



Comhairle na nDochtúirí Leighis  
Medical Council



## LISTENING TO COMPLAINTS

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LEARNING FOR GOOD PROFESSIONAL PRACTICE



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## ACKNOWLEDGEMENTS

This report introduces a review of complaints to the Medical Council conducted by Simon O'Hare, Research, Monitoring and Evaluation Manager at the Medical Council of Ireland and by Professor Deirdre Madden, School of Law and Dr Orla O'Donovan, School of Applied Social Science, University College Cork.

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Complaints to the Medical Council are handled by the Preliminary Proceedings Committee and the Fitness to Practise Committee; the role of the current Chairs of these committees, Ms Anne Carrigy and Dr Michael Ryan, together with the former Chairs and the current and former members is acknowledged.

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Finally, this report is based on some 2,000 complaints to the Medical Council. Complaints were made by patients, their families or representatives, and responded to by doctors. Through reviewing complaints and identifying learning for good professional practice, we hope that the public and the medical profession can benefit from these experiences and that the Medical Council can strengthen its role in supporting good professional practice.

## FOREWORD FROM PRESIDENT AND VICE PRESIDENT

Doctors play an essential role in the public's health and wellbeing. Each year in Ireland it is estimated that the average adult consults a GP three times; furthermore, 3-in-10 adults attend a hospital.<sup>1</sup> It is critical that the public experience safe, high quality care from doctors they trust who are engaged in good professional practice.

In general, this is the current situation in Ireland. Previous studies reported by the Medical Council have demonstrated that over 9-in-10 people trust doctors and that 94% of people were satisfied with the care they received from their doctor; furthermore, 9-in-10 people never had an experience with a doctor which led them to consider making a complaint.<sup>2</sup>

While the relationship between the public and doctors in Ireland is generally positive, we cannot take this position for granted. A number of recent high-profile failings of care in Ireland have asked difficult but important questions about how healthcare quality and safety is assured. Sometimes the care which patients experience from their doctors falls short of their expectations, giving them cause for concern and some will make a complaint.

Ron Paterson, former Health and Disability Commissioner in New Zealand noted:

*"Complaints matter: to the people who make them, usually as a last resort after the frustration of trying other avenues without success; to the person complained about, in whom the complaint may provoke a fierce reaction, ranging from shame to indignation; and to the agency required to handle the complaint, charged with resolving a problem when parties' recollections and objectives may be sharply divergent".<sup>3</sup>*

Making a complaint about a doctor is not an easy step for a patient or their family to take. It is important that their voices are listened to and that their concerns are taken seriously. While those making a complaint are interested in understanding their specific experience of care, most see a complaint as a way to identify a problem and to point to learning for the benefit of other patients.<sup>4</sup>

All of us involved in responding to patient's complaints have a duty to meet these expectations if public trust is to be maintained.

A key function of the Medical Council is responding to complaints about doctors through fitness to practise procedures. Through our *Statement of Strategy 2014-2018*, we aim to provide leadership to doctors in enhancing good professional practice in the interests of patient safety. In setting ourselves this aim, we asked how we can provide leadership through our role in responding to complaints. Each year, we report on our handling of complaints about doctors in our Annual Report; however, we have never systematically reviewed complaints to identify what we - and everyone interested in safe, high quality care for patients - can do better. Sir Liam Donaldson, former Chair of the World Health Organisation World Alliance for Patient Safety, pointed to the leadership challenge for all of us who are involved in driving safe, high quality care for patients: *"to err is human; to cover up is unforgivable; and to fail to learn is inexcusable."*<sup>5</sup> Leadership and learning go hand in hand. Learning from complaints is something which those making complaints expect and is in the interest of the public and doctors alike.

*"Listening to Complaints, Learning for Good Professional Practice"* is the first time that the Medical Council has systematically reviewed complaints it has received about doctors so as to identify learning for improvement.

Through this review, which looks at some 2,000 complaints handled over a 5-year period, we have a clearer and more detailed understanding of the complaints received and managed by the Medical Council. It enables us to take better account of the issues which cause particular concern for patients and their families, and the sorts of challenges which doctors face in day-to-day practice. We can link this learning from complaints with our role in supporting good professional practice among doctors so as to address particular areas that would benefit from additional focus.

1 Central Statistics Office, 2010. Health Status and Health Service Utilisation - Quarterly National Household Survey, Q3 2010

2 Medical Council of Ireland, 2014. Talking About Good Professional Practice - views on what it means to be a good doctor.

3 Paterson, R. Not so random: patient complaints and frequent flier" doctors". BMJ Qual Saf 2013; 22: 252-257.

4 P Bark, C Vincent, A Jones, and J Savory. Clinical complaints: a means of improving quality of care. Qual Health Care. 1994 Sep; 3(3): 123-132.

5 Sir Liam Donaldson speaking at the launch of the World Alliance for Patient Safety in Washington DC on 27 October 2004.

This important review provides lessons for the Medical Council, for our partner organisations, for doctors and for everyone interested in safe, high quality care. Together with our fellow Medical Council Members, we look forward to the discussions that will follow since it is through shared discussion and collaboration that we can better support good professional practice among doctors for the benefit of patients.



*Freddie Wood.*

Prof Freddie Wood  
President



*Audrey Dillon*

Dr Audrey Dillon  
Vice-President

## ABOUT THE MEDICAL COUNCIL

Through the regulation of doctors, the Medical Council enhances patient safety in Ireland. In operation since 1979, it is an independent statutory organisation, charged with fostering and ensuring good medical practice. It ensures high standards of education, training and practice among doctors, and acts in the public interest at all times. The Medical Council is noteworthy among medical regulators worldwide in having a non-medical majority. It comprises 13 non-medical members and 12 medical members, and has a staff of approximately 70.

The Medical Council's role focuses on four areas:



### Maintaining the register of doctors

The Medical Council reviews the qualifications and good standing of all doctors and makes decisions about who can enter the register of medical practitioners. At the end of 2014, over 19,000 doctors were registered, allowing them to practise medicine in Ireland.

### Safeguarding education quality for doctors

The Medical Council is responsible for setting and monitoring standards for education and training throughout the professional life of a doctor: undergraduate medical education, intern and postgraduate training and lifelong learning. It can take action to safeguard quality where standards are not met.

### Setting standards for doctors' practice

The Medical Council is the independent body responsible for setting the standards for doctors on matters related to professional conduct and ethics. These standards are the basis to good professional practice and ensure a strong and effective patient-doctor relationship.

### Responding to concerns about doctors

Where a patient, their family, employer, team member or any other person has a concern about a doctors' practice, the Medical Council can investigate a complaint. When necessary, it can take appropriate action following its investigation to safeguard the public and support the doctor in maintaining good practice.

Through its work across these four areas, the Medical Council provides leadership to doctors in enhancing good professional practice in the interests of patient safety. You can find out more about the Medical Council at [www.medicalcouncil.ie](http://www.medicalcouncil.ie).

## AT A GLANCE

- Good complaint handling identifies learning for improvement. This report describes learning from listening to some 2,000 complaints about doctors over a 5 year period, 2008-2012.
- During the review period, complaints to the Medical Council about doctors rose by 46%.
- Most complaints come from members of the public; compared to similar bodies, the Medical Council receives relatively few notifications of concern about doctors from employers and other healthcare professionals.
- Some doctors may be more prone to complaint than others: for example male doctors and those in older age groups.
- Doctors subject to one complaint are at increased likelihood of further complaint.
- In the review period, 1-in-10 complaints investigated went forward to fitness-to-practise inquiry and at inquiry, findings were made in respect of 7-in-10 doctors and sanctions were applied by the Medical Council.
- “Higher-impact” disciplinary decision-making was more common for males, older doctors, those who qualified outside Ireland and those without specialist qualifications.
- Complainants present complaints in a wide variety of styles meaning that some complaints may be more “hearable” than others.
- While clinical knowledge and skill featured as causes of concern, poor experience of communication, lack of compassion and failure to take appropriate account of patient knowledge were key factors in complainants making a complaint. Appropriate interactions with families as well as patients were also important.
- Unanswered questions, acknowledgement of poor experience and concern for other patients motivate complainants.
- Doctors respond to complaints in a wide variety of ways ranging from formal rebuttals to acknowledgments and apologies. They experience a significant impact from the experience of being complained about.
- These findings provide valuable insights for how the Medical Council handles complaints and how it supports good professional practice among doctors. The report also raises implications for everyone interested in safe, high quality care for patients.

# INTRODUCTION

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## Key Points

- Handling complaints is one way in which the Medical Council ensures high standards among doctors.
- The complaints handling process is governed by the Medical Practitioners Act 2007 and has three stages, which are discharged by the Preliminary Proceedings Committee (PPC - Stage 1), the Fitness to Practise Committee (FTPC - Stage 2) and the Medical Council (Stage 3). Decisions made about doctors who have been complained about can be appealed to the High Court.
- Good complaints handling should include measures to ensure there is feedback and lessons learnt from complaints that can contribute to improvement.
- Under its Statement of Strategy 2014-2018, the Medical Council aims to provide leadership to doctors in enhancing good professional practice in the interests of patient safety. Learning from complaints is one way through which the Medical Council can demonstrate leadership.
- The project Listening to Complaints, Learning for Good Professional Practice is based on learnings from complaints received by the Medical Council, and aims to provide evidence to inform the development of guidance on good professional practice for doctors, such that our role in protecting the public through ensuring high standards among doctors is enhanced.
- A mixed methods review was conducted which combined quantitative and qualitative approaches.
- The review examined complaints handled by the Medical Council in the period 2008-2012. Almost 2,000 complaints were included in the quantitative review and 100 complaint files were selected for deeper analysis through the qualitative review.

