and healthcare regulators, professional educators and trainers as well as patients, families and the public was discussed. It was agreed that, in light of the Medical Council's function to protect the public, the report would be published. This decision was made in good faith and perceived to be strongly in the public interest by the Medical Council and the researchers.

9. Methodology

Qualitative content analysis and narrative analysis were used sequentially whereby the qualitative content analysis informed the selection of cases for narrative analysis. This allowed for more in-depth exploration of key issues that emerged during the first phase of the research. The rationale for the use of these combined methods together with a description of the research process is provided below.

10. The qualitative content analysis

i. Rationale

Qualitative content analysis has been employed in a number of previous studies of complaints made about doctors⁷. All forms of content analysis involve the systematic categorization of textual data in order to make sense of it. What makes qualitative content analysis particularly suited to studies such as this one is that categories are largely derived from the data and applied to the data through close reading. This allows for the emergence of insights and learning that might otherwise be lost in research using predetermined categories. In our study, this largely inductive process of moving from specific observations to generating categories was used to generate meaningful categories of factors which caused concern among complainants and categories of responses from doctors who were subject to complaint. Additionally, it was used to generate categories of complainants' descriptions of the effects the cause of concern had on them and their motivations for submitting a complaint to the Medical Council. Indicative of the inductive nature of this approach, these categories of effects on the patient and of motivations were not part of the original research brief but were included in the analysis because they featured so prominently in the content of the correspondence reviewed.

ii. Sampling strategy

In the period 2008 – 2012 the Medical Council received approximately 2,000 complaints. This is the overall dataset used for both this qualitative analysis and the quantitative analysis conducted in-house by the Medical Council. At the outset of this study we planned to undertake a qualitative content analysis of a ten per cent sample or 200 of these case files; however, for reasons explained

⁷ For example Wofford, M. et al. 2004. "Patient complaints about physician behaviors: A qualitative study", *Academic Medicine*, 79, 2, 134-138, and Allsop, J. 1994. "Two sides to every story: Complainants' and doctors' perspectives in disputes about medical care in a general practice setting", *Law & Policy* 16, 2, 149-183.

below including the quality of the data and aim of the study to provide an in-depth analysis of the complaint files, it was later decided to reduce the sample to 100. This is in keeping with the conventional approach to determining sample size in qualitative inquiry which is based on guidelines rather than rigid rules. Acknowledging the importance of an evolving research design, and in contrast to probability sampling in quantitative research, factors taken into consideration in determining sample size include the quality of the data and the research scope and topic.⁸

A combination of random and purposeful sampling was used to select the sample. We began by randomly selecting 160 cases from the Medical Council's data system using numbers generated by the online tool Random Number Generator⁹. The intention was to purposefully select the remaining 40 cases to address gaps in the random sample in regard to complainant, doctor or any other characteristics. A review of Preliminary Proceedings Committee decisions regarding the 160 randomly selected cases found that very few of them had been referred to the Fitness to Practise Committee. In keeping with the rationale for purposeful sampling where the focus is on exploring particular characteristics of a population that are of interest, to allow some examination of cases referred to the Fitness to Practise Committee it was subsequently agreed that a further 20 such cases would be randomly selected by the Medical Council and included in the sample.

Following an initial data immersion and discovery phase during which each of the researchers read through the 180 selected complaint files and began the development of a coding system, the sampling strategy was refined and it was decided to reduce the sample size to 100. This decision, which was made in consultation with Medical Council staff Dr Paul Kavanagh and Simon O'Hare, was based on the quantity and quality of data in the case files and the time required to code them using the by then agreed and highly detailed codebook. Originally, the unit of analysis for this part of the study was a complaint file, consisting of a letter of complaint and doctor's response. However, the initial review of case files revealed that many of them contain multiple letters of correspondence from complainants and responses from doctors. For example, one file pertaining to a complaint from a patient who alleged she was sexually assaulted in the course of a medical examination contains three letters from the complainant. Another in which complaints were made about a number of doctors includes four letters from the complainant and eight responses from doctors.

⁸ Morse, J. 2000. "Editorial: Determining sample size", *Qualitative Health Research*, 10, 1, 3-5.

⁹ <http://randomnumbergenerator.intemodino.com/en/>

iii. The sample

There was considerable variation in respect of the complainant and doctor characteristics in the sample of 100 complaint files. Additionally, the numbers of complainants and doctors involved in individual complaints varied, as did the form in which the original complaints were submitted.

Twelve complaints were submitted by more than one complainant resulting in there being 114 complainants in total involved in the sample. A number of these complaints were submitted by both parents of a child but other instances of multiple complainants include three daughters of an elderly patient and two senior colleagues of a doctor. The sample also includes two separate complaints submitted by the same individual.

In the sample female complainants outnumbered male complainants: 69 (61%) complainants were women and 45 (39%) were men.

Complainants were most likely to be patients themselves (53 / 46%) but 47 (41%) complainants were family members of the patient whose treatment was the focus of the complaint. The remaining 14 (13%) complainants included solicitors and patient organisation representatives advocating on behalf of patients, doctors' employers and medical colleagues, and a pharmacist. (It worthwhile noting that this profile of complainants differs from the profile of those submitting complaints to the General Medical Council in Britain; there in 2012, 62% of complaints were made by members of the public, 12% by the GMC, 10% by individual doctors, 7% by employers, 2% by policy and 7% by other bodies).¹⁰ Complaints submitted by these various professionals were considerably more likely to be referred to the Fitness to Practise Committee than those submitted by patients' themselves or their family members. Of those 14 complaints, seven were referred to the Fitness to Practise Committee, and of the four complaints submitted by solicitors, three were deemed to have a Prima Facie case that warranted further action.

A further variation in the sample of complaints is the form in which they were submitted. While most of the complaints were submitted in typed form either by letter or email, 12 were hand-written. Many of these hand-written complaints, all of which were submitted by patients on their own behalf or by family members, include spelling and grammatical errors indicative of the complainants' limited literacy skills and low levels of formal education.

Thirteen of the complaints involved allegations against more than one doctor and consequently a total of 128 doctors were included in the study sample. The gender ratio was the reverse of that of

¹⁰ See http://www.gmc-uk.org/20131004_Chapter_2_SoMEP.pdf_53705052.pdf

complainants as 95 (74%) of the doctors were men and 33 (26%) were women. Doctors from all age groups were included, but the highest percentage (33%) were between 46 – 55 years. Seven percent were in the younger age group (20-25 years) whereas ten per cent were over 65 years. The majority of doctors in the sample (71%) completed their medical qualifications in Ireland, but 21% did so in non-EU countries and 7% in the EU. Regarding the doctors' registration type, 68% had specialist registration and 32% had general registration.

iv. Coding and analysis

Using the qualitative data analysis software NVivo as a data management and coding tool, the qualitative content analysis of the 100 case files was undertaken in three iterative stages. Firstly, following the uploading of the case files, which were fully redacted by the Medical Council and supplied to the researchers in electronic form, the two researchers immersed themselves independently in the data to familiarise themselves with the whole data set. In the course of this initial reading of the sample of case files the iterative process of identifying themes and developing a preliminary coding system began. Secondly, in keeping with good practice in qualitative research, this was followed by a series of lengthy discussions and sharing of suggested categories which eventually led to agreement of a codebook. In developing this codebook every effort was made to replicate the terminology and modes of expression used in the complaint file correspondence. All quotations used in the report are taken verbatim from the correspondence. For example, one category of complaints is where the complainants reported their concerns were “fobbed off” or dismissed by the doctor in question. Similarly, “trauma” was included as a category of complainants' reported emotional reactions to the incident or issue that was the subject of the complaint. In the final stage, to enhance the robustness of the qualitative analysis the entire sample of complaint files was reread independently by both researchers (and where appropriate, recoded), to identify cases for narrative analysis, cases that are especially data rich and provide particular insight into key issues emerging from the content analysis.

The detailed codebook used for the qualitative content analysis was organised into nine nodes which included the original complaint, doctor's first response, further correspondence from the complainant and further correspondence from the doctor. Additionally, the data was coded using five other nodes related to specific areas of learning for the Medical Council, including education and training; professional standards; other stakeholders; other organisations that receive complaints, and complainants' feedback on the Council's complaints process. Categories were generated in each

of these nodes. For example, the content of the original complaints was coded using the four categories effect on patient, motivation, narrative style of complaint and nature of complaint. In turn, nineteen different categories of nature of complaint were generated, along with many subcategories.

11. The narrative analysis

i. Rationale

Narrative analysis of four case files was used to provide more in-depth insight into key issues that emerged in the qualitative content analysis. While the qualitative content analysis necessarily fragmented the narratives of complainants and doctors, the narrative analysis allowed for more detailed and contextualised descriptions of instances that afford particular understanding and learning.

Social scientists have long emphasised how narrative studies can assist in crossing “the line of fault that separates lived experience of illness from academic and professional analyses of these experiences”¹¹. They have demonstrated that even though people’s lives rarely intersect so intimately as in clinical settings, doctors’ and patients’ fundamental structures of relevance and meaning can differ profoundly. As argued by Arthur Frank “Each needs to hear the other’s stories to make sense of why the other is as he or she is: why physicians seem patronizing or patients seem noncompliant. Until these stories are heard, clinics will remain tense places.”¹²

The relevance of narrative analysis to clinical practice has also been recognised in medical circles for many years, evident for example in the publication in 1999 in the *British Medical Journal* of a five-part series of articles on “narrative-based medicine”.¹³ Propagated to complement (and counteract the limitations of) evidence-based medicine, proponents of narrative-based medicine also emphasise its potential to foster mutual understanding between patients and doctors¹⁴. Different genres of narratives have been identified (e.g. patient narratives, doctor narratives, narratives about

¹¹ Frank, A. 2000. “The standpoint of storyteller”, *Qualitative Health Research* 10,3, 354-365

¹² Frank, A. 2000. “The standpoint of storyteller”, *Qualitative Health Research* 10,3, 354-365

¹³ BMJ 1999, January Vol 318

¹⁴ Kalitzkus, V. and Matthiessen, P. 2009. “Narrative-based medicine: Potential, pitfalls, and practice”, *The Permanente Journal*, 13, 1, 80-86

doctor-patient encounters and metanarratives) as have the technical and attitudinal challenges of this approach to what Kalitzkus and Matthiessen refer to as the “rehumanisation of medicine”.¹⁵

ii. Selection of case files for narrative analysis

As noted above, key themes emerging from the qualitative content analysis informed the selection of case files for narrative analysis. Following discussion with Medical Council staff, it was agreed that it would be necessary to obtain consent from the complainants and doctors involved in the complaints selected for narrative analysis as although anonymised, the detailed contextual information that is crucial to narrative analysis could result in the individuals involved being identified. Complainants and doctors involved in 15 complaints were approached by the Medical Council for permission to use their correspondence with the Medical Council in this second part of the study. Full permission for use of the data in the study was given by the complainants and doctors involved in four of the cases.

iii. Dimensions of the narrative analysis

The narrative analysis of complaint files undertaken as part of this study focused on the content and meaning of the documentation, or the complainants’ and doctors’ accounts of what happened and why. We were mindful of the institutional context in which the documentation was produced and how narratives can be shaped according to their intended listeners or audience. The narratives were approached as having at least two functions, to provide a chronological description of the events in question, and also to establish the meaning of those events and experiences. We were interested not only in convergences and divergences in the complainants’ and doctors’ descriptions of the events but also in the meanings attributed those events, specifically in regard to the four following dimensions:

- the causal links made between events and experiences, and the associated attribution of responsibility
- the credibility tactics employed to establish the truthfulness of the accounts, including the forms of evidence mobilised in support of the story
- the personal identities constructed by the narrators

¹⁵ Kalitzkus, V. and Matthiessen, P. 2009. “Narrative-based medicine: Potential, pitfalls, and practice”, *The Permanente Journal*, 13, 1, 80-86

- the inherent morality, the narrator's sense of what counts as good and bad professional practice, of how doctors should and should not behave, and the moral beliefs and judgements embedded in their narratives.

As will be seen in Chapter Five, we present a narrative analysis of four cases that were included in the sample of 100 case files used for the qualitative content analysis. In the discussion of each case we ask: What is illustrated by this case? What were the contents of the complaint file? What happened (according to the complainant and doctor)? Why did it happen (according to the complainant and doctor)? We conclude the analysis of each case by highlighting the learning afforded to the Medical Council by the complainants' and doctors' narratives.

Chapter Three - Content analysis

1. Introduction

This chapter presents the results of the qualitative content analysis of the sample of 100 complaint files. It begins by describing the narrative style of the complaints which can be seen to fall along a continuum of degrees of formality and reflect varying levels of actual, medical and regulatory literacy. We then describe and discuss the causes of concern raised by complainants, many of whom tell detailed stories that raise multiple and what they regard as densely entangled concerns. In the telling of their stories many complainants described the emotional effects and other consequences of their experience, and because of the prominence of these descriptions in the letters of complaint, we have devoted a section of this chapter to an analysis of this aspect of their complaints. We also examine the stated motivations for the complaints. In this analysis particular efforts have been made to use the language used by complainants, referencing extracts from the letters of complaint where appropriate.

We also analysed the responses from doctors against whom complaints have been made. We begin by looking again at the narrative style of the responses varying along a continuum from strident rebuttals to acknowledgements of the events complained of and apologies for any harm or offence caused. We examine the explanations offered, the difference in perspective of the events offered by patient and doctor, the effect of the complaint on the doctor and the challenges they mention in relation to their own practice such as management and communication of uncertainty, dealing with patients' families, heavy workload and rationing of scarce resources.

2. Narrative Style of Complaints

i. A continuum of degrees of formality and medical and regulatory literacy

There was considerable variation in the narrative style in which letters of complaint were written. A profound challenge to the Medical Council is to avoid privileging complaints that "speak the language" of the Council and to render those that do not "hearable"¹⁶.

¹⁶ Frank, A. 2000. "The standpoint of storyteller", *Qualitative Health Research*, 20, 4, 408-437.

Not surprisingly, letters of complaint submitted by solicitors on behalf of patients were written in a formal, succinct and legalistic style. One of the complaints submitted by a patient's association on behalf of the brother of a deceased patient resembled the narrative style of those submitted by solicitors. It is notable that three of the four letters of complaint submitted by solicitors were referred by the PPC to the FTPC. Of the 14 complaints submitted by professionals, (including solicitors, patient organisation advocates, employers and medical colleagues and a pharmacist) seven were referred to the FTPC, a much higher proportion than complaints submitted directly by patients or their family members.

The complaints submitted by solicitors stand in sharp contrast to some complaints submitted directly by patients that use a more informal colloquial style of communication and offer a lengthy "story" of the events in question. An example of the use of colloquialisms is in the following complaint about a doctor's conduct: "Fair enough for him trying to intimidate a man who can take care of himself, but bullying a [age] woman, that is only done by a gurier, or in this case a gurier with a licence to practice medicine!"

The sample included 12 hand-written letters of complaint, and some of these can be regarded as being at the far end of a continuum of degrees of formality to those submitted by solicitors. A number of these hand-written complaints demonstrate differences in communicative capacity such as spelling and grammatical errors, and words crossed out; the communicative and literacy skills of complainants are therefore another dimension along which the complaints vary.

There is also evidence of variations in medical literacy. Some complainants note their lack of medical knowledge and that they are not conversant in medical language whereas others display considerable medical knowledge and capacity to communicate using medical terminology, what has been referred to as "lay expertise"¹⁷ and "interactional expertise"¹⁸. For example, "Mom had all the signs of limb Ischaemia. A simple pulse examination with Doppler Scan should have been ordered." This was also a feature of complaints where the complainant was both a patient and a doctor, such as the complainant who reported an incident that "shattered the one thing that I was proud of; being a member of the medical profession". Others still describe how their concerns about

¹⁷ Epstein, S. 1995. "The construction of lay expertise: AIDS activism and the forging of credibility in the reform of clinical trials", *Science, Technology and Human Values*, 20, 4, 4-8-437.

¹⁸ Collins, H. and R. Evans. 2002. The third wave of science studies: Studies of expertise and experience, *Social Studies of Science*, 32, 2, 235-296.

medical treatment led them to acquire greater medical literacy. In the extract below the complainant explains how she acquired greater knowledge about the recommended prescribing of pharmaceuticals:

“I became interested in these drugs when I and other family members noticed a sharp decrease in my mother's moods and behaviours. Starting over a year ago, she gradually became more irrational, impatient, irritable and depressed. As I could not figure out what was causing this, I decided to investigate her prescription drug use and studied the label of the sleeping pill container. Amongst other things, the label mentioned that the pills should be taken for no longer than two weeks and should never be considered for long term use. I then asked my mother how long she had been prescribed these drugs. To my shock and amazement she said over five years!”

Some complaints also display what might be called regulatory literacy, a familiarity with legislation and guidelines for the regulation of the medical profession. For example, one complaint refers to “the Medical Practitioners act 2007 which lists poor communication in professional performance” (C012-12). Another begins with “I wish to make the following formal complaints of "Professional Misconduct" and/or "Poor Professional Performance" as described in "GUIDE TO PROFESSIONAL CONDUCT AND ETHICS FOR REGISTERED MEDICAL PRACTITIONERS, 7TH EDITION 2009.”” Some letters of complaint address the doctor in question rather than the Medical Council. This possibly indicates a misunderstanding of the remit of the Council as a mediator in conflict resolution between doctors and patients rather than a regulator of the medical profession.

A further striking variation in the narrative style of the letters of complaint is their emotional content; some make no references to emotions whereas others are replete with emotional expressions and descriptions of the emotional consequences of the incidents and causes of concern that are the focus of the complaint.

With these variations in mind, our analysis suggests that complaints submitted by solicitors and other professionals may have been more “hearable” to the Medical Council in at least three ways, involving processes of *translation* into formal language, *reduction* to succinct accounts and *definition* of what constitutes relevant content.

ii. Credibility tactics

Complainants employ a number of “credibility tactics” (Epstein 1995)¹⁹ mobilising various forms of evidence in support of their allegations. While in the doctors’ responses to complaints many of them appeal to the authority of their medical notes as providing an objective or “factual account”, that authority is contested by complainants in a number of ways. One complainant, for example, noted an error in his in-patient file.

Some complainants provide evidence of expert endorsement of their allegations. For example, one class action-type complaint submitted by a solicitor noted “All of these 5 cases have been reviewed by independent obstetrical and gynaecological experts who have been critical of the standard of care provided to these women by Dr A”. The following extract provides another illustration of the use of expert opinion to endorse a complaint, in this case, a complaint about delayed diagnosis:

“My mother died in [Hospital] 2 weeks after a diagnosis of primary lung cancer. During 2008 and 2009 she had 7 chest x-rays taken at [Hospital]. I was told all were reviewed by consultant radiologists without and significant delays and no evidence of cancer was seen until a few weeks before diagnosis in 2010. However when I got her x-rays reviewed by an independent consultant radiologist (his report is attached), it is clear that she should have undoubtedly been diagnosed 17 months earlier.”

Other forms of evidence provided by complainants include a screen shot of Facebook supplied by a complainant who alleged she was being stalked by a doctor, and a record of text messages provided by a complainant who also made an allegation of harassing sexual behaviour. As evidence of the precision of his memory of the incident that was the focus of the complaint, one complainant described the doctor’s clothing: “On the [date of consultation] Dr A was wearing brown shoes. A red shirt with white lines down it. With a white collar. Also a wearing of white slacks. I have an excellent memory Sir”.

As will be discussed further below, complainants’ descriptions of the emotional consequences of their experiences can be regarded as a form of evidence that they present, where for example they

¹⁹ Epstein. S. 1995. “The construction of lay expertise: AIDS activism and the forging of credibility in the reform of clinical trials”, *Science, Technology and Human Values*, 20, 4, 4-8-437.

suggest that the duration of their distress is an indicator of the depth of harm caused and the extent of professional incompetence of misconduct on the part of the doctor.

