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The Complaints and Disciplinary Process in New Zealand and the Effect of Complaints on Doctors.

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ABSTRACT.

New Zealand society assumes that the medical complaints process enhances the delivery of medical care, although the literature suggests that complaints may impact negatively on doctors, and their ability to practice.

This thesis examines the impact of the complaints process on doctors in New Zealand. It considers the practice of medicine from the viewpoints of the epistemology of medicine; the doctor-patient relationship; and the notion of professionalism.

It presents the results of research methods investigating New Zealand doctors using focus groups; a cross sectional questionnaire based survey; and in-depth semi-structured interviews.

Findings include:
- One in three doctors has received a complaint. The annual rate of complaint is 5.70%, 15% of complaints are upheld.
- Complaints impact negatively on the person of the doctor, the doctor-patient relationship, and doctors’ ability to practice.
- The purposes of a complaints system include: the maintenance of trust and professional standards; being a voice for patients; and learning from mistakes and errors.
- Doctors’ attitudes are consistent with notions of professionalism.
- Defensive medicine is an adverse outcome of the complaints process.
- Doctors suggest a Complaints Tribunal as a single point of entry into the complaints process.
- The current complaints process is not improving the delivery of medical care to New Zealand society.

New Zealand doctors are aware of both the biomedical and bio-psychosocial paradigms underlying modern medicine, and the results confirm the importance of the self of the doctor and the doctor-patient relationship in medical practice. The emergence of defensive medicine indicates that doctors may respond to complaints by practicing in a way that is not in their patients’ best interests, but which serves to protect doctors themselves. Defensive medicine risks being unrecognised and becoming normalised into mainstream medical practice. The negative impact of complaints on doctors’ values and beliefs indicate an erosion of values based professionalism.

This thesis suggests that an appropriate model for considering medical professionalism is as a state of relationship between doctors and society. Appropriate change to the complaints process may enhance the doctor-society relationship and ultimately enhance the delivery of medical care in New Zealand.
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# TABLE OF CONTENTS.

Title .................................................................................. i
Abstract .................................................................................. ii
Acknowledgments ......................................................................... iii
Table of Contents ........................................................................ iv
List of Tables and Figures ........................................................... vi
List of Appendices ......................................................................... viii

## Chapter 1. Introduction.

1.1 Introduction to the thesis......................................................... 1
1.2 The medical complaints process in New Zealand.................. 3
1.2.1 Demographic data related to the complaints process in New Zealand and overseas... 7
1.3 What is known about the impact of complaints in New Zealand? 9
1.3.1 Implications of these findings for the research presented in this thesis........... 12
1.4 What is known about complaints and litigation from the overseas literature? ........ 13
1.4.1 Defensive medicine.......................................................... 16
1.5 Three viewpoints from which to examine the impact of the complaints system on doctors in New Zealand ................................................. 19
1.5.1 The epistemology of western medicine and its relevance to medical complaints ...... 20
1.5.2 The notion of the doctor-patient relationship and the self of the doctor in the delivery of medical care..................................................... 29
1.5.3 The notion of profession and professionalism in medicine ............................. 35
1.6 The goals and objectives of the studies reported in this thesis .......... 39


2.1 Introduction........................................................................... 41
2.2 Method.................................................................................. 42
2.3 Strengths and limitations of the method ............................... 47
2.4 Consideration of bias............................................................. 51
2.5 Ethical approval ..................................................................... 52

## Chapter 3. The purpose of the medical complaints system and the identification of problematic areas.

3.1 Introduction........................................................................... 53
3.2 The purpose of the complaints system.................................... 53
3.3 Significant problems within the current complaints system and suggested solutions 55
3.4 Discussion............................................................................. 58
Chapter 4. The incidence of complaints and the characteristics of doctors who receive them.

4.1 Introduction .............................................................................................................. 61
4.2 Results ...................................................................................................................... 62
4.2.1 The incidence and rate of complaint ........................................................................ 63
4.2.2 Doctor characteristics perceived reasons for complaint, and time to resolution .... 66
4.3 Discussion ................................................................................................................. 73
4.3.1 Key demographic issues to be recognised or addressed with respect to the complaints process ............................................................................................................. 74

Chapter 5. The immediate and long term impact on doctors of receiving a complaint.

5.1 Introduction .............................................................................................................. 78
5.2 Results ...................................................................................................................... 79
5.2.1 The impact of complaint analysed by vocational group ............................................. 83
5.2.2 The immediate response to receiving a complaint ..................................................... 83
5.2.3 The long term response to receiving a complaint ..................................................... 84
5.3 Discussion ................................................................................................................. 85
5.3.1 The implication of these findings for the delivery of healthcare in New Zealand and the relationship between the medical profession and New Zealand society ....................... 87

Chapter 6. Doctors’ attitudes towards the complaints and disciplinary process.

6.1 Introduction .............................................................................................................. 89
6.2 Results ...................................................................................................................... 89
6.3 Discussion ................................................................................................................. 94
6.3.1 Areas of consistency between doctors and society .................................................... 95
6.3.2 The complaints system as a tool for the enhancement of medical care .................... 97

Chapter 7. Doctor’s suggestions for changes to the complaints system in New Zealand.

7.1 Introduction .............................................................................................................. 99
7.2 Methods .................................................................................................................... 99
7.3 Results ..................................................................................................................... 100
7.3.1 The nature of medical practice in contemporary New Zealand society .................... 100
7.3.2 Notions about the current complaints system ......................................................... 104
7.3.3 Suggestions for change ........................................................................................ 110
7.4 Discussion ................................................................................................................. 113
7.4.1 Tensions, purposes and change in the complaints process ...................................... 113

Chapter 8. Defensive medical practice in New Zealand.

8.1 Introduction .............................................................................................................. 116
8.2 Methods .................................................................................................................... 117
8.3 Results ..................................................................................................................... 121
8.3.1 Defensive medical practice in doctors who have ever received a complaint ............. 121
8.3.2 Defensive medical practice in doctors who have never had a complaint ................. 136
8.3.3 Evidence of change in practice in the direction of “good practice” ......................... 142
Chapter 9. Discussion.

9.1 Introduction .............................................................................................................. 150
9.2 Summary of findings ............................................................................................... 151
9.3 The nature of medical practice – epistemology, relationship and professionalism .. 154
9.4 Suggestions for change ........................................................................................... 159

Appendices .................................................................................................................. 163

List of References ........................................................................................................ 183
LIST of TABLES and FIGURES.

Chapter 1. Introduction.

Figure 1  Death by 1000 Arrows: the multiple pathways of the current complaints system in New Zealand ................................................................. 5
Table 1   Patient-Centred Clinical method ................................................................. 24
Figure 2  Factors Influencing Patient-Centredness ....................................................... 26


Table 2   Research Styles ......................................................................................... 48

Chapter 4. The Incidence of Complaints and the Characteristics of Doctors who Receive Them.

Figure 3  Number of Complaints per Year by Respondents ....................................... 64
Table 3   Complaint Outcomes by Body to which Complaint Lodged ........................... 65
Table 4   Complaint Received by Practitioner Characteristic ........................................ 68
Table 5   Place of Graduation and Complaint Status .................................................... 69
Table 6   Procedural Table ......................................................................................... 70
Figure 4   Age Distribution of Doctors at Time of Receiving Complaint .................... 71
Table 7   Reasons for Complaint and Time to Resolution ............................................. 72

Chapter 5. The Immediate and Long Term Impact on Doctors of Receiving a Complaint.

Table 8   The Impact of Receiving a Complaint ........................................................... 80

Chapter 6. Doctors’ Attitudes Towards the Complaints and Disciplinary Process.

Table 9   Attitudes to Complaint ............................................................................... 91

Chapter 7. Doctors’ Suggestions for Change to the Complaints System in New Zealand.

Table 10  Desirable Characteristics of a Complaints Tribunal as a Single Point of Entry into the Complaints System ................................................. 112
List of Appendices

Appendix 1  Medical Disciplinary Complaints and their Outcome to the MPDC 1992-1996.......163
Appendix 2  ACC Medical Misadventure Data as of 1 June 2005........................................165
Appendix 3  Letter of Invitation.........................................................................................166
Appendix 4  Questionnaire Regarding Respondent *Ever* or *Never* in Receipt of Complaint........167
Appendix 5  Ethics Committee Approval...............................................................................182
CHAPTER 1.

INTRODUCTION

1.1 Introduction to the thesis

"I felt very insecure in my ability to keep working as a doctor. I felt that all the good I had done for my patients and all my hard work on behalf of my patients paled into insignificance in the shadow of this complaint. It was absolutely devastating.

I felt very insecure that my future as a doctor and as an earner for my family was in the hands of the HDC. I felt angry with patients in general. I probably don’t “give” of myself to my patients to the same extent now, don’t trust them as much”.

General Registrant Complaint # 352

"I became suicidal in the six to nine months between receiving the complaint and the hearing. I used to think that if I killed myself they (the couple) would know I was sorry. There has never been an opportunity to reconcile with the complainants...

My practice was found to be totally competent...

I believe them to have unresolved grief issues which may still be focused on me...

I believe I should have shortened the labour in which their daughter was damaged, but I never intended them any harm, nor do I believe what I did was bad”.

General Practitioner Complaint # 255

"I felt stunned, ashamed, and so upset when I sat down to write a draft-response I could not put pen to paper...

The patient I had thought of as a friend as well as a patient...

I thought the complaint was unfounded and couldn’t believe it...

The complaint was a major shock that went to my very being, when I have always practiced medicine with dedication and enthusiasm. It was my worst experience in 27 years of medical practice”.

General Practitioner Complaint # 266

These three written responses from New Zealand doctors, give an indication of just some of the issues that are brought into focus by the experience of a complaint and its associated process. The window of the complaints experience is one way by which being a doctor and practicing medicine can be considered. This thesis will introduce, discuss the methodology of, and present
the findings of three research projects related to the complaints and disciplinary process in New Zealand. It will attempt to clarify the role of the medical complaints process in the New Zealand healthcare system, document the incidence and impact of complaints, and make recommendations as to how changes may be made that could improve both the complaints process and the delivery of healthcare to the New Zealand public.

In this chapter I will outline the current medical complaints process, present data about complaints from New Zealand and overseas, and present what is currently known about the impact of the complaints process in both the New Zealand context and from the literature, and the implications of those findings for the research presented in this thesis.

There are three themes that underlie the practice of medicine and the potential impact that complaints against doctors may have on medical practice that will be considered in this thesis. These themes are the epistemology of western medicine; the notion of the doctor-patient relationship and the self of the doctor as it relates to the delivery of medical care; and the notion of profession and professionalism in medicine. This chapter will present the background behind these three themes in terms of how they relate to the impact of complaints. It will consider questions about how the complaints system might be changed in order to facilitate change in the epistemology of medicine (if that appears to need changing); whether there is evidence of an impact of a complaint on doctors in terms of reported changes in themselves; whether doctors appear to change their behaviour in response to a complaint; and whether the complaints system is an important component of the relationship between the medical profession and society, and whether that system is serving that relationship well.

This thesis will present the results of three separate research projects using three different methods, including focus group, questionnaire, and semi-structured interviews of doctors in receipt of a complaint. The rationale for the methodology will be presented and critiqued in chapter two, and successive chapters will present the results of those studies and discuss the implications of the findings for the way in which medical care in New Zealand is delivered and what, if any, impact the complaints process or experience of a complaint is having. This thesis will present research that I have conducted over a five-year time period, and many of the findings have been published in refereed scientific journals. With particular results such as demographic data related to the incidence and rate of complaint in New Zealand, the results are unavoidably “frozen in time” and risk appearing outdated. They are however, the first published data of a nationwide survey of doctors about complaints in New Zealand, and they remain the only published data of their type. Other findings, such as attitudes towards the
complaints system and of the impact of complaints and the practice of defensive medicine are less transitory, and should remain valid in at least the medium term. However, the publication of some of the findings presented in this thesis have already had an impact on the politico-medical landscape of New Zealand, and some of the recommendations for change that will be presented are already being considered by different medical organisations at the time of writing.

This thesis will consider why changes to the way complaints are initiated and dealt with need to take into account the underlying principles of epistemology, relationship, and professionalism, if they are to allow meaningful change that will be of benefit to doctors and patients alike.

1.2 The medical complaints process in New Zealand.

At the time of writing of this thesis two significant shifts are under way with regard to the complaints process in New Zealand. The first shift, under the auspices of the Health Practitioners' Competence Assurance Act 2003 \(^1\) is toward the streamlining of medical complaints through the Office of the Health and Disability Commissioner, coupled with increasing emphasis on the resolution of complaints by advocacy. The second recent change is alteration of the Accident Compensation Corporation’s approach to medical misadventure which came into effect on 01/07/05. Under the revised Act \(^2\), the responsibility for finding fault in a practitioner’s practice of medicine before compensation for injury could be awarded to a complainant, has been removed.

These shifts suggest that for New Zealand doctors the pathway of complaint is relatively straightforward. However, as is illustrated in Figure 1, the so-called “Death by 1000 arrows” diagram (personal communication, Gaeine Phipps, Barrister, Wellington), multiple pathways of complaint remain open to complainants wishing to seek some form of redress against their doctor or perhaps an institution. It is possible for a complainant to fail to gain satisfaction from one body and to revisit the complaint using a different pathway. Not illustrated in Figure 1, is the network of internal enquiries that may accompany complaints about care in larger institutions.

The disciplinary body for most complaints against doctors outside of civil or criminal proceedings is the Medical Practitioners’ Disciplinary Tribunal (MPDT). This tribunal replaced the former Medical Practitioners’ Disciplinary Committee (MPDC) in 1996. The MPDT is the
body which has the power to sanction doctors including limiting or suspending their right to practice.
Figure 1. Death by 1000 arrows: the multiple pathways of the current complaints system in New Zealand.
With regard to the research presented in this thesis, the terms complaint, discipline, and disciplinary complaint need to be clarified. For most New Zealand doctors, these terms can be used almost interchangeably. This probably stems from the days of the MPDC, and although the Office of the Health and Disability Commissioner (HDC) is quick to point out that the complaints process is different and quite separate from the disciplinary process, most doctors will regard these things as virtually one and the same. Similarly, many New Zealand doctors confuse the role of the Medical Council of New Zealand (MCNZ) with that of the Disciplinary Tribunal. For the purpose of this thesis, doctors' responses have been regarded as being about the complaints process despite the use of different terminology in the verbatim transcripts that will be presented in the qualitative research results.

Similarly, the word “litigation” is in relatively common use amongst New Zealand doctors, and is used interchangeably with the notion of complaint.

The Act that created the Office of the Health and Disability Commissioner, and the development of the Code of Patient Rights grew out of the Cartwright Inquiry into practices at the National Women’s Hospital in Auckland. The stated purpose of the Office of the Health and Disability Commissioner is to “facilitate the fair, simple, speedy and efficient resolution of complaints about the quality of healthcare and disability services.” Under this system HDC, on receipt of the complaint can initiate a system of mediation and conciliation for both parties within the Code of Patient Rights, which emphasises the rights of the patient and the responsibilities of the provider. The Commissioner may find that the practitioner has breached the Code of Patient Rights and may refer such a practitioner on to the Medical Practitioner’s Disciplinary Tribunal.

In 2001, the Ministry of Health conducted a review of the HDC complaints system known as the Cull Report. Although that report critiqued the HDC system and found fault with the process (finding it “confusing, cumbersome, difficult to access and costly – both financially and emotionally”), it did not significantly critique the underlying ethos of the complaints process, which is something that this thesis will seek to consider.

The multiple pathways of complaint remain a major limitation to obtaining data about the incidence and rate of complaint in New Zealand. One of the objectives of this research is to document the incidence and rate of complaint experienced by New Zealand doctors without being dependent on data provided by the different organisations involved. For this reason, coupled with the ability of complainants to shift from complaints body to another, the notion of
complaint will be considered as any complaint from a patient or (usually) a relative, which is dealt with by some judicial body whether internal or external to the organisation in which that doctor works.

1.2.1 Demographic data related to the complaints process in New Zealand and overseas.

A review of historical data from the Medical Practitioner’s Disciplinary Committee between 1992 and 1996 (see Appendix 1) shows a steady rise in the number of complaints over that time period. It documents spouses, parents and others as comprising up to 50% of the total number of complainants (that is, other than the patient themselves) and that many complaints during that time period were about the doctor’s practice of medicine. The percentage of complaints that was upheld dropped from 67% in 1992, to 35% in 1996. The length of time of enquiry increased, so that in 1996 25% of complaints took over six months to resolve.

The annual report from the Office of the Health and Disability Commissioner for the year ended 30th June 2004, notes that the number of new complaints to that office had remained fairly static at 1142, compared with 1159 in the year to the 30th June 2003. The report shows that 59% of all files are closed within three months, and claims that focus on early resolution of complaints has led to a significant decrease in the number of formal investigations arising from the initial complaint (down to 179 for the 2003/04 year). Of these 43% were found in breach of the Act, but only 18 cases resulted in referral to the Director of Proceedings, incurring the possibility of significant disciplinary action, such as being struck off the medical register.

In the 13 years prior to June 2005, the Accident Compensation Corporation (ACC) received 29475 medical misadventure claims, of which 8754 were accepted, 1188 being attributed to medical error (personal communication, Melissa Field, analyst, Medical Misadventure Unit ACC, 2005, Appendix 2).
The Medical Protection Society receives between 30 and 60 calls daily from doctors to their medico-legal advisors, of which about 40% relate to complaints. In 2002 the Medical Protection Society opened 850 "complaint files" for their doctor members (personal communication, Dr Denys Court, medico-legal advisor, MPS, 2003). In New Zealand, the MPS continues to receive more enquiries for assistance from its doctor members per head of doctor population than in any other country in which it operates, and continues to regard New Zealand as one of the most medico-legally hostile environments in the world.

It is very difficult to obtain accurate data about levels of complaint against doctors in New Zealand by approaching the individual organisations that are concerned. Coupled with the notion of multiple pathways of complaint (but noting that the current situation is that all complaints to health professional regulatory bodies such as the MCNZ are now required to be processed by the HDC before being passed back to those bodies if appropriate), it is clear that there is a need for data about the incidence of complaint to be collected without recourse to those agencies directly involved.

Since the data reported in this thesis were collected, one further report has been published which gives an idea of rates of complaint. A survey of surgeons in New Zealand revealed that 58% of the surgeon respondents had received a complaint, giving an annual rate of complaints per person of 0.16 over the years 1996 to 2002. However, that rate peaked between 2000 and 2002 at 0.34. In 91.1% of cases either no action was taken or the surgeon was found not to be in breach of the Health and Disability Commissioner Act and only 2.2% of cases were referred for disciplinary proceedings. This study was published in 2004 and it provides the only other data on rate of complaint available in New Zealand in addition to data reported in this thesis.

The impact of receiving a complaint in the New Zealand context may be comparable to the effect of litigation as it is experienced in "litigious" cultures such as the United States. To that end, it is interesting to consider some of the demographic data that have emerged from the overseas literature in the last decade or so, examining rates of complaint in Australia and the U.K, and rates of litigation in the United States.

In the United States, malpractice payment rates vary between states from 0.7% to 3.7% per physician per year. This has prompted the comment that "such a great discrepancy seems to challenge the notion that the risk of malpractice litigation consistently promotes the quality of healthcare". This poor correlation between actual medical negligence and subsequent malpractice litigation has lead to such litigation even being described as a "lottery".
The rate of complaint to the General Medical Council in Britain rose by over 30% between 1999 and 2000, with 77% of cases having been heard and concluded within six months, acknowledging that “justice delayed is justice denied”. 

In 1999 a paper from Australia reported that doctors in the 40–49 year age bracket were almost twice as frequently involved in complaints as those in the 30–39 and 50–59 year age range brackets.

There are conflicting notions about the characteristics of doctors who receive a complaint. A study in Florida found that male, board certified, U.S. or Canadian medical school graduates had 56% risk of being sued at least once, compared with a 17% risk for female physicians graduating from medical schools outside the U.S. Doctors who had experienced three or more malpractice suits had characteristics associated with greater knowledge. In contrast, a study in Michigan found that lower training credentials (medical school and residency training program rankings) were strongly predictive of future malpractice experience.

Some specialties may have a higher risk of complaint than others – surgeons in one American study had twice the rate of complaints of non-surgeons and in Tapers’ study in New Zealand, sub-specialty general surgeons were at greater risk of complaints than other surgeons.

This thesis will present data that confirm that the impact of receiving a complaint is comparable to the impact of being litigated against, and in that sense it is reasonable to consider complaints and litigation similarly. However, there is clearly significant variance worldwide in the incidence of complaint and litigation and one important function of this research is to collect data relevant to the New Zealand situation and interpret it.

1.3 What is known about the impact of complaints in New Zealand?

When the research reported in this thesis commenced, there was only one published paper in the refereed medical literature in New Zealand on the effect of a complaint. This paper, written by myself and S. Dovey summarised my research published as a thesis for the degree of Master of General Practice (Otago). The Cull report had yet to be published and all writing on medical complaints was either in the popular medical newspaper-like publications, or in the lay press in the form of magazine articles. These articles tended to be commentaries on the overall nature of the disciplinary system and of issues of professional regulation and peer assessment.
They also tended to examine the severe end of the spectrum where doctors were found guilty of medical misconduct or conduct unbecoming of the medical practitioner. This section will summarise the findings presented in my Masters thesis which forms the foundation for the further research that will be presented in this thesis.

The research method employed in that study was qualitative analysis of in depth semi-structured interviews conducted with ten general practitioners who had had complaints made against them to the former Medical Practitioners Disciplinary Committee (MPDC) which had not proceeded to a formal hearing. The underlying assumption was that because the complaint was never formally upheld, any changes made by these doctors in their practice would then be the result of internalised change rather than changes due to recommendations or sanctions on their practice imposed from without.

Thematic analysis of these interviews revealed four emergent themes. These were an immediate impact on the person of the doctor; a long term impact of the complaint on the person of the doctor; changes in the doctors' perception of patients, society, and their role as a doctor; and strategies they felt they developed to prevent or minimise the risk of future complaint.

There was evidence of:
1. An immediate impact on the person of the doctor, showing an intense negative emotional response associated with feelings of guilt and questioning of self.
2. An immediate impact on the doctor's practice of medicine that was associated with a reduction in their capacity to practice medicine efficiently and to tolerate uncertainty in the consultation.
3. An immediate impact on the doctor-patient relationship not only related to the relationship with the complainant, but to a reduction in the level of trust that doctors were able to bring to subsequent doctor-patient relationships.
4. An immediate impact on doctor's relationships with their spouse, family and colleagues in the direction of help seeking behaviour that indicated an immediate need for meaningful support.

The results also indicated a significant long term impact of the complaint on:
1. The person of the doctor that indicated a persisting emotional response, (often including anger or depression), a change in the way they perceived themselves as doctors and a general erosion of goodwill towards patients.
2. A significant impact on the doctors’ practice of medicine characterised by the development of strategies to reduce the risk of recurrence of complaint. The strategies mostly took the form of negative defensive medicine.

3. A significant long term negative effect on the doctor-patient relationship with patients other than the complainant.

4. A change in doctor’s perceptions of other doctors who have had a complaint.

The results indicated a change in the participant doctor’s perception of their role as a doctor and their place in society. They indicated their need for skilled advocacy throughout the disciplinary process, a process for which they felt ill prepared. The only positive effects of a complaint appeared to be a sense of having had their practice of medicine tested or vindicated by the complaint process.

Analysis also revealed that doctors respond in two immediate and entirely different ways on receiving a complaint. I presented this as an intellectual vs emotional dichotomy. Immediately on receiving a complaint doctors analysed their practice of medicine. They analysed whether their practice had been “good” in term of its soundness using a biomedical paradigm. They were also aware that the same biomedical paradigm would be used in the judgment of their practice.

The respondent’s emotional responses in that study were often at variance to their intellectual response. There was evidence of a change in the way respondents perceived themselves as doctors and as people, and the intensity of the emotional response was often not proportional to the gravity of the complaint. Some quotes from these doctors illustrate this point. One doctor said “my emotional self made me feel that I was obviously at fault”. Another doctor noted that she felt “like a failure” and noted her feelings of “utter hopelessness”. Another doctor noted that she felt like “a bad person” and noted that she must be “a bad doctor because someone’s complained about me”.

These negative emotional responses were closely associated with negative feelings towards subsequent patients illustrated by a general erosion of goodwill and trust towards patients. My conclusion from that study is that it is these negative emotional responses that have the direst implications for the care of subsequent patients because of the impact that they have on the person of the doctor, and that it is that person of doctor which is so important in maintaining the doctor-patient relationship. I will discuss this notion further in section 1.5.2. My hypothesis from this study was that the effect of receiving a complaint for some doctors is that they are
shamed, and that this is evidenced by their responding along either a shame-rage or a shame-depression axis.\(^{23}\)

In summary, the results of my research published at the beginning of the work presented in this thesis indicated that receiving a complaint has a significant impact in both the short and the long term on both the person of the doctor, and on their practice of medicine. Alterations in doctors' ability to practice are predicated on changes in the doctor-patient relationship which are themselves based on these respondents having been shamed by the receipt of a complaint.

### 1.3.1 Implications of these findings for the research presented in this thesis.

Having been derived from a relatively small sample group using qualitative research methods, the question about the transferability versus the generalisability of the findings of the initial project\(^{17}\) needed to be addressed. To this end, New Zealand based research was needed which was able to consider the response to complaints across a wide cross-section of doctors, and also to address some of the questions that were unanswerable from the research that was presented in section 1.3.

Three significant items were missing from that research published in 2000\(^{17}\). The first was that there were no demographic data. As discussed, information about the incidence and rate of complaint existed from separate institutions involved in the process, but no data from the population of New Zealand doctors was available. We did not know if particular groups of doctors were more or less vulnerable to the risk of complaint, and what the implications might be for the profession and New Zealand society if significant differences between groups of doctors did exist. The second point related to a lack of sampling outside of the discipline of general practice. The question was whether other specialties would respond differently to receipt of a complaint, perhaps indicating some particular vulnerability or resilience intrinsic to those practitioners or to some characteristic of their work. The final problem again related to the small sample size, and is about suggestions for change. If a medical complaints and disciplinary system is to be altered with input from the profession, then the sampling of that opinion needs to be appropriately wide with the opportunity for a range of opinions to be canvassed and presented.

Some of the respondents in the first study came up with particular ideas about complaints, complainants and the complaints process. Further research using a cross sectional survey was
necessary to test ideas such as "complainants are not like normal people, are they?" 21. Similarly, when asking about the way complaints impacted on them, respondents had often talked about the complaints system. One important implication was the need to explore attitudes towards the complaints system and to try and define the purpose of a complaints system from the point of view of doctors.

A final prompt for the research presented in this thesis was to take the opportunity to avoid bias from influential members of the medical profession, or at least to consider where their views may sit within a spectrum of opinion. The point here is whether the opinions expressed by policy makers are held by rank and file members of the profession, and what implications this may have for both the setting of policy regarding the complaints system and for how the body of doctors in New Zealand functions at a professional level.

1.4 What is known about complaints and litigation from the overseas literature?

Although this thesis is about the complaints process and its impact on doctors in New Zealand, one of the issues around the complaints process addressed in the overseas literature is about why patients instigate complaints or litigation. The Medical Protection Society in New Zealand (MPS) has taken an interest in this subject and the message that it currently delivers to doctors is that "a patient will not become a complainant if they continue to value the professional relationship more than their right to complain" (Personal communication Dr Denys Court, medico-legal advisor, MPS 2004).

This professional relationship is, according to MPS, predicated on patient satisfaction determined by the quality of the communication that they receive from their doctor.

Based on studies from both the United States and the U.K. 24,25,26,27, MPS's belief is that poor communication may pre-dispose to complaint and that if a subsequent adverse event occurs, that the adverse event coupled with pre-existing poor communication may precipitate a complaint. MPS also holds the converse to be true, that is that good communication may mitigate the impact of an adverse outcome and that good quality information about the possibility of an adverse outcome needs to be provided in order to reduce the likelihood of a complaint, and that such behaviour will be seen as appropriate to the professional relationship by the patient. This is consistent with the notion expressed by Vincent 26 that complainants are seeking to find out what happened and why it happened. This view is also held by HDC 28 who
takes the notion one step further and claim that many complainants are seeking both explanation and apology for an adverse event or outcome, and that provision of an apology by the doctor may lessen the likelihood of a complaint being instigated.

The potentially negative impact of litigation on the medical profession has recently been cited as one of the leading causes of dissatisfaction with medical practice in the United States. The rise in medical malpractice in the United States over the last thirty years has been described as reaching crisis proportions and is being cited as one of the reasons that doctors are considering leaving the medical profession, practicing increasingly defensive medicine and damaging the doctor-patient relationship. Zuger comments that "Doctors are not yet inured to the emotional punch of law suits", and that doctors report feelings of shame, self doubt, and disillusionment, in that context.

Recent evidence of the size of the professional liability insurance (PLI) crisis in the United States has emerged from a study of obstetricians in Missouri, finding that one in seven physicians in that state had had their PLI terminated and/or application for new insurance denied. PLI premiums had increased 22% in 2001 and 60% in 2002 resulting in a reduction of salary for the obstetricians that were surveyed. Nearly one in five of them had needed to take out secured loans, nearly one in ten had liquidated assets and 55% had significantly limited the clinical services that they provided. The authors of that study concluded that many life saving specialists were being forced out of business and becoming less willing to care for emergency and indigent patients for fear of liability exposure.

The psychological effects of litigation in the American context were reported in the 1980's and early 1990's by Sara Charles from the University of Illinois. Her findings form a comparison for the findings summarised in section 1.3, and the overall findings of this current research.

Charles comments on the importance of the immediate reaction, and describes it as being a feeling of being stunned, misunderstood, immobilised or driven to frantic activity. She describes feelings of intense anger and rage, and interprets these as being normal reactions to an assault on one's sense of self and personal integrity. However, she notes that the initial stress of receiving a complaint may have such profound emotional impact that doctors are not always able to initiate their own coping strategy, and succumb to depression, adjustment disorder and exacerbation of previously diagnosed physical illness. She also notes that malpractice litigation draws the doctor into a legal system over which they have very little control and which
repeatedly challenges the professional integrity of the physician with the result of lowering their self esteem.

Charles notes changes in practice behaviour "becoming phobic about certain patients, practice situations or procedures" and finding that "medicine isn't fun anymore". Her findings were echoed in a review of studies of the psychological impact of complaints and suits on doctors from the US, Canada, UK and Australia, highlighting the emotional and physical disequilibrium that can result from such an event.\(^{35}\)

Literature from countries associated with a less litigious culture than the United States suggests that receiving a complaint has a significant impact on doctor behaviours. From the Canadian literature comes evidence of a change in doctor behaviour with regard to what is seen as at risk activities.\(^{36,37}\) Specifically, Canada has seen a marked reduction in the provision of obstetric services, the administration of anaesthesia and the undertaking of emergency work, especially in rural localities. It appears from these studies that the perceived risk of litigation and complaint is associated with increased evidence of the practice of defensive medicine and having lower thresholds for investigation and referral. As long ago as 1989, the perception of liability issues was recognised as having a profound influence on the provision of primary care in Canada, significantly impacting on the delivery of care in rural and remote places. Follow up reports suggest that there has been no change in this finding.\(^{36}\) This is despite there having been no particular change in the actual amount of litigation or complaint against physicians in Canada.

Recent evidence from Australia\(^{39}\) indicates that the proportion of rural doctors in Queensland willing to offer procedural medicine is declining. One of the major factors influencing the decision of these doctors about remaining in procedural practice or considering leaving was the cost of indemnity insurance and the possibility that that cost could rise.

From the Dutch literature, comes a finding that even if patient dissatisfaction was not communicated through legal action, the complaint may not be any less threatening to the doctors involved than if it had been.\(^{40}\) In this study, the responses of 56 family doctors were analysed, identifying factors that contributed to what they saw as their own defensive behaviours. For these Dutch doctors, defensive behaviours were predicated by concern for the doctor-patient relationship. They tried to avoid overt conflict with the patient, having patient lose confidence in them, and to reduce a sense of loss of appreciation by patients of their doctor. It was these relational considerations that most influenced their practice. That paper signposted
evidence of change of behaviour by doctors due to concern for the doctor-patient relationship, and highlighted the need for study of this aspect of practice in the New Zealand context.

1.4.1 Defensive Medicine.

Defining and examining aspects of defensive medicine is important in the context of this study. There are several important issues around the definition of defensive medicine that have implications for the practice of individual doctors, the attitude of the profession towards practice and the relationship between the medical profession and society.

One definition of defensive medicine is “deviations induced by threat of liability from what the physician believes is, and was generally regarded as, sound medical practice” 41. A second definition introduces the notion of “medical practice decisions which are predicated on a desire to avoid malpractice liability, rather than a consideration of medical risk benefit analysis” 42.

The implication from the first definition is that “sound medical practice” can be defined (by some group within society), and is seen to be deviated from by the practitioner of defensive medicine. In the second definition, the decisions made are not actually required to deviate from “sound medical practice”, but fail to satisfactorily consider the risk benefit of the particular practice. Using this definition, it is possible that a system of medical liability could in fact provide incentives for a physician to practice in a way that did enhance the risk benefit analysis and which deterred the physician from practicing in a way that could increase risk. One could then argue that defensive medicine is a desirable way of practising, as long as the risk benefit analysis is appropriately enhanced. It appears however, that much defensive medicine is not justified by risk benefit analysis but is practiced on the basis of liability avoidance.

There is some evidence that the direction of change of defensive medicine is towards increased use of diagnostic procedures with doctors responding to what has been called “malpractice pressure” 43. The defensive use of diagnostic tests may improve clinical outcomes for some patients, although it worsens the clinical outcomes for others especially if the clinical strategy of care is changed 43. These authors continue to say that defensive testing necessarily reduces the overall quality of patient care.

Positive defensive medicine then, is about the increased use of resources – investigations, referrals and so on. It is also important to define negative defensive medicine.
Negative defensive medicine has been misdefined as practicing in a way that is "contrary to clinical ideals" by legal experts publishing in New Zealand\textsuperscript{44}, whereas a more appropriate definition of negative defensive medicine relates to the withdrawal of services by doctors as a response to the perceived threat of litigation. The implication of this is that doctors will remove themselves from exposure to liability if they perceive that particular patients, particular conditions or even on a larger scale, particular areas of work such as rural general practice place them at greater risk of receiving a complaint.

The Medical Protection Society uses the phrase "defensible practice"\textsuperscript{45}. They refer to this as practice in which the doctor stays within the limits of their own expertise, keeps up to date and conducts audit, ensures that administration is effective and that there is good communication with patients, carers and colleagues, and that the medical records recall all salient facts relating to the patient. They go on to say that if things go wrong, the doctor should be open, investigate the facts, explain the situation to the patient and not be afraid to apologise. This advice is consistent with advice given by defence attorneys in the United States\textsuperscript{46,47} but the thrust of such advice is towards good record keeping in particular, in order to provide a defence when a complaint or litigation happens. Defence attorneys are quite clear about the underlying principle of the medical record as a defensive document\textsuperscript{47}. The underlying notion is that why the practitioner acted in a particular way is more important than what was actually done. In this way, the appropriateness of a particular action may be assessed and the practitioner can in effect, act as their own expert who can provide a rationale for why and what they did.

In the New Zealand context, the thrust of advice about defensible practice from the Medical Protection Society has included advice about appropriate record keeping, and coupled this with advice about the importance of maintaining the doctor-patient relationship and communication. The interesting point is that aside from more complex issues regarding the doctor-patient relationship that will be discussed in section 1.5.2, proof of adequate doctor-patient communication and evidence of appropriate decision making recorded in the medical records are essentially how the indemnity insurers view defensive medical practice.

This notion of providing evidence of appropriate practice is quite different from the overuse of diagnostic procedures which is the predominant way in which defensive medical practice is actually practiced by doctors. Herein lays a major potential problem that is of direct relevance to the study of the impact of complaints on doctors. If defensive medical practice becomes more widely practiced, it risks becoming normalised as mainstream practice. In a curiously
circuitous manner, if such practice becomes incorporated into clinical practice guidelines, such practice may come to define the requisite standard of care for medical treatment and this standard may itself impact on medical malpractice litigation practice.\(^{48}\)

The medical workforce is also one that is currently aging as fewer and fewer new graduates train and enter both the general and specialist workforce. A study from the United Kingdom\(^{49}\) examined defensive medical practice in a psychiatric hospital setting, and found that junior psychiatrists were particularly prone to practice defensively, with previous experience of complaints (against colleagues or themselves) being an important contributing factor to their defensive practice. Not only then, does defensive practice risk becoming normalised by decree, it also risks entering the doctor's repertoire of practice during formative stages of their training.

