

Communication complaint types and contributory factors

March 2018

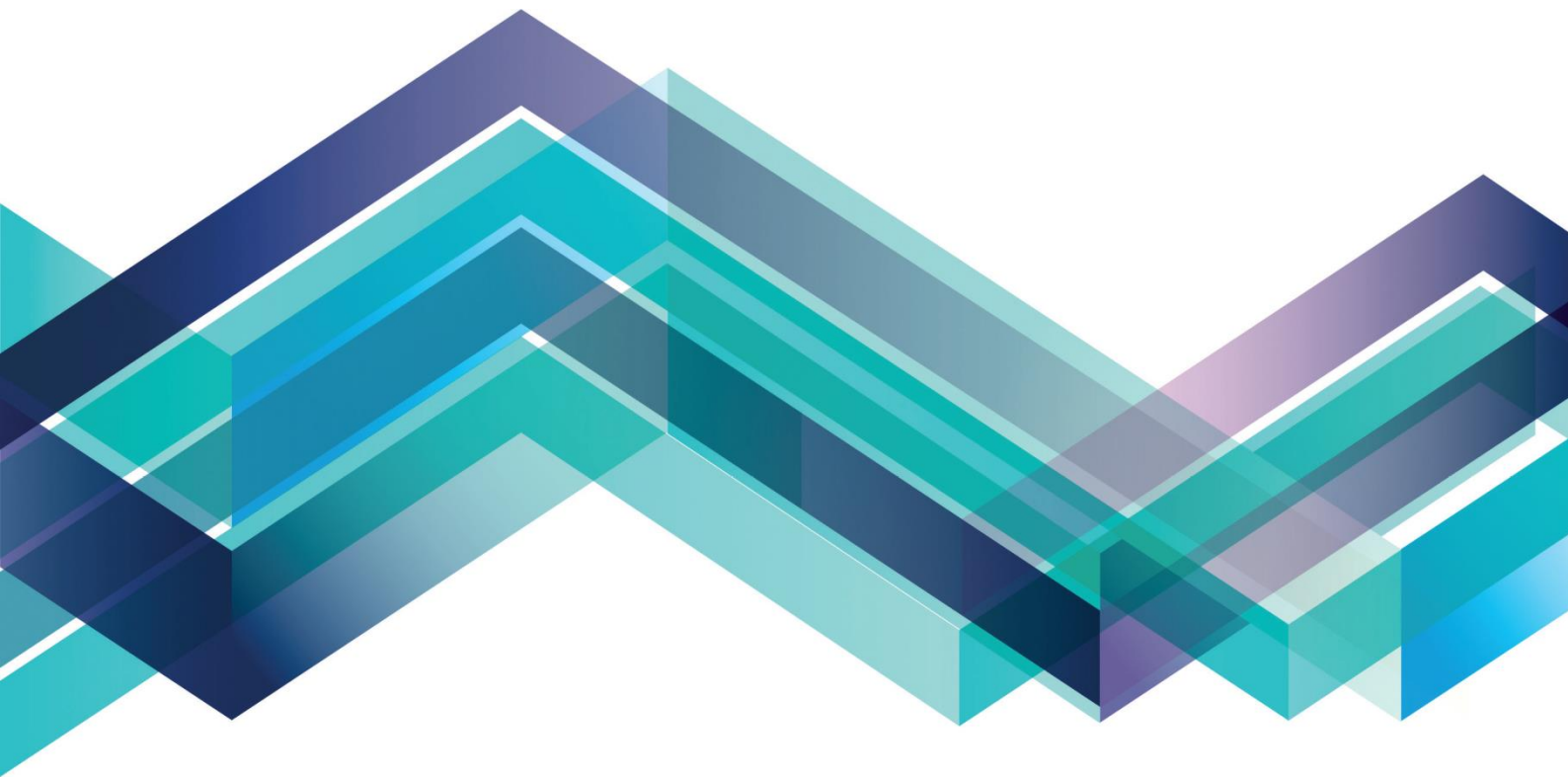


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1. Introduction

1.1 Background

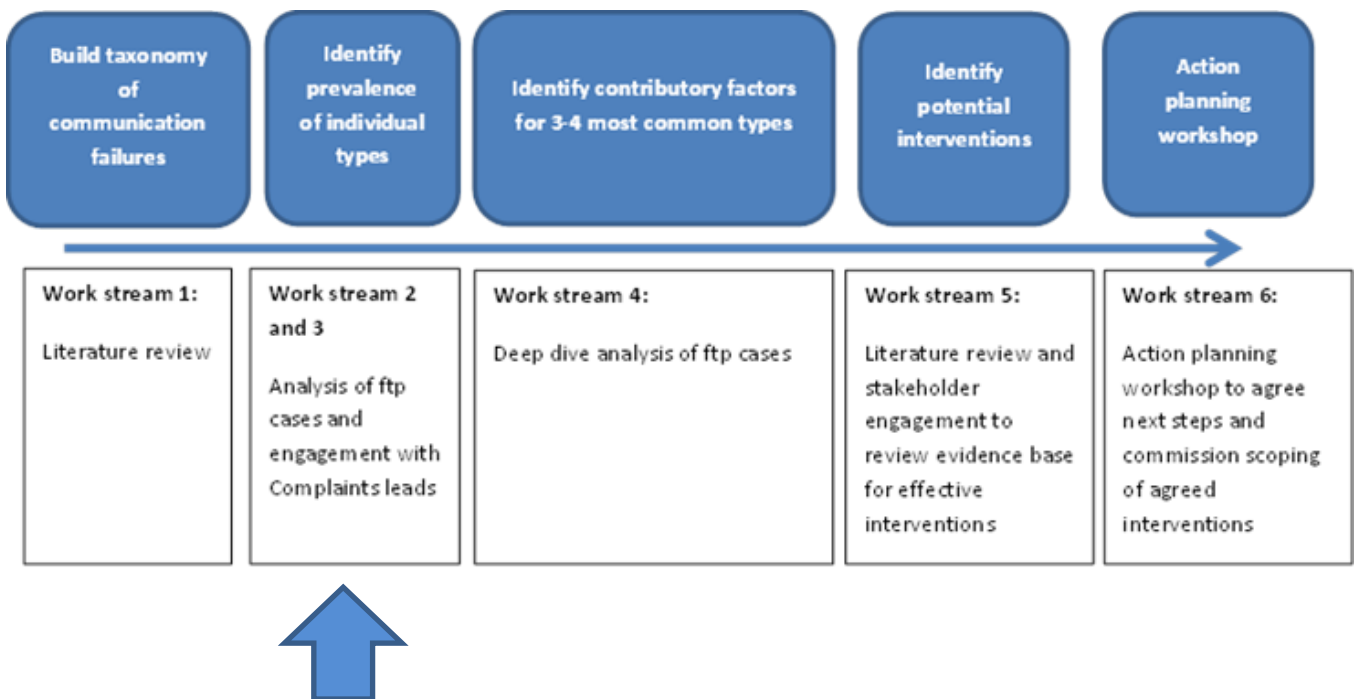
In recent years, we've been exploring how we might better use our data and resources to identify risk, target our support more effectively and adopt a more intelligence-led model of regulation.

Our aspiration is to use the data we hold to explore areas of risk that could result in, harm to either doctors or patients. For example -inadequate communication.

We are carrying out a project exploring communication-related harm which aims to:

- 1 Identify and understand the different types of communication failings that lead to substandard care and in some cases, patient harm.
- 2 Identify evidence based interventions for reducing the prevalence of communication failure and consider how these may be implemented.

There are a number of different strands to the project (see figure 1).



This report forms the output from work stream 3: engagement with complaints leads.

1.2 Research aims and objectives

The aim of this work stream was to carry out a small number of interviews with complaints leads working with NHS Health Boards and other national bodies in Scotland to explore:

- What types of communication complaints are received about doctors? (For example, how are they categorised, in what volumes are they received, what are the most common types etc?)
- What are the contributory / causal factors that drive their occurrence?

The research findings will contribute to the wider communication-related harms project. It will help to determine which types of cases we should explore further in work stream 4 – a deep dive of our fitness to practice cases.

1.3 Methods and scope

The research involved semi-structured telephone interviews with seven interviewees. The interviewees all had knowledge of communication-related complaints received in Scottish NHS health boards. Interviewees included:

- Patient and Advice Support Service (PASS) Advisors
- a complaints lead at a health board,
- those working in national organisations such as the Scottish Public Services Ombudsman (SPSO), NHS National Services Scotland and the Medical and Dental Defence Union of Scotland (MDDUS).

The interviews covered communication-related complaints received in Scotland only and was intended to support the literature review in work stream 1 which was largely funded by the Scottish government

The main focus of the research was on 'interpersonal' communication rather than 'organisational' communication which relates to systems and processes unless this was considered to be a contributory factor for interpersonal communication complaints.

The majority of communication complaints received by the organisations we spoke to are complaints between doctors and their patients however a smaller number are also received that relate to doctors and their colleagues and where relevant these are also included.

1.4 Notes on reading the report

There are a number of caveats that need to be considered when reading the report.