3. Description and discussion of the main causes of concern raised by complainants

The nature and number of causes of concern raised by complainants varied considerably, as did the timeframe and the narrative style used to describe the concerns. Some reported a single and very specific concern, such as a complaint about a doctor's failure to respond to requests for a copy of a patient's medical records. Others relate to a series of events over a number of years, such as a complaint about a doctor's prescribing behaviour. Many letters of complaint recount complex stories of complainants' or their family members' medical encounters that identify multiple and densely entangled concerns. For example, one letter of complaint provided a numbered list of 30 causes of concern. In some instances, where complainants provide a lengthy account written in an unconventional or informal style, their causes of concern cannot be readily deciphered.

Previous studies of complaints against doctors²⁰ have distinguished allegations of technical failure (failure of clinical technique or judgement) from normative failure (transgressions of codes of behaviour, including tacit ones). Our research suggests the need for caution with such categories because in many of the complaints we reviewed multiple, and what were regarded as strongly inter-related, causes of concern were raised. Furthermore, the boundaries between technical and normative failures are not always clear. The enmeshing of multiple causes of concern is illustrated in the extract below in which a complaint about a delayed diagnosis also raised concerns about the doctor not listening, not taking the patient's concerns seriously, rushing the consultation, and failing to conduct a full examination:

"I understand that [medical condition] is very difficult to diagnose, but I feel [Doctor] did not listen to me or take any of my complaints seriously. Had she taken the time to fully examine me and listen to what I was telling her or sent me for a simple blood test or scan, a lot of this could have been avoided. I understand it could not have been prevented but I would have less of the complications I have now ..."

This instance suggests that not listening to the patient is not only a normative transgression, a failure to treat the patient with respect, but also a competency or technical one because it is crucial to the diagnostic process. The complainant implies that the doctor failed to take her "experiential and

²⁰ E.g. Allsop, J. 1994. "Two sides to every story: Complainants' and doctors' perspectives in disputes about medical care in a general practice setting", *Law & Policy* 16, 2, 149-183

embodied knowledge” (Potts 2004)²¹ into consideration, knowledge that could have contributed to a speedier diagnosis. Therefore, categories of causes of concern, including those we use below, necessarily fragment and simplify many complainants’ narratives. It is because of this that the results of the qualitative content analysis of the complaint files are supplemented with the narrative analysis of specific complaints.

i. Medical contexts

The qualitative content analysis of the sample of 100 complaint files provides evidence that complaints may be more likely to arise in certain medical contexts more than others, and that certain types of complaint may be more likely to arise within the context of certain medical specialities. This suggests that context-specific guidance to doctors may be required.

Ten complaints in the sample related to medical care provided by a locum doctor, a Doctor on Call service or an Out of Hours service, situations where the patient did not have a long-term relationship with the doctor, and where in the absence of electronic medical records, the doctor did not have access to the patients’ records. Prominent amongst these were complaints about misdiagnosis, such as the misdiagnosis of an adverse drug reaction in a child who was subsequently diagnosed as having suffered an ischemic stroke. As can be seen in the extract below, the child’s parents informed the doctor the child had taken the drug in question previously, but this knowledge of his medical history was disregarded:

“He examined [Patient – a child] and came to the conclusion that [Patient] was having an allergic reaction to the [medication] he was prescribed to him by [Doctor] consultant Paediatrician the day before, even though we said [Patient] had taken [medication] before he dismissed this and stood by his diagnosis reaction to this medication and advised us to stop the medication and to give it 24 hours to clear up”.

Allegations of an “uncaring” attitude also featured in complaints against doctors working in Doctor on Call services. An example is a complaint made a woman in relation to palliative treatment her husband received as he died at home. When the doctor arrived, she “did not even look at [Patient] as she passed his bed when she entered the house” and when asked by family members to

²¹ Potts L. “Mapping citizen expertise about environmental risk of breast cancer” *Critical Social Policy* November 2004 vol. 24 no. 4 550-574

administer pain relief “turned to us and standing at the foot of my husband's bed, she said “if you think I am going to give him something to kill him, you are mistaken””.

Eight complaints arose in the context of psychiatric medicine, many concerning issues of patient consent. In a number of these the complainants disputed their psychiatrists’ diagnosis, e.g. “I do not have a [psychiatric condition]” and treatment. Complaints also related to disrespectful communication, including being shouted at. Others complained their wishes in relation to medication were disregarded. One complainant reported “I desperately objected to a decision, by him not to place me onto a powerful anti-psychotic medication known as [medication], however acting in collusion with vengeful family elements he managed to do so”. A similar complaint was made by a patient diagnosed with treatment-resistant psychiatric condition. Complaints such as these, where complainants’ diagnosis is understood by medical professionals to impair their perception and judgement, including about their own best interest, pose particular challenges to doctors and the Medical Council.

In the context of plastic surgery, recurring complaints related to patients who were unhappy with the outcome of their treatment and who reported the risks of treatment had not been adequately explained. Complaints about professional incompetence resulting in patients having “horrific” experiences and being “traumatised by the entire procedure and level of care” recur in complaints arising in the context of obstetrical medicine. Concerns about patient consent also arose in this context, as expressed by one complainant as follows – “[Doctor] had the final say over my treatment whether or not I was to deliver naturally but yet he never saw me, except at week 17 of my pregnancy for a mere few minutes”.

ii. Misdiagnosis, inadequate examinations and misprescribing

Concerns about misdiagnosis featured prominently in many complaints, along with concerns about doctors’ conduct of medical examinations and their prescribing behaviour. The 29 complaints about diagnosis took a number of forms including allegations of a failure to diagnose (he “told me I was fine”), disputed diagnosis from four complainants who disputed their psychiatrists’ diagnosis, misdiagnosis that in some cases allegedly resulted in blindness and death, and delayed diagnosis (“My mother died in [Hospital] 2 weeks after a diagnosis of [medical condition – cancer]. ...it is clear that she should have undoubtedly been diagnosed 17 months earlier”). Allegations of failures and delays in the diagnosis of breast cancer featured in four cases.

Complaints about misdiagnosis tended to be combined with allegations of mismanagement of the patient's condition, including instances where unnecessary surgery was performed, for example: "I feel my wife's medical condition was completely misdiagnosed and the resultant mistreatment and unnecessary operation, ultimately led to her death." Allegations of mismanaged medical interventions in the absence of a clear diagnosis were also made, such as a complaint about an obstetrician who induced a woman's labour "for reasons which are not entirely clear".

Fourteen complaints raised concerns about what one complainant described as "incomplete and careless assessment[s]". These complaints about doctors' conduct of medical examinations indicate that some patients have clear ideas about what constitutes an investigation or examination conducted in "a full, timely and regular and proper manner". Additionally, they reveal expectations of the time required to conduct such an examination ("An examination of just ten minutes took place"). One complainant who suffered from back ache was concerned that during the consultation the doctor did not "examine my spine or movements", whereas another who told her doctor she had a pain in her breast reported he did not conduct a breast examination.

Concerns about doctors' prescribing behaviour featured in 11 complaints. These included concerns about inappropriate prescribing, such as the prescribing of anti-anxiety medication, which in the view of the complainant constituted "medicating something that ... is purely down to a stressful lifestyle", and the prescribing of medicine containing penicillin subsequent to the patient informing the doctor he was allergic to it. Concerns about doctors' failure to provide information about possible side effects were also raised. The quantity of medicine prescribed was the focus of several complaints, including what was regarded as an excessive quantity of an individual drug used to induce labour, overmedication over a period of time, and polypharmacy, particularly in the treatment of elderly patients. One complaint about the latter was described as follows:

"Both I and other members of my family have long since held reservations around [Doctor] treatment of [Patient] most especially around the quantity and variety of prescription drugs — these running to two full pages of prescription paper and dispensed on a regular basis."

In another complaint regarding the prescribing of medicine, the complainant reported that the doctor in question regularly just gave him a prescription as a matter of routine without further examination or discussion

iii. Poor or absent communication

Complaints about communication included allegations of doctors' failure to listen, insensitivity, poor communication with the patient's family, failure to keep the patient informed, and failing to use appropriate language.

Eighteen complaints raised concerns about doctors not listening to their patients or their family members. Many of these complainants identify listening as crucial to medical care, such as the following one who alleged the doctor in question "failed in his duty of care to my mother as he ignored our concerns regarding her level of distress". Significant numbers of complaints include allegations of patients' and family members' concerns and knowledge being dismissed or "fobbed off". The experience of the complainant who reported his doctor "showed total disregard for me also all the information I gave to him" resembled the experiences reported by many others. For example, a complainant who had attended her doctor on several occasions with concerns about a lump in her breast reported that "each time I was brushed off"; she was subsequently diagnosed with breast cancer. These complaints indicate that the complainants accord a different status to patients' experiential knowledge to that accorded by the doctors concerned; the complainants regarded it as knowledge relevant and vital to their medical care whereas the doctors did not.

In some instances, doctors' dismissal of patients' concerns and knowledge was regarded by complainants as taking the form of ridicule. One complainant reported that his doctor "told me I did not have [medical condition], I just wanted it!!". Another complainant who had been very concerned about her symptoms felt insulted when the doctor accused her of "playing games". In another case the complainant reported that when the doctor "treated my mother in [Hospital] A&E ... only 5 weeks before she died (undiagnosed) she was extremely rude commented on the amount of hospital admissions [she] had implying she was faking her symptoms, she actually said upon discharge *"you look disappointed you are going home"*".

Complaints about doctors' lack of sensitivity and care in their communication with patients also featured prominently. There were several complaints about insensitive communication with older people. One illustration is a complaint from a family member about a doctor's insensitive communication with his mother five weeks before her death from lung cancer. The complainant reported that his mother "was very weak and upset by this she was [age] and very quiet and respectful of all medical staff. This doctor actually made her cry and she tried to pull out the IV herself she was so upset." Similar complaints were submitted by patients who identified as being vulnerable, such as one who complained about her doctor's "very cold hearted" communication,

despite the fact that she was feeling “upset and anxious”. Insensitive communication with patients facing surgery featured in a number of complaints, including one where the patient’s confidence in the treatment was undermined when the doctor “informed me that the machine she used to examine me was not a “great machine””.

Complaints about doctors’ insensitive communication with their patients were frequently enmeshed with other complaints. This is illustrated in the extract below from a patient whose first language was not English but who nonetheless was fluent in English, who claimed the doctor was both patronising and insensitive:

“Having detected my accent, [Doctor] proceeded to engage with me as if I were unable to understand a word of what he was saying. He spoke slowly throughout my brief consultation and at one point even passed the remark that: “Oh, you understand me very well, don’t you?” I should point out that I did not take this as a complimentary observation. Rather, to my mind and that of my partner, it was made in a patronising fashion that we both found highly offensive.

This lack of sensitivity was to be the least of my concerns however.”

Poor communication with family members was a recurring theme in the complaint files reviewed. Many of these arose in the context of hospital care. For example, one complainant reported that he and his family “felt very aggrieved that for 17 days that Dad was under your care in [Hospital], and for the last 2 days he spent there, following confirmation of his condition and poor prognosis, you did not seek to meet any family member, nor did any of your team”. Another complaint was made by the sister of a woman who died shortly after surgery; she complained that when the doctor “spoke to me at Seven O Clock that morning he told me my sister would be going back down for further surgery, he gave me no indication that my sister had deteriorated and to inform my family”. However, insights into the challenges that can face doctors in communicating with their patients’ family members are also provided by some of these complaints. There are instances where communication with family members is regarded as a breach of patient confidentiality. This is illustrated by one complaint which reports the doctor “has confirmed to me that she has been speaking with both extended families, at this is breach of patient confidentiality, and compromising with the lies and allegations made up by my mother”.

Doctors’ failures to keep their patients and their family members informed were the focus of a series of complaints. Examples include a complaint from the parents of a boy who died of leukaemia who

reported they were “kept in the dark” about their son’s treatment. Several complaints pertained to doctors’ non-communication of test results to their patients, including one in which a general practitioner did not communicate the results of an amniocentesis that indicated that the complainant or her partner may be the carrier of a genetic disorder. This complainant stated “I feel that [Doctor] had a duty of care to me as her patient and I feel very let down by her and her inaction in communicating such vital information to me”. Another arose from a doctor’s failure to communicate results of an imaging procedure: in this case the complainant reported that her “dear late mother felt very cheated that she was not informed of the result when it was reported on and she could have had a better outcome had there been earlier intervention”.

Keeping patients informed was identified by a number of complainants as crucial to professional conduct. One stated “I feel that there should be a professional responsibility on doctors and consultants to keep patients informed of progress with their case”.

A final notable theme relating to doctors’ communication with their patients concerns communication across the lay / professional language divide. A number of complainants reported their difficulties understanding professional “jargon”. However, others complained about doctors’ use of crude language, especially when discussing sex. One complainant reported the doctor spoke to him and his partner as “if we were dogs”. Another complainant reported that the doctor spoke to her in a lewd manner and that “because I was in so much shock at this level of vulgarity from a supposed professional, I cannot remember the way the conversation continued or ended”.

iv. Lack of care and compassion

Doctors’ lack of care or compassion for their patients was a recurring theme in the complaints reviewed. These complaints provide insights into patients’ expectations of their interactions and relationships with doctors that go beyond clinical technique, and especially the “emotional labour”²² they expect doctors to perform.

Examples of these complaints include he “showed no empathy or consideration for our mother’s agony” and he “showed no warmth or understanding ... I just felt railroaded, a nuisance — would I please just go away. ... I wasn’t being a nuisance; I was asking to be looked after”. Another

²² Hochschild, A. 1983. *The Managed Heart*. Berkeley: University of California Press.

complainant reported “His initial attitude was one of not only disinterest but blatant condescension. He sat with arms folded in a belligerent manner and looked us up and down as if we were beneath contempt”.

Some of these complainants’ expectations of care extended beyond the immediacy of medical consultations as illustrated by the following extract: “I know [Doctor] did not want to harm my baby but why did she not even ring on Monday to see how she was. She did know what happened because the hospital had contacted her”. Similarly, another complaint about a psychiatrist’s lack of “continuity of care” arose when the doctor did not respond to a “tearful message” from a family member of a former patient of 20 years requesting her to contact the patient following a tragic death in the family. In this instance the complainant noted that the doctor “was known to be an important part of [Patient] life ... hence the very direct attempt to communicate the very serious concerns the family had for their mother in a time of great distress”.

Alongside these complaints about doctors’ lack of care and compassion are a number of complaints that express the view that the doctor was more concerned about money. One complainant, whose doctor demanded payment before he would treat her sick infant, reported that “This made me sick to my stomach that he could actually say something like that. How could he put [fee] before a child’s life”. Another complainant who was told by her GP’s receptionist that the doctor would not see her until she paid for a previous appointment reported “on that day it was all about money. I now realise it was never about patients and their well-being, but a money making business.” Similarly, a further complainant attributed his experience of a rushed consultation and inadequate examination to the doctor being motivated primarily by money:

I felt in general the appointment was so rushed that a proper examination was not done. I also feel that as it was so heavily overbooked that he did not give any attention to my problem, that is was just focusing on rushing to get to the next appointment and make as much money as possible. I was charged [fee] for an appointment that lasted 5mins.”

In a similar vein another complainant alleged the doctor was “simply trying to extract money out of me at a time when I was vulnerable”. In another complaint, this concern was generalised in the statement “with most doctors it usually is all about the money and being important and usually it has very little to do with the client”.

Concerns about financial matters were the focus of a further series of complaints. These included a complaint that “my late husband spent a weekend in Hospital as an in-patient under the care of [Doctor] and was not seen or examined by him. He did however submit an account to the [medical insurer] for medical attendance”. Another complainant stated “It also angers me to think that I paid [Doctor] the sum of [fee] in cash to tell me that I had a strained neck”.

v. *Inappropriate sexual comments and behaviour*

Seven of the 100 complaints we reviewed made allegations of sexual assault, harassment or inappropriate sexual comments. Three involved allegations of sexual assault, one from a medical secretary who also reported the incident to the Gardaí, another from a patient who reported the doctor assaulted her in course of an intimate medical examination, and a final one also involving a medical examination described as follows:

“He started at my feet and touched every inch of my body asking if it hurt. I was so uncomfortable, however I was not feeling very well and I didn't voice my discomfort ...Then he leaned over and kissed my forehead. For the next while every time he came in he would tell me to relax, say he was just going to give me a massage for the pain: first my head, then my belly, then my chest, then my legs. I repeatedly told him it was not helping but he kept doing it. ... He told me he would give me his number if I ever felt stressed or lonely.”

Other complaints related to sexualised communication that made one complainant “extremely uncomfortable”. Also included in this category is a complaint from a medical student reporting she was stalked by a doctor with whom she had worked while on placement: “he has consistently disturbed me over the past three months”. Significantly, this complainant expressed concerns about possible consequences of making a complaint to the Medical Council, fearing it would result in a “threat to my privacy or safety”.

vi. *Discrimination*

Concerns about discrimination of various forms featured in nine complaints. Four of these raised concerns about homophobia. One complainant said his doctor had an “intractable strong dislike of homosexuals”. Another who felt his doctor had laughed at him because he was gay reported “I was

made to feel humiliated and victimized, something I had not felt since I was bullied in the school yard many years ago, and certainly not something I would expect of a professional in such a position!”. Allegations of ageism were also made, such as that the doctor’s attitude was that the patient was elderly and should not be wasting time and resources. Concerns about racism were raised, such as “We gained the impression that he basically did not like us. ... I am wondering if there was a racist element to his behaviour as we have English accents and [Patient] has obviously some foreign blood”. In another complaint, the patient wondered if the doctor’s unprofessional treatment was a consequence of racism combined with the stigmatisation of mental illness: “Is he being racist because I am [foreign national], a fact that could only have been made known to him by reception as my surname is (surname), or, is he stigmatizing me because I had a breakdown”. Similarly, another complainant stated “I hope because he is a special needs child you do not treat him any differently than any other child”.

vii. Practice-related issues

A series of complaints raised concerns about administrative and procedural aspects of doctors’ practices, such as failures to forward medical records and patients having to wait for their appointments. Concerns about the process whereby doctors terminate their relationship with a patient, what one complainant described as being “struck off” by her doctor, were also prominent.

There were nine complaints about medical records, many of which related to failures to respond to requests to forward these records to legal firms or other doctors. For example, one complainant stated “My request and subsequently my newly appointed doctor's request have been met with a lack of cooperation on behalf of your administration office”. Another complained that on requesting “a copy of chest X-Ray results, we were told ... they were missing and un-reported this is unacceptable”. Complaints about having to wait to see the doctor included some that raised concerns about GP practices that operate a no appointment policy, such as “Any time I arrived to see [Doctor], the waiting room was full and I would have to wait to see her for almost two hours as no appointments can be made”.

Another complaint raised concerns about the delay in finding a hospital bed for a seriously ill family member who subsequently died:

“They waited and he was finally found a bed at 4pm A long time to be left waiting in his condition. All this time my brother was struggling with his breathing and at one point stated "if they don't do something soon I am going to smother".”

Five complaints raised concerns about how GPs handled the termination of their relationship with patients. In one, the complainant reported “she did not say much just that I have to attend a new doctor”. This patient expressed her distress at her doctor’s decision and emphasised the importance of her relationship with the practice:

“...now to add insult to injury she stops me from being a patient in the [practice] that I have been a patient for 16 years. How could she do such a thing it would be different if I was a troublemaker but I get on very well with all the nurses and doctors there ...”

Similarly, another patient complained he was “given no explanation” by his doctor about his advice to seek another doctor. Two complaints raised concerns about the angry manner in which doctors communicated the decision, for example one reported that the doctor had suggested in an angry manner that the patient should switch to another GP, and another described how

“She told me "to take my files and find another doctor to treat me for free" I asked her again "was she refusing to treat me a sick woman as my doctor?" again she ranted about money. I told her "her behavior was a disgrace and she should be ashamed”.

4. Effect on complainant

In the study sample there was a good range of complainant characteristics, varied by age, gender and relationship to the patient who was the primary subject of the complaint. In addition to complaints from patients themselves, many complainants were family members of elderly patients, or parents of young children, as well as sometimes siblings of deceased patients. This provided an insight into the effect of the subject-matter of the complaint not only on the patient but also other family members and carers.

