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The effect on New Zealand general practitioners of receiving a complaint from the (former) Medical Practitioners Disciplinary Committee

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ABSTRACT

The effect of receiving a disciplinary complaint

There is evidence from the literature that in both litigious and non-litigious cultures, there is an effect on the person of the doctor that is associated with either the threat of litigation, or a perceived threat to the doctor-patient relationship. Furthermore, such threats are associated with the practice of negative defensive medicine. There is a paucity of literature in an Australasian context on the effect of receiving a disciplinary complaint in general practice. This study investigated the effect on general practitioners of receiving a complaint from the (former) Medical Practitioners Disciplinary Committee, that did not proceed to a formal hearing. It examined the effect of such complaints on doctors and their practice of medicine in New Zealand.

This study used the qualitative research method of in-depth semi-structured interviews with transcript analysis, and the development of a theory to enhance understanding of the results. Ten New Zealand general practitioners responded to an invitation to participate in this study. All had had a disciplinary complaint considered by the Medical Practitioners Disciplinary Committee within the last five years. Telephone interviews were conducted by the investigator. Transcripts of the interviews were thematically analysed and the results returned to the participants for their further input.
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 doctors’ 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 that not only related to 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 doctors’ relationships with their spouse, family and colleagues in the direction of help seeking behaviour that indicated an immediate need for meaningful support.

The results further indicated a significant long-term impact of the complaint on:

1. The person of the doctor that indicated a persisting emotional response, a change in the way in which they perceived themselves as doctors and a general erosion of goodwill towards patients.
2. A significant impact on doctors’ practice of medicine characterised by the development of strategies to reduce the risk of recurrence of a complaint, that 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 doctors’ perceptions of other doctors who have had a complaint.
The results indicated a change in the participant’s perception of their role as a doctor and their place in society and of their need for skilled advocacy throughout the disciplinary process, a process for which they felt ill prepared.

Positive effects of the complaint emerged as a testing or vindication of their practice of medicine.

The results indicate that the changes in the person of the doctor are consistent with those of shame as an emotional response to the receipt of a complaint. The long-term changes in their practice of medicine are consistent with the shaming response.

The results indicate a need for the impact of a disciplinary complaint to be recognised by the medical profession, and for changes in the way in which the profession responds towards those doctors who have received a complaint. There is a need for an immediate appropriate and highly co-ordinated response to effectively meet the needs of doctors on a receipt of a complaint. The author presents a case for this being the responsibility of the Royal New Zealand College of General Practitioners and the Medical Defence Societies providing legal representation. To fail to acknowledge the impact of a complaint on the person of the doctor and the doctor-patient relationship, is to perpetuate a system that ultimately impacts negatively upon patient care.
I am most grateful for the input from the participants in the study. Without them it would not have been possible.

Roger Caudwell, Secretary of the Medical Practitioners Disciplinary Committee made it possible for me to contact the participants, and Gay Fraser and her staff kindly provided the demographic data.

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1. INTRODUCTION

The effect of receiving a disciplinary complaint

The objective of this study is to explore the effect on practice of receiving a complaint from the (former) Medical Practitioners Disciplinary Committee (MPDC). This study examines the effect on practice from the point of view of general practitioners, looking at their perceptions and understandings of a disciplinary complaint, the experience and the effect that it has had on them and on their practice of medicine.

This study specifically set out to explore the effect on doctors of a disciplinary complaint to the MPDC against the doctor, that did not proceed to a formal hearing, which will be referred to throughout this thesis as the ‘complaint’.