This was qualitative research with a very small number of interviews in Scotland alone and is not intended to be statistically reliable nor does it permit conclusions to be drawn about the extent to which something is true for the wider population.

For some of the interviewees, only very small numbers of communication-related complaints are received so their views are often anecdotal and cannot be generalised from.

All quotes and examples have been anonymised and identifying characteristics or facts may have been changed (e.g. gender) or concealed (e.g. procedure) to preserve the anonymity of those involved. Quotes have been used to illustrate particular points or viewpoints. They express the views of individuals and may not necessarily represent the view of the organisation they work for.

1.5 Structure of the report

The report sets out the main findings from the interviews. The report has two chapters covering:

- Communication complaints about doctors – this section describes the main types of communication complaints received about doctors and the circumstances around them. It looks at what and who complaints tend to be about, what type of communication method they relate to and what stage in the process they are about. It also describes the contributory factors relevant to that type of complaint.
- Emerging themes – themes emerging from the research such as the types of communication complaints that are considered to be most prevalent and to cause the most severe harm.

2. Communication complaints about doctors

2.1 How do organisations categorise communication complaints?

Organisations categorise communication complaints in different ways including:

- The nature / type of complaint e.g. consent and communication
- The type of care e.g. complaints about GPs or hospital doctors

Table 1 shows examples of the types of categories that are used to record communication complaints or were suggested as categories:

Table 1: Examples of communication categories

Examples of how communication complaints are categorised		
<ul style="list-style-type: none"> • Written communication – medical records • The way things are said • Not being listened to • Inconsistent information changes • Language and jargon 	<ul style="list-style-type: none"> • GP complaints • Hospital complaints • Whether they go to the ombudsman 	<ul style="list-style-type: none"> • Staff communication – oral <ul style="list-style-type: none"> ○ Lack of clear communication ○ Misunderstanding ○ Patient not being verbally told things ○ Test results not being communicated to patients • Staff communication - written <ul style="list-style-type: none"> ○ Lack of explanation ○ Misunderstandings ○ Consent and communication • Staff attitudes and behaviour <ul style="list-style-type: none"> ○ Abruptness ○ Conduct ○ Confrontation ○ Inappropriate comments ○ Insensitive to patient needs ○ Lack of support

A key finding from the research is that communication issues are often not framed or recorded as a complaint about communication. Often they're part of a complaint about something else such as a patient's treatment and care. This means that communication issues may be under-reported in the data.