## The Role of the Medical Council in Handling Complaints about Doctors

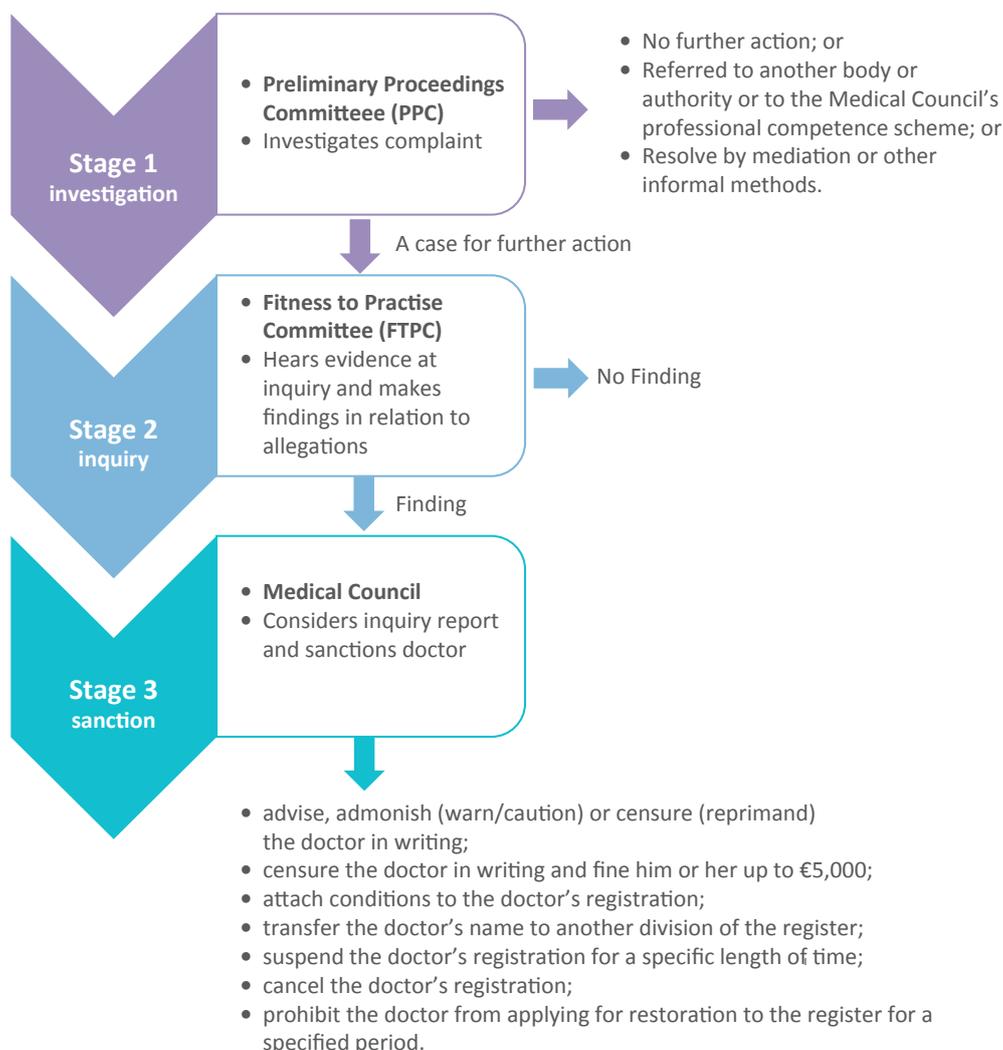
The Medical Council is responsible for regulating doctors in Ireland in the public interest. Its role spans the professional life of doctors: from their undergraduate medical studies, through postgraduate training, to continuing practice and lifelong learning. Through our *Guide to Professional Conduct and Ethics*, we explain what it means to be a good doctor. With our functions in education, training and continuing professional development, we seek to ensure that doctors are equipped with the knowledge, skills and attitude they need to meet these standards. Where there is a concern that standards are not being fulfilled, we can investigate complaints about doctors and take action to protect the public and ensure proper standards are maintained.

Each week, the Medical Council receives between 5 and 10 complaints about doctors. Anyone can make a complaint to the Medical Council about a doctor. This includes members of the public, employers, and other healthcare professionals. We cannot, however, respond to complaints about other healthcare professionals or about organisations that deliver healthcare. Figure 1 provides an overview of the process:

- **Stage 1:**  
The Preliminary Proceedings Committee (PPC) investigates all complaints received by the Medical Council; no complaint is refused or closed without being considered by the PPC. A Case Officer is assigned to the case, liaises personally with the complainant and doctor, and gathers further information at the direction of the PPC to enable the PPC to form an opinion on how the complaint should be managed by the Medical Council. The PPC can refer the complaint for an inquiry under the Fitness to Practise Committee (FTPC) if it believes that the matter raises concerns regarding a doctor's practice and is sufficiently serious to merit an oral inquiry. Alternatively, the PPC can give an opinion to the Medical Council that there should be no further action in relation to the complaint where there is no prima facie (at first appearance) evidence of poor professional performance or professional misconduct; that the complaint should be referred to another body or authority or to the Medical Council's professional competence scheme (which leads to a workplace-based assessment of the doctor's performance in practice); or that the complaint could be resolved by mediation or other informal methods, wherein this is agreeable to the doctor and the complainant.
- **Stage 2:**  
Some complaints are referred by the PPC to the FTPC for inquiry. An inquiry is a sworn oral hearing similar to a hearing before a court or tribunal. The Committee hearing the inquiry is made up of three people: two non-medical and one medical. Inquiries are usually held in public, unless there are specific reasons to hold the matter in private. This means that members of the public, including journalists, can attend. All or part of the inquiry may be held in private if the Committee believes that this would be appropriate, for example, in cases relating to matters of a very personal, intimate or sensitive nature. The Chief Executive Officer of the Medical Council presents allegations against the Doctor in the public interest. Evidence relevant to the inquiry is presented to the Committee by the Chief Executive Officer of the Medical Council and a response to the allegations is presented by the doctor or his/her representative. At the end of the inquiry, the Committee gives their findings in relation to the allegations presented against the Doctor and the reasons for these. In some cases, a finding is made in circumstances where allegations against the doctor are proven, in other cases, no finding is made and the matter is then closed.
- **Stage 3:**  
Where the FTPC makes a finding in relation to the complaint, its report is then considered by the Medical Council who determines the disciplinary sanction to be applied to the doctor. Sanctions can include: advise, admonish (warn/caution) or censure (reprimand) the doctor in writing; censure the doctor in writing and fine him or her up to €5,000; attach conditions to the doctor's registration; transfer the doctor's name to another division of the register; suspend the doctor's registration for a specific length of time; cancel the doctor's registration; prohibit the doctor from applying for restoration to the register for a specified period after their registration has been cancelled.

The procedures used by the Medical Council to handle complaints about doctors are prescribed by the Medical Practitioners Act 2007. There is more information about how the Medical Council handles complaints at [www.medicalcouncil.ie](http://www.medicalcouncil.ie).

Figure 1: Overview of the Medical Council procedures for handling complaints against doctors.



### Why Listening to Complaint, Learning for Good Professional Practice?

The public interest is at the centre of the Medical Council's role. Responding to complaints about doctors is a core function. Through responding to complaints, the Medical Council safeguards the public and ensures high standards among doctors. While we focus on handling each individual complaint, this report is based on a comprehensive review of some 2,000 complaints managed over a 5-year period, 2008-2012. Why did we undertake this review?

### Complaints as signposts for quality improvement

Nationally and internationally, it is increasingly recognised that, while there is a need to focus on the concerns of the individual complainant, good complaint handling must also ensure there is feedback and lessons learnt which can contribute to service improvement and serve a wider public interest.<sup>6,7,8</sup> Furthermore, reports into

6 Donaldson L, 2002. An organisation with a memory: Learning from adverse events in the NHS. London: Department of Health, 2000.

7 Office of the Ombudsman, 2014. Learning to get better - An investigation by the Ombudsman into how public hospitals handle complaints.

8 British and Irish Ombudsman Association, 2007. Guide to principles of good complaint handling.

various high-profile failings of care have shown that effective response to patient complaints, in particular linking complaints with learning and improvement, is an important way of assuring the safety and quality of care.<sup>9,10</sup> As Donald Berwick, an international leader in patient safety and healthcare quality, noted: “*in the discovery of imperfection lies the chance for processes to improve*”.<sup>11</sup>

Not only is learning from complaints a recognised good practice for individuals and organisations charged with their handling, research with those who make complaints shows that a strong motivation in coming forward with a concern about healthcare is an interest in preventing harm to other patients.<sup>12,13</sup> Those of us involved in handling complaints, therefore, have a responsibility to manage each individual complaint effectively, but also to recognise that these complaints may be signposts to deeper issues and to review complaints so as to identify learning for improvement.

### Providing leadership through learning from complaints

The Medical Council launched a new *Statement of Strategy* in 2014, and it aims to provide *leadership to doctors in enhancing good professional practice in the interests of patient safety*.<sup>14</sup> While the Medical Council pursues this aim in various ways, our *Guide to Professional Conduct and Ethics*, which sets out what is expected of a good doctor in Ireland, is central to all our functions: education and training, registration and responding to complaints. The *Guide to Professional Conduct and Ethics* is reviewed and revised each five years by the Medical Council to ensure that it continues to reflect what is expected of a good doctor. This process commenced under its current term in 2013, led by Dr Audrey Dillon, Vice President of the Medical Council, and the Ethics and Professionalism Committee.

The complaints made by the public, responded to by doctors and handled by the Medical Council present unique and important opportunities for learning. While the Medical Council has previously used initiatives such as “closed case” analysis and case reports in our newsletter to identify and share learning from complaints, and while we publish information on complaints each year through our Annual Reports, we have never systematically and comprehensively reviewed a large volume of complaints with the aim of better supporting good practice among doctors.

The project, *Listening to Complaints, Learning for Good Professional Practice*, was conceived to realise this opportunity. It is conducted pursuant to Section 7(1)(a) of the Medical Practitioners Act 2007 which empowers the Medical Council to do all things necessary and reasonable to further its object in protecting the public through promoting and better ensuring high standards among doctors. It is published and shared with the public and other stakeholders recognising the significant public interest in disseminating learning from the project.

### Overall aim and specific objectives of Listening to Complaint, Learning for Good Professional Practice

The project aims to provide evidence, based on learning from complaints the Medical Council has received about doctors’ practice, to inform the development of guidance on good professional practice for doctors, and other work, such that the role of the Medical Council in protecting the public through ensuring high standards among doctors can be enhanced.

The overall project comprised a quantitative and qualitative review of complaints 2008-2012, and the specific objectives were as follows.

9 Holohan T, 2014. HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006-date) - Report to the Minister for Health Dr James Reilly TD.

10 Francis R, 2013. Report of the mid-Staffordshire NHS Foundation Trust Public Inquiry.

11 Berwick, D. Continuous improvement as an ideal in health care. *NEJM* 1989; 320(1): 53-56.

12 Bark P, Vincent C, Jones A, et al. Clinical complaints: a means of improving quality of care. *Qual Health Care* 1994;3:123-32.

13 Gallagher TH, MD; Waterman AD, Ebers AG et al. Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors. *JAMA*. 2003;289(8):1001-1007.

14 Medical Council, 2014. *Statement of Strategy 2014-2018*.

### Quantitative Review

- To describe the trends in complaints made to the Medical Council 2008-2012 by source of complaint and by demographic factor of the doctor complained against;
- To describe the trends in Medical Council disciplinary decision-making 2008-2012 by demographic factor of the doctor complained against.

### Qualitative Review

- 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 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.

### Overall Review

- To identify ways in which current Medical Council guidance to doctors can be revised and strengthened to 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.

## How did we approach the review?

Details of the individual reviews are presented in the respective reports and a general overview of the approach is described here.