In analysing the nature and causes of complaints, it was evident that the consequences and effects of the complainants’ experiences were highly significant in terms of their motivation in contacting the Medical Council with their concerns but also as a form of evidence in itself. The depth of harm,

both physical and/or psychological, described by many complainants appears to have been regarded by them as contributing to their credibility and their appeal to the Council to listen to their story. Therefore we considered it important to include a description and analysis of the effect on complainants as part of our content analysis.

The experiences and effects described by complainants ranged from emotional reactions, to adverse effects on quality of life, financial disadvantage and consequent loss of confidence and trust in the medical profession. Some of these consequences were temporary in nature but others had long-lasting effects on the complainants and their families. Each of these themes will be described in turn, using samples of descriptions from the complainants themselves to illustrate their stories and experiences.

i. Emotional reaction

Emotional reactions were commonly described by complainants both in relation to the incident as they experienced it at the time of the event, as well as its immediate aftermath and longer-term consequences. The most common emotion expressed was that of distress or upset at the time of the incident, often linked with poor communication between the doctor and patient and/or the patient's family. For example, in one case in which a family complained about the care their mother received before her death, they said "She was completely distressed and really upset at not being allowed a sip of milk or water". This was an experience which caused the patient and her family considerable distress and was caused, in part, by an absence of communication or explanation about the need for the patient to avoid liquids for medical reasons.

In another case involving communication, the manner in which a patient was informed about his diagnosis caused him distress "On two occasions such terrifying diagnosis, were given to me by Dr A in a very simple manner that caused enormous distress to me." Others expressed distress in relation to communication during the whole episode of care. For example, a family who complained about the care of their son who died of [medical condition] said "We are deeply unhappy with the way in which we were treated, kept in the dark and actually lied to."

In some cases the distress experienced by the complainant lasted for a considerable time after the incident, with some complainants expressing upset at re-living the event in writing the complaint - e.g. "I just cry every time I think about it". Many complainants experienced the incident as a traumatic event in their lives, either using the word 'trauma' in the telling of their stories, or

describing the experience as “horrendous”, “horrific”, or as a “nightmare”. The language used by the complainants in these incidences often describes deep and long-lasting emotional and psychological distress.

“This letter has taken me eight months to write as so many times I have started and stopped because it upsets me so much. The trauma could have and should have been avoided if the doctors listened, but unfortunately they just brushed me off and ignored my concerns.”

The effect of the incident can also affect the complainant’s quality of life and work or study, e.g. “Because of Dr. A’s misdiagnosis I suffered immense trauma, pain and had to miss time from my university course” as well as the complainant’s trust and confidence in the medical profession or the health service, e.g. “I fear going anywhere near a hospital in case such a traumatic event should occur again.” The complaints demonstrated that the trauma experienced by the complainant can have an impact on other members of the patient’s family, often children, e.g. “My children and I are traumatised by all this unnecessary suffering that she put F1 through” or “the children are still traumatised with their security disturbed by these bewildering events”. These are considered again below.

Another common consequence of the incident complained of is anxiety and stress in relation to the actions or behaviour of the medical practitioner e.g. one complainant left her GP’s office feeling “very down, upset and worried,” while another felt that her elderly mother was caused “totally unnecessary stress and anxiety” as a result of the incident. This anxiety may be also in relation to potential on-going health consequences, e.g. “I am very worried and angry about the effects that all this medication is having on their health” and can affect their relationship not only with their own doctor, but also their confidence in the profession as a whole, e.g. “I put my trust in Doctors but now it will be a worry.”

In the aftermath of the incident, complainants’ initial distress can sometimes give way to anger which can also affect complainants in coming to terms with bereavement e.g. “The anger is too great for grief” and can become all-consuming, e.g. “The anger towards that woman is eating me up”.

Other strong emotions expressed by complainants include shock at the doctor’s conduct, e.g. “We are deeply shocked and are finding it very difficult to forget the way we were treated”; fear e.g. “I was shaking at this stage as I couldn’t believe what had happened and I was very afraid”; and some

expressed long-term difficulty in getting over the incident e.g. “I am still finding it increasingly difficult to overcome what has happened to me.”

Some complainants felt humiliated by their experience e.g. “I was made to feel humiliated and victimized”, or “embarrassed and insignificant “. One particular complainant was left “feeling like a nonentity” after a verbal altercation with her doctor, while some other complainants felt disgusted by the doctor’s conduct, e.g. “we are disgusted at what had occurred prior to this and the potential damage that this incompetent doctor's actions could have had” or by a doctor’s comments “This made me sick to my stomach that he could actually say something like that.”

Other emotional reactions experienced by complainants including feeling “vulnerable”, “violated”, “deprived of dignity”, feeling guilty or blamed by health care staff, disappointed and let down by their doctor, depressed, with complainants expressing in different ways how the incident has had lasting consequences e.g. “This whole incident has left a deep mark on me both physically and psychologically”.

ii. Quality of life issues

In addition to the emotional effects of the incident or conduct complained of, complainants also referred to the effect on their quality of life, with pain and other physical symptoms commonly mentioned e.g. “I have been unable to return to work and found it extremely difficult to manage my baby, the pain and the IV after the hospital.” This can also cause complainants to miss work or study e.g. “Because of [Doctor]’s misdiagnosis I suffered immense trauma, pain and had to miss time from my university course.” These on-going symptoms can have long-term or permanent physical consequences e.g. “I now have a permanent scar on my right eye and have suffered severe pain discomfort and distress since undergoing this operation.”=For some complainants, the future is uncertain as a result of the nature of the incident e.g. “Her future reproductive capacity is uncertain due to the extensive damage caused.” The consequences can also be psychological e.g. “This whole incident has left a deep mark on me both physically and psychologically”.

iii. Harm to family

Many complainants also expressed distress and anger at the consequent harm caused to their family arising out of the incident. In some complaints, this is expressed as a sense of injustice e.g. “The serious injustice that has befallen myself and my family, has been extremely upsetting” while others

describe the impact on the patient and her family in more emotional terms as simply “devastating”. The incident was sometimes expressed as having on-going negative effects e.g. “a terrible nightmare for me and rest of my family and is playing on my mind day and night and causing pain and distress beyond belief” or “we are all still affected by what has happened, ourselves, the children and the relatives they stayed with have all been through hell.”

Others complain that their relationships or time with their family were affected by what happened e.g. “The [medical condition] that was not detected by your team took away any quality time he had left with his family as it killed him in the end.” In some cases, the conduct complained of caused relationship difficulties between family members e.g. in one particular case the complainant alleged that the doctor had caused “terrible friction” between family members and his conduct “has been the source of more pain and served to drive family members apart.” Others indicated that part of the reason for making the complaint was that they did not want “another family to go through this stress.”

iv. Loss of trust or confidence in the profession

Another notable trend in the complaints was the expression of disillusionment with the medical profession and/or the health system as a result of their experience. This may be expressed either in relation to the particular doctor concerned e.g. “[Patient] had lost all confidence in [Doctor]” or more widely expressed in relation to medical professionals more generally. Some complainants also express loss of confidence in hospital care or the wider healthcare system as a consequence of the events complained of, e.g. “The recent events have damaged my faith in Irish healthcare system” or “I fear going anywhere near a hospital in case such a traumatic event should occur again.”

v. Financial disadvantage

Some complainants express annoyance and anxiety in relation to the financial outlay that has resulted from the event complained of e.g. “I have been placed under financial stress due to the cost of my medication, hospital fees, paying babysitters and time off work for both myself and my husband” or “I am more than 5000 euros out of pocket.”

5. Reasons for making complaint

In many, though not all, instances the complainants explained the reasons why they had contacted the Medical Council to make a complaint. For some, it was about investigation of the events complained of in an attempt to get answers to their concerns or questions about what happened. Others framed their complaints in broader concerns about patient safety and prevention of recurrence of the incident. Some felt that they had a moral duty to complain in the public interest, while others wrote to the Medical Council seeking specific outcomes such as an apology or the imposition of sanctions on the doctor.

i. Investigation

For those who sought an investigation by the Medical Council, this was often expressed as seeking answers e.g. one complainant asked the Council to “look into this matter for me and find out why these errors were made” and many others referred to “questions left unanswered”. Some complainants saw the Medical Council as a mechanism for resolving their particular concerns about the event, providing information or objective answers to their questions about their care or treatment, and taking action if necessary as a result of the investigation sought. E.g. one complainant referred to the complaint mechanism of the Council as providing the necessary “scrutiny and analysis of impartial qualified experts”.

Others who had sought answers from the doctor in question complained that their questions or concerns were either unanswered or not answered in a manner that the complainants could understand. E.g. some complainants felt that they were “shoved from pillar to post” or that the doctor had answered with “misleading comments”. Other simply wanted an explanation in terminology they could understand, e.g. one particular complainant who had been given information relating to the cause of her mother’s death using highly technical medical terminology simply wanted to know “Did Mom die from stroke?”

Some complainants felt that they had a moral duty to bring the events to the Medical Council’s attention e.g. “it is my moral and social duty to make this complaint”. Others expressed this sense of duty as arising from a “very real concern for any vulnerable people who may ever have to go to [Doctor] for help” and stated that they felt that this moral duty was satisfied by informing the Council e.g. “our conscience is now clear that we have informed you”.

ii. Prevention of harm to others

Many complainants expressed their concerns in terms of patient safety and prevention of future harm to others. E.g. one complainant stated that she wanted to “stop [Doctor] from doing this to any other patient” while others used similar language in seeking to “protect any women who may be misfortunate enough to attend [Doctor]” or “I would hate to think that this could happen to anyone else in the future.” This theme was common amongst complainants with some expressing the motivation that although an apology would be welcome, their main motivation was to ensure that no other patient had a similar experience.

Another complainant recognised that errors can occur in medical practice but said “I understand that to make errors is human, but only a medical mistake has an expensive price – someone’s life. I have great hope that you take measures to prevent this case and others to suffer.”

iii. Seeking specific outcome

For those who wrote to the Medical Council seeking a specific outcome, the most common of these was punishment and/or accountability which the complainants felt would provide ‘justice’ for them. For these complainants, accountability was interpreted as holding the inquiry in public so as to protect others or to ‘name and shame’ the doctor e.g. “It is our hope that someday a full audit will be conducted on the medical files of all (Name) Ward patients who came under the care of [Doctor] and [Doctor] and that the findings will be made public” or “If I have to put his name in the papers I will.” One particular complainant described the outcome sought as follows “I also want a head on a plate even if they are retired.” Other complainants did not clarify what they meant by accountability and simply wanted the doctor to be “held accountable for conspiring against their own patients rights to justice”. Another who complained about feeling frustrated and angry as a result of her experience said “I feel like I need some justice.”

Some complainants specified the form of sanction they expected the doctor to receive e.g. “it would be my expectation that the Council would impose the most severe sanctions permissible under the Medical Act 2007 on [Doctor].” Others insisted that the doctor should not be allowed to practise medicine as he was “negligent and incompetent but also a liar and a thief” or “This man should not be putting Irish women's lives at risk. Allowing him to continue in practice is doing just that.” Some felt that the doctor should receive a warning coupled with further education and training e.g. “I

would at least expect [Doctor] to receive a warning and be made aware of how her willingness to prescribe drugs is not always the best course of action to take.”

iv. Seeking acknowledgement

For others, the sense of acknowledgement and vindication of their stories was also important e.g. Some complainants spoke about the need for an acknowledgement from the doctor for the incident. E.g. “I would like [Doctor] to acknowledge that my mother was poorly treated as a patient” while others felt that an apology would be an appropriate response e.g. “This whole incident has left a deep mark on me both physically and psychologically and I feel I deserve an apology”. Another family of a deceased patient felt that an apology was “not too much to ask” and stated: “A simple apology goes a long way.”

Some complainants appear to have misunderstood the remit of the Medical Council as they requested the Council to change their diagnosis e.g. “my Doctors have been fraudulent in their medical decisions and they have medically declared me to having a delusional disorder”. Others sought a change of treatment e.g. “I wish to come off medication immediately and request a course of [psychiatric medication]” or “I demand the termination of the [psychiatric] treatment and a course of [psychiatric medication] to reverse a clinical fatigue complex.” One complainant sought help from the Council in accessing care “So please help me I need a diagnose and treatment”. Some complainants asked the Council to get their consultation fee refunded by the doctor e.g. “At the very least we would be seeking a re-imburement of these costs immediately” or “I also think it fair that she should receive a refund of her initial consultation fee.” The mechanism by which the complaint would be addressed by the Council was also an issue for some complainants who specifically sought an oral hearing or formal meeting at which their grievances could be discussed e.g. “I feel an oral hearing of some form, with you, is the best form of communication”. One complainant suggested that the Medical Council should be doing more in order to adequately protect patients - “The council needs to do a lot more to regulate the plastic surgery industry in Ireland.” These issues raise concern about the lack of awareness or understanding of the role of the Council which is something the Medical Council might consider addressing in terms of further public information and education strategies.

6. Response from doctors

i. Style of response

The nature and style of responses to complaints from doctors varied from on the one hand formal or legal observations and comments sent by the doctors themselves or by solicitors on their behalf, often containing strident rebuttals or denials, to very minimalist responses dealing only with the clinical facts of the alleged incident and often relying on clinical notes and/or recollections of professional colleagues. In some cases the doctor took the opportunity to express concern for the patient, sympathy for their distress, and expressed an acknowledgement and/or apology for their negative experience.

In a very high proportion of cases the doctor's response opened with a standardised formal denial of all allegations e.g. "I deny all allegations of professional misconduct and/or unfitness to engage in the practice of medicine and/or poor professional performance and insofar as this matter may proceed to an inquiry, the Registrar is on formal proof of each and every allegation made." This is typically followed by a description of the doctor's educational qualifications and professional experience e.g. "In [Date], I graduated from [University]; From [Date] to [Date], I completed my internship at [Hospital] which included six months of Medicine and six months of Surgery. I was then a Senior House Officer ("SHO") at [Hospital] where I gained experience in E.N.T, Paediatrics and Obstetrics and Gynecology". While some doctors state that they are providing this information as background for the Council, others specifically use their qualifications and experience to deny the claims made by the complainant e.g. "I also have been a trainer with the G.P. Training Scheme for about twenty-five years. I fully understand the importance of the doctor patient relationship and there is no way that I would be rude to any patient."

Some of the descriptions of qualifications given by doctors were extensive and gave details of honours and awards received by the doctor e.g. "I have won prizes for the presentation of research both nationally and internationally, as well as hospital grand rounds clinical case presentations" or "I am not bragging about myself, but proud of my clinical skills which I am honing day after day since my graduation from the top medical college in [country] in [date]". Others sought to reassure the Council that they had never been the subject of a complaint previously e.g. "In my ten years of practice as a Consultant, my fitness to practise and my professional performance have not been called into question by any of my colleagues or by any of the institutions in which I have worked" or "In thirty six years of practice, this is the first complaint he is aware of to the Irish Medical Council in respect of care and treatment he has provided to a patient."

The similarity in the style of these responses suggests that professional legal or indemnity advice is sought by doctors who receive complaints as to how they ought to respond to the Medical Council in the first instance and that a standardised approach or template is often used.

Other responses take a more minimalist approach confining their comments to a succinct referral to clinical facts e.g. one response from a doctor in relation to a complaint regarding a failure to adequately diagnose and treat the patient stated “[Patient] attended me from [date] to [date] approximately. His main complaints were: [medical condition 1] for which he was referred to [ENT Surgeon, Hospital]; [medical condition 2] which were treated but the public health nurses and referred by me to the [medical condition] clinic. His [medical condition] were slow to heal. There is a family history of [medical condition]. I enclose copies of all the reports I have on this patient. I have no further notes on him.” In response to subsequent correspondence from the complainant, the doctor simply replied “I have nothing to add to my previous reply”.

Many doctors use the authority of medical notes in their defence, claiming that they provide an accurate and unassailable record of facts regarding the incident. E.g. “the computerised record which was inputted during the consultation on that date confirms that I examined the breasts on this occasion.” The doctor may also rely on the notes to provide verification of his recollection:

“I can confirm, however, that I reviewed the patient on an urgent basis at the request of nursing staff at 9.15 a.m. on the morning of [date] due to [medical condition]. I personally supervised the initial management of his [medical condition] and a bed was booked in the Coronary Care Unit. This was available to us at 10.00 a.m. In the interim period, I was physically present at bedside with [Patient] and supervised and implemented the emergency management. These facts can be verified from medical notes.”

Doctors sometimes state in their response that the notes provide an objective statement of facts e.g. “Objectively however, all reports in his notes do not mention any particular problems with the [surgical procedure].” It may be argued in this regard however that medical notes are not necessarily always accurate or contemporaneous and, if authored by the doctor in question, may not provide an objective description of the event. This is particularly problematic where the complainant’s recollection is at odds with the description in the notes. This is a matter for the PPC to consider in its assessment of the complaint and response.

Doctors also use other credibility tactics such as witness statements from colleagues or employees to dispute the complainant’s account e.g. “My secretary witnessed that I was not offensive in any

way to [Patient]" even though it may be argued that their objectivity may be disputed due to their relationship with the doctor. Others claim that their peers would have come to similar conclusions or behaved similarly in the circumstances and thus, their competence and/or actions should not be called into question. E.g. "A number of other Consultant Radiologists and physicians have viewed this x-ray on PACS, without foreknowledge of the ultimate diagnosis, and all have come to the same conclusion that [medical condition] could not have been called on the basis of that x-ray."

Other doctors call in aid of their defence extracts from medical textbooks or journal articles e.g. "In order to provide a comparison, I have attached a copy of a paper in the British Journal of Ophthalmology in 2005 in which the authors state that postoperative complications were recorded in 15.6% of patients having periocular skin grafts" or "All of these points are covered and highlighted in the photocopied extracts from the book "Fundamentals of Obstetrics and Gynaecology." They also occasionally refer to their standard custom and practice even where they have no specific recollection of the incident in question e.g. "I have an invariable approach to every ... examination I conduct" or in explaining a particular lapse from their usual practice e.g. "I wish to confirm to the Committee that this was an isolated incident and we have a robust system in the practice for opening post."

Others refer to compliance with the Ethical Guide of the Medical Council in their defence e.g. "In accordance with the Medical Council's publication Guide to Professional Conduct and Ethics for Registered Medical Practitioners (Paragraph 24.2), I am aware that patient information remains confidential even after death" and others respond to the complaint by directly appealing to the knowledge and expertise of members of the PPC. E.g. "As You know such cysts are normal findings among 2-3 % of fetuses, but if they are accompanied by any other abnormalities for example congenital heart abnormalities they can be the symptom of [medical condition] or [medical condition] or other genetic diseases.." It may be argued that there is a potential for this sort of comment to be seen in a negative light by complainants as an attempt to rely on a sense of collegiality within the profession.

ii. Dealing with the complaint

Again the style of responses varied considerably between doctors. Some entered into robust denials of the allegations and on some occasions this resulted in criticism or disparagement of the complainant. Others provided explanations or sought clarifications as to the facts contained in the

allegations. Some doctors stated that they had no recollection of the complainant or the alleged incident while others acknowledged the facts as alleged and expressed regret or offered an apology to the complainant. A number of doctors expressed concern for the complainant and reassured the Council that they had learned lessons from the complaint as a result of which the Council could be satisfied that there would not be a recurrence of the behaviour complained of. Many responses spoke about the challenges facing doctors and the effect of the complaint on them and their families. These will be discussed in turn below.

iii. Denials

A high proportion of responses contained denials of varying degrees and styles. Some used formal or legal expressions e.g. “I deny any breach of Section 57 of the Medical Practitioners Act 2007 either as alleged or at all and I particularly deny any misconduct and or poor professional performance or indeed any of the other matters referred to in Section 57 of the Medical Practitioners Act 2007, At all times I believe that the late [Patient] was treated appropriately and in accordance with my professional responsibilities and in accordance with the standards of professional conduct and ethics as set out in the Medical Council Guide to Professional Conduct and ethics for Medical Practitioners.” Others denied the allegations by referencing their typical practice e.g. “[Patient] indicates that I stated that she had the "most beautiful eyes" when greeting her. This extremely personal comment would be quite inappropriate and not something that I would ever say to a patient.”

