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editorials

FEMI OYEBODE

Expressing grievance

The NHS complaints procedure is part of the growing armoury that is being deployed to open up health care delivery systems to scrutiny and to make trusts and clinicians more accountable to the patients they treat and to the public in general. The varying ammunition includes the National Institute for Clinical Excellence (NICE), the Commission for Health Improvement, clinical governance, audit, consultant appraisal, revalidation and assessment and support centres. As Richard Smith (1999) wrote, "many doctors will be wondering how . . . [these] are all intended to fit together". What cannot be gainsaid is that there is little doubt that these new institutions, mechanisms and procedures are intended to address the issue of quality within health care organisations. But there is an understanding that for quality to become what drives, shapes and influences all decisions in the NHS, the culture of this large institution will have to change to embrace this principle. It is envisioned that part of this process, if not the most significant component, is the recognition that the institutional culture must accept the scope for acknowledging and learning from past mistakes (Department of Health, 1998). This idea of an institution learning from and adapting to its environment is fashionably described as the development of learning organisations. It is said that one of the key cultural values of a learning organisation is tolerance of mistakes (Davies & Nutley, 2000). It is within this context that the primacy and importance placed on the complaints process within the NHS must be understood.

Most doctors are more used to the verb 'to complain' being used in relation to an ailment, as in history of presenting complaints. Current usage within the NHS, however, emphasises the sense in which it refers to the expression of a grievance or injustice suffered. It is with this sense in mind that Pitarka-Carcani *et al* (2000, this issue) present the results of their study of complaints about care in a mental health trust. They report that complaints about technical and interpersonal aspects of care, respectively, are equally represented in their sample. They dispel the false assumption that complaints in mental health settings may be unduly influenced by psychosis, and show that it is not a small and deviant group of patients making all the complaints. More important, they report that policies and procedures were altered as a direct result of the investigation of a small but significant number of complaints.

Davies and Nutley (2000) have argued that the simplest, most basic level of learning within organisations (single-loop learning) can be demonstrated when the organisation detects and corrects an error, usually following clinical audit. This level of organisational learning is exemplified in Pitarka-Carcani *et al*'s report (2000, this issue). Davies and Nutley go on to argue that more sophisticated approaches, which include 'double-loop learning' and 'meta-learning', characterise progressive organisations. For example, in double-loop learning, detection of error leads to redefining and revision of an organisation's goals, norms, etc. In such an environment, the complaint process becomes very much part of an integrated system for evaluating the quality of the performance of the institution. The key here is that investigation and resolution of complaints should form part of a system that includes audit, evidence-based practice, life-long learning and patient surveys. Patterns of defects found in analysis of complaints may form the basis of audits or inform educational programmes. More radically, they may come to determine which administrative or clinical systems are reviewed and altered. A complaints process is in fact a belated process, because it is responding to perceived failure. Therefore a system that genuinely inquires from patients, using surveys of their experiences of the health care environment, may provide more useful information. Indeed, regular and systematic patient surveys might act to reduce the use of the current complaints process.

It is important not to understate the impact of complaints on clinicians. In a qualitative study of general practitioners' experiences of patients' complaints, Jain and Ogden (1999) found that some doctors contemplated suicide, some developed doubts about their clinical competence and others had conflicts with family and colleagues. In some doctors these adverse emotional consequences were resolved by a retreat to defensive medical practice and plans to leave general practice, whereas some grew immune to complaints. In a sense, complaints are like grit in an oyster shell, which even though irritating and impure, helps to produce a flawless pearl, or as Baker (1999) put it "every defect is a treasure", although for patients it can be a disaster. The hope is that the analysis of complaints can help to identify the defects in the administrative or clinical systems of care without an undue human cost. In the end it is improvements in the quality of care that we all desire.

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