### Why mixed methods?

The review used a mixed methods approach. This type of approach combines elements from both qualitative and quantitative paradigms to produce converging findings in the context of complex questions.<sup>15</sup> Quantitative methods were used to measure the magnitude and frequency of complaints and associated characteristics, such as the age and gender of doctor complained against; this answered "how many", "when" and "who" type questions.

We were also interested in understanding "why" complaints arose and "how" the issues were experienced by the complainant and the doctor. Each complaint describes an individual experience in rich detail. While it is possible to code and classify complaints, it is very difficult to do so in a standard and consistent way without reducing their unique value.<sup>16</sup> Simply counting the frequency of various issues fails to capture important information like why complaints are made, and how the issues have been experienced for the complainant and the doctor. For this reason, a qualitative approach was used to address the questions of "why" and "how" through exploring the context, meaning and understanding contained in experiences reported in complaints and doctors' responses.

These two approaches each have their strengths relevant to the questions they seek to address, and when used in combination, complement each other and enable the integration of their respective findings to answer the overall aim of the review.

This review was conducted pursuant to the Medical Council functions under Section 7(1) of the Medical Practitioners

15 Lingard L., Albert M. Levinson, W. Grounded theory, mixed methods, and action research. *BMJ* 2008;337:a567.

16 Reader TW, Gillespie A, Roberts J. Patient complaints in healthcare systems: a systematic review and coding taxonomy. *BMJ Qual Saf* doi:10.1136/bmjqs-2013-002437

Act 2007. The review was an evaluation of the complaints function operated by the Medical Council designed to inform service improvement; it was not a research project, did not involve any changes to usual services and was intended to make findings referable to the Medical Council's context only.

## Quantitative review

The quantitative review focuses on the period 2008-2012. Medical Council data on complaints is rich but complex. While we have generally sought to present straightforward analyses of complaints, some rules were applied to how data was handled. The total number of complaints included in the review changes slightly depending on the context of analysis presented and discussed. This is because time elapses from initial receipt of a complaint to final decision, especially if a Fitness to Practise Inquiry is called.

When analyses relate to the numbers of complaints received between 2008-2012 this includes all complaints made to the Council in that time-frame, regardless of whether or not complaints were fully investigated in the same period (2056 complaints in total).

When analyses explore decisions made about complaints, we include a number of complaints that were received before 2008, but all complaints included must have been fully investigated in the period 2008-2012 (some 1961 complaints in total). This means that some complaints received in the period 2008-2012, that were not subject to a decision in the same period, were excluded from analyses about decisions.

Most complaints involve a single doctor. For complaints that involved multiple doctors, we counted each doctor complained about in our analyses - so if a complaint involved 4 doctors in the same incident, our analysis treated this as 4 separate events of doctors being complained about. In other words, in general, we have presented counts of doctors complained about which, because some complaints relate to more than one doctor, is greater than the total number of complaints. However, this approach allows us to better understand doctor-related characteristics and how these are associated with the likelihood of being complained about or subject to a decision.

Basic information on the complaint was extracted from our complaints handling databases (with a small amount of missing information being manually added by referring to the paper-based case file). This data was merged with data held about doctors in the Medical Council's Registration database, so that we could gather more insight into the relationship between complaints and doctor characteristics.

The following variables were available for analysis: the registration number of the doctors subject to a complaint, the year in which the complaint was received, the year the final decision about a complaint was made, the doctor's date of birth, the doctor's gender, the type of registration held by the doctor, the region in which the doctor gained their Basic Medical Qualification, whether or not the doctor had legal representation during the complaint investigation, the decision by the Preliminary Proceedings Committee, the recommendation of the Fitness to Practise Committee, and the sanction imposed by the Medical Council. A new variable - source of complaint - was routinely collected post mid-2011 and so an interrupted time series analysis is shown for this variable.

To enable clearer data analysis some variables were recoded into more useful categories, for example, the sanctions applied by the Medical Council were recoded into "High Impact outcomes" (including decisions that attached conditions to a doctor's registration, suspended the doctor's registration for a specific length of time; cancelled the doctor's registration; or, prevented the doctor from applying to put their name back on the register for a specific period of time), and "Lower Impact outcomes" (including decisions to admonish, advise or censure the doctor, or to fine the doctor up to €5000). It is important to note that "lower impact outcomes" are serious and imply that a finding has been made in relation to the doctor's practice.

In this report we provide basic frequencies for some data (for example the number of complaints received each year) however a large proportion of the analysis is devoted to exploring associations with likelihood of complaint, and outcomes at different stages of the investigation process, with multiple doctor characteristics. For example, we include analysis on whether or not doctors' gender was associated with different likelihood of complaint.

To help determine significant associations between doctor characteristics, the likelihood of complaints, and outcomes at different stages in the investigation processes, some descriptive statistical analysis is provided; usually in the form of chi-squared measures of association or odds ratio analysis.<sup>17</sup> All tests that reported a p value of < .05 were considered as statistically significant.

Some modelling is included to explore which, if any, doctor characteristics could be said to be associated with outcomes at each stage of investigation process (through the use of decision-tree analysis).

A summary of the complaints included in the quantitative review is shown in the Statistical Annex.

### Qualitative review

The qualitative review focused on a subset of the complaints analysed in the quantitative review and were sampled from the same period, i.e. 2008-2012. A content analysis was conducted with all selected cases, and a narrative analysis was conducted with a subset of these.

A combination of random and purposeful sampling was used to select the sample of 100 cases for analysis. Case files comprised of the letter of complaint, the response from the doctor and all associated relevant correspondence.

The files were collated at the Medical Council by Medical Council staff and scanned to produce text files; identifiable information was then removed before the anonymised text files were transmitted securely to the researchers.

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, 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. This was followed by a series of lengthy discussions and sharing of suggested categories which eventually led to agreement of a codebook. 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.

Narrative analysis of 4 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. Key themes emerging from the qualitative content analysis informed the selection of case files for 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.

Further detail on the methods is available in the quantitative review.

A summary of the complaints included in the qualitative review is shown in the Statistical Annex.

<sup>17</sup> An odds ratio (OR) is a measure of association between a characteristic (for example, in this review, doctor's gender) and an outcome (for example, in this review, being subject to a complaint). ORs are presented with a reference point (for example, in this review, OR of complaint for gender is made with reference to females, where the OR for females is 1). Where OR is >1, the characteristic is associated with an increase in the likelihood of an outcome; where OR <1, the characteristic is associated with a reduction in the likelihood of an outcome.

## WHAT WE FOUND - QUANTITATIVE REVIEW

## WHAT WE FOUND - QUANTITATIVE REVIEW

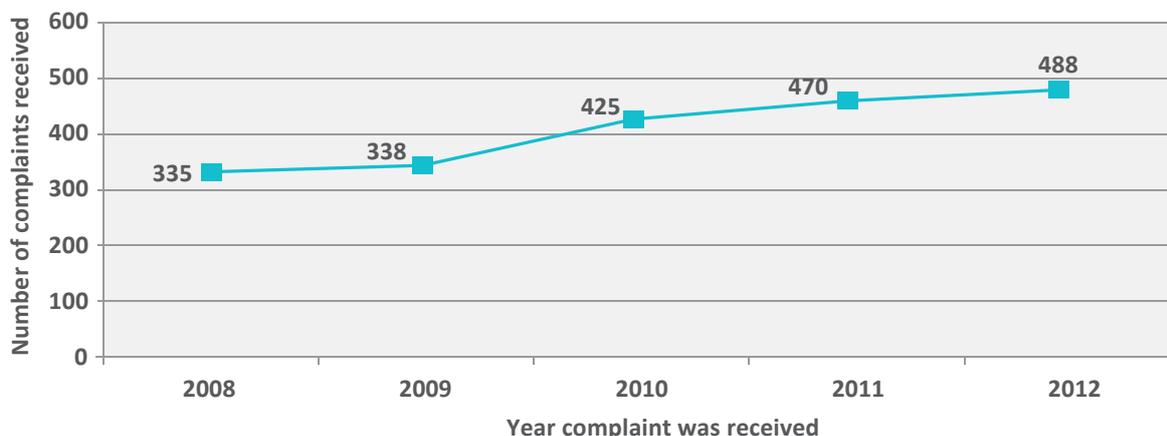
### Key Points

- There were 1723 complaints made to the Medical Council in the period 2008-2012. Of these, 211 complaints cited more than one doctor, so, in total, there were 2056 complaints about doctors during this period; 325 doctors were subject to more than one complaint.
- The number of doctors complained against to the Medical Council each year rose from 335 in 2008 to 488 in 2012, a 46% relative increase. For doctors, the likelihood of being complained about rose from 1.9% to 2.7%.
- In total, of those complaints that were assigned a source (mid-2011 onwards), 86% were from members of the public and 2% were from the HSE and other employers. Complaints investigated by the Medical Council were most likely to proceed to inquiry when they were made by the HSE or other employers. However, the majority of inquiries held arose from complaints by the public.
- Certain groups of doctors were more likely to be subject to a complaint to the Medical Council: males, older doctors, doctors who qualified in Ireland and specialists.
- For doctors subject to a complaint in the review period, the likelihood of being subject to at least one further complaint was 21%.
- In the period 2008-2012, 11% of cases considered by the PPC went forward to inquiry by the FTPC (a “high impact” decision).
- Certain groups of doctors were more likely to be subject to a high impact decision by PPC: males, younger doctors, doctors who qualified outside Ireland and non-specialists.
- In the period 2008-2012, 68% of cases subject to inquiry under the FTPC were subject to a finding (a “high impact” decision).
- While there were some differences, in general there was no group of doctors who appeared more likely to be subject to a high impact decision by FTPC.
- In the period 2008-2012, 27% of cases subject to a finding who were considered by the Medical Council were subject to a high impact sanction.
- Doctors who qualified in the EU and doctors without legal representation were more likely to be subject to a high impact sanction by the Medical Council.

### Increasing number of complaints 2008-2012

In the period 2008-2012, the numbers of doctors who were complained against rose from 335 in 2008 to 488 in 2012; this represents a 46% increase in number of complaints against doctors to the Medical Council in the review period (Figure 2). For doctors, the likelihood of being complained rose from 1.9% to 2.7%.

Figure 2: Number doctors with complaints made against them per year, 2008-2012



### Source of complaint matters

Source of complaint was assigned from mid-2011 onwards. The predominant source of complaint to the Medical Council was members of the public (86%) followed by other healthcare professionals (7%). This pattern is different to the sources of complaint to other medical regulatory bodies; for example 64% of complaints made to the General Medical Council in the UK are made by members of the public and 18% are made by other doctors or employers of doctors.<sup>18</sup> Source of complaint matters because we found that complaints made by employers of doctors and other healthcare professionals were most likely to proceed to inquiry following investigation by the PPC (Table 1); in the UK, the General Medical Council report similar experience. The majority of inquiries from mid-2011 onwards (52%), however, arise from public complaints about doctors.