Other forms of denial range from more vigorous language e.g. “I absolutely deny in the strongest possible terms possible, this outrageous allegation” to those which claim that the complainant’s version of events does not make medical sense e.g. “With regard to the cream that [Patient] says caused side effects for him. I would like to state that this cream was [medication] cream which is a very safe and effective cream. I am not aware that this could cause any upset to his stomach. I feel that this complaint does not make sense from the medical point of view.” Some doctors claimed that the allegations were simply incorrect e.g. “entirely incorrect to suggest the protocol used was out of date” sometimes using the authority of the medical notes to establish the inaccuracy: “Ms C is not correct in her allegation that I did not give any attention to her problem; the clinical material including handwritten aide memoire and immediately dictated typed letter that I previously provided clearly indicate careful establishment of symptoms, relevant examination and detailed assessment of scan, comprised of personal assessment of the images and consideration of the

reporting radiologist's opinion. Ms C is seriously mistaken in her contention that her appointment lasted 5 minutes".

A number of doctors claimed that the allegations lacked any foundation or credibility "I feel that overall, Ms. C's complaint against me is unsubstantiated and her reactions are exaggerated" or "the vast majority of his allegations of breaches of confidentiality are generalized and utterly unsubstantiated." The doctors often referred to their medical notes to refute the credibility of the allegations e.g. "Re: [Patient] saying that he being told he had [medical condition]... during the surgery and a letter was sent to his GP. There is nothing to substantiate this in the operation note on that day, there is no copy of any letter in his chart to his GP about this and my secretary tells me she has no copy of this letter"

Some responses claimed that the complaint was based on a misinterpretation of what happened e.g. "There is a possibility that at some point or other, our knees may have brushed against each other but not in the manner that [Patient] describes nor in any intentional manner"; or "I would not consider a number of short messages over a period of months to be the serious harassment alleged. I was merely being friendly and courteous." Others claimed that the doctor's behaviour had been taken out of context, exaggerated or misinterpreted e.g. "If she thought I was in any way rude this certainly was a misunderstanding and not intentional." This misinterpretation of the facts also caused resentment by doctors e.g. "As a common courtesy I would have invited her to go up the stairs ahead of me and I strongly resent any implication that there was any ulterior sexual motivation in walking up the stairs behind her."

Some doctors claim that the making of a complaint against them is particularly unfair in circumstances in which they are part of a larger clinical team or under supervision of a more senior clinician who would be primarily responsible for the management of the patient. E.g. "As a medical registrar, I work in a team led by a consultant physician. All the decisions and plans of management are made for the best interest of the patient by the team collectively and under supervision of the team leader. For fairness if there were any deemed shortcomings regarding the level of care, this should be addressed to the team and not specifically to a member of the team who is not having the final say". Others question the motivation for the complaint, particularly if a civil action is also underway relating to the same complaint e.g. "It is difficult not to reach the conclusion that [Patient]'s intentions in lodging his complaint against me are an effort in some way to bolster up his client's civil claims." Some doctors felt that the allegations indicated that the complainant was

suffering from a psychiatric disorder e.g. “His statements in this regard appear to me to have the quality of formal thought disorder.” Where the response is submitted by solicitors on behalf of the doctor, the response sometimes claims that the complaint is an abuse of process or “vexatious, tainted by unconscionable delay and unfairly prejudicial” to the doctor.

Where the complaint has alleged that the doctor did not communicate the risks of the particular procedure, the doctor’s response may refer to the inherent risk of surgery e.g. “the level of satisfaction in Cosmetic Surgery procedures never guaranteed 100% anywhere in the Europe or internationally and risk related to surgery are always explained prior to the procedure” or refer to and submit to the Council written documents to substantiate the doctor’s claim that all risks were outlined to the patient “on his 2007 consent form are written the following operative risks; infection, bleeding, healing problems, recurrence of ectropion, incomplete repair of ectropion further surgery, eye injury and reaction to local anaesthetic.”

iv. Explanations

In offering explanations to the Council for the alleged incident or behaviour there is a wide variety of responses. Some offer extensive background or contextual information to explain the incident and others refer to detailed clinical information to explain their diagnoses and management of the patient. Some responses disclosed significant factual discrepancies from the accounts of the event given by the complainant while others simply explained that they had done their best in difficult circumstances. Although a small number admitted that they had made a mistake, others blamed the patient for misinterpretation or unacceptable conduct. These and other forms of explanation will be discussed below.

Many doctors respond to the complaint by giving a detailed explanation of the background or context in which they had made a particular decision or behaved in a particular manner. In a case where it was alleged that a patient had been prescribed methadone in contravention of prescribing protocols, the doctor explained in some detail the choices available to him at the time he agreed to prescribe methadone and the context in which he had made that decision

“[Patient] explained to me that he had been released from prison [date] where he was on a maintenance dose of 30mg [medication]. [Patient] also explained that he was due to be seen in the [healthcare facility] on the coming [date] and that he needed his [medication] for the next four days... [Patient] had no signs or symptoms of withdrawal and in addition

he was well groomed and in good spirits. [Patient] spoke of his [age] son and stated that he wanted to remain [free of medical condition] and be a good father. “

In relation to a complaint alleging that a doctor refused to see the complainant until she settled her account the doctor explained that “From registering with the practice to date [Patient] had a total of 22 consultations either with locum G.P.s, practice nurse or myself. On no occasion did [Patient] offer to settle her bill despite many verbal requests to do so by my practice secretary and myself.” Some doctors refute the complainant’s allegations by explaining the background to his or her medical condition, particularly if this involves a psychiatric diagnosis “It is important also to note that [Patient] has been referred on three different occasions to three different consultant psychiatrists for the management of multiple medical symptoms for which there is no objective evidence.”

Many doctors give clinical explanations for their management of the patient e.g. “she is the only patient in the practice for whom I have reluctantly prescribed [medication] on a fairly long term basis. She was involved in a Road Traffic Accident earlier this year and finds that [medication] is the only medication, which gives her relief from neck and back pain” or “At the time of my examination on [date][Patient] was not displaying symptoms necessarily suggestive of [medical condition]. His symptom profile at that time was more general and non-specific.”

In many instances doctors also refer to their practice policies to explain the background to the complaint by the patient, for example they refer to the need for security policies in light of the location in which they work. For example in relation to a complaint relating to a patient being kept waiting for a repeat prescription in a doctor’s clinic:

“In our surgery we offer open access to care every morning and by appointment in the afternoon. This ensures prompt attention to those requiring medical care. This system of open access is usually associated with a busy clinical session every morning and it is because of this that 11 years ago we advised patients that repeat prescriptions will be provided with 24 hours notice. This is common practice in most surgeries in Dublin. It allows less interruptions to clinical care during the morning and afternoon consultation times.”

Doctors also often refer to best practice or clinical guidelines to support their management of the patient or their treatment decisions e.g. “the treatment of [Patient] [medical condition] was in-keeping with then best practice” and “[Parent] did raise questions concerning [medication], medication prescribed to [Patient]; however, at the time of the relevant consultations and indeed to date, this medication remains approved for use in the treatment of [medical condition], including

the treatment of young children, where appropriate.” They may also refer to hospital protocols to explain, for example, visiting restrictions “ICU and ICU are critical care areas and have restrictions on visiting as per hospital protocol.” In a small number of cases the doctor has responded to the complaint by referencing compliance with Medical Council guidelines e.g. “I felt I had handled a difficult situation with a family I had never met before well, in the best interest of the child and in keeping with my duty under the medical council guidelines of suspected sexual abuse.”

In many situations doctors also refer to inefficient hospital systems or system failures to explain the incident complained of, for example that they did not receive test results or other communication from other healthcare professionals e.g. “I am shocked and concerned to learn that during the week prior to his attendance with me on [date] [Patient] was a patient in [Hospital] undergoing treatment for [medical condition]. I was not aware of this until I received your recent letter. No discharge letter was issued from [Hospital] to me concerning that admission.”

Sometimes doctors respond to the complaint by explaining that on the date in question they were completely unaware of the patient’s distress or concern about the incident e.g. “I was unaware that ...he would have been more comfortable seeing a male doctor” and that had they been made aware, they would have acted differently. This may be in situations where the patient himself did not inform the doctor of relevant information e.g. “[Medication] was not on the list, as it was not prescribed by me, and I would not have prescribed this medication to a patient already prescribed [medication], another long acting [medication]... I was unaware that he had obtained a prescription for any medication other than that which I prescribed to him”. Or sometimes the lack of awareness is a result of a failure to pass on clinical information within the healthcare setting e.g. “I would have expected to have been contacted by the ICU team had [Patient]’s life been considered to be in imminent danger. I received no such contact from ICU.”

It is difficult for doctors to deal with concerns that are not expressed by patients at the time of treatment, e.g. in a case where the patient alleged that she was inappropriately prescribed anti-anxiety medication, the doctor responded that he had “explained the indications and side effects of the prescribed treatments to [Patient] and was unaware at the time that she had any concerns about my intended approach”. However it may be useful in such circumstances to simply ask the patient if she has any concerns or questions as some patients may otherwise feel intimidated and not inclined to raise their concerns.

Sometimes the explanation given by the doctor is strikingly at variance with the account given by the complainant in the sense that one might question whether they were referring to the same event. A

very clear example of this is provided by a complainant who explained in detail her difficult experience of giving birth to her daughter:

“My baby girl was born two days before her due date by kiwi vacuum delivery. It was horrendous. The doctor present admitted he didn't know what to do as I was very restricted due to my [medical condition]. The epidural was given only superficially (because of my [medical condition]). That too was a problem because for a period of time during my labour there was no anaesthetist present in the hospital. So, a Caesarean section was no longer an option, even though there were problems getting the baby out. Eventually a vacuum was used, I was cut twice and my baby's head was badly bruised, cut and disfigured. Half the bed was taken away in an attempt to pull my baby out and my husband saved me from falling to the floor several times. The whole experience was horrific. I lost so much blood that I had to have a transfusion. My baby was so bruised she suffered jaundice and had to be under lights for several days.”

In response to the letter of complaint, the doctor replied “She made good progress in labour on the evening of the [date]. After about 7.30pm progress was slower and her delivery was assisted by a Kiwi Vacuum device. A baby girl was born weighing 3.7kgs.” The difference in language and tone is significant as it identifies the marked experiential gap between the woman and her doctor. The complainant describes the delivery as ‘horrendous’ and ‘horrific’, expressions which graphically indicate a very negative experience from her perspective which one might expect the doctor involved must have been aware of at the time, whereas the doctor’s experience was that ‘she made good progress’.

Other examples of conflicting perspectives are less dramatic but also refer to instances where a complainant alleges that a particular examination was not carried out e.g. “The claim by [Patient] that I did not examine her back is false” or details relating to, for example, the chronology of events or the presence of other persons during the incident. In this regard doctors often rely on their clinical notes or computerised records to verify their accounts. E.g. in a case where the complainant alleged that her mother had been kept waiting to see the doctor for 15-20 minutes in emergency circumstances, the doctor responded “From my computer records, as all consultations are timed and logged, she could not have been waiting more than five minutes as I was well into my 9.01 AM appointment when I got the call about [Patient]’s emergency.”

In cases where complainants allege that they received inadequate treatment or lack of due care, doctors sometimes respond by saying that they tried to explain the challenges and risks of treatment

to the patient but perhaps the patient misunderstood the information e.g. “I have tried my best, on a number of occasions to explain all these difficulties to [Patient], and felt that at all times I was empathetic, and never at any time tried to mislead him” and “As regards [Patient]’s concern about the withholding of information from him about his condition, I wish to reassure him that this is not the case and that I have made every attempt to explore his symptoms with him and educate him about them.” While attempts to give information and to discuss the patient’s condition are appreciated by patients, many complain that the explanations were too technical, too rushed or insensitive. For example, a complainant alleged that a doctor used crude and graphic terminology in explaining the causes of her urinary tract infection, the doctor responded “I appreciate that the nature of the matters set out above can be of a sensitive nature and sometimes explanation of such matters can only be done so in a direct manner that could be considered insensitive.” It is important to explain clinical matters in a way that the patient can understand but clearly the use of vulgar, crude or insensitive language must be avoided.

v. Patient’s own behaviour and family relationships

In explaining the background to the incident which is the cause of the complaint, doctors sometimes refer to the dynamics of a family relationship or the patient’s own behaviour. This is a difficult area for doctors as they can get embroiled in a family dispute which can sometimes also involve legal proceedings relating to child welfare or other contentious issues. In cases where patients allege rudeness or aggression on the part of the doctor, doctors often defend their behaviour by referring in turn to challenging behaviour on the part of the patient. This is often the case where the doctor seeks to end the professional relationship with the patient.

In relation to family dynamics, doctors sometimes seek to put the complaint in context by referring to a potential personal motivation for the complaint e.g. “Since I do not know [Patient] he gave me the background of her family and informed me of the present situation of a major and dangerous interfamily feud which has been going on between the for the past three years and is presently at boiling point ... [Patient] is a relatively single mother as her husband [Husband] tends to spend a lot of time in prison.” Although relaying the background of the case is understandable, it may be worthwhile for the doctor to be aware that the comments may be sent to the complainant for further observations and therefore caution may be advisable. There were also examples in the cases of complaints against doctors in family law situations and where there was considerable underlying conflict between siblings. In one example, a complainant alleged that her deceased father had been

harmful by passive smoking by the complainant's sister, a fact of which the GP was aware and did nothing to prevent. The underlying conflict between the siblings in this family were identified by the doctor in his response "While there, [Patient] was anxious and wished to smoke; there was a lot of stress in the house". A further example concerned a family who were worried about the safety of their elderly parents due to the violence of one particular family member. They alleged that their requests for advice and assistance from the GP were met with disinterest and condescension. The doctor acknowledged that the conversation with the family was difficult and said he had been concerned at further escalation of the existing conflict.

"They requested me to arrange for [Patient] to be admitted to a mental hospital for the protection of their mother and father. I explained to them that [Patient], (who is like his parents a patient of his practice for many years) would have to be examined and that if I found him to be normal on examination or not suffering from a committable condition at the time that there would be no grounds for me committing him. Further I cautioned them that a failed attempt at committal might negatively impact on the prevailing domestic situation."

Patients have made complaints in relation to being asked to transfer their care to another doctor, with some complainants referring to this as being 'struck off' by their doctor. These complainants often allege that this experience has caused them great distress and confusion as they do not understand the reasons behind the doctor's decision. In response, it is often the case that doctors refer to challenging behaviour on the part of the patient or the breakdown of trust in the professional relationship as the reason for the decision. For example

"I felt that I had no option other than to ask [Patient] to move to an alternative General Practice. The aggressive, abusive and threatening behavior reported to me is not acceptable. This behavior has taken place in a very busy General Practice in front of a number of other patients and has caused our Practice Receptionist great distress. This was not the first occasion upon which there had been inappropriate behavior by [Patient], who, as referred to above, had shouted at the secretary/ receptionist at the Practice here when his demands were not immediately met."

It is clearly unacceptable for a patient to behave in an abusive or threatening manner towards the doctor or any staff member and the doctor is legally entitled to seek to end the professional relationship in such circumstances. It might be beneficial for the Council to provide additional

guidance for doctors on how to manage the end of the professional relationship in such circumstances to avoid distress to patients and any complaints being raised as a consequence.

vi. Other factors

In addition to those outlined above, there are other types of response which occur less frequently such as reference to inexperience, language difficulties or cultural differences. In one example, the complainant alleged that the doctor had been rude to her mother and had caused her great distress by alleging that she was fabricating her symptoms. The doctor responded “it is quite possible that misunderstanding may have happened or resulted from miscommunication secondary to my lack of experience or poor communication skills. It is not unexpected to make such mistakes when one is very new to a system and is just beginning to learn local language, culture and familiarizing with medical practice in a challenging environment.” Another complainant alleged that the doctor was rude in pointing his finger at her or waving his hand in front of her face. The doctor referred to his cultural background in explaining his gestures “Moving the hand while talking is the way we talk in our regions in Africa and the Middle East. I agree this way of talking is not common in western Europe, but it is part of our tradition and a sort of body language to explain things.”

Other responses referred to collegiality, for example in a case where the doctor was alleged to have provided a false reference for a colleague, he replied that his actions were “entirely predicated on the sense of misplaced loyalty and empathy for his position. I was also very conscious that he had been my Consultant, teacher and mentor at [Hospital] and that we had maintained close contact since he left [City] and that I owed him in some way” or embarrassment, for example in a case concerning the failure of a doctor to provide a patient with a date for surgery, the doctor replied “I did not contact her possibly because of a combination of my embarrassment for my inability to get her into hospital and concern that I would have just inflamed the situation or upset her even further”.

In responding to a complaint, doctors should be aware that the Council may send the doctor’s comments to the complainant for further observations. In this respect it is advisable that doctors should guard against making personal comments about complainants which may serve to inflame the situation further e.g. a doctor responded about a complainant’s father “[Patient] would be known locally as a mean and contrary man who would be quite happy to take everything that is going and give very little in return.”

vii. Admissions and acknowledgements

A high number of responses from doctors acknowledge or admit the facts as alleged by the complainants and offer expressions of regret and apologies. “In light of [Patient] expressing his upset through this complaint to the Medical Council of Ireland, I accept that it would have been preferable for me to contact [Patient] on [date] explaining that I was retaining the instructions for weekly dispensing, and my rationale for doing so” or “I absolutely accept that I acted in an improper and inappropriate manner towards her.” Others go further and not only acknowledge the facts as alleged but also the distress caused to the complainant e.g. “I first wish to acknowledge the grave upset and distress caused to [Patient] at the incorrect preliminary diagnoses reached by me in my treatment of her.”

In acknowledging the facts alleged by the complainant, some doctors reflect on the event in question and admit that with the benefit of hindsight, they ought to have done things differently e.g. “In hindsight perhaps I should have tried more extensive surgery” or “With hindsight, I should have made sure that you made a review appointment so that I could re-examine you on a different date.”

Some doctors also offer to meet the complainant if it would be beneficial to discuss the event or the complaint in person in order to dispel any confusion e.g. “I understand how confusing it can be reviewing case notes, and my offer is still available to sit with [Patient] to review the notes and help her understand the care we provided for her mother, in the hope that it will help her come to terms fully with her mother's death and that she will acknowledge that appropriate treatment was provided at all times by the Medical Team” or to reassure the complainant that the doctor acted appropriately e.g.

“If the Committee deemed it fit I would be willing to meet with [Patient] in person to give her any extra explanations she may request to reassure her that there was nothing improper in my motives or my behaviour. I am sure that this complaint was made with great sincerity and, if it would help reassure [Patient] that I acted at all times in what I considered her very best interests and that I always try to treat patients with courtesy, respect and competency and am hopefully possessed of a decent dose of professional humility then I would be willing to meet with her in person.”

viii. Sympathy for complainant

Some doctors' responses included an expression of sympathy for the patient's situation or an offer of condolences where the complaint relates to the death of a family member. In some cases the expression of sympathy or condolence is simple and formal e.g. "I would like to express my condolences to [Patient] and her family" while in others it may appear as conditional or lacking in sincerity e.g. "While I recognise the upset and concern of [Patient] and her family arising from the untimely death of her late brother, I respectfully suggest that this was not as a result of any treatment provided by me" , or "While obviously I am very sympathetic to [Patient] for the loss of her kidney, I reject any suggestion that there was any element of professional misconduct in my treatment of [Patient] and the carrying out of the operation."

Other expressions of sympathy for the patient's plight appear more heart-felt and genuine e.g. in two cases of late diagnosis of breast cancer, the doctors both expressed their concern and sadness to the patient as follows "I am also very sorry to learn that you have been diagnosed with [medical condition]. You are a young woman with three children and I'm sure that your current condition is hugely distressing and worrying" and "I am shocked and saddened to hear of [Patient] subsequent diagnosis of [medical condition]. I can only imagine how traumatic this whole experience has been for her, not only to have a diagnosis of breast cancer but also to have to undergo such long and difficult treatment." Other examples also express empathy and compassion for the patient's difficult condition "I am sure that [Patient] has gone through a terrible ordeal. I am very sorry that she has had such a distressing time and has had to suffer an exceptionally complex and debilitating illness" or to the family in their bereavement "I would like, first of all, to express my sincere condolences to the family of the late [Patient] for his tragic death at such an early age."