There are two aspects of the relationship between the law and defensive medical practice that are important in this context. The first is that there is some evidence that not only does the perception of legal pressure directly relate to the practice of defensive medicine\(^{50}\) but that doctor's knowledge of the law itself may be significantly flawed and that legal defensiveness and knowledge of medical law may be inversely related.\(^{51}\) The second aspect is that although there is obviously an impact of law on the practice of medicine through fear of litigation, there may well be a complementary influence of medicine on law itself.\(^{52}\) In this sense, medical practice itself influences the values and beliefs of society and the evidence of these values and beliefs is to be found in the law. Thus medicine and law develop dialectically. Both medicine and law shape the way in which the other develops.\(^{52}\) This notion of the sense of relationship between defensive medicine and medico-legal law needs to be explored before meaningful changes to the medico-legal environment can be proposed. The idea will be further explored in the discussion on professionalism in section 1.5.3.

What is of concern with relation to defensive medical practice is that values held by both medicine and the law may be out of step with values held by the public. A comparative study between American and Dutch consumers of healthcare\(^{53}\) showed that respondents reported greater concern with empathy and with continuity of care in terms of defining preferences for quality of care, over and above ideas around waiting times, autonomy and efficiency. They valued knowledge, information and the relationship between themselves and their doctor. It is possible therefore, that not only are doctors' actions in practicing defensive medicine out of step with the recommendations from the indemnity insurers, out of step with so called "sound medical practice" and out of step with reducing "risk benefit analysis", but also out of step with what consumers of healthcare actually value.
This thesis will present evidence of defensive medical practice amongst New Zealand doctors, and will consider whether they appear to be following the footsteps of their overseas colleagues or are actually seeking to improve the delivery of healthcare to their patients, in response to either a complaint or the perceived risk of one.

1.5 Three viewpoints from which to examine the impact of the complaints system on doctors in New Zealand.

In this section I will present a justification for conducting research into the complaints system in New Zealand. As discussed in section 1.3, my previous research has indicated the potential that complaints have to significantly impact upon the person of the doctor, the doctor-patient relationship, and on doctors’ practice of medicine. However, there are wider questions that need to be considered with relevance to complaints and the complaints process, and the generalisability of my previous findings needs to be explored. This thesis will consider complaints from three different viewpoints. These relate to the epistemology of modern western medicine; notions around the self of the doctor and the doctor-patient relationship; and the relationship that exists between the medical profession and society. This section will provide background information from which to consider these issues.

Viewpoint 1: With regard to the epistemology of modern western medicine there are three questions that I will consider. They are 1) how we define the underlying epistemology of western medicine; 2) what insight do New Zealand doctors demonstrate into that epistemology; and finally 3) how might the complaints process itself be changed in order to facilitate change in thinking from within that paradigm or to even encourage paradigmatic shift? In order to do this, I will consider the origins of the biomedical paradigm, the emergence of the bio psychosocial paradigm with patient centred clinical method and critique the difficulties created by adhering to a strictly biomedical positivist epistemology.

Viewpoint 2: With regard to the self of the doctor and the doctor-patient relationship, this thesis will consider the legitimacy of the notion of self and the place of the doctor-patient relationship in medical practice. The questions to be considered include; whether there is evidence of an impact of complaints on the self of the doctor and the doctor-patient relationship; and whether doctors appear to change their behaviour in response to the complaint or the perceived threat of one.
Viewpoint 3: The final viewpoint to consider is whether analysis of the complaints system and its impact on doctors helps in our understanding of the notion of professionalism. This thesis will seek to develop the idea that medical professionalism exists not as an isolated concept, but as a relationship between the body of doctors in this country and New Zealand society. The questions to be addressed include; is the complaints system an important component of the relationship between the medical profession and society; and is the current complaint system serving that relationship well? In order to provide a framework for understanding these issues, I will introduce the notion of profession and professionalism in terms of its historical development and present some of the challenges to professionalism from the recent medical literature.

1.5.1 The epistemology of western medicine and its relevance to medical complaints.

Understanding the underlying epistemology of medical practice is important in contextualising doctors' attitudes towards a complaints system, how that system impacts on their practice, and how changes to a complaints system may be effected.

Epistemology is about "knowing", that is understanding how it is that a particular field of enquiry understands itself, its knowledge base and the application of that knowledge. The nature of medical complaints is that at some point in time, a judgment has to be made about behaviour or decisions or outcomes, and that judgment is predicated upon the underlying epistemology of medicine. Judgment, whether internal or external to the practitioner, is about the difference between right and wrong which are two polarised extremes. This section will explore the construction of the biomedical paradigm and explore some of the recent shifts in thinking around that paradigm, in order to explore the difficulties inherent in judging right from wrong.

The biomedical model is based on positivism and on systems theory. It is a very powerful model and seeks to understand disease in terms of causative agents and correlation between pathology and clinical presentation. It is extraordinarily useful. Over the past one hundred years or so, the biomedical model has lifted western medicine out of the grasp of supposition and superstition and allowed it to claim to be "scientific". The science that is used in this biomedical model relies on the notion that the observer of the object in question is by definition, detached from that object and is able to consider that object without its own involvement and unaffected by the presence of the scientific observer. From a medical standpoint, one can think of many situations where this would appear to be an entirely valid way of practicing. Taken to
an extreme, it would seem to be possible to practice a lot of medicine without ever engaging with a patient as a person. The “fractured ankle in cubicle three” could be diagnosed and appropriately treated without the doctor ever knowing the patient’s name, or a course of radiotherapy could be ordered based purely on magnetic resonance imaging of a tumour.

Taking this argument one step further, the biomedical model influences western medicine’s epistemology because it in effect, states that a detached observer (the doctor) by applying correct medical understanding (history taking, examination and investigations), can “know” the best way to treat their patient’s disease. Whether setting a fracture, managing a myocardial infarction, treating a psychosis, reading a cytology slide, delivering a baby or counselling a grieving patient, doctors in every discipline are expected to know the disease and thereby know the treatment. The biomedical model then can be used as a basis of judgment as to whether a particular doctor’s medical practice has been right or wrong.

Despite the enormous gains in the quality of healthcare able to be delivered during the twentieth century with the advent of safe anaesthesia and surgery, the emergence of antibiotics and chemotherapeutic agents, limitations with to the biomedical model became apparent. George Engel in his seminal article entitled “The clinical application of the bio psychosocial model” commented that the biomedical model “assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological and behavioural dimensions of illness”. He went on to comment that the biomedical model sees disease to be “an entity independent of social behaviour” 22. What Engel articulated was the tension faced by doctors presented with patients for whom their clinical presentation did not correlate with recognised disease entities. Increasingly in the latter part of the twentieth century, doctors recognized that some patients were not responding to their therapies or fitting into recognised diagnostic categories, despite the emergence of increasingly sophisticated investigative technologies.

Engel’s proposal of the bio psychosocial model is based on systems theory. He takes the organisational hierarchy comprising a person so that it extends from the levels of atoms, molecules, cells, organs and systems to include units of a social hierarchy in which the person is a component of two person relationships, families, communities, cultures, societies and the wider biosphere. Engel’s point is that the relationship between these systems is continuous and that the cells and organs of the person are in the same hierarchy as the social structures.

My critique of Engel’s bio psychosocial model is that the hierarchical systems theory on which it is based fails to articulate the complex relationships that may exist between different levels of
the hierarchy. For example, a patient’s alcohol abuse may be considered in terms of biological gut or liver dysfunction but needs to be contextualised into that person’s notions of self esteem, their depression, and their wider context of family and work. Searching for causality in a linear manner may be fruitless, and systems theory alone fails to convey the complex interplay between the various levels of the hierarchy, and seldom provides guidance as to that patient’s care.

The complex interplay between the notions of disease and illness has been explored by medical anthropologists. This has been stated in simple terms by Cecil Helman as ‘disease then is something an organ has; illness is something a man has’. Medical anthropology, being concerned with meanings rather than measurements has contributed significantly to the epistemology of western medicine. It has drawn attention to the meanings that doctors attached to patient’s presentations from within the culture of their medical background, and the influence of that background itself on the type of presentation made by that particular person.

This anthropological approach recognises that there is a cultural basis from which the doctor or patient arises and acts, and a societal and cultural milieu in which they exist. This notion is relevant to the study of complaints and their effects. It recognises that lay beliefs about health may be different from those held by the medical profession, and this idea may contribute understanding of how conflict may occur when the beliefs or expectations of a patient are not respected or met.

This recognition has influenced the emergence of patient centred medicine. The notion of patient centred medicine or the patient centred clinical method is relevant to this discussion of the epistemology of medicine. The term is now in widespread use in undergraduate medical training and in some medical circles it has almost reached a level of political correctness to refer to one’s own practice as being patient centred. The model has developed over the last twenty-five years or so in response to the need to integrate biomedicine, bio psychosocial medicine and the experience of illness that each patient brings to the consultation that is unique to them. The patient centred model is fundamental to a contemporary understanding of the doctor-patient relationship, and the model gives legitimacy to discussing several of the issues that arise with regard to the impact of complaints on the person of the doctor.

The teaching of patient centred method (PCM) in New Zealand medical schools has been strongly influenced by the Canadian approach published in 1995 by Wayne Weston and Judith Belle Brown. At a much simplified level, the model seeks to consider both the patient’s illness experience, the conceptualisation of that illness experience using the biomedical disease
centred approach that has been discussed, and the interplay of these two things within the notion of the person of the patient and the wider context of both that person’s life and the context of delivery of that medical care. From this, the outcome of the interaction is seen as being negotiated between the doctor and the patient with input that is appropriate from both sides to reach a satisfactory outcome. Weston and Brown claim that the model is valuable in four ways. Firstly, it seeks to define how doctors can function well in a consultation so as to help their patients, by recognising specific doctor behaviours that can guide the practitioner’s interaction. Secondly, they see the model as being realistic in that it is applicable to real life practice situations. Thirdly, the model can be applied to ordinary consultations in the majority of cases, and finally, it provides a framework for research by helping to define what effective doctoring is (and by implication, what ineffective doctoring might be too). They list six interactive components of the patient centred method shown in Table 1.
Table 1: Patient-Centred Clinical Method.

The six interactive components of the patient-centred process:

1. Exploring both the disease and the illness experience
   A. Differential diagnosis
   B. Dimensions of illness (ideas, feeling, expectations, and effects on function)

2. Understanding the whole person
   A. The “person” (life history and personal developmental issues)
   B. The context (the family and anyone else involved in or affected by the patient’s illness; the physical environment)

3. Finding common ground regarding management
   A. Problems and priorities
   B. Goals of treatment
   C. Roles of doctor and patient in management

4. Incorporating prevention and health promotion
   A. Health enhancement
   B. Risk reduction
   C. Early detection of disease

5. Enhancing the patient-doctor relationship
   A. Characteristics of the therapeutic relationship
   B. Sharing power
   C. Caring and healing relationship
   D. Self-awareness
   E. Transference and counter-transference

6. Being realistic
   A. Time
   B. Resources
   C. Team building

Source: Weston & Brown 56
The model as expounded by Weston and Brown takes into account some of the issues that I have introduced from the bio psychosocial model and the ideas contributed from medical anthropology. The notion of the disease as an abstraction is consistent with the biomedical approach and illness as being a patient derived experience are preserved in this model. The model includes requirements for effective care that bear a direct relationship to satisfaction, compliance and outcome. If the bio psychosocial model and systems theory is accepted, then the first three components of the patient centred process as laid out in Table 1 are reasonably straightforward. The last three points however, are important in the consideration in the doctor-patient relationship and in the potential for the negative impact of inappropriate medical behaviour within consultation. The implication of this is that if the doctor’s contribution to the consultation process is impaired, then optimal delivery of healthcare may not be achieved.

Health enhancement and risk reduction are, by their nature, behavioural processes that involve change from the patient’s point of view. To enhance the doctor-patient relationship, aspects of power sharing, self awareness, (by which the implication is not only self awareness by the doctor but also that by the patient) and issues of transference and counter-transference all require both patient and doctor participation. Similarly, issues of being realistic place on the doctor the requirement to “respect their own limits of emotional energy and not expect too much of themselves”\textsuperscript{56}. In this more sophisticated model of the doctor-patient interaction, the place of the doctor is recognised. Furthermore, the model does not view the doctor as being solely responsible to patients, and patients as being only responsible to themselves. It clearly lays out the responsibility of the doctor to ensure that conditions are optimal for that doctor to perform adequately to meet the patient’s needs, and for patients to enter into a relationship whereby they share responsibility for their own healthcare.

Despite being in widespread use, the notion of PCM still holds significant ambiguity. In an extensive review of patient centredness, Mead and Bower\textsuperscript{57} found that five conceptual dimensions to patient centredness could be identified. These were: the bio psychosocial perspective; the “patient as person”; the idea of sharing power and responsibility; the notion of a therapeutic alliance between doctor and patient; and the notion that I will discuss in section 1.5.2 of the “doctor as a person “. Figure 2 is taken from their paper and it clearly identifies the central position of both the doctor and the patient in the delivery of patient centred care. It also illustrates the link between the idea of the doctor-patient relationship and the person of doctor that will be discussed in section 1.5.2 and of the notion of professionalism that will be discussed in section 1.5.3.
Figure 2: Factors influencing patient-centredness.57

- ‘Shapers’
  - Cultural norms and societal expectations
  - Socioeconomic background
  - Formal and informal learning (e.g. the media)
  - Personal experience
  - Medical training and clinical experience (doctor)

- Doctor factors
  - Attitudes
  - Values
  - Knowledge
  - Personality
  - Gender
  - Age
  - Ethnicity
  - Knowledge of patient

- Patient factors
  - Attitudes and expectations
  - Knowledge
  - Personality
  - Gender
  - Age
  - Ethnicity
  - Nature of problems
  - Knowledge of doctor

- Consultation-level influences
  - Communication barriers
  - Physical barriers
  - Interruptions
  - Presence of third parties
  - Time limitations
  - Workload pressures

- Doctor behaviour
- Five dimensions of patient-centredness
- Time
- Patient behaviour

Professional context Influences Professional norms Performance incentives and targets Accreditation Government policy initiatives
Although Mead and Bower’s work is primarily about the utility of discovering measures that will impact on the outcome of care, the model does provide us with some insight into the types of factors that impact on the doctor-patient relationship and that are valid in terms of the epistemology of western medicine. A danger however of this model, is that it still uses a positivist philosophy which states that there is a correct or right way in which to practice.

A counterpoint to that view can be found in the theological notion of polarities. This notion espoused by Tillich in the 1950’s suggests that notions such as right and wrong, good and bad, or life and death, are extreme points on different continua. The experienced reality of people in any aspect of their life is unlikely to fall at one of these extremes and more likely to fall at some point along one of these axes. This notion is relevant to our discussion of the medical complaints process and its impact because in order to define mistakes, errors or wrong-doings by doctors, society must make the distinction between right and wrong. Most medical practice, of course, is not absolutely good or bad but lies along a continuum between these extremes.

Additionally, Tillich’s notion of a polarity between an actual and a potential state of being has immediate relevance to the practice of medicine. If a doctor’s practice is either internally or externally assessed (that is assessed by the doctor or by some external agency), and that assessment is focused on the potentiality of the situation, ignoring the actuality or reality involved, then it is unlikely that the doctor will be found to have measured up and will be seen to have failed. Furthermore, if the expectations of society (which may be internalised by the doctor and used as a basis for their own internal assessment) are unrealistic, the likelihood of the perception of failure by the doctor is further increased.

Although the models of PCM consider some of the “shapers, factors and influences” that impact on the doctor-patient interaction, these models do not explicitly state the idea that there are many different axes that lie between different polarities that need to be considered in order to make a judgment about the quality of delivery of care.

The dilemma of how to define a single epistemology of western medicine can be seen in discussion around the subjects of evidence-based medicine and of quality. Each at first sight would appear to have a clear cut epistemology as a requisite for their existence. Evidence-based medicine (EBM) emerged in the late 1980’s, based on the notion that properly applied scientific method could accurately evaluate medical practice (diagnostic and therapeutic techniques especially) and inform doctors about the best way of practicing. EBM’s fundamental assumption is that “practitioners whose practice is based on an understanding of
evidence from applied healthcare research will provide superior patient care compared with practitioners who rely on understanding of basic mechanisms and their own clinical experience." 59.

The challenge to EBM lies in several domains including questioning what constitutes valid healthcare research, what the best findings are from this research, when it should be applied and to whom? Probably the greatest challenge to EBM as noted by Haynes, is that the basic elements of clinical decision making are found in an overlap of not only the research evidence but also of patient’s preferences and the clinical circumstances. Although Haynes does not include in here the doctor’s viewpoint, clearly the challenge to EBM is to discover how findings from groups within a study population can be applied to individual patients.

The second subject to be mentioned in the context of epistemology is the notion of quality. In order to evaluate or judge a doctor’s practice it should be possible from within any given epistemological base, to make a judgment on whether that doctor’s practice has been of satisfactory quality or not. However, some of the tensions laid out in 1997 by Avedis Donabedian have yet to be resolved 60. He notes the conflict that may exist between three different definitions of quality which he describes as being the absolutist, the individualised, and the social. The absolutist definition of quality is derived from the biomedical notions of what can be done in any particular presenting circumstance. That of course, may be in conflict with the “individualised” notion of quality in which what could be done may be at variance with the individual’s wishes or personal judgment. Furthermore, those two ideas may be in conflict with the idea of the social quality of delivery of care in which what is possible should or could be done for an individual, may still be in conflict with what is appropriate within a particular community or society.

What Donabedian raises that is pertinent to this discussion of epistemology and medical complaints, is that defining quality of care is difficult and of necessity, multi-factorial. He also draws attention to looking at the delivery of care along two different axes, that he calls the “technical” and the “interpersonal”, noting that each needs to be considered in order to arrive at a judgment on the quality of care delivered.

These apparently disparate ideas of quality of care and evidence based medicine are both relevant to how a doctor’s practice may be judged, but are both struggling with difficulties in their definition and application. They do however illustrate that while modern western medicine is still embedded in a positivist biomedical philosophy, the role of the illness
experience and the place of the doctor and the doctor-patient relationship in patient care is recognised as important. It follows that how both doctors and society view complaints must to be considered in light of the prevailing positivist epistemology. The implication is that any proposed change in the complaints process must take into account the epistemological basis of medicine as defined by a number of different stakeholders in the process. This thesis will present evidence of how New Zealand doctors (being significant stakeholders) actually view the practice of medicine and what their expectations are of the basis on which they may be judged.

1.5.2 The notion of the doctor-patient relationship and the self of the doctor in the delivery of medical care.

This section will seek to establish the legitimacy of exploring the notion that the self of the doctor and the doctor-patient relationship are important components in the delivery of medical care. If receiving a medical complaint can be shown to impact negatively on the person of the doctor in a way that affects their ability to practice medicine or to engage in appropriate doctor-patient relationship, then that finding has significant implications for the care of patients and for suggestions as to how the complaints process may be altered.

Looking at the practice of medicine from ancient times and until the early twentieth century, medicine has been characterised by grossly inadequate understanding of the nature of disease and of disease treatment, at least by modern standards. In order for medicine to have persisted, it must have had some redeeming values, and a likely conclusion as summarised recently by Eric Cassell is that “the treatment has been doctors themselves through the vehicle of their relationships with patients – not any relationship, but the doctor-patient relationship.” Cassell comments on aspects of the doctor-patient relationship that are fundamental to this thesis. He proposes that the nature of the relationship as being “inherently benevolent in nature” and goes on to recognise its dependency on trust between the two parties involved and the fact that it is grounded in the social roles of both the doctor and the patient. Importantly, it is also dependent on an understanding on the effect of sickness on the particular patient involved.

Inherent to this discussion are two premises that need to be clearly stated. The first is that the doctor-patient relationship involves two parties (the doctor and the patient), with both parties making at least some contribution to the relationship that exists between them. Secondly, is the premise that changes detrimental to the doctor-patient relationship may be detrimental to patient care. Detrimental change may occur on either side of the relationship.
That the doctor-patient relationship is in itself a therapeutic one is a notion that was popularized by Michael Balint in his writings from the 1950's when he and Enid Balint introduced the concept of "the doctor as the drug". However, this idea had been recognised even earlier by Houston in 1938 when he wrote that "the doctor's attitude towards the patient is perhaps more fundamental than the patient's attitude towards the doctor". This therapeutic state however, is continually being reassessed by patients during the consultation, and this has been researched. Patients assess issues such as willingness and ability of the doctor to help them, and patients are acutely aware of the nature of the relationship that they have with their doctor and are looking to establish the security of it. The process may occur during a single consultation but will also be carried on over a long period of time if there are multiple consultations, and so the relationship needs to remain stable and be protected from circumstances that may reduce the doctor's ability to deliver an appropriate level of care.

Also relevant to this discussion is the notion that doctors carry on therapeutic relationships with large numbers of patients over time, and that often their patients are unselected and have unselected conditions. With each patient a satisfactory relationship needs to be established and perpetuated. Furthermore, as articulated by Ian McWhinney, the doctor needs to be acquainted with the details that pertain to "the particular patient" with whom they have that relationship. This notion that in order to respond to the particular needs of a patient, the particular doctor needs to bring to that consultation those attributes that will best meet that patient's needs, is central to the justification of the doctor-patient relationship as a legitimate focus of study.

The doctor-patient relationship is a relationship with a particular purpose; to help the patient in a therapeutic manner and to facilitate healing. The relationship has other attributes including caring, feeling, trust, power, and a sense of purpose, and it is a relationship that continues over time and which requires constancy. The therapeutic relationship also includes other attributes such as empathy, congruence, genuineness, respect, positive regard and concern for the other. The relationship is also reciprocal, to the point where "doctor and patient are bound in a reciprocal relationship — failure to understand that is failure to comprehend clinical medicine". That reciprocal relationship is dependent upon trust. Clearly, a satisfactory doctor-patient relationship is not something that exists as a right or comes into existence simply because a doctor and their patient are present at a point in time. A satisfactory doctor-patient relationship is dependent upon a number of intensely personal and human characteristics which are
vulnerable and which could be impacted upon by characteristics of either the doctor or the patient.

One way of approaching the topic of the doctor-patient relationship is to examine instances where the doctor-patient relationship fails. There is extensive exploration of “the heartsink patient” in the recent medical literature. At the risk of over-simplifying the subject, heartsink patients illustrate the difficulty that particular doctors have in establishing and maintaining a therapeutic relationship with particular patients. Ultimately, the problem does not lie so much with the patient, but with those particular characteristics of the attending doctor that make it difficult for that doctor to function in a therapeutic manner for that patient. Not every heartsink patient will induce the same response in different doctors, and the implication from this is that it is the personal characteristics that doctors bring to particular relationships that are themselves fundamental to establishing and maintaining these therapeutic relationships.

The notion of “heartsink” illustrates how the effectiveness of the doctor is determined by the doctor themselves and not just by the patient or the disease or illness that they have. The notion provides an illustration of the importance of the self of the doctor in the practice of medicine, and this concept of self can be defined and to an extent, understood.

Collin’s concise dictionary defines self as being “one’s own personality or individuality.” Awareness of self becomes more important when it is in jeopardy, and if the sense of self is challenged or exposed by the process of a complaint then understanding the notion of self may assist in proposing change to the complaints process. Koestler notes that an understanding of self can never be perfectly reached by one’s self alone, and quotes Karl Popper’s proposition that “no information system can embody within itself an up to date representation of the system that includes that up to date representation”, which means that one can approach but never fully attain true understanding. In the context of a complaints process, it means that doctors in receipt of a complaint are going to need the participation of others in order to facilitate improving their own self awareness.

In his self trauma model, John Briere does not define self, but does explore three aspects of self function and capacities that relate to the individual’s response to traumatic or challenging events. These have relevance to this discussion. The three areas of “identity”, “boundary”, and “affect regulation” relate to the individual resources that someone has to deal with distressing events.

Briere defines identity as “a consistent sense of personal existence, of an internal locus of conscious awareness”. This internal locus needs to be secure, to preserve its integrity and
avoid being overwhelmed by events so as to preserve awareness of its own "needs, perspectives, entitlements and goals". The implication of these comments is that if one examines someone's thoughts and behaviours after a particular event and finds evidence of a lack of awareness of needs, perspectives, and so on, then the implication is that there has been a significant disruption to that person's sense of identity. It follows that evidence of disrupted behaviour after receiving a complaint implies that that doctor's sense of self may have been damaged.

Briere's concept of boundary is relevant in this context. He defines it as referring to "an individual's awareness of the demarcation between self and other". Clearly, the concept of boundary will vary in time and place. The result of having weak boundaries will be that the person has difficulty knowing where their "identity, needs, and perspectives end and others begin, such that they either allow others to intrude on them or they inappropriately transgress upon others". This component of our understanding of self is important in the consideration of the effect of complaints. If the effect of a complaint is to transgress upon a doctor's boundaries then there is potential for that doctor to become less aware of their own rights to safety, and inappropriate acceptance of the behaviours that may have led to the complaint initially. Conversely, doctors could inappropriately transgress the boundaries of other patients if they see themselves as being threatened, and this links with the notions around defensive medical practice that have been discussed.

A third self function is of affect regulation, and this has two components, modulation and tolerance. An individual with good affect tolerance will be able to "experience negative affects without having to resort to external activities", for example aggressive behaviours, or the use of psycho-active substances. Affect modulation refers to the individual's ability to deal with upsetting events internally, to place such events into their correct perspective and in some positive way, to deal with the problem. Although these ideas do not in themselves define self, taken in partnership with the notions of identity and boundary they provide insight into how internal mechanisms exist that help deal with challenges to self. Again, if there is evidence of negative coping behaviours exhibited by doctors on receipt of a complaint, then these may indicate that there has been a significant challenge to the self of that doctor and that possibly the internal capacity of that doctor to deal with the problem has been overwhelmed.

Further to the legitimacy of studying the self of the doctor in response to receiving a complaint, is to understand that the idea of "person" is more than just the notion of mind. Although any typology of person will be limited, examining the different components of person help identify how suffering may occur and to help consider how a complaint may impact on the person of the
doctor. Eric Cassell lists several headings under which one might consider the nature of person. These include that person’s personality and character; their past; their life experiences; their cultural background (which will include the underlying culture and epistemology of medicine that they hold); their roles and significant relationships with others; their political views, actions and behaviours; their physical body; and their “transcendent dimension” or spiritual life.

These ideas are valuable in terms of considering whether a complaint may impact on the self or person of the doctor, which, as has been discussed, is an integral component of the therapeutic doctor-patient relationship. A further notion in terms of looking for evidence of impact on the self of the doctor is that of shame. According to Michael Lewis, shame can be defined as “the feeling we have when we evaluate our actions, feelings, or behaviour and conclude that we have done wrong” \(^{23}\). It encompasses the whole of our selves; it generates a wish to hide, to disappear, or even to die. Lewis has developed the idea that shame is a “global attribution”. This means that the emotion felt is applied or referred to our entire selves. In essence, the shamed person feels bad about themselves, and about their sense of self, opposed to feeling bad about a particular action or thought or some other form of behaviour that does not impact as significantly on their sense of self.

Emotions such as shame, guilt or pride are secondary emotions, in that they all require consciousness of self. In this way they are different to the primary emotions of joy, sadness, anger or fear. Because the secondary emotions rely on a consciousness of self, they have some value in a self regulatory role. In other words, they permit self reflection, interpretation and evaluation of thoughts and behaviours. This links with notions around the epistemology of medicine. A significant challenge to that epistemology (having been internalized by the doctor to the extent that it forms a significant component of that doctor’s sense of self), accompanied by an assessment of failure, may lead to the emergence of one of these secondary emotional responses.

Shame and guilt are experienced as consequences of the self’s failure in regard to some internalised or externalised standard or rule. The difference between guilt and shame lies in the concept of global attribution, whereby shame is experienced as a total failure to meet a standard whereas guilt is a specific self failure that does not impact on the whole of the self. It follows that the way in which one responds to failure may be able to be altered. Lazare asserts that the experience of shame results from the interaction of three factors; the shame inducing event; the vulnerability of the subject; and the social context which includes the roles for people involved
All of these determinants may be able to be manipulated to alter both the induction of a shaming response and the downstream effects of shame. These downstream effects can be either adaptive or maladaptive. A relatively minor shaming event can be dealt with using humour or laughter. A more meaningful shaming event may be responded to with a hiding response, which may be protective against further intrusions against the self but taken to an extreme, excessive distancing removes the individual from normal social contact and in an extreme case may result in suicide.

There are also consequences of prolonged shame. This may involve a prolonged reaction to a single shaming event, or a reaction to multiple shaming events that the individual is unable to protect themselves from. Lewis introduces the idea of the shame-rage axis and the shame-depression axis as responses to shaming events that are commonly seen in response to prolonged shame. The implication for research into the effect of complaints, is that evidence of prolonged rage or depression following a complaint may signpost the complaint as having been a shaming event for that doctor and if so, this has implications for how to assist doctors after receipt of a complaint.

Shame inducing events may include failure to diagnose or treat in a way that does not comply with one’s own (internal) or colleagues’ (external) standards; the induction of shame through “empathic identification” where there is over identification by the physician with the patient, and lastly, the experience of disrespectful behaviour by the patient or the patient’s family including threatening to sue or complain.

So, it is possible to be shamed by the actions of others and this includes the risk of being shamed by a person or organisation that a complained about doctor turns to for help. It follows that it is important for any helper in a complaint situation to be aware of the presence and power of their own emotional response towards the complained about doctor.

It may be that guilt is the preferable secondary emotion to having been judged to have transgressed a particular standard. Guilt has a less pervasive affect on the self of the person than shame does. It implies cognisance of wrong-doing and the potential to separate the action from the self of the person who did that action. In this way, a transgression is “out there” rather than inside the self of the person. The difference between guilt and shame could be expressed as “I did that horrible thing” (guilt), versus a failure of the self “I did that horrible thing” (shame). The idea of how doctors make this judgment as related to a particular standard links with the notion of polarities and the underlying epistemology of medicine. A guilt response
suggests that the doctor has placed that transgression at an appropriate point on the axis between good and bad or right and wrong, and may be in a position to make that failure right, or to reduce the likelihood of it happening again. A guilt response is conducive to learning, whereas a shame response is not.

In summary, the doctor-patient relationship is essentially the vehicle through which healing occurs. One half of that relationship involves the person of the doctor. If the complaints process significantly negatively impacts on the self of the doctor it will impact on the doctor’s ability to deliver good quality medical care. This thesis will seek evidence of an impact of the effect of complaints on the person of the doctor and suggest how any negative effects may be dealt with. Differentiating between shame and guilt as secondary emotional responses to receiving a complaint may open the door to appropriate education as the way to deal with evidence of poor practice when it emerges.

1.5.3 The notion of profession and professionalism in medicine.

This thesis will explore the idea that complaints may impact on the functioning of the medical profession and thereby, on the society that the profession purports to serve. This impact may be positive or negative, and if one is to argue for change in the complaints process contingent on improving the situation for society, then the nature of profession and professionalism needs to be made explicit. This section will explore the development of these notions and contextualise these in modern medical practice.

The word “profession” is derived from the ancient notion of “to profess”, and relates to the idea that an individual or a group will make a statement to society in which they profess to have knowledge or skill in some particular area. In the late nineteenth century, society recognised three learned professions; divinity, law and medicine. Since that time, other so called professional groups have arisen and the notion of profession and professionalism has come under academic scrutiny.

The last eighty years has seen the development of two different but significant notions of how profession and professionalism may be considered. The first of these notions is where profession is seen as a social construct around the idea that a group within society holds special knowledge or skills, with the associated idea of self regulation. The second notion involves seeing a profession as the embodiment of particular values, ethics and morals, exhibited in the behaviour of both individual members of the profession, and of the profession as a whole. This
section will discuss the components of these two notions and develop an alternative view of the medical profession as the state of *relationship* between doctors and society.

The sociological notion of profession was developed in the 1920's and 1930's by Talcot Parsons using what is regarded as a "structural-function" approach. Using this approach, professions are seen as a social phenomenon exhibiting three particular characteristics. These are specialised knowledge and expertise; dedication to public service; and socially approved self governance or self regulation. In this sense, the basis of professionalism is a social contract between profession and society, and without this contract professionalism cannot exist. This approach includes the notion of dedication to service, such that the professional is expected to "subordinate personal financial gains to the higher value of responsibility to the patient and to public interests". The key point to the structural-function approach is summed up by Oreopalous as "in exchange, society grants the professional the authority to control key aspects of their market and working conditions through licensing and credentialing, and are given rights not generally accorded to the public".

Richard and Sylvia Cruess and Sharon Johnston expand on some of these ideas as follows. They note that the specialised knowledge held by professionals is not easily understood by the average person and so the professional is given a monopoly over its use and held responsible for its teaching. The knowledge is to be used altruistically for the benefit of individuals in society, and in return society is to grant professions sufficient autonomy to establish and maintain standards for their practice, using self regulation as the means of ensuring appropriate quality. In exchange for that autonomy, professionals are required to assume responsibility for the integrity of that knowledge base, to research it in order to expand it, and to ensure that there are the highest standards for its use. A more modern way of restating the structural-function approach is that the health professionals embody the intellectual property associated with that profession.

What may not be obvious in a relatively egalitarian society such as in New Zealand is that ideas originating with Talcot Parsons grew out of a European context in which particular classes, status groups and other entities such as political parties were seen to be competing for economic, social and political awards. So the idea of profession from this sociological viewpoint is a way of explaining what reward society grants to a particular group by way of market control and controlled working conditions, and why these rights and rewards are not given to the public. Any sense of relationship between the professional and society using this sociological model is still viewed in terms of service and services provided and rewards gained.
These services and rewards separate that professional group from other groups within that society.

The major advantage of the structural-function approach is that technical expertise can be defined and refined, it becomes teachable to novices and able to be practiced by members of the profession, and can be recognised as professional skills, behaviours and expertise by society. Society in turn can place a value on that expertise and seek to limit or reward it in a particular way. Particular to medicine and with relevance to the delivery of healthcare, the awarding of professional status to doctors may arise from "a primal human urge to project on to some group the power to heal".79

The limitation of the structural-function approach is that it leaves professions open to the claim that self regulation may be tantamount to monopolisation of trade. This is exactly what happened in the late 1960's and early 1970's 82,83 and this critique led to the development of the notion of professionalism as a value. An important point with regard to this discussion is that these notions are ways of developing an understanding of how doctors function; they are ways of looking at and trying to make sense of medical practice and are not in themselves instigating or reflecting the development of new ways of behaving or of ways in which doctors relate to society. In other words, neither the structural-function or values approaches are new forms of professionalism, they are simply ways in which professionalism might be considered.

The values perspective of profession can be examined in two ways. There are the characteristics of the person of the professional, and there are characteristics of professionalism seen in the behaviour of the group.

Included in the notion of the person of the medical professional are the ideas that the practitioner must conform to the technical or ethical standards of the profession, exhibit particular types of behaviour in the workplace and have an obligation to respect individual patients' human worth with a sense of trustworthiness and protection of values.79 These values include a sense of commitment, of non-exploitation and of not abandoning patients. Other responsibilities will include protecting confidentiality, acting with compassion, integrity and interprofessional respect. The professional will also exhibit a lifelong commitment to learning. Expressed in these ideas is that a values based view of the professional requires the professional to be capable of holding these values at a personal level. The implication is that if they become incapable of holding such values for whatever reason, then they cease to be truly professional.
Characteristics of professionalism as a behaviour exhibited by doctors as a group include similar values such as respect for human worth and trustworthiness, but also include a commitment to altruism in its dealings with society. Wynia et al consider professionalism as an activity that involves the distribution and the fair allocation as of a social good, but is "uniquely defined according to moral relationships". They see professionalism as a morally protective force in society, charged with the protection of both vulnerable persons and vulnerable social values. This is an extraordinarily important point. Abject failures of medical professionalism in modern times include the misuse of psychiatry for political gain in the USSR, the misappropriation of medical resources in apartheid South Africa and the unconscionable undertaking of human experimentation in Nazi Germany. This expansion of the definition of professionalism as a morally protective force within society differs from the structural-functional approach of the earlier sociologists and if it is valid, reinforces the importance of considering how to deal with negative influences on professionalism.

Charlotte Paul’s notion of medicine having both an internal and external morality is another way of approaching these ideas. In considering the process and outcome of the Cartwright Inquiry into practices at National Women’s Hospital, she draws attention to the external regulatory processes brought to bear on the medical profession during the Inquiry and also highlights the importance of the internal morality of the medical profession exhibited by both the whistle blowers in that particular case and by the vast majority of doctors in their day to day practice. She highlights the notion that “trustworthiness is enhanced by the self-respect accompanying ownership of professional standards”. The danger is that trust and trustworthiness can be lost with the inappropriate exercise of external morality by society on the profession.