The reason for taking this approach was two-fold. In the first instance, I wanted to examine the possibility that there were changes in practice that had occurred as a result of an internal process specific to the doctor rather than an external process that had been imposed upon the doctor. The second reason was that I wanted to examine the effect of complaints about issues that we would normally consider “minor”, rather than “major” complaints where a significant degree of censure could be expected if the doctor was to be found guilty. It is important to understand that having a complaint that did not proceed to a formal hearing did not mean that the doctor was necessarily “not guilty”. It meant that one of two scenarios had occurred. Either (1) a degree of conciliation was achieved between the doctor and the complainant (for example an appropriate apology)
or, (2) that in the opinion of the Chairman of the Disciplinary Committee, the complaint did not have sufficient grounds to warrant a formal hearing.

This thesis seeks to document both the experiential evidence of doctors who have been involved with the disciplinary process, and to seek an understanding of why changes in the person of the doctor and of their practice of medicine might occur as a result of a complaint.

By examining the effect of a complaint this study will signpost ways in which the complaints system in New Zealand can be improved for the benefit of doctors and patients alike.

This chapter will outline the background to this study, describe the medical disciplinary process in New Zealand and present demographic data on disciplinary complaints and outcomes relevant to the time period during which the doctor participants received their complaints.

This chapter will then present findings about the effect of medical discipline in New Zealand and overseas, comparing the influence of litigious and non-litigious cultures, and explore the notions of defensive and defensible medicine. Because of the importance to this thesis of the doctor-patient relationship, the origins of this relationship will be discussed, as will the development of medical paradigms that influence current approaches to the doctor-patient relationship in western medicine.
The person of the doctor is important in the doctor-patient relationship, and this chapter will outline understanding of the self of the doctor, some characteristics of the psychological makeup of doctors, their medical education experience and notions of professionalism and role.

To conclude, this chapter examines shame as an emotional response, introducing its theoretical basis and importance in a clinical context. The importance of shame as an emotional response to the receipt of a complaint will be furthered in the discussion.

1.1 BACKGROUND

When doctors are amongst doctors and talking of medical issues, they are invariably drawn to case histories. In my ten years of experience in general practice, I have found that doctors will tell the stories of their contacts with patients, of the illnesses and diseases that they have encountered, and of the contradictions/paradoxes of the art and science of medicine. There is a sharing of the experience of practising medicine.

What doctors do not talk about are their disciplinary complaints. In my experience it is very unusual for a group of doctors to talk about their complaint experiences in a group setting, especially where there is no particular structure to the meeting. It is interesting that even in structured group settings specifically looking at topics of medical discipline, doctors will often remain silent and not feel able to discuss complaints, especially if they pertain personally to them.
The question is, why should this be? What is it that happens in the receiving of a complaint and the process that follows that inhibits otherwise shared experiences? Many negative aspects of practice are usually openly discussed with considerable comfort. Doctors will talk about their treatment failures, misdiagnoses and often the emotional pain of practice, such as the death of patients for whom they have cared for a long time, or of tragedies that may have befallen a particular patient or family. However, doctors will seldom discuss their complaints. It is this observation that led me to form the question, “what is the nature of the effect on practice of a complaint?” and to construct a theory as to why this should be. From this, I will look at what could be done, if appropriate, to alter adverse effects on practice if they are significant.

1.2 The medical disciplinary process in New Zealand

At the time of conducting this research, there were two parallel systems of medical discipline operating in New Zealand. This resulted from a change to the old system involving the Medical Practitioners Disciplinary Committee, to a newer one based on a Code of Patient Rights, and the Office of the Health and Disability Commissioner 1. There were still a number of complaints received under the “old system” being processed. New complaints received after June 1996 were under the auspices of the Health and Disability Commissioner’s Office and the Medical Practitioners Disciplinary Tribunal.

The change from one system to another, and the development of the Code of Patient Rights grew out of the Cartwright Inquiry 2 into practices at the National
Womens Hospital in Auckland. The “new system”, amongst its other procedures, encourages the use of low level conciliation between the complainant and the health professional involved. The underlying philosophy is that issues of dispute between the parties should be resolved without having to proceed to a more formal hearing when this is possible. Nonetheless, there will still be the receipt of a complaint at some point, by the doctor involved.