“We have a single category for communication complaints and confidentiality so that’s one single category. But we also have a category which is about care and treatment which is fairly broad and within that we may well get communication issues. We have some numbers on complaints categorised as ‘communication complaints’ but when we look at our case summaries and recommendations communication does come up a lot more than would be suggested by that... [Communication] is under-represented in the figures and is often a feature of other complaints.”

Drawing together the findings from the interviews, table 2 shows the main issues relating to communication. We have indicated whether these tend to be complaints relating to GPs or hospital doctors or both; however this should be treated as anecdotal.

Table 2: Main types of communication issues

GP complaints	Hospital complaints
Communication during consultation	
	Consent and communication
	Communication on discharge
Difficult conversations around prognosis & EOLC	
Patients & relatives not feeling listened to	
Doctors not feeling listened to by colleagues	
Misunderstandings & lack of clarity	
Lack of ownership or responsibility for communication	
	Not being kept informed or updated
Medical records & referral letters	
Rude, arrogant & dismissive attitudes	
Organisational or system issues	

The next section describes each type of communication issue in further detail including any contributory factors. Often these issues can overlap and there can be a combination of communication issues and contributory factors in one complaint. For example complaints concerning patients not feeling listened to might also involve a rude, arrogant

or dismissive attitude. Complaints about consent might also involve misunderstandings and lack of clarity and issues around the terminology or jargon used.

It also may not be clear exactly what has taken place and what might have caused a communication breakdown – this can be because the individuals have different recollection of events or because it hasn't been possible to identify through the case investigation. However even if a doctor disagrees with the version of events there is a *perception* by the patient that there is a communication issue.

2.2 Communication during consultation

Complaints relating to poor communication during a consultation can include:

- the patient feeling rushed through a consultation, not having an opportunity to discuss everything they want to during the time allotted for their appointment.
- the doctor failing to effectively communicate diagnosis or treatment options.
- the doctor not involving the patient in decisions or failing to give appropriate advice.

“Either being rushed through the consultation, a failure to discuss diagnosis or treatment options, failing to give them appropriate advice at the consultation. The consultation has been rushed in some way and there hasn't been effective communication from the doctor to the patient about what their plan is and potential diagnosis and what the patient should look out for subsequently.”

For example, a patient who had a delayed diagnosis of cancer complained that their doctor had failed to communicate to them throughout their journey, from getting a diagnosis and afterwards once the diagnosis had been made.

These complaints tend to concern GPs, with locum GPs receiving a larger proportion which may be due to the GP not being familiar to the patient or to the practice.

Complaints about communication during consultation can also be received for hospital doctors and these tend to be about the patient:

- not seeing the consultant they had expected to see during a clinic
- being triaged to see a more junior doctor,
- suffering an adverse reaction and not feeling this was adequately communicated to them during the consultation
- expressing a wish for, or concerns about, a specific type of treatment and feeling that they have been ignored.

“A patient is triaged to see someone else, someone they weren’t expecting at the clinic because the person they were expecting to see simply had too many patients and has triaged some of their patients to a junior colleague and that person hasn’t known their background or hasn’t taken the time during the appointment to discuss their concerns.”

Hospital doctors tend to see more complaints from patients with longer term chronic conditions or pain issues where it can be difficult to get a diagnosis or to fix the issue such as in rheumatology or with patients waiting for steroid injections.

The vast majority of these complaints relate to face-to-face communication during the consultation and in hospital settings can also involve written correspondence to their GP not including all details and consent forms.

The main contributory factors for communication issues during consultation include:

- not having enough time during the consultation for a full detailed discussion or to cover all the items the patient wants. This can be a perceived lack of time due to a mismatch with the patient’s expectations or an actual lack of time because of pressures in the system where a doctor has to get through a number of patients in a clinic.
- a lack of effective rapport with the patient.
- the doctor feeling they have explained something, but they haven’t checked the patient has understood it. This can be related to an assumption that a patient has a certain level of background information and understands the information they have been given.
- a patient seeing a new doctor who doesn’t know their background or history or a locum not familiar with the patient or practice.
- language barriers or perceived language barriers.
- lack of acknowledgement if a concern hasn’t been addressed due to time.

“I think workload is often a factor that we hear from many doctors, and they would like to have explained things in the level of detail that the patient is complaining that they didn’t but time pressures meant that they didn’t feel able to.”

“A considerable proportion are due to a lack of developing effective rapport with the patient, where there seems to have been some kind of difficulties in the doctor-patient relationship from the outset and that’s either escalated concerns for the patient and also made it difficult for the doctor potentially to communicate with the patient because they’re either nervous or anxious and that resulted in the patient expressing their concerns more formally.”

One interviewee commented that for the most part they think doctors don't set out to have a poor consultation and, while sometimes they may recognise a consultation has been difficult, other times the doctor is genuinely surprised when a complaint is received.

