The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

EDITORIAL

GUEST EDITORIAL

Complaints: their toll, why, and how we need the medical profession to act

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For many years I have worked as a rural general practitioner and academic, teaching undergraduate and postgraduate general practice. I have given a lot of thought to medical professionalism and how it is supported and diminished by how society, professions, and individual healthcare providers deal with patient complaints.

Receiving a complaint is an awful experience for most doctors, and the idea of the doctor as the 'second victim' is well established.[1,2] Regardless of practising in litigious or non-litigious cultures, complaints take an emotional toll on doctors and damage vital components of the doctor-patient relationship such as caring, trust, and commitment.

In this issue of the Journal, Wilkinson and Marshall[3] confirm what we already know about the impact of complaints on doctors[4] and on other health professionals[5] here in New Zealand. Australian doctors are similarly impacted, despite their somewhat different complaints system.[6] Here and overseas, researchers have documented the emergence of defensive medicine which is another outcome of the complaints process.[7,8] Despite this, the New Zealand medical profession has not formalised care for doctors in receipt of a complaint, and I believe that the time has come to do so for the sake of doctors' wellbeing and to improve patient care.

Acknowledging these impacts is one thing but determining what the profession needs to do to care for doctors, is another. However, there are insights around complaints that are worth exploring, and I will consider some of these in this article. I will examine situations that might give rise to complaints, discuss how society judges medical practice and how doctors respond, and ponder how doctors learn in response to complaints.

Perhaps I should deal with an 'elephant in the room'. I am not advocating abolition of the complaints process, because to do so would be naïve and unhelpful. The complaints process is one way to maintain the relationship between society and the medical profession, and society values its right to complain about doctors. What I would say, is that there are various situations where medicine can 'go wrong' and that complaints about individual doctors may be more helpful or less helpful in these different contexts. Acknowledging such distinctions might be worthwhile as society's use of complaints evolves.

Arguably, only three things can go wrong in medicine.[9] These are systems errors (wrong-side surgery, mistakenly prescribed or dispensed medication, misfiled results and so on); wrongdoing (unethical or criminal acts such as by murderer Harold Shipman); and error in the practice of medicine (failure to diagnose, inappropriate or substandard treatment, delayed referral, poor interpersonal skills, and the like). In the aviation industry, analysis of systems errors now means that your next commercial flight is probably going to be safer than driving home from work. Using complaints to identify medical systems failures may result in systems improvements. Complaints that expose and correct unethical or criminal behaviour by doctors may strengthen the trust that society has in the profession, but the most problematic area is where complaints are made about error in the practice of medicine.

The underlying issue with medicine error is that the epistemology of medicine (how medicine knows what is right or wrong) is based in biomedicine.[10] Biomedicine sees patients' diseases as independent of both the person of the patient and the person of the doctor and claims that diseases can be diagnosed and managed if the doctor practises 'correctly'. But biomedicine sets us up for failure and to

be held to account. The problem of course, is that neither your practice nor mine is perfect. Even when we do practice well and deliver whole-person care, things still go wrong; patient outcomes can be poor, and when judged by the standards of biomedicine, we feel that we have failed.

Regardless of the situation giving rise to a complaint, doctors respond emotionally and intellectually. These responses are not always congruent with the nature of the complaint, its severity, or with each other. Emotionally, judged by the standards of biomedicine to have failed, doctors may be shamed.[11] Shame makes us want to withdraw, to hide. We feel unworthy, perhaps unable to continue, and sometimes doctors commit suicide. I have spoken with doctors who were too ashamed to tell their spouse about a complaint, let alone seek meaningful support from others. They had been damaged and their ability to care for patients (not just the complainant), reduced. We have confirmed the benefits of counselling support for doctors[12] but it appears that no respondents in the research by Wilkinson and Marshall in this issue availed themselves of this.

Intellectually, doctors scrutinise their practice, reading and re-reading their notes, test results and so on, to determine where they went wrong (mostly using a biomedical perspective) and to figure out how to avoid having such a complaint happen again. The problem is that this intellectual response often happens without guidance and impartial critique. Doctors may then change their behaviour towards defensive medicine (such as to order more tests, refer earlier, intervene sooner or later, or to remove themselves from types of patients or areas of practice) which indicates learning, but the learning is maladaptive; it is wrong, wastes valuable resources, exposes patients to potential harm and in the case of withdrawal, deprives patients and communities of care.

These outcomes of our complaints processes – damage to the person of the doctor, damage to their relationships with patients, and the emergence of defensive medicine have been documented in New Zealand for nearly 20 years. The paper by Wilkinson and Marshall in this issue broadens the impact to other health professionals, but otherwise tells me that nothing much has changed, and our colleagues are still struggling, still damaged.[3]

I suggest that responding to the impact of complaints is our professional responsibility, not that of society's regulatory structures or our indemnifiers (although they do their best), and that the Colleges are the appropriate bodies to take on this task. In our own discipline, the Royal New Zealand College of General Practitioners (RNZCGP) is well placed to start caring for all its members, addressing the emotional and intellectual impacts of complaints.

My suggestion is that the RNZCGP establishes a Complaints Care Unit (CCU) that all members are encouraged to contact if they receive a complaint. A CCU could provide emotional support using well qualified internal or external resources, aiming to reduce the psychological toll of complaints. It would also provide intellectual support using trusted, experienced, and expert colleagues who would visit and sit quietly with members who have received a complaint, review and critique their practice, guiding reflection and learning. Properly trained and themselves supported, these experts will promote 'adaptive' learning, better practice and reduce the emergence of defensive medicine. Then, perhaps an outcome of complaints will be better for doctors, patients, and society. I leave you with a troubling question – if caring for its members is a professional responsibility, and our profession will not care for us, then what have we become?

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Response from the Royal New Zealand College of General Practitioners

The College endorses the sentiments expressed in this article by Dr Cunningham regarding the impact on members when they are the subject of a complaints process.

The Board has been actively discussing ways in which the College could provide a heightened level of support and care for members at times when their wellbeing is being impacted. We expect to be able to share these additional support services with members very soon.

Dr Samantha Murton, President of the RNZCGP