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Editorial

Handling of Patients' Complaints

P Y Cheong

Complaints against doctors are always newsworthy. Thus, a ten-year review of complaints in the Accident and Emergency (A&E) Department of a hospital[1] published in this journal in April last year immediately made front-page news in the Straits Times of 1 April 1997, with the head-line "Misdiagnosis and rude doctors cited by patients".

In response, the Singapore Medical Association (SMA) wrote to the Straits Times Forum on 9 April 1997 to point out that the frequency of complaints at 300 per 100,000 attendance needs to be seen in perspective. It is lower than those in other similar studies and comparable to that of the A&E facility at King's College in London. The SMA also observed that such reviews augur well on the maturity and integrity of the healthcare system in Singapore and emphasised the need for both the healthcare profession and society to take a constructive approach on handling complaints.

The SMA hopes that the study of complaints in the Ministry of Health's Family Health Service[2] which is published in this issue (page 390), would be viewed in this same light. The rate of complaints for patients receiving primary outpatient care was low, at 4 per 100,000 attendance. This is understandably a fraction of the figure in the A&E study where patients were in more clinically tense situations.

However beyond numbers, it is constructive to compare the percentages attributable to broad categories of complaints in the A&E study to that of 'justifiable' complaints in the primary healthcare study in order to gain a perspective of the nature of grievances leading to patients' complaints in Singapore. Complaints which raise professional issues such as skills in diagnosis and treatment form about a third of the cases of both studies. Complaints about attitude or conduct of staff and poor communication constitute about half of the cases in primary healthcare study and one-third in the A&E study. Complaints about long waiting time constitute a higher percentage in the A&E study, as is to be expected.

There are therefore three types of complaints viz: (1) on staff-patient relationship; (2) on administrative issues like waiting time that relates to logistics and resources, and (3) on the standard of medical care. We need to pay attention to all three categories of complaints. Complaints concerning the staff-patient relationship such as for example, perceived rudeness and attitude could be tackled proactively. The primary healthcare paper proposes the 'L-I-S-T-E-N' approach, an acronym for a set of skills which can help cultivate or foster better staff-patient communication. This deserves close attention. Healthcare administrators also need to look into the administrative issues which clinicians have no control over.

Complaints alleging malpractice and negligence have other dimensions. The media has often focussed on the plights of patients. It is often forgotten that the doctors complained against are also humans with feelings. The Singapore Chief Justice Yong Pung How cited one such case in a Straits Times report on 13 September 1998, on the occasion of the First Anniversary of the Singapore Mediation Centre. He related the account of a mediated case involving a woman who sued an obstetrician after her baby died soon after birth. Although a goodwill payment was agreed upon in settlement

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without admission of liability, the doctor insisted on expressing his heartfelt regrets against the advice of his counsel. The woman was touched when she saw that the doctor too had suffered emotionally and this helped 'to heal the scars left by the tragedy'.

Complaints can also be used by patients or their relatives for selfish reasons. Doctors are aware that a patient's death may precipitate a formal complaint if there is a background of dissatisfaction. Relatives may more readily complain to assuage feelings of guilt about not having done more for the patient when he/she was still alive. This appeared to be the reason for the attempt by a relative to malign a doctor on the unsubstantiated charge that the doctor refused to give emergency first aid to a distressed patient who died soon after. This case was reported in the SMA News in September 1996[3] as 'Rashomon Redux' – an allusion to the Kurosawa's classic movie that explored seemingly truthful yet contradictory accounts by various interested parties of a rape-cum-murder that was committed.

To the individual doctor, being complained against and waiting for it to be resolved can be a traumatic experience regardless of its outcome. It may permanently affect a doctor's confidence to practise. This experience was described by Dr Jean Edwards[4] in the Journal of the Medical Defence Union. Though vindicated of alleged negligence of inserting an IUCD which later migrated to the abdomen, she recounted that 'sitting in a courtroom and having my professional integrity attacked was one of the most traumatic events of my life and which I hope would never happen again'.

The profession as a whole also needs to be protected against frivolous and malicious complaints that have deleterious effects on the doctor-patient relationship. The British Medical Journal reported on 23 May 1998[5] the plea by the Indian Medical Association (IMA) to amend India's Consumer Protection Act to protect doctors from what it regards as "baseless and frivolous allegations of medical negligence". After a high court ruling made two years ago that medical negligence cases could be heard in consumer courts, IMA estimated that more than 10,000 cases of medical negligence have been filed in the country. However, more than 90% of these cases were subsequently dismissed. The IMA suggested that amendments to the act which would make consumers liable to pay half the amount claimed as compensation if the charges of medical negligence remain unproven.

It is important that the medical profession and administrators are seen to publicly support the doctor where it is clear that a complaint is frivolous and baseless. Only with such actions can doctors feel safe to practise cost-effective medicine and not defensive medicine. Medical associations can play an active role in advising doctors on what is proper behaviour and also stand by doctors who are doing things right. These are the ethos of the Singapore Medical Association's Ethics Committee.

Singapore has developed and refined a hierarchical system of handling complaints within the medical profession. Patients can lodge their complaints at various levels, from senior staff and medical boards of institutions, to independent professional groups such as the Ethics Committee of SMA, and to statutory regulatory bodies such as the Singapore Medical Council. The formal mediation process should probably be increasingly left to the above bodies instead of the law courts, as the process of justice can be extremely stressful for both doctors and patients.

Complaints reflect patients' grievances, real, misdirected or even misconceived. While all complaints have to be taken seriously, there must be appropriate checks and balances. There is a need to protect rights of the individual patient. There is also a need to ensure that doctors can continue to practice good medicine in the wider interests of all patients.

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