2.3 Consent and communication

These complaints involve poor communication related to informed consent and patients feeling they have not been adequately informed about a procedure or treatment and the risks, side effects and potential complications. Often they arise when a patient has experienced a complication or adverse outcome which they feel they weren't aware of or wasn't explained to them as a possible risk beforehand. Complaints have also been received where there is no recollection of any communication around consent.

"There was a case where a patient had an infection and was in a lot of pain and was on a lot of pain relief which left them out of it and the patient can't actually remember giving consent to have their limb amputated and can't remember any of the things that were apparently explained to them and also their family wasn't involved... the patient didn't have capacity and they [doctors] said 'the patient definitely did, he was aware' so that's really difficult when they can't remember."

Mostly they relate to surgical consent although they do arise in other complaints around consent to medication and discussions around procedures or treatment during a consultation.

In the surgical environment communication complaints involve:

- An over-reliance on consent forms with patients being asked to sign consent forms in the absence of a detailed discussion suitably far enough in advance for the patient to reflect on it and not having the opportunity to raise any concerns or questions in advance.
- Having a 15 minute chat on the day of the surgery and, not having the time to reflect or ask questions.
- Surgeons delegating the consent discussion to a junior doctor.
- Doctors and patients having a different understanding of what has been discussed or agreed.
- Patients being given a huge amount of information without any kind of sense check to see if they have understood and absorbed it.
- Misunderstandings on the ward where patients have not fully understood, possibly because they are ill / in pain and not enough account has been taken of the difficulty absorbing information at that point.

The mode of communication tends to be verbal and face-to-face and also involves consent forms and written communication.

The main contributory factors for communication issues relating to consent include:

- Not taking the time for a full and detailed consent conversation and insufficient time is given for patients to go away and reflect and return with any questions. This can be about individual doctors not doing this but also where the process is set up such that a 15 minute conversation with a junior doctor is held on the day of surgery or consent forms are signed just before surgery when patients may be less likely to absorb information.
- Workload pressures contributing to lack of time for full consent discussion.
- Not tailoring information to the individual – having confidence in the basic amount of information that’s appropriate to convey and then tailoring it to the individual patient.
- Communication about procedures and risks or complications between the doctor and patient has either not been understood or has been misunderstood and the doctor has not checked back that the patient has understood correctly.
- Not tailoring to an individual’s communication needs e.g. where someone has a disability or health literacy need and needs extra time or where there is a need to present information in an alternative format.
- The need for doctors to have advanced communication skills whereby they are able to communicate effectively with people from all backgrounds in difficult situations, to anticipate what their communication needs might be, tailor their communication accordingly and use techniques such as the teach-back method¹ to check that the patient has correctly understood.

“I think much of the problem with communication generally in healthcare is that communication is seen as quite a soft skill. There is an assumption that any reasonable doctor can communicate clearly whereas in practice the communication required is really very advanced. You need to be ready to meet people from all walks of life and all sorts of backgrounds in very intense and difficult situations and you need to be anticipating how you are going to be understood and you need to be aware of techniques for checking that you’ve

¹ Teach back is a technique to check that the health professional has clearly explained information to the patient and that the patient has understood what they have been told. It goes beyond simple questions such as asking ‘is that clear?’ and involves asking the patient to explain or demonstrate using their own words what has just been discussed.

http://www.scottishhealthcouncil.org/patient_public_participation/participation_toolkit/teach-back.aspx#.WuxneKQvyUk

been understood not just asking 'have you understood this?' That's really quite an advanced skill there that's not really always recognised."

2.4 Communication on discharge

Some communication complaints relate to a lack of communication about how patients should manage their condition and aftercare on discharge from hospital. Examples include:

- A patient who was discharged without having had the correct assessments and brain scans that they should have had on discharge. These were to enable baselining and monitoring of their condition in the future.
- A discharge note which said 'red flag warning given' but the patient did not understand this phrase or its significance (discussed further in the section on misunderstandings).
- The use of equipment for a life-threatening condition wasn't explained properly.
- Lack of communication about possible side effects from medication and how to take medication.
- Lack of information on support available.

"People quite often don't receive any information when they're discharged on managing their condition and they have to find it out themselves when they get home. Generally people don't get any information on third sector organisations that might be able to support them when they're discharged."

With these examples it's not clear whether the responsibility for communication is that of doctors or wider healthcare professionals or what the contributory factors are. Lack of knowledge, people being too busy to take into account everything a patient needs, mistakes and a need for bed spaces were given as possible reasons.

2.5 Difficult conversations around prognosis and end of life care

These complaints relate to doctors either not communicating bad news at all, effectively, or sensitively. Examples of these types of complaints include:

- Family not being told that their relative is dying (or the message not being understood). In one case they had not understood the term 'palliative care'.
- A patient being told in a waiting room in front of other patients that they had cancer.

- A patient being told by in an angry manner that they have a terminal diagnosis with no pre-warning and no relatives present.
- A doctor organising a test to diagnose cancer but not communicating to them verbally that this was what was suspected; the patient then received a diagnosis of cancer in the post.

Mostly these complaints relate to face-to-face verbal communication but also include non-verbal body language and tone of voice. These can be difficult to investigate because they are about personal interactions and there are often two different versions of the experience by the doctor and patient.

They happen in a range of settings but predominately in hospitals or GP practices.

One interviewee said they regularly receive complaints where no one has told the person that their relative was dying and often they receive a defensive response from the health board. She felt this was missing the point – even if they were spoken to the message was not understood so it's about making sure not only that the message is given in the first place but that it is received and understood. She felt that doctors need to actually use the word 'dying' so it is understood.