The impact of managed care on the delivery of medical care to vulnerable groups in the United States, has led to the development of a modern model of “civic professionalism”. Problems in American medical professionalism are seen to include standards of behaviour with poor service, lack of alliances with consumer groups, lack of advocacy on behalf of patients and an inappropriate impact of pharmaceutical company influence. In response to these problems, civic professionalism requires devotion to medical service including the maintenance of obligation to care for financially disadvantaged patients, the public profession of values including that of commitment and respect for human life and health, and the negotiation of professional and other social values that protects core health values but remains accountable to public need.
The ideas from both the structural-function approach and the values based approach provide a basis for considering the potential impact of complaints on doctors. Evidence of the impact of complaint may be found if the body of professional knowledge skills and behaviour is changed, if the attitude of doctors towards patients (especially with regard to the values of service and commitment) are changed, or if the propensity of doctors to engage in civic professionalism in terms of devotion to service, profession of values, and negotiation at the societal level is reduced.

What is lacking in modern writings about medical professionalism is a sense that there is a reciprocal relationship between doctors and society analogous to the doctor-patient relationship. Neither the sense that the profession trades its commodity of knowledge with society in return for some privilege, nor that it uses its values to the benefit of society actually encompasses the notion that each party may impact on the other in a reciprocal manner. This thesis explores the proposal that it is this sense of relationship that is missing from the discussion of medical professionalism in the literature. In this thesis I will seek evidence of New Zealand doctors' awareness of that sense of relationship, and assess the degree of importance that they place on it.

1.6 The goals and objectives of the studies reported in this thesis.

Collectively, the studies reported in this thesis have three goals. The first is to consider whether the findings from the research I completed in 1999 and 2000 about the impact of receiving a complaint published 21,17 are generalisable to the population of New Zealand doctors. The second goal is to consider the notion of medicine as a profession by examining the attitudes and behaviours of doctors in response to complaints as an example of a particular type of interaction that society has with doctors as a group. The third goal is to consider and develop ideas for change with regard to the complaints process which may promote the post-complaint ability of doctors to practice good medicine, and improve outcome for patients and society.

The results of the research will be presented in chapters three to eight. A summary of the objectives of those studies is:

- To consider the purpose of a medical complaints system
- To describe the characteristics of doctors receiving medical complaints
- To evaluate the impact of receiving a complaint on doctors
• To explore New Zealand doctors' attitudes towards the complaints process
• To test doctors' ideas about the practice of medicine and their role in society
• To study defensive medical practice and its relationship to the complaints process
• To develop and present doctors' suggestions for change with regard to medical complaints

Although clearly dependent on the method chosen, the test of whether or not the objectives have been met lies in the validity of the results obtained, and whether study data are sufficient to allow interpretation, confirm previous knowledge or create new knowledge.
CHAPTER 2.

METHODS.

2.1 Introduction.

To meet the goals, aims and objectives of this research as introduced in section 1.6, I employed three distinct research methods. There were several issues that needed to be considered in order to undertake this research, including some which were unique to the topic of the effect of complaints on doctors. The key considerations were the degree of sensitivity that the topic of medical complaints engenders in doctors, the difficulty in accessing research participants who are known to have had a complaint, and when an existing research base in the New Zealand context is lacking (as in the practice of defensive medicine) there was need for a method that was open to exploring the range of possible effects of a complaint allowing new data to be collected without predetermining those data and attempting to quantify the variables in it. Because of the sensitive nature of the research, it was of paramount importance that the personal safety of the participants was preserved, that the confidentiality of their responses was held, but that the data were collected and presented in a manner meaningful to the medical profession and to the wider New Zealand society.

In overview, much of the data presented in this thesis comes from a cross-sectional survey of New Zealand doctors randomly selected from the New Zealand Medical Register. This survey aimed to determine the characteristics of doctors who declared themselves to have either ever or never been in receipt of a medical complaint. The survey also aimed to test the findings of my previous research 21 with regard to the immediate and long term impact of receiving a complaint. It sought to consider doctors' attitudes towards the complaints process, and in a "free text" section, to solicit suggestions for change.

A separate focus group study was used to consider the profession's views with respect to the purpose of the complaint system.

The third project aimed to determine the extent of the practice of defensive medicine in New Zealand. This project used a qualitative method - taped in depth semi-structured interviews with thematic transcript analysis. In summary, the analyses presented in this thesis use a mixture of qualitative and quantitative methods appropriate to the goals, aims and objectives of each component of the research.
This chapter will consider specifics of the method as it relates to each of the chapters that present the results, will critique the strengths and limitations of the research method, consider bias in the study and present details of the ethical approval for this research.

2.2 Method
Details of the method of the focus group study.

The focus group research was conducted at a workshop addressing issues around the complaints process that was held in Queenstown, New Zealand on the 13\textsuperscript{th} and 14\textsuperscript{th} of July 2002. The workshop was part of a continuing medical education program (CME) under the auspices of the South Link Health Independent Practitioners Association (IPA), which is a body that represented at the time, 452 general practitioners in the South Island. 35 general practitioners self selected their attendance at this component of the workshop. The focus group was held over consecutive sessions each lasting two and a half to three hours. The workshop was also attended by invited senior representatives of organisations that have a significant stake in the complaints and disciplinary process. These participants included –

- Dr J. Adams: Chairman, New Zealand Medical Association
- Dr M.A.H Baird: President, Medical Council of New Zealand
- Dr D.Court: Medico-legal advisor, Medical Protection Society
- Mr R. Paterson: Health and Disability Commissioner
- Ms G. Phipps: Barrister, Medical Protection Society
- Dr P. Robinson: Medico-legal advisor, Medical Protection Society
- Dr H. Rodenberg: President, Royal New Zealand College of General Practitioners

Invited, but unable to attend was Dr D. Rankin: General Manager, Healthwise, Accident Compensation Corporation.

The workshop was chaired by Prof M. Tilyard (Department of General Practice, Dunedin School of Medicine) and facilitated by myself. The workshop used a mixture of small group discussion followed by plenary overview sessions to discuss specific questions about the complaints process and to collate recommendations. Focus group discussions were not recorded and transcribed, but each small group reported their findings back to the larger group for open discussion. During the course of the workshop the participants were set two tasks. The first was to define the purpose of a complaints system and the second was to identify major problematic issues that beset the current complaints system in New Zealand.
Once collated, the key notions arising from each of these discussion areas were presented back to the participants in the study for their further comment and clarification.

**Details of the method of the questionnaire.**

Between 1999 and 2001, I reviewed the qualitative research that I had conducted about the effect of receiving a disciplinary complaint on general practitioners, and developed questions about the impact of the complaints process and suggestions for change. These questions were trialled within the Department of General Practice, Dunedin School of Medicine. The letter of invitation is attached as Appendix 3. The questionnaire is attached as Appendix 4. Advice on sampling and statistical analysis was given by Associate Professor Peter Herbison, Department of Preventive and Social Health, Dunedin School of Medicine.

Following this process, in June 2001 I mailed 1200 questionnaires to doctors on the New Zealand Medical Register using a stratified systematic sampling technique. From each of the alphabetically ordered lists of (1) vocationally registered general practitioners, (2) hospital based specialists, (3) general registrants (junior hospital doctors, medical officers of special scale [MOSS], and general practitioners not on the indicative vocational register); every seventh name was selected until each group of potential participants contained four hundred names. Potential participants were then encoded and entered into a computerised database. The medical discipline or area of practice of each respondent was taken as that indicated on the medical register at June 2001.

Each selected doctor received: (1) a mailed invitation to participate in the survey; (2) an information sheet; (3) a consent form; (4) two sealed envelopes containing questionnaires. Because of the importance of distinguishing the responses from doctors who had ever received a medical complaint from those who had never received a complaint, the participants were asked to only open the envelope containing the questionnaire relevant to their circumstances. In so doing, I hoped to avoid “contamination” of responses between the respondent groups, especially in trying to avoid never had participants submitting responses biased by excessive or inappropriate focussing of thought on the potentially negative implications of complaint.

The notion of a complaint itself was not further defined, leaving participants free to decide if their experience of a particular event should be called a complaint. Participants were however, asked to indicate to which body a complaint had been directed.
All respondents, whether they had ever or never had a complaint were requested to provide demographic data including age, gender, details about their place and year of graduation, how many years they had been in practice in New Zealand, and their post graduate qualifications. All respondents were also asked to provide their views about the medical complaints system in New Zealand and to provide suggestions for change.

Respondents who had ever received a complaint were asked to complete additional sections about the short term and long term impact on themselves and on their practice of medicine. The respondents were asked to recall both their early response to having received a complaint and what their current response is, reflecting on a series of paired statements to indicate their level of disagreement or agreement using a five point Likert scale.

Specific demographic data was sought with questions asking with which organisation the complaint had been laid, the time that elapsed from the event or incident that led to the complaint to actually receiving the complaint, the time to resolution of the complaint process and whether the complaint had been upheld or dismissed. Participants were also asked to present their view of the reason for the complaint.

Attitudes towards the complaint process were explored in a further section of the questionnaire which contained attitudinal statements to which the respondents were asked to indicate on a Likert scale, their level of disagreement or agreement.

To test associations between doctors' experience of complaints and the demographic variables, Chi-square tests were used. All statistical testing was performed on an SPSS statistical package. To compensate for multiple testing, the level of significance chosen for all statistical testing in this study was p<0.01.

One important question that the survey sought to answer was whether there was statistically significant difference between doctors who had ever or never received a complaint. A further important question was whether there would be any difference been doctors practicing in different vocational groups.

Chi-square tests for differences in proportions were used to determine whether respondents in different vocational groups responded differently to a complaint in both the short and long term.
Because the early and late responses to receiving a complaint required the statistical testing of the same set of respondents over time, the test chosen was the Wilcoxon matched pairs signed rank sum test.

To test the difference between respondents in different vocational groups and between those who had ever or never had a complaint with regard to the attitudes about the complaint system that they held, Chi-squared tests were again chosen to test the associations between these responses and the demographic variables. Again, the level of significance was set at p<0.01.

The initial return rate for the full completed questionnaire was 49.8% (598 out of 1200). In September 2001 the 602 non-respondents were re-surveyed with a single request; please indicate whether you have ever or never received a complaint. Using a stamped self-addressed return envelope as was used in the original survey, I received 373 replies for an overall total of 971 out of 1200 (76%). This allowed the respondent group to be compared with the non-respondent group with regard to the single most important question, being the incidence of receipt of a complaint amongst New Zealand doctors.

All respondents were asked to make a free text reply to the question “how do you think that the medical disciplinary complaints system could be improved in this country?” The responses were transcribed and analysed using line-by-line inductive analysis as described by Strauss and Corbin. Emergent themes and sub-themes were analysed with the aim of developing ideas for potential change in the complaints and disciplinary process, and developing theories about the respondent’s perceptions about the nature and practice of medicine. These transcripts of their responses were not returned to the participants. I conducted the thematic analysis without recourse to any personal identifying features of the respondents apart from knowing their field of practice (vocationally registered general practitioner, general registrant or hospital based specialist) and whether they had ever or never received a complaint. This was in order to identify whether a particular vocational group may have specific needs for complaint reform, or if the experience of a complaint might inappropriately or so strongly bias the response as to render it unacceptable to the wider profession or to New Zealand society.

**Details of the method of the interview study of hospital based specialists in receipt of a medical complaint.**

The third arm of this project primarily sought understanding of defensive medical practice in New Zealand as a result of receiving a complaint. Because there is no published research in this country on this subject, the research methodology chosen was a qualitative interview based
study using in depth semi-structured interviews with inductive thematic analysis to allow the emergence of significant themes and sub-themes\textsuperscript{87, 88}.

The major difficulty in conducting research of this nature is limitation of access to potential participants. Knowledge of the names of doctors who have received a complaint is tightly guarded. Whereas my previous research with general practitioners had accessed participants via the secretary of the former Medical Practitioners Disciplinary Committee, the number of different complaints bodies that currently exist made this approach too difficult to use in the hospital based specialist project.

My solution was to send an information sheet and consent form for participation to potential participants via the Medical Protection Society (MPS) New Zealand office based in Wellington. The MPS was asked to forward my invitation to doctors working in hospital based specialties for whom they had provided medico-legal advice in the last five years. Forty letters of invitation were sent out from the MPS office and twenty-five replies received.

During 2004 and 2005, twelve of these participants were approached by telephone and arrangements made for taped telephone interviews to be conducted at a time of their choosing. By replying and consenting in writing and then again verbally during the interview, participants agreed to be part of the research. Due to confidentiality issues, it was not possible for me to ever know who was approached but declined to participate.

A total of twelve interviews were conducted, as analysis indicated that by the twelfth interview saturation was reached and new data were not emerging. The participants were encouraged to tell the story of their complaint, to explore any particular points that arose from this and then, using semi-structured interview prompts to explore ideas around the subject of defensive medical practice as it pertained to their experience.

The tapes were transcribed and analysed by immersion, identifying emergent themes and sub-themes. Because the subject of the research was the effect on practice, I searched for evidence of causal networks of particular relevance to change in practice and behavioural change in the participant doctors\textsuperscript{89}.

46
2.3 Strengths and limitations of the method.

A critique of the strengths and limitations of the research method used will be presented as part of each subsequent results chapter. Because much of the research presented in this thesis uses a qualitative methodology, this section will present a review of the place of qualitative research, of its origins in social science research, current views on how qualitative method should be used, and characteristics of “good” qualitative research. Although much is sometimes made of the dichotomy between qualitative and quantitative research, comparing the relative strengths and weaknesses of each is less important than making the correct choice of method for answering the question posed by the study. Table 2 considers the notion that there are different ways of knowing depending on the intent of the researchers.
<table>
<thead>
<tr>
<th>Characteristics of Style</th>
<th>Experiment</th>
<th>Survey</th>
<th>Documentary-Historical</th>
<th>Field</th>
<th>Philosophy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Camera</td>
<td>Laboratory</td>
<td>Instrument</td>
<td>Multi-method</td>
<td>Researcher</td>
<td>Thinker</td>
</tr>
<tr>
<td>Scene of Focus</td>
<td>Casual hypothesis</td>
<td>Probability sample</td>
<td>Artefacts</td>
<td>Human field</td>
<td>Ideal concept</td>
</tr>
<tr>
<td>Filter</td>
<td>Quantitative</td>
<td>Quantitative</td>
<td>Qualitative/Quantitative</td>
<td>Qualitative</td>
<td>Logic</td>
</tr>
<tr>
<td>Intent</td>
<td>Test casual hypothesis</td>
<td>Generalise to population</td>
<td>Description/explanation/prediction of nonreactive data</td>
<td>Holistic, realistic description/explanation</td>
<td>Establish underlying principles</td>
</tr>
</tbody>
</table>

Table 2: Research Styles\(^{90}\)
Table 2 illustrates an important point. It is the intent of the researchers themselves, and the belief system in which that research is conducted, that influences not only the method but also the publication and use of the research itself. Jackson makes the following rather cynical comment – "the dominance of bio-medical reductionism and laboratory based experimentalism, and a reliance on controlled trials and statistical manoeuvres to establish "truths", have silenced alternative accounts of health, disease and medicine. Thus the "dehumanising education" of doctors ... has retained its position of cultural and intellectual supremacy." 90 The argument between qualitative and quantitative research may be less related to its validity, and more related to the people who hold power in a medical culture at a point in time.

Initially, the origins of qualitative research probably lay in the way the natural world was initially described and chronicled 91. Since then, it has been increasingly used by sociologists and anthropologists as they study issues related to human behaviour and relationships. Qualitative research usually expresses in words, rather than numbers, some insight or understanding into the world that is being observed. This concept of describing in words was furthered by the early anthropologists who often studied people who were non-literate. The main technique that they used (ethnography) was one of participant observation, meaning that the researcher would immerse themselves within a particular group of people for some time, and participate in and describe their lifestyle as though it was through the eyes of the study group themselves 92. From this type of study two important concepts emerged; firstly of distilling out certain universals of human behaviour and secondly, the description of unique features of a particular group. These concepts remain valid in a modern context. Obviously a study group of doctors in New Zealand will be literate in a modern western society, but there will still be aspects of their behaviour that are of wider relevance to the study of humanity, and other aspects that are only of relevance to those particular circumstances of the study.

By attending to the meaning of an experience for a particular group we may gain insight into the way participant members of that group behave. In a medical context, the cultural and sub-cultural practice of medicine influences the quality of healthcare that is provided to patients 92. There is an interesting parallel between qualitative research and clinical practice. As Griffith and Marinker put it, "we attempt to let clinical data speak for itself, listening sufficiently to our patients to let them tell us what is wrong, a technique similar to exploratory qualitative research. As general practitioners, we take account of the context and individuality of our patients as does qualitative research." 91.
It follows then, that qualitative methods are particularly appropriate when researching a previously unexplored topic or one that is poorly understood or ill-defined, and are particularly appropriate for the study of medical practice. Qualitative research techniques are well suited to finding out what the relevant issues to a study population actually are and generating an understanding that then informs the development of other research, using different techniques to test hypotheses, to enable generalisations to the wider or to other populations, and so on. To that end, to investigate the possible emergence of defensive medical practice amongst New Zealand doctors, a qualitative technique is initially appropriate to discover what relevant issues exist, and to inform further study. Qualitative research is well situated to explore information that may be dependent on details of circumstance. In this way, it becomes possible to define the way of knowing that is being used (as outlined in Table 2) and from that to consider the different ways of understanding that may emerge.

Performing qualitative research may not be an appropriate end in itself. The call is for qualitative research to be based on an underlying theory with the notion that "theory informed" research should lead to "theory informed" analysis which should in turn lead to "theory enhanced" interpretation. Qualitative research does not simply identify themes in the responses and narratives that participants give, but also questions why a particular pattern of responses is found and places those theories within a theoretical framework. Some commentators go further than this and propose that in order to develop an answer, one needs to start from a particular theoretical perspective. Simply asking a participant "what does this mean to you?" is inadequate unless the answer is either based on or leads to the development of a theoretical perspective which will allow understanding. In other words, one critique of qualitative research is that it is simply not enough to "allow the data to speak for itself", and one must seek to understand the conceptual basis from which the data arises.

The issue of generating theory enhanced interpretation is partly resolved in the development of the notion of "grounded theory" by Corbin and Strauss. There are two important requirements of grounded theory. The first is that the account should be "clearly recognisable to the people in the setting", and the second is that it should also be "more structured and self conscientiously explanatory than anything that the participants themselves would produce". It is this requirement for grounded hermeneutic qualitative research with an explanatory goal that this thesis is in part based on.

A final question is to consider what the characteristics of "good" qualitative research might be. Given that all research is in some way selective and that all methods have their own particular
strengths and weaknesses, qualitative research relies in part on identifying participants who will allow a particular aspect of relevant behaviour to be researched. This means that it is entirely acceptable to use a sampling method that is systematic and non-probabilistic. The purpose is not to establish a random or representative sample but to identify specific groups of people who either possess characteristics or live in circumstances relevant to the social phenomenon being studied. Having gained access to this information it is important that it is validated by feeding the findings and interpretations of the research back to the participants, and also to search for “deviant” cases if their contribution appears to contradict the emergent themes or interpretations.

Good research will also take account of bias, and this will be discussed in section 2.4. The important point is that researchers will take a degree of bias into their study, and the solution probably lies not in trying to minimise the bias as one does when using the methods of classical epidemiology (for example a double blind, randomised, placebo controlled, crossover study) but in recognising where bias may exist, and confronting it in an explicit manner.

In overview, the difference between qualitative and quantitative methodologies is simply the difference in the type of method that one uses in order to answer a particular question. The most important thing is to have a methodology that is appropriate to the goals, aims and objectives of the particular study and to ensure that the method is used appropriately. Methodology should not be seen as “good” or “bad”, but it should be the correct methodology to give an answer that is appropriate for a particular question.

2.4 Consideration of bias.

Two aspects of consideration of bias need to be made explicit in my presentation of this work.

The first is my own personal experience of complaints and the complaint process. My Master of General Practice degree thesis was stimulated by having received two complaints over a period of time - both dealt with by the former Medical Practitioners Disciplinary Committee. Neither of these complaints was upheld, but observation of my own and my colleague’s experiences led me to believe that the complaints process was at times unpleasant and stressful, and it was difficult to identify a positive outcome for any party to a complaint.

Since that time in 1999, I have received three separate further complaints of medical misadventure that were dealt with by the Medical Misadventure Unit of the ACC. All of these
related to adverse outcomes, none of the claims was upheld, and my delivery of care was exonerated. My response at a personal level to receiving these complaints was that I still found them unpleasant and stressful but with the understanding that I had gained about the effect of complaints from conducting and publishing my research, I was in a better position to understand the complaint from the complainant’s point of view and to understand and accept my own personal emotional and intellectual responses. I have had a lot of feedback from colleagues to whom I have presented the results of my findings at various meetings, who have read what I have published on the subject, and who have been similarly helped by gaining insight into their own experiences and responses.

This leads to the second area of bias that needs to be considered with respect to this research. Over the time period that the research presented in this thesis has been conducted, participants in the studies themselves (especially with regard to the interviewed hospital based specialists and defensive practice) have become aware of the earlier findings and this has introduced “participant bias”. I do not think that it is an overstatement that publication of my earlier work has changed the culture of medicine in New Zealand with regard to the notion of complaints. It has brought the subject of complaints into open discussion within the medical profession and even at the time of writing, is impacting on decisions made by different doctor groups throughout the country as they consider support procedures and organisations to help look after colleagues in receipt of a complaint.

A recent editorial in the New Zealand Medical Journal by Ron Paterson, Health and Disability Commissioner made reference to complaints as being “a toxic treasure”, noting the potential for complaints to harm, and questioning in quite an enlightened way, a societal belief that complaints may improve the quality of delivered healthcare. In my opinion, such editorial comments would have been highly unlikely to have been made as little as five years previously.

I do not think that this notion of participant bias necessarily detracts from the quality of the results. It simply means that the onus is on the methodology to be sound and the interpretation of the results to be transparently valid.

2.5 Ethical approval.

Ethical approval for the project was obtained from the University of Otago Ethics Committee. Appendix 4 is the letter of approval from the Ethics Committee.
CHAPTER 3.

THE PURPOSE OF THE MEDICAL COMPLAINTS SYSTEM AND THE IDENTIFICATION OF PROBLEMATIC AREAS.

3.1 Introduction.

As introduced in section 2.2, this chapter will present the results of focus group and conference proceedings from a workshop held in Queenstown, New Zealand in mid July 2002, at which a group of interested general practitioners and selected representatives of organisations with an interest in the complaints process met to present and debate issues which were felt to be of concern around that process. Prior to that conference, there was no published definition of the purpose of a complaints and disciplinary system for doctors in New Zealand. Defining the purpose of a complaints system is essential before meaningful suggestions for improvement or change can be made. Any change to a complaints system should seek to enhance that system in a way that is consistent with its stated purpose. This workshop allowed input from both important policy makers and leaders in the area and from general practitioners with an interest in the subject in order to make the purpose of a complaints system explicit and to provide a benchmark definition against which ideas from the wider medical profession could be compared.

The workshop was also able to address the question of what major issues beset the current system, and what solutions might be offered to these problems. The meeting provided the opportunity for particular groups to present important issues around the subject as they saw them, and for these viewpoints to be debated and for possible solutions to be offered.

3.2 The purpose of the complaints system.

The workshop participants identified that the complaints system provided a link between the medical profession and New Zealand society. They recognised a sense of relationship between the profession and society, and viewed the complaints process as being an important part of maintaining that relationship.

Two different axes were identified by which that relationship might be considered. The first was defined by the potential for medical practice to be less than ideal at one pole of the axis,
and at the other, a need for the maintenance of trust between society and the medical profession. The potential for less than ideal practice was seen within the limitations of the delivery of healthcare at a biomedical and socio-political level, with the potential for any practitioner’s care to be substandard at some point.

The second axis related to a sense of relationship. It was identified as lying between the potentially opposing needs for reconciliation between doctors and complainants at one pole, and of achieving a sense of closure for both parties at the other pole. At this level, the workshop recognised a persisting sense of relationship at a personal level, and recognised that despite the tension inherent in a complaint, that the process needed to achieve closure that was satisfactory for both complainant and doctor.

Specific purposes of a complaints system were identified as:

- The maintenance of trust between society and the profession and between doctors and their patients, including the maintenance of accountability.
- To act as a voice for patients and to meet specific patient needs, including –
  - Explanation
  - Maintenance of safety
  - Maintenance of boundaries
  - Compensation
- To provide the opportunity for reconciliation and closure between doctor and patient in an environment of transparent equity and fairness to both parties.
- To maintain standards of professional practice, including acting as a deterrent against malpractice and corruption.

Some of these specified purposes were consistent with the recognised relationship between profession and society and doctors and patients. Some ideas were specifically related to sociological notions of professionalism. The specific patient needs of explanation, safety, boundaries and so on were viewed within the construction of “good” medical practice. A very important finding is the notion of the “maintenance of standards” which was primarily defined in terms of the technical aspects of medicine that comprise competence. This was presented with considerably more weight than the values based notion of professionalism, which was voiced as an avoidance of corruption and the idea of maintenance of trust.
3.3 Significant problems within the current complaints system and suggested solutions.

The senior representatives of New Zealand organisations with a significant stake in the complaints process have been listed in the methodology section 2.2. Each key organisation’s representative was asked to present their own particular views of the major issues that beset the current complaints system. These were presented to the entire audience, collated and summarized, and six major problematic issues were identified. Focus groups comprising general practitioners and representatives from these organisations convened and addressed specific issues and presented possible solutions to the large group. In this way, specific solutions were able to be identified and a collective opinion obtained.

Major problems identified in the current complaints system and their suggested solutions were as follows.

1) Multiple pathways of complaints.
As presented in introduction section 1.2 Figure 1, the multiple pathways of complaint were seen as being particularly problematic.

Suggested solution. The workshop felt strongly that a single point of entry for all complaints related to doctors was required. Characteristics of the single body to which such complaints would be directed were that it would need to be adequately resourced, and be capable of triaging complaints and facilitating low level resolution where possible, between the complainant and the doctor.

The process would be expected to provide a definite end point and to limit the possibility of further complaint. Workshop participants recognised that significant legislative change would be required to create a single point of entry system, that this change was possible only if there was determination from within the medical profession and sufficient political support was enlisted.

2) The timeliness of the process.
The workshop identified the speedy resolution of complaints as being important for both doctors and complainants and that re-entry into further complaints needed to show just cause. The workshop considered that the current process for the resolution of complaints
was unduly slow but recognised that the process needed to provide sufficient time for both parties to be adequately heard and for unwarranted complaints to be removed.

The workshop participants mooted the introduction of a statute of limitations in order to counter the problem of receiving complaints long after the event. They also noted that such a statute would require flexibility to account for the varying nature of complaints, recognising the possibility that particular outcomes of poor care may take longer to become evident than others.

An important outcome of the discussion around the timeliness of the process was that the process needed to be able to determine the level of harm that the complainant had incurred and to have the ability to improve outcome for the complainant. The workshop participants recognised the gap in the provision of care for those who have suffered a poor outcome secondary to poor medical care, and the need for a revised system to be able to close that gap by facilitating the provision of appropriate care.

3) **Appropriate clinical standards and advisors.**

A particular problem raised by both the Medical Protection Society representatives and by the Health and Disability Commissioner was the difficulty in determining whether a practitioner's practice was of an appropriate standard. The workshop debated this at length, and noted that clinical standards of care range from potential negligence through to best practice, and that all judgment about practice needed to be based on a realistic standard for the circumstance in question. They found that advisors needed to be transparently appropriate for the task and for the circumstances that they were asked to comment on. They also raised concern that although the profession is asked to provide appropriate advisors (usually through the representative colleges) that process of appointment may not be transparent and that advice is sometimes given that is contentious or out of touch with reality.

**Suggested solution.** The workshop participants recommended a review of the process of selection of advisors used by complaints bodies and recommended by colleges. They recommended a pool of appropriately nominated, selected, and funded advisors from all medical fields should be created to address this issue.

4) **The use of expert witnesses.**

Although highlighted by representatives of the Medical Protection Society, the problems around the use of expert witnesses were also raised by the Medical Council and the
Office of the Health and Disability Commissioner. All parties recognised that being an expert witness is difficult at both a personal level (for the witness) and at an organisational level (for both defence and prosecuting bodies). The workshop participants highlighted concerns under the following headings:

Desirable characteristics of the expert witness.
The expert witness needs to be transparently appropriate for the role. They need to be knowledgeable of the standards of practice in question, and experienced in the type of practice that is being discussed. They need to be able to communicate their expertise well and be able to devote sufficient attention to the details of each case.

Issues facing the expert witness.
Being an expert witness is stressful. The witness may find him or herself judging their colleagues' performance in an unfamiliar, adversarial court-based setting. They may lack confidence and the process is time consuming. These factors contribute to the perception that the most appropriate people for the job are the ones least likely to be available.

Suggested solutions. The workshop participants felt that attending to the particular personal needs of the expert witness was essential to encourage people to actually act as an expert witness and to protect those who did so. Some of the specific suggestions included –

- Specific training to include both the rights of witnesses and how they should respond to legal questioning, and on how they should provide appropriate reports.
- Having access to good legal counsel and having appropriate access to relevant evidence.
- Having clearly defined protection from liability so that they themselves do not face subsequent complaint as a result of their participation in the process.
- Appropriate remuneration for the time and effort involved, and the use of a pool or a roster of experts to avoid overuse.

5) Reduction of complaint-related stress.
The workshop participants highlighted awareness of the stressful nature of receiving a complaint on doctors and of a sense of inevitability of receiving a complaint.
Suggested solutions. The workshop participants suggested that doctors should-

- Have strategies for dealing with the effect of receiving a complaint that are meaningful to them personally and that the type of support that they need should be pre-determined and their access to that support should be planned.
- Have a doctor and make use of them.
- Ensure that they have and use legal/indemnity advice.
- Make necessary changes in their practising and personal lives that may reduce of a similar complaint being received in the future.

6) The need for appropriate support systems.
The workshop participants identified the need for doctors in receipt of a complaint to have support systems that were both personal to them and meaningful. They recognised that doctors in receipt of a complaint may feel unsupported and alone, and that this situation was not satisfactory.

Suggested solutions. The workshop participants suggested the creation of a group of appropriate contact persons for doctors in receipt of a complaint. That group was seen as having specific needs itself, including needs for appropriate training and funding and creating the capacity to work in privacy and with confidentiality. The workshop participants viewed the professional colleges and independent practitioners associations as being bodies well placed to create and administer support groups, and suggested that individual practices may be able to take on this task as well.

3.4 Discussion.

The findings of this research were published in March 2003. For the first time in the New Zealand medical literature, the report provided a definition of purpose of the complaints process derived from representative bodies within the New Zealand medical profession. These definitions may now be contrasted with definitions from both inside or outside the medical profession.

A particular strength of the methodology used was that the focus groups allowed identified problems to be addressed as specific research questions and the suggested solutions were able to
be discussed in open forum. The results and recommendations presented are subject to minimal researcher interpretation because of the process that allowed them to be collectively identified and debated.

Conversely however, a potential limitation of the methodology is that even with a reasonably large group of "ordinary" general practitioners present to contribute to the debate, the presence of powerful and influential people representing the key organisations involved risked skewing the recommendations and defining the purpose of the complaints system, in a somewhat "high brow" way.

My interpretation of the results is that this group was using a predominantly sociological structural-function approach to the conceptualisation of professionalism as it related to the complaints system. Although these participants acknowledged the importance of the doctor-patient relationship, their concern for the relationship between the profession and society was predicated on the notion of maintenance of trust, not as a values driven notion, but as a requisite for the ongoing transaction between the two parties. Notions such as the maintenance of safety, boundaries, accountability and particularly of standards of practice are all consistent with the structural-function approach.

Workshop participants were explicit about the importance of a complaints system as a deterrent to malpractice and corruption. The implication of this finding is they held a belief system suggesting that a complaints system is capable of acting as such a deterrent, and that it is effective when it is used.

The importance of the findings presented in this chapter is two fold. The findings with reference to the purpose of a complaints system provide a baseline against which the views of other doctors or other groups can be compared. This comparison with be explored in Chapter 7, using responses from the questionnaire to consider whether the survey respondents have similar views.

In addition, defining and publishing these issues has allowed them to be legitimised as "real" and to have been presented to the medical profession as issues of legitimate concern about which the profession may enter into debate and dialogue within itself and with society. Publication of this research has at least challenged the medical profession that there is a need to consider what objectives or purpose it thinks that a complaints system should have. Bringing the particularly problematic issues into the arena of professional discussion may also help reduce the personal load on both doctors in receipt of a complaint, and on those who are
contributing to the running of the complaints process, as well as providing a basis from which purposive change may be instigated and the effect of that change may be measured.
CHAPTER 4.

THE INCIDENCE OF COMPLAINTS AND THE CHARACTERISTICS OF DOCTORS WHO RECEIVE THEM.

4.1 Introduction.

The research questions.

This chapter will present the results of the survey appended in Appendix 3. The survey aimed to estimate the incidence and rate of complaints against doctors, the characteristics of the doctors who receive complaints, and document doctors' perceptions of the cause of the complaint and the time frames associated with the complaint being laid and its resolution.

Rates of complaint as determined by a complaints body such as the HDC or ACC are limited in that they only provide data relevant to that particular avenue or pathway of complaint. By surveying doctors directly, the results presented in this chapter describe associations between demographic characteristics of doctors and particulars of complaints at a national and professional level. By providing data about the collective experience of New Zealand doctors, the results help answer the more personal and individualised question of "why me?" that doctors in receipt of a complaint ask themselves.

Nationally (and internationally), the medical profession continues to experience change on many different fronts. Not only has New Zealand been subject to extensive politically driven health care structural reforms since 1992, but other long term changes in the medical workforce and their distribution have relevance to questions about complaints. Current debate continues about the exodus of junior doctors seeking employment in Australia and the United Kingdom, but other shifts have occurred over the last thirty years or so that have the potential to impact on the delivery of healthcare, especially at a cultural and community-based level. Particularly, the New Zealand medical workforce has seen influxes at different times of doctors from United Kingdom, from Asia (in particular from Sri Lanka) and more recently from South Africa. With relevance to the complaints process, the question is whether these doctors are able to practice competently in both the medical sense (given non-uniformity of training), and in a cultural sense given their wide diversity of backgrounds. In addition, the feminisation of the medical workforce and the declining popularity of rural practice also raise questions about the complaints process at a stereotypical level of attitudes and behaviour, and at a geographical level.
Other issues related to the complaints process involve exposure to risk as a function of time in and type of practice, and of doctors’ perceptions of the genesis of a complaint. Is it inevitable that certain doctors will be involved in complaints, simply because of external factors such as where they practice or the length of time they have been there?

Another question relates to the timeliness of complaints. This study seeks to identify the time involved in the resolution of complaints and to consider whether there may be a difference between complaints that are upheld and those that are dismissed in terms of how quickly they are received and how quickly they are dealt with.

Analogous to the disease model of western biomedicine, this chapter seeks to report data that are valid for the population of New Zealand doctors. This chapter addresses the who, when, and (partially) the why questions around complaints.

4.2 Results.

The validity of the survey.

Twelve hundred questionnaires as detailed in section 2.2, were posted to potential participants in April 2001, and 598 (49.8%) completed questionnaires had been returned by the end of June. Initial data entry and analysis found that 201 of the respondents (33.6%) indicated that they had received a complaint at some time during their medical career. 397 (66.4%) indicated that they had never received a complaint.

It was possible to identify the non-respondents, and they were re-surveyed asking them to indicate only whether they had ever or never received a complaint. From those 602 non-respondents who were re-surveyed, I received 373 replies. Within the “non-respondent” group, 129 (34.6%) indicated that they had ever received a complaint and 244 (65.4%) indicated that they had never had one. So, the single most important indicator of the validity of the survey (the experience of a complaint) was within one percent in the respondent and non-respondent groups.

The 598 replies from the initial responder group and the 373 replies from the re-surveyed non-responders gave a total of 971 replies and a response rate to the survey of 75% with respect to the experience of a complaint. In total, 330 (34.0%) of the respondents indicated that they had ever received a medical complaint, and 641 (66.0%) had not.
Analysis of the gender distribution of the respondents also indicated that the survey sample is valid for the population of New Zealand doctors. Of the 591 respondents who indicated their gender, 192 (32.5%) were female and 399 (67.5%) were male. These percentages are nearly identical to the gender distribution of doctors in April 2001. At that date the New Zealand Medical Register data indicated 2791 registered female doctors (32.0%) and 5924 (68.0%) registered male doctors.