This study focuses on complaints received under the “old system”, and may provide insight into the effect of receiving a complaint, that is transferable to the receipt of a complaint under any circumstances.

The former Medical Practitioners Disciplinary Committee (MPDC), is a committee responsible to the Medical Council of New Zealand. The process of a complaint relevant to the participants in this study, is that a written complaint either to the MPDC or to the Medical Council directly would be forwarded to the Chairman of the Committee. From there, the doctor involved would receive by post, a letter from the Chairman giving notice of the complaint and the nature of it. The doctor would be instructed to reply in writing to the Chairman, within a defined time period. The reply from the doctor would then be sent to the complainant who would in turn reply to the Chairman of the Committee. At some point in the process, the Chairman would decide whether the complaint in the circumstances was of a nature that required a formal hearing, or whether the complaint could be dismissed. Usual practice would be that the doctor involved would contact his or her medical insurers, being in New Zealand the Medical Defence Union or the Medical Protection Society, and the replies to the
Chairman would be at least edited by the legal advisors of those societies. The process also allowed the complainant to withdraw the complaint if they were satisfied with the response from the doctor.

If the complaint was felt to warrant a formal hearing, the Chairman of the Committee could direct that this occurred, with the potential for the doctor to be found guilty of one of two charges, that is "disgraceful conduct" or "conduct unbecoming of a medical practitioner". The doctor could face a fine, responsibility for a portion of the cost of the inquiry and removal from the medical register or have their practice limited in a particular way. For example, they may be required to work under particular types of supervision or to have restricted access to the public monies or to not undertake particular types of work.

Under the new system, if appropriate, the Office of the Health and Disability Commissioner on receipt of a complaint can initiate a system of mediation aimed at providing satisfactory conciliation for both parties within the Code of Patient Rights, which emphasises the rights of the patient and the responsibilities of the provider. If mediation is not appropriate the complaint is referred to the Medical Practitioners Disciplinary Tribunal (MPDT) and proceeds to a formal hearing.

1.3 Demographic data relating the MPDC

Appendix 1 details the nature of complaints received by the MPDC in the years 1992 through 1996.
These are the years during which the participants in this study received their complaints, with June 1996 marking the change to the "new system".

Over these years, around 70% of complaints were either resolved or dismissed, and this figure was stable across these years. Of the complaints that proceeded to an inquiry, the percentage of upheld complaints dropped from 67% in 1992 to 35% in 1996. The length of time of inquiry increased over the years 1992 to 1996 so that in the last year 25% of complaints were taking over six months to resolve.

For the purpose of this study, analysis of the demographic data indicates that receipt of a complaint in any particular year confirmed neither advantage nor disadvantage to any participant.

1.4 What is known about the effect of medical discipline in New Zealand?

A search of the New Zealand literature over the last ten years failed to identify any published literature in a refereed journal about the effect of medical discipline in this country. All writing on medical discipline was either in the popular medical newspaper-like publications, or in the lay press in the form of magazine articles. All of these articles are commentaries on the overall nature of the disciplinary system and on issues of professional regulation and peer assessment. Articles tend to look at the severe end of the spectrum where
doctors have been found guilty of medical misconduct or conduct unbecoming of a medical practitioner. 3,4,5

A search at the University of Otago Law Library also failed to identify any publications on the effect of the complaint process on doctors, and of interest there were no articles either, pertaining to the effect on legal practitioners of complaints from within their system. There are significant parallels between the medical and the legal professions in terms of their disciplinary bodies and there are no publications in New Zealand on the effect of disciplinary procedures on lawyers themselves. 6 Perhaps a significant comment was that most complaints against legal practitioners are about fraud issues and the misappropriation of clients' monies.