The main contributory factors include:

- Lack of experience in having difficult conversations. It was felt that newly qualified consultants received more of these types of complaints due to them not having had that much exposure to breaking bad news.

"I know from discussions with doctors that this is one of the issues that they find most difficult, particularly quite new consultants. They've not had that much exposure to difficult conversations with patients and it's not maybe seen as the skill that it used to be seen as around breaking bad news for example. It's probably underplayed whereas I think it should be seen as much more of an advanced skill."

- Avoiding having these conversations due to lack of confidence and skill. It was felt this is an advanced communication skill that is not recognised as such and which some doctors are very good at but others struggle and avoid.
- Work-related pressures including lack of time to have a full and complete discussion.
- Lack of suitable spaces to hold such conversations.
- Poor use of language and not checking people have correctly understood.

"Because it's about human beings doing this there's a huge variation and a lot of that is about the interpersonal skills, the values and behaviours of each individual doctor. Some of them are amazing at it and do really really well, others struggle and because of that they avoid some of

these difficult conversations because they don't feel confident. Many of them feel [from feedback] really quite stressed and don't feel confident or skilled at having these types of conversations. There is a pattern of avoidance with difficult conversations, for example with someone who had relatives who are particularly anxious or for whatever reason it's difficult to have conversations with. You'll often find cases where staff won't be updating family or will be avoiding conversations because they're not confident."

2.6 Patients and their relatives or carers not feeling listened to by doctors

These complaints relate to patients and relatives or carers feeling that their concerns have not been listened to by doctors. Examples of these complaints include:

- Parents with sick children feeling they haven't been listened to at A&E and persisting until it's discovered the child is very sick. One serious case where the parents feel their concerns hadn't been listened to resulted in a child being airlifted for further treatment.
- Relatives of sick family members feeling that they are giving relevant information about the patient's condition or situation to the doctor and this not being taken on board or listened to and action subsequently not being taken.
- Clinicians not being willing or available to listen to a patients relatives.
- Patients expressing a wish for a specific type of treatment or expressing concerns about treatment and feeling that they have been ignored.
- Doctors being dismissive of patients concerns. For example a patients concern that their cancer has returned being dismissed by a doctor and this subsequently being found to be true.
- Patients feeling that they have been labelled as a troublemaker or someone who is always coming into the practice, and not being listened to or taken seriously.
- Complaints received about a psychiatrist who was not listening to her patients, was being very dismissive and changing medications without consulting their patients causing them to be unwell.

These complaints tend to be about verbal communication and occur in both GP and hospital settings, including in A&E.

Contributory factors include:

- This was felt to be linked to attitude (see 2.11) and a sense that doctors are dismissive of the views of patients and relatives over their own views.

- It was also commented that there may be good reasons for the decisions taken by a doctor. However, if patient or their relatives' views are not acknowledged and the reasons for the course of action are not effectively communicated, the patient or relative can feel that they have not been listened to.

“I have had clients where they feel that they haven’t been listened to, particularly families where they’ve had a sick parent or wife or family member and they feel they are giving information to the medical profession and that’s not being taken on board or listened to. It’s potentially a very difficult one in terms of the doctors and nurses are the professionals and when the family are there saying ‘we think it’s this’ there are definitely complaints around the family not being listened to and action not being taken on.”

2.7 Doctors not feeling listened to by other doctors

Similar complaints are also received from doctors who feel they have not been listened to or their views dismissed by other doctors, particularly GPs feeling not listened to by consultants or their referrals being downgraded. Examples given include:

- GPs making an urgent referral to A&E but the consultant downgrades this and the reason isn’t communicated effectively to the patient or GP.
- GPs making referrals to consultants but their concerns are not taken seriously.

Contributory factors were seen to be a lack of professionalism and taking ownership for communication and being respectful of colleague’s opinions and patients. Where there are locums this may have an impact in that there is less continuity and GPs don’t already have a working relationship with consultants in the hospital and are perhaps less likely to take their concerns as seriously.

“Quite often have a GP making an urgent referral to A&E but then the consultant body in the hospital thinking it’s not, so it’s confusing for the patient but when it transpires the GP was right it’s also a potential patient harm so it’s about improving that communication and what’s coming in from that GP on why they are concerned and it being followed up a bit more robustly.”

It was also noted that being dismissive of the opinions of others also extends to nursing staff and others.

“I’ve dealt with complaints where consultants have been dismissive of the opinions of GPs. They were dismissive of other specialties and the views of nursing staff, dismissive of the views of other people and that essentially had a significant impact and bearing on patient safety.”

2.8 Misunderstandings and lack of clarity

These complaints involve communication that has been misunderstood by the patient, family/carer or doctor either in terms of its meaning or the significance/importance of the

information communicated. Other complaints relate to a misunderstanding of who will act next or where incorrect assumptions have been made.

It applies across the board with all types of doctors and settings and is mainly verbal but can also include misunderstandings or incorrect assumptions made in written communication such as referral letters.

“[We had] one very serious incident, and when you spoke to the client and the clients family they had no idea of the significance of the information they had been given so they didn’t act on it and the whole situation got far more serious than it should have been. With the specific example the discharge note said very clearly: ‘discharge red flag warning given’ but it was verbal communication being given to the patient as they were being discharged. They didn’t know and they didn’t understand what this phrase ‘red flag warning given’ meant so they didn’t actually understand the information they had been given or the seriousness of the information they had been given. From the doctors perspective, the red flag warning meant something, meant ‘right I’ve given them a warning and told them they have to act’ but to the client and to the patient they didn’t understand that at all.”