Table 1: Source of complaints (2011-2012) and referral to inquiry

Source	Number of complaints received	% of all complaints received	Number of complaints referred by PPC to inquiry	% of complaints by source referred by PPC to inquiry
Members of the public	330	86%	23	7%
Doctors & other healthcare professional	25	7%	6	24%
HSE & other employers	11	3%	9	82%
The Medical Council*	10	3%	4	40%
Others**	6	2%	2	33%
Total	382	100%	44	12%

\*Anonymous complaints or complaints arising from other Medical Council functions

\*\*Includes other regulators, patient advocacy groups and solicitors

18 General Medical Council, 2014. State of Medical Education and Practice, 2014.

## Are some doctors more “complaint-prone” than others?

The likelihood of being complained against for doctors rose from 1.9% in 2008 to 2.7% in 2012; however, the rate of complaint was higher for some groups of doctors:

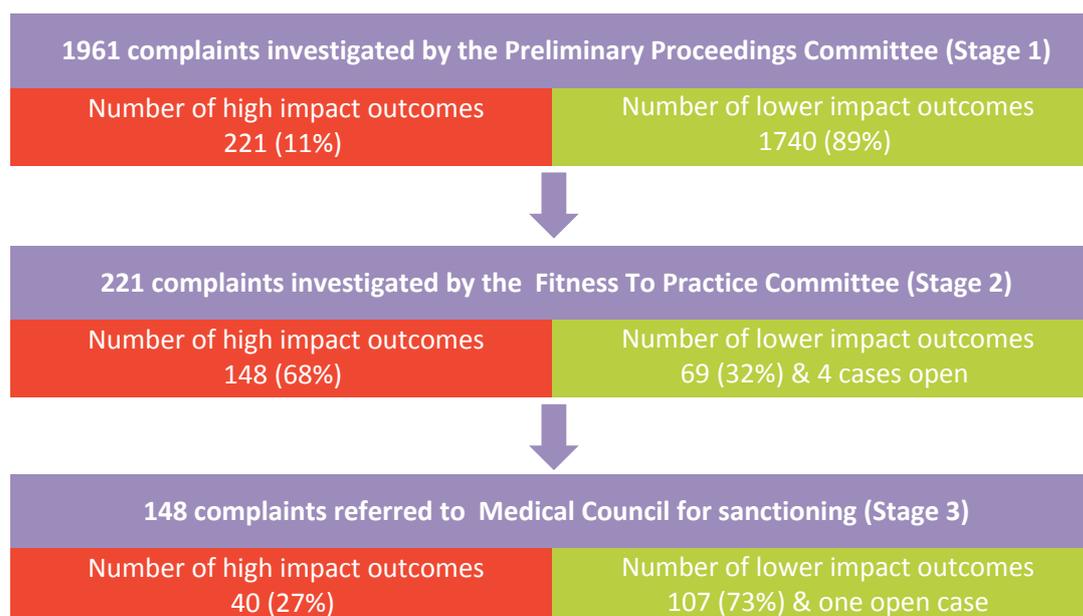
- Compared with female doctors, male doctors were more likely to be complained (Odds Ratio (OR) 2.2, 95% CI 2.0-2.4,  $p < 0.001$ ).
- Compared with younger doctors (aged 20-35 years), older doctors were more likely to be complained (e.g. aged 56-65 years OR 9.4, 95% CI 7.8-11.3,  $p < 0.001$ ).
- Compared with doctors who qualified in Ireland, doctors who qualified outside Ireland were less likely to be complained (qualified in EU OR 0.8, 95% CI 0.7-0.9,  $p = 0.012$ ; qualified outside EU OR 0.6, 95% CI 0.5-0.7,  $p < 0.001$ ).
- Compared with specialists, non-specialists were less likely to be complained (e.g. doctors registered in General Division OR 0.4, 95% CI 0.3-0.5,  $p < 0.001$ ).

For doctors who were subject to one complaint in the period, the likelihood of being subject to at least one further complaint was 21%.

## Likelihood of “higher-impact” disciplinary decisions 2008-2012

In total, of 1961 complaints investigated by the PPC, 221 (11%) were taken forward for inquiry (a “high impact” decision). At inquiry by FTPC, findings were made in 148 (68%) cases (a “high impact” decision). Sanctions were applied by the Medical Council to doctors in all 148 cases; in 40 cases (27%) the sanction impacted on the doctor’s continuing registration (a “high impact” decision). This is summarised in Figure 3.

Figure 3: Outcomes at each stage of disciplinary proceedings (2008-2012)



Complaints made by employers and other healthcare professionals were more likely to be subject to higher impact disciplinary decision-making.

There was also some variation in the severity of disciplinary decision making by doctor characteristics at the different stages of the process. Higher impact decisions at PPC stage were more likely for male doctors, younger doctors, doctors who qualified outside Ireland and non-specialists. Severity of decisions at FTPC stage did not vary by doctors characteristic. Higher impact sanctions at Medical Council stage were more likely for doctors who qualified outside Ireland and those without legal representation.

## WHAT WE FOUND – QUALITATIVE REVIEW

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### Key Points

- 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.
- Key themes that emerged included the importance of acknowledging and managing different components of competency of medical practitioners. 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. 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.
- 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" and "lay expertise" of their health. 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 was the challenges that may arise for doctors in dealing with the families of patients. In many ways a patient's family can be of critical importance and value to the doctor in describing symptoms, explaining concerns, and 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 him or herself. 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.

### How are complaints presented – are all complainants equally "hearable"?

Complaints are presented to the Medical Council in a wide variety of ways: some are written by patients and their families, others by solicitors or healthcare managers; some are long, other are short; some focus on specific facts, other focus on feelings and experience; some display a detailed knowledge of medicine and the role of the Medical Council, others do not. Given this continuum of ways in which complaints are presented, there is a challenge to avoid privileging complaints that "speak the language" of the Medical Council and ensure that all complainants are equally "hearable".

“I have felt very upset, angry and traumatised by the manner in which the events unfolded on the day”

“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”

## Good communication and compassionate attitude matter

The nature and number of causes of concern raised by complainants varied considerably. While it is intuitive to distinguish the cause of complaint between “what” was done (i.e. a doctor’s technical knowledge and skill) from “how” it was done (i.e. a doctor’s overall approach to the patient and their family), complainants perceive these as highly inter-related: they see good professional practice as being about the integration of knowledge and skills with attitudes and behaviours. Failure by the doctor to both take account - and to be seen to take account - of the experience of the patient and the family is an important factor in why complaints are made. Good communication and a compassionate attitude are perceived by complainants as essential. Diagnosis, approach to assessment, and prescribing were particular causes of concern. Some context of medical practice present environments where these factors more readily come together to create a situation where a complaint can arise: out-of-hours care, psychiatry, and plastic surgery.

“[Doctor] showed total disregard for me also all the information I gave to him”

“[Doctor] showed no warmth or understanding ... I just felt railroaded, a nuisance – would I please just go away”

## What do complainants experience and what do they expect?

The consequences and effects of their experiences were highly significant in complainants contacting the Medical Council. Negative emotional reactions were very commonly reported by complainants and were often linked with poor communication. These ranged from upset and anxiety to anger. For some complainants, these reactions continued for a long time after the experience and for others, their experience also impacted their families. Loss of trust or confidence in the medical professional was reported by many complainants. Different reasons were reported for contacting the Medical Council. It was common for complainants to seek an investigation of their complaint to answer questions. Acknowledgement of the complainant’s experience was also commonly sought. While complainants brought forward concerns about their own experience, many did so out of a sense of public duty, a concern for patient safety and an interest in the prevention of future harm to others.

“I just cry every time I think about it”

“The recent events have damaged my faith in Irish healthcare system.”

“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”

## How do doctors respond - deny and rebuke, or acknowledge and apologise?

Doctors present a variety of responses to complaints. Some were very formal and contained legal observations and comments sent by the doctors themselves or by solicitors on their behalf, often containing strident rebuttals or denials. Other responses were very minimalist, 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 negative experience of healthcare.

“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.”

“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.”

### **Complaints impact doctors too**

In their responses, many doctors expressed their own experience of the impact of the complaint: from distress and anxiety, to shock and disappointment, and concern about negative publicity. The challenges of day to day medical practice were highlighted as factors relevant to the complaint; these included finding the right balance between their relationship with the patient and with the patient's family.

**“[Patient]’s complaint has occupied my waking thoughts almost constantly since I received it ... I have been trying to work out how [Patient] could possibly have misconstrued my words and actions”**

## CONCLUSIONS AND NEXT STEPS

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### Key Points

- The *Listening to Complaints, Learning for Good Professional Practice* project provides a more informed perspective on complaint received by the Medical Council and contribute to an evidence base for improvements.
- The rising tide of complaints observed at the Medical Council in the period of the review is common to other bodies that handle complaints and relates to a wide range of social, political and cultural factors. There is a need for the health system to take this demand into account and to plan ways to better listen to public feedback on healthcare.
- Compared to similar bodies, the Medical Council receives a greater proportion of complaints about doctors directly from members of the public and less commonly receives complaints from employers and other healthcare professionals. While public complaints are an important source of information and contribute to the majority of fitness to practise inquiries, complaints from employers and other healthcare professionals appear more likely to contain serious fitness to practise concerns requiring regulatory action.
- The overall system for handling complaints from the public needs to be easier to understand, more supportive to patients, streamlined and joined up. Healthcare organisations need to develop systems of clinical governance with improved processes to handle complaints that will – as appropriate – link public complaints with other local information and refer concerns regarding a doctor’s fitness to practise to the Medical Council.
- Challenging work contexts for doctors need to be better understood since these contribute to the public’s experience of medical care.
- Our findings about doctor-related factors that are associated with an increased likelihood of complaint or disciplinary action are similar to findings elsewhere. We can use this information to implement initiatives that can help address risk and causes of concern.
- Failings in communication skills and compassionate attitude point to a need to maintain a strong and consistent focus on medical professionalism from medical school, through specialist training to continuing practice. While educational bodies must take this agenda forward with the Medical Council, medical professionalism can only flourish where leadership and culture in healthcare settings and the wider health system supports a strong and effective patient-doctor relationship.

### A more informed perspective and an evidence base for improvements

*Listening to Complaints, Learning for Good Professional Practice* is the first time which the Medical Council has comprehensively reviewed its experience of handling complaints about doctors. This review provides a more informed perspective on our work in handling complaints and is an evidence base for how we – and everyone interested in safe, high quality care – can make improvements in the interests of the public.

### The rising tide of complaints

Over the period of the review, the Medical Council faced a rising tide of complaints about doctors. This phenomenon is common across a range of organisations that receive complaints about public services generally, and about healthcare in particular.