1.5 What is known about the effect of medical discipline/litigation in the overseas literature?

1.5.1 The culture of litigation

Some overseas societies, typified by the United States, function with a widely accepted culture of litigation. The system of litigation is said to have a deterrent function within the medical liability system. 7 What this means is that "the threat of liability will cause physicians to exercise a prudent level of care in the medical decision making". 7 As I will discuss, this concept is directly related to that of defensive medicine, but before examining this I will discuss some issues from the literature that have been examined from the viewpoint of litigation.
The underlying implication is that the threat and process of litigation is directly comparable to the threat and process of medical discipline in New Zealand, and although this may not be the case, there are enough similarities between the processes to warrant consideration.

Before examining the effect of litigation itself, one study looking at perceived causes of family physicians’ errors is worth mentioning. These American authors examined what they referred to as “memorable errors” made by physicians, using in-depth interviews with transcript analysis looking for categories of errors and their perceived causes. Although the authors introduce the paper by noting that errors in patient care “can lead to long lasting remorse and guilt” they did not actually examine the effect of these errors on the participants’ practice of medicine. Instead, they documented the reasons that the doctors gave for making these errors. They were given as being hurried, distracted, lacking knowledge, closing the diagnostic process prematurely and having inadequately aggressive patient management. It is interesting to note that in this study only 4 of the 53 errors led to malpractice suits despite 47% of the cases leading to the patient dying.

We do have existing literature from the US on the effect of receiving litigation and being involved in the litigation process. Probably the foremost researcher in this field has been Sara C Charles, a Professor of Clinical Psychiatry from the University of Illinois. Charles’s findings are worth detailing, as they will provide a point of comparison for the findings from this study.
Charles comments on the importance of the immediate reaction.\textsuperscript{9,10,11} She describes it as a feeling of being stunned, misunderstood, immobilised, or being driven to frantic activity. She describes intense feelings of anger and rage and describes the accusation of the litigation as resulting in feelings of hurt and narcissistic injury. These are seen as being normal reactions to an assault on one's sense of self and personal integrity.

Charles makes the comment that the initial stress of receiving a complaint has such a profound emotional impact that doctors are not always able to initiate their own coping strategies. She describes a 33% incidence of symptoms suggestive of a major depressive disorder, and a 26% incidence of adjustment disorder characterised by anger, irritability, tension and/or somatic symptoms. A further 16% of doctors will have an exacerbation of a previously diagnosed physical illness, such as hypertension, coronary artery disease and so on.

The advice that she gives to physicians involved in litigation is firstly to access social support so that they can discuss their feelings with their spouse, peers, staff members and associates. She makes an important point that litigation challenges the physician’s feelings of control over their lives and induces considerable anxiety. Furthermore, she notes that the malpractice suit draws the doctor into a legal system over which they will have very little control. She notes that as it is an ongoing process, the professional integrity of the physician will be repeatedly challenged, which will lower the physician’s self-esteem. She states that “the challenge to the physician is to live with this charge of negligence”, and her advice to doctors is to alter the meaning of the litigation
and come to the realisation that caring for sick and high risk patients often place
the doctor at risk of being the target of legal actions.\textsuperscript{11}

A telling comment is that "life goes on but is forever changed". She notes that
doctors' feelings about their vocation and themselves will be transformed by the
experience. She notes that changes in practice behaviour include "becoming
phobic about certain patients, practice situations or procedures", also that
"medicine isn't any fun anymore" and recommends that if either physical or
emotional symptoms persist after litigation, consultation (presumably
psychiatric) should be obtained. Charles also raises the possible use of peer
support groups, commenting that they should be under the leadership of people
who have had experience with such events.

Clearly there are significant effects for the doctor who is involved in litigation.
I was unable to find any literature from litigious cultures that specifically
addressed the issue of doctors' practice of medicine in more depth. What has
been examined in the Canadian literature though, is the effect that the threat of
litigation has had, specifically with reference to general practice and the
undertaking of what are seen as at risk activities.