The contributory factors include:

- A mismatch between the doctor and patients understanding of a situation. A doctor incorrectly assumes the patient or their family have understood the information they have given and doesn’t check they have understood. This is possibly due to not enough time for the doctor to clarify or give more detailed information or for the patient to take on board what they have been told and ask questions.
- Not taking account of a patient’s individual situation. For example they may be in pain, anxious, vulnerable or affected by medication and even if the doctor has explained something they may not actually have heard it and taken it on board. Alternatively they may choose not to have heard or believe what is being said to them.

“If someone is anxious and vulnerable sometimes they don’t hear what is being said, sometimes they are being given the info but they’re choosing not to hear it.”

- The language used is not clear to patients and their families and is not tailored to the individual needs. This could be for various reasons including:
 - differences in health literacy levels between the doctor and patient,
 - the patient has a communication need due to a disability that hasn’t been met
 - using jargon, technical language and euphemisms.

“Using euphemisms or jargon or language that is not clear to the patient or understandable to the patient, even little things e.g. where a patient hasn’t understood what the term ‘palliative

care' meant. That's quite a normal phrase that folk would use but it has meaning and they [patient/family] hadn't picked up on the meaning of that word... you wouldn't think that was jargon but I think it probably is. Just really making sure that it's very very clearly set out...it's that playback of checking that the person has actually understood what has been said."

"Lack of understanding of the recipients communication needs – its ensuring where technical language is required that people are given technical language where there is a need e.g. for example my family aren't medical and the needs of my parents would be very different when they went to a consultant and what you might find is a doctor uses a lot of technical language."

- Linked to tailoring to the individual's needs is also anticipating the level of detail a patient wants and tailoring communication accordingly, however it was acknowledged that this can be difficult as people have different wants and needs and expectations as this example demonstrates:

"It is a real skill and I don't know how you go about training someone, in getting someone to understand what the client or patient wants them to say because everyone wants something different... I've got two clients complaining and the [same] GP is at the heart of it, it's a common GP but two different issues. The GP says to them 'so what would you like me to do about it?' One of them takes that and says 'that's fantastic, he's asking me what I want to do and engaging me in the process.' And the other one goes 'he's the GP, why's he asking me?'"

- Misunderstandings due to English not being the first language or strong regional accents.

"[There is a] fundamental language barrier where in some parts of Scotland people have very very strong accents and it may be that the doctor doesn't understand what the patient is saying or the patient will not understand due to the language barrier as well."

- Misunderstanding about what the next steps are and who should act next so assumptions are made or the patient is left not knowing. This can occur for example in the gap following a referral to a consultant and it not being clear who to go to with any concerns or who acts next.

2.9 Not being kept informed or updated

These complaints relate to patients or their relatives or carers not being proactively informed or updated when something changes or being given inconsistent information. They tend to occur in these two scenarios:

- In a hospital environment when a patient's diagnosis or condition changes in a developing situation and there hasn't been proactive communication to keep the patient or relative informed as to what has changed and why. This is particularly the case where someone has come into hospital with one thing which develops into something else and where a patient may be in the later stages of life with multiple health issues.

- In a GP setting where a patient has seen multiple different GPs with different approaches or they've been told it's one thing by one GP and then been told something different by another GP.

In these complaints, patients and their families feel they have not been taken on a journey with clear and proactive communication as a situation changes or develops and are left unsure why something has happened. While it's not always the core of a complaint it is what people remember, particularly when someone is in the later stages of life and the lack of clarity and updates makes them concerned that something has gone wrong.

Mostly this relates to a lack of verbal communication but also applies to written communication and updating of records. Often patients or their relatives will get copies of their medical records at a later date to try and piece together the version of events and what actually happened.

"If I had a magic wand my wish would be communicating with families should be part of the daily plan of care. Most often people say 'I don't feel I was updated, I don't feel I was informed enough.' It's not a proactive part of care to inform and speak to relatives about what is going on, particularly in hospitals. That's a really common theme in complaints and it can be a really tricky complaint because what I might say is reasonable in terms of the amount of communication (based on the recorded meetings or dialogues in the notes) is not enough for relatives, particularly about end of life and difficult decisions. It's really tricky because it's about what people expect or want and how clinicians can then meet that and I think sometimes the whole way its managed is in a very reactive way rather than it being a part of the care."

It's not clear what the contributory factors are, however these complaints seem to be linked to communication between staff, updating of medical records, different expectations and who is actually responsible for updating patients and their families.

2.10 Lack of ownership or responsibility for communication

These complaints are about a lack of overall responsibility for communication to a patient or their family when multiple doctors are involved in that persons care. It can occur in both GP and hospital settings and in different circumstances, for example:

- In a hospital setting where multiple clinicians are involved in someone's care but it's not clear who has overall responsibility for communication with the patient about their situation.
- When a diagnosis is not clear and someone has been seen by several different consultants who have ruled something out and then they have been referred back to the GP - a "well it's not my specialty, try somebody else" attitude.
- With a GP and patient where there has not been sufficient clear communication on who is to act next at the end of a consultation.

“We had one particularly sad case where a person was told they were dying very openly: ‘it’s far too late for that’ kind of attitude... they had at no point been told that, whereas the consultant assumed that they knew because it had been evident from the medical records by the time he’d picked them up in the care pathway. When the investigation and review was done it wasn’t really clear at any point which clinician may have been responsible for doing that.... It’s something about ownership of care and the patient being communicated with to say if you have questions, if you don’t understand this is the person that is looking after you.”

