Complaints against psychiatrists: a five year study

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Complaints made against doctors are increasingly important given the current emphasis on consumerism in the National Health Service and the publication of the report of the Wilson Committee which reviews complaints procedures. There have also been recent changes in medical indemnity and increased litigation. The origins of complaints made against psychiatrists were studied. Most complaints were made by relatives and advocates rather than the patients themselves and half were made after the patient was discharged from hospital. It was found that most complaints arose out of a breakdown of communication between psychiatrist and patient.

Few comprehensive studies of complaints made against psychiatrists have been published. In America a review of the National Association of Insurance Commissioners Claims showed that only 0.3% of the 71 788 malpractice claims filed by American physicians between 1974–78 were against psychiatrists. Diagnostic errors, suicide and self injury were the main reasons for claims. Claims resulting from the use of electroconvulsive therapy (ECT) and psychotropic drugs represented 5% and 16% respectively of total psychiatric claims.

Claims in Britain have followed a similar pattern. Psychiatrists are among the greatest users of the medico-legal advisory services of the medical defence organisations but they are not the heaviest users when it comes to claims. Some psychiatric claims are relatively expensive to settle, however, particularly when a patient has suffered head or spinal injury during a suicide attempt (Bradley, 1989). Again, suicide and attempted suicide account for most of the claims and physical treatments account for relatively few. The view of one of the medical defence societies was that many claims arise from alleged breakdowns of communication rather than poor treatment.

Within the Loddon NHS Trust, strong emphasis is placed on dealing with the complaint at the point at which the complaint is made. If a complaint cannot be resolved locally it is then referred on to the complaints counsellor. Complaints can be either written or verbal and can come through a variety of routes, for example from relatives or representative bodies such as the Community Health Council, from local MPs or from the Purchasing Commission. Standards are set for the time of acknowledging receipt of the complaint and for investigating and replying to it. The complaints counsellor is directly accountable to the chief executive for the Trust. The Purchasing Commission monitor achievement of standards for handling of complaints through quarterly reports made to them by the complaints counsellor. If there is dissatisfaction with the response of the complaints counsellor, the complaint can then be referred on to a board of appeal which is formed by the Trust's non-executive directors or to external appeal, for example the Health Service Commissioner. Doctors will be asked to respond in writing when a complaint involves them.

The study

Complaints against psychiatrists in two health districts (Winchester and Basingstoke) made over five years (January 1988 to March 1993) were collected. We extracted information from the confidential file on each complaint including the patient's age, sex, marital status, employment status, legal status, psychiatric diagnosis (ICD–9 World Health Organization, 1978) and whether they were in-patients or out-patients. We also noted the number of complaints made by each complainant and the nature and timing of each complaint, (e.g. early or late in the course of the illness, and whether before or after discharge). We also recorded the subsequent action taken, the speed of reply to a complaint, whether the complaint was withdrawn, and whether

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further action such as litigation was required. Finally, the regional solicitor's office provided information on cases that lead to litigation.

We excluded complaints made against the Winchester Health Authority psychiatric out-patient clinic service because they were not dealt with by the Basingstoke complaints counsellor and relevant records were not available.

Findings

Over the five year study period a total of 47 complaints were made against the two psychiatric services. There were 37 (79%) complaints made by relatives or advocates of the patient concerned and most were received more than two weeks after the index incident occurred. Of these, 21 (51%) were received after the patient was discharged from the ward.

Of the patients 27 (57%) were younger than 65, 25 (53%) were male, and 24 (51%) of the patients were married. The patients' commonest psychiatric diagnosis was of manic depressive illness, occurring in 16 (34%) patients, most of whom were depressed. This was followed closely by schizophrenia (15, 32%), mostly of the paranoid type. The next commonest diagnosis was senile dementia (10, 21%).

There were 25 single complaints, that is, about one aspect of care and involving one professional and the rest were multiple complaints involving several aspects of care and several professionals. This gave a total of 68 specific complaints. A perceived failure to give an adequate explanation of, or information about, treatment or diagnosis was the commonest cause of complaint in 20 (29%). This was followed by complaints regarding the treatment plan while in hospital (18, 26%). Of the remaining complaints, eight were about disputes over timing of discharge or placement of patients on certain wards and seven were about disputes over diagnosis. A further seven concerned perceived insensitive attitude, two disputes over management of patients' affairs, two concerning confusions over appointment times and one complaint about the lack of accessibility of a professional to the patient. There were two complaints about suicide, one about ECT and no complaints about adverse drug effects.

The majority of complaints were against psychiatrists in acute adult services (25, 53%) followed by psychogeriatrics (19, 41%). There were no complaints against psychotherapy, child and adolescent and drug and alcohol services.

Most complaints (37, 78%) were acknowledged within the first month. The complaints counsellor found it easier to investigate complaints where there was accurate documentation of the index incident. Within two months three-quarters of the complaints had been investigated completely and replied to in full. Most of the complaints (40, 82%) were dealt with at first by an explanatory letter. Other initial responses included two formal apologies, two payments in addition to an explanatory letter, and two reviews of procedures. On investigation, there proved to be no basis for three complaints. Six complainants were dissatisfied with the initial explanatory letter and so the complaints counsellor made further investigations and gave a further letter of explanation. None of these complaints proceeded further than this and none went on to litigation.

The regional solicitor's office reported that most of the local legal cases concerning psychiatry were part of the benzodiazepine class actions. The single specific claim handled by the regional solicitor during the period of study arose from alleged negligent use of psychiatric medication.

Comment

Most complaints against psychiatrists were made by relatives and advocates rather than the patients themselves. Many complaints were made after the patient was discharged. This may reflect patients' and relatives' concerns that complaining while patients are still in hospital could cause patients to suffer adversely or prolong the time they are in hospital.

Most of the complaints related to perceived failure of psychiatrists to give adequate explanation regarding treatment or diagnosis or disputes over treatment plans while in hospital. There were relatively few complaints about serious adverse events, such as drug side effects or suicide. The only complaint about ECT concerned disagreement over the clinical need for it, rather than adverse effects arising from it. Two complaints resulting from completed suicide (one of an in-patient, the

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other of an out-patient) resulted in requests for information about the management of and level of observation of the patients concerned.

The study suggests that psychiatrists may reduce the number of complaints against themselves by improving the communication with the patient and relatives with particular attention to the area of diagnosis and treatment. There were a small number of complaints from out-patients and none against child and adolescent, drug and alcohol, or psychotherapy services. This may be because these services are more focused on interpersonal relationships, and allow effective communication within a one-to-one relationship with the therapist.

Responding effectively to complaints can be greatly helped by accurate legible documentation in the medical notes. In our service satisfaction with the complaints procedure was generally high; few complainants requested a further response and none proceeded beyond a second explanation, or went on to an outside agency.

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