There is evidence from the Canadian literature that there have been
demonstrable changes over a ten year period in physician behaviours with
regard to what is seen as being at risk activities.\textsuperscript{12,13} Specifically, there has been
a marked reduction in the provision of obstetric services, the administration of
anaesthesia and undertaking emergency work amongst Canadian doctors,
especially in rural localities. These authors comment that the risk of litigation is associated with increased evidence of the practice of defensive medicine, and having lower thresholds for investigation. As long ago as 1989, the perception of liability issues was recognised to have had a profound influence on the practice of primary care in Canada, and follow up reports suggest that there has been no change in this finding. The interesting point from Canada is that there has not been any particular change in the actual amount of litigation against physicians, and it is noteworthy that these fears about at risk activities were held in a society in which the risk for litigation is believed to be about eight times less than in the US.

1.5.2 Other Non-litigious cultures

Internationally there is a paucity of literature on the effect of complaints in what we would regard as “non-litigious cultures”. The available literature focuses on the practice of defensive medicine, which will be discussed in section 1.5.3. However, an important notion to emerge with regard to this study, came from the Netherlands in 1994, highlighting that even if patient dissatisfaction was not communicated through legal action, it may not be any less threatening to the doctors involved than if it had been. The author analysed the responses of 56 family doctors who were asked to identify factors contributing to their own defensive behaviours. Defensive behaviours were predicated by concern for the doctor-patient relationship. Doctors worked to avoid:

1. Overt conflict with patient.
2. Lack of confidence of patient.
3. A loss of appreciation by patients of their doctor.
It was the relational considerations made by Dutch family physicians that most influenced their practice of defensive medicine.

The Dutch paper signposts evidence of a change of behaviour by doctors due to concern for the doctor-patient relationship, and it highlights the need for study of possible effects on the doctor-patient relationship, of a complaint in a New Zealand context.

1.5.3 Defensive and defensible medicine

Defining and examining aspects of what is meant by defensive and defensible medicine is important in the context of this study. The terms carry with them connotations that maybe viewed as desirable or undesirable depending upon one's standpoint. One definition of defensive medicine is "deviations induced by threat of liability from what the physician believes is, and what is generally regarded as sound medical practice". A second definition introduces different concepts thus: "medical practice decisions which are predicated on a desire to avoid malpractice liability rather than a consideration of medical risk-benefit analysis".

We see in the first definition the concept 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 required to actually deviate from "sound medical practice", but to fail to satisfactorily consider the risk-benefit of the particular practice. From the second definition arises the interesting concept that the use of a system of
medical liability can provide the incentive for a physician to practice in a way that favourably enhances the risk-benefit analysis, and which conversely can deter the physician from practising in a way that may increase risk. The argument would then proceed that defensive medicine is a desirable way of practising as long as the risk-benefit analysis is appropriately enhanced. In general however, much defensive medicine is not justified by risk-benefit analysis, but is practiced on the basis of liability avoidance.7

An important consideration is that defensive medicine may be defined in both positive and negative terms, with positive defensive medicine meaning the overuse of medical resources of whatever nature, such as investigation, intervention, referral and so on, and negative defensive medicine meaning that the resource is withheld.

It is important therefore, to be quite specific about the form of defensive medicine being practiced. It needs to be considered in terms of whether it is desirable or not, whether the risk-benefit analysis is appropriate and whether it consists of the over or under utilisation of medical resources.

The financial cost of defensive medicine it is clearly significant even in cultures which are predominantly non-litigious. A recent Canadian editorial claimed that “defensive medicine appeared to contribute greatly to health care costs”.12

In the mid 1980s, the total cost of professional liability was estimated to represent about 15% of US health expenditure for physicians services, with only
about a quarter of this (at the time about US$3.1 billion) being attributable to liability insurance premiums and the cost of defending claims. The remaining 10 billion dollars or so was estimated as the cost produced by defensive alterations in practice patterns.