The similarity in the distribution of the experience of a complaint between those who completed the questionnaire and the re-surveyed non-respondents, as well as the nearly identical distribution of gender in the study sample, indicate that responses to this survey are representative of the experiences of all New Zealand doctors.

4.2.1 The incidence and rate of complaint.

The incidence of complaint in this survey is 34%. Figure 3 indicates the number of complaints received per year, reported by the respondents in this survey. The total for 2001 is up to June of that year (at which point it surpasses the half way mark for 2000). There appears to be a rise in the rate of complaints beginning in the mid 1980s and rising substantially from 1995. The annual rate of complaint for the respondents in this study in the year 2000 is 5.8% (34/589).

Table 3 indicates the body to which the complaint was lodged. Over a third was lodged with the Office of the Health and Disability Commissioner (in existence from 1996) and about a third had been lodged with the former Medical Practitioner’s Disciplinary Committee. Just over 10% of the complaints were lodged within the institution the doctor worked in, and less than 5% were lodged with the ACC. A further 10% were lodged with other authorities such as the Civil Courts or the Office of the Coroner.

These results indicate that for the respondents in this study, the receipt of a complaint was recognised as being a complaint to a significant or powerful institution, and these respondents were not reporting “lesser” complaints such as a letter expressing annoyance received at the practice, or made verbally to themselves or staff. It is reasonable to assume that most of these complaints would have been made in writing and would have required the doctor to have made a personal response, with or without medico-legal assistance, although information about these aspects was not provided from the survey.
Figure 3: Number of Complaints Reported per Year (to June 2001) by Survey Respondents.
Table 3: Complaint Outcome by Body to which Complaint was Lodged.

<table>
<thead>
<tr>
<th>Body</th>
<th>Upheld n (%)</th>
<th>Dismissed n (%)</th>
<th>Proceeding n (%)</th>
<th>Unknown n (%)</th>
<th>Total n</th>
</tr>
</thead>
<tbody>
<tr>
<td>HDC</td>
<td>9 (11.8)</td>
<td>47 (61.8)</td>
<td>16 (21.1)</td>
<td>4 (5.3)</td>
<td>76</td>
</tr>
<tr>
<td>MPDC</td>
<td>9 (12.2)</td>
<td>57 (77.0)</td>
<td>4 (5.4)</td>
<td>4 (5.4)</td>
<td>74</td>
</tr>
<tr>
<td>In-house</td>
<td>4 (17.4)</td>
<td>14 (60.9)</td>
<td>3 (13.0)</td>
<td>2 (8.7)</td>
<td>23</td>
</tr>
<tr>
<td>ACC</td>
<td>3 (37.5)</td>
<td>5 (62.5)</td>
<td>-</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>2 (10.0)</td>
<td>13 (65.0)</td>
<td>5 (25.0)</td>
<td>-</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>27 (13.4)</td>
<td>136 (67.7)</td>
<td>28 (13.9)</td>
<td>10 (5.0)</td>
<td>201</td>
</tr>
</tbody>
</table>
4.2.2 Doctor characteristics, perceived reasons for complaint, and time frames for resolution.

Table 4 summarises the characteristics of the respondents in this survey. Considering the issue of the risk of receiving a complaint, the data indicate that doctors with higher risk are more likely to be male, vocationally registered general practitioners, and those who hold higher post-graduate degrees.

No differences in complaint experiences were found for doctors practicing in urban or rural locations, for doctors whose place of graduation as a medical practitioner was New Zealand or overseas, and (within the hospital-based specialties) who perform procedural as compared with non-procedural work.

Table 5 indicates respondents' country of origin using country of qualification as a medical practitioner as proxy. The numbers are too low to allow a comparison between graduates from specific overseas countries, but they do allow comparison between New Zealand and overseas graduates, and indicate no difference in rate of complaint.

Table 6 indicates the incidence of complaint amongst the respondents in hospital-based specialties. The hospital-based specialties were grouped into disciplines in which procedural or interventional work could be reasonably expected. The procedural group included all surgical sub-specialties as well as anaesthetics, emergency medicine, and obstetrics and gynaecology. All other specialties including radiology were considered non-procedural. Reclassifying radiology into the procedural group later did not alter the non-significant outcome of comparison of complaint experience in the procedural and non-procedural groups.

Figure 4 indicates the age distribution of the respondents at the time they received a complaint. As indicated in Table 7, less experienced doctors were less likely to have received a complaint than those who had been in practice for more than twenty years. Figure 4 indicates a rise in the number of complaints during the 1990s, and indicates that from 1995 to 1998 about 50% of the doctors who received a complaint were aged between forty and sixty years. In the years 1999 and 2000, this age group accounted for 68% of the complaints received. Analysis of the age distribution of respondents before and after 1997 (being an approximate half way point for the year of receipt of a complaint) shows no significant difference (p>0.01). The data indicate that the age and experience of the doctor are independent risk factors. This finding is consistent
before and after 1997, which suggests that it is the doctor being of an age and experience that is important, rather than the process of aging and practicing.

Table 7 indicates the reason for complaint as perceived by each respondent, whether the complaint was upheld or dismissed, or whether it was still proceeding. In over one third of cases (if fraud is excluded) respondents indicated that a perceived error in the practice of medicine was significantly implicated in the genesis of complaint. Perceived error in the practice of medicine accounted for nearly 40% of cases where the complaint was upheld.

Some respondents used free text answers in the “other” category, and these included:

*The patient had serious relationship problems with his wife... I was involved in a counselling role... the husband took exception to this.*

  Vocationally registered GP

*The patient had major psycho-social problems... mistakenly included my name in the complaint.*

  Hospital based specialist

*Another doctor implying that I had not acted appropriately.*

  General registrant

Table 7 also indicates time elapsed data for complaints that were eventually upheld, dismissed and which were proceeding. The data indicate that upheld complaints were more likely to be received within 12 months of the incident that led to the complaint, and that complaints received more than 24 months from the time of the incident’s occurrence were more likely to be dismissed.

In total, 56 of the 191 complaints for which data were available had not been resolved by 12 months after receipt of the complaint. Dismissed complaints tended to be resolved more quickly, with 74% being resolved within 12 months, but of the upheld complaints, only 59% had been resolved within that time frame.
Table 4: Complaints Received by Practitioner Characteristic.

<table>
<thead>
<tr>
<th>Doctor characteristic</th>
<th>Complaint received n (%)</th>
<th>Complaint never received n (%)</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>44 (22.4)</td>
<td>148 (37.5)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Male</td>
<td>152 (77.6)</td>
<td>247 (62.5)</td>
<td></td>
</tr>
<tr>
<td><strong>Years in practice in NZ</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5</td>
<td>12 (6.1)</td>
<td>82 (20.8)</td>
<td></td>
</tr>
<tr>
<td>6-10</td>
<td>19 (9.7)</td>
<td>77 (19.5)</td>
<td></td>
</tr>
<tr>
<td>11-20</td>
<td>62 (31.6)</td>
<td>123 (31.2)</td>
<td></td>
</tr>
<tr>
<td>&gt;20</td>
<td>103 (52.6)</td>
<td>112 (28.4)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td><strong>Vocational group</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General practitioner</td>
<td>93 (46.3)</td>
<td>122 (30.7)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Hospital-based specialist</td>
<td>69 (34.3)</td>
<td>136 (34.3)</td>
<td></td>
</tr>
<tr>
<td>General registrant</td>
<td>39 (19.4)</td>
<td>139 (35.0)</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital-based specialty</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedural</td>
<td>33 (45.8)</td>
<td>51 (37.8)</td>
<td>ns</td>
</tr>
<tr>
<td>Non-procedural</td>
<td>39 (54.2)</td>
<td>84 (62.2)</td>
<td></td>
</tr>
<tr>
<td><strong>Place of graduation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Zealand</td>
<td>140 (71.4)</td>
<td>270 (68.7)</td>
<td></td>
</tr>
<tr>
<td>Overseas</td>
<td>56 (28.6)</td>
<td>123 (31.3)</td>
<td>ns</td>
</tr>
<tr>
<td><strong>Postgraduate qualifications</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fellowship and postgraduate</td>
<td>107 (54.9)</td>
<td>157 (39.8)</td>
<td></td>
</tr>
<tr>
<td>Fellowship only</td>
<td>64 (32.8)</td>
<td>129 (32.7)</td>
<td></td>
</tr>
<tr>
<td>Postgraduate only</td>
<td>10 (5.1)</td>
<td>56 (14.2)</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>14 (7.2)</td>
<td>52 (13.2)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td><strong>Site of practice</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>156 (79.6)</td>
<td>339 (86.0)</td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>16 (8.2)</td>
<td>18 (14.6)</td>
<td></td>
</tr>
<tr>
<td>Small town (&lt;15 000 population)</td>
<td>17 (8.7)</td>
<td>29 (7.4)</td>
<td></td>
</tr>
<tr>
<td>Non-practising/retired</td>
<td>7 (3.6)</td>
<td>8 (2.0)</td>
<td>ns</td>
</tr>
</tbody>
</table>
Table 5: Place of Graduation and Complaint Status.

<table>
<thead>
<tr>
<th>Place of Graduation</th>
<th>Ever had a Complaint</th>
<th>Never had a Complaint</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otago University</td>
<td>110</td>
<td>180</td>
<td>290</td>
</tr>
<tr>
<td>Auckland University</td>
<td>30</td>
<td>90</td>
<td>120</td>
</tr>
<tr>
<td>Australia</td>
<td>5</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>34</td>
<td>60</td>
<td>94</td>
</tr>
<tr>
<td>South Africa</td>
<td>6</td>
<td>23</td>
<td>29</td>
</tr>
<tr>
<td>Canada</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>India</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Switzerland</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Yugoslavia</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Egypt</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Germany</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>USA</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Fiji</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Iraq</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ireland</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Netherlands</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Unspecified</td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>201</td>
<td>397</td>
<td>598</td>
</tr>
</tbody>
</table>
Table 6: Procedural Table.

<table>
<thead>
<tr>
<th>Fields of Practice</th>
<th>GROUP</th>
<th>Ever</th>
<th>Never</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple Anaesthetics</td>
<td>6</td>
<td>14</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>4</td>
<td>24</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Occupational</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Emergency</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Palliative</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>2</td>
<td>15</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>General surgery</td>
<td>6</td>
<td>7</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Public Health</td>
<td>1</td>
<td>10</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td>16</td>
<td>17</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>O&amp;G</td>
<td>7</td>
<td>5</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Ortho surgery</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Otolaryn surgery</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Paed surgery</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td>9</td>
<td>16</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Admin</td>
<td>4</td>
<td>4</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Paeds</td>
<td>11</td>
<td>11</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Rad Onc</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Sexual health</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Sports</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Neuro surgery</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>78</td>
<td>149</td>
<td>227</td>
<td></td>
</tr>
</tbody>
</table>
Figure 4: Age Distribution of Doctors at Time of Receiving a Complaint.
Table 7: Reasons for Complaint and Time to Resolution.

<table>
<thead>
<tr>
<th>Reason for complaint</th>
<th>Upheld n (%)</th>
<th>Dismissed n (%)</th>
<th>Proceeding n (%)</th>
<th>Total n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Error</td>
<td>20 (38.5%)</td>
<td>83 (34.9%)</td>
<td>17 (21.8%)</td>
<td>120</td>
</tr>
<tr>
<td>Communication</td>
<td>5 (9.6%)</td>
<td>35 (14.7%)</td>
<td>11 (14.1%)</td>
<td>51</td>
</tr>
<tr>
<td>Third party</td>
<td>7 (13.5%)</td>
<td>21 (8.8%)</td>
<td>6 (7.7%)</td>
<td>34</td>
</tr>
<tr>
<td>Fraud</td>
<td>1 (1.9%)</td>
<td>2 (0.8%)</td>
<td>28 (35.9%)</td>
<td>31</td>
</tr>
<tr>
<td>Personality clash</td>
<td>3 (5.8%)</td>
<td>24 (10.1%)</td>
<td>2 (2.6%)</td>
<td>29</td>
</tr>
<tr>
<td>Own behaviour</td>
<td>3 (5.8%)</td>
<td>23 (9.7%)</td>
<td>1 (1.3%)</td>
<td>27</td>
</tr>
<tr>
<td>Systems</td>
<td>4 (7.7%)</td>
<td>9 (3.8%)</td>
<td>6 (7.7%)</td>
<td>19</td>
</tr>
<tr>
<td>Other</td>
<td>9 (17.3%)</td>
<td>41 (17.2%)</td>
<td>7 (9.0%)</td>
<td>57</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>52 (100.0%)</strong></td>
<td><strong>238 (100.0%)</strong></td>
<td><strong>78 (100.0%)</strong></td>
<td><strong>368</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time from incident to receipt of complaint</th>
<th>Upheld n (%)</th>
<th>Dismissed n (%)</th>
<th>Proceeding n (%)</th>
<th>Total n</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;12 months</td>
<td>22 (81.5%)</td>
<td>96 (70.6%)</td>
<td>17 (60.7%)</td>
<td>135</td>
</tr>
<tr>
<td>12-18 months</td>
<td>1 (3.7%)</td>
<td>6 (4.4%)</td>
<td>0 (0.0%)</td>
<td>7</td>
</tr>
<tr>
<td>18-24 months</td>
<td>0 (0.0%)</td>
<td>8 (5.9%)</td>
<td>3 (10.7%)</td>
<td>11</td>
</tr>
<tr>
<td>&gt;24 months</td>
<td>0 (0.0%)</td>
<td>19 (14.0%)</td>
<td>6 (21.4%)</td>
<td>25</td>
</tr>
<tr>
<td>Unknown</td>
<td>4 (14.8%)</td>
<td>7 (5.1%)</td>
<td>2 (7.1%)</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27 (100.0%)</strong></td>
<td><strong>136 (100.0%)</strong></td>
<td><strong>28 (100.0%)</strong></td>
<td><strong>191</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time from receipt of complaint to resolution</th>
<th>Upheld n (%)</th>
<th>Dismissed n (%)</th>
<th>Proceeding n (%)</th>
<th>Total n</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;12 months</td>
<td>16 (59.3%)</td>
<td>101 (74.3%)</td>
<td>18 (64.3%)</td>
<td>135</td>
</tr>
<tr>
<td>12-18 months</td>
<td>2 (7.4%)</td>
<td>18 (13.2%)</td>
<td>4 (14.3%)</td>
<td>24</td>
</tr>
<tr>
<td>18-24 months</td>
<td>2 (7.4%)</td>
<td>6 (4.4%)</td>
<td>2 (7.1%)</td>
<td>10</td>
</tr>
<tr>
<td>&gt;24 months</td>
<td>4 (14.8%)</td>
<td>5 (3.7%)</td>
<td>1 (3.6%)</td>
<td>10</td>
</tr>
<tr>
<td>Unknown</td>
<td>3 (11.1%)</td>
<td>6 (4.4%)</td>
<td>3 (10.7%)</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27 (100.0%)</strong></td>
<td><strong>136 (100.0%)</strong></td>
<td><strong>28 (100.0%)</strong></td>
<td><strong>191</strong></td>
</tr>
</tbody>
</table>
4.3 Discussion.

There is no other survey in the medical literature which reports the incidence of complaint for an entire country. The data indicating the experience of a complaint was derived from responses from 11% of the 8715 doctors registered in New Zealand in April 2001 on the New Zealand Medical Register.

The method used to obtain the results reported in this section has particular strengths and limitations. The weakness is the rate of response to the original survey, but this is addressed by the resurvey of the non-respondent group. The conformity between the incidence of complaint for the respondents and non-respondents to this survey indicates that the results have good face validity.

Data related to the rate of complaint is clearly limited by the timing of the survey and the speed at which the results can be reported. The survey’s findings were disseminated at local medical meetings in early 2002, but were first reported nationally in October 2003. To date however, only one other survey has been published in the New Zealand medical literature indicating a rate of complaint and in this group of surgeons, 58% had received a complaint and those in their mid career (10 – 15 years of practice) were at increased risk of complaint. These findings are consistent with the results of my survey, which show that 19 out of 35 (54%) of surgeons had received a complaint.

The shift towards having all complaints directed through the Office of the Health and Disability Commissioner may result in HDC data more closely indicating the true rate of complaint. However, with multiple pathways of complaint still in existence, direct survey of doctors is likely to yield the most reliable data about complaint incidence and rate.

The anonymity required to conduct this study prevented validating the accuracy or truthfulness of the respondents’ replies, relying solely on self-reported data. However, the conformity between respondents and non-respondents in terms of the incidence of complaint suggests that complaints data are likely to be appropriately reported.

The questionnaire failed to consider whether the amount of actual working time that a doctor engages in is associated with the risk of receiving a complaint. This is particularly important with regard to gender considerations. It is possible that the apparently lower risk of complaint
carried by female doctors may be due to their having a reduced work load associated with part-time work. This variable was not considered in the survey design and it limits the interpretation of the data with regard to gender distribution.

4.3.1 Key demographic issues to be recognised or addressed with respect to the complaints process.

This study raises issues about the distribution of complaints, and about the implications that has for individual doctors, health care institutions and for the medical profession and society.

The results presented in this chapter identified for the first time in New Zealand, some of the characteristics of doctors receiving a complaint. A high incidence and rate of complaint; a perception amongst doctors of the importance of error in a biomedical sense as being an important determinant of why a complaint may be made; an unduly long time frame for the resolution of complaints; and a set of data which collectively identifies the doctors most at risk of receiving a complaint as being those who are most likely to be taking responsibility for patient care, are the key findings of this study.

There is a high incidence of complaint against doctors in New Zealand. Overall, one in three doctors in this survey had received a complaint and the annual rate of complaint had risen by the year 2000 to 5.7% (albeit with an 85% dismissal rate). If the rate of complaint in New Zealand stabilises at this level, one in every 17 doctors can expect to receive a complaint in any year in which they decide to continue to practice. This rate of complaint is almost twice as high as the highest reported rate of litigation in the United States. It confirms the Medical Protection Society’s assertion that the New Zealand environment is one of the “most medico-legally hostile in the world”.

The high rate of dismissal of complaints calls into question the validity of the complaints process at a societal level. If the process by which the complaint is upheld or dismissed is in itself valid, there should be evidence of sufficient positive gain for society from the complaints process as to justify engaging one hundred doctors in a process that will only find fifteen of them wanting in some respect. It is unlikely that there is any other legal or pseudo-legal process in New Zealand society in which an adversarial system fails to identify culpability in 85% of cases. An alternative viewpoint could be derived from medical therapeutics. The concept of “numbers needed to treat” (NNT) is well established in preventative therapies such as the
treatment of hypertension, hypercholesterolemia and so on. Using that rationale, the medical complaints process should then be able to show a positive outcome with an NNT of one in seventeen, in which any negative side effect or outcome was well compensated for by the positive impact on every seventeenth recipient of such a therapy.

The results of this study indicate that complaints are not evenly distributed throughout the medical workforce. Some doctors are at higher risk of receiving a complaint than others, and to a limited extent, the findings are counterintuitive. If, as discussed in section 1.4.1, the risk of receiving a complaint is increased by deficient communication and interpersonal or relationship skills, one might expect a highest risk of complaint to be found in doctors whose care of patients is episodic, without the opportunity to develop long term relationship and in those whose lack of clinical experience increases their risk of missing clues related to the person of their patient. The findings of this study suggest exactly the reverse however. General registrants (who are predominantly younger doctors earlier in their training) are at lesser risk of a complaint than their senior colleagues either working in hospital-based practice, or in general practice.

General practitioners, who regard the doctor-patient relationship as of paramount importance in the delivery of medical care, find themselves at highest risk of receiving a complaint. Overseas trained doctors, who one might reasonably expect to be less familiar with the subtleties of cultural variation experienced in New Zealand practice, are found in this study to be at no higher risk than their New Zealand trained colleagues of receiving a complaint.

If the perception of error as being paramount in the genesis of a complaint is valid, then one would expect a higher level of medical error to be found in the practice of junior less experienced doctors, and to be less prevalent in the practice of senior colleagues both in hospital and in general practice. Furthermore, if one assumes that holding a higher post-graduate qualification is evidence of increasing specialisation and knowledge, then one would expect more highly trained doctors to be “protected” from a complaint which is quite the reverse of this study’s findings.

This study indicates that the major determinant for risk of a complaint may be the level of responsibility assumed for patient care. General practitioners, being at the highest risk of receiving a complaint, are often in a position of making decisions about patient care without recourse to their colleagues’ opinions. In a hospital-based setting, several doctors are likely to be involved in the care of a patient, but the more junior doctors are less likely to be held responsible for that care. The responsibility is most likely to lie with the most highly qualified
and senior doctor. The age distribution of doctors at the time of receiving a complaint (Figure 4) suggests that the bulk of complaints are being received by doctors in the forty to sixty year old age group. This is the age group that primarily takes responsibility for patient care, and this finding links comfortably with the idea of error as being important in the genesis of a complaint. If in fact, the key determinant of whether a complaint is made or not is the outcome of care, and the complainant applies a biomedical approach as their way of “knowing” and by which they may decide right from wrong or good from bad practice, then the logical doctor to complain about would be the one who is perceived as taking responsibility for that care.

If so, then this finding has important implications for both individual doctors and health care institutions. At an individual level a combination of a high rate of complaint, a perception of the importance of medical error in the genesis of a complaint, and working in a position of responsibility for patient care may cause doctors to seek to practice in such a way that error is minimised and that an adverse outcome can be defended on biomedical grounds. Potentially, this could lead to an increase in both positive and negative defensive medicine and lead to doctors placing less emphasis on significant components of the patient centred clinical method such as communication and enhancing the relationship that they have with their patient. The implication of these findings therefore, is that the medical complaints process may lead individual doctors to perceive themselves to be at increased risk and to practice in a way that does not enhance patient care.

In terms of health care institutions, the finding that the risk of complaint is not necessarily associated with the procedural specialties is probably of lesser importance than the notion that being responsible for patient care is important in determining the risk of receiving a complaint. Health care institutions are dependent on their experienced, highly trained, and specialised staff to deliver high quality health care. If it is this group that are most at risk of receiving a complaint, and the impact of that complaint is deleterious to the person of the doctor, their ability to sustain an appropriate doctor-patient relationship and to deliver high quality patient care may be reduced, and the ability of the health care institution to function effectively will be compromised.

The time to resolution of complaints in New Zealand is unduly long. This has implications for both doctors and for complainants, in that resolving complaints rapidly and providing alternative treatment may be the only opportunity that a patient has to get a satisfactory outcome from poor medical care. Timely investigation and resolution of complaints may serve to protect society from errant doctors practicing bad medicine, and it is likely that the rapid resolution of
complaints will improve the personal well-being of the doctor involved and thereby, the standard of care provided to subsequent patients.

The incidence and rate of complaint are disturbing findings in a society with a self-perceived non-litigious culture, and the notion of the importance of error raises the spectre of defensive medical practice and a shift away from patient centred clinical method, as probable outcomes of a perpetuation of the current system. If it can be demonstrated that there is a negative impact of complaints, it may be that society's best interests are not served by complaining about that group of doctors on whom society is most dependent for the delivery of high quality medical care.
CHAPTER 5.

THE IMMEDIATE AND LONG TERM IMPACT ON DOCTORS OF RECEIVING A COMPLAINT.

5.1 Introduction.

The research questions.

The research completed before the work presented in this thesis indicated that receiving a complaint impacts on the person of the doctor, the doctor-patient relationship and on the doctor's practice of medicine. That research indicated that there were both immediate and long term effects to be considered. Immediate effects included an intense emotional response (indicating the impact of a complaint on the person of the doctor); reduced ability to consult with speed and confidence and to tolerate uncertainty (indicating an impact on the doctor's ability to practice medicine); and hostility towards the complainant and loss of trust in other patients (indicating an impact on the doctor-patient relationship).

In the long term, some of the respondents in that study \(^{21,17}\) held persisting emotional responses such as depression or anger for several years after receipt of the initial complaint. Some of those respondents had an altered perception of themselves as doctors, and some indicated an erosion of goodwill towards patients generally. I raised the possibility that these doctors had been shamed by receipt of a complaint. Because for doctors, sense of self may be intimately related with being a doctor and practising medicine, the sense of shame had a pervasive impact on both their personal and practising lives. The implication of that study of general practitioners was that receipt of a complaint may actually reduce doctors' ability to deliver high quality medical care, and that finding has implications for considering the purpose of a complaints system and for investigating potential pathways for improving complaints processes.

When I have presented the results of that research to groups of doctors around the country, the findings appeared to have face validity. It was as if the truth had actually been spoken, despite that truth having been really known all along by the doctors in the audience. The results presented in chapter 4 confirm that the experience of complaints is widespread in New Zealand. One of the objectives of the study reported in this chapter is to consider whether the qualitative research findings may be generalisable to the wider population of New Zealand doctors and whether its apparent face validity is actually real.
The study reported in this chapter sought answers to the following specific questions: what is the range of doctors’ responses to receiving a complaint; is there a shift in any impact of a complaint over a period of time; and do different vocational groups in medicine respond differently to receiving a complaint?

The question of over-riding importance however, is to consider whether the findings of the impact of a complaint are generalisable to the wider population of New Zealand doctors, and whether the direction of change in the way in which doctors function is likely to meet a societal need for better medical practice as a likely outcome of complaining about doctors? Society must expect that complaints will impact on doctors both individually and as a profession, because without any impact there would be no driver for change. The assumption that has been untested however is that the direction of change is necessarily positive and will result in better medical care. By considering the self reported impact of a complaint by doctors on these three areas of person, doctor-patient relationship, and effect on practice, this study will provide some insight into this issue.

5.2 Results.

This section will present the results obtained from the 201 respondents who had ever received a complaint and who completed the questionnaire. The results are presented in Table 8, and the responses are clustered into questions related to the emotional response to receiving a complaint, to attitudes towards themselves, their patients and complainants, and questions related to their perceived ability to practice medicine. The responses are indicated on a five point Likert scale with responses ranging from strongly disagreeing through to strongly agreeing with the statement. For each question, the respondents’ immediate and long term responses are shown and the Wilcoxon signed rank sum test p score indicates the level of significance of difference between the immediate and long term responses for each question.
Table 8: The Impact of Receiving a Complaint.

<table>
<thead>
<tr>
<th>Statement (n)</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>No Strong feelings</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Wilcoxon signed rank sum test</th>
</tr>
</thead>
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<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Emotional responses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt/feel angry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate (n=197)</td>
<td>6</td>
<td>(3%)</td>
<td>19</td>
<td>(9.6%)</td>
<td>29</td>
<td>(14.7%)</td>
</tr>
<tr>
<td>Long Term</td>
<td>22</td>
<td>(11.2%)</td>
<td>37</td>
<td>(18.8%)</td>
<td>66</td>
<td>(33.9%)</td>
</tr>
<tr>
<td>I felt/feel depressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate (n=198)</td>
<td>20</td>
<td>(10.1%)</td>
<td>25</td>
<td>(12.6%)</td>
<td>24</td>
<td>(12.1%)</td>
</tr>
<tr>
<td>Long Term</td>
<td>57</td>
<td>(28.8%)</td>
<td>67</td>
<td>(33.8%)</td>
<td>50</td>
<td>(25.3%)</td>
</tr>
<tr>
<td>I felt/feel guilty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate (n=200)</td>
<td>63</td>
<td>(31.5%)</td>
<td>54</td>
<td>(27.0%)</td>
<td>18</td>
<td>(9.0%)</td>
</tr>
<tr>
<td>Long Term</td>
<td>84</td>
<td>(42.0%)</td>
<td>70</td>
<td>(35.0%)</td>
<td>29</td>
<td>(14.5%)</td>
</tr>
<tr>
<td>I felt/feel ashamed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate (n=198)</td>
<td>52</td>
<td>(26.3%)</td>
<td>43</td>
<td>(21.7%)</td>
<td>31</td>
<td>(15.7%)</td>
</tr>
<tr>
<td>Long Term</td>
<td>75</td>
<td>(37.9%)</td>
<td>66</td>
<td>(33.3%)</td>
<td>34</td>
<td>(17.2%)</td>
</tr>
<tr>
<td>I derived/derive a sense of joy from</td>
<td></td>
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<td></td>
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</tr>
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<td></td>
</tr>
<tr>
<td>Immediate (n=198)</td>
<td>30</td>
<td>(15.2%)</td>
<td>46</td>
<td>(23.2%)</td>
<td>23</td>
<td>(11.6%)</td>
</tr>
<tr>
<td>Long Term</td>
<td>3</td>
<td>(1.5%)</td>
<td>16</td>
<td>(8.1%)</td>
<td>33</td>
<td>(16.7%)</td>
</tr>
<tr>
<td>Attitudes towards Self, Patients and</td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Complainants</td>
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</tr>
<tr>
<td>I felt/feel that I was/am a good</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>doctor</td>
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<td></td>
</tr>
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<td>Immediate (n=200)</td>
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<td>(3.5%)</td>
<td>26</td>
<td>(13.0%)</td>
<td>15</td>
<td>(7.5%)</td>
</tr>
<tr>
<td>Long Term</td>
<td>1</td>
<td>(0.5%)</td>
<td>4</td>
<td>(2.0%)</td>
<td>15</td>
<td>(7.5%)</td>
</tr>
<tr>
<td>I felt/feel that I was/am a good</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>person</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Immediate (n=198)</td>
<td>8</td>
<td>(4.0%)</td>
<td>20</td>
<td>(10.1%)</td>
<td>21</td>
<td>(10.6%)</td>
</tr>
<tr>
<td>Long Term</td>
<td>1</td>
<td>(0.5%)</td>
<td>1</td>
<td>(0.5%)</td>
<td>17</td>
<td>(8.6%)</td>
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</tbody>
</table>

80
<table>
<thead>
<tr>
<th>I wanted/want to keep on practising medicine</th>
<th>Immediate</th>
<th>(n=196)</th>
<th>(7.1%)</th>
<th>33 (16.8%)</th>
<th>19 (9.7%)</th>
<th>66 (33.7%)</th>
<th>64 (32.7%)</th>
<th>p&lt;0.0001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term</td>
<td>6 (3.1%)</td>
<td>12 (6.1%)</td>
<td>20 (10.2%)</td>
<td>89 (45.4%)</td>
<td>69 (35.2%)</td>
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<tr>
<td>I held/hold the same sense of commitment to the patient (complainant)</td>
<td>Immediate</td>
<td>(n=169)</td>
<td>55 (32.5%)</td>
<td>30 (17.8%)</td>
<td>34 (20.1%)</td>
<td>36 (21.3%)</td>
<td>14 (8.3%)</td>
<td>p=0.223</td>
</tr>
<tr>
<td>Long Term</td>
<td>46 (27.2%)</td>
<td>42 (24.9%)</td>
<td>29 (17.2%)</td>
<td>35 (20.7%)</td>
<td>17 (10.1%)</td>
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</tr>
<tr>
<td>I held/hold the same sense of commitment to other patients</td>
<td>Immediate</td>
<td>(n=198)</td>
<td>3 (1.5%)</td>
<td>16 (8.1%)</td>
<td>15 (7.6%)</td>
<td>96 (48.5%)</td>
<td>68 (34.3%)</td>
<td>p=0.650</td>
</tr>
<tr>
<td>Long Term</td>
<td>1 (0.5%)</td>
<td>20 (10.1%)</td>
<td>13 (6.6%)</td>
<td>101 (51.0%)</td>
<td>63 (31.8%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I continued to trust/trust patients as before</td>
<td>Immediate</td>
<td>(n=199)</td>
<td>15 (7.5%)</td>
<td>61 (30.7%)</td>
<td>29 (14.6%)</td>
<td>70 (35.2%)</td>
<td>24 (12.1%)</td>
<td>p=0.001</td>
</tr>
<tr>
<td>Long Term</td>
<td>9 (4.5%)</td>
<td>54 (27.1%)</td>
<td>23 (11.6%)</td>
<td>86 (43.2%)</td>
<td>27 (13.6%)</td>
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</tr>
<tr>
<td>I put at least the same effort into my patients</td>
<td>Immediate</td>
<td>(n=199)</td>
<td>4 (2.0%)</td>
<td>9 (4.5%)</td>
<td>9 (4.5%)</td>
<td>111 (55.8%)</td>
<td>66 (33.2%)</td>
<td>p=0.471</td>
</tr>
<tr>
<td>Long Term</td>
<td>2 (1.0%)</td>
<td>10 (5.0%)</td>
<td>7 (3.5%)</td>
<td>112 (56.3%)</td>
<td>68 (34.2%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt/feel at least the same sense of goodwill towards patients</td>
<td>Immediate</td>
<td>(n=199)</td>
<td>6 (3.0%)</td>
<td>51 (25.6%)</td>
<td>20 (10.1%)</td>
<td>82 (41.2%)</td>
<td>40 (20.1%)</td>
<td>p&lt;0.0001</td>
</tr>
<tr>
<td>Long Term</td>
<td>6 (3.0%)</td>
<td>30 (15.1%)</td>
<td>15 (7.5%)</td>
<td>99 (49.7%)</td>
<td>49 (24.6%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| Practice of Medicine | I was/am able to consult as well as before the complaint | Immediate | (n=198) | 8 (4.0%) | 48 (24.2%) | 30 (15.2%) | 81 (40.9%) | 31 (15.7%) | p&lt;0.0001 |
|--------------------------------|------------------------------------------------------|-----------|---------|------------|-----------|------------|----------|----------|
| Long Term | 1 (0.5%) | 16 (8.1%) | 12 (6.1%) | 98 (49.5%) | 71 (35.9%) |            |          |          |</p>
<table>
<thead>
<tr>
<th></th>
<th>Immediate</th>
<th>Long Term</th>
<th>Immediate</th>
<th>Long Term</th>
<th>Immediate</th>
<th>Long Term</th>
<th>Immediate</th>
<th>Long Term</th>
<th>Immediate</th>
<th>Long Term</th>
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<th>Immediate</th>
<th>Long Term</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
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<td>I was/am able to perform technical tasks as well as before the complaint</td>
<td>2 (1.0%)</td>
<td>19 (9.6%)</td>
<td>40 (20.3%)</td>
<td>99 (50.3%)</td>
<td>37 (18.8%)</td>
<td></td>
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</tr>
<tr>
<td>(n=197)</td>
<td>1 (0.5%)</td>
<td>3 (1.5%)</td>
<td>13 (6.6%)</td>
<td>102 (51.8%)</td>
<td>78 (39.6%)</td>
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<tr>
<td>I was/am able to tolerate uncertainty in my practice of medicine</td>
<td>20 (10.2%)</td>
<td>63 (32.1%)</td>
<td>27 (13.8%)</td>
<td>66 (33.7%)</td>
<td>20 (10.2%)</td>
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</tr>
<tr>
<td>(n=196)</td>
<td>8 (4.1%)</td>
<td>40 (20.4%)</td>
<td>21 (10.7%)</td>
<td>91 (46.4%)</td>
<td>36 (18.4%)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>I was/am confident in my clinical judgment</td>
<td>10 (5.1%)</td>
<td>49 (24.7%)</td>
<td>15 (7.6%)</td>
<td>91 (46.0%)</td>
<td>33 (16.7%)</td>
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</tr>
<tr>
<td>(n=198)</td>
<td>1 (0.5%)</td>
<td>29 (14.6%)</td>
<td>13 (6.6%)</td>
<td>102 (51.5%)</td>
<td>53 (26.8%)</td>
<td></td>
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</tr>
<tr>
<td>I continued to provide/provide the same range of services to my patients</td>
<td>8 (4.1%)</td>
<td>16 (8.1%)</td>
<td>12 (6.1%)</td>
<td>112 (56.9%)</td>
<td>49 (24.9%)</td>
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<tr>
<td>(n=197)</td>
<td>8 (4.1%)</td>
<td>28 (14.2%)</td>
<td>10 (5.1%)</td>
<td>96 (48.7%)</td>
<td>55 (27.9%)</td>
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<td></td>
<td></td>
<td></td>
<td>0.194</td>
<td></td>
</tr>
<tr>
<td>I viewed/view the complaint as being a good thing</td>
<td>107 (53.8%)</td>
<td>64 (32.2%)</td>
<td>17 (8.5%)</td>
<td>9 (4.5%)</td>
<td>2 (1.0%)</td>
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</tr>
<tr>
<td>(n=199)</td>
<td>90 (45.2%)</td>
<td>55 (27.6%)</td>
<td>28 (14.1%)</td>
<td>24 (12.1%)</td>
<td>2 (1.0%)</td>
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<td></td>
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<td>0.0001</td>
<td></td>
</tr>
</tbody>
</table>
5.2.1 The impact of complaint analysed by vocational group.