The Ombudsman’s Office recently reported an 11% increase in the number of complaints it received between 2013 and 2014, in part explained by an increase in the number of organisation that fall within its scope;<sup>19</sup> the HSE

19 Ombudsman Office, 2015. Annual Report, 2014.

also recently reported an increase in the number of complaints about health services.<sup>20</sup> In the same period as the current review of complaints against doctors (2008-2012), applications to the Nursing and Midwifery Board for inquiries on the grounds of concern about nursing practice rose from 75 to 89, a 19% increase. Looking internationally, a similar trend of increasing complaints to the medical regulator can be observed. For example, in the period 2007-2012, the UK's General Medical Council experienced a doubling in the total number of complaints (from 5,168 in 2007 to 10,347 in 2012).

### What drives this rising tide of complaints?

Archer et al sought to answer this question by examining the experience of the General Medical Council in the UK so as to identify contributory social, political and cultural factors.<sup>21</sup> It was found that an increasing number of complaints from the public was a feature common to many regulatory bodies, albeit most pronounced for the General Medical Council. This was explained by a number of factors. In the period, the public profile of the General Medical Council rose; however, this was not accompanied by an increased level of understanding of the General Medical Council, its remit, or the limitations of what can be achieved through a fitness to practise complaint to a professional regulator. At the same time, opportunities to make complaints, especially through new communication technologies, has increased. It was also identified that, although the reputation of the medical profession remained generally positive, a sustained diet of negative coverage, conforming to a few stereotyped models and media coverage of the professional failings of individual doctors may create a highly critical backdrop against which the medical profession is perceived by the public affecting their likelihood to make a complaint. The relationship between individual patients and their doctors has also changed, with less deference and a greater willingness to raise questions. Furthermore, many patients now see making a complaint as an altruistic step taken in the wider public interest. Finally, a sense of considerable confusion surrounding the wider system of complaint-handling in place in the healthcare sector suggested that it was difficult for members of the public to know where to address their complaints, and that this confusion may be driving people towards long-standing organisations such as the General Medical Council, as it may be more recognisable. These factors, summarised in Box 1, go some way to explaining the same rising tide of complaints against doctors experienced by the Medical Council in the same period.

#### Box 1: Social, political, and cultural factors that contribute to the rising tide of complaints

Contributory factor
Increasing public profile and recognition of medical regulatory bodies
Poor understanding of the precise remit of medical regulatory bodies in wider complaints system
Sustained diet of negative media coverage of doctors
Changing patient-doctors relationship with less deferential and more questioning public
Complaints increasingly seen as a "public interest" measure to protect patients
More information about making a complaint and more avenues to pursue this
Public confusion about complaints processes may lead them to contact more recognisable bodies

Adapted from Archer et al<sup>22</sup>

20 Health Service Executive 2015. Annual Report 2014 - Caring and providing for the health of our nation..

21 Archer J, de Bere SR, Bryce M, et al, 2014. Understanding the rise in Fitness to Practise complaints from members of the public. Report for the General Medical Council. <http://www.gmc-uk.org/about/research/25233.asp>

22 Archer J, de Bere SR, Bryce M, et al, 2014. Understanding the rise in Fitness to Practise complaints from members of the public. Report for the General Medical Council. <http://www.gmc-uk.org/about/research/25233.asp>

## Knowing where to turn with a concern – a complex and confusing system?

In the context of this rising tide of complaints, in Ireland, like many health systems, there are a range of bodies to which members of the public can turn if they have a concern about their experience of healthcare.

The first and most important point of recourse is the point at which healthcare is delivered. Many people will raise, and successfully resolve, their concern immediately as it arises with the individual, team, or organisation from which they are receiving care. The merits of an early acknowledgement, apology and resolution of patient concerns in healthcare are well recognised and widely promoted.<sup>23</sup> However, sometimes this early and local response is weak or absent. And other times, patients may not feel comfortable enough to raise their concern or may be dissatisfied with the initial response, and will want to turn to another option.

An online resource, known as [healthcomplaints.ie](http://healthcomplaints.ie), is designed to sign-post members of the public to various options available for making a complaint, which include:

- Bord na Radharcmhastóirí (The Opticians Board)
- CORU (Health and Social Care Professionals Council)
- Dental Council
- Food Safety Authority of Ireland
- Health Information and Quality Authority (HIQA)
- Health Products Regulatory Authority (HPRA)
- Health Services Executive: Your Service Your Say
- Medical Council
- Mental Health Commission
- Office of Radiological Protection
- Office of the Ombudsman
- Ombudsman for Children (complaints by children or adults on their behalf)
- Pharmaceutical Society of Ireland
- Pre-Hospital Emergency Care Council
- The Nursing and Midwifery Board of Ireland

While not every option will be relevant in each situation, for many people with a concern about their experience of healthcare, there may be more than one organisation to which they can complain.

The reality is that the range of options available for patients and families who are concerned about their experience of healthcare is confusing and complex. This is a point noted by Archer et al and in part contributes to the rising tide of complaints facing professional regulators.<sup>24</sup> A recent review of complaint handling in the NHS shared this view, noting that vulnerable people find the complaints system in healthcare complicated and hard to navigate.<sup>25</sup>

23 Health Service Executive, 2013. Open Disclosure National Guidelines - Communicating with service users and their families following adverse events in healthcare.

24 Archer J, de Bere SR, Bryce M, et al, 2014. Understanding the rise in Fitness to Practise complaints from members of the public. Report for the General Medical Council.

25 Clwyd A and Hart T, 2013. A Review of the NHS Hospitals Complaints System Putting Patients - Back in the Picture.

The same challenge faces patients and their families in Ireland. In its review of the handling of complaints about healthcare in Ireland, the Ombudsman's Office identified that understanding of how to make a complaint among the public is poor.<sup>26</sup>

While the public need to know where to turn with a concern about healthcare, they must also have confidence that they will be listened to and that there will be appropriate action. The review of NHS complaints handling conducted in the wake of the failings of care at Mid-Staffordshire Trust found that patients were often concerned that raising a complaint would result in personal repercussions and that their complaint would not be handled in an effective and independent manner;<sup>27</sup> similar concerns were heard by the Ombudsman's Office when it explored the public's view of making complaints to the Health Service Executive in Ireland.<sup>28</sup>

We have found that the leading source of complaint to the Medical Council is the public - patients, family members, or those acting on their behalf. Table 2 shows the proportion of complaints to a selection of professional regulators which come from the public.

*Table 2: The public as a source of complaint to the Medical Council and some benchmark medical regulators*

Organisation	Time Period	% of complaints or notification from the public
Medical Council of Ireland	Mid 2011-2012	86%
General Medical Council UK	2010-2013	64%
Medical Council of New Zealand* <ul style="list-style-type: none"> <li>• Direct</li> <li>• Via Health and Disability Commissioner</li> </ul>	2013-2014	<1% 34%
College of Physicians and Surgeons of Ontario	2013	66%
<b>Total</b>		<b>100%</b>

\*In New Zealand, members of the public with concerns about doctors are directed to the Health and Disability Commissioner and usually do not go direct to the Medical Council - see Box 2.

Compared to other professional regulators, the proportion of concerns brought to the Medical Council's attentions which come from members of the public is high. Complaints from other sources, like healthcare organisations and other healthcare professionals are less common. We have previously reported attitudes among doctors regarding raising a concern about a colleague: only 50% of doctors said they completely agreed that doctors should report all instances of significantly impaired or incompetent colleagues to the relevant authorities.<sup>29</sup>

The Medical Council exists to protect the public so complaints from patients and their families are an important source of information for our role. However, comparison of the source of complaints to the Medical Council versus other medical regulatory bodies asks some important questions. A more accessible, simpler, and effective system for public complaints about healthcare may mean that patients and their families would be more confident to raise their concern locally and achieve a satisfactory outcome before needing recourse to the medical regulator. At the same time, systems of clinical governance in healthcare organisations, including systems for handling complaints, need to mature and link more effectively with the medical regulator on fitness to practise concerns about doctors. This is underscored by the findings reported by the Health Information and Quality Authority following its investigation into the safety, quality and standards of services at Portlaoise Hospital.<sup>30</sup>

26 Office of the Ombudsman, 2015. Learning to Get Better - An investigation by the Ombudsman into how public hospitals handle complaints.

27 Clwyd A and Hart T, 2013. A Review of the NHS Hospitals Complaints System Putting Patients - Back in the Picture.

28 Office of the Ombudsman, 2015. Learning to Get Better - An investigation by the Ombudsman into how public hospitals handle complaints.

29 Medical Council, 2014. Talking about good professional practice - views on what it means to be a good doctor.

30 Health Information and Quality Authority, 2015. Report of the investigation into the safety, quality and standards of services provided by the Health Service Executive to patients in the Midland Regional Hospital, Portlaoise

## Better support for concerned patients and families

In addition to knowing where to turn, and having confidence that their concerns will be taken seriously, many members of the public will need support in bringing forward their concerns about their experience of healthcare.

We found that patients present their complaints to the Medical Council in a wide variety of ways. Some complainants may be more “hearable” than others and it can be easier for bodies like the Medical Council to give attention to complaints which are clear, well-structured, supported with evidence, and written in a way which links with our legally-based fitness to practise procedures. Furthermore, some complainants misunderstand the role of the Medical Council or have expectations regarding our functions which cannot be met.

In many health systems, members of the public with a concern about their experience of healthcare can turn to independent patient advocacy services for advice and support; they can be helped to understand and navigate the complaints system, linked with the most appropriate agency, and supported to set out their concern in a way which enables prompt and effective action.

Both the Health Information and Quality Authority and the Chief Medical Officer identified the need to establish patient advocacy services following failings of care at Portlaoise Hospital.<sup>31,32</sup> This is also a measure supported by the Ombudsman.<sup>33</sup> It is welcome that the Department of Health has committed to the establishment of a Patient Safety Agency in the context of the strategic reform of the health services, which is expected to include patient advocacy and related services. Once it is in place, the Medical Council will identify the best way to coordinate its role with the Agency’s patient advocacy services. In the interim, it will continue to communicate its role to the public, and to work with groups that represent patient’s interests.

## The role of fitness to practise procedures in handling complaints about doctors

Good handling of complaints is essential element of a modern, effective and patient-centred framework for the assurance of safety in quality in healthcare. Complaints from the public, which report patient experience first-hand, are important measures of quality and can sometimes herald more deep-seated problems.