Complainants have sometimes expressed dissatisfaction and frustration in circumstances where they feel they were not listened to, their concerns were not heard and their complaints not taken seriously. Some doctors respond openly to such complaints by acknowledging the concerns "I now sincerely apologise for not doing so and particularly given what I now learn from [Patient]'s letter and how frustrating, distressing and disappointing it was for [Patient]" or by appreciating the difficulties experienced by the complainants e.g. "I appreciate and acknowledge that [Patient] has ongoing severe knee pain and that it is causing him great frustration and depression"

Some doctors express concern for the patient's ongoing medical condition and express their satisfaction where the patient's symptoms have been alleviated e.g. "I am pleased to learn that [Patient]'s surgery has gone very well with another surgeon, with an excellent result" and "I am

very pleased for her that there do not appear to be any long-term sequelae.” Others express the hope that their response addresses the complainant’s concerns or offer to discuss the matter further e.g. “I hope that my response addresses the concerns that [Patient] has raised and I am happy to clarify these matters further if necessary.”

ix. Lessons learned

In response to complaints made about their practice doctors often reflect on their systems and policies as well as their own behaviour and communicate to the Council and to the complainants that they have learned a lesson from the complaint which will change their practice or conduct for the future. Sometimes this is expressed in broad terms such as “I have learned a harsh lesson from this unfortunate episode and would like to reassure the PPC that I will not put myself in a similar position in the future”; or that the complaint has provided “a valuable learning point for me in any future similar management decision that I may face.” Others refer specifically to the nature of the allegations e.g. in relation to an allegation about the manner in which a serious diagnosis was communicated to a patient: “I have however taken on board [Patient]’s comments and I certainly am now more cautious in the manner that I convey the diagnosis to patients.” Others refer to changes in the organisation of their practice “Having received the copy of the letter between consultants I made an incorrect assumption that this matter was being dealt with by my hospital colleagues. In the future I will endeavour to ensure that any such matters that are outside my sphere of competence as a G.P. are being dealt with effectively by an appropriate colleague” and “It is also clear that there was miscommunication between my 2 secretaries on this issue and systems are being put in place to ensure that communication with the team is robust and that a recurrence of this does not happen.”

x. Regret and apology

A significant number of responses expressed regret at what happened and offered apologies to the complainants. These responses provide an acknowledgement of the facts as well as the consequences arising from the incident such as worry “I fully appreciate the extreme worry when a very young child is unwell. I regret that [Parents] were dissatisfied by the service provided by me”; or loss of trust and confidence “I regret that he felt a loss of confidence in my surgical ability due to any conversation he may have overheard at that time.”

In 36 cases doctors apologised for their actions and/or the distress or anxiety caused to complainants. The language used by doctors varied from formal apologies “I was sorry to hear of [Patient]’s concerns and would like to reassure you that it was not my intention to cause her any distress and I apologise unreservedly if this has been the case”, to more personal or expressed in more sincere language “I am sorry that my comments during a consultation with [Patient], have led [Patient] to conclude that I was insinuating that he was lying to me. Whilst I understand that [Patient]’s belief is genuinely held, at no stage did I intend to convey such a message. Without reservation, I apologise to [Patient] for the unintended outcome of my remarks.” In fact there are many good examples of doctors who take the opportunity to express apologies to the complainant in terms which acknowledge the event in question as well as the upset caused to the complainant: “I am sorry that this lady found the whole process upsetting and that she feels angry and I understand completely that the process is upsetting and can make her angry”; and “I am aware that this matter was a source of distress to [Patient] and has caused upset to the complainant. This of course, was never my intention and for that, I am truly sorry”. One doctor also expressed an apology to the medical profession - “I wish to apologise unreservedly for this lapse in judgement. I have let the medical profession, myself and my family down. I can only emphasize how genuinely sorry I am and I will never repeat this again.”

Other apologies however may be viewed as more conditional, expressing regret if their behaviour caused offence “Unfortunately whatever happened cannot be undone, nevertheless I would like to make a sincere apology if my words or actions at any stage hurt the feelings of the patient or her relatives”; or offering a form of apology while at the same time appearing to dispute the complainant’s version of events “If this was the case, I again must apologise. However, I find this highly unlikely as my team would be present on [Ward] on a daily basis and would have made every effort to meet members of the family on request.”

7. Effect of complaint on doctors

A number of doctors in their response to the complaint made against them took the opportunity to express the effect that the complaint had on them and their families. These ranged from distress and anxiety, to shock and disappointment, and concern about negative publicity.

i. Emotional reaction

The most frequently expressed reaction was upset or distress e.g. “[Doctor] is also deeply hurt by this allegation”, and “[Patient] implies lewdness and sexually inappropriate behaviour on my part which has greatly upset me”, or “I was dismayed to read the letter of complaint to the Medical Council, and found it to be very upsetting, untrue and offensive”.

In addition to distress, many doctors express their shock and disappointment at receiving the complaint e.g. “I would never abuse my role as a doctor and I find [Patient] allegation shocking and very hurtful”, and “I was very happy for her when I found that the baby was healthy but I felt disappointed and upset that she found something improper in my conducting the examination.” Some doctors are mystified by the complaint and find it difficult to understand, particularly where they are of the view that the patient has misunderstood their actions or comments, for example

“[Patient] complaint has occupied my waking thoughts almost constantly since I received it from the Council. I have been trying to work out how [Patient] could possibly have misconstrued my words and actions almost from beginning to end and made such a series of allegations of seductive, lewd and inappropriate behaviour from the moment I encountered her in my waiting room...”

A small number of doctors also expressed concern about the effect of negative publicity arising out of the complaint. For example “The allegations made against me are extremely damaging to my reputation. [Patient] allegation have had a very serious impact on my reputation and the entire situation is extremely embarrassing” and “It must be stressed that the experience of other doctors has been a devastating blow to their public reputations and careers where the Medical Council has embarked on a public hearing of allegations which have been determined to be unfounded and untrue.”

ii. Challenges in medical practice

In their responses doctors sometimes referred to the challenges they face on a daily basis in their practice in order to explain or at least put in context their management of the patient. These challenges most frequently refer to the management and communication of uncertainty, dealing

with patients' families, heavy workloads and lack of time, rationing of resources, and deference to senior clinicians.

The practice of medicine is described by Gawande²³ as "an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals". He refers to the gap between what doctors know and what they aim for as complicating everything they do. This is reflected in some of the complaints we analysed. For example, in a case where it was alleged that the doctor confused a trapped nerve with a broken hip, the doctor stated "It seemed to me that [Patient] may have been suffering pain as a result of irritation of the nerve roots coming from the L1/L2 area of her lumbar spine. It was not possible to make an exact diagnosis and I therefore referred her for an x-ray and physio." In other cases the doctor states that his diagnosis of the patient was reasonable based on the presentation of symptoms and the information available at the time but that the symptoms subsequently changed or deteriorated, e.g. a doctor diagnosed the patient's pain as muscular in origin in circumstances where she was subsequently admitted to hospital with a subarachnoid haemorrhage. The doctor explained

"As an illness develops, the patient can get persistent or worsening symptoms, and a potentially serious illness may often be diagnosed only by repeated medical examination over time. That is why I told [Patient] the likely diagnosis of pain of muscular origin. I advised, as is my custom and practice, that if her symptoms persisted or worsened she should also get further medical attention with her own GP."

Doctors can sometimes experience difficulties in dealing with patients' families, either due to conflict within the family e.g. "a major and dangerous interfamily feud which has been going on between the for the past three years and is presently at boiling point"; a complaint submitted by a family member without the patient's knowledge or consent e.g. "I discussed the letter of complaint with them. They reported that the complaint was made without their knowledge or consent. I explained that all patients are entitled to change doctor as they wish. Both [Patient and Family Member] are adamant that they are very pleased with our care and have no wish to change doctor at present"; or the challenges of treating a minor whose parents are in dispute regarding contraceptive treatment for her e.g. "I decided that, in [Patient] best interests, I should arrange a consultation with her on her own and, immediately thereafter, meet with her parents jointly. I was anxious to gain rapport with [Patient] and to obtain her trust". Another issue that can arise here

²³ Atul Gawande, *Complications: A Surgeon's Notes on an Imperfect Science* (Picador 2002)

relates to confidentiality where family members make enquiries about the diagnosis or management of the patient's condition. This can cause conflict with the doctor who correctly refuses to provide such information without the consent of the patient e.g. "I did take a call from [Patient]'s brother. However, I explained that I did not have [Patient]'s consent to discuss his medical details and I asked if he would put his concerns in writing in order that I could discuss them with [Patient] and [Partner] at the next outpatient appointment."

In other cases doctors state that they have been harassed or bullied by family members who try to insist on specific treatments or medication for the patient. A striking example of this is a case in which the complainant alleged that her dying husband was attended at home by a doctor who behaved in an "unprofessional high handed, uncaring and downright wrong manner" in refusing to provide appropriate pain relief. In her response the doctor states

"I was bullied by this family, I have been in practise for [no. of years] both here and abroad and never have I been subjected to such behaviour in front of a dying patient. They tried to determine how this patient should be managed and did not allow the doctor or nurse who has vast experience in this fields do their job in an appropriate manner."

Another challenging issue for doctors, particularly GPs, relates to patients who become abusive or aggressive. This has also been referred to earlier. The management of the professional relationship can become strained in these circumstances, leading to a breakdown in trust and the ending of the relationship in a hostile or confrontational manner. The patient's alleged aggression can affect the doctor him/herself e.g. "The incident upset me because it was uncalled for and although I kept calm I felt very upset and my heart was thumping. I sat quietly for a while and recovered. I felt that I had been verbally attacked unfairly and I was humiliated in front of my patients and staff", as well as other staff at the GPs practice e.g. "She has advised me that she was shocked at [Patient]'s behavior towards her, which she found to be aggressive and intimidating and on my return to the Practice, following leave, I received a complaint about this issue from our practice Receptionist, on grounds that she believed her health and safety to have been compromised by [Patient]'s behavior and attitude." This is an area in which the Medical Council could consider providing further guidance to practitioners.

Other challenges for doctors may involve heavy workloads e.g. "I am working in a Unit of [a number] Consultants delivering over [a number] women per annum. It is my practice to see as many as possible at the first Ante-Natal visit. With this work load it is not possible to see Ante-Natal patients for multiple visits personally and I do rely on junior Doctors in this regard"; insufficient time to meet patients and their families "It is important also to understand that I may have up to [a number]

patients under my care at any one time, and that I also depend on my team at times to communicate both with patients and their relatives”; pressure caused by the necessity to ration resources e.g. “While [Patient]’s clinical condition was still very significant and debilitating from her perspective it was not irreversible or permanently blinding and In terms of clinical priority I was unable to justify expediting her surgery ahead of these cases”; and the difficulty in explaining to patients that their requests for specific examinations or treatments may not be met. This can be particularly difficult where the patient is also a medical practitioner, for example

“I told [Doctor] that I would do a physical neurological examination on her. She interrupted me during this multiple times, saying that she wanted to be seen directly by a neurology registrar and get the MRI. I tried to explain to her several times in different ways that the access to an urgent MRI scan is limited (especially at the period of year) and that I needed to see if she fitted conditions for it, otherwise she might well be managed as an outpatient. It seemed that she didn't want to accept that she had to be seen by me first and not "just call" the neurology registrar. She told me that: "you are just an A&E doctor. I know how it works, for you the only important thing is to make this trolley clear."

8. Conclusion:

This qualitative content analysis of 100 case files has enabled us to provide rich and detailed descriptions of complainants’ concerns and doctors’ responses to those concerns. A key advantage of this form of qualitative analysis is that it can highlight a broad range of issues which can then form the basis of the development of revised or new guidance for doctors. However, this method necessarily fragments the story of the complaint and therefore it is important to combine this analysis with a narrative analysis of a number of selected cases to give a more in-depth insight into the key themes that have emerged from the analysis such as the importance of listening and communicating in appropriate language, dealing with families, bridging the experiential gap between doctors and patients, the management of uncertainty and the appropriateness of touch in a clinical context. This will be addressed in the next chapter.

Chapter Four - Narrative analysis of selected cases

Introduction

In this chapter we present a narrative analysis of four cases that were included in the sample of 100 case files used for the qualitative content analysis. This provides more in-depth insight into some of the key issues that emerged from that first phase of the analysis of case files. Furthermore, it offers a detailed consideration of the varying ways in which the complainants and doctors perceive and narrate the events that are the focus of the complaints. The lessons afforded by each case for the Medical Council are noted.

More so than in other jurisdictions such as the United Kingdom, a significant proportion of complaints received by the Medical Council are submitted on behalf of patients by family members. As will be seen below, two of the cases presented here address challenges that can arise in responding to complaints submitted by family members about medical care provided to elderly relatives, specifically in regard their concerns about the prescribing of medicines and poor follow-up communication. Two other cases provide insights into instances where family members challenge doctors' diagnostic authority and complain about the doctors in question not heeding their definitions of the family members' medical needs. Similar to many complaints received by the Medical Council which relate stories of considerable emotional distress, these two cases concern family members' requests for pain relief for a dying patient from an out-of-hours doctor service and for a GP to secure an involuntary psychiatric admission of a violent relative.

Case 1

Dealing with patients' families and their concerns about the prescribing of medicines

What is illustrated by this case?

This case refers to a pattern of behaviour over a number of years rather than one particular incident. It is of interest here because it highlights the extent to which patients and their families have become increasingly more knowledgeable about their health care, treatment options and medications and the way in which this 'lay' knowledge is sometimes used to challenge professional practice. It also illustrates the complex and sometimes difficult family situations with which medical practitioners have to deal from time to time.

Contents of the complaint file

This file contains a single letter of complaint and two letters from the medical practitioner. The letter of complaint is 1 ½ pages in length, is clearly and succinctly written, describes the issues of concern and sets out the complainant's expectation that the practitioner will receive a warning about the conduct complained of.

What happened?

The allegation relates to the long-term prescription of sleeping tablets and blood pressure medication to the complainant's mother. The complainant is concerned at the ready recourse to medication without providing his mother with advice and recommendations for lifestyle improvements, leading to the patient 'becoming too dependent on prescription drugs, and as a result not making any serious attempts to improve diet and lifestyle'. The complainant alleges that the patient's family has noticed a change in their mother's behaviour where she has become 'more irrational, impatient, irritable and depressed'. They did some research on the drugs in question and found that it was advised that patients should not be prescribed these drugs for more than two weeks. The complainant alleges that the patient has been prescribed sleeping tablets for over five years and is addicted to them to the extent that she will become agitated if there is a suggestion that she might do without them. 'For example, when I found out how long she had been taking them and suggested she quit, she became irrational and angry and wouldn't listen to my advice.' This alleged dependency is also described as affecting her social life with the patient refusing to stay anywhere overnight without the tablets – 'There have also been occasions when she would be at a relative's house but would never stay the night as she would become anxious and panicked and want to go

home to take her drugs. On other occasions, where she does decide to stay overnight I have been asked to deliver her drugs to her. If I could not or would not, she would have to come home.'

The complainant also alleges that the patient has been prescribed blood pressure medication although her readings are normal and she has not been given useful advice about lifestyle, diet or exercise which could improve her health and lower her blood pressure naturally. The complainant expressed these concerns to the GP and the patient was sent for a counselling session but this was an isolated event and the prescribing practice remained unaltered.

The complainant says he 'would at least expect Dr A to receive a warning and be made aware of how her willingness to prescribe drugs is not always the best course of action to take, though it may be the easiest.' He alleges that Dr A's practice is too busy with the result that 'too many patients equals an over stretched doctor which leads to a need for quick solutions and hence the issuing of prescriptions.' He refers to his mother as a 'direct victim' of this situation.

In the first letter of response, Dr A mentions that she has been treating the complainant's mother for almost ten years and the complainant himself no longer resides in Ireland. Dr A states that she met with the patient and her husband to discuss the complaint and they reported that the complaint was made without their knowledge or consent. They were 'adamant that they are very pleased with our care and have no wish to change doctor at present. In fact, they wished to distance themselves from the complaint and apologised.' Dr A. declined to provide further medical information without the patient's consent and also defended the allegation regarding the busy nature of the practice by saying that 'the surgeries are often busy and sometimes delayed by medical emergencies or complex problems that require extra time.'

In the second response to the Medical Council, Dr A summarises and attaches the patient's medical records. She describes the patient's difficulties with insomnia, the lifestyle measures that were advised and the reason for the prescription of sleeping tablets. Dr A also discusses difficult family circumstances and the stress which affected the patient over a period of years and her advice to attend counselling to deal with those issues. The patient did attend one session of counselling but subsequently refused to attend any further sessions as they were 'not for her'. The patient 'absolutely insists that her prescribed sleeping tablet...suits her great, helps her to sleep and assists her to cope with reported family stress. She has no wish at present to stop the medication.'

In relation to the allegation regarding blood pressure medication, Dr A refers to the medical records which show her advice regarding exercise, weight loss, avoidance of salt and blood pressure monitoring. The patient's blood pressure was regularly monitored according to the medical records.

Dr A states that the patient has a stressful family situation and appears not to have discussed with the complainant the various advices received from Dr A. She states that the patient 'is a competent, independent adult free to choose to follow or decline medical advice. While family support is always welcome, [she] has the same rights to medical confidentiality and autonomy as any other patient.'

Why did it happen?

Causal links

The causal links made by the complainant and the doctor differ significantly. The complainant asserts there is a causal link between the 'sharp decrease' in his mother's 'moods and behaviours' and the doctor's prescribing practices. Shifting from concern about doctors' in general overprescribing medications to concern specifically about his mother's treatment, he notes 'Though I know this is common practise I cannot understand the rationale behind this, especially when my mother has been given no useful information on diet or exercise which could help lower her blood pressure naturally and give her an overall improvement in health.' In turn, the complainant suggests a causal link between the doctor's poor prescribing behaviour, which he describes as resorting to 'easy prescription drug solutions', to 'the way in which Dr. A's practice is run and operated'. He offers the opinion that 'she has way too many patients' and consequently 'does not have enough time to properly assess a patient's physical and mental health in the time she allows for each patient'.

In contrast, the doctor makes a causal link between her patient's poor mental health and family stress, noting that 'Over the years, Mrs. F1 has continued to present and request night sedation to assist her coping with Family Stress'. Other health problems too she suggests 'appear to be closely related to what is undoubtedly a stressful family situation'. In further contrast to the complainant's narrative, the doctor asserts that the medications she has prescribed to the patient have resulted in improvements in her health. She notes that the patient 'reported that she found the [night sedation] treatment beneficial'. Furthermore, noting that she also prescribes regular medications for the patient for hypertension, hypothyroidism and gout, she adds that 'These three other conditions have responded well to ongoing treatment ...' The assertion that the prescribed medications have been successful treatments is repeated in the doctor's response where she states 'Mrs. F1's most recent blood test results from August 2012 are *great* with normal liver and kidney function, normal fasting glucose, normal full blood count, normal thyroid levels on her current prescribed dose of Eltroxin, *excellent* gout prevention with a serum Urate level of 358 umol/l (target level less than 360.1 umol/l) [emphasis added]'.

Evidence

The complainant and the doctor mobilise very different kinds of evidence to support the veracity of their stories. The complainant's main form of evidence are his and his family member's observations of their mother's health over time, for example, stating 'I became interested in these drugs when I and other family members noticed a sharp decrease in my mother's moods and behaviours. Starting over a year ago, she gradually became more irrational, impatient, irritable and depressed'. Similarly, as evidence of his mother's addiction to sleeping pills he cites his observations of family occasions when his mother refused to stay overnight with relatives because 'she would become anxious and panicked and want to go home to take her drugs'. Experiential knowledge of the practice with an 'over stretched doctor' is also mobilised: 'I have direct experience of what goes on'. A more formalised form of evidence in support of the allegation about the doctor's poor prescribing behaviour is also presented, namely the advice on a pill container that it 'should be taken for no longer than two weeks and should never to be considered for long term use'.