Chi-square analysis indicated that there is no statistically significant difference between the respondents in the three vocational groups (vocationally registered general practitioners, hospital-based specialists, and general registrants) to any item, either in the immediate or in the long term. This is an important finding. It strongly suggests that although doctors as a group demonstrate a full range of response to receiving a complaint from having virtually no impact through to having a profound impact, the range of responses is statistically the same for doctors practising in any of these three vocational groups.

5.2.2 The immediate response to receiving a complaint.

The results indicate that there is a significant impact on the emotional state of doctors, their attitudes towards themselves and patients, and on their practice of medicine in the first few days and up to six weeks after receiving a complaint. Analysis of the emotional impact responses shows that 72.5% of respondents indicated that they had feelings of anger after receiving a complaint and 65.1% indicated that they had feelings of depression; 38.4% indicated that they had reduced levels of enjoyment of the practice of medicine, and specific questions relating to guilt and shame indicated that 32.5% and 36.4% of respondents indicated that they felt impacted on by a complaint in an emotional sense in those ways respectively.

In the short term, with regard to the doctor-patient relationship, these respondents indicated a reduction in both trust of patients (38.2%) and of their sense of goodwill towards patients (28.6%). Some 14.1% of respondents indicated that receiving a complaint had impacted negatively on their view of themselves, and for 23.9% of respondents receiving a complaint had impacted negatively on their desire to keep on practising medicine. Despite this, 82.8% and 89.0% of respondents preserved a sense of commitment and effort into patient care, respectively – but commitment to the complainant was preserved in only 29.6% of cases and commitment to the complainant was reduced in 50.3% of cases.

42.3% of respondents indicated that their ability to tolerate uncertainty in their practice of medicine was reduced, and 29.8% indicated reduced confidence in their clinical judgment. These results suggest that in the short term there is a significant impact on receiving a complaint on a doctor’s ability to practice medicine. Only 56.6% felt that they were able to consult well,
although most respondents felt that they continued to perform technical tasks well and that they continued to provide the same range of services.

Only 5.5% of respondents indicated that the complaint was a good thing. It is interesting that for most questions between 80 – 90% of the respondents were able to either disagree or agree with the statement and that only between 10 – 20% felt neutral towards them. These results suggest that most respondents were able to make reasonably clear judgments about how they felt that a complaint had impacted on them in the immediate period.

5.2.3 The long term response to receiving a complaint.

The results suggest that the impact of receiving a complaint softened in the long term for most of the items studied.

36.6% of respondents indicated feelings of anger that persisted in the long term, but persistent feelings of depression, guilt, shame and loss of joy of practice fell to around about 10%. All of the items related to the emotional response of receiving a complaint showed a significant difference between the immediate and the long term responses. Comparison between a test question about feelings of depression given to the respondents who had never received a complaint indicated that more respondents who had ever received a complaint felt that they were currently depressed (p=0.009). The results suggest that even though the emotional impact of receiving a complaint may soften, doctors who have ever received a complaint may be at higher risk of emotional damage.

Similarly, comparing those doctors who had never received a complaint with those who had ever received a complaint showed that even though only 2.5% respondents felt bad about themselves as a doctor in the long term, this was still significantly different from those doctors who had never received a complaint (p=0.007).

In the long term, even though trust and a sense of goodwill towards patients are seen to return, 31.6% of respondents indicated persisting reduction of trust in the long term after receiving a complaint, and 18.1% indicated that they still had a reduction in goodwill towards patients.

In the long term, only 27.2% of respondents indicated that the complaint was “a good thing”, and 9.2% indicated that they did not wish to keep practicing medicine at the time of completing the survey.
Doctors who had received a complaint showed no statistically significant change in their reduction of commitment towards the complainant between the short and the long term, or of their preservation of effort and commitment towards other patients, although 10.6% of respondents still indicated that their sense of commitment towards other patients remained reduced in the long term.

In terms of practising, 24.5% of respondents indicated reduction in their tolerance of uncertainty in the long term after receiving a complaint. However, comparison of this group with a test question given to those who had never received a complaint, indicated no significant difference in this component (p=0.239). 15.1% of respondents who had ever received a complaint indicated a reduction in their level of confidence in their clinical judgment in the long term.

The results indicate a return towards a doctors being able to consult as well as they did before a complaint in the long term, although 8.6% of respondents indicated a persisting sense of reduction in this ability. The results indicate that although 18.3% of respondents felt that that the range of services that they provide in the long term is reduced, this is not statistically significantly different from the reported reduction of services immediately after receiving a complaint.

5.3 Discussion.

The questions used were derived directly from the notions and themes from my previously reported qualitative research. All statements were phrased in a positive sense to avoid any ambiguity or use of double-negatives that could create confusion. The low percentage of respondents who felt neutral towards any statement (with the exception of anger and depression in the long term) indicates that most respondents were able to make a reasonably clear decision about how they felt. Furthermore, the results do show that for most items there is a significant shift in response between the immediate and the long term, suggesting that these are considered and thoughtful answers.

A clear limitation of the methodology relates to these answers being self reported. They are not independently observed changes in attitudes as evidenced by the actual behaviour of these respondents.
An important finding in this study is the lack of difference in the self reported impact of a complaint on doctors practising in different vocational groups. The sub cultural stereotyping of doctors practising in different fields is readily apparent when doctors from different disciplines gather together. A potential problem with such stereotyping with reference to the complaints process is that positive or negative impacts of a complaint may be viewed as something that happens to them, rather than something that happens to me or us.

The finding that there is no significant difference between these vocational groups to any item asked, suggests that doctors are able to be considered collectively as a group, and that their similarities as a group outweigh the individual range of responses which are also evident from these results. An important implication from this finding is that any suggestions for change in the complaints process needs to account for a wide range of views, and not be unduly influenced by individuals whose response to a complaint may lie at either extreme of a spectrum.

The findings of anger, depression, shame, and experiencing “loss of joy of practice” in the immediate time period after receiving a complaint, indicate that a complaint has a significant emotional impact on the person of the doctor. These responses, by falling along a shame-rage or shame-depression axis may indicate a shame response. These are powerful emotions, and (if present) need to be recognised by the doctor involved and their work-place colleagues, and by the institution in which they work. These results suggest that for some doctors it may be entirely appropriate for them to cease to practice in the immediate term and to take time away from work. The results also suggest that the response to receiving a complaint in the New Zealand situation may be directly analogous to the impact of litigation in the American setting, and the finding that about one in every ten doctors have persisting negative emotional responses after receiving a complaint suggests that some individuals may be deeply hurt by the experience. Despite these respondents indicating a softening in the emotional impact of a complaint over time, there is clearly a significant emotional residue for some.

This study suggests that important components of the doctor-patient relationship risk being damaged by the receipt of a complaint. It is disturbing that around one in three doctors indicated that in the long term they held a sense of reduced trust of patients (remembering that this is not the complainant but other patients whom they encounter as a normal part of their
practising lives), and that around one in five doctors indicated that they held a reduced sense of goodwill. This suggests that complaints have the potential to damage the doctor-patient relationship with patients who may have played no role whatsoever in the preceding complaint and it implies that the ability of that doctor to be effective as a healer for that patient may be significantly reduced.

Persisting loss of confidence in clinical judgment and of tolerance of uncertainty in medicine may also be outcomes of receiving a complaint and although there was no statistically significant change in the indicated reduction in the range of services delivered to patients, it is disturbing that 18.3% of these respondents indicated a long term reduction in the range of services offered. This raises the question as to whether doctors are practicing negative defensive medicine (withdrawal of services) in response to receiving a complaint, and this notion will be considered further in chapter 8.

5.3.1 The implication of these findings for the delivery of healthcare in New Zealand and the relationship between the medical profession and New Zealand society.

As discussed in chapter 1, the importance of the doctor-patient relationship in the delivery of medical care is paramount, and the person of the doctor in terms of their sense of self and their attitude toward the patient is an integral component of that relationship.

The results presented in this chapter suggest that for many doctors, the receipt of a complaint has the potential to seriously negatively impact on their ability to deliver appropriate healthcare for individual patients (and by implication for society) as a result of receiving a complaint. For each of the categories of person of doctor, doctor-patient relationship, and practice of medicine, this study provides evidence of the potential complaints have to damage the medical profession on whom society is dependent for the delivery of high quality medical care. This is entirely contrary to the stated purpose of the complaints system as reported in Chapter 3, and it suggests that the relationship between the medical profession and society in relation to the complaints process may be dysfunctional.

Using the analogy of the use of the complaints system as a “therapy” given to the medical profession by society, it is inconceivable that any modern therapeutic drug, surgery, or other intervention would be countenanced when there is evidence of such profound negative impact on those patients whose condition was being treated. Even the 10% increased morbidity rate reported in this survey would have to be balanced by a profound advantage for the remainder of
the patients who received such a therapy. Using the same analogy, pain and suffering induced by major surgical or chemotherapeutic interventions are viewed as side effects of the therapy, because their effects are not long lasting and because there are demonstrable benefits in patient outcome as a result.

Without taking this analogy too far, this study finds no evidence that the “therapy” of complaint as prescribed by New Zealand society is having the desired positive effect on some of the most fundamental components on the delivery of healthcare as embodied in the person of doctor, the doctor-patient relationship and in the doctor’s perceived ability to practice medicine.

These results confirm the previously reported qualitative findings and document that in the New Zealand context, the effect of complaint is similar to that of litigation.
CHAPTER 6.

DOCTORS’ ATTITUDES TOWARDS THE COMPLAINTS AND DISCIPLINARY PROCESS.

Introduction.

6.1 The research questions.

This chapter will report the results of the survey portion of the questionnaire that was administered to both those doctors who had ever and those who had never received a complaint. By comparing these groups I aim to define differences in attitudes held towards complainants and the complaints process that are associated with personal experiences of the process. Additionally, this chapter will assess New Zealand doctors’ attitudes and consider how these attitudes relate to underlying views of professionalism, using both the structural-function and values based approaches to understanding professionalism. The results will indicate where there appears to be an appropriate and functional relationship between society and the medical profession, and where doctors’ attitudes seem to be divergent with the values espoused in the purposes of a complaints system that were documented in chapter 3.

The research question to be addressed is whether there is a continuum of consistency between a) the attitudes of the medical profession and that of New Zealand society; b) the attitudes of doctors practicing in different vocational groups; and c) the attitudes of doctors who have ever or never received a complaint.

The study documents the extent to which some of the attitudes held by the respondents in my earlier research\(^{17,21}\) are generalisable to the wider population of New Zealand doctors, and to do this, respondents were asked to indicate on a Likert scale their level of disagreement or agreement with positively phrased attitudinal statements. Chi-square tests were used to test associations between doctors’ experience of a complaint and demographic variables. The level of significance was set at \(p<0.01\), in order to be conservative in interpreting results.

6.2 Results.

598 doctors completed the full questionnaire, and of these, 201 respondents had ever and 397 had never received a complaint.
Table 9 presents the overall attitude of these respondents towards each statement; the percentage responses on the five-point Likert scale for all respondents combined; the percentage responses for those who have *never* or *ever* received a complaint; the level of significance of difference between those who have *never* or *ever* had a complaint; and whether those who have *ever* had a complaint are more or less supportive of the statement when a significant difference between the *ever* and *never* groups had been found.
Table 9: Attitudes of New Zealand Doctors towards the Complaints Process

<table>
<thead>
<tr>
<th>Statement</th>
<th>Overall attitude towards statement</th>
<th>All respondents</th>
<th>Never had Complaint</th>
<th>Ever had Complaint</th>
<th>Ever vs Never</th>
<th>Ever had complaint more or less supportive of the statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of responses (n)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Never had a complaint (N)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Ever had a complaint (E)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is important that society can complain about doctors (n=596 N=596 E=201)</td>
<td>95% Agree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Strongly Disagree (SD)</td>
<td>SD 0.7</td>
<td></td>
<td>0.5</td>
<td>1.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disagree (D)</td>
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<td>0.53</td>
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<td>Neutral (N)</td>
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<td></td>
<td>2.3</td>
<td>54.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree (A)</td>
<td>A 63.6</td>
<td></td>
<td>61.3</td>
<td>68.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Agree (SA)</td>
<td>SA 31.4</td>
<td></td>
<td>35.4</td>
<td>23.3</td>
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<td></td>
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<tr>
<td>The rights of patients and the responsibilities of doctors are the best starting point to initiate and judge a complaint (n=594 N=394 E=200)</td>
<td>62.8% Agree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>% Strongly Disagree (SD)</td>
<td>SD 1.7</td>
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<td>1.3</td>
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<tr>
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<td>14.2</td>
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<td></td>
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<td>17.0</td>
<td>23.5</td>
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<tr>
<td>Agree (A)</td>
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<td></td>
<td>62.4</td>
<td>48.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Agree (SA)</td>
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<td></td>
<td>5.1</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The medical profession is capable of self regulation (=594 N=393 E=201)</td>
<td>68.3% Agree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Strongly Disagree (SD)</td>
<td>SD 1.0</td>
<td></td>
<td>0.3</td>
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<tr>
<td>Disagree (D)</td>
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<td>15.3</td>
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<td>18.0</td>
<td>12.9</td>
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<td></td>
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<tr>
<td>Agree (A)</td>
<td>A 58.2</td>
<td></td>
<td>59.5</td>
<td>55.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Agree (SA)</td>
<td>SA 10.1</td>
<td></td>
<td>6.9</td>
<td>16.4</td>
<td></td>
<td></td>
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<tr>
<td>Most complaints against doctors are warranted</td>
<td>39.5% Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=592 N=395 E=197)</td>
<td>49.5% Neutral</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>11% Agree</td>
<td>A 11.0</td>
<td></td>
<td>10.7</td>
<td>11.1</td>
<td></td>
<td></td>
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<tr>
<td>Strongly Agree (SA)</td>
<td>SA 0.0</td>
<td></td>
<td>0.0</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most complaints are about errors and actual wrong-doings</td>
<td>51.5% Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=586 N=389 E=197)</td>
<td>49.2% Agree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Strongly Disagree (SD)</td>
<td>SD 7.9</td>
<td></td>
<td>6.3</td>
<td>11.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disagree (D)</td>
<td>D 41.3</td>
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<td>41.4</td>
<td>41.2</td>
<td></td>
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<tr>
<td>Neutral (N)</td>
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<td>29.8</td>
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<td></td>
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</tr>
<tr>
<td>Agree (A)</td>
<td>A 21.0</td>
<td></td>
<td>21.7</td>
<td>19.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Agree (SA)</td>
<td>SA 1.2</td>
<td></td>
<td>0.8</td>
<td>2.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most complainants are trying to make sure that a bad event does not happen again to someone else (n=595 N=396 E=199)</td>
<td>49.2% Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Strongly Disagree (SD)</td>
<td>SD 7.9</td>
<td></td>
<td>6.3</td>
<td>11.1</td>
<td></td>
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<tr>
<td>Disagree (D)</td>
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<td>41.4</td>
<td>41.2</td>
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<tr>
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<td>29.8</td>
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<tr>
<td>Agree (A)</td>
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<td>21.7</td>
<td>19.6</td>
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<tr>
<td>Strongly Agree (SA)</td>
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<td></td>
<td>0.8</td>
<td>2.0</td>
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P=0.007 Less support

P<0.001 More support

ns
<table>
<thead>
<tr>
<th>Complaints are a useful tool to improve medical practice (n=592 N=392 E=200)</th>
<th>50.1% Disagree</th>
<th>SD 12.3</th>
<th>11.7</th>
<th>13.5</th>
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<tr>
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<tr>
<td></td>
<td>A 26.4</td>
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<td>30.5</td>
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<tr>
<td></td>
<td>SA 0.0</td>
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<td>0.0</td>
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</table>

<table>
<thead>
<tr>
<th>Most complainants are normal people (n=591 N=393 E=198)</th>
<th>31.5% Disagree</th>
<th>SD 3.2</th>
<th>2.0</th>
<th>5.6</th>
<th>P&lt;0.001</th>
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<tbody>
<tr>
<td></td>
<td>33.2% Neutral</td>
<td>D 28.3</td>
<td>24.2</td>
<td>36.4</td>
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<tr>
<td></td>
<td>35.3% Agree</td>
<td>N 33.2</td>
<td>37.4</td>
<td>24.7</td>
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<tr>
<td></td>
<td></td>
<td>A 34.1</td>
<td>35.1</td>
<td>32.3</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>SA 1.2</td>
<td>1.3</td>
<td>1.0</td>
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<table>
<thead>
<tr>
<th>It is important to have lay input to the process (n=595 N=397 E=198)</th>
<th>75.3% Agree</th>
<th>SD 1.5</th>
<th>0.8</th>
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<tr>
<td></td>
<td>A 60.2</td>
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<td></td>
<td>SA 15.1</td>
<td>16.6</td>
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<table>
<thead>
<tr>
<th>Medical complaints should be resolved in a court of law (n=596 N=396 E=200)</th>
<th>88.5% Disagree</th>
<th>SD29.9</th>
<th>28.0</th>
<th>33.5</th>
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<td>52.5</td>
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<td>N 7.0</td>
<td>6.9</td>
<td>7.5</td>
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<td></td>
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<tr>
<td></td>
<td>A 3.0</td>
<td>2.0</td>
<td>5.0</td>
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<td>SA 1.5</td>
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<table>
<thead>
<tr>
<th>The doctors best positioned to advise the Health and Disability Commissioner are to be found within the same specialty (as that involved in the complaint) (n=597 N=396 E=201)</th>
<th>85.4% Agree</th>
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<th>0.5</th>
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<td>59.3</td>
<td>54.2</td>
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<tr>
<td></td>
<td>SA27.8</td>
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<table>
<thead>
<tr>
<th>Doctors are the group best able to judge a complaint (n=594 N=394 E=200)</th>
<th>68.5% Agree</th>
<th>SD 0.9</th>
<th>0.3</th>
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</table>

<table>
<thead>
<tr>
<th>Within the process, doctors are judged by appropriate standards (n=588 N=394 E=194)</th>
<th>24% Disagree</th>
<th>SD 2.2</th>
<th>0.5</th>
<th>5.6</th>
<th>P&lt;0.001</th>
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<tr>
<td></td>
<td>D 21.8</td>
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<td>25.3</td>
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<tr>
<td></td>
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<td>42.3</td>
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<th>It is important that at the end of the complaints procedure there is a sense of completion for both the doctor and the complainant (n=598 N=397 E=201)</th>
<th>93.6% Agree</th>
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It is important that the complainant and the doctor are reconciled (n=593 N=393 E=200)
In terms of a continuum of consistency between doctors practicing in different vocational groups, the results indicate that there was no significant difference between any of the statements when the results were considered by vocational group. Although not reaching a level of statistical significance, it appeared that general registrants may disagree more than the vocationally registered general practitioners and hospital based specialists with the statement "most disciplinary complaints against doctors are warranted" (p=0.019).

In terms of consistency between doctors who had ever or never received a complaint, analysis of the results within each of the three separate vocational groups showed that there was no significant difference between those who had ever or never received a complaint to any of the statements except "most disciplinary complaints against doctors are warranted", where vocationally registered general practitioners who had ever had a complaint were significantly more likely to disagree with that statement than if they had never received one (p=0.001).

Comparing the responses of all doctors combined who had ever versus those who had never had a complaint, indicated that doctors who had ever had a complaint were more supportive of the statements "the medical profession is capable of self regulation" and "doctors are the group best able to judge a complaint", and were less supportive of the statements "most complaints are about errors and actual wrong-doings", "most complainants are normal people", "within the process, doctors are judged by appropriate standards", and "it is important that at the end of the complaints procedure there is a sense of completion for both the doctor and the complainant".

To the statements that had the widest range of responses, ("most complaints ... are warranted"; "most complainants are normal people"; and "... doctors are judged by appropriate standards"), respondents who had ever had a complaint disagreed more than those who had never had a complaint.

6.3 Discussion.

The questionnaire had a sufficiently high response rate to allow statistical comparison between the three vocational groups being considered, and between doctors who had been exposed to the complaints process and those who had not.

The statements used were deliberately derived from verbatim transcripts of the general practitioner respondents who contributed to my original study. They arose from the opinions and values expressed from that research and were deliberately phrased as positive statements to minimise the negative implications that several of the statements appear to carry. The statements used were designed to consider the societal values associated with the purposes of the complaints process, the values that
doctors hold about that process and also the attitudes that doctors may hold towards those systems and towards the complainants that are involved.

The strength of this particular method lies in testing statements about the complaints process that have arisen from within the profession itself, rather than using a particular and potentially different research paradigm such as Marxism or feminism. The two main limitations of the method are related to the limited number of questions (constrained in deference to the overall magnitude of the survey) and to the influence on the response that simply asking a question might have in itself.

6.3.1 Areas of consistency and divergence between doctors and society.

The survey results indicate that doctors’ attitudes towards the complaints and disciplinary system fall on a continuum from being internally consistent (that is where the respondents appear to be generally in agreement), through to being divergent. The results suggest that there may also be a continuum of consistency between the medical profession’s attitude and that of New Zealand society. By considering where the profession’s attitudes are consistent with and diverge from those of society, the results have implications for the way in which society may interact with the profession, and the direction that any proposed changes to the current system should take.

The consistency of responses from the three vocational groups suggests that doctors are capable of representing themselves as a single professional body within our society. Although the range of responses documented in the results demonstrates that an individual doctor may hold a polarised view, no particular vocational group holds an extreme position. Similarly, respondents who have ever received a complaint hold beliefs that are largely consistent with those who have never had a complaint.

The results indicate that doctors strongly support society’s right to complain, having lay input into the process, achieving a sense of completion for both parties, and having those responsible for making decisions about complaints advised in an appropriate manner. Respondents did not indicate support for using a court-based system to resolve complaints. All of these statements are reflections of values held by New Zealand society and legislated for. With regard to these issues, the medical profession’s attitudes are internally consistent and the findings suggest that these attitudes are consistent with those held by New Zealand society.

Respondents indicated support for the notions that “the rights of patients and the responsibilities of doctors are the best starting point to initiate and judge a complaint”, and that “... the medical profession is capable of self regulation”. This is consistent with society’s expectation of having rights in its interaction with doctors and is consistent with the notion of self regulation as an indicator of professionalism using the structural-function approach.
Considered together with support for the statement that "doctors are the group best able to judge a complaint", these responses suggest that attempts to increase regulation without competent input from doctors may well be met with resistance by the profession.

Respondents were less internally consistent but still indicative in their responses to three statements related to the purpose of the complaints system. Around 50% of respondents indicated they believe that most complaints are not about error and actual wrong-doings, that complainants are not acting to reduce the risk of a bad event happening to someone else, and that making complaints is not a useful tool to improve medical practice. It is significant that nearly 50% of the respondents in this study are uncomfortable with some of the important beliefs that society appears to hold as to why it reserves the right to complain about doctors, especially with respect to the notion of the maintenance of professional standards. New Zealand doctors are by no means sure that the quality of medical care delivered to patients is improved by the current complaints system.

Divergent responses (with increased negativity from respondents who had ever had a complaint) were elicited to some statements that relate to how society interacts with doctors through the complaints process. To the statement "most complaints against doctors were warranted", nearly 50% of this study's respondents were neutral, and nearly 40% did not think that the statement was true. The notion of whether complaints are perceived as warranted is important with regard to the relationship that exists between society and the medical profession. In order for society to relate appropriately, the right to complain must be exercised in a responsible way. There must be a sense of "buy-in" from the medical profession into the process if it is to be effective. Indeed, if most complaints are not warranted, then the continued misuse of the right to complain risks damaging the relationship between the profession and society.

Only one third of the respondents in this study believed that complainants "are normal people"; and one third were neutral towards the statement and one third disagreed. This finding has two important implications. If the perception of these respondents is correct, then care of the complainant (especially if they are themselves a patient) must be taken into account in the complaints process as the complaint may be an indicator of underlying disorder in that patient, and an indicator of need for them receiving appropriate care.

The second important implication of this statement is that complainants are the vehicle through which society exercises its right to complain, and if the 42% of respondents who had ever had a
complaint and felt that complainants were not normal people were indeed making a valid assessment (and not simply being disgruntled or derogatory), then society’s use of complainants in its interaction with the profession is called into question. If our society is using the complaints process to improve the delivery of medical care, then it requires a vehicle of entry into the process that can be relied on to meet that objective. Peter Davis’ research into error in New Zealand hospitals confirms reports from the litigation experience in the United States that indicates a lack of correlation between actual medical error and complaints. These results raise the question as to whether an alternative process of assessing and rectifying substandard medical practice needs to be developed that still takes account of input from complainants, but which is not dependent on them.

Although 41.3% of respondents agreed that “…doctors are judged by appropriate standards”, nearly one in four respondents disagreed with that statement, and a third were neutral. Furthermore, respondents who had ever had a complaint disagreed even more with it, and this is despite the findings reported in Chapter 4 which indicated that nearly 85% of complaints were not upheld. These findings suggest disquiet within the medical profession about the standard that society uses to judge complaints and in a similar way to the notion of whether complaints are warranted or not, this statement has implications for the “buy-in” of doctors into the complaints process.

6.3.2 The complaints system as a tool for the enhancement of medical care.

The results of this study suggest that New Zealand doctors hold attitudes and beliefs towards the complaints system that are consistent with notions of professionalism using either a structural-function or a values-based approach. The results indicate awareness of the relationship that exists between the profession and the society in which it functions. The respondents in this study believe that there should be a complaints system, that there should be appropriate input from both the profession and society, and that there should be a point of conclusion for both parties.

In order for professionalism to be considered as a relationship between doctors and society, a common set of values is required. Although broad values about the place of the complaints system within New Zealand society appear to be held by these respondents, these results suggest that the use of the complaints system to identify problems in practice, to prevent the perpetuation of poor practice, and to improve practice may be problematic. Disagreement about
these core purposes of the complaints system may indicate that unresolved tension could lead to a breakdown of the relationship between the profession and society. The most disquieting aspect of these results is that they raise questions about whether the interaction is truly respectful. In a respectful relationship, complaints should be warranted, there should be an appropriate vehicle for entry into the process and the process should be judged appropriately. If these requirements are not met then there is a risk that the relationship between the profession and society becomes dysfunctional, which is not to the benefit of either party.
CHAPTER 7

DOCTORS’ SUGGESTIONS FOR CHANGES TO THE COMPLAINTS SYSTEM IN NEW ZEALAND.

7.1 Introduction.

This chapter will document New Zealand doctors’ opinions about the current complaints process and will develop a proposal for change based on doctors’ critique of the current system and identified limitations that are amenable to improvement. Prior to the publication of these findings there was no documentation in the New Zealand medical literature of the opinions of New Zealand doctors about the complaints process or of constructive notions for change. Not only then are these findings important in providing evidence of where doctors stand with regard to suggestions for change, but they also allow consideration of other issues related to the complaints process.

One issue for consideration is whether suggested changes are consistent with the values that underlie having a complaints process as documented in chapter three, and if not, then what values might underlie such changes? A second consideration is that suggested changes should clarify particular points of pressure or difficulty as perceived by doctors in regard to the current system. Given that the research findings presented in chapter five indicate that the current complaints process has significant potential for negative impact of the person of the doctor, the doctor-patient relationship and on the practice of medicine, then doctors’ suggestions for change should, taken collectively, seek to redress some of that negativity.

7.2 Methods

This section presents further results from the postal survey. Included in the questionnaire received by those who had ever or never received a complaint was the question “how do you think that the medical disciplinary complaints system could be improved in this country?” The answers were provided in hand-written form on the returned questionnaires. 453 respondents provided a written answer to this question, and of these, 158 (35%) had ever received a complaint and 295 (65%) had never received a complaint.

The responses were transcribed and analysed using line-by-line inductive analysis, the method developed by Strauss and Corbin. The emergent themes and sub-themes were analysed with
the aim of developing ideas for potential change in the complaints and disciplinary process and
developing theories about respondents' perceptions about the nature of the practice of medicine.

7.3 Results

Three thematic categories emerged from this analysis. These will be elaborated in sections
7.3.1, 7.3.2, and 7.3.3. The thematic categories are: 1) ideas around the nature of medical
practice; 2) notions about the current complaints system; and 3) suggestions for change. Sub-
themes within these groupings emerged suggesting that New Zealand doctors have considerable
insight into the type of work that they do and values held by themselves and by New Zealand
society. It was clear that for many respondents, their suggestions for change in the process were
predicated by the values that they held about the practice of medicine and how the medical
profession should relate to and engage with society. In other words, many respondents justified
their suggestions for change by either critiquing aspects of the current system or by using a
values based notion of professionalism.

7.3.1 The nature of medical practice in contemporary New Zealand society.

Respondents indicated awareness of a wide range of issues related to the complexity of
practicing, to tensions between the limitations of medicine and the expectations of society
including those related to the humanity of doctors themselves, and of tensions between the
rights and responsibilities of doctors and of patients.

Medical practice, complexity, fallibility and systems of care.

Respondents associated errors with complaints and commented on the unreasonably high
expectation held by society that errors in medical practice are unacceptable.

"I feel that society has an unreasonably high (zero tolerance) expectation of doctors, as
though no errors should happen." (General practitioner, no complaint, No. 196)

"Need ongoing education to public about limitations of doctors as human beings and the
limitations of technology and procedures." (General practitioner, no complaint, No. 96)
"Need more lay information that the medical profession is not infallible, that mistakes can happen within the best of intentions and will happen even with the 'best doctors'."

(General practitioner, complaint, No. 158)

Respondents noted that that doctors were not infallible, and they linked this to ideas of "humanness", to the issue of decision making and carrying the load of responsibility.

"Recognise that doctors are human and that decision-making always carries the possibility of being wrong. The more decisions the greater the inevitability of an error. All doctors will be wrong, albeit rarely"

(Hospital based specialist, no complaint, No. 066)

"Medical errors are usually 'human' errors in a high risk industry."

(General registrant, no complaint, No. 246)

"... the humanness of doctors – we're never perfect but do our best most of the time. We can also have areas of not knowing everything about medicine. We are not God."

(General registrant, no complaint, No. 171)

"The public seem to expect perfection now, but this is not going to be possible."

(Hospital based specialist, no complaint, No. 389)

"It is not possible for medical practitioners to be infallible."

(Hospital based specialist, complaint, No. 190)

How a patient reacts to an error and to the outcome of care was seen as being important to the genesis of a complaint, and respondents felt that the complaints process also reflected a societal need to apportion blame:

"How a patient reacts to an error may be the deciding factor in whether there is a disciplinary complaint, rather than the nature of the error itself."

(Hospital based specialist, no complaint, No. 066)

"Stop treating complaints like mistakes for which there must be a responsible person who must be hunted down and punished."

(General registrant, no complaint, No. 145)

"Most complaints relate to poor outcome rather than true error."

101
Several respondents noted that doctors practiced within complex systems, but that individual doctors were held responsible for the delivery of care:

"Judgment is based on idealistic practice where everyone does things where there are clearly defined rights and wrongs – like a soap opera. Not enough attention to the complex backdrop against which we work full of strange pressures and perverse incentives."

(General practitioner, complaint, No. 321)

"Our problems are systematic and [yet] there is no accountability above provider level."

(General practitioner, no complaint, No. 127)

The ability to deliver services and meet societal expectations.

Respondents noted conflict between societal issues and the ability of doctors to deliver care. They were aware of the limitations of the health care system, and felt that society’s expectations were not always realistic:

"We cannot have a Rolls Royce system on a Japanese import budget."

(General registrant, complaint, No. 085)

"Time and resource constraints need to be considered rather than comparing us to some abstract best practice standard which may not be attainable in New Zealand."

(General practitioner, no complaint, No. 200)

"It seems increasingly we are whipping boys for a pervasive sense of societal inequity or malaise. I think we need clearer guidelines on how much individual responsibility any doctor can be expected to take for societal problems of injustice or inequity. The patient’s primary right is to safe and appropriate clinical care, there is a limit to how much we can prop up a sick system."

(General practitioner, no complaint, No. 057)
"Get society/policy-makers to accept we cannot in New Zealand have an expectation of a first world level of service, expertise, technology, access, and accountability with recourse to first world levels of recompense when operating within third world levels of funding/systems."

(General practitioner, no complaint, No. 069)

Perhaps the most straightforward quote with regard to this issue was:

"The public seem to expect perfection now but this is not going to be possible."

(Hospital based specialist, no complaint, No. 389)

Issues around rights and responsibilities.

Many respondents commented on their perception of an imbalance between rights and responsibilities such that the rights of patients and the responsibilities of doctors were overemphasised in the complaints process, and insufficient emphasis placed on the responsibilities of patients and the rights of doctors. One respondent wrote:

"The rights of doctors have been progressively diminished concurrently with an ineffective delineation of the responsibilities of patients."

(General practitioner, complaint, No. 043)

Some called for:

"A need for a code of doctor's rights and patient's responsibilities."

(General practitioner, complaint, No. 121)

Several respondents commented on what they saw as their right to be treated respectfully by patients and some wanted to have the right to be able to complain against patients whom they saw as being abusive.

"Doctors and their staff have rights – not to have to put up with rude or abusive patients and to be treated courteously, and to have time off, i.e. when I'm shopping, out with the kids"
or at home, I do not expect to be molested by people asking me about their health problems.”

(General practitioner, no complaint, No. 035)

"The doctors should also have the right to complain about difficult, rude and non-compliant patients."

(General practitioner, complaint, No. 115)

Several respondents considered that it was too easy to make a complaint, and that there was no disincentive in the system for doing so.

"I would like there to be some penalty for patients who wrongly complain about us, it is all very one sided, e.g. financial compensation. I think we are stupid to allow a situation where there is no disincentive to lodge complaints. It reflects our continuing paternalistic attitudes in part, plus our benevolent generosity to patients."

(General practitioner, complaint, No. 346)

Taken collectively, these respondents indicated that their experienced reality of practicing medicine appears to be out of step with their perception of the values that underlie the complaints system. They feel that society’s expectation of them as doctors is that they will be infallible, able to deliver high quality health care to their patients irrespective of the socio-political conditions in which they practice and that in doing so they will be held personally responsible for the outcome of that care. They appear concerned that this sense of personal responsibility is not balanced by personal rights that take into account infallibility and humanness, and that the complaints system does not require a sense of responsibility from either society or individual patients for their well-being.

Viewed in terms of a relationship between the profession and society, these respondents draw attention to aspects of relationship that indicates satisfactory awareness of each party’s viewpoint and position, which appeared to be missing from the current complaints system.

7.3.2 Notions about the current complaints system.

Three sub-themes within this analysis emerged as related to practical and problematic issues. These sub themes are: 1) The need for complaints to be resolved as rapidly as possible; 2) facilitating a system in which unwarranted complaints could be recognised and dealt with
expeditiously; and 3) the importance of minimising the adverse impact of the media on the complaints process. In addition, respondents also commented on what they thought the system should achieve for both doctors and complainants. They included definitions of the purposes of a complaints system, notions associated with its process and outcome, and ideas about who should sit in judgment on a complaint. This section will present six sub-thematic categories with comments and examples related to each.

The need for rapid resolution of complaints.

Out of the 453 respondents to this portion of the survey, 148 mentioned the need for rapid resolution as being important in the complaints process. Perhaps the moist poignant quote was:

"Speed; in my situation I was devastated by the length of time it took to resolve. I contemplated suicide, leaving the profession, leaving New Zealand, etc. It was a very terrible time of my life and for years it was very difficult to talk about it."

(General practitioner, complaint, No. 048)

Ideas around the purpose of a complaints system.

Respondents indicated that a complaints system should be used to improve medical practice and to provide a forum in which complainants could be heard and appropriately compensated. Several respondents commented on the opportunity for the complaint to become a learning event for the doctor, and this contrasted with a perception of a culture of blame within New Zealand society. Respondents noted that a shift in societal attitude would be needed to move away from this perceived culture of blame towards one of educative opportunity. Comments regarding the use of complaints for education included:

"The emphasis should be on correcting/improving a doctor’s practice and systems or failure rather than being vindictive, i.e. emphasis on improvement and prevention rather than disciplinary action."

(General practitioner, no complaint, No. 248)

"... change attitudes of both doctors and society so that ... we can learn and work together openly sharing our mistakes."

(General practitioner, no complaint, No. 126)
"I am strongly opposed to there only being a 'disciplinary' system. The emphasis should be on learning from mistakes not punishment, and being open about admitting fault."

(General registrant, no complaint, No. 246)

The difficulty in linking quality improvement in medicine to the complaints process was commented on by several respondents:

"Educate public about evidence for quality in medicine not necessarily being linked to a punitive complaints system."

(General practitioner, no complaint, No. 106)

"More emphasis on the process involved in the mistake 'how did it happen?', 'how can we learn from it and prevent it happening again'?"

(Hospital based specialist, no complaint, No. 073)

Respondents felt that complainants needed to be heard and appropriately compensated:

"Complaints should be heard promptly for the benefit of all involved. Reasonable compensation should be available to patients who have suffered injury from medical error - the lack of this compounds complainants' feelings of injustice."