The lack of overall responsibility for communication can be about verbal and written communication and can occur in both hospital and GP settings and particularly where a patient has a complex journey of care or a getting diagnosis has been difficult. It can also involve wider healthcare professionals.

Contributory factors are unclear but appear to be linked to silo working with doctors only taking responsibility for their own individual speciality and a lack of clarity on who ultimately has lead responsibility for communication.

They are also linked to lack of overall responsibility for communication between doctors and decision making where multiple clinicians are involved:

“The other issue I’ve seen quite a bit of is where patients have had a complex journey of care and there are a number of different clinicians involved. If there’s not a lead clinician taking overall responsibility then that can result in decisions not being made which ultimately could mean severe harm because things might be missed. It’s often about the communication element, so each consultant is maybe thinking and probably doing the right thing but no one clinician is ensuring that that is communicated in a holistic way. Continuity of care and having someone seeing the big picture is vital.”

2.10 Medical records and referral letters

These complaints tend to be about medical records not being updated, not being updated in a timely manner, not updated accurately, incorrect assumptions being made or the records not corresponding with someone’s recollection of events. It can also relate to poorly written referral letters between doctors.

These complaints are about written and electronic communication and happen in both GP and hospital settings and may also apply to the recording of notes by wider healthcare professionals such as nurses and paramedics.

Contributory factors are unclear but appear to be poor skill in documenting communication, with some people writing very briefly so insufficient detail is provided, not writing clearly enough where things are being inferred or alluded to and in some cases not being legible. It’s also possible that lack of time to write detailed notes is an issue and also that in the heat of the moment people don’t think about how what they have written might be perceived at a later stage.

“Inability to document as a form of communication i.e. to write appropriate clinical notes which document what communication has taken place or if communication has taken place. For example in one case although the consultant said they had been doing many different things along the way that was never documented and it’s then very difficult to demonstrate to the patient that a due process wasn’t followed”

Complaints may directly relate to medical records, however often they grow out of a complaint about something else where a patient or relative has requested access to their medical records as part of another complaint and identifies errors or inaccuracies in the records which can exacerbate the original complaint.

One person commented that they expect this type of complaint to increase as more people get access to their medical records through GDPR.

“Communication between doctors it tends to be about the way things are said - things being inferred in letters or alluded to within letters. I come from an IT background and we were always very aware that anything you write down the person can come then and ask for. I don’t know if doctors are trained or realise that, particularly with things like referrals, is the person aware that at some point the person can come and ask for this and then view what has been said? It’s not necessarily the start of a complaint, it’s quite often it’s a clinical issue that’s the start of the complaint but then when they get access to their medical records it makes the whole thing much worse.”

2.11 Rude, arrogant and dismissive attitudes

These complaints are about a doctor’s manner and the way they speak to a patient being perceived as rude, dismissive, arrogant, uncaring, disrespectful or inappropriate.

Complaints are often about hospital consultants, with some seen to play to the gallery in front of junior colleagues on ward rounds and being dismissive of the patients concerned, or about rude or abrupt GPs.

Complaints are also received about doctors being rude to other colleagues including to management and nursing staff, consultants being rude to GPs and also by senior consultants being rude to junior doctors.

Contributory factors seem to be a combination of being under time pressure, particularly for GPs, the natural personality of a doctor and a poor leadership culture.

“There’s a local surgery here where one or two of the GPs do not have a very good reputation for communication skills with their patients. That’s probably more an oral problem and they come across as a bit bolshie and a bit arrogant. In a small community word does get around. I think it’s their natural personality.”

“In general practice you have colleagues who are under stress and will speak to patients in an inappropriate manner.”

“There was a situation where a patient was sent home from hospital and subsequently died and what became apparent was that there was a culture where that particular doctor who was the Head of Service was being dismissive towards the nursing staff and dismissive towards their professional colleagues and they were essentially required to step down from their leadership role because they felt that they weren’t actually leading the service in an appropriate manner.”

2.12 Other types of communication complaints

A number of other examples of communication breakdowns due to organisational, geographical, administrative or system failures were given including:

- IT systems between hospitals not working as well as they should causing problems when a patient has a pathway with follow-on care, for example referral letters going to generic inboxes.
- Written outpatient letters being sent without sufficient detail eg. no details on what the appointment is for or the consultants name and not being advised on preparation for the appointment such as bringing a urine sample.
- Overlapping letters between hospitals eg. someone has a referral letter, the appointment is cancelled, they see someone in between, a new appointment is still generated and difficulty contacting someone over the telephone to clarify whether they should still attend.
- System or equipment breakdowns.
- Some complaints have a geographical element, such as very strong Scottish accents in certain areas and system or administrative difficulties with communication between services in the islands of Scotland and major regional centres.
- Breakdowns in communication between GP partners in a practice, usually related to workload responsibilities.

3. Emerging themes

3.1 Which types of communication complaints are most prevalent?

We were unable to establish which communication issues are the most prevalent due to the way different organisations categorise complaints and because some interviewees dealt with small numbers overall.

Anecdotally however, there was a sense that in a hospital setting the most common communication complaints from patients and their relatives were in relation to communication and surgical consent and holding difficult conversations around prognosis and end of life care. For GPs, complaints tend to be more common where patients have felt rushed through a consultation, where there has been a delay or failure to diagnose, where there have been numerous GPs involved in someone's care or where a GP has been rude or dismissive.

Overall most complaints the interviewees received were from patients, relatives or carers about communication issues with doctors with fewer complaints from doctors about other doctors.