A key form of evidence presented by the doctor is her clinical notes. In the opening paragraph of the second letter of response she states 'I have enclosed a typed transcript of the original handwritten contemporaneous clinical records to facilitate interpretation.' In refutation of the allegation that she did not discuss lifestyle changes with the patient she refers the reader 'to my Clinical Notes of January 8th 2008 which records "I advise exercise and weight loss, avoid salt and to check Blood Pressure one month later."' Emphasising that such advice is standard practice, she also states that '*Of course*, we continue to encourage her to adopt lifestyle strategies to cope with stress' [emphasis added]. As noted above, the patient's own reports of health benefits, along with blood test results are the forms of evidence presented by the doctor to support the claim that the medications she has prescribed have been successful.

Identities

The complainant presents himself as acting 'on behalf of my mother'. This identity however is challenged by the doctor who explains that the patient and her husband 'reported that the complaint was made without their knowledge or consent' and that 'they wished to distance themselves from the complaint and apologised'. The doctor constructs herself as a professional running busy but 'receptive, inclusive practice', welcoming of concerned family members 'given the patient's consent'. She formally denies any misconduct and / or poor professional performance.

Inherent morality

The letter of complaint concludes with the statement 'A good doctor who is over stretched inevitably becomes a bad doctor, providing quick fixes rather than long term solutions'. In this statement and elsewhere in the letter, the complainant explicitly indicates that for him a good doctor is one who has adequate time for thorough patient consultations but also one who prioritises offering advice on lifestyle approaches over the prescribing of pharmaceuticals. This interpretation of what constitutes a good doctor is also evident in the doctor's two letters of response, the first of which notes that 'We endeavour to adhere to best practice guidelines at all times with all patients'. In her implicit assertions that she is a good doctor, the doctor repeatedly notes the non-medical measures she discussed with the patient, e.g. 'We discussed lifestyle measures to improve health'. Furthermore, noting the date when the patient is next due to attend a consultation she adds 'This will include, *as always*, assessment of her mental and physical health plus review of medication and blood test results. [emphasis added]'. A further feature of what constitutes a good doctor implicit in the doctor's responses is responsiveness to patients' wishes in regard to medication. Regarding her prescribing of night sedation, she reports that 'Mrs. F1 absolutely insists that her prescribed sleeping tablet Zolpidem (Stilnoct) 10mg nocte suits her great, helps her to sleep and assists her to cope with reported Family Stress. She has no wish at present to stop the medication.'

Comment

This case demonstrates how medical practitioners are expected not only to be competent and careful in relation to treatment regimens such as prescribing, but are also expected to navigate challenging family relationships while at the same time prioritising the best interests of the patient. It also shows the extent to which family members of a patient can become concerned about the care of an elderly parent, demonstrating not only their anxiety to become involved in decision-making for the parent (even those who have full capacity, as in this case), but also the ease with which they seek to become knowledgeable about their parent's condition and are comfortable and articulate in expressing their concerns. **The management of family relationships might benefit from further guidance by the Medical Council.**

A final point of concern here might be the extent to which Dr A appears to defer to the patient's autonomy in relation to her on-going use of sleeping pills. The challenge in a case such as this is to balance autonomy with other ethical considerations such as beneficence. The patient may well wish to continue with these tablets due to a dependency problem, in which case it may be argued that Dr

A should prioritise her best interests by attempting other measures to wean her off these tablets rather than continuing to prescribe them indefinitely simply because the patient wants them.

Case 2

Dealing with patients' families and their concerns about poor communication

What is illustrated by this case?

This case refers to a single incident of lack of communication which led to a patient experiencing anxiety, distress and loss of confidence. The case is of interest as it illuminates how an episode such as this can cause a patient to feel embarrassed and insignificant but also because of the open and honest manner of the doctor's response to the complaint.

Contents of the complaint file

The file contains a letter of complaint from the patient's daughter, a response from the medical practitioner, and a further letter from the patient's daughter. The letter of complaint is clearly and succinctly written, describing the cause of concern and seeking an acknowledgement that the patient was poorly treated by the practitioner. She also seeks a refund of her consultation fee of €120.

What happened?

The complaint relates to a patient who was seen by Dr A at a private clinic in relation to cataracts in her eye. Having conducted the examination, Dr A advised that the patient would require to be assessed for her suitability for general anaesthetic to ensure she remained still during the procedure to correct the cataract. He advised that he would get in touch with the anaesthetist in question and an appointment would be made within two weeks. The patient paid €120 consultation fee and did not express any concern relating to the consultation itself. However, the patient was not subsequently contacted in relation to the appointment and made numerous telephone calls to Dr A's secretary and was "met with various different reasons as to why no appointment had been made." The patient's sight deteriorated and she became anxious, upset and unable to leave the house. She was prescribed anti-depressants by her GP as a result. The GP also wrote to Dr A to explain the deterioration in the patient's sight but did not receive any response. "At this point we stopped calling as it became clear that we were not going to get any response and it was only causing more distress as time went on." The patient "lost all confidence in Dr A and we all felt that his lack of response meant that he did not want to take her as a patient." As a result, the patient attended a public clinic and was told she would have to wait for 12 months for the procedure or go to a different private consultant. The patient did go on to have the procedure successfully carried out by another consultant.

The impact of this poor communication on the patient is described by her daughter as having caused “totally unnecessary stress and anxiety”. The patient “felt embarrassed and insignificant” and “her quality of life was seriously compromised as a direct result.” The complainant feels that “there should be a professional responsibility on doctors and consultants to keep patients informed of progress with their case and it is totally unacceptable to treat any patient the way my mother was treated.” She goes on to say “Courtesy is widely expected across all professions and so I would hope that it is highlighted to Dr A as being a significant element of patient care, especially when dealing with more vulnerable elderly patients.” She seeks an acknowledgement from Dr A that the patient was poorly treated by him and also seeks a refund of the consultation fee.

In his response Dr A fully acknowledges and apologises for the distress caused to the patient, explains the circumstances, describes how he has made changes in his practice as a result, and offers to refund the consultation fee. His letter is long and comprehensive in dealing with the complaint in detail. He begins with an apology – “The first thing that I wish to say is how sorry I am to learn of the distress which is expressed in the letter...I wish to absolutely apologise to [the patient] for the circumstance in which [she] was treated.” He goes on to say that he understands and entirely agrees with the sentiments expressed in the letter of complaint and confirms the details of the consultation he had with the patient as described in the letter of complaint. Dr A explains the system in place at the relevant hospital in relation to operating lists and that there was a backlog of 145 retinal cases presenting with permanent and irreversible vision threatening disease that had to be dealt with due to the retirement of a colleague. He explains that all cases are treated according to need irrespective of whether they are public or private and that “while [the patient’s] clinical condition was still very significant and debilitating from her perspective, it was not irreversible or permanently blinding and in terms of clinical priority I was unable to justify expediting her surgery ahead of these cases.” He also explains other factors such as the curtailment of theatre availability, the unexpected closure of theatres on two occasions as cost containment measures and for building works. Dr A explains that had he known that his surgical access was going to be so severely curtailed he would have suggested to the patient at the initial consultation that she might have sought treatment from another surgeon. He states that he did not receive any letter from the patient’s GP as alleged.

Dr A accepts entirely that his secretaries may not have clearly explained these circumstances to the patient and apologises for any misunderstanding. He says he can “entirely appreciate how [the patient] may have felt helpless or that she was being dismissed or ‘fobbed off’ under the circumstance.” He apologises for not contacting her directly, which he explains by reference to his embarrassment at not being able to get her into hospital and concern that he would have upset her

further. “However, I now believe that I should have personally phoned [the patient] and her daughter to at least apologise for the lack of progress and that I was unable to deliver on what was initially expected, at least that way some of the distress may have been allayed, and I now sincerely apologise for not doing so and particularly given what I now learn from the [letter of complaint] and how frustrating, distressing and disappointing it was for [the patient].” He goes on to explain how things might have been handled differently and that he has agreed with his secretaries a new system for communicating with patients in such circumstances, and to send a written progress update to patients. He has no difficulty refunding the fee and is happy to hear that the patient has had the procedure carried out with an excellent result.

The final letter from the complainant in response to the doctor’s letter states that she is “very happy to see such a thorough response” from Dr A. She is glad that Dr A has made changes in relation to communication with patients and they accept Dr A’s apology and his good wishes towards the patient.

Why did it happen?

Causal links

In the original letter of complaint, the complainant makes a causal link between the doctor’s inaction and the severe distress experienced by her mother. She states that she feels her mother was ‘caused totally unnecessary stress and anxiety as a result of the inaction of Dr. A’. His inaction resulted in her being ‘unable to leave the house unaccompanied as her sight had deteriorated so much’ and in her being prescribed ‘an anti depressant to help with the anxiety she was experiencing’. Efforts to establish the reason for the delay in receiving notification of the promised appointment with the anaesthetist were abandoned because they were ‘only causing more distress’. Crucial to the complainant’s story is a further causal link that attributes the doctor’s inaction to his decision that he did not want to treat the patient. The complainant relates ‘we all felt that his lack of response meant that he did not want to take [the complainant’s mother] as a patient’.

In his response the doctor fully acknowledges that his inaction has caused distress to the patient and that he ‘agree[s] entirely with the sentiments expressed’ in the letter of complaint. However, his explanation of the cause of this inaction is very different to that found in the complaint. Amongst the number of reasons given by the doctor were ‘a more Formalised new system of Preoperative Anaesthetic Assessment Unit was in the initial phases of development at UM but this process had not been completed or finalised yet’ and that he ‘had expected my emergency work load to be lighter’. Highlighting the link between staffing and delays in medical treatment he notes ‘Up until

May 2011 I was the only retinal surgeon in the [name of region] attending to a population of near 1 million.’ In a similar vein, he points to the ‘difficulties’ arising from the closure of ophthalmic operating theatres for “‘cost containment purposes’”. In contrast the conclusion reached by the complainant that the doctor did not want to treat the patient, he explains that he did not contact her ‘possibly because of a combination of my embarrassment for my inability to get her into hospital and concern I would have just inflamed the situation or upset her event further, as I still remained in a position where I could not offer her surgery’.

Further correspondence from the complainant indicates her acceptance of the doctor’s explanation of the cause of his inaction and that ‘the problem’ was ‘mainly related to theatre time’.

Evidence

Personal recollections are the main form of evidence presented by the complainant. The gravity and veracity of the grievance relating to the doctor’s inaction is however reinforced by references to the patient’s GP. The complainant describes how the GP prescribed an antidepressant to assist the patient cope with the distress caused by the delay and that she wrote to the doctor who is the focus of the complaint ‘asking what the delay was and explaining how [the patient] was deteriorating.’

The doctor also draws on personal recollections, and additionally, information provided by his secretary. For example, he notes ‘my secretary informed me that [the patient] had indicated that unless a date was sorted the following couple of weeks she would be seeking treatment elsewhere’. Furthermore, reference is made to documentary evidence in the form of the ‘surgical log book data [which] demonstrates that there were 145 retinal cases presenting with permanent and irretrievable vision threatening diseases requiring surgical procedural intervention between [date] and the end of August.’

Identities

In the original letter of complaint the doctor is constructed as being unprofessional because he has failed in his ‘professional responsibility ...to keep patients informed of progress with their case’ and because of his lack of courtesy, which the complainant deems ‘a significant element of patient care, especially when dealing with more vulnerable elderly patients’. Acknowledging that ‘things could have been handled differently’ and expressing regret that he did not make personal contact the patient, in his response the doctor cast himself as a medical professional working within a healthcare system experiencing many ‘difficulties’. These difficulties, such as staff shortages and ‘cost containment’ measures, combined with a ‘constant stream of urgent cases’, are presented as

resulting in him being an embarrassed doctor, embarrassed because of his 'inability to get [the patient] into hospital'.

Inherent morality

Embedded in the complaint is the belief that doctors have a moral obligation to be courteous to their patients, especially 'more vulnerable elderly patients', and to keep them 'informed of progress with their case'. Courtesy is identified as being 'widely expected across all professions' and as 'a significant element of patient care'. The doctor's apology suggests that even when doctors such as himself are frustrated in their efforts to provide medical treatments to their patients because of limited healthcare resources, they should keep them apprised of the situation.

Comment:

This case demonstrates how important communication is with patients, not only in relation to the obvious issues around their diagnosis and treatment options, but also in relation to referrals, scheduling surgical procedures, hospital admissions and other 'administrative' matters. Patients may become confused, distressed and anxious at the lack of communication regarding the progress of their care which may result in stress and depression as well as physical deterioration in their condition. The patient and her daughter experienced the lack of communication in this case as a sign of discourtesy, disrespect and a lack of professionalism.

The response from the medical practitioner in this case provides a good example of the importance of listening to the patient's concerns, acknowledging and admitting the truth of the facts underpinning those concerns where appropriate, explaining why the incident occurred and what has been done to prevent its recurrence, and apologising for the patient's poor experience. The case illustrates very effectively the application of the **principles of honest and open disclosure**, which is advocated in the Medical Council's Guide, and exemplifies the value of such an approach in addressing the concerns raised. The final letter from the complainant shows her satisfaction at her concerns having been heard and acknowledged and the changes brought about in the doctor's practice as a result.

Case 3

Dealing with patients' families and their definitions of medical needs (in the context of out-of-hours services and palliative care)

What is illustrated by this case?

This case highlights a marked gap in perception or experience between the wife of a dying patient and the doctor who called to the house in answer to a request for assistance. The experience as described by the complainant is completely at variance with the recollection of the incident by the doctor and given the lack of corroboration on either side, this demonstrates the difficulties inherent in the function of the Council in investigating such complaints. A further point of significance in this case is the fact that the doctor in question was called as part of an Out of Hours service and therefore was not familiar with this patient or his family on the evening in question. This case demonstrates the difficulties for patients and families as well as doctors in such circumstances, particularly where, as here, the patient in question was near death and the family were experiencing grief and stress at the time of the alleged incident.

Contents of the complaint file

This file contains a lengthy letter of complaint, observations and comments from the doctor, and a further letter of response from the complainant.

What happened?

Ms C begins her letter by saying that she wishes to complain 'in the strongest terms' the conduct of Dr A who treated her husband and Ms C herself in 'a most unprofessional high handed, uncaring and downright wrong manner.' Ms C explains that her husband was in the 'final stages of his life having being diagnosed with Cancer and he was taken home to have his final time with us.' She explained that her husband needed regular pain relief and that on the day in question, after the night nurse had left at 7am, her husband was in pain and 'getting very agitated' so she followed the nurse's advice and rang the out of hours service to ask for someone to call and give her husband some medication. Ms C states that at 9.10 am the doctor returned the call and 'refused to come in stating that she had spoken to the homecare team and someone was calling between 1 & 2 pm and she would call after that.' The complainant says that she told the doctor that this 'was not good enough' as her husband was in pain. She alleges that the doctor replied, 'I have other things to do and people to see and I will call after the nurse has been'. The complainant says that she told the doctor that her

husband was dying but the doctor reiterated that she would be out after the nurse has been and 'then HUNG UP THE PHONE'.[sic]

The complainant relayed the conversation to her daughters and son who were at their father's bedside and she says they 'were all very distressed at her attitude.' They were also trying to comfort the patient who 'was aware of all that was going on as the phone was next to his bed. He is bound to be aware that no extra pain relief is coming yet.'

The complainant alleges that at 10.10am Dr A arrived and did not even look at the patient as she passed his bed when she entered the house. Ms C says that she apologised to Dr A for being so abrupt on the phone 'but as she could see my husband was in pain, she did not answer me.' Dr A asked about what medication the patient was receiving and looked at his medical notes. The complainant alleges that Dr A then said, in front of the patient, 'if you think I am going to give him something to kill him, you are mistaken' and left the house. The complainant says that the family was in 'disbelief' as they had not asked her to kill the patient, rather to give him pain relief. The complainant says 'How dare she ignore my husband's needs at this time.'

The complainant was very distressed and rang another health professional who called at 11.10am and administered the pain relief, 'three long hours' after the first telephone call. At 3pm the patient again became agitated but the morphine driver successfully alleviated his pain so there was no requirement for the doctor to call. At 7pm the patient was again in pain and the complainant contacted the out of hours service. The nurse 'asked if I realised that this was the final stage and it would not be long now before it would be all over. I told her I didn't, but had guessed as much. She said that the doctor would give him something for the secretions to ease him and she expressed her sympathy to me and my family.' When Dr A arrived, the complainant alleges that she asked why a nurse was not present as she had been told a nurse was in the house. Ms C asked that something be given to the patient for secretions and Dr A injected the patient and left the house having said 'I'll leave you in peace then' on the way out. The complainant was in disbelief that this was the extent of the assistance Dr A intended to provide and says 'It was surreal, what happens now?' She alleges that the secretions never eased and that the patient died at 8.40pm. The family called the out of hours service to call in order to pronounce death but they requested that Dr A not be sent to the house. The complainant alleges that she checked the drugs box in the house and is satisfied that no drugs were used by Dr A to alleviate the patient's secretions; she alleges that Dr A must have administered a saline solution as the patient's symptoms did not change and Dr A did not sign any records or drug administration sheets to indicate that the patient had been given any medication.

The complainant says that she and her family are 'traumatised by the unnecessary suffering' that Dr A put the patient through. She says that she hopes that one day Dr A 'will be in the same situation' as the complainant's husband and that she will 'get a 'doctor' like we had, on her death bed', that 'her family have to see her suffer the way she let [my husband] suffer, and not be able to help ourselves.' She hopes that she will see what Ms C's husband saw and heard 'as he lay dying'. She says that 'words cannot ease pain that was her responsibility as she was the doctor on CALL.' [sic]

The complainant acknowledges that she is angry towards Dr A – 'I can't grieve for my husband, I can't let go. The anger towards that woman is eating me up.' She goes on to say that 'The anger is too great for grief, and when I get this scenario sorted out, then maybe I will be able to grieve for [my husband].' She has sought help from her GP 'as I have felt very upset, angry and traumatised by the manner in which the events unfolded on the day that my husband passed away. I don't believe my husband was attended to in a timely manner and his symptoms were not even alleviated when the doctor attended to him on the date in question. Her attitude to me and my family beggars belief and I continue to have ongoing treatment from my GP.' She wishes to have this matter investigated in full by the Council.

Dr A responds that she was on call with the out-of-hours service when a call was received to see this patient. She called a hospice nurse for information on the patient and was advised that the patient was at max on medication via pump and SC and that she had seen the patient at least 3 times in the previous 24 hrs. She went to the house and examined the patient 'who was obviously dying and was not responding to any stimuli.' She says that she explained to the family that the patient was sedated and did not need any more medication. She says the family 'were not happy with this so I reluctantly gave hyoscine im to patient.' Dr A says she was called back to the house 3-4 times but as the out of hours service was very busy with urgent calls she only went back to the house twice. She alleges that each time she went to the house she was 'intimidated to give medication, in fact I was bullied.' She says that 'the patient was mottled and dying and I was told by a person there (whose friend was ambulance personnel) that the medication would do him no harm; I advised I did not want to be the person to end this patient's life.' On the next occasion she saw the patient she gave him more Hyoscine not morphine as she felt that if she gave him morphine and 'he died on the spot there would be a very different complaint at this stage.' She states that 'the patient was never disrespected and I was respectful to the family but would not do their bidding. I explained my situation and reluctance to give any more medication to the patient. I would never disrespect a

patient and never have but I resent being bullied into giving inappropriate medication to a patient even a dying one.'

In conclusion Dr A says that she 'was bullied by this family, I have been in practise for the 30 yrs both here and abroad and never have I been subjected to such behaviour in front of a dying patient. They tried to determine how this patient should be managed and did not allow the doctor or nurse who has vast experience in this field do their job in an appropriate manner.' She acknowledges that their perception of events differs and that the complainants 'perception of events I cannot change but they are nothing like my recollection.'

A further letter from the complainant relates a number of other unrelated allegations of professional misconduct or poor professional performance in relation to Dr A. She concludes that 'as a bereavement counsellor myself, I have never come across the likes of what my late husband, I and my family experienced on that day. I hope no one else ever has to either.'

Why did it happen?