(General practitioner, no complaint, No. 200)

Respondents were also aware of the effect that the complaints process has on complainants and of the importance of addressing their particular concerns and expectations. One respondent commented on:

"Effort to avoid unnecessary harm to a practitioner and his/her practice and to prevent unnecessary long-standing concerns or expectations of a complainant."

(General practitioner, no complaint, No. 248)

Frivous, vexatious, and malicious complaints.

Respondents raised several different issues which can be considered under this general heading. They use these phrases to define complaints that should not reasonably be made (frivous), and recognised that there were occasions where the complainant had malicious intent towards the
doctor, and other instances where complainants had a long term history of complaining. They noted that some complainants were psychiatrically unwell or personality disordered and that the complaints process had a responsibility to look after those people and to protect the complained about doctor from the stress of receiving such a complaint. This was summed up by one respondent as:

"Some way of accessing support for mentally unstable complainants so they do not cause unnecessary stress to good doctors."

(General practitioner, no complaint, No. 075)

Respondents made mention of the need for triaging complaints so as to allow rapid resolution.

"Complaints which clearly have no foundation (where complainants clearly have been disadvantaged but where the doctor could not have altered or was not responsible for the problem) should be sifted out early and discharged."

(Hospital based specialist, no complaint, No. 301)

Respondents differentiated between complaints of differing severity, and several respondents wanted doctors to be able to take action against complainants where the complaint was seen to be unjustified. Some requested a mechanism to have complainants apologise to doctors for the stress caused by an unwarranted complaint, but others were more aggressive and felt that doctors should be able to take legal action against complainants in those circumstances. Others recognised that there is no reciprocal process by which doctors can complain about patients:

"Doctors should also be allowed to make complaints against patients. They should be allowed to document harassment in the clinic and [have] some disciplinary action taken."

(General practitioner, no complaint, No. 268)

The role of dialogue, mediation, and complaint resolution.

Although these ideas are linked to those around the purpose of a complaints system, respondents indicated considerable support for a mediated process involving the doctor and the complainant, and which took the opportunity to explore both sides of the issue in question. Having an appropriately mediated resolution process was believed to reduce the need for higher level complaint procedures and several respondents linked this notion to complainants' needs to
feel heard and seek explanation about what had happened, and to doctors' needs for fairness and transparency of process:

"Mediate reconciliation prior to hearing since many complaints arise because there has not been an opportunity to air feelings and explain. The disciplinary proceedings should follow this if needed."

(General practitioner, no complaint, No. 032)

"It may be better to have a mediation process which is transparent, i.e. doctor and team versus patient and team, mediated by external agency."

(General practitioner, no complaint, No. 147)

The difficulty of seeking redress without recourse to a complaints process was also mentioned with one respondent calling for:

"Improved availability of help for aggrieved patients without encouraging complaint."

(General practitioner, no complaint, No. 008)

Using a mediated approach was also seen as being a way of improving doctor-patient communication:

"Facilitation/mediation encouraging early and effective communication between complainant and doctors essential, and would undoubtedly decrease complaints to disciplinary committee."

(Hospital based specialist, no complaint, No. 032)

"Most complaints (in my experience) are based on failure of communication – by the doctor in explaining what the patient is and how it can be fixed, by the patient not understanding the problem and what is being done, and by having too high expectations of the outcome."

(Hospital based specialist, complaint, No. 399)

A number of respondents had personal experience of working in the United States and were all opposed to the introduction of a court-based system of complaints resolution, which was seen as being ineffectual in terms of improving outcome for patients or for healthcare more widely, and which was seen as only benefiting the lawyers involved in such cases. Those respondents who did wish to use a court-based system gave as their justification, the need to make it more
difficult for complainants to introduce a complaint or to allow doctors to be able to take action against complainants in vexatious cases, so as to discourage further complaints.

The role of the media.

Respondents commented negatively about the involvement of the media in the complaints process. They were aware of the influence of the media on society’s attitudes towards doctors and several respondents commented on “trial by press”, and wanted media coverage restricted until after the complaint process had been completed.

“Media coverage [is] probably the most destructive aspect in view of the sensational type of reporting and doctor bashing culture. Reporters do not appear on the whole to have a good intelligent grasp of the issues, and try and exploit the emotive angle.”

(General registrant, no complaint, No. 025)

Respondents were aware of the risk of media sensationalising the issue, of being influenced by pressure groups and for the potential for adverse publicity to affect the final judgment against the doctor. Several respondents found the idea of “trial by media” deplorable.

Who should judge complaints?

Respondents indicated that only transparently appropriate people should provide expert advice and sit on complaints tribunals. They felt that tribunal members should be in touch with the practiced reality of medical practice, and that tribunals must include competent practitioners from the same field of practice as the doctor involved:

“In deciding merits of a complaint – input from respected peers in the same field, e.g. rural GPs for complaints against rural GPs.”

(General practitioner, complaint, No. 244)

Some respondents criticised the type of people whom they saw as sitting in judgment:

“Need ... wider spectrum of doctors. Not all the ‘committee’ people who are often hopeless at the coalface. The ‘old school tie’ too often in evidence.”

(General practitioner, no complaint, No. 118)
However, respondents were also aware of the burden of responsibility placed on tribunal members, of the personal qualities required, and of the need for lay input:

"People paid to do the work not ad hoc, trying to do it in addition to their current work load. However, need training in it and also the medical people need a background of working in the area being challenged."

(General practitioner, no complaint, No. 371)

"They can start by being humane, caring and kind – the very qualities that lead most of us into medicine."

(General practitioner, complaint, No. 267)

"Doctors provide the basic understanding of assessing doctors. Lay input is essential to keep doctors on track and responsive to the community."

(General practitioner, no complaint, No. 241)

Respondents did not object to the notion that a judgmental tribunal may be required to decide the merits of a particular complaint. They wanted such a tribunal to be seen to be transparently appropriate for the task required of it. This required the appropriate selection of both medical practitioners and lay persons so that the course of natural justice would be seen to have been taken.

7.3.3 Suggestions for change.

Not all respondents had ideas about how the complaints process might be improved. Some were unaware of the complaints process and some felt that their lack of personal experience precluded them from commenting. However, there was no suggestion that there should not be a complaints or disciplinary process. Some respondents had sat on complaints assessment committees and commented positively on the process. Others related examples where the process had been used inappropriately or destructively towards the doctor involved.

Across all three groups of respondents, vocationally registered general practitioners, general registrants and hospital based specialists, including those who had ever and those who had never received a complaint; there was support for the notion of a Complaints Tribunal as the single point of entry into the complaints process. Some representative quotations included:
"One 'point of entry' for complaints."  (General practitioner, no complaint, No. 075)

"Need one body and need to address complaint and resolve within two months of it first being raised."
(General practitioner, no complaint, No. 168)

"Reduction in the number of avenues available for complaint – single streamlined system."
(General practitioner, complaint, No. 244)

"Have one avenue of complaint only."
(General practitioner, complaint, No. 308)

"To have only one stop shop will help a lot."
(General registrant, no complaint, No. 089)

"There should be one central ‘forum’ for complaint."
(General registrant, complaint, No. 077)

"Have a single complaints authority, medical, input and the right of a court appeal by the doctor or complainant. The current multiple authorities place a doctor in double, triple, quadruple or more jeopardy. This denies natural justice."
(Hospital based specialist, complaint, No. 324)

A summary of the desirable characteristics of a complaints tribunal as a single point of entry into the complaints system is given in Table 10. This table summarises the attributes seen as desirable in such a tribunal by the study's respondents.
Table 10: Desirable Characteristics of a Complaints Tribunal as a Single Point of Entry into the Complaints System.

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<tr>
<td>1</td>
<td>Be the point of entry for all complaints</td>
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<tr>
<td>2</td>
<td>Be capable of rapid response to a complaint</td>
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<tr>
<td>3</td>
<td>Provide a safe environment for dialogue and mediation between complainants (and their advocates) and doctors (and their advocates)</td>
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<td>4</td>
<td>Be based on rights and responsibilities of both parties</td>
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<tr>
<td>5</td>
<td>Be capable of weeding out complaints lacking in substance, or malicious or vexatious complaints</td>
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<tr>
<td>6</td>
<td>Seek to improve the delivery of healthcare, being able to discriminate between failings attributable to medical (health) systems, error in the practice of medicine, or of wrong doing</td>
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<tr>
<td>7</td>
<td>Be aware of the limitations of medicine</td>
</tr>
<tr>
<td>8</td>
<td>Consist of members or appointees who are properly trained and funded, appropriately experienced, and whose judgements are seen as being fair and appropriate</td>
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<tr>
<td></td>
<td>▪ Not composed ad hoc</td>
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<td></td>
<td>▪ Grounded and competent in the field in question</td>
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<tr>
<td>9</td>
<td>Be capable of seeking improved outcome for the patient</td>
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<tr>
<td>10</td>
<td>Be independent of the influence of the media, offering protection from premature or emotive reporting</td>
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7.4 Discussion.

Although many of the written responses to this portion of the questionnaire were limited to two or three sentences, the sheer size of the overall number of responses compensates for lack of depth or richness of text. Unlike the in-depth interview based qualitative methodology, this broad but superficial mode of enquiry allowed significant themes and sub-themes to emerge, and for each response to be considered in terms of those themes and sub-themes.

The method allowed outliers to be identified and their responses to be put into an appropriate context (for example, one respondent with extremely negative views of the complaints process wrote particularly derogatory comments about the Health and Disability Commissioner).

Because of the reasonable response rate (453 respondents), the notions about what New Zealand doctors value in the complaints process does not need to be further tested as did the results of my early work on the effect of complaints on general practitioners as reported in chapter 1 in this thesis.

The main limitation in the interpretation of these findings is that the methodology precludes deeper exploration of the reasoning behind these respondents' comments, as one would do in an in-depth interview situation. The technique did however, demonstrate considerable uniformity of response between the groups of doctors surveyed, including between those who had ever and those who had never received a complaint.

7.4.1 Tensions, purposes and change in the complaints process.

This study aimed to obtain New Zealand doctors' suggestions for change (if any) to the complaints and disciplinary system. The respondents not only provided suggestions for change, buy they also showed insight into the nature and practice of medicine and the socio-political context of the delivery of medical care. Their responses indicated a perceived mismatch between their view of societal expectations of medicine, and their perceptions of their own ability to deliver that care. They also indicated a mismatch between the complaints system's process and its ability to achieve a desirable outcome for both doctors and complainants.

By focusing specifically on the complaints process, the respondents identified tension between idealised and real-life practice. One idealisation is the theoretical or "best possible" delivery of
medical care which is the standard by which these respondents fear they will be judged in the event of a complaint. They drew attention to notions of “humanness” and fallibility and are aware that even the “best doctors” will inevitably make errors in the practice of medicine. They drew attention to two standards of judgment; the judgment by which a complainant determines that an error has occurred; and judgment they fear will be used when a complaint is assessed. The tension then lies between what is theoretically ideal, and what doctors are capable of delivering. The resolution of this tension lies in a complaints system that is capable of recognising that tension and using appropriate standards of judgment.

The second idealisation relates the standard of care that doctors would like to be able to provide, but which they struggle to achieve because of constraints in the health care system over which they feel that they have no control. Their fear is that these systematic inadequacies expose them to the risk of a complaint because of an inability to deliver not just some idealised notion of how care should be, but a standard of delivered care to which they would aspire.

The results suggest that there is need for attitudinal shift from society towards a better understanding of the limitations of medicine, better definition of the rights and responsibilities of doctors and patients, and a shift away from what is perceived as being a prevailing culture of blame. Aside from rallying calls for “better education of the public”, these respondents did not propose any useful suggestions as to how this could be achieved. There were no useful suggestions as to how the actual incidence of initiating of complaint could be reduced, and the implication from this study is that the only way of dealing with these attitudinal problems is to have an enlightened complaints process capable of appropriately considering the real-life nature of medical practice, the nature of which these respondents are acutely aware.

None of the 453 respondents to this study mentioned the purpose of a complaints system as contributing to the maintenance of professional standards, professional accountability, or the desire to maintain a relationship of trust between the profession and society. Instead, they focused on transforming the complaints process into providing an opportunity for learning from mistakes and errors, providing a mediated forum in which both the doctor and the complainant could be adequately and safely heard, and in creating a process capable of achieving a satisfactory outcome for both parties.

This is an extraordinarily important point. It contrasts directly with the stated purposes of the complaints system as reported in chapter 3. It suggests a collective awareness of the values of professionalism in terms of a relationship with society in which the notion of professional
internal morality is able to be validated and used within a societally imposed complaints process.

Respondents gave very little, if any, support for the complaints process as it stood at the time of this survey. The study suggests that there is significant support within the medical profession for change to that process, and respondents were clear on the attributes of a system that would provide rapid resolution of a complaint using a process that was transparently fair to both parties involved.

It is also clear that these respondents felt that there was little impetus for change from forces external to the profession. The implication of this is that the responsibility for creating change lies within the profession itself. Perhaps the points of “buy in” for change in the process suggested by these respondents and likely being acceptable to society, lie in the opportunity for the complaints process to improve the delivery of health care by focusing on doctors’ education and by identifying problems in health care delivery systems that are amenable to change.

Furthermore, the characteristics of a complaint system as outlined in Table 8 would not only contribute to societal well-being, but could potentially improve the outcome for individual patients whose care has been substandard.
CHAPTER 8.
DEFENSIVE MEDICAL PRACTICE IN NEW ZEALAND.

8.1 INTRODUCTION.

This chapter will report the findings of the postal survey and an interview-based study considering aspects of change in the practice of New Zealand doctors associated with experience of the complaints and disciplinary system. The responses of participants in the questionnaire based study will be reported alongside analysis of interviews with hospital based specialists who have been the subject of a medical complaint. In all cases, these are self reported perceived changes in practice, as it is outside the scope of this study to verify and document actual change in practice.

In addition to the hospital based specialists who participated in the interviews, the written responses in the questionnaire study were provided by vocationally registered general practitioners, general registrants, and hospital based specialists, with analysis that differentiated between those who had ever or never received a complaint.

The results presented in this chapter have yet to be published elsewhere, but have been presented at medical meetings at the Dunedin School of Medicine and at the annual conference of the Association of Salaried Medical Specialists, in 2005.

This chapter aims to develop understanding of what changes (if any) New Zealand doctors perceive that they make either in response to a complaint or to awareness of other doctors' complaints, and to determine whether doctors in different vocational groups change their practice differently; and whether there is evidence of either positive or negative defensive medicine (as discussed in section 1.4.1) being practiced in response to experience or awareness of the complaints process.

Furthermore, if there is evidence of defensive medicine being practiced, this chapter will explore the place of such practice in patient care, and the implications of defensive medical practice for doctors, patients and society.
8.2 Method.

A total of 527 written responses were received from respondents to the questionnaire who had ever received a complaint, in response to the following questions related to changes in practice. 117 were received from general registrants, 259 from general practitioners, and 161 from hospital based specialists. Questions included being asked to specify changes in performance of technical tasks in the short term after receiving a complaint; to continuing to provide the same range of services to patients; and they were also asked to elaborate on any other short term effects that respondents were aware of after receiving a complaint. In the long term, they were asked to specify any changes in consulting; in performance of technical tasks; and in the provision of range of services provided. Participants were also asked to specify any strategies that they believed that they had undertaken in order to reduce the likelihood of another complaint.

The questionnaire based survey sought evidence of any change in practice made by doctors who had never received a complaint. This was done with an open text question asking respondents to specify in what way their day to day practice of medicine had been changed by awareness of other colleagues’ complaint experiences. The notion behind this question was to allow a comparison with the responses of those doctors who had ever received a complaint and felt that their practice had altered in some way.

Twelve interviews were conducted with hospital based specialists, and the transcripts were analysed using line by line inductive analysis as described by Straus and Corbin seeking evidence of defensive medical practice.

Some of the characteristics of these practitioners and features of the complaints that they were involved with are as follows. Particular details that could allow identification of individual respondents have been omitted in order to preserve confidentiality. With particular reference to the surgical sub-specialties, respondents will be identified in this chapter only as a “sub-specialist surgeon”. Sub-specialties represented in the interviews include plastic surgery, urology, orthopaedic surgery, and specialist breast surgery.
Interview Respondent 1.

Paediatrician. Peripheral hospital
This doctor reported the issues around and impact of a complaint to the Office of the Health and Disability Commissioner relating to the care of a baby who died from the effects of extreme prematurity. The complaint centred on the doctor not having saved the child’s life, and the interview included discussing the ramifications of this for both the doctor personally, for the ward staff, and the medical community more generally.

Interview Respondent 2.

Sub-specialist surgeon. Main center and peripheral hospital
This doctor practices as a sub-specialty surgeon in both a major centre and a peripheral hospital setting. His complaint involved both the Office of the Health and Disability Commissioner and the Accident Compensation Corporation, and related to a female patient with a complaint about a plastic surgical procedure. The interview discussed the details of the complaint and its impact on the doctor’s practice. The doctor also discussed a complaint laid with the Medical Council from a patient who had been prosecuted by the ACC for fraud, and was now seeking damages from this doctor who had testified for the prosecution in that fraud case.

Interview Respondent 3.

Sub-specialist surgeon. Main centre.
This respondent discussed three separate complaints made to the Office of the Health and Disability Commissioner which centred around an operation based on an incorrect pathology report, an accusation of inadequate management of the patient with an adverse outcome, and an accusation of an inappropriate internal examination of a female patient. The interview discussed each of these complaints in detail and explored ways in which this respondent’s practice had changed.

Interview Respondent 4.

Sub-specialist surgeon. Main centre.
In this interview a single complaint about wrong side surgery was discussed in detail. The interview considered the particulars of the complaint, aspects of the impact of the complaint on the respondent’s personal life, and aspects of systems change that were highlighted from this complaint. In this interview, aspects of the impact of the complaint on the entire surgical team were discussed.
Interview Respondent 5.

Accident and Emergency specialist. Peripheral hospital.

In this interview two particular complaints were discussed related to delayed diagnosis after a surgical intervention, and a death as an adverse outcome of an overdose. Details of both cases were discussed at length, the impact on the doctor’s life and his experiences of the investigative process and hearings were discussed at length, and changes in practice were detailed. The impact of police and coronial investigations in a small town setting were important issues raised during this interview.

Interview Respondent 6.

Paediatrician. Peripheral hospital.

The major complaints discussed during this interview included issues around the defense of the doctor’s assessment of a sexually abused child, the accusation against the doctor that came from a lawyer who was related to the perpetrator of the offence; a complaint related to a dysfunctional family where other colleagues were not prepared to care for the child patient; and a complex complaint related to the management of a child with an intractable chronic condition in a setting with limited opportunity for obtaining specialised backup opinion. The interview related to the impact of the process on the doctor and on the processes associated with the resolution of the complaints and changes in practice predicated on those complaints.

Interview Respondent 7.

Sub-specialist surgeon. Main centre.

During this interview multiple complaints related to the doctor’s surgical practice were discussed involving the MPDC, the HDC, the ACC, and even being sued in the High Court. Complaints related to post operative scarring; to consenting procedures to post-operative complications; and to adverse outcome. Much of the interview related to the details of those complaints, the impact on the person of the doctor involved, and on the strategies adopted within the practice in response to these complaints. The respondent also described difficulties in relationships with colleagues in a competitive environment, with special reference to the difficulties of obtaining unbiased expert witness evidence.

Interview Respondent 8.

Sub-specialist surgeon. Main centre.

This interview centred on the impact of a single complaint late in the career of the doctor, in which a patient died of a well recognised but unpredictable post-operative complication.
The interview dealt with details associated with the case and the inquiry which was still proceeding at the time of the interview. The interview explored the personal impact of the complaint on the doctor’s life and discussed issues related to relationships with colleagues in the context of the complaint.

**Interview Respondent 9.**

**Obstetrician Gynaecologist. Main centre.**

This doctor had been held to account for post-operative complications and inadequate consenting procedures for a procedure performed by a visiting expert for whom this respondent was providing oversight on behalf of the Medical Council of New Zealand. The complaint went to the Office of the Health and Disability Commissioner, and eventually involved regulatory authorities in the country of origin of the visiting specialist. The interview detailed the case in question and issues around changes in practice and approaches to patients highlighted by and following from the complaints process. The effect of the complaint on the respondent and on colleagues associated with it was discussed.

**Interview Respondent 10.**

**Sub-specialist surgeon. Main centre.**

The main complaint discussed during the interview related to one of alleged inappropriate sexual behaviour that was dismissed. The doctor said that the clearly disturbed complainant presented to the Complaints Committee wearing a see-through dress without underwear, and he thought this prompted dismissal of the complaint. The discussion ranged around the particulars of the doctor’s practice, the demands of decision making in difficult environments and the experiences of other colleagues who have received complaints. The impact of complaints at both a personal and professional level was discussed.

**Interview Respondent 11.**

**General surgeon. Main centre.**

This doctor detailed a case that ended in the High Court and that was only resolved in favour of the doctor when fraudulent activity related to the claim that originated within a major hospital was exposed, and the doctor exonerated. The interview ranged around the profound personal impact the case had had on the doctor, his family, and on his practice.
Interview Respondent 12.

General surgeon. Peripheral hospital.

This respondent doctor had faced extensive inquiry in both the media and from complaints processes involving both the office of the Health and Disability Commissioner and the College of Surgeons. The interview detailed the complexities of a series of complaints related to alleged surgical mismanagement and the impact that had on the doctor’s personal and professional life.

8.3 Results

Thematic analysis revealed evidence of both positive and negative defensive medicine, in both the written questionnaire-based responses, and from the in depth interviews. In both positive and negative defensive medicine, it was possible to identify change in practice that was specific to the particular circumstances or nature of the complaint (“situation specific”), and of changes in practice that were more global in character, which pervaded doctors’ practice generally, and which could be called “non-situation specific”.

Analysis of the responses of doctors who had never had a complaint, in which they detailed their perceived changes in practice due to the influence of the experience of other doctors’ complaints experiences, will be presented separately.

The results section will also present an analysis of the differences in response between the three different vocational groups, and of changes in practice predicated by a complaint or perceived influence of a complaint, that appear to be in the direction of “good practice”.

121
8.3.1 Defensive medical practice in doctors who have ever received a complaint.

Positive defensive medicine, non-situation specific.

This section will use the definition of positive defensive medicine as being practice that is identified by the doctor as being different from their normal mode of practice and which is for the purpose of either reducing the likelihood of receiving a complaint or increasing the doctor’s ability to defend a complaint.

For both the written and interviewed respondents, most positive defensive medicine was non-situation specific. That is, the respondents did not relate their change in practice specifically to the complaint that they had received, but rather referred to changes in their practice of a more global level that they felt would either reduce the likelihood of a complaint or increase their ability to defend one. There was very little difference in the written answers between the short term and long term changes. Some respondents wrote similar answers in both sections, and these results will present both short and long term responses together. The same sub-thematic categories were reported in the responses from both sections.

Five sub-themes with respect to positive defensive medicine, non-situation specific were identified.

Investigations.

Several of the general registrant respondents linked an increased rate of investigation to a perceived reduction in their level of confidence and reduced ability to make decisions:

"I ordered increased investigations, felt less confident."

(General registrant complaint No. 256)

"Felt less confident. Became indecisive. Questioned my diagnosis."

(General registrant complaint No. 022)

Some general practitioners were also aware of their using increased investigations and some of the impact of that.
"I cost too much in investigations ... cover my ass too much."

(General practitioner complaint No.293)

Notions around increased investigations were explored more thoroughly during the interviews with hospital based specialists who had received a complaint. It is clear that doctors are making conscious decisions to order more investigations even though they are aware of the risks and costs associated with this action. This was explained in one interview.

"I think that I actually expose kids to risk more. I'm less willing say in my clinical judgment 'I do not believe it is worth this investigation or that test'. In other words, not only will I spend money – health dollars on testing, but I will also put kids through painful and potentially risky procedures in order to satisfy parental concern."

(Paediatrician, interview)

This respondent further discussed the issue of patient (in this case parental) pressure as it relates to modern practice.

"Now I would tend to acquiesce to parental demands for investigations and tests which I do not believe are necessarily going to add to the management – or help decisions with management. We have clued up parents. We have people who have gone onto the internet, who have read widely. We have people, who have a belief that a particular investigation can rule in or rule out one hundred percent conditions; who are not willing to accept the natural ambiguities and dilemmas and gray zones."

This respondent went on to explain,

"I think that I'm protecting myself from a perception of not having done something, in case things go wrong."

It was clear that this respondent did not see this form of defensive medical practice as being advantageous to either himself or to his patients, but was clearly aware of the utility of such practice in terms of societal pressure for certainty, and as a defense mechanism, should a complaint occur.

Tension between the use of investigations and the way doctors feel that they should practice was also noted:
"I hate to think that I'm doing things that are really unnecessary. I can always remember at Medical School being taught that 90% of the diagnosis is made on the history. So clearly with CT scanning and MRI and ultrasound, that proportion has changed somewhat. In the past, I've probably thought 'Well let's do that and see how we go, if things don't improve come back, we'll talk again about it and maybe go a bit further'. I think now probably there's more of the feeling that let's do the ultrasound and CT scan now and we'll get a few extra blood tests which I don't think are probably necessary and probably won't contribute much, but - you know, you're covering your butt in case you've got one of those unpleasant people that says 'Well I told him the problem and he missed it'."

(General surgeon, interview)

**Referrals and Admissions.**

Increased levels of referral and admission were understandably utilised more by general registrants and general practitioners than the hospital based specialists. There were no written responses from hospital based specialists that alluded to an increased rate of referral to colleagues for second opinions. A representative quote from the written responses from a general practitioner, explained one of the strategies that he felt was likely to reduce the likelihood of another complaint:

"I continue to practice more defensively and continue to admit people to hospital, just in case I get sued. I order far more tests and admit many more people to hospital 'on suspicion'. I refuse to sit on mild cases overnight and so send to hospital many more people."

(General practitioner complaint No. 026)

Asked specifically about the strategies to reduce the likelihood of a complaint in a surgical setting one of the sub-specialist surgeons said:

"I don't think that tandem surgery helps, but I think that tandem opinion has helped a lot. Sometimes when I have a problem patient, I'm increasingly saying 'well listen, I can get you a free internal opinion' and they snap that up."

(Sub-specialty surgeon, interview)

This doctor also went on to talk about the use of referral to defuse a potential complaint:
"I'll see (my colleague's) patients and they'll say 'I didn't like that doctor, I didn't know how to say it, but you're listening to me'. It's just bullshit but you know, they want to be angry with that doctor and the good guy/bad guy. So tandem consultation could allow a differing level of anxiety and communication which is helpful for the patient."

(Sub-specialist surgeon, interview)

**Time and Workload.**

Several respondents commented on their tendency to use more time during consultations and to try to reduce their perceived workload as a strategy for reducing the risk of a complaint. Although not stated by the written respondents, it is reasonable to assume that they may have associated the initial complaint with their having taken insufficient time with the patient and were now seeking to remedy that.

However, one surgeon noted that within a hospital context, the doctor's workload may actually increase because of the need for closer supervision of junior colleagues.

"I've had a couple of cases investigated by the H&DC in which the registrars have perhaps had too much freedom, and they haven't consulted with me enough and consequently the patients have been mismanaged and it's rebounded on me – so, I would certainly watch the registrars more carefully and I think be more punctilious with the way I supervise in outpatients."

(General surgeon, interview)

The pressure of the workplace was also recognised, and one sub-specialist surgeon commented on the pressure of running outpatient clinics with between fifty and a hundred patients being examined for skin cancers and the difficulty of being expected to maintain a 100% accurate diagnosis rate.

Clearly, respondents were aware of tension between the demands of practice to provide medical services for a number of patients within a limited timeframe, but also the dangers of inadequate practice related to that.
Identification of problem patients.

Written responses from all three vocational groups alluded to the necessity to have chaperones present during the consultation and that their practice had changed in that direction. It was clear however, that not all respondents regarded this as being necessarily “good practice” and one of the sub-specialist surgeons drew attention to the difficulty of providing chaperones for every patient in a busy hospital outpatient clinic where there were limited numbers of female nursing staff.

“We often do a skin clinic with one nurse and four doctors putting through something like a hundred patients in a morning, and there is just no way that you can run that sort of efficiency with a nurse present at all times, so I guess quite frequently we’re pushing the boundaries of accepted practice just to deal with the numbers.”

(Sub-specialist surgeon, interview)

Several respondents made mention of trying to identify which patients might complain.

“Increased effort to identify possible complaints and spend increased time addressing any issues.”

(General registrant complaint No. 034)

“More likely to refer ‘likely complainers’ for secondary level of assessment regardless of whether it is objectively justified.”

(General registrant complaint No. 047)

Several of the interviewed respondents were aware of a sense of teamwork at the consulting rooms to try and identify people who might become complainants.

“The receptionists and nurses, when they’re taking the details, will identify or give you a call of any agro there’s been at the front desk – I mean bad interaction when filling in information. You know – the girls might just say ‘watch out’.”

(Sub-specialist surgeon, interview)
Several of the interviewed respondents were aware of changes in their practice associated with reduced trust of patients, consistent with the results published in Chapter 5.

"I mean, I now look at everybody that comes through my door as a potential complainant really which is — you know, an unpleasant way to be, but — I mean, that’s the reality of it because you can’t pick them. I think I’m a reasonably astute judge of character, but you get to the point where you just know that you can’t trust anyone and it means, I think, unfortunately that you perhaps overinvestigate ... you’re aware of the fact that if you miss something you could be on the block again.”

(General surgeon, interview)

Wariness did not just extend to patients, but to colleagues as well.

“(The complaint) has certainly changed some of the professional relationships, that’s for sure. I’m very guarded in my dealings with a lot of people now. (The complaint) was fed from behind the scenes on sort of other issues with which some colleagues have other issues — you know, that was sort of pretty obvious to me.”

(Sub-specialist surgeon, interview)

The results indicate that doctors who have ever been in receipt of a complaint will seek to identify in a non-specific manner, patients about whom they should be increasingly wary. These strategies appear to be based around a sense of adverse relationship with the patient, either personally or noticed by other staff within the practice.

**Documentation and consent processes.**

Respondents in both the written questionnaire and the interviews placed a great deal of emphasis on note keeping and consenting. Many of the written responses simply noted this with phrases such as “keep better notes”, but in the interviews, particulars around note keeping and consent processes were emphasised, especially by those working in interventional specialties. A representative written quotation was:

“I’m very particular – probably obsessive about doctor-patient communications, and try to record all details in my records. Have realised that good records are absolutely vital – you never know what small detail may become terribly important.”

(Hospital based specialist complaint No.246)
Clearly, respondents were aware of the importance of adequate note keeping should they be required to defend their actions. However, one of the interviewees drew attention to the problem that note keeping is unlikely to provide an adequate defense if the diagnosis in question has never been suspected.

"I'm a lot more careful about documentation, although I wasn’t that bad before in that I'll write down very carefully anything I think there is a possibility of. If you know you’re seeing someone and there’s a nagging doubt in the back of your mind that this could be something more serious, you’ll be a lot more careful in that you’ll make better arrangements for follow up and maybe you’ll do some investigation. The problem is I guess, that it can never protect you when you completely miss something – when you’re completely off the ball and you’re missing some early signs of something that’s going to be deadly, and then you’re not going to be as careful about documentation because you haven’t got that level of concern or suspicion in the first place."

(Accident and emergency specialist, interview)

Phone consultations and follow up by phone call were seen as being particularly problematic. Several written responses commented on being more careful with documenting phone consultations and this problem was expanded upon in several interviews. On occasions, these doctors had needed recourse to logs of their phone calls in order to refute complainants’ claims that they had not contacted the complainant to follow up on a particular issue.

"I then instituted a change in my practice. I instituted a phone log where every phone call from a patient was logged and I have to cross off if I’d returned their call. I’ve since given that up, but I maintained that for about five years."

Interviewer: “Did you ever have recourse to use it during those five years?”
Subject: “No.”

(Sub-specialist surgeon, interview)

It is probably testament to the profound impact that a complaint can have, that such a general, non-situation specific change in practice could be instituted and maintained for such a long time before finally being appraised as being useless, and ceased.
Although increased awareness of consenting was mentioned in the written responses, it was in the interviews with the proceduralist hospital based specialists that the profound impact that complaints have with regard to this issue became apparent. Increased awareness of the importance of appropriate consent prior to procedures was a non-situation specific response. That is, these doctors instituted changes in their consenting procedures to all patients, not just those procedures related to the original complaint.

Changes in consenting were not limited to simple documentation. Consenting is clearly linked by proceduralists to communication within the consultation. Respondents were aware of the difficulty that patients have in retaining information given at the time of consultation and sought strategies that would prove in a subsequent investigation, that issues important to that procedure had indeed been raised.

"Well my whole approach since then has been to dictate in my notes the fact that I've given standard brochures to the patient, that I've shown them that and the diagrams, that I've shown them photographs of befores and afters, that I've shown them computer generated images or power-point presentations -- I write down everything that I've shown my patient and discussed. At the end of the consultation with them, I write the complete consultation out -- it's very repetitive but I do it. If there's any, if there's ever any investigation again, I've got a thorough record of exactly what transpired. I find the majority of the patients remember probably not much more than about 20% of what you tell them. And patients will sometimes invent things, or well, misconstrue things, or think that they remember something that perhaps wasn't there. Some people are quite unreliable about what they think they remember."

(Sub-specialty surgeon, interview)

In keeping with the sense of suspicion that some of the respondents alluded to with patients whom they suspected might complain, the same respondent went on to comment that:

"If there's anybody I feel suspicious of, if I feel they're a bit mentally unstable, and we get quite a few in [named specialty] - I send them two copies of my consultation notes, and I ask them to sign one to say that it's a true and accurate record of the consultation and have it returned. I probably have five or six patients a year where I do it."

(Sub-specialty surgeon, interview)

Several of the interviewed respondents commented on dual storage of the consent forms for procedures, so that a record remained in both the hospital notes and in the doctor's consulting
notes. Several of the interventional specialists who commented on the importance of the consent forms, drew attention to ensuring that the consent obtained prior to the procedure was done prior to any pre-anaesthetic medication being administered, and as in the case of the O&G specialist who was in a supervisory role, ensuring that there was no change from the consented procedure.

**Positive defensive medicine, situation specific.**

There were no particular sub-themes that emerged in this analysis, just examples of a where doctor’s practice had changed. The responses elicited probably evidence the degree of impact that the complaint has had, in that they are especially specific to the conditional situation of the complaint. Some examples of these situation specific responses are as follows.

“*Anxiety over minor illness in children, could this be another case of Meningitis?*”

(General registrant complaint No. 066)

“*Greater tendency to check cord gases at delivery than before.*”

(General registrant complaint No. 077)

“*Every patient now gets an x-ray (one hour trip) prior to steroid injections to feet and tendons.*”

(General registrant complaint No. 346)

“*Don’t push labour as hard for a normal delivery. If I’m not happy I’m more likely to perform a caesarian section rather than trying for a vaginal birth.*”

(General registrant complaint No. 020)

In none of the written or interview responses was there any link of situation-specific positive defensive medicine to any educative process. The responses seemed more related to a particular situational condition being perceived as ‘at risk’, with the doctor attempting to accumulate sufficient evidence to provide a future defense as being their strategy for dealing with these situations. In the interview situation it was possible to explore this in more depth.
This response is from a sub-specialist surgeon, in the context of breast implant surgery:

"It’s made me very suspicious of women and the implant situation – very scared to get that sort of thing happening again. I make very careful notes of what I’ve said to the patient each time. I write down their own comments, I haven’t taken to taping the conversations but I know in America a lot of guys do – particularly in California. I’ve developed a little computer programme ... to show them the different sorts of breasts and the different sorts of (operations) that they need. I’m very scrupulous now about showing women who have (a risk of unsatisfactory outcome from breast implant surgery) this information."

**Interviewer:** “In the belief that ... ?”

**Subject:** “If there’s ever any investigation again, I’ve got a through record of exactly what transpired.”

(Sub-specialist surgeon, interview)

Another surgeon involved in breast surgery made reference to the potential complaint risk working with women requesting breast augmentation.

“If we look at a cosmetic patient for breast augmentation surgery I have learnt one, they have a very, very detailed information package sent to them and a detailed consultation with a cosmetically trained breast nurse. Secondly, they have photographs before and after. Thirdly, the breast enlargement patients are all seen by my psychologist ... and I also have my nurses very well attuned to when there’s a problem arising.”

(Sub-specialist surgeon, interview)

In summary, the evidence for situation specific positive defensive medicine suggests that mostly (with the exception of the increased rate of caesarian section), doctors are seeking to document their process of consulting and investigating so as to provide a defense in the event of a complaint.