In common with other professional regulators, the Medical Council responds to concerns about doctors’ practice through complaint handling which links with our fitness to practise process. Ultimately, in responding to a complaint against a doctor, the Medical Council seeks to answer the question as to whether or not we should take action against a doctor’s registration in the interests of public protection and to maintain public trust in doctors. The process is not aimed at punishment for a particular incident. We cannot offer redress to a complainant in relation to a particular experience of healthcare; neither can we provide an apology. The Medical Council’s processes are governed by legislation and supervised by the Courts. There is a subtle but important difference between the role of fitness to practise procedures and other systems for handling complaints about healthcare such as those operated by a local healthcare organisation or by an Ombudsman. In the UK, the Professional Standards Authority, which oversees professional regulation in the public interest, has sought to better explain the purpose of fitness to practise procedures to the public.<sup>34</sup>

To determine if it needs to take action against a doctor’s registration through its fitness to practise process, the Medical Council reviews the issue reported about the doctor’s practice against two principle standards: professional misconduct and poor professional performance, the latter being a newer test established under the Medical Practitioners Act 2007.

31 Health Information and Quality Authority, 2015. Report of the investigation into the safety, quality and standards of services provided by the Health Service Executive to patients in the Midland Regional Hospital, Portlaois

32 Holohan T, 2014. HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006-date) - Report to the Minister for Health Dr James Reilly TD.

33 Office of the Ombudsman, 2015. Learning to Get Better - An investigation by the Ombudsman into how public hospitals handle complaints.

34 Professional Standards Authority 2014. A statement explaining the purpose of the fitness to practice process.

In February 2015, Supreme Court published its decision on an appeal by the Medical Council against a successful High Court judicial review of a decision it made against a doctor.<sup>35</sup> The Supreme Court judgment determined that the Medical Council should hold an oral inquiry into matters only where a threshold of “seriousness” has been met; in other words, the nature of a matter should be sufficiently serious to merit the holding of an oral inquiry into a doctor’s conduct or fitness to practise.

In short, the Supreme Court has clarified the role for professional regulators in responding to complaints through fitness to practise processes; it has indicated that, to warrant professional regulatory action, complaints should raise serious fitness to practise concerns.

We found in the period of the review of complaints that 11% of complaints investigated by the Medical Council went forward to an inquiry into a doctor’s fitness to practise; in relation to inquiries held, 68% resulted in a finding against the doctor and subsequent sanction. Table 3 presents this in comparison with some international reference points. Our ability to present “like-with-like” comparison is limited since the structure and stages of complaints handling processes are different in different health system. Compared with the General Medical Council, a greater proportion of complaints go forward at the Medical Council to inquiry; the General Medical Council, however, has mechanisms to close complaints before inquiry including, for example, issuing warnings or directing the complaint for local resolution. At inquiry, a slightly greater proportion of complaints to the General Medical Council result in some form of sanction compared with the Medical Council; this may be because it resolved some less serious complaints without inquiry. At the College of Physicians and Surgeons in Ontario, compared with the Medical Council of Ireland, a lower proportion of complaints proceed to inquiry.

Table 3 also shows that the proportion of complaints going forward through Medical Council procedures was greater among complaints presented by sources other than the public (41% for complaints from other sources versus 7% for complaints from the public). While the Medical Council investigates all complaints under its PPC, the General Medical Council, which also exercises its function against a legal threshold for taking action against a doctor’s registration, has different fitness to practise processes; for example, while all complaints to the Medical Council are brought forward to the PPC for investigation, the General Medical Council can close complaints without investigation and can direct complaints back to local healthcare organisations for resolution. The General Medical Council reported conducting full investigations in respect of 33% of complaints handled in 2012. However, the likelihood of a full investigation of the complaint varied by source: while 20% of complaints from the public were fully investigated, 84% of complaints made by an employer were fully investigated; similarly, compared with complaints from the public, complaints made by employers were over six times more likely to result in a sanction or warning against the doctors subject to complaint.<sup>36</sup>

35 Denham C.J., Hardiman J., O’Donnell J., McKechnie J., Dunne J. 2015. MARTIN CORBALLY v THE MEDICAL COUNCIL, IRELAND AND THE ATTORNEY GENERAL.

36 General Medical Council, 2013. State of Medical Education and Practice Report, 2013.

Table 3: Proportion of complaints that proceed through disciplinary process

Organisation	Time Period	% of complaints that proceed to fitness to practice or disciplinary inquiry	% of fitness to practice or disciplinary inquiries that result in sanction
Medical Council of Ireland	2008-2012	11%	68%
• All	Mid 2011-2012	7%	35%
• Public	Mid 2011-2012	41%	85%
• Employers and other healthcare professional			
General Medical Council UK*	2010	4%	80%
	2011	2%	86%
	2012	2%	77%
College of Physicians and Surgeons of Ontario	2012	3%	n/a**
<b>Total</b>		<b>100%</b>	

\*The proportion relate to all enquires that require triage by the Medical Council to consider whether it raises a question about a doctor's fitness to practise.<sup>37</sup>

\*\*There is no data available.<sup>38</sup>

The Medical Council take seriously all concerns from any source regarding the fitness to practise of any doctor. The public are an important source of information about the quality of healthcare and about doctors' practice. Complaints from patients and their families require an effective response. In fact, the majority of fitness to practise inquiries held by the Medical Council relate to complaints from the public. However, there is a specific purpose to the fitness to practise process and a defined legal threshold for a medical regulator to hold an oral inquiry into the conduct or performance of a doctor and thereafter take action against a doctor's registration, in appropriate circumstances. In common with other medical regulatory bodies, the Medical Council finds that this threshold is more commonly met when concerns are brought to it by employers and other healthcare professionals. In the context of a complex, confusing and disjointed system for public complaints about healthcare, this threshold, combined with misunderstanding about the purpose of the fitness to practise process, may lead to an "expectations gap", which can result in dissatisfaction with how complaints are handled.<sup>39</sup> That gap can only be addressed through improving public understanding of the current complaints handling system or by reforming the system for managing public complaints so that there are better ways to respond to public complaints and to link these with fitness to practise processes.

Box 2 provides some examples of how other medical regulators deal with public complaints.

37 General Medical Council, 2013. 2013 annual statistics for our investigations into doctors' fitness to practise

38 College of Physicians and Surgeons of Ontario, 2013. Annual Report 2013.

39 Bismark MM, Spittal MJ, Gogos AJ et al. Remedies sought and obtained in healthcare complaints. *BMJ Qual Saf.* 2011 Sep;20(9):806-10.

## Box 2: Some examples of how medical regulators link with public complaints in other health systems

### General Medical Council, UK

Like the Medical Council in Ireland, the UK's General Medical Council can receive complaints direct from the public; however, it has a different set of powers to deal with complaints before needing to call a fitness to practise inquiry. While all complaints at the Medical Council are brought forward to an investigation, the General Medical Council has powers to re-direct complaints to the local healthcare organisation and the doctor's employer without conducting a full investigation. This direction is made with a request for further information if the complaint is indicative of a wider pattern of concerning practice; if that is the case, the General Medical Council can proceed to a full investigation. Furthermore, following a full investigation and without proceeding to a fitness to practise inquiry, the General Medical Council has the powers to issue a warning to a doctor where there has been a departure from good practice but where the issue does not call into question the need to inquire into the doctor's fitness to practise. Undertakings can also be agreed with doctors following a full investigation and without a need for a fitness to practise inquiry.

### The Medical Board and the Health Care Complaints Commission, New South Wales

In New South Wales, complaints about doctors can be made to both the Medical Board and the Health Care Complaints Commission (HCCC) under a co-regulatory model. Regardless of the route, all complaints are assessed by both bodies, and a decision is then made as to which should lead on action. Complaints about doctors which demonstrate or appear to demonstrate reckless, unethical, wilful or criminal behaviour in either clinical or non-clinical domains will usually be referred for investigation to the HCCC, which has powers to conduct a tribunal. In other circumstances, where public protection can be achieved through the application of non-disciplinary and educative responses, the Medical Council can direct the doctor to one of its Conduct, Health or Performance Programs, or to the HCCC's Resolution Service for conciliation or assisted resolution. Even where one body takes a lead on handling a complaint, there are provisions for cross referral during the management of the complaint if a role for the other body is identified.

### The Medical Council and the Health and Disability Commissioner, New Zealand

In New Zealand, a member of the public who has concerns following their experience of healthcare brings a complaint to the Health and Disability Commission (HDC); the Medical Council cannot deal with a public complaint and must refer it to the HDC, however, employers and other doctors can contact the Medical Council directly with a concern. Public complaints relating to doctors can be investigated by the Health and Disability Commissioner and it can conduct a tribunal. The HDC can also refer matters to the Medical Council in circumstances where this is the best course of action; for example, where there is a concern about a doctor's health or performance.

## Are some doctors more prone to complaint and disciplinary action?

For the first time, we have identified doctor-related characteristics which are associated with an increased likelihood of being subject to a complaint to the Medical Council: being male, being in an older age group, qualifying in Ireland and being registered as a specialist. We have also identified that doctors who are subject to one complaint are more likely to be subject to a second complaint than doctors in general. Our qualitative review has also suggested that doctors working in psychiatry, cosmetic surgery, obstetrics and gynaecology and in locum/out-of-hours contexts may face particular challenges in relation to complaints. Finally, we have found that some doctors are more likely to experience disciplinary action once a complaint is investigated: younger doctors, those who qualified outside Ireland and those without specialist qualifications.

Our experience is, in many ways, similar to that reported internationally.

In the UK, the National Clinical Assessment Service (NCAS) is a body which receives notifications from healthcare organisations of doctors whose practice is causing concern. An analysis of its data has found that doctors whose first medical qualification was gained outside the UK were more than twice as likely to be referred to NCAS as UK-qualified doctors; male doctors were more than twice as likely to be referred as women doctors; and doctors in the late stages of their career were nearly six times as likely to be referred as early career doctors.<sup>40</sup>

40 Donaldson LJ, Panesar SS, McAvoy PA, Scarrott DM. Identification of poor performance in a national medical workforce over 11 years: an observational study. *BMJ Qual Saf.* 2014 Feb;23(2):147-52.