Causal links

The complainant asserts that the doctor's conduct caused her and her children to be 'very distressed' and 'traumatised by all this unnecessary suffering that she put [her husband] through.' By failing to attend to him 'in a timely manner' and administer the pain relief the complainant regarded her husband as needing, 'she ignore[d] my husband's needs' and 'let my [husband] suffer'. In addition to causing unnecessary suffering to the dying man, what is perceived as the doctor's harsh and uncaring manner and misinterpretation of the request for pain relief ('we hadn't asked her to kill [him]') caused considerable anguish to members of the family. In subsequent correspondence from the complainant she reports that she had been referred by a bereavement counsellor to her GP 'for query PTSD'. A causal link is also made by the complainant between 'what happened on the day he died' and her inability to grieve. Her anger towards the doctor that is preventing her from grieving is intensified by the occurrence of 'the events [that] unfolded on the day my husband passed away' in the family home. As reported by the complainant 'she came into MY HOUSE and did all that to him.'

These causal links are disputed by the doctor, as is the family members' identification of the patient's need for pain relief. Key to the doctor's narrative is the assertion that 'he was sedated and did not need any more medication'. In her description of how the family challenged the authority of her professional judgement the doctor states 'They tried to determine how this patient should be

managed and did not allow the doctor or nurse who has vast experience in this fields (sic) do their job in an appropriate manner.’ From her perspective, the bullying and intimidating behaviour of the family caused her to administer medicine when in her professional assessment none was required: ‘so I reluctantly gave hysocine im (sic) to patient’. She records that she ‘resent[s] being bullied into giving inappropriate medication to a patient even a dying one’.

Evidence

The complainant’s recollections are the main form of evidence enlisted in this complaint and twice these are referred to as the ‘facts’ of the incident. Running to over 2,000 words the complainant’s lengthy description of what happened provides a time line of events on the day her husband died, from 12.35am up to his death at 8.40pm. Professional endorsement of the complaint is presented as further evidence: the complaint includes the postscript ‘A complaint was sent via [name of our-of-hours service] by myself and my GP.’ In subsequent correspondence from the complainant, further endorsement of her complaint by others is presented, such as an account of a conversation with a local pharmacist who ‘commiserated’ and said the doctor ‘has a bad reputation and this is well known in the area’.

The doctor also relies on recollections as the key form of evidence, and acknowledges that her recollections differ from those of the complainant and her family: ‘Their perception of events I cannot change but they are nothing like my recollection’. Additionally, she draws on her many years of experience of working as a doctor to support her allegation of having been bullied by the family: ‘I was bullied by this family, I have been in practice for the 30 yrs both here and abroad and never have I been subjected to such behaviour in front of a dying patient.’ In subsequent correspondence the complainant mirrors this claim saying ‘As a bereavement counsellor myself, I have never come across the likes of what my later husband, I and my family experienced on that day.’

Identities

In the original letter of complaint the construction of the identity of the doctor as a ‘high handed’ and ‘uncaring’ professional who failed in her responsibility to ease a dying man’s suffering (‘words cannot ease pain that was her responsibility as she was the doctor on CALL’) is reinforced by the contrast in how her and the family members’ behaviour is described. While the doctor ‘did not even look at’ the patient when she first visited the house, the letter of complaint provides a poignant account of family members singing favourite songs to the dying man and holding his hand. The complainant describes how for ‘four months I never left him, I saw to his every need, looked after him day and night, even sleeping on the floor next to his bed when they took him to X Hospital to

give me respite.’ This is then contrasted with the uncaring approach of the doctor who ‘came into MY HOUSE and did all that to him.’

In her response the doctor casts herself as a busy out-of-hours doctor who has to respond to multiple urgent demands: ‘The car which does house calls was busy at this time of day covering a large area (all of County) and we had urgent calls which need attention.’ Furthermore, she asserts that while she is a respectful practitioner, she is guided by her professional knowledge and experience rather than the demands of patients’ families: ‘The patient was never disrespected and I was respectful to the family but would not do their bidding.’

Inherent morality

In the opening sentences of the letter of complaint the complainant records that she believes she and her deceased husband ‘were dealt with in a most unprofessional high handed, uncaring and down right wrong manner’. The wrongs that she accuses the doctor of committing include that she ‘ignored’ her husband’s need for pain relief (as identified by the family) and also her uncaring behaviour such as she ‘HUNG UP THE PHONE’ and communication with family members that left them in ‘disbelief’. Implicitly it is suggested that a ‘right’ manner entails heeding family members’ identifications of patients’ needs and compassionate interaction and communication with them.

An implicit morality is also evident in the subsequent correspondence from the complaint. She reports that having discussed with a neighbour another alleged incident of poor professional performance on the part of the doctor, when she suggested making a complaint ‘the reply I got was no as nothing would be done, as you all stick together’. The suggestion here is that medical professionals collude in each other’s poor performance thereby nullifying complaints processes.

The doctor’s letter of response makes implicit reference to the ethical quandaries that can face doctors, particularly in palliative medicine. Despite pressure from the family to administer pain relief she reports ‘I felt if I gave morphine and he died on the spot there would be a very different complaint at this stage’.

Comment

This case demonstrates the stress and grief that can accompany the death of a patient at home. The patient’s family may feel isolated, frightened and helpless in the face of the pain and distress experienced by their loved one. The facts of this case illustrate the frustration and anxiety felt by the patient’s family as they tried to alleviate his symptoms. This was exacerbated by an unfamiliar doctor who arrived to their home without, as they saw it, knowledge of the patient’s situation and

medication requirements. Their attempt to summarise and address the patient's needs were perceived by the doctor who was unfamiliar with the patient and his family, as an attempt to bully her into prescribing medication which, in her opinion, was not required by the patient.

Even if the doctor did feel herself to be bullied and/or intimidated in the situation in question, the issue arises as to whether a different form of communication with the family might have been preferable to explain more clearly the symptoms the patient was experiencing, where those symptoms lay on a trajectory of the dying process and what the family might expect to see over the following hours. **Dealing with dying patients and their families requires considerable communication skills and empathy and doctors owe a duty of care in this context to ensure that the patient dies with as much comfort and dignity as possible and that the family is supported through the dying process.** Although these matters are already addressed in the Guide to Professional Conduct and Ethics, the Council might consider using this case as a learning tool in its newsletter to doctors to further highlight the challenges in this area and how to apply the guidance to best effect.

Case 4

Dealing with patients' families and their definitions of medical needs (in the context of psychiatry)

What is illustrated by this case?

This case refers to a single incident involving a consultation between a family and a GP in relation to the safety of the elderly parents of the family. It is of interest in highlighting the difficult challenges faced by doctors in navigating family dynamics and trying to act in the best interests of different members of a family when these may be in conflict. It also raises issues in relation to confidentiality and the different understandings and expectations that families have in relation to that context.

Contents of the complaint file

The file contains four letters from the complainants and two letters from the medical practitioner. The letters are clearly and succinctly written describing the incident in question and the expectation of the complainants that the Medical Council will act to prevent such an incident occurring again in the future to any other person.

What happened?

This case arises out of an incident in which the complainants, who are the adult daughters of elderly parents, allege that their parents GP treated them in an unprofessional manner during a consultation. The complainants had made an appointment to speak with the GP on the recommendation of a member of an Garda Síochána due to their fears for the parents' safety. This arises from the fact that the complainants' brother 'has a troubled history including several prison terms. In recent times he has become more irrational and experiences violent episodes, of which, sadly our parents, among others seem to be the victims.'" Their father had previously been assaulted by their brother and they also expressed concern for their brother's mental health. They were accompanied to the consultation by a social worker.

The complainants explained that having expressed their concerns to the GP, who had treated their parents for 40 years, 'his initial attitude was one of not only disinterest but blatant condescension.[sic] He sat with arms folded in a belligerent manner and looked us up and down as if we were beneath contempt. He offered no advice or indeed did he ask any questions.' The complainants allege that when they stated that they were afraid that their brother might hurt someone, a member of the family, a stranger, or perhaps even the GP himself, 'he smugly informed us that he didn't need to worry that he was very quick on his feet and had not one but two panic buzzers, one of which is connected directly to the Garda Barracks.' The complainants state that while

this may offer security to the doctor, it offered no comfort to them in relation to their elderly parents who are not as agile and are helpless in the face of an attack.

The complainants allege that the doctor was 'callous and unprofessional' when they asked what could be done to prevent a tragedy. They allege that the doctor replied that nothing could be done. Further, when one of the complainants asked 'what will it take, one of my parents in a body bag?' before he would do something he replied 'exactly'. During the visit, on suggestion from the complainants, the GP rang their brother's consultant psychiatrist and 'laughed and chatted about this situation in front of us.' The complainants said that their parents were prepared to have their son 'sectioned' i.e. detained under the Mental Health Act, but the doctor informed them that if that were to occur he would be released straight away as in his doctor's opinion 'he was bad not mad.'

The complainants state that they were 'appalled by his attitude' and have been in touch with other authorities in order to protect their parents, including securing a protection order from the court. They have also changed the locks on the house and booked their parents into temporary accommodation for their protection. They say that their 'very real concern' is for other vulnerable people who seek help from this doctor that 'he will treat them with such a cavalier attitude.' They dread to think 'how he would of treated our elderly parents if we had not been present.' [sic.] They say they have a sense of having discharged a moral duty by writing to the Medical Council and 'How you act on receipt of this letter is of course up, to you, but our conscience is now clear that we have informed you that the GP may have issues that need addressing.'

In the first letter of response from the doctor he opens by saying that 'It is always a matter of great regret when a patient or relative is further distressed in the course of a consultation. I cannot accept however the complaints made against me and refute them absolutely.' He acknowledges that the complainants attended him regarding concerns about the 'violent and abusive behaviour of their brother' who was also a patient of this GP. He says that they sought to have their brother detained under the Mental Health Act but that the GP explained that he would have to be examined first and if found not to be committable, could not be sectioned or detained under the Act. He also says that he 'cautioned them that a failed attempt at committal might negatively impact on the prevailing domestic situation.' He says that he asked them to encourage their brother to attend the surgery for consultation and that it was in this context that he explained that he had adequate security in place to protect himself and others. He also explained to the family that the psychiatrist treating their brother did not consider that he was suffering from a mental disorder that could justify his committal. During the consultation he telephoned the psychiatrist who confirmed this view and says that although it may have appeared that the telephone conversation was 'light hearted', this 'must

be taken in the context of both Dr 1 and myself being familiar with the patient and the limits that now exist in regard to compulsory committal.' He acknowledges that he said that there was 'nothing medical' that could be done and when the complainants said 'It would take one of their parents to be in a body bag' the doctor says that 'it was in acceptance of my inability to produce a medical solution that I said "exactly".'

The doctor says he understands the frustration the family felt due to their lack of familiarity with committal procedures and mental health law, and he understands that 'they might perceive my lack of not being able to afford their parents protection by medical means as inaction on my part.' He says he regrets that they 'perceive my attitude as one of indifference and condescension when in fact what they were seeing was my frustration at not being able to help them resolve their situation.' He concludes by advising that the parents and the complainants' brother continue to be patients of his practice notwithstanding this incident.

A further letter was submitted by the complainants in response to the doctor's observations and comments in which they say they 'were not surprised by his comments, indeed it was what was expected. We did not expect him to admit he had behaved in an unprofessional, dismissive and condescending manner.' They also allege that 'there is a tendency for professionals to close ranks when one of their colleagues has a complaint made against them' but that independent verification of what transpired at this consultation could be sought from the social worker who was also in attendance. They say that they found her to be of an 'honest, trustworthy, caring nature and we believe she is a woman of integrity.'

A further letter from the complainants indicates that the Council did in fact seek verification from the social worker in question and that this correspondence was copied to the complainants. They say that they were 'disappointed that she did not emphasise in her report the extent of the outrage, dismay and disbelief that she felt and indeed expressed to us on the day in question' but that they 'fully understand the impossible position she is in and as such bear her no ill will.' They are of the view however, that the Medical Council is not in a similar position as the social worker and as 'the authority responsible for overseeing professional standards' should have no such concerns. As the social worker had stated in her report that she found Dr. A's tone and language to be 'dismissive and indeed very unhelpful for this family' and as she had also used the phrase 'negative impact' in relation to how the family was treated, the complainants say they expect the Council 'to take action'. They allege that the social worker's report supports their claim that they were treated in a 'poor professional manner.' They ask 'is this really an acceptable way for a patient and/or his family

to be treated by a health care professional?’ They conclude by stating that they expect the doctor to be disciplined accordingly.

The PPC decided that there was not a prima facie case on which to hold an inquiry into this doctor’s fitness to practise. Following communication of this decision to the complainants they wrote a final letter to the Council in which they stated that this was ‘sadly what we had been expecting.’ They suggest that if the PPC found the doctor’s conduct to be acceptable and within the guidelines, then they ‘respectfully suggest’ that ‘perhaps it is time the guidelines were reviewed, improved and vigorously implemented in order to protect the vulnerable people in our society.’ They conclude by advising that they feel they have done their duty by bringing to the attention of the Council ‘a person whom we feel is not fit to practice’ and that ‘the decision not to take this matter further is now on your conscience.’

Why did it happen?

Causal links

From the perspective of the complainants, a consequence of what they perceive as the doctor’s inaction is that the welfare and even the lives of their parents and others are being put at risk. Emphasising his ‘inability to produce a medical solution’ to the problem of their brother’s violent behaviour, the doctor rejects this causal link. These differing causal links are underpinned by contrasting interpretations of the brother’s need for medical intervention. Implicit in the complainants’ story is a challenge to the doctor’s diagnostic authority: for them, their brother’s ‘need for medical intervention’ and for being ‘sectioned’ is clearly apparent. However, asserting his professional authority to diagnose, the doctor records that he explained to the complainants that their brother would have to be examined by him and that ‘if I found him to be normal on examination or not suffering from a committable condition at the time that there would be no grounds for me committing him’. In a further assertion of his and other medical professionals’ diagnostic authority the doctor notes that ‘I pointed out that ... [he] does not suffer from a committable condition’. The doctor states that he understands why ‘they might perceive my lack of not being able to afford their parents protection by medical means as inaction on my part’, but again rejects this perception stressing that the ‘appropriate course of action was legal rather than medical’. Furthermore, the doctor attributes the complainants’ failure to appreciate this ‘appropriate course of action’ and their frustration to their lack of knowledge of mental health policy

and law: 'they would not necessarily be aware of the current position re committal procedures and the strict laws applying to personal committal'.

Subsequent correspondence from the complainants, however, emphasises that these different perceptions of their 'brother's mental health is not the issue here, but [the doctor's] attitude.' In this regard too, we can see different causal links being made in the complainants' and the doctor's accounts. The complainants' attribute the doctor's alleged poor professional performance to his 'cavalier attitude' and 'belligerent manner'. Yet again, the doctor notes that he understands the complainants' view but asserts they were mistaken. His manner during the consultation was not caused by 'indifference and condescension' but by 'my frustration at not being able to help them resolve their situation'.

Evidence

In this case, both the complainants and the doctor appeal to evidence in the form of endorsement by other professionals to enhance the credibility of their stories. The doctor describes how in the course of the consultation he contacted the complainants' brother's psychiatrist who endorsed his diagnosis that their brother 'was not mentally ill in a way that would allow him to accept him as a non-voluntary patient'.

The complainants suggest that if the Medical Council wishes to have their complaint about the doctor's attitude 'verified by an independent witness' that the social worker who accompanied them to the consultation should be contacted. They acknowledge the 'tendency for professionals to close ranks' in the context of complaints being made against them, but indicate that the social worker would be unlikely to succumb to this tendency because they found her to be 'a woman of integrity'. However, subsequently, having received a copy of the social worker's response to the Medical Council's request for her comments and observations, the complainants state they are 'disappointed that she not emphasise ...the extent of the outrage, dismay and disbelief that she felt and indeed expressed to us on the day'. But they go on to say they 'fully understand the impossible position she is in and as such bear her no ill will'. Though not to the extent they expected, they note that the social worker's professional endorsement of their story, including that the doctor's tone and language was 'dismissive' and 'unhelpful', 'supports our claim that we were treated in a poor professional manner'.

Identities

In their story, the complainants cast themselves as concerned family members doing everything they possibly can to 'prevent a tragedy' but who have been 'treated in a poor professional manner'. Asserting that they have acted morally, in the first and last of their letters to the Medical Council they note that having submitted a complaint about the doctor who they deem unfit to practise, their 'conscience is now clear'. Having received notification of the PPC's decision not to refer their complaint to the Fitness to Practise Committee, a decision that was 'sadly what we had been expecting', they note the decision is 'now on your [the Medical Council's] conscience'.

In refuting the complainants' allegations, the doctor casts himself as a frustrated but patient and caring doctor. Acknowledging his frustration 'at not being able to help them resolve their situation', the doctor nonetheless reports that the duration of consultation was in excess of thirty minutes, during which time he 'explained', 'cautioned', 'suggested' and 'pointed out' to the complainants why he acted as he did. Acknowledging indirectly the challenges facing doctors treating family members whose interests may collide, he modestly states 'We continue to strive to meet their medical needs to the best of our ability.'

Inherent morality

Ideas about what constitutes a good professional inherent in the complainants' narrative can be discerned in the part of the story about the evidence provided by the social worker. Using the military metaphor of 'closing ranks', the complainants claim there is a tendency for professions to collude in the poor professional practice of others when a complaint is made against them. However, they expected the social worker would not participate in such collusion because they found her to be of an 'honest, trustworthy, caring nature' and 'a woman of integrity'. While suggesting that individual professionals have a moral obligation not to participate in collusion, they nonetheless accept that what they perceive as the social workers' somewhat self-censored endorsement of their story was a consequence of her being in an 'impossible position'.

Comment

This case demonstrates the expectations that patients and their families have of their general practitioners not only in relation to their technical or clinical competence but also in terms of their loyalty and advocacy for their patients. This can place doctors in a potentially difficult situation where, as in this case, the interests of different members of a family collide. The doctor in this case was expected by the complainants to take some form of action to protect their parents even if this resulted in the detention of their brother. On the other hand, the doctor must also have regard to

the fact that their brother was a patient of his and therefore a person whose best interests he had to prioritise. This collision of interests is particularly marked in circumstances in which there are fears for the safety and wellbeing of all family members involved.

A further challenge in this case, though not one that is explicitly referred to in the correspondence, is the fine line to be taken by a doctor in such circumstances in relation to respect for the confidentiality of all of his patients. While he would be at liberty to listen and take account of the concerns of the family members in relation to their parents and brother, a doctor would not be in a position to discuss the diagnosis and prognosis of their brother without his consent unless the doctor felt the breach of confidentiality came within one of the exceptions set out in the Guide to Professional Conduct and Ethics. The letters do not indicate that any reflection or discussion about confidentiality took place at the consultation with this family or indeed subsequently.

The lessons to be learned from this incident relate not only to the need for further guidance to be given to doctors in relation to management of families as patients and the expectation of loyalty and advocacy that many patients have, but also primarily about good communication. The doctor in this case acknowledged that some of his communication during this incident was borne out of his own inability to provide a solution to the concerns raised by the family, however a more empathetic and compassionate approach to the family's fear and anxiety might have helped their understanding of the limitations of the legal process in play here and might have prevented their perception of the doctor as being 'callous' and 'unprofessional'. **Further guidance from the Council in relation to good communication, empathy, and dealing with families might be helpful in this regard.**

Chapter Five - Themes and Recommendations

1. Introduction

Arising from the content analysis of complaints which has been described in Chapter 3 and the narrative analysis of selected cases in Chapter 4, this chapter suggests areas or themes which might be considered by the Council for revision of the Guide to Professional Conduct and Ethics, or for the inclusion of new guidance and/or enhanced training. These suggestions, (in bold font), are based on the causes of concern which have most frequently arisen in the complaints analysed during this project or those that are highlighted in the cases selected for narrative analysis.

Our analysis has also provided evidence of particular concern in relation to misdiagnosis, inadequate clinical examinations and misprescribing. The Medical Council has a statutory role in approving programmes of medical education and training and specifying standards for the maintenance of professional competence. The three areas above which featured most strongly in our analysis of complaints warrant particular focus in this context.