Clearly the monetary cost is significant, but one needs to consider this in light of the first definition of defensive medicine that was offered, and the concept of “sound medical practice” which will undoubtedly shift patterns of health expenditure over time. What requires consideration, is that shifts in health care expenditure have been shown to exist in both litigious and non-litigious cultures and that whatever approach we take as a society to the issue of complaints and censures against doctors, it is going to have significant associated monetary costs.

Defensible medicine by comparison is more compatible with the concept of “sound medical practice”. Defensible medicine does not imply a “deviation” from an accepted pattern of practice or behaviour, but rather the inclusion of accepted patterns of practice into one’s routine. If defensible medicine is to be encouraged, then changes in practice need to be along the lines of desirable changes that take into account risk-benefit analysis, so that there is an improvement in the health benefit regardless of the direction of change in medical costs, and that this is seen as being appropriate.
This study will look for evidence of changes in practice by the participating doctors, that have been influenced by the receipt of a complaint or predicated by a desire to avoid a further complaint.
1.6 The doctor-patient relationship

Central to this thesis is the doctor-patient relationship and the pivotal role it plays in the medical encounter. Examining the practice of medicine over the centuries, we see evidence of inadequate understanding of the nature of disease and equally of its treatment. In order for medicine to have persisted, it must have had some redeeming values though, and we are led inescapably to the conclusion as summarised recently by Eric Cassel that “the treatment has been doctors themselves through the vehicle of their relationships with patients – not any relationship, but the doctor-patient (healer-patient) relationship”. Cassel comments on aspects of the doctor-patient relationship that are fundamental to this thesis. He comments on 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 upon an understanding of the effect of sickness on the particular patient involved.

In this section I will explore the origins of the doctor-patient relationship and the development of medical paradigms that are relevant to it.

Inherent to this discussion are two premises that need to be clearly stated. The first is that the doctor-patient relationship involves two parties; despite our tendency in medicine to look outwards at the patient’s experience, there is also a need to examine the side of the equation related to the doctor. Secondly, is the premise that changes that are detrimental to the doctor-patient relationship are
detrimental to patient care. Again, these detrimental changes may occur on either side of the relationship.

Also inherent to the discussion is that the doctor-patient relationship is in itself a therapeutic one. This concept has long been espoused in general practice literature, predominantly due to the writings of Michael Balint and his concept of "the doctor as the drug". 16

The idea of the doctor as a therapeutic agent 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". 17 This shows recognition not only of the doctor as a therapeutic tool, but the importance of doctors' attitudes towards their patients.

This therapeutic state however is not a natural given. More recent research looking at the thought processes of patients during consultations shows that patients are continually assessing the doctor during the consultation. 18 Furthermore, not only are they assessing issues such as willingness and ability to help them, but patients are also acutely aware of the nature of the relationship that they have with the doctor and are looking to establish the security of it. Not only are the patients determining the doctor's quality at the level of a personal relationship with them, this assessment is an ongoing process. Given that this process is likely to happen not only within a single consultation by also over a long period of time, the therapeutic effectiveness of the doctor-patient
relationship needs to remain stable and be protected from circumstances that may reduce the doctor’s ability to deliver an appropriate level of care.

Another understanding important to this discussion is the need for the doctor to be able to carry on therapeutic relationships with relatively large numbers of patients over time, being aware that the patients are unselected and have unselected conditions. Put simply, after you finish seeing one patient, you will see another and another and so on. With each patient there is a need to develop and perpetuate a satisfactory relationship. Furthermore, one of the really important aspects of general practice, as articulated by Ian McWhinney, is the need to be acquainted with the details that pertain to the particular patient with whom one has that relationship. This differs from the concept of generalisations and generalisability. It is central to the justification of the doctor-patient relationship as a legitimate focus of study. 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 patients’ needs.

Perhaps the essence of this argument is summed up best by Marinker when he said that “if we fail to value the uniqueness of the doctor and the patient, the role of feelings and situations in the interpretations of symptoms and findings, we are condemned to be second rate players in a second hand game”.

