The evolution of complaint management in the Hong Kong Hospital Authority. Part 2: The 'complaints' iceberg

As most medical colleagues are aware, the term 'clinical iceberg' is used to describe the phenomenon whereby the visible part of a disease—that which is detected or diagnosed—is only the 'tip of the iceberg'. What may matter even more is that there might be a significantly greater part which has not yet been uncovered.[1]

We may perhaps use the same analogy to consider what may be usefully gained from the complaints process. It may be that what we can see from the complaints received is only the tip of the 'complaints iceberg'. Nonetheless, just as it is useful to work from what is visible to try to discern pointers as to what is happening in the greater, unearthed portion, so there may perhaps be useful 'lessons to learn' from a sampling of the cases we have received over the years.

Complaint case 1: Informed consent for teaching purposes

In a patient complaint which happened at a teaching and clinical session of the gynaecology clinic of a public hospital, the complainant was dissatisfied with the hospital's arrangement whereby she had to undergo vaginal examination 3 times (one by the specialist and the others by two medical students). She alleged that no prior consent for the vaginal examination for teaching purposes was sought from her.

Observations and conclusion

The case was subsequently submitted to the Hospital Authority (HA) Public Complaints Committee (PCC)—the final appeal body for patient complaints within the HA—which ruled that:

(1) the specialist did not clearly inform the patient that the vaginal examination by the medical students was for teaching purposes;
(2) no prior consent was sought from the patient for the vaginal examinations by the medical students; and
(3) the medical students were not clear about the concept of patient informed consent as reflected in their statements submitted during the complaint investigation.

Recommendations and follow-up actions

Following the PCC's recommendations, a review was conducted by the HA on the issue of patient consent for physical examination by medical students for teaching purposes as part of the Authority's risk management initiatives. Since the review, the concerned medical staff have been reminded that prior patient consent must be obtained. The case was also shared by all frontline staff through the Risk Management Release (a corporate electronic publication on risk management) to prevent recurrence of similar problems. The PCC Secretariat has also formally written to the deans of the medical schools drawing their attention to the case and suggesting that they alert medical students of the importance of patient consent for physical examination.

Complaint case 2: The importance of good medical records keeping

In a complaint against a public hospital for inappropriately discharging a patient who was suspected to be suffering from peritonitis, the PCC noted that the patient had had a history of Sjogren's syndrome complicated by thrombocytopenia and hyperviscosity for 8 years. She also suffered from nephritis and was maintained on immunosuppressive therapy.

She was admitted to hospital A for fever and abdominal distension and was discharged 2 days later upon stabilisation. Six days later, the patient was admitted to hospital B through the Accident and Emergency Department for a similar complaint and it was treated as peritonitis. She was subsequently transferred back to hospital A for further treatment.

Observation and conclusion

The complaint was received 2 years after the incident. During the course of investigation, the patient's medical records during the first episode of hospitalisation at hospital A were found to be missing. This had posed great problems for the PCC in reconstructing the chronology of events and what transpired when the patient was hospitalised. The hospital had made tremendous efforts to retrieve other available evidence, including medical information in the computerised laboratory results report, the prescription records during her hospital stay, and the discharge summary. These records revealed that abdominal parencentesis was not indicated during the patient's hospitalisation, that her condition at the time of discharge was stable, that she was not on antibiotics during her hospital stay nor upon discharge and that a follow-up appointment was only scheduled for 3 weeks' time.

Based on expert advice, the available medical information and circumstantial evidence during the patient's 2-day stay in hospital A, the PCC concluded that it was unlikely that the patient was suffering from peritonitis at the time. The allegation of inappropriate discharge of the patient was unsubstantiated.

Recommendations

Good medical records and thorough documentation are

essential in responding to complaints and claims. They provide an objective record of treatment of a patient. Arising from this case, the PCC had made a general recommendation to remind management and staff of all HA hospitals on the importance of proper record management.

Complaint case 3: Use of less flammable disinfectant

In a complaint against a public hospital for causing a burn injury to the patient during an emergency appendictomy operation, the PCC noted that the patient was suffering from acute appendicitis. Emergency appendictomy under general anaesthesia was arranged. After induction and intubation, Hibitane, a disinfectant, was used to prepare the patient for operation. Bleeding was noted during the operation. To stop the bleeding, coagulation diathermy was applied. When diathermy was applied for the second time, smoke was noted coming out beneath the drapes covering the patient. A longitudinal burn was subsequently found on the patient's right loin and upper part of the right buttock.