The General Medical Council has reported on the phenomenon of “complaint-prone” and “discipline” prone doctors through its State of Medical Education and Practice report series. For example, it has reported that it both received more complaints about, and was more likely to take forward disciplinary action about, male doctors and older doctors.<sup>41</sup> Qualification outside the UK is also relevant; while these doctors are no more likely to be complained about to the General Medical Council, once a complaint is received, it is more likely to move forward through the regulator’s disciplinary process. This pattern of “higher impact” disciplinary decision-making by the General Medical Council affecting overseas qualified doctors has also been reported by Humphries et al.<sup>42</sup> Also examining General Medical Council data, Dacre et al found that the likelihood of being sanctioned following disciplinary action was greater for males, for doctors who qualified outside the UK, for doctors with increasing duration of practice, and for general practitioners.<sup>43</sup>

Spittal et al have examined the factors that predict the likelihood of doctors being subject to a formal patient complaint in Australia. Being male, being an older doctors and being subject to a previous complaint were all associated with being “complaint-prone”.<sup>44</sup> In addition to psychiatry, cosmetic surgery, obstetrics and gynaecology, they also found that complaints were more likely among doctors working in a number of specialities: internal medicine, general practice, surgery and dermatology. Pooling data on disciplinary action against doctors between Australia and New Zealand across the period 2000-2009, Elkin et al found that the likelihood of disciplinary action was greater for males and for doctors working in general practice, psychiatry and obstetrics and gynaecology.<sup>45</sup> Examining the data of medical regulators in a number of Australian states, Elkin et al also found that overseas qualified doctors were more likely than Australian-trained doctors to attract complaints and adverse disciplinary findings.<sup>46</sup>

In the US, analysis of State Medical Board disciplinary data has shown that likelihood of being subject to disciplinary action was greater for males, non-specialists, older doctors, and internationally qualified doctors; specialities associated with a greater likelihood of disciplinary action included general/family practice, psychiatry, obstetrics and gynaecology and emergency medicine.<sup>47,48</sup>

Box 3 summarises characteristics which appear to be more commonly associated with an increased likelihood that a doctor will face a complaint and/or disciplinary action.

41 General Medical Council. State of Medical Education and Practice Report Series, 2011-2014. <http://www.gmc-uk.org/publications/25452.asp>

42 Humphrey C, Hickman S, Gulliford MC. Place of medical qualification and outcomes of UK General Medical Council "fitness to practise" process: cohort study. *BMJ*. 2011 Apr 5;342:d1817. doi: 10.1136/bmj.d1817

43 Unwin E, Woolf K, Wadlow C, Dacre J. Disciplined doctors: does the sex of a doctor matter? A cross-sectional study examining the association between a doctor's sex and receiving sanctions against their medical registration. *BMJ Open*. 2014 Aug 7;4(8):e005405.

44 Spittal MJ, Bismark MM, Studdert DM. The PRONE score: an algorithm for predicting doctors' risks of formal patient complaints using routinely collected administrative data. *BMJ Qual Saf*. 2015 Jun;24(6):360-8.

45 Elkin KJ, Spittal MJ, Elkin DJ, Studdert DM. Doctors disciplined for professional misconduct in Australia and New Zealand, 2000-2009. *Med J Aust*. 2011 May 2;194(9):452-6.

46 Elkin K, Spittal MJ, Studdert DM. Risks of complaints and adverse disciplinary findings against international medical graduates in Victoria and Western Australia. *Med J Aust*. 2012 Oct 15;197(8):448-52.

47 Khaliq AA, Dimassi H, Huang CY, Narine L, Smego RA Jr. Disciplinary action against physicians: who is likely to get disciplined? *Am J Med*. 2005 Jul;118(7):773-7.

48 Kohatsu ND, Gould D, Ross LK, Fox PJ. Characteristics associated with physician discipline: a case-control study. *Arch Intern Med*. 2004 Mar 22;164(6):653-8.

*Box 3: Doctor related factors associated with being complained about or disciplined*

Factor
Male gender
Older age
Not holding specialist qualifications
Qualifying as a doctor in another health system
Certain areas of practice including general practice, psychiatry and obstetrics and gynaecology
Being subject to a previous complaint, especially multiple complaints

**Maintaining a focus on good communication and compassionate care**

This review identified a range of issues which caused concern about doctors' practice for those making complaints to the Medical Council. It was not our intention to explore the frequency of these issues, since we already report these through our Annual Reports (See Table 4), but rather to understand the issues in depth. While some of these related to doctors' clinical knowledge and technical skills, the importance of good communication and compassionate care is clear; this includes respecting the role which patients play in their own health and taking appropriate account of their own knowledge of their illness.

*Table 4: The 5 leading contributory factors in complaints to the Medical Council, 2013*

Contributory factor	Number of complaints
Diagnosis	123
Communication	112
Clinical investigations and examinations	80
Follow-up care	74
Appropriate Professional Skills	46

Source: Medical Council Annual Report, 2014

These attributes of doctors' practice are often referred to as "professionalism". We have found that most patients positively experience these aspects of the patient-doctor relationship. For example, in a survey of the general public in 2013, 94% were satisfied or very satisfied with their experience of the doctor they attend most often; and 9-in-10 said that their doctor communicates effectively, provides understandable explanation, listens, and takes them seriously.<sup>49</sup>

However, it is clear through our review of complaints that there is variability in how patients experience doctors and that a more consistent focus on communication and compassion is required. This is similar to the experience of other bodies that respond to complaints about doctors; for example, the General Medical Council in the UK report that approximately 1-in-3 complaints it handles relate, in full or in part, to communication skills; for public complaints, this proportion of communication-related complaints rises to approximately 1-in-2.<sup>50</sup>

49 Medical Council, 2014. Talking about good professional practice - views on what it means to be a good doctor.

50 General Medical Council, 2013. 2013 annual statistics for our investigations into doctors' fitness to practise

Professionalism is a complex concept. While there is a knowledge-base and a skill-base required for a doctor to be professional, professionalism concerns attitudes and behaviours. These attitudes and behaviours are formed and maintained through informal interactions in the workplace and are strongly shaped by culture. Formal education, training and lifelong learning programmes must provide a foundation for good professional practice but for these programmes to be effective, the leadership and culture at the settings where healthcare is delivered and the wider healthcare system must support appropriate professional attitudes and behaviours.<sup>51,52,53</sup>

### Challenging work contexts for doctors

This review identified that the context in which a doctor works can, sometimes, contribute to causes of concern. While it is necessary for doctors to have the knowledge, skill and attitudes for good care, the environment in which a doctor practices can influence patients' experience of care. For example, heavy workloads, poor facilities and equipment and ineffective team-working can all contribute to poor care for patients; these factors may be outside the control of the doctor who is complained about (Box 4).

#### Box 4: Examples of contextual factors that influence doctors performance in practice

Factors
Leadership in the workplace
Organisational culture and climate
Physical facilities
Equipment
Information systems and ICT
Policies, procedures and guidelines
Appraisal (including audit and indicators), feedback and learning
Team working
Workload and job design

Source: Adapted from Cox et al<sup>54</sup>

In responding to complaints about doctors, it is important the Medical Council continues to recognise the challenges which doctors face in day-to-day practice and seeks to provide advice on how best to navigate these so as to ensure good care for patients.

### Can we address risk and causes of concern?

Now that we have a better understanding of risk and the causes of concern about doctors' practice, are there ways that we can begin to address these?

The Medical Council's role is wider than responding to complaints; it includes providing guidance for doctors' conduct and ethics, and quality assuring doctors education, training and lifelong learning.

51 Lesse CS, Lucey CR, Egener B et al. A Behavioral and Systems View of Professionalism JAMA. 2010;304(24):2732-2737

52 Holohan T, 2014. HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006-date) - Report to the Minister for Health Dr James Reilly TD.

53 Francis R, 2013. Report of the mid-Staffordshire NHS Foundation Trust Public Inquiry.

54 Cox J, King J, Hutchinson A, McAvoy P, 2006. Understanding doctors' performance.

The *Guide to Professional Conduct and Ethics* is at the core of the work of the Medical Council. It sets out what we expect of good doctors. This review was conducted to inform a revision of that Guide, and the content has been updated to take specific account of the issues which have been identified in 2008-2012. For the first time, our guidance to doctors on conduct and ethics has been based on evidence regarding issues which cause concern. To coincide with the launch of this review, we will be commencing consultation on a draft version of the revised *Guide to Professional Conduct and Ethics* and we will be establishing ways to support these through topic-specific supplementary information so that doctors can embed the guidance in day-to-day practice.

There is good evidence to demonstrate that doctors who are complained about to medical regulatory authorities have sometimes been a cause of concern at medical school, either because of their conduct or their academic performance.<sup>55</sup> Ensuring medical schools are guided and supported to deal effectively with issues arising for medical students - including removing students from the programme where this is in the public interest - is important.

The Medical Council has previously welcomed the increasing emphasis on communication skills and professionalism at undergraduate level.<sup>56</sup> We need to ensure that this emphasis is maintained along the continuum of medical education and training for doctors, and is well embedded in lifelong learning. The age profile of doctors complained about indicates that a focus on maintaining communication skills and professionalism is required throughout doctors' professional lives. Since 2010, the Medical Council has been working with doctors to ensure they are engaged in lifelong learning. While this is a developing area, there is good evidence to show that doctors who engage in lifelong learning, especially learning activity which is based in their day-to-day practice and involves learning with peers, are less likely to experience a complaint to the medical regulator.<sup>57</sup> Now that this system is established for doctors in Ireland, we must find ways to maximise its benefit for doctors and patients.

We also need to ensure that doctors benefit from adequate support to get a good start when they enter practice in Ireland for the first time.

Through our registration function, we assess doctors to determine who can enter practice in Ireland. Pre-registration exams for internationally qualified doctors are a common safeguard across professional regulatory authorities and it has been found that doctors who perform well in these exams, especially in assessment of communication skills, are less likely to experience a subsequent complaint to the medical regulator.<sup>58</sup> We already require some internationally qualified doctors to participate in our examinations, which are specifically designed to address communication skills as well as clinical knowledge and practical skills, and we are further strengthening the Medical Council Pre-registration Examination System in 2015. However, there are some limitations to our registration function. Due to EU legislation governing professional mobility and the free market, the Medical Council cannot test English language skills of doctors who are seeking to practice medicine in Ireland and we continue to work with legislators to address this concern. Furthermore, the current legislation provides mechanisms for entry to register which bypass our examination and we welcome legislative plans to revise these provisions through amendment to the Medical Practitioners Act 2007.

Through *Your Training Counts*, we have highlighted gaps and weakness in induction and orientation for doctors in training and it is reasonable to conclude that these same issues apply to all doctors who are new to practice. We will continue to work with employers to emphasise how pivotal good induction and orientation are to supporting doctors in good professional practice who are new to a health care setting. We also identified that doctors transitioning from medical school to practice for the first time may experience particular challenges in taking this important step, including a sense of being under-prepared. We are currently consulting with trainees and other stakeholders to better understand these issues and are preparing some changes to internship training in Ireland which will better support these doctors.

55 Papadakis MA, Teherani A, Banach MA, et al. Disciplinary action by medical boards and prior behavior in medical school. *N Engl J Med*. 2005 Dec 22;353(25):2673-82.

56 Medical Council 2013. *Medical Education, Training and Practice in Ireland - A Progress Report*.

57 Wenghofer EF, Campbell C, Marlow B, et al. The effect of continuing professional development on public complaints: a case-control study. *Med Educ*. 2015 Mar;49(3):264-75.