**Negative defensive medicine.**

The use of the term negative defensive medicine in this section will be consistent with the definition of negative defensive medicine used in Chapter 1. That is, perceived changes in
practice that are related to the withdrawal of some part of that doctor’s practice of medicine such as the doctor removing themselves in part or in whole from an area of practice or from performing particular procedures or seeing particular patients.

The results presented are the self reported perceived changes in practice made by doctors in receipt of a complaint. Some written responses evidence actual withdrawal from practicing in some way, such as leaving a field of practice. It is not possible to tell from the data if there is a significant difference between short and long term responses that evidence negative defensive medicine. However, there is a reversal of emphasis, as compared with positive defensive medicine, with most negative defensive medicine being situation specific rather than the more global non-situation specific responses. This section will present the results of analysis of the written questionnaire data and the interviews, divided into non-situation specific responses and situation specific responses.

Two themes emerged from analysis of non-situation specific responses with regard to negative defensive medicine. These are as follows.

**Non-situation specific strategies of withdrawal from situations of perceived risk.**

Some respondents noted withdrawal from particular situations where they saw themselves as being at increased risk. These included placing limitations on their workload such as ceasing to provide extra clinics and trying to limit the number of patients seen, to not offering phone opinions, and one response from a general registrant as follows:

> “I do not undertake procedures to correct ‘someone else’s created mess’ anymore.”

(General registrant complaint No. 264)

**Non-situation specific strategies of withdrawal of personal effort or commitment to the doctor-patient relationship.**

One of the interview respondents considered aspects of the impact of the complaint on the doctor-patient relationship quite deeply. This doctor made a number of statements during the interview with regard to this that I will summarise as follows:

> “Its (the complaint’s) affect directly, has been to prevent me from getting as close to parents of sick and vulnerable children as I would like to. The very same parents who seem to be
more dependent upon you are much more likely to turn on you when things don’t go well. My experience ... seems to show that the very ones you walk the extra mile for are the ones who are more likely to serve notice on you when things don’t go well. To avoid that, you become more mechanistic, more stuck to protocol, more or less engaging, then you’re also less likely to establish a therapeutic relationship with those parents, and that is the dilemma that I’m continuing to grapple with.”

This respondent went on to comment that, in the context of taking on difficult and complex cases that:

“If I’m not prepared to take those on, those are the very kids where I have skills and abilities and interests and believe I have a significant contribution (to make).”

He also drew attention to the difficulty of the situation of colleagues withdrawing from responsibility for care in complex situations.

“No-one is prepared to make a decision in case something might go wrong; ... it takes a lot, lot longer to come up with a management plan for some of the more difficult cases so that the same condition or the same therapy now takes literally more person hours.”

He commented on the vulnerability of other members of the multi-disciplinary teams such as speech language therapists, occupational therapists, developmental therapists and nurses, noting that the multi-disciplinary assessments and decisions themselves are becoming increasingly defensive in the hospital setting:

“And I think that it makes them less effective because literally there are a limited number of us and we can see fewer people if it takes literally many more person hours in order to come to the same decision. It takes more professionals to see the same number of kids.”

(Paediatrician, interview)

Withdrawing from practice is a non-situation specific response to a complaint or the perceived threat of one discussed by one respondent who was quite clear about the effect that a new complaint could have on him now.

“I’m closer to retirement than starting out. I’m sufficiently advanced that I’m thinking of pulling out of it anyway, if I had any major problem I’d just give up I think.”
This respondent went on to comment:

"I know a number of us have talked along these lines and we feel undervalued now – I mean, there’s a whole lot more issues than just a complaint thing, we’re no longer valued as part of a management team, nobody listens to us, we can take all the flak when things go wrong, and a number of people are certainly thinking ‘Well, what’s the point if I carry on?’, and I do think a significant complaint could well push some people over the edge.”

(Sub-specialist surgeon, interview)

However, one younger sub-specialist surgeon who did not hold some of his colleagues in particularly high regard commented that:

"I sometimes think of giving up, but then I think it will leave the field to those fuckwits and – you know, I am emboldened to continue.”

(Sub-specialist surgeon, interview)

**Situation Specific strategies of withdrawal from fields of practice.**

Analysis of the questionnaire results revealed that many respondents from all three vocational groups reported that they had stopped practicing in particular fields, having had a complaint. The main fields involved were obstetrics, intensive care, and accident and emergency for general registrants; after hours work, rural and urban general practice and obstetrics for the general practitioners; and in terms of fields of practice, from obstetrics for the hospital based specialists.

Strategies of withdrawal from conditions and procedures were perceived to place the respondents at lesser risk of a complaint.

Specific details were provided mostly from the hospital based specialists and general practitioners. Conditions such as working with drug addicted patients, working in psychotherapy, prescribing particular drugs such as amiodarone, performing procedures such as vasectomy, and screening of pre-term infants, were amongst the specifics that were mentioned by these respondents.
Evidence of situation specific negative defensive medicine was also found in the interviews: one sub-specialty surgeon withdrew from operating on young children as a direct result of a complaint; and a paediatrician who had been involved in a complaint about a child who had been sexually abused commented that:

"I stopped seeing children who had been sexually abused over that time, and it left an absolute sour taste in my mouth in relation to continuing to look after children with that issue. I basically haven’t assessed children with those issues since."

(Paediatrician, interview)

The same respondent commented on awareness of the need for provision of ongoing care to patients despite having received a complaint. The same respondent as in the previous quote, but in respect to a different complaint commented that:

"None of my colleagues were prepared to look after this family. There wouldn’t have been another paediatrician in the town, and the child needed a paediatrician. In terms of clinical care, I was quite comfortable with what I was doing clinically."

Interviewer: "If you had the option of unloading the responsibility?"

Subject: "No question."

Interviewer: "Would you have done so?"

Subject: "Oh yeah, without a doubt – and I mean, it wasn’t a thing, a relationship that I enjoyed. I certainly didn’t trust them even though they seemed to trust me, but still needed to complain."

(Paediatrician, interview)

In summary, the results presented in this section demonstrate the emergence of both situation specific and non-situation specific positive and negative defensive medical practice in New Zealand doctors, in response to receiving a complaint. The next section will seek evidence of the impact of awareness of complaints in doctors who have never received one.
8.3.2 Defensive medical practice in doctors who have never had a complaint.

Introduction.

The questionnaire based survey sought evidence of any change in practice made by doctors who had never received a complaint. This was done with an open text question asking respondents to specify in what way their day to day practice of medicine had been changed by awareness of other colleagues’ complaint experiences. The notion behind this question was to allow a comparison with the responses (as reported in section 8.3.1) of those doctors who had ever received a complaint and felt that their practice had altered in some way.

Results.

A total of 135 written responses were received. 65 responses were received from general registrants, 62 responses from general practitioners and 80 responses from hospital based specialists writing in response to the survey question. The themes that emerged from analysis of this data were similar to those who had ever had a complaint, with emphasis on note-keeping predicated on the recognition of problem patients, and of potential areas of difficulty such as consent, side effects and possible bad outcomes.

Respondents who had never had a complaint demonstrated awareness of the potential for receiving a complaint. This group of doctors had tried to consider how a complaint could come about, and how they might protect themselves from that happening and/or defend themselves if required.

There was little difference between the strategies employed by the different vocational groups in this section, with evidence of both positive and negative defensive medicine in both situation specific and non-situation specific circumstances. General practitioners and general registrants alluded to an increased rate of early referral to specialists or admission rates to hospital, whereas examples of positive defensive medicine given by hospital based specialists tended to be more situation specific related to increased rates of investigation, despite recognition that such practice may not lead to more effective delivery of patient care. All groups gave examples of negative defensive medicine with withdrawal from fields of practice or from specific patients or procedures.
Examples of positive defensive medicine (both situation specific and non-situation specific)

Three main sub-thematic categories emerged from analysis of data in this section. They were related to note-keeping; to investigation and referral; and to the recognition of problem patients and situations:

Note keeping.

Respondents demonstrated awareness of keeping excessively detailed notes, and were aware of problematic areas in their practice, and of potential complainants:

"I document a lot more – this distracts me from direct patient care."

(Hospital based specialist no complaint No. 099)

"I am careful of my documentation – detailed and accurate but no long lists of differentials that have not been mentioned to patient and family."

(Hospital-based specialist no complaint No. 293)

"More likely to document given warnings, i.e. side effects to patients."

(General practitioner no complaint No.126)

"Documenting options presented to patients but which they refused at the time."

(General practitioner no complaint No.224)

"Communications and records being more explicit and often more detailed, e.g. warning about possibility of scarring with liquid nitrogen application."

(General practitioner no complaint No.240)

"I write even more notes than usual. I write more fully about the absence of symptoms and signs as well as positive findings. I document every contact/relevant event to an obsession level."

(General practitioner no complaint No.320)

Several respondents demonstrated awareness of the role of documentation in their defence, should they be involved in a complaint:
“Ensure my records are as detailed as possible in case of litigation.”

(General practitioner no complaint No.337)

“Very careful what I write to families regarding their children as colleagues have been complained about to the Medical Council by families taking exception to something that was written.”

(General registrant no complaint No.099)

“Meticulous note-taking, over inclusive dotting I’s and crossing t’s to protect against possible complaint.”

(General registrant no complaint No.312)

Referral and investigation.

Respondents indicated awareness of their investigation and referral patterns associated with the perceived risk of a complaint, and of the costs associated with their behaviour:

“Generally I practice defensively, e.g. use of investigations to decrease the possibility of litigation later, rather than because of a specific clinical indication. It makes the process much more expensive, and not necessarily more effective.”

(Hospital-based specialist no complaint No.283)

“I over-refer. I over-investigate and as a result I’m more expensive. I leave less and less to chance and accept less and less uncertainty as time goes by, even though I’m a better doctor and more experienced than ten year’s ago.”

(General practitioner no complaint No.168)

“In excess of fifty percent of special investigations ordered, the test is ordered simply to cover one’s self in terms of medico-legal issues. Also increased number of referrals simply on a medico-legal basis.”

(General registrant no complaint No.082)
Pressure from patients was seen as important:

"I order more tests – I will often agree to tests or treatments if patients are demanding although medically I feel these are not justified. I refer earlier."

(General practitioner no complaint No.320)

"I will sometimes admit a child without good medical reason because I feel under serious pressure from parents. I watch my consultants and feel they practice very defensive medicine."

(General registrant no complaint No.040)

"Undertake investigations and some treatments that I feel are not required in the circumstances, depending on attitude/aggression of patient."

(General registrant no complaint No.158)

One respondent commented on receiving requests for investigations that were seen as being for defensive reasons:

"There is a 'cover your ass' mentality to the practice of medicine now. Investigations are performed more to cover the doctor than to benefit the patient. I'm a radiologist on the receiving end of an enormous number of unnecessary 'cya' requests for tests."

(General registrant no complaint No.223)

**Recognition of problem patients or situations.**

Respondents indicated their awareness of making an evaluation of the risk that they associated with particular conditions or patients in response to the complaints experience of other colleagues:

"Increased awareness about how easy it can be to find fault. More cautious about interactions with patients, need for escorts, witnesses and documentation for everything discussed. Less willing to provide assistance in cases where I cannot justify/prove experience (following experience of colleagues who have had to prove adequate experience with relation to particular cases)."

(Hospital based specialist no complaint No. 084)
"Lower threshold for caesarian section."
(Hospital based specialist no complaint No.228)

"Specifically, close proximity to mothers whilst examining their baby's ears has potential problems."
(Hospital based specialist no complaint No.276)

"Care with patients who appear to be anti-doctor, aggressive or sixth sense says they may complain – on occasions document concerns 'legally', i.e. events signed by a witness."
(Hospital based specialist no complaint No.328)

"I try to identify the small group of adults who fall into the 'difficult' patient with an increased propensity to complain."
(Hospital based specialist no complaint No.354)

"I have a lower threshold for suggesting that some patients transfer to another doctor's care."
(General practitioner no complaint No.057)

"I'm cautious when I meet a patient I think could be a trouble maker (e.g. expresses dissatisfaction with other doctors)."
(General practitioner no complaint No.346)

"I'm very conscious when dealing with irritated patients of the risk of being complained against."
(General registrant no complaint No.040)

"Photograph eye before laser to prove the previous lasering was not by myself."
(General registrant no complaint No.175)

Negative defensive medicine.

Respondents provided few examples of negative defensive medicine. Non-situation specific response examples included avoiding innovative or unfashionable treatments and avoiding assisting colleagues if that assistance appeared to involve personal risk. Situation specific
responses of negative defensive medical behaviour indicated awareness of examples of complaints experienced by colleagues. Examples of both forms of negative defensive medicine are as follows.

"Felt free to resume the use of epidural steroids after a colleague's hearing."
(Hospital based specialist no complaint No.039)

"Refusing to allow video tapes at ultrasound scans."
(Hospital based specialist no complaint No.067)

"More reluctant to carry a load I cannot manage properly."
(Hospital based specialist no complaint No.357)

"Less willing to look after people and to take risk."
(General practitioner no complaint No.010)

In summary, respondents indicated awareness of the experience of other doctors who had received a complaint, and gave examples of how they might try to predict risk. They also indicated awareness of processes by which they might defend themselves should a complaint arise. These terms - predict and defend, -summarise the first, basic approach to responding to the threat of litigation.

There was no comment from these respondents about the influence of outcome of care on how a complaint might arise, and only the general practitioners provided responses suggesting significant awareness of the doctor-patient relationship as possibly being important in this process. Although the experience of a complaint may have been discussed with one or two colleagues, there was little evidence from these responses of a systematic or coordinated approach from the profession in terms of education about the complaints process and how to appropriately manage risk.
8.3.3 Evidence of change in practice in the direction of “good practice”.

Introduction.

This section will present evidence from both the written questionnaire responses and from the interviews of doctors who have ever had a complaint, of changes in practice that are in the direction of “good practice”. Good practice is practice that could reasonably be expected to have an improved outcome for patient care either at an individual or societal level. For those doctors, it would represent a useful change from the practice that they would consider to be normal. There is an element of subjectivity in this analysis. “Good practice” will change over time, as the belief systems of the profession and society as to how medicine should be practiced and delivered change. However, it is clear from the results in the preceding sections that many of the respondents did not value changes in their practice such as increased note-keeping, increased rates of investigation and referral and so on, as being advantageous to patient care.

Results.

From the written questionnaire responses to questions related to changes in practice, some of the following examples of changes towards good practice emerged:

“Ensure I’m contacted in deterioration of patient’s health.”
(General registrant complaint No.066)

“A change in my consultation practice to make sure that all patients were asked whether they were satisfied with the advice or treatment proposed.”
(General registrant complaint No.222)

“Knowing my limitations.”
(General registrant complaint No.292)

“More communication with family members if a suicidal patient goes home.”
(General registrant complaint No.356)

“Within time constraints, try and spend more time with ‘difficult’ patient.”
(General registrant complaint No.034)
"When under pressure I take care not to panic and consult too speedily."

(General practitioner complaint No.315)

These results indicate that some of the respondents have recognised the importance of the doctor-patient relationship in the practice of medicine. They suggest a shift in practice towards placing more emphasis on that relationship, and this is consistent with good practice within the broad notions of patient centred clinical method 67.

Many respondents commented on the increased use of chaperones. In my opinion, this could be seen not just from a defensive viewpoint but as genuinely good practice.

There was not a single written response that alluded to the increased use of continuing medical education to remedy some perceived deficiency in their practice of medicine. However, there were two responses from the interviews that suggested that the complaints that they had experienced were either instrumental in the instigation of systems change, or reinforced the need for systems change that was already underway. These examples are as follows.

For one sub-specialist surgeon who had operated on a patient on the basis of incorrect pathological diagnosis of a biopsy specimen, systems change in terms of communication and the relationship between pathologists and surgeons was instigated by the complaint.

"The case enforced a closer relationship with one's pathology colleagues, as if there is any doubt at all you go back and have another talk. You ask them to review the case once again, wouldn't hesitate to get a further opinion - so in that respect it's made it a little bit more robust in terms of sharing decision making."

This respondent went on to say:

"We have weekly discussions, path meetings, so we share cases between ourselves - bring up cases for discussion, so whilst the patient may not be aware of it, in many cases there is in fact a consensus of management. That, I think, has been a very good outcome. It has encouraged us to talk amongst each other."

(Sub-specialist surgeon, interview)

For another sub-specialist surgeon who was involved in wrong side surgery, that complaint led to the development of a proposal for a change in operating room practice that they called "time out".
"What happens is that just before we start the surgery we make a final check. The anaesthetist, the circulating nurse, myself go through, check, make sure that everything is as it should be, including the images on the screen which are sometimes a problem.”

(Sub-specialist surgeon, interview)

This respondent clearly considered this change in practice to be in the direction of “good practice”, and at the time of conducting the interview, that doctor was proposing to take it to his relevant surgical association for introduction as standard practice. However, the same proposal had already been developed overseas, and because the problem of wrong side surgery is so important and members of that sub-specialty are so aware of it, it is possible that these changes may have been instigated even if that doctor’s complaint had never occurred.

The results suggest that receipt of a complaint has caused respondents in this study to pause and reflect on their practice. For some respondents, part of the outcome of the complaint and its process has been positive. Awareness of the importance of the doctor-patient relationship has been heightened, and in some instances the complaint has highlighted issues around systems of delivery of care that have been subsequently addressed. These changes in practice were instigated by the practitioners themselves and were not changes imposed on them by any regulatory body. The inference is that doctors are capable of considering their practice and at times, making changes in a positive direction. The question to be considered is whether the current medical complaints and disciplinary process has encouraged an appropriate balance between defensive medicine and changes in the direction of good practice, and whether another mechanism could prompt the same response without initiating negative responses. This will be discussed in section 8.4.

8.4 Discussion.

Defensive medical practice as an outcome of the complaints and disciplinary process.

One of the underlying notions of the purpose of the complaints and disciplinary process in New Zealand is that it should lead to improved delivery of healthcare for both individuals and society. In this chapter I have presented the results of data collected from doctors who have both ever and never received a complaint and have shown that, at least in their own opinion, many New Zealand doctors have altered the way they practice as an outcome of having had a complaint, or of being aware of complaints against other doctors.
Although the changes are self reported, it is reasonable to assume simply from the number of responses, that there is more than a modicum of truth in what these respondents are reporting. In my opinion, measuring actual change in practice would require a different study methodology to verify shifts in the way that doctors function, and such methodology is clearly outside the scope of this particular study. It is reasonable though, to assume that the respondents in both the written and interview settings did give some consideration to their replies, and do genuinely believe that what they have reported is factual.

Accepting that change in practice has actually occurred, this discussion will consider the results from four different perspectives. These relate to whether practice is changed or improved by a complaint; whether complaints lead to defensive medical practice; whether that defensive medical practice appears to improve the delivery of healthcare; and finally whether defensive medicine is an appropriate or acceptable form of practice.

**Do complaints or the awareness of complaints change or improve doctors’ practice of medicine in a positive direction?**

There is no doubt from the results of this study that complaints have the potential to change medical practice. Although specific instances of complaint may not lead to any change in practice, this has been after close consideration of the circumstances of a complaint, where the moment-to-moment practice of medicine has been scrutinised and found to be at least appropriate, if not exemplary. Several of the interviewed subjects commented on instances of complaint, usually predicated on an adverse outcome of care, where they made no change to their practice because no change in practice was indicated. However, for many doctors, a complaint at the very least instigates a reflective process, and this may well lead to a change in practice.

The results presented in this chapter suggest that there is certainly potential for complaints to improve practice in three areas. The first, exemplified by the increased use of chaperones, is where there has been a shift in both societal expectation and accepted medical practice towards a particular way of practicing that is, by standards of reasonableness, something that the practitioner should be doing. Given that standards of acceptable behaviour will continue to evolve as society changes, the complaints process at least reinforces the need for doctors to keep abreast of such change and to behave accordingly.
Many respondents commented on changes that they were aware that they had made in terms of the relationship that they had with patients, especially where they thought that those patients were “difficult” or where they perceived that a patient may become a complainant. Several respondents commented on this increased awareness of the doctor-patient relationship in a favourable light. This should be seen as a positive outcome of the complaints process even though the complaints process is not necessarily the most appropriate vehicle by which to affect such change.

The third and probably best outcome of complaint-driven improvement in practice came from examples of changes to health care delivery systems where a complaint had highlighted a deficiency in the system and where steps were able to be instituted to modify that deficiency. The proposal given by one interview respondent for “time out” immediately prior to commencing surgery in order to reduce sources of systems error, was particularly useful, as were the changes to minimise laboratory reporting errors that could then have an adverse outcome for patients in terms of subsequent decision making influencing inappropriate surgical interventions.

My contention is that complaints have the potential at least, to highlight systemic deficiencies and to at least encourage systems modification. The question is whether systems change should be reliant on the complaints process for its initiation, or whether systems monitoring is a professional responsibility that should be continually undertaken by individual practitioners, healthcare delivery institutions, and professional and regulatory organisations. There is good evidence from these results that positive outcomes are possible from the complaints process in terms of the delivery of healthcare, but the challenge is to balance positive outcomes with any offsetting negatives.

Do complaints lead to the practice of positive or negative defensive medicine?

These results indicate that New Zealand doctors practice both positive and negative defensive medicine in response to a complaint. With respect to positive defensive medicine, the results suggest that the perceived purpose of such practice is to provide a form of defence in the event of receiving a complaint. This is a very important notion. When the word defence is used in other contexts, such as defensive driving or having a defensive strategy in a game of rugby or basketball, the purpose is to reduce the risk of an adverse outcome – a car accident or the opposition scoring a goal in a sporting event. This use of the word “defense” is very different from the use of the term “defensive medicine”. Defensive medicine is (in the sense of positive
defensive medicine) aimed not at improving the outcome for the delivery of healthcare to patients or society, but to provide the practitioner with a legal or quasi-legal defence to a complaint or the perceived threat of a complaint.

Many respondents acknowledged the risk to patients of practicing positive defensive medicine without any tangible benefit to that patient or to society in general. Respondents were aware of the material and financial cost of practicing defensively, and the increased burden that defensive medicine places on the healthcare system. Respondents were aware of the cost of investigations, of referrals and of an increased rate of admission from primary to secondary care facilities. Many respondents were clear that this behaviour was not designed to improve an outcome for the patient, but to provide a defence for themselves should there be a complaint.

Particularly with regard to defensive medical note-keeping, many respondents commented on and acknowledged the futility of such practice. The results indicate that some interventional specialists are prepared to go to extreme lengths to document explanations and decision making, and to “over consent” patients prior to a procedure. This behaviour is an acknowledgement that having a good doctor-patient relationship may reduce the likelihood of a complaint, and that many doctors are aware of the underlying principles of patient centred clinical method. They are seeking to communicate as effectively as possible, with their patients. However, the preoccupation of these doctors is not so much with enhancing the doctor-patient relationship, but in making sure that they document their efforts in this regard, as documentation is their only defence in the event of a complaint.

This behaviour relates to the relationship between law and medicine. These results suggest that it is the process of defending a complaint (or at least doctors’ perception of that process) that is driving these forms of positive defensive behaviour. That is, the complaints and disciplinary system itself is asking for evidence of particular behaviours – note-keeping, consenting, and evidence of “good” biomedical practice that is driving these behaviours over and above what is actually required for the patients’ and society’s benefit.

If, as these respondents suggest, positive defensive medicine has no tangible benefit for patient care, then there must be a particularly powerful driver of that behaviour. Much of New Zealand medical practice is carried out in an environment where there is little if any financial reward to the doctor for doing investigations or referrals and so on. The notion of “kick-back” is deemed ethically and morally repugnant in this country. The majority of respondents in this study were
New Zealand trained and it is reasonable to assume that the major driver of defensive practice was a desire to provide evidence that could defend these doctors in the event of a complaint.

Negative defensive medicine is also evidenced in the results of this study. It is clear that respondent doctors see themselves as having withdrawn from areas of practice or from patients with specific conditions, and this has important implications for both healthcare institutions in terms of the provision of an adequate workforce, and for communities in terms of the provision of primary healthcare services. The research presented in this thesis leads to the conclusion that negative defensive medical practice is a reflection of the severity of the impact of complaints on the person of the doctor, consistent with a shaming response in which the shamed person seeks to withdraw, hide or in some other way evade a situation in which they see themselves as vulnerable to being exposed to another complaint.

From a societal viewpoint, negative defensive medicine may be even more sinister than positive defensive medicine. At the time of writing, medicine faces a global shortage of doctors, and New Zealand is vulnerable to the loss of its graduates for many different reasons including financial incentives and lifestyle opportunities. Adding to those pressures by using a complaints and disciplinary process which is causing some doctors to withdraw from practice may not be in this country’s best interest.

**Does defensive medicine improve patient care or the outcome of healthcare delivery to society?**

This study finds no evidence of defensive medical practice as a strategy to improve the outcome of healthcare delivery to either patients or society. To the contrary, it provides evidence that New Zealand doctors believe that positive defensive medicine carries with it increased personal risk to the health of the patient and increased monetary cost to the healthcare system. It places an added burden on limited resources. The impact of negative medicine is the withdrawal of personnel and services with the potential to further diminish the delivery of healthcare to communities and society.
Is defensive medicine "good practice"?

The answer to this question is more complicated than the preceding discussion might suggest. It is clear from the evidence presented so far, that defensive medical practice is different from good practice. It involves changes in practice that are over and above those that would normally be appropriate for good patient care. However, two issues arise. The first is whether it is "good" to practice in a way that provides a defence in a legal sense, should a complaint arise. From an ethical and moral viewpoint, because such practice clearly places patients and the healthcare system at risk, the answer would appear to be an emphatic "no". However, the persistence of the current complaints system, and increasing use of the system (as evidenced by the climbing rate of complaint) suggests that New Zealand society considers that this is the direction in which medical practice should proceed. My contention is that this state of affairs should be appropriately challenged, perhaps raising societal awareness of the incidence and impact of this practice.

The second issue is about the recognition of defensive medical practice. If change in practice, especially with regard to investigations and referrals is not recognised as being defensive by those who are practicing it, defensive medicine risks becoming normalised into mainstream medical culture and practice. Particularly within large institutions, if particular patterns of investigation arise initially in response to the practitioner's desire to protect themselves from future complaints, but this is not recognised and is observed and mimicked by junior and trainee doctors, then these medical behaviours risk becoming normalised within a short period of time. Entrenched behaviour then becomes very difficult to change. This thesis has commented on the limitations of evidence based medicine, and even if particular practices are recognised as being problematic, it may take a great deal of time before sufficient evidence is accumulated to show that those practices are not of value or are indeed dangerous. Bad practice once entrenched is very difficult to remove.

In summary, the results presented in this chapter provide evidence of the practice of both positive and negative defensive medicine in response to a complaint by doctors who have ever or never received one. There is evidence of positive outcome of the complaints process, particularly with respect to systems change, but these positive benefits may be outweighed by the negative impact of the adoption of defensive medicine.
CHAPTER 9.

DISCUSSION.

9.1 Introduction.

One of the purposes of research of this nature is to inform discussion about the complaints process in general, and to contribute meaningfully to proposals for change. This chapter will be presented in three parts. It will summarise the key findings of the research presented in this thesis; it will discuss the implications of these findings for the three issues that were presented in section 1.5 regarding the epistemology of medicine, the place of the person of the doctor and the doctor-patient relationship in the practice of medicine, and of these findings in relation to issues around professionalism; and it will present suggestions for change to the complaints process in New Zealand.

These ideas provide a platform for discussion around the complaints process and proposals for change need to be appropriately informed. To be informed, discussion needs to be backed by reliable data that is valid for the population of New Zealand doctors, and that is consistent with the values and beliefs held by those doctors. To that end, the findings contributing to that discussion need to be generalisable or transferable as is appropriate. In order for the findings to be understood from outside the medical profession, the data need to be generalisable, and it must inform society about the incidence and impact of complaints in a way that can be readily understood. Returning to the "therapeutics" analogy, a therapeutic agent, be it a drug or a surgical intervention or other maneuver or intervention, should have a definable purpose or role and a measurable outcome. The complaints process could be seen as a therapeutic intervention used by society on the population of doctors in order to improve medical practice and improve the health care of the population.

So, in order to address this issue, research findings need to be generalisable in the sense that they can be understood by society. In order to have validity within the medical profession, transferable findings related to doctors’ own experiences needs to be presented so that even if doctors have not experienced a complaint themselves, they can relate to the experience of those who have. In order to inform discussion and change, both generalisable and transferable information is required to link both societal and professional needs. To return to the therapeutics analogy, both society and the profession’s decision to engage in the complaints process should be based not only on their understanding of the rationale behind its use, but also
on their understanding of how that process will impact on them in both a wider (professional) and personal sense.

The following section will summarise the key findings and implications that have been presented in this thesis.

9.2 Summary of findings.

With regard to the demographics of complaints in New Zealand it is clear that there is a high incidence of complaint. These results present a “snapshot in time”, and it is noteworthy that the rate of complaint of 5.7% percent per annum is significantly higher than the highest reported litigation rate from the American literature. Although the incidence of complaint on average across all doctor types is about 34%, the annual rate of complaint suggests that about one in every seventeen doctors will receive a complaint each year if they remain in practice.

This study suggests that those at higher risk of complaint are general practitioners, male doctors and doctors with higher post-graduate qualifications. The findings suggest that it is the doctor being of an age and experience that is important rather than the process of aging and practicing. The implication of this finding is that it is the more experienced doctors who carry the burden of responsibility for patient care and are thereby more vulnerable to receiving a complaint. The implication of this finding is that the very doctors, on whom our health care system depends most for the delivery of high quality care, are most at risk of receiving a complaint.

Furthermore, it is clear that increased levels of training and specialisation may not protect against receiving a complaint.

Error in the practice of medicine was perceived by these respondents as important in the genesis of a complaint. This has implications for the promotion of defensive medical practice, and if this finding is generalisable to New Zealand society, then it suggests a complaint culture driven by apportioning blame that is predicated on outcome. The corollary of this finding is that the value of the doctor-patient relationship may be diminished, and doctors may seek to practice in ways that places less value on the whole of the patient, and more value on the diagnosis and treatment of simply the disease with which they are presented.

The long time frame for the resolution of complaints has implications for both doctors and patients. If the complaints process is the only way that patients with adverse outcomes of care can have their situation improved, then these patients may be significantly disadvantaged by
this process. The notion that "justice delayed is justice denied", is applicable to doctors in receipt of a complaint, and is also applicable to patients whose standard of care has been poor and who have suffered as a result of this. My concern from a patient’s perspective is that the complaints process may be an inappropriate vehicle for the delivery of restorative or rehabilitative medical care that could actually improve an individual patient’s lot.

Further to my analogy of the complaints process being a “therapeutic intervention” made by society on the medical profession, it is clear from the results of these studies that there is a significant impact of complaints on doctors both individually and as a group. Despite practicing in different fields, the study found no evidence of different responses between different vocational groups. At an individual level, there may be a full spectrum of response and this finding has particular implication for the process of change in the complaints process at a practical level. Suggestions for change must not be biased by either preconceived or stereotypical notions of how doctors practicing in different specialties might respond, or by particular individuals whose experience and understanding of the complaints process may lie at one or other end of the spectrum.

These results confirm that findings of anger, depression, shame, and experiencing loss of joy of practice in the immediate time period after receiving a complaint are generalisable to the population of New Zealand doctors. The finding of persisting negative emotional responses in the long term after receiving a complaint suggests that some doctors may be deeply hurt by the experience. The finding of reduced trust and sense of goodwill towards patients in the long term suggests that important components of the doctor-patient relationship may be significantly damaged, and that care of patients who have had no role to play what-so-ever in the complaint, but present to that doctor some time later, may have their care adversely affected. It is also clear that doctors’ ability to practice in the immediate post complaint period can be significantly negatively affected, and this has important implications for support of that doctor that may extend to needing to have protected time away from work.

Within the limitations of the self reported nature of the results, the study finds no evidence of the complaints process being a useful therapeutic intervention in the delivery of health care. If the complaints process was an intervention such as a drug or an operative procedure that was seeking approval from an appropriate licensing body, it is most unlikely that it would be granted such approval on the basis of any improved therapeutic outcome. If so, then the continued use of the complaints process in New Zealand as a therapeutic intervention by society needs to be openly questioned, and opportunities for improving this outcome sought.
This study sought evidence, both generalisable and transferable, about doctors’ attitudes towards the complaints and disciplinary process. The purpose of a complaints system was defined by influential and leading policy makers from within the profession as including the maintenance of trust between society and the profession, acting as a voice for patients and meeting specific patient needs which included the maintenance of safety and boundaries and seeking compensation, providing an opportunity for reconciliation and closure, and maintaining appropriate standards of professional practice.

At a grassroots level however, the results of this study suggest that New Zealand doctors are more focused on using the complaints process as an opportunity for learning from mistakes and errors, providing a mediated forum in which both the patient and complainant can be heard, and in achieving a satisfactory outcome for both parties. A complaints process that focuses on the educational and rehabilitative issues around the complaint and which does so in an environment that is acceptable to both doctors and complainants will inevitably meet the more elevated purpose of maintaining an appropriate professional relationship between society and the profession.

The results find that New Zealand doctors strongly support society’s right to complain and to take an active part in the complaints process. Doctors hold to the structural-function notions of professionalism associated with self regulation and determination of what constitutes appropriate professional behaviour. Less internally consistent were doctors’ beliefs about the values that society might hold about the complaints process. They do not believe that complaints are necessarily a useful tool to improve medical practice or that complainants are actually motivated to reduce the risk of adverse events happening to someone else. In terms of the complaints process itself, the results suggest considerable disquiet with notions around whether complaints are warranted, whether the person of the complainant (as the vehicle of entry into the complaints process) is appropriate in the instigation of a complaint, and whether doctors are judged by appropriate standards. Persistence of such disquiet has potential to damage the relationship between the profession and society if it continues. The implication of these findings is that at a nuts-and-bolts level any change to the complaints process should address these issues by introducing processes that are acceptable to both doctors and society.

The study found evidence of both positive and negative defensive medicine being practiced in response to a complaint or to the perceived threat of one. Although the study does suggest the potential for the complaints process to highlight deficiencies in the delivery of health care at a
systemic level, these positive gains are probably outweighed by the cost of defensive medical practice. While excessive note keeping and obsessive consenting procedures and documentation are wasteful of time and effort, the use of inappropriate investigations and referrals is recognised by the study’s participants as being potentially dangerous for patients and wasteful of scarce health care dollars. Negative defensive medicine in response to a complaint has the potential to deplete the country of valuable medical manpower, and deny patients access to care especially in smaller centres where most doctors’ practice is likely to be more “generalist” and less “specialist”.

The most dangerous implication of defensive medicine may be that the adoption of practice that originates as defensive is not recognised as such, and becomes incorporated into mainstream practice by stealth. Untested, such practice may then become the standard against which complaints about other doctors’ practice may be judged. Such a cycle is contrary to the principles of medical professionalism.

The study’s respondents demonstrated considerable insight into the nature of medical practice in a contemporary New Zealand setting. They were aware of the complexity of practice and the fallibility of doctors, of a mismatch between societal expectations of care and their own ability to deliver that, of issues around the rights of doctors that appear to be overlooked in the current legislation, and they demonstrated awareness of the importance of the doctor-patient relationship and what they bring to that relationship in their day to day work.

Respondents were clear and articulate in their views about the current complaints system and of the required characteristics of a new system. These characteristics have been summarised in Table 10 Chapter 7, and a vast majority of respondents called for these characteristics to be found within a system based on a single point of entry. Despite the introduction of the Health Practitioner’s Competence Assurance Act that post dates these results, multiple pathways of complaint remain and the issue of single point of entry remains one of the critical notions of complaints reform.

9.3 The nature of medical practice – epistemology, relationship and professionalism.

In section 1.5, I introduced the idea of using research into the complaints process to examine the nature of medical practice from three different viewpoints. These were about the epistemology of modern western medicine, the self of the doctor in the doctor-patient relationship and around
the notion of professionalism. In this section I will address the questions posed in relation to these topics and consider their implications for change in the complaints system.

The results presented in this thesis indicate that New Zealand doctors demonstrate considerable understanding of the epistemology of medical practice, demonstrating awareness of the limitations and use of both the biomedical and bio psychosocial paradigms. They are acutely aware of both the advantages and disadvantages of the biomedical model, especially with regard to both their own and the health system’s ability to deliver patient care.