Observations and conclusion

Although the blue flame generated by fire involving Hibitane would normally not be visible under operating theatre lighting, the Committee considered that the patient's injury was caused by accidental diathermy burns as a result of inadvertent collection of excessive Hibitane beneath the drapes covering the patient.

Recommendations

Since Hibitane is an inflammable disinfectant used to prepare patients for operation, the Committee recommended that extra care should be exercised when applying the disinfectant and diathermy in any operative procedure.

Follow-up actions taken by the hospital

Following the Committee's recommendation, the hospital reviewed and considered the use of an alternative and less flammable disinfectant other than Hibitane for preoperative preparation of patients to prevent future recurrence of similar incidents.

Over the years, the hospitals and the PCC have built up a valuable and substantial cache of thousands of complaint cases, derived from all areas of HA operations.

However, attention has to date been focused mainly on the handling of individual complaint cases—some of which could be very complex, involving more than one hospital or department, and encompassing comments relating to varied aspects of hospital care. Whilst the satisfactory resolution of individual cases is important, it is also important, particularly from the viewpoint of a hospital authority overseeing over 40 hospitals, to try to discern whether there are particular trends, or systemic problems. A broader overview of the range of issues that have been raised in the complaints received, or of the characteristics of the patients, departments or hospitals involved in the complaint cases, would also be useful.

Focusing only on dealing with individual complaints also means that the chance is lost to prospectively and systematically learn from circumstances that have led to complaints in the past, in the hope that proactive action or precautions may be taken to minimise the chances of similar complaints arising again in the future—the opportunity to effect 'system changes' through using sentinel events as the trigger or the alert.[2]

The HA is therefore aiming to enhance proactive mining of the complaint cache that exists in the HA, so as to develop a system to more sensitively monitor system failures and to achieve organisation-wide enhancements.

Discussion

The potential value of clinical complaints as a means of improving quality of care is also accepted in overseas health care systems. In the United States, the Joint Commission on Accreditation of Health Care Organizations, in its publication *Using Quality Improvement Tools in a Health Care Setting*,[3] sets out a ten-step model for monitoring and evaluation of health care quality including the collation of patient complaints as an important step in carrying out a full evaluation of health care quality standards. In the quality process as set out, it was also noted that while the collation of complaints as an initial step was important, just as important was the communication of results of the evaluation back to the source of the feedback and/or complaint, thereby ensuring that the loop was closed and that there was a genuine continuous quality 'cycle' at work.

This is particularly relevant to a health care organisation. It is one of the most complex of professional organisations as professionals have a large degree of control over such an organisation.[4] As a result, the ability of managers to influence decision-making is more constrained than in other organisations[5] and ways have to be found to generate change from the bottom up, not just the top down. Hospital doctors are unwilling to make changes unless they see benefits for their own practices and patients.[6]

Similar recognition of the value of complaints can be found from various studies in the United Kingdom, for example, the study by Bark et al[7] where 1007 complaints in 24 hospitals in the North West Thames region of England were surveyed and various aspects of each of the complaints were examined, including the nature of the complaint, the reasons for making a complaint, and factors that could have prevented complaints.

The authors concluded that a better response to complaints at the clinical level by the staff involved in the original incident was needed, staff training in responding to

complaints was essential, and *monitoring complaints must form part of a more general risk management programme*.

As a further recognition of the value of complaints, the National Health Service (NHS) in the United Kingdom expressly linked complaints with comprehensive proposals for reforming the approach to clinical negligence in its June 2003 consultation paper 'Making amends'.[8]

In this paper, it was proposed that the new NHS Redress Scheme would be closely aligned with the new NHS complaints procedure and it is envisaged that there would be a full investigation for each complaint case. This was partly so that individual complaints could be satisfactorily responded to, but the paper also calls for "the (health care) organisation (to) vigorously (investigate) and (learn) effectively from complaints...", and that investigation of complaints and incidents should be coordinated under a single senior manager.

It would therefore seem that the evolution of complaints management in Hong Kong does mirror similar developments overseas.

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I. Chronic benign neutropenia among Chinese children

A	1. False	2. True	3. True	4. False	5. True
B	1. True	2. True	3. False	4. False	5. True

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II. Gout: a review of its aetiology and treatment

A	1. False	2. True	3. True	4. True	
B	1. True	2. True	3. True	4. False	5. False
C	1. True	2. True	3. True	4. False	5. False