2. Communication and valuing knowledgeable patients

Issues regarding communication arose in many complaints such as those which related to an absence of communication e.g. where an elderly patient became confused, distressed and anxious at the lack of communication regarding a hospital appointment, which resulted in stress, depression and exacerbation of her symptoms (case 2 Chapter 4). Other examples of this contained in Chapter 3 include 'We were kept in the dark as to what was the problem with [Patient]' to poor communication 'Why would he not be more sensitive with the information he was giving me?', and allegations of rudeness and aggression 'On my first encounter with him as an inpatient he was so rude to me I asked for a nurse to be present for his second visit to my bedside, when he asked why, I told him he was rude the first time, he threw an absolute wobbler, screaming and roaring, despite cancer patients being on the ward and he reduced me to tears.' Doctors also themselves acknowledge in their responses the challenges in communicating their own uncertainty about diagnosis and treatment. This echoes comments from Gawande, surgeon and author, who says "The story of medicine is the story of how we deal with the incompleteness of our knowledge and the

fallibility of our skills”.²⁴ These complaints and responses provide evidence that **further efforts must be made to ensure that medical practitioners receive adequate education and training regarding effective communication skills and further professional guidance regarding good communication.**

Sometimes patients complain about doctors’ rudeness, bad manners or lack of courtesy, being deprived of dignity, feeling humiliated, and insulted. This can arise from the manner or tone of the doctor’ communication and can result in the patient feeling disrespected e.g. one complainant alleged that when she went to visit her GP he said “‘Look at my computer, what do you see, your name, all the way down. You can't just call in here any time you feel like it I have other patients you know and have more to do than dealing with people like you. I hope I don't see you for a very long time. In fact, why don't you go elsewhere.” After which he held the door open for me to leave.’ Such an interaction can be very distressing to some patients who can feel belittled e.g. ‘I just felt railroaded, a nuisance — would I please just go away. I was very surprised that my doctor didn't see me to explain my results and medication and treatment. I was still in shock which happens to people like me who are normally very fit. I wasn't being a nuisance; I was asking to be looked after.’ In light of these complaints **the Council might consider the inclusion in the revised Guide to Professional Conduct and Ethics of a provision requiring doctors to treat patients with courtesy and politeness.**

Another illustration of patients feeling disrespected arising out of poor communication is where the patient feels that they were dismissed, not listened to, or ignored. A number of complainants felt that their symptoms were ignored or dismissed e.g. ‘I feel [Doctor] did not listen to me or take any of my complaints seriously... I feel she brushed me off’, and ‘My mother felt that he didn't really think there was anything really wrong with her and he was rather distracted through this consultation and wasn't very interested at all in what my mother was saying.’ This can exacerbate the patient’s distress e.g. ‘this letter has taken me eight months to write as so many times I have started and stopped because it upsets me so much. The trauma could have and should have been avoided if the doctors listened, but unfortunately they just brushed me off and ignored my concerns.’ Effective communication is a two-way process of exchanging information but it necessarily also involves non-verbal communication such as body language and facial expressions, attentive listening, and understanding the emotion behind the information being shared. This is particularly important in health care where the information being shared is often very personal, sensitive and difficult information to relay. It is increasingly widely recognised that actively involved and knowledgeable patients can help to improve their own health experiences and outcomes by feeling confident to ask

²⁴ Atul Gawande, “Why doctors fail” Reith lecture <http://www.theguardian.com/news/2014/dec/02/-sp-why-doctors-fail-reith-lecture-atul-gawande>

their health professional for alternative treatment options; seeking support and advice from a variety of different sources; and contributing experience and new ideas on how to improve medical practice. Therefore **the value of listening to and valuing patient knowledge about their own health is also an important theme that could be further developed in the Guide to Professional Conduct and Ethics which mentions the word 'listen' on just one occasion.**²⁵

In some cases a different form of inappropriate behaviour and/or communication is alleged with complainants stating that comments were made to them which made them distressed or uncomfortable, e.g. 'His reply to this was 'You have beautiful breasts and they are well in proportion with your body' I felt extremely uncomfortable with his remark '; 'He also asked me several times if there was a chance that I was pregnant, did I have sex regularly and if I had a good boyfriend. Then he asked why I didn't have a boyfriend.' A particularly graphic example discusses in crude language the causes of cystitis in a manner which was offensive to the patient. In this particular case the doctor responded by saying 'I appreciate that the nature of the matters set out above can be of a sensitive nature and sometimes explanation of such matters can only be done so in a direct manner that could be considered insensitive. Any distress caused to [Patient] is regretted and was not intended on my part.' This case demonstrates that **although the use of lay language is to be encouraged, it is important that doctors refrain from language that would be considered offensive, derogatory or crude and also refrain from any inappropriate sexual behaviour.**

Aligned to complaints regarding poor or absent communication, many complainants expressed concerns about not being kept informed about their condition or prognosis. For example a woman who had previously had a child with Down's Syndrome was distressed at not having been told about the possible cause of this condition until she was pregnant with a second child. She says 'At no time was my husband or I ever made aware that my son's Down Syndrome could have been caused by a [genetic factor] as suspected in [Doctor] letter to [Other Doctor]. To discover this information during another pregnancy was devastating to both my husband and me...I feel that [Doctor] had a duty of care to me as her patient and I feel very let down by her and her inaction in communicating such vital information to me.' **The relationship between patients and doctors is based on trust and confidence; the Council should consider strengthening its guidance in relation to the process of ongoing communication of information to patients regarding the management of their own health care and information regarding reproductive decision-making where relevant.**

²⁵ For example, the GMC advises doctors as follows: 'You must listen to patients, take account of their views, and respond honestly to their questions.' http://www.gmc-uk.org/guidance/good_medical_practice/communicate_effectively.asp

A further aspect of good communication relates to how doctors respond to concerns raised by patients. Some complainants have described their attempts to raise their concerns with the medical practitioner but without success – ‘I have tried to contact [Doctor] but she has chosen not to reply’. This has caused further upset and frustration in many cases with the result that the complainant has sent a letter to the Medical Council e.g. ‘He refuses to answer my emails or letters, I have no option but to go down this road to get answers! I have been left very frustrated and depressed due to his lack of care and professionalism’ ; ‘we have been shoved from pillar to post and as of today... we still have no answers to why this GP got it so wrong and has left our son so sick.’ Those who have managed to get a response from the doctor are not always satisfied with the manner of the response, particularly where the doctor blames a systems failure as this is seen as an attempt to avoid personal responsibility e.g. ‘[Doctor]’s simplistic comment in his response that an ‘administrative systems failure’ in his office is to blame for his failure to read or seek the results of an investigation he personally requested, is both insulting and belittling to [Patient]’s memory and her grieving family’.

On the other hand, where doctors respond in an open and apologetic manner to patients, this is usually appreciated by complainants. A good example of this is seen in the following extract from a response from a doctor ‘The first thing that I wish to say is that how sorry I am to learn of the distress which is expressed in the letter by [Family member] in relation to her mother [Patient]. I wish to absolutely apologise to [Patient] for the circumstance in which [Patient] was treated and for my inability to address her eye problem in a time frame that was initially hoped for and expected.’ This response was well received by the complainant who said ‘I was happy to see such a thorough response from [Doctor] regarding our complaint... we would like to accept [Doctor] apology. We appreciate his good wishes towards my mother and look forward to receiving our refunded consultation fee.’ This case demonstrates a thorough and sincere response by the doctor with the result that the complainant felt that her concerns had been listened to, acknowledged and appropriately dealt with. **The Council could consider providing additional guidance to doctors in relation to responding to concerns raised by patients in a manner that enables local resolution of the issues without recourse to legal or professional regulatory bodies. In many cases this would serve both the interests of the doctors and patients in resolving matters that do not raise issues of clinical competence or fitness to practise as the latter may require investigation by the Council in the public interest.**

3. Dealing with families

Many of the complaints which raise concern in relation to poor or absent communication have been submitted by family members, usually spouses and children, of patients who have had serious debilitating conditions or patients who have died. This raises a significant issue in terms of communication with families of patients and the extent to which doctors are perceived by families as having a responsibility not only to the patient but also to the patient's family. Examples of the distress and frustration experienced by families in this context include: 'When did [Doctor] intend informing the family of much crucial and critical news?'; 'Any effort to clarify the situation with your team was very difficult for us, due to the unavailability for the most part of any member to meet us. At no point were we offered an opportunity to speak with you'; 'We were never informed of these changes or the importance of same'; and 'I was in constant touch with him and met him at the hospital also, at no time did he tell me my sister's life was in danger.'

In some cases the patient's family has complained about being given false hope e.g. 'At this point the family left in good spirits. Any worries we seemed to have were addressed and reassurances were given. We informed [Patient] of the good news. I feel this was very unfair. It was bad enough giving the family false hope let alone [Patient] herself. Almost 6 hours later, [Patient] was resuscitated and died the following day', or in some cases being left completely in the dark about the likelihood of the patient's death. E.g. 'We feel that the level of care you provided for Dad falls very far short in many ways, not least from a humane point of view, and from a practical point of view, in preparing us as a family for what we were about to face.'

The complainants do not mention issues of patient consent or confidentiality as it is often assumed by family members that the patient would have no objection to their medical information being shared with their loved ones. This may not however be the case for every patient and cannot be predicted. This is illustrated by case 4 in Chapter 4 where the interests of family members concerned about the safety of their elderly parents collided with the interests of another family member who was a patient of the same doctor. The challenge this raises for doctors is to be able to ethically negotiate the boundaries of communication with the patient and his/her family. **Further guidance should be given to doctors in relation to good communication, empathy, confidentiality and dealing sensitively with families in such situations.**

Case 3 in Chapter 4 demonstrates the stress and grief that families may experience when a loved one is dying. Families may be fearful and unprepared for the death, they may feel isolated

particularly if the person is dying at home, and they may feel helpless in the face of the worsening condition of the person who is dying. Dealing with dying patients and their families requires considerable and specific communication skills and empathy and it is important to strike an appropriate balance between caring for the patient and sensitively preparing a family for what lies ahead. **Communicating with families is an area which could benefit from further exploration in the Ethical Guide.**²⁶

4. Discrimination or bias

Some complainants alleged that they were discriminated against on grounds of age, sexual orientation, race, disability, mental health diagnoses, and the fact that they were public patients.

It might be of benefit to practitioners to further develop the guidance in the Ethical Guide in relation to treating all patients equally and with respect for their dignity.

A number of complaints were submitted by patients with psychiatric disorders who complained that their diagnosis or treatment was incorrect or inappropriate, or that they were the victims of discrimination. These cases demonstrate the difficulty in assessing complaints in this context and the importance of ensuring that there is no bias against such complainants on the grounds of their psychiatric condition. **The Medical Council should consider what further guidance it can give to doctors treating persons with psychiatric disorders to ensure as far as possible that their rights, interests and expectations are met in the same way as all other patients. The Council might also consider further training for members of the PCC and FTPC in relation to ‘hearing’ complaints from persons with psychiatric disorders to ensure that these complaints are accorded due legitimacy and credibility. Such training might benefit from collaboration with patients, advocacy groups and the Mental Health Commission.**

²⁶ The General Medical Council advises in its guidance to doctors that ‘You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.’ http://www.gmc-uk.org/guidance/good_medical_practice/communicate_effectively.asp

5. Compassion / empathy

In addition to clinical competence, patients also generally expect medical practitioners to demonstrate compassion and empathy for their situation. This is demonstrated in a case where the complainant was distressed that her GP did not call to find out how her young baby was doing after an incident in which the baby had been admitted to hospital with a query of meningitis 'I know [Doctor] did not want to harm my baby but why did she not even ring on Monday to see how she was. She did know what happened because the hospital had contacted her.' This shows that some patients expect doctors not only to be technically competent clinicians but also to be caring, attentive, humane and compassionate in their dealings with patients.

A further example is seen in a case where the complainant had sought a house call for pain relief for her husband who was dying 'she replied, "I have other things to do and people to see and I will call after the nurse has been", I answered "but my husband is dying" and she reiterated that she would be out after the nurse has been and then HUNG UP THE PHONE.' The lack of empathy perceived by complainants can be interpreted as lack of care or arrogance e.g. '[Doctor] demonstrated an arrogance that suggests that he does not possess the necessary empathy or thoroughness of a clinician in his position... He appears to have lost the essential level of empathy required to practise as a consultant.' **The Council might consider reflecting and further advising doctors on the different aspects of competence, incorporating not only clinical and technical knowledge and application of skill, but also normative behaviours such as compassion, empathy, listening skills and good communicative abilities.**

6. Context-specific guidance

Our research provides evidence that complaints may be more likely to arise in certain medical contexts more than others, and that certain types of complaint may be more likely to arise within the context of certain medical specialities. This suggests that context-specific guidance to doctors may be required in areas such as psychiatry, cosmetic surgery and obstetrics. Concerns about the provision of care in locum and out-of-hours contexts has also featured strongly in the complaints and should be considered for further guidance to medical practitioners.

7. Medical Council procedures

Our analysis demonstrates that complainants have varying levels of communicative capacity, formal education, and “medical and regulatory literacy”. Efforts should be made to avoid privileging complaints that “speak the language” of the Council, such as those submitted by solicitors or other health professionals, over those that use a more informal style of communication. Consideration might be given by the Council to whether complainants might be offered additional assistance and support in making a complaint, either in-house from the Council itself or by referral to a patient advocacy group.

Both complainants and doctors raised concerns regarding the Medical Council’s management of complaints. In cases where the PPC decided not to hold an inquiry some complainants expressed their disappointment at the outcome but stated that they were not surprised e.g. ‘I am very disappointed, but not surprised, with the decision that has been made’ and ‘Your comments, observations and decision were sadly what we had been expecting.’ Others found the decision incomprehensible and queried the basis upon which the decision had been made:

‘Given that the Medical Council’s only response to my request, that they give an explanation as to how they reached their decision, was to send [Doctor]’s reply - the only conclusion which can be drawn is that no investigation was carried out or indeed attempted. The Medical Council made no attempt to understand (or investigate), for example, why [Patient]’s INR deteriorated so rapidly within days or in fact what was the cause of her acute symptoms and therefore the cause of her premature demise and then draw conclusion as to whether or not the treatment she received was appropriate or even just adequate. Given the content of the complaint raised I find it almost incomprehensible that the Medical Council didn’t consult [Patient]’s hospital notes or indeed the hospital staff prior to reaching a conclusion.’

Questions were raised by complainants about the decision-making process and the procedure by which an expert is sought to assess the competence or conduct of the practitioner complained about. ‘I raised questions over the medical council asking someone so close to the person I am complaining about [Doctor], I see that in other cases the medical council asked experts from abroad. Can you tell me why this was not the case here, especially since I requested it.’

Complainants sometimes state that they have an expectation that their complaint will be dealt with in a particular way e.g. ‘We trust that the Medical Council, whose mission statement claims to *‘protect the public by promoting and better ensuring high standards of professional conduct and*

professional education, training and competence among doctors' will ensure that [Doctor]'s errors will be investigated thoroughly and fairly in order that the poor standard of his current practice will be improved and be brought into line with those high standards expected of a consultant of his alleged status.' For this reason, they react with disappointment and frustration when their complaint does not proceed to an inquiry e.g. 'I accept that the Medical Council has stated that they intend to take no further action in respect to this matter but I still, nonetheless, wish to express my complete dismay and antipathy at the Medical Council's approach to, and handling of, this matter.' As a consequence they may question the rationale for the PPC's decision e.g. 'I am somewhat confused by the Medical Council's remark (in the aforementioned letter) that my correspondence of [date] *"did not contain any additional information that would warrant reconsideration of its original opinion..."*. I was not seeking to provide additional information: I was pointing out the Medical Council's obligation, under its own code of ethics and moral conduct to provide an honest and open communication and explanation of how it reached its decision.'

Some complainants question the fairness of the Council's handling of the matter by seeking observations and comments from the doctor e.g.' It seems very clear, to me, from [Doctor]'s response, that the Medical Council's approach was to ask [Doctor] if he was in any breach of appropriate standards of medical care and having received his reply that he wasn't, consider the matter closed. To my mind, there is no way that this can be considered an adequate, nor fair, judicial process.' This particular complainant felt that the intercession of the Council was required in order to provide an independent assessment of the matters complained of, and was unhappy with the reliance the complainant felt the Council had placed on the response to the complaint submitted by the doctor ' With all due respect to him, had I felt inclined to accept such an assurance from him alone (and given the circumstances as outlined in the original complaint, I didn't) then I would not have sought the intercession of the Medical Council. It is here that I feel most let down by the Medical Council. They have the means and expertise to draw, independent, conclusion in these matters and in doing so give the family of a deceased patient (under these circumstances) the explanations, conclusions and openness which should be their right to receive.' The complainant concluded 'The medical profession are afforded the unique privilege of *self-regulation* but with privilege comes responsibility and, in this case at least, the Medical Council has failed to adequately execute this responsibility.'

Others allege that there is a public perception that the Council operates through principles of networking and collegiality rather than the public interest e.g. One complainant stated that when he asked others who had been similarly affected by the conduct of a particular doctor whether they

were intending to take any action 'the reply I got was no as nothing would be done, as you all stick together.'

One complainant suggested that the fact that the Council had not proceeded with an inquiry meant that its guidance was in need of revision - 'May we respectfully suggest that if the committee found [Doctor]'s conduct to be acceptable and within the guidelines as detailed in your letter then perhaps it is time the guidelines were reviewed, improved and vigorously implemented in order to protect the vulnerable people in our society.'

A number of complainants raised queries regarding Medical Council procedures e.g. 'let me know if the PPC committee refers to patient's records before they make a decision that there is not a prima facie case for holding an inquiry... Please let me know why I cannot release this information to a third party', and 'I would very much like to know who this email of complaint has been forwarded to.' Allegations are sometimes made about bias of PPC and Council members - 'the PPC have joined the doctors in them aiding and abetting the offenders' and 'I am sure you will get off with this complaint against you as you have a powerful lobby representing you that allows you to act as you do'.

One complainant seeks further information in relation to Council procedures – '[Doctor] states this is the first complaint of its kind against him, can this be confirmed internationally? Is there a robust system in place to track this?' and 'Does the medical council have any procedures/recommendations for situations like this where serious errors occurred and need following up but it is not directly the fault of the Doctor?'

Two complainants sought to appeal the decision of the PPC – 'As I feel that questions I raised regarding my late father's care under [Doctor] have not been addressed or at least the findings made known to me, I wish to know what recourse I have now to acquire this information, and if I have any right to appeal the decision of the PCC' and 'Perhaps you would review your decision in the light of the facts as outlined above.'

Finally, there is a small number of complainants who, despite their unhappiness with the outcome, wish to express their gratitude to the staff at the Medical Council for their help – 'To you personally I would like to say thank you for the courteous and professional manner with which you have assisted with this matter.'

These complaints indicate a level of dissatisfaction with the way in which the PPC makes its decisions not to proceed with an inquiry. While such disappointment and dissatisfaction is to some extent inevitable given the strength of emotion which often motivates complainants, **there may be further**

opportunities here for public awareness and education campaigns to provide clear and accessible explanations as to the remit of the Council and the manner in which it conducts its decision-making in the area of fitness to practise.

In some cases doctors have raised queries in relation to Medical Council procedures such as whether consent has been obtained for release of patient information by the doctor or whether the doctor's response will be sent to the complainant. E.g. 'I am also unsure as to whether it would be appropriate to provide [Patient] with a copy of this letter in which I set out my preliminary response to her recent complaint. therefore urge you to ensure that, before any decision is made to forward this letter or indeed my patient's Clinical Notes to her, the specific advices of her Consultant Psychiatrist, [Doctor], should be sought.' The issue of sending clinical notes to the complainant is one that has arisen in a number of cases e.g. the Council 'should carefully consider whether it is necessary and/or appropriate to provide [Patient] Clinical Notes to her son, particularly as those Notes contain reference to a number of other consultations and issues raised, which appear to have nothing to do with the issues raised by [Family Member]. **The Council might consider providing additional information to complainants and doctors in relation to the legal basis for the procedures used by the Council and an explanation in lay language as to what these procedures entail.**

Doctors have also made submissions either personally or through legal representatives as to why an inquiry should not be held at this time or at all e.g. 'I would respectfully submit that the holding of an enquiry at this juncture would constitute an interference with the administration of justice in the Courts'.