58 Tamblyn R, Abrahamowicz M, Dauphinee D, et al. Physician scores on a national clinical skills examination as predictors of complaints to medical regulatory authorities. *JAMA*. 2007 Sep 5;298(9):993-1001.

Our review – in common with other reviews of complaints and disciplinary decision – highlighted a need to consider internationally qualified doctors. It is a huge transition to move between health systems for any health professional and it can be difficult to quickly adapt to the sometimes subtle differences in professionalism expectations, like how doctors relate to patients and their families, and how doctors work with other healthcare professionals; these expectations are culturally constructed and can be very different in different health systems.<sup>59</sup> In response to findings similar to those in this review, on behalf of the General Medical Council, Slowther et al explored the potential difficulties experienced by internationally qualified doctors in their transition to practice within the UK ethical and professional regulatory framework.<sup>60</sup> It was found that these doctors often lacked relevant information about legal, ethical, and professional standards and guidance, experienced variable levels of training and support specifically in the areas of communication and ethical decision making, and isolation in non-training posts; in particular, these doctors were challenged by the emphasis on individual autonomy and shared decision making between doctor and patient which is the current norm in the UK and the contrast with their experience of a more paternalistic model of the patient doctor relationship in their country of qualification.

Ensuring doctors new to practice in Ireland – both Irish qualified and internationally qualified – is a priority for the Medical Council and we are undertaking further research this year to better understand the issues and to establish how it can support all doctors with a “safe start”.

## Conclusion

Ron Paterson, former Health and Disability Commissioner in New Zealand noted:

*“Complaints matter: to the people who make them, usually as a last resort after the frustration of trying other avenues without success; to the person complained about, in whom the complaint may provoke a fierce reaction, ranging from shame to indignation; and to the agency required to handle the complaint, charged with resolving a problem when parties’ recollections and objectives may be sharply divergent”.*<sup>61</sup>

Because complaints matter, we have a duty not only to seek to address these individually as they arise, but to consider what we can learn to improve our role in overseeing doctors in Ireland for the benefit of patients and to share with everyone interested in patient safety and healthcare quality. *Listening to Complaints, Learning for Good Professional Practice* is the first time that the Medical Council has comprehensively reviewed its role in responding to complaints about doctors.

59 Chandratilake M, McAleer S, Gibson J. Cultural similarities and differences in medical professionalism: a multi-region study. *Med Educ.* 2012 Mar;46(3):257-66..

60 Slowther A, Lewando Hundt GA, Purkis J, Taylor R. Experiences of non-UK-qualified doctors working within the UK regulatory framework: a qualitative study. *J R Soc Med.* 2012 Apr;105(4):157-65.

61 Paterson, R. Not so random: patient complaints and frequent flier” doctors”. *BMJ Qual Saf* 2013; 22: 252-257.

## Next steps

In summary, here are the steps we intend to take to ensure that this learning informs improvements in our work.

<b>Supporting complainants and the wider system for complaints about healthcare</b>
We will continue to ensure that accessible information about our role in handling complaints is available to support anyone who may have a concern about their experience of healthcare.
We will continue to work with complainant expectations by clarifying our specific role in relation to fitness to practise of doctors, highlighting the legal threshold for our action and explaining what can - and what cannot - be achieved through a complaint to the Medical Council.
We will continue to work with existing patient advocacy services to ensure that complainants are supported and that our role, in the context of the wider healthcare handling complaints system, is understood. We will consider how we can ensure that there are specific supports made available for complainants who may have particular needs, such as those with mental health difficulties.
We will support and collaborate with national patient advocacy services established under the new Patient Safety Agency to ensure that we can continue to play an appropriate and effective role in the wider system for handling complaints in healthcare.
<b>Working with doctors who are complained about</b>
We will ensure that our procedures for handling complaints are clearly explained to doctors who are asked to respond to a complainant. We will explain what role acknowledgements, apologies, and implementation of practice improvement can play for doctors in responding to complaints.
We will continue to advise doctors of the importance of ensuring that they have professional indemnity which is sufficient to ensure they can access support for disciplinary investigation.
We cannot offer support to doctors who are complained about; however, it recognises that the complaints process is difficult for all parties and continues to advocate with doctors' training and representative organisations to ensure that collegial support is available to doctors.
<b>Enhancing our handling of complaints - ensuring a fair, consistent and effective process</b>
We will continue to ensure our role in handling complaints is fair, consistent and effective through following process that is clearly documented and available to all parties. We will continue to ensure that everyone involved in complaints handling - Case Officers and Members of the PPC, FTPC and the Medical Council - benefits from training to ensure that they can discharge their role effectively.
We have developed a policy on equality and diversity and will ensure that this is embedded in our complaints handling functions through training and monitoring.
We will ensure that the effectiveness and consistency of decision-making is assured through continuous monitoring and audit of our complaint procedures.
<b>Preventing concerns and promoting good practice - standards and guidance for doctors</b>
We have revised the Guide to Professional Conduct and Ethics to reflect lessons learned from this review and will finalise it later this year based on feedback from the public, doctors, and all other stakeholders.
We will develop further information for doctors and design educational supports so that they understand how best to embed the Guide in day to day practice.
We will seek to address specific contexts and issues where, based on this review, it appears that doctors may need further support to ensure good practice, for example, interacting with families.

<b>Preventing concerns and promoting good practice - entry to practice</b>
We will continue to work with the Department of Health to ensure that the system of registration of doctors is robust and effective. This includes ensuring that we are empowered through legislative amendment to assess English language competence among doctors new to practice in Ireland.
We will continue to strengthen our Pre-Registration Examination System to ensure that it effectively assesses skills, including communication skills, necessary for practice in Ireland.
We will assess the needs of doctors who are new to the practice of medicine in Ireland to determine who we can support them make a "Safe Start".
We will continue to highlight the importance of robust and effective induction and orientation to doctors who are new to specific healthcare settings.
<b>Preventing concerns and promoting good practice - entry to practice</b>
We will continue to emphasise the teaching and learning of communication skills, compassionate care, and professionalism across the continuum of education, training, and lifelong learning and through our quality assurance role, we will conduct a thematic review in this area to determine current strengths and opportunities for further development in the medical education and training sector.
We will support medical schools to ensure medical student professionalism is promoted through guidance; this guidance will clarify our expectation that concerns regarding medical student conduct and academic performance, which might herald future problems, are effectively managed.
We will examine how doctors' lifelong learning can be designed to prevent concerns and promote good practice, especially among doctors who are at an increased likelihood of complaint. We will begin by considering the needs of non-specialists who are not in training.
We will pilot patient feedback with doctors as a tool to focus lifelong learning on communication skills and professionalism.
<b>Preventing concerns and promoting good practice - developing evidence-base and information</b>
We will develop our information systems that support our role in complaint handling. We are already gathering enhanced information on complaints (for example source of complaint, healthcare setting and location where concern arose) and we will develop greater intelligence about medical practice in Ireland.
We will continue to periodically review and report on our role in complaints handling so as to identify learning for improvement.
We will examine how best we can share information with everyone interested in safe, high quality care and how we might contribute to patient safety surveillance in Ireland.
<b>Healthcare organisations and employers of doctors</b>
Healthcare organisations and employers of doctors need to develop systems of clinical governance with improved processes to handle complaints that will - as appropriate - link public complaints with other local information and refer concerns regarding a doctor's fitness to practise to the Medical Council.
Healthcare organisations and employers of doctors need to ensure there is effective support, beginning with induction and orientation, for doctors entering new practice settings, especially those new to the practise of medicine in Ireland.
Healthcare organisations and employers of doctors need to ensure the medical professionalism is enabled through leadership and culture which supports a strong and effective patient-doctor relationship.

## STATISTICAL ANNEX

## STATISTICAL ANNEX

### Summary of doctors subject to complaint included in the quantitative review

Characteristic	Number of registered doctors (%)*	Number of doctors complained (%)	Number of PPC decisions (% total)	Number of FTP decisions (%)	Number of Medical Council Sanctions (%)
<b>Gender</b>					
Female	7120 (39%)	463 (22%)	433 (22%)	26 (12%)	16 (11%)
Male	11352 (61%)	1593 (78%)	1528 (78%)	191 (88%)	131 (89%)
<b>Age Group</b>					
20-35 years	5662 (31%)	148 (7%)	146 (7%)	26 (12%)	20 (14%)
36-45 years	5080 (28%)	493 (24%)	480 (25%)	61 (28%)	45 (31%)
46-55 years	4031 (22%)	701 (34%)	662 (34%)	68 (31%)	46 (31%)
56-64 years	2232 (12%)	525 (26%)	495 (25%)	39 (18%)	22 (15%)
65+ years	1447 (8%)	189 (9%)	178 (9%)	23 (11%)	14 (10%)
<b>Country of qualification</b>					
Qualified in Ireland	11960 (65%)	1519 (74%)	1463 (75%)	91 (42%)	59 (40%)
Qualified in EU	1559 (8%)	161 (8%)	160 (8%)	42 (19%)	29 (20%)
Qualified outside EU	4893 (26%)	376 (18%)	338 (17%)	84 (39%)	59 (40%)
<b>Division</b>					
Specialist registration	9274 (50%)	1289 (63%)	1216 (62%)	70 (32%)	44 (30%)
General registration	6682 (36%)	721 (35%)	701 (35%)	139 (64%)	99 (67%)
Intern	686 (4%)	1	1	1	-
Trainee specialist	1706 (9%)	45 (2%)	43 (2%)	7 (3%)	4 (3%)
<b>Total</b>	<b>18472</b>	<b>2056</b>	<b>1961</b>	<b>221</b>	<b>148</b>

\*interpolated annual average in the review period

Summary of complaints included in the qualitative review

Characteristic	Number of complainants (%)*	Number of doctors (%)
<b>Gender</b>		
Female	69(61%)	33 (26%)
Male	45(39%)	95 (74%)
<b>Source</b>		
Patient	53(46%)	-
Family	47(41%)	-
Others	14(13%)	-
<b>Age group</b>		
20-35 years		7%
36-45 years		24%
46-55 years		33%
56-64 years		26%
65+ years		10%
<b>Country of qualification</b>		
Qualified in Ireland		91(71%)
Qualified in EU		9(7%)
Qualified outside EU		28(21%)
<b>Division</b>		
Specialist registration		87(68%)
General registration		41(32%)
<b>Total</b>	<b>114</b>	<b>128</b>

*Summary of context of complaints and some issues identified in the qualitative review\**

Issue	Number of complaint files
<b>Contexts of complaint</b>	
Locum services	10
Psychiatry	8
<b>Issue arising</b>	
Misdiagnosis	29
Inadequate examination	14
Prescribing	11
Not listening	18
Sexual assault, harassment or inappropriate sexual comments	7
Discrimination (including homophobia)	9 (4)
Medical records	9

\*the qualitative review was not designed to make a generalizable assessment of statistical frequency.



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