The results suggest that many doctors believe that complaints are predicated on an adverse outcome of care as determined by a biomedical model, but doctors themselves consider care in a context based manner. This is much more consistent with the model of patient centred clinical method described by Weston and Brown 56, and it is clear that a complaints system that is acceptable to doctors needs to be cognisant of this contextual component of care. This idea links to Tillich’s 58 notion of polarities, especially the polarity that lies between actuality and potentiality. Awareness of the context in which medical care is delivered allows an assessment of the actuality of medical practice, and allows a doctor’s actions to be judged by real world standards that are consistent with the experienced reality of that doctor and colleagues in similar circumstances. Awareness of the importance of the context of care was demonstrated by doctors in all three professional groups surveyed.

This study did not find any evidence of a shift in the currently understood biomedical and bio psychosocial paradigms. The findings suggest that the doctors surveyed were all working within those paradigms and there was no suggestion that any other paradigm is needed or is appropriate in order to understand and possibly improve the complaints process. However, the findings highlight that doctors perceive the complaints process as focusing on purely biomedical aspects of care and being less cognisant of the psychosocial and contextual issues that are espoused in the model of patient-centred clinical method.

My interpretation of these findings is that most doctors have an up-to-date and appropriate understanding of the epistemology of western medicine, but that New Zealand society in general and the complaints process in particular, may still be bound by the biomedical approach. The implication for any proposed change to the complaints process is that society is likely to continue to use the biomedical approach to determine whether a complaint should be laid, especially in situations where there has been an adverse outcome. Consideration of the wider psycho-social and contextual aspects of care will be the responsibility of the complaints
process, and such consideration is essential if the process is to meet doctors’ expectations of receiving fair and reasonable consideration and appropriate judgment in relation to a complaint. It is unlikely that doctors will continue to accept standards of judgment based purely on a biomedical epistemology.

The results presented in this thesis confirm the legitimacy of the notion of the self of the doctor and of the place of the doctor-patient relationship in medical practice. Although none of the research was designed to test differences in the actual outcome of care for doctors who had ever or never received a complaint, the research confirms that there is significant impact of a complaint on the process of delivering that care. This study provides generalisable data about the impact of complaints on the self of the doctor and the doctor-patient relationship in a New Zealand context, and it confirms previous qualitative (transferable) research findings. Furthermore, the impact of a complaint can be seen to be similar across doctors practicing in many different disciplines and this finding should have the effect of creating a sense of unity amongst the medical profession. Much of the data presented in chapter seven relates to doctors’ own perceptions of who they are and how the relate to both their patients and to the health care system. In this sense, awareness of complaints has perhaps catalysed doctors’ abilities to consider their own sense of self and what aspects of themselves they take into each patient encounter.

Much of the anthropological literature \(^5\), the medical literature \(^7\), and to an extent, my own previous work \(^1\) has developed these notions of the self of the doctor and the doctor-patient relationship from in-depth study of small groups of doctors or of personal experiences built up over a significant time period. This research presents quantitative data from a population of doctors practicing in one country. It confirms the sense of universal humanity of doctors (at least practicing in a western medical paradigm), and this notion relates to both the issue of the epistemology of medicine and to professionalism by confirming humanity and human-ness of doctors as being central to the delivery of good quality patient care.

Particularly with reference to the link to epistemology, this research confirms that (at least in the view of practicing doctors) the biomedical paradigm alone is insufficient to provide good quality patient care, that the bio psychosocial paradigm is an improvement but is incomplete, and that the bio psychosocial paradigm requires the inclusion of concepts of patient centred method which account for the person of the doctor and the doctor-patient relationship, in order to achieve a better understanding of how the process of healing occurs.
Viewed from the perspective of a perceived or actual threat to the self or person of the doctor, this research demonstrates the emergence of defensive medical practice in both its positive and negative forms. Defensive medical practice is not about providing improved patient care. It is about the protection of the self of the doctor from perceived or actual threat. If the self of the doctor was not integral to the delivery of medical care, the problem of defensive medical practice would not arise. The finding of this research that defensive medicine does emerge in response to either a complaint or the perceived threat of a complaint, confirms the centrality of the notion of the person of the doctor in medical care. Not only are these findings important in their own right, but they suggest that any changes proposed to a complaints or disciplinary process that do not account for an impact on the person of the doctor involved, are likely to be ineffective and perpetuate or encourage defensive medical practice to the detriment of both individual patients and society as a whole.

In section 1.5 I raised the question as to whether the complaints system was an important component of the relationship between the medical profession and New Zealand society, and whether that system is serving that relationship appropriately. Using both the structural-function and values based ways of considering of professionalism, it is clear that the complaints process has the potential to impact negatively on the medical profession. The emergence of defensive medical practice in response to a complaint is clearly a threat to the structural-function notion of the profession embodying particular knowledge and skills which may be used for the benefit of society. The clear obligation of the profession is to only practice medicine in ways which are believed to be of benefit, and conversely not to practice in a way that is counter to these ideals.

Of particular concern is the possibility that defensive medical practice becoming normalised as mainstream practice, creating a shift in that embodied knowledge and skill that risks being unquestioned and promulgated, ultimately to the detriment of society. The link between defensive medical practice and “negative professionalism” particularly at times of constrained societal resource needs to be addressed both by medical educators and by reform of the complaints process. I think the link between complaints and medical education is where the potential to optimise the outcome of the complaints process will come from, and may be the foil to the negative impact of complaints on the person of the doctor that leads to the emergence of defensive medicine.

This research demonstrates a clear and profound impact on values based professionalism. It clearly demonstrates negative impact on the values and beliefs that doctors bring into each
doctor-patient encounter which are fundamental to the notion of values based professionalism. Particularly, loss of a sense of trust in patients and of goodwill towards patients as a consequence of receiving a complaint impacts on professionalism “defined according to moral relationships” 85. Interestingly, recent published work in the New Zealand medical literature has drawn attention to lack of professionalism from doctors as perceived by complainants 29. Complainants were aware of the importance of trust, commitment, non-exploitation, and of not abandoning patients at times of need. Of course, such non-professional behaviour does not need to be precipitated by a complaint.

However, if the complaints process reduces those professional values that contribute to the moral relationships on which medical professionalism is based, then the complaints process may itself be viewed as being “unprofessional”. This notion links to the importance of the doctor-patient relationship in the delivery of medical care and reinforces (and certainly does not detract from) the idea of medicine as being a true profession. Because the delivery of high quality patient care is dependent upon the doctor-patient relationship, and that relationship itself is dependent upon the professional values bought into it by the doctor, the notions of professionalism and doctor-patient relationship have become inextricably linked.

Do these research findings then, help to develop the notion of professionalism as a state of relationship between doctors and society? I believe that they do. I think that this research demonstrates that the actions of society (through the actions of the complaints process) clearly impact on the person of the doctor, on the professional values that they hold, and on how they engage with their patients in the doctor-patient relationship. The results also confirm that doctors respond to this interaction with society by changing their behaviour, that is, by changing the structural-function basis of the profession. These changes then impact on the quality of care that is then received by society from the profession. Thus, doctors and society are in a professional relationship, with the behaviour of either party having a direct demonstrable and important impact on the other.

Viewed in such a way, the research presented in this thesis provides a basis for considering the notion of professionalism as one of relationship between the medical profession and the society in which it functions. Analogous to the doctor-patient relationship, the practice of medicine is not something that the profession does “to” society, but rather something that is done “with” society, for the benefit of that society, but which retains cognisance of the bases of professionalism that lie in the knowledge, skills, and attitudes that the profession must continue to embody.
9.4 Suggestions for change.

From the research presented in this thesis and previously published two important areas have emerged for suggested change to the complaints and disciplinary process. The first relates to support systems for doctors in receipt of a complaint, and the second to the need for systemic change centred on the notion of a single point of entry into the complaints process. In this section, I will discuss some of the issues around these ideas and expand on what I see as being the potential that the complaints process holds for enhancing medical education.

The purpose of a complaints system should be the enhancement of patient care. Whether this relates to the current and ongoing health care needs of an individual patient or their family involved in a complaint, or whether this relates to the ability of the doctor or institution complained about to deliver high quality care on an ongoing basis, the primary objective of the complaints process remains the same. If issues related to the provision of high quality health care are enhanced by a complaints process, then the other ideas of the maintenance of professional standards and professional accountability will be met, as will the “grass roots” notions of improving medical education and meeting individual doctor’s and patient’s needs. This thesis considers these issues from the viewpoints of the epistemology of western medicine, the place of the person of the doctor and the doctor-patient relationship in the delivery of health care, and from the notion of professionalism. This research has demonstrated that New Zealand doctors are cognisant of all of these issues, and that any changes in the complaints process must acknowledge and account for the important facets of each of these.

The need for support for doctors comes in three forms. The first is legal, and issues around legal support are largely outside of the scope of this thesis, but on receipt of a complaint doctors may find themselves engulfed in a legal system over which they have little understanding and even less control. The remaining needs for support are emotional and intellectual. Each of these issues needs to be addressed and the responsibility for doing so lies within the medical profession. I will discuss these proposals separately.

This thesis has presented clear evidence of a significant impact of complaint on the emotional well being of doctors (which relates to doctors both in terms of their sense of person and to the doctor-patient relationship), both in the immediate and long term after receiving a complaint. It is clear that some of the more negative emotional responses subside over a period of time, but
that aspects of values based professionalism such as trust and goodwill risk being eroded for a significant number of doctors. In order to address this, emotional support needs to be provided by appropriately trained specialised psychotherapists who are able to engage with doctors immediately on receipt of a complaint and for whatever length of time subsequently is required.

Because of the length of time needed for resolution of some complaints, and the potential that the multiple pathways of complaint hold for further litigation, doctors need to be able to form an appropriate ongoing therapeutic relationship which would provide significantly more support than simply relying on a sympathetic ear from friends, colleagues or family members. Many doctors in their professional lives will not have had the opportunity to explore issues around the epistemology of medicine and what they themselves bring to their day to day work, and the introduction of skilled support in the circumstances of a complaint could reduce the likelihood of the emergence of many of the unprofessional values based changes that may erode the integrity not only of the individual doctor but of the profession as a whole.

In my opinion, such a support service needs to be centrally organised and regionally delivered, using a team of appropriately selected and trained therapists. Clearly there are funding and administrative issues to be addressed, but it is my contention that an appropriate system of support once up and running, would become an acceptable and well received component of the culture of medical practice in this country, and would have a high level of acceptance by New Zealand doctors. Once established, I believe that it would become normalised into the culture of medicine in the same way that continuing medical education is also an accepted part of medical practice.

Intellectual support refers to doctors' needs for assessment of their medical practice as it pertains to the specific details of a complaint. For this, doctors in receipt of a complaint need the opportunity to meet with a trusted and respected colleague who practices in their own field, within days of receipt of a complaint. Many doctors are unable to bring themselves to discuss the details of the complaint with their work colleagues, and even then they risk responses from those colleagues that are inappropriate. It is the responsibility of the professional medical colleges to hand pick a cohort of doctors (again centrally coordinated and regionally delivered) who are appropriately trained and motivated to engage with their own colleagues who need such support.

As shown in the findings presented in Chapter 3, these supportive colleagues themselves need to be protected from the requirement to give evidence on behalf of either the indemnity insurers
or any complaints body. Their function would be to provide the complained about doctor access to an objective opinion about the complaint and that doctor’s own practice of medicine, in a situation where sometimes the only counsel that those doctors have access to, is their own.

New Zealand doctors believe that the advisors to both the indemnity insurers and the complaints body use a largely biomedical paradigm to explore and critique the complained about doctor’s practice. Respondents in this study were very clear about the need for the appropriate contextualisation of a complaint. Appropriately chosen supportive colleagues will be able to offer the type of contextualised intellectual support that is required.

Suggestions for systemic change to the medical complaints system has been presented in Chapter 7 and summarised in Table 10. The key issues relate to the creation of a single point of entry into a system that is transparently fair, whose judgments are seen by the profession as being appropriate, and that meet society’s needs for improved outcome for the individual complainant, for the improvement of systems of care and which are free from the potentially negative influence of the media. The detailed suggestions for systemic change are consistent with both the structural-function and values based notions of professionalism. They reinforce the notion of relation-based professionalism, and in addition to reducing the potentially negative impact of complaints on the person of the doctor and their practice, they provide the opportunity for the enhancement of patient care through the identification of systemic error and improved medical education.

Some, but by no means all, adverse outcomes of care will be related to deficient medical care. If that deficiency lies within a system (such as within an institution) then a complaints process that is capable of recognising systemic error rather than focusing on individual responsibility is likely to reduce the likelihood of that systemic error being repeated and ultimately will improve the delivery of patient care.

A reformed complaints process possessing the characteristics outlined in Table 10 could operate successfully alongside an appropriate medical education system. Even when there has been no error in the practice of medicine, all complaints present the opportunity for learning. Where a complaint does relate to deficiencies in a doctor’s practice, there is opportunity for learning. It is possible that appropriate emotional and intellectual support provided at the time of receiving a complaint may actually instigate a learning process even before a complaint has come to a formal hearing, but even if it takes until the completion of the complaints process to identify a remediable deficiency, it is still the responsibility of the complaints process to work alongside the medical profession to facilitate that doctor’s required learning.
If what is currently seen as a threatening and adversarial complaints process could be changed to become regarded as a process allowing the opportunity for learning, I believe that many of the unprofessional changes in doctors' behaviours would be prevented, and that the ultimate purpose of a complaints system, specifically the enhancement of the delivery of medical care to society by the medical profession, would be achieved. If these changes are not brought about, the ongoing negative impact of a complaint will continue to damage the relationship between the profession and society, to the detriment of both.
### APPENDICES

Appendix 1. Medical Disciplinary Complaints and their Outcomes to the MPDC 1992-1996

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<td>Year</td>
<td>No. of complaints</td>
<td>%</td>
<td>No. of complaints</td>
<td>%</td>
<td>No. of complaints</td>
</tr>
<tr>
<td>----------</td>
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<td>-------</td>
<td>-------------------</td>
</tr>
<tr>
<td>1993</td>
<td></td>
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<tr>
<td>1994</td>
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</tr>
<tr>
<td>1995</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1996</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>AFTER MERGER/DIVORCE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Misconduct upheld</td>
<td>3</td>
<td>9%</td>
<td>12</td>
<td>17%</td>
<td>6</td>
</tr>
<tr>
<td>Conduct unbecoming upheld</td>
<td>28</td>
<td>72%</td>
<td>11</td>
<td>27%</td>
<td>3</td>
</tr>
<tr>
<td>Professional Misconduct dismissed</td>
<td>1</td>
<td>2%</td>
<td>12</td>
<td>3%</td>
<td>4</td>
</tr>
<tr>
<td>PMC dismissed UBC upheld</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>1</td>
</tr>
<tr>
<td>Inquiry did not proceed</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>18</td>
<td>45%</td>
<td>63</td>
<td>100%</td>
<td>32</td>
</tr>
<tr>
<td><strong>LENGTH OF TIME OF INQUIRY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-3 months</td>
<td>168</td>
<td>33%</td>
<td>63</td>
<td>33%</td>
<td>40</td>
</tr>
<tr>
<td>3-6 months</td>
<td>66</td>
<td>26%</td>
<td>115</td>
<td>25%</td>
<td>38</td>
</tr>
<tr>
<td>6-12 months</td>
<td>28</td>
<td>11%</td>
<td>48</td>
<td>11%</td>
<td>16</td>
</tr>
<tr>
<td>&gt;12 months</td>
<td>3</td>
<td>1%</td>
<td>7</td>
<td>2%</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>265</td>
<td>100%</td>
<td>306</td>
<td>100%</td>
<td>407</td>
</tr>
<tr>
<td><strong>TYPE OF DOCTOR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practitioner</td>
<td>126</td>
<td>48%</td>
<td>41</td>
<td>48%</td>
<td>42</td>
</tr>
<tr>
<td>Daily GP</td>
<td>38</td>
<td>14%</td>
<td>12.5</td>
<td>14%</td>
<td>44</td>
</tr>
<tr>
<td>Locum GP</td>
<td>3</td>
<td>1%</td>
<td>1</td>
<td>1%</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>138</td>
<td>51%</td>
<td>45.5</td>
<td>51%</td>
<td>40</td>
</tr>
<tr>
<td>TOTAL</td>
<td>305</td>
<td>100%</td>
<td>284</td>
<td>100%</td>
<td>416</td>
</tr>
</tbody>
</table>
### Appendix 2. ACC Medical Misadventure data as of 1 June 2005

<table>
<thead>
<tr>
<th>Financial year lodged</th>
<th>Claims lodged</th>
<th>Current</th>
<th>Withdrawn</th>
<th>Gone to branch</th>
<th>At review or appeal</th>
<th>Declined</th>
<th>Accepted</th>
<th>% accept</th>
<th>Error</th>
<th>Mishap</th>
<th>% error</th>
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</thead>
<tbody>
<tr>
<td>1992-1993</td>
<td>1657</td>
<td>0</td>
<td>100</td>
<td>56</td>
<td>1</td>
<td>901</td>
<td>599</td>
<td>36</td>
<td>107</td>
<td>492</td>
<td>18</td>
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<tr>
<td>1993-1994</td>
<td>2196</td>
<td>0</td>
<td>247</td>
<td>132</td>
<td>0</td>
<td>1011</td>
<td>806</td>
<td>37</td>
<td>115</td>
<td>691</td>
<td>14</td>
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<tr>
<td>1994-1995</td>
<td>2640</td>
<td>0</td>
<td>240</td>
<td>270</td>
<td>0</td>
<td>1139</td>
<td>991</td>
<td>38</td>
<td>167</td>
<td>824</td>
<td>17</td>
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<td>1995-1996</td>
<td>2538</td>
<td>0</td>
<td>177</td>
<td>325</td>
<td>0</td>
<td>1162</td>
<td>874</td>
<td>34</td>
<td>137</td>
<td>737</td>
<td>16</td>
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<td>1996-1997</td>
<td>2088</td>
<td>0</td>
<td>116</td>
<td>237</td>
<td>2</td>
<td>954</td>
<td>779</td>
<td>37</td>
<td>93</td>
<td>686</td>
<td>12</td>
</tr>
<tr>
<td>1997-1998</td>
<td>1470</td>
<td>0</td>
<td>96</td>
<td>158</td>
<td>3</td>
<td>694</td>
<td>519</td>
<td>35</td>
<td>49</td>
<td>470</td>
<td>9</td>
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<tr>
<td>1998-1999</td>
<td>1277</td>
<td>0</td>
<td>59</td>
<td>77</td>
<td>6</td>
<td>598</td>
<td>537</td>
<td>42</td>
<td>50</td>
<td>487</td>
<td>9</td>
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<tr>
<td>1999-2000</td>
<td>2281</td>
<td>0</td>
<td>222</td>
<td>71</td>
<td>6</td>
<td>1288</td>
<td>694</td>
<td>30</td>
<td>109</td>
<td>585</td>
<td>16</td>
</tr>
<tr>
<td>2000-2001</td>
<td>2489</td>
<td>0</td>
<td>209</td>
<td>119</td>
<td>20</td>
<td>1419</td>
<td>722</td>
<td>29</td>
<td>92</td>
<td>630</td>
<td>13</td>
</tr>
<tr>
<td>2001-2002</td>
<td>2366</td>
<td>0</td>
<td>243</td>
<td>98</td>
<td>34</td>
<td>1379</td>
<td>612</td>
<td>26</td>
<td>81</td>
<td>531</td>
<td>13</td>
</tr>
<tr>
<td>2002-2003</td>
<td>2735</td>
<td>0</td>
<td>413</td>
<td>78</td>
<td>52</td>
<td>1552</td>
<td>640</td>
<td>23</td>
<td>93</td>
<td>547</td>
<td>15</td>
</tr>
<tr>
<td>2003-2004</td>
<td>2948</td>
<td>144</td>
<td>529</td>
<td>93</td>
<td>96</td>
<td>1455</td>
<td>631</td>
<td>21</td>
<td>62</td>
<td>569</td>
<td>10</td>
</tr>
<tr>
<td>2004-2005</td>
<td>2790</td>
<td>1058</td>
<td>400</td>
<td>69</td>
<td>38</td>
<td>875</td>
<td>350</td>
<td>13</td>
<td>33</td>
<td>317</td>
<td>9</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>29475</td>
<td>1202</td>
<td>3051</td>
<td>1783</td>
<td>258</td>
<td>14427</td>
<td>8754</td>
<td>30</td>
<td>1188</td>
<td>7566</td>
<td>14</td>
</tr>
</tbody>
</table>

**NOTES:**
Current refers to claims currently being investigated for cover.
Withdrawn is where a claimant has withdrawn the claim.
Gone to branch means that the claim is not a medical misadventure one so sent to a branch for consideration under other parts of the ACC legislation.
At review or appeal means that ACC’s decision is being reviewed or appealed.
Some “current” claims have been reopened.
Appendix 3  Letter of Introduction

Dear Dr,
My name is Wayne Cunningham, and I am a practising General Practitioner and a Senior Lecturer in General Practice in the Department of General Practice, Dunedin School of Medicine.

I am conducting research into the effect on practise of receiving a medical disciplinary complaint.

I have randomly selected doctors in New Zealand from the range of medical specialties, to invite to participate. I have no knowledge whatsoever about whether or not you have ever had a medical disciplinary complaint, and this study seeks respondents from both those who have ever, or never had a complaint.

My previous research has highlighted the impact that a complaint can have on the person of the doctor, and on their practise of medicine. It suggests that the result of a complaint may be a reduction in the level of patient care, and I believe that this warrants further study. It is also a topic seldom discussed by doctors, but of considerable importance to both the profession and the public, and your participation in this study is most important.

Getting down to the nuts and bolts, this is quantitative research, using a questionnaire that explores some of the themes that emerged from the previous study. The study seeks generalities about the experience of a disciplinary complaint for doctors in this country. I will include this study in my MD thesis. I expect the questionnaire to take about 20 minutes of your time to complete.

No information allowing personal identification of participants will appear in any thesis or publication. The questionnaires will have an identifier coded so that I am the only one able to identify the participants, and the questionnaires will be stored in a locked cabinet within the Department of General Practice, and you will not be personally identified on the questionnaire, or in its analysis.

If you would like to participate, please complete the consent form sheet and the appropriate questionnaire.
I enclose a post-paid return envelope.

Thank you for considering this request.
Yours faithfully,

Wayne Cunningham  
BHB MBChB MGP FRNZCGP  
Department of General Practice Dunedin School of Medicine PO Box 913 Dunedin
Appendix 4. Questionnaire Regarding Respondent Ever or Never in Receipt of Complaint.

QUESTIONNAIRE

THE EFFECT OF MEDICAL DISCIPLINARY COMPLAINTS

Please complete this questionnaire if you have EVER had a disciplinary complaint that has gone to the (former) Medical Practitioners Disciplinary Committee, the Office of the Health and Disability Commissioner, or through a formal “in house” complaints procedure.
This part of the questionnaire looks at a disciplinary complaint that has gone to the (former) Medical Practitioners Disciplinary Committee, the Office of the Health and Disability Commissioner, or through a formal "in house" complaints procedure.

To which body did the complaint go?
MPDC  H&DC  Other (specify)

In which year did you receive the complaint?

How many months elapsed from the time of the incident to receiving the complaint?

How many months elapsed between receiving the complaint and
a) resolution  b) if still proceeding, time to date...

If the process has been completed, was the complaint
a) Upheld  b) Dismissed

In your view, indicate if the complaint was related to one or more of the following notions

a) A perceived (or actual) error in the practice of medicine
   Examples might include: incorrect diagnosis or failure to diagnose, technical incompetence, adverse reaction or procedural complication, failure of follow-up.

b) A perceived (or actual) breakdown of communication with the patient, their family, or some other institution such as a hospital or rest home.

c) A perceived (or actual) clash of personalities between yourself and the patient or complainant.

d) A perceived (or actual) systems failure.
   Examples might include a referral not being done or lost, results lost, telephone messages not received or acted on.

e) The actions of a third party such as Practice/Hospital Staff, ACC, WINZ, the HFA, for which you were held responsible.

f) Your behaviour (perceived or actual).
   Examples might include inappropriate language, sexually inappropriate behaviour.

g) Fraudulent activity.
   Examples might include accessing public monies (ACC, HBL) or insurance fraud (within the practice of medicine).

h) Other issues- please specify in broad terms that maintain confidentiality.
It has been suggested that receiving a medical disciplinary complaint may impact many different aspects of life as a doctor. The impact may be in the short-term, or be sustained over a long period of time. It may be that a medical disciplinary complaint instigates changes that are beneficial or deleterious, and this part of the questionnaire explores some of these issues.

The following questions ask you to look at the impact of a complaint on you in the short term (that is, in the first few days and up to six weeks after receiving the complaint).

Recalling your early response to receiving a complaint, to what extent do you agree/disagree with the following statements?

<table>
<thead>
<tr>
<th>I felt angry</th>
<th>Strongly disagree: -2</th>
<th>Disagree: -1</th>
<th>No strong feelings: 0</th>
<th>Agree: 1</th>
<th>Strongly agree: 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt depressed</td>
<td>Strongly disagree: -2</td>
<td>Disagree: -1</td>
<td>No strong feelings: 0</td>
<td>Agree: 1</td>
<td>Strongly agree: 2</td>
</tr>
<tr>
<td>I felt guilty</td>
<td>Strongly disagree: -2</td>
<td>Disagree: -1</td>
<td>No strong feelings: 0</td>
<td>Agree: 1</td>
<td>Strongly agree: 2</td>
</tr>
<tr>
<td>I felt ashamed</td>
<td>Strongly disagree: -2</td>
<td>Disagree: -1</td>
<td>No strong feelings: 0</td>
<td>Agree: 1</td>
<td>Strongly agree: 2</td>
</tr>
<tr>
<td>I felt that I was a good doctor</td>
<td>Strongly disagree: -2</td>
<td>Disagree: -1</td>
<td>No strong feelings: 0</td>
<td>Agree: 1</td>
<td>Strongly agree: 2</td>
</tr>
<tr>
<td>I felt that I was a good person</td>
<td>Strongly disagree: -2</td>
<td>Disagree: -1</td>
<td>No strong feelings: 0</td>
<td>Agree: 1</td>
<td>Strongly agree: 2</td>
</tr>
<tr>
<td>I derived a sense of joy</td>
<td>Strongly disagree: -2</td>
<td>Disagree: -1</td>
<td>No strong feelings: 0</td>
<td>Agree: 1</td>
<td>Strongly agree: 2</td>
</tr>
<tr>
<td>I wanted to keep on practising</td>
<td>Strongly disagree: -2</td>
<td>Disagree: -1</td>
<td>No strong feelings: 0</td>
<td>Agree: 1</td>
<td>Strongly agree: 2</td>
</tr>
<tr>
<td>I was able to consult well</td>
<td>Strongly disagree: -2</td>
<td>Disagree: -1</td>
<td>No strong feelings: 0</td>
<td>Agree: 1</td>
<td>Strongly agree: 2</td>
</tr>
<tr>
<td>(Please specify any changes in</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>your consulting at that time)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I was able to perform</td>
<td>Strongly disagree: -2</td>
<td>Disagree: -1</td>
<td>No strong feelings: 0</td>
<td>Agree: 1</td>
<td>Strongly agree: 2</td>
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<td>technical tasks well</td>
<td></td>
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<td>(Please specify any changes in</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>your performance at that time)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I was able to tolerate</td>
<td>Strongly disagree: -2</td>
<td>Disagree: -1</td>
<td>No strong feelings: 0</td>
<td>Agree: 1</td>
<td>Strongly agree: 2</td>
</tr>
<tr>
<td>uncertainty in my practise of</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I continued to be confident in</td>
<td>Strongly disagree: -2</td>
<td>Disagree: -1</td>
<td>No strong feelings: 0</td>
<td>Agree: 1</td>
<td>Strongly agree: 2</td>
</tr>
<tr>
<td>my clinical judgement</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Short term effects continued...

I continued to provide the same range of services to my patients
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2
(Please specify any change in your practice such as the withdrawal of services, use of additional time, investigations, recalls and so on)

I held the same sense of commitment to the patient (complainant)
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

I held the same sense of commitment to other patients
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

I continued to trust patients as before
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

I put at least the same effort into my patients
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

I felt at least the same sense of goodwill towards patients
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

I viewed the complaint as being a good thing.
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

I felt supported by my colleagues at that time
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

I felt supported by my family at that time
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

I contacted my medical defence legal advisors as soon as was possible
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

I was aware of feelings of tension within colleagues and staff due to the complaint
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

I was aware of feelings of tension within my family due to the complaint
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

Were there any other short-term effects you were aware of?
The following questions ask you to look at the impact of a complaint on you in the long-term (that is, those responses that may have persisted after receiving the complaint).

Considering your current response to having received a complaint, to what extent do you agree/disagree with the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree: -2</th>
<th>Disagree: -1</th>
<th>No strong feelings: 0</th>
<th>Agree: 1</th>
<th>Strongly agree: 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel angry</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2</td>
<td></td>
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<td></td>
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<tr>
<td>I feel depressed</td>
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<td></td>
</tr>
<tr>
<td>Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>I feel guilty</td>
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<td></td>
</tr>
<tr>
<td>Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>I feel ashamed</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2</td>
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</tr>
<tr>
<td>I feel that I am a good doctor</td>
<td></td>
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<tr>
<td>Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2</td>
<td></td>
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<tr>
<td>I feel that I am a good person</td>
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</tr>
<tr>
<td>Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I derive a sense of joy from practising medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I want to keep on practising medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am able to consult as well as before receiving the complaint</td>
<td></td>
<td></td>
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<td>(Please specify any changes in your consulting)</td>
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<tr>
<td>I am able to perform technical tasks as well as before receiving the complaint</td>
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<td>(Please specify any changes in your performance)</td>
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<td>I am able to tolerate uncertainty in my practise of medicine as well as before receiving the complaint</td>
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<td>Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2</td>
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<tr>
<td>I am as confident in my clinical judgement as before receiving the complaint</td>
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<td>Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2</td>
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</table>
Current response continued...

I provide the same range of services to my patients as before receiving the complaint

<table>
<thead>
<tr>
<th>Strongly disagree: -2</th>
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</table>

(Please specify any change in your practice such as the withdrawal of services, use of additional time, investigations, recalls and so on).

| I hold the same sense of commitment to the patient (complainant) as before receiving the complaint |
| Strongly disagree: -2 | Disagree: -1 | No strong feelings: 0 | Agree: 1 | Strongly agree: 2 |

| I hold the same sense of commitment to other patients as before receiving the complaint |
| Strongly disagree: -2 | Disagree: -1 | No strong feelings: 0 | Agree: 1 | Strongly agree: 2 |

| I trust patients as before receiving the complaint |
| Strongly disagree: -2 | Disagree: -1 | No strong feelings: 0 | Agree: 1 | Strongly agree: 2 |

| I put at least the same effort into my patients as before receiving the complaint |
| Strongly disagree: -2 | Disagree: -1 | No strong feelings: 0 | Agree: 1 | Strongly agree: 2 |

| I feel at least the same sense of goodwill towards patients as before receiving the complaint |
| Strongly disagree: -2 | Disagree: -1 | No strong feelings: 0 | Agree: 1 | Strongly agree: 2 |

| I view the complaint as having been a good thing. |
| Strongly disagree: -2 | Disagree: -1 | No strong feelings: 0 | Agree: 1 | Strongly agree: 2 |

| I have adopted strategies designed to reduce the likelihood of another complaint |
| Strongly disagree: -2 | Disagree: -1 | No strong feelings: 0 | Agree: 1 | Strongly agree: 2 |

(Please specify what these might be)

| I take better care of myself than before the complaint |
| Strongly disagree: -2 | Disagree: -1 | No strong feelings: 0 | Agree: 1 | Strongly agree: 2 |

(Please specify in what way)
I am more open to talking with colleagues about potential difficulties than before the complaint
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

I devote the same or more time to my family than before the complaint
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

I have the same or more commitment to activities such as College committees, NZMA, ethical committees, IPA activities and so on, as before the complaint
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

Faced with another complaint, I would be more likely to discuss it with a peer group, mentor or supervisor, than before the complaint
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

When faced with clinical circumstances similar to those of the original complaint, my recollection of the complaint is strong enough to interfere with how I would normally practise
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

Faced with another complaint, I would discuss the issues with my medical defence legal advisors as soon as possible
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2

Faced with another complaint, I would discuss the issues with colleagues as soon as possible
Strongly disagree: -2  Disagree: -1  No strong feelings: 0  Agree: 1  Strongly agree: 2
Doctors sometimes hold views about how the medical disciplinary process could be improved. Doctors may also have had the opportunity to reflect on how they feel about themselves, on the values and beliefs of our society in general, and on the medical profession in particular, in light of having been through the disciplinary process. Your candid replies to the following statements and questions may help identify ways in which the process could be improved.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
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<td>It is important that society can complain about doctors</td>
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<td>It is important that at the end of the complaints procedure there is a sense of completion for both the doctor and the complainant</td>
<td>-2</td>
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<td>Most complainants are normal people</td>
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<td>Most complaints are about errors and actual wrong-doings</td>
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Most complainants are trying to make sure that a bad event does not happen again to someone else
Strongly disagree: –2  Disagree: –1  No strong feelings: 0  Agree: 1  Strongly agree: 2

Disciplinary complaints are a useful tool to improve medical practice
Strongly disagree: –2  Disagree: –1  No strong feelings: 0  Agree: 1  Strongly agree: 2

How do you think that the medical disciplinary complaints system could be improved in this country?
Demographic data may reveal differences (in attitudes towards and responses to medical disciplinary complaints) influenced by age, gender, specialty and so on. Your candid replies to the following questions would be appreciated and all data will remain confidential.

Please complete the following questions

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University of graduation:
Otago Auckland Australia UK SA
Other (please state)

Indicate if you are a
House Surgeon Yr1 House Surgeon Yr2 MOSS
Registrar (state specialty)

If not indicated above, in which field or fields do you currently practise?

Are you on the vocational register of the New Zealand Medical Council?

What post-graduate qualifications do you hold?

In total, for how many years have you practised (as a doctor) in New Zealand?
0-5 6-10 11-20 >20

In an average working week, how many tenths do you work in
a) private practice b) a salaried or contracted role

On average each week, how many hours outside of your regular or contracted hours, are you “on call”?

Is your practice primarily Urban Rural or Small Town (<15,000 pop)
QUESTIONNAIRE

THE EFFECT OF MEDICAL DISCIPLINARY COMPLAINTS

Please complete this questionnaire if you have NEVER had a disciplinary complaint that has gone to the (former) Medical Practitioners Disciplinary Committee, the Office of the Health and Disability Commissioner, or through a formal "in house" complaints procedure.
Doctors sometimes hold views about how the medical disciplinary process could be improved. Doctors may have also had the opportunity to reflect on how they feel about themselves, on the values and beliefs of our society in general, and on the medical profession in particular, by considering the disciplinary process.

Your candid replies to the following statements and questions may help identify ways in which the process could be improved.

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In general, I cope well with uncertainty in medical practice
Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2

Medical disciplinary complaints should be resolved in a court of law
Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2

A strongly litigious culture such as in the United States, promotes the delivery of better quality health care
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Most complainants are trying to make sure that a bad event does not happen again to someone else
Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2

In general, I feel depressed
Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2

Disciplinary complaints are a useful tool to improve medical practice
Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2

In my day to day practice, I am mindful of other colleagues' disciplinary experiences
Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2

My day to day practise of medicine has been changed by other colleagues' disciplinary experiences
Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2
(Please specify such changes)

I feel that I would cope well with receiving a disciplinary complaint
Strongly disagree: -2 Disagree: -1 No strong feelings: 0 Agree: 1 Strongly agree: 2
What sort of support system would you like to have in place for yourself, if you were to receive a disciplinary complaint?

How do you think that the medical disciplinary complaints system could be improved in this country?
Demographic data may reveal differences (in attitudes towards and responses to medical disciplinary complaints) influenced by age, gender, specialty and so on. Your candid replies to the following questions would be appreciated and all data will remain confidential.

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- SA

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Registrar (state specialty)

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Is your practice primarily
- Urban
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Appendix 5 Ethics Committee Approval

W K Cunningham
Department of General Practice

Dear W K Cunningham

I am writing to let you know that, at its recent meeting, the Ethics Committee considered your proposal entitled:-

The Effect of Disciplinary Complaints on Doctors
As a result of that consideration, the current status of your proposal is:- Approved

For your future reference, the Ethics Committee's reference code for this project is:- 00/134.

Yours sincerely

[Signature]

Mr G K Witte
Manager, Academic Committees
List of References

2. Injury Prevention, Rehabilitation, and Compensation Act, 2001


97. Griffith F. Qualitative research: The research question that can help answer, the methods it uses, the assumptions behind the research questions, and what influences the direction of research. Fam Pract 1996; 13(Suppl 1): S27-S30.


103. Cunningham W. The medical complaints and disciplinary process in New Zealand: Doctors’ suggestions for change. NZ Med J 2004; 117(1198): U974