3.2 Which communication complaints are associated with the most severe harm?

Views on which communication complaints were associated with the most severe harm varied across the interviewees. One interviewee explained that there are some cases which stick in their mind more so they may have a biased view. The following types of cases were seen to be associated with more severe harm however this should be treated as anecdotal:

- Breakdowns in communication between doctors e.g. referral not being acted on or differences in opinion between doctors.

"I would say its where there's often a lack of communication between healthcare professionals where you see the greatest risk of harm where the dynamics and professionalism between the members of the team is not great."

- Where there is a complex journey of care with multiple doctors involved and no one is taking overall responsibility for communication and decision making.
- Poor communication around informed consent.

"I think [the most severe ones] are in relation to informed consent and certainly in terms of complaints and high value claims I think they trouble the doctor who faces them the most and because they can escalate so quickly."

- Patients not understanding the information they have been given or the significance of it and doctors not checking that information has been understood.
- Where patients and their families haven't been listened to by a doctor.

"It's the ones where patients or their families haven't been listened to [that are associated with the most severe harm] because we've had some poor outcomes and some emergency care that could have happened sooner – perhaps respecting that a parent knows their child better for example and if they're really not pulling round or reacting as they would expect them to they

should be listened to as a valid part of that persons care rather than it only being what the doctor decides is the right thing to do next.”

3.3 Is communication at the heart of these complaints?

In some cases poor communication is the main complaint, however more often communication is part of a complaint about something else. The communication issue can be a trigger for a complaint or part of other errors and can also arise during the complaints process e.g. when a patient gets access to their medical records.

There was a strong view however that communication issues runs through most, if not all, complaints and this is often what people remember:

“[Communication] is so important, it’s not necessarily the start of my complaints but it comes up in all of them along the line.”

“Staff attitude and behaviour is a common theme running through just about all of them. How people are communicated with often influences whether a patient will make a complaint or not. E.g. if they’ve been given bad news they might not make a complaint if it’s done in a very sensitive, patient-centred way, where they feel valued.”

Appendix A – interview brief

Background

In recent years, we (the GMC) have begun to explore how we might better use our data and resources to identify and understand areas of risk and target our support more effectively, adopting a more intelligence-led, upstream model of regulation.

Our aim is to use the data we hold to explore those areas of risk that result in, or have the potential to result in, harms to either the doctor or patient.

One such area is **inadequate communication**. This is a common issue in the complaints the GMC receives from patients about their medical care. We also know from a series of high profile service failures, that poor communication between professionals can contribute to poor quality, unsafe care.

We are therefore piloting a project to identify and understand the different types of communication failings that lead to substandard care and, if feasible, identify interventions to reduce the risk of such harm occurring. The project involves:

- 1) Literature review and interviews – to identify the main types of communication failures and understand the causal pathways that drive their occurrence.
- 2) Deep dive – once we have identified the prevalence of individual types of communication we will carry out deep dives of GMC fitness to practise cases to identify the contributory factors for small number of common types.
- 3) Workshops - with limited number of stakeholders to sense check findings and identify potential interventions.

Purpose of the interview

During this interview, we would like to understand more about the **different types of communication complaints** your organisation receives about doctors and what the **contributory factors** are that drive their occurrence.

The focus of the study is on complaints that relate to **'interpersonal'** communication only. This study is not looking at 'organisational' communications which relate more to systems and processes for sharing information, unless this is considered to be a contributory factor for complaints relating to interpersonal communication.

We would like to hear about communication complaints between doctors and their patients as well as between doctors and their colleagues including other doctors and members of multi-disciplinary teams such as nurses, admin staff.

Permissions

We would like to audio record the interview. This is to help ensure we accurately capture your answers. Yes / No

We are planning to publish a short summary of the interviews as an annex to a full project report (which will also include a literature review). Confirm preference for any comments to be attributed:

- Named and quoted
- Organisation name and job title
- Anonymous

Do you have any questions before we begin?

Questions

- 1 Can you describe the different types of communication complaints you receive [about doctors and patients / doctors and other doctors / doctors and multi-disciplinary teams]?
- 2 How do you categorise them?
 - If don't currently categorise them, anecdotally what would you say are the main categories?
- 3 Which are the most common types?
 - Roughly what volumes are they received in?
- 4 I'd like to explore the circumstances around each type of communication complaints between [doctors and patients / doctors and other doctors / doctors and multi-disciplinary teams]? Can you describe:
 - Who they are about? (e.g. are any particular types of doctors, other members of teams such as nurses or admin staff or types of patients that are more prevalent?)
 - What they are about? (e.g. consent, cultural differences, information given, sympathetic response etc)
 - Method & mode of communication? (e.g. verbal, written, electronic, face-to-face, telephone etc.)
 - Where the problems occur? (e.g. on the ward, out-reach service etc.)
 - What stage in the process? (e.g. consultation, referral, handover, discharge etc.)
 - Any areas of medicine where communication complaints are more prevalent? (e.g. general practice cosmetic surgery, emergency etc)

- Is communication at the heart of these complaints or are other issues involved too? (e.g. clinical issues)
 - What do you think are the contributory factors or causes of this type of communication complaint? (e.g workload pressures, language barriers, cultural issues, dysfunctional teams, limited supervision and staffing gaps etc.)
- 5 Are certain types of communication complaints associated with more severe patient harm than others? Which ones?
 - 6 Has your organisation (or others) carried out any research or taken any action to address communication failures that you are aware of?
 - 7 Do you have any further comments?

Thank interviewee and close interview.