Although he was referring in part to the justification of general practice as a separate academic discipline, these sentiments are applicable to all doctor-patient encounters.
In the following sections I will examine in more detail concepts related to the doctor-patient relationship, the recognition of the bio-medical paradigm and the emergence of the bio-psychosocial paradigm leading to our current concept of patient centred medicine.

1.6.1 The historical basis of general practice and the doctor-patient relationship

The historical origins of general practice illustrate the emergence of sets of particular values. Given our close historical links with the United Kingdom, it is pertinent to look at the emergence of general practice, in that context. It appears that up until the start of the 19th century there was little to suggest that the relevance of a strong interpersonal relationship between the doctor and patient had been recognised. This is not to contradict my previous assertion that the doctor-patient relationship was probably almost all that was offered in antiquity, but to make the point that the business of medicine lay in the dispensing of medicines, the performing of surgical procedures and of obstetrics. The doctor only needed to apply the virtues of kindness and humanitarianism in the cause of keeping hold of patients. 22

Emerging from this rather mercenary attitude has been the general practitioner, who over a period of only 20 years or so early last century became idealised in an almost saintly fashion, both in Victorian literature and within the medical profession itself. Characteristics of devotion, working long hours, being prepared to accept material poverty, and being ready to listen, advise and to
form close interpersonal relationships with patients, became the hallmark of the
genral practitioner.

It is interesting to then consider why general practice persisted predominantly in
the UK (and clearly in New Zealand) despite the emergence of “scientific
medicine” around the turn of the 20th century. Perhaps the answer lies in the
writings of Abraham Flexner when in 1925 he commented on the process of
scientific medicine being in conflict with the humanity, the human response to
need in others, which should characterise the physician in the presence of
suffering.23

This perception of being in touch with the experience of suffering, which
implies entering into a relationship with the sufferer, has perhaps been the factor
that has allowed general practice to persist through to modern times.

1.6.2 The biomedical and the bio-psychosocial paradigms

The relevance of discussing biomedical and bio-psychosocial paradigms in this
thesis lies in recognising that not only has paradigm shift occurred, but that the
nature of this paradigm shift highlights the importance of the role of the doctor
within the doctor-patient relationship. If we hold to the worldview of the
biomedical paradigm, the role of the doctor-patient relationship becomes almost
an irrelevance. The shift to the biopsychosocial paradigm requires doctors to
understand the meaning of illness for their patients and to do so requires
entering into a relationship with them.
But firstly, do these paradigms exist and has a shift occurred?

To answer this one must examine models of understanding, ways of knowing. Thomas Kuhn introduced the concept of paradigm shift in his theory of scientific revolution and he referred to the way in which scientists hold on to a set of received beliefs as a paradigm. In essence, he states that when there are a sufficient number of anomalies recognised within the accepted set of beliefs, a crisis occurs and there is a shift in the world view so that a new paradigm or belief system comes into existence. It is reasonable to look at the same concept within medicine, and the starting point of modern biomedicine is probably related to the mechanist Newtonian worldview of the 19th century, and the disease-centred approach that came to prominence in the early part of the 20th century.

Emerging in the latter part of this century has been tension and conflict with the traditional biomedical paradigm. George Engel in his seminal article entitled "The clinical application of the biopsychosocial model" stated in 1977 that the biomedical paradigm "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 comments that the biomedical model sees disease to be "an entity independent of social behaviour".

Engel went on to propose the biopsychosocial model which is based on a hierarchy of natural systems, called systems theory. In this theory, the person
represents both the highest level of organismic hierarchy (the atoms, molecules, cells, organs and systems that go to make up the structure of the person) and is the lowest level or unit of a social hierarchy in which the person is a component of two person relationships, families, communities, cultures, societies and the wider biosphere. The point is that the relationship is continuous. The cells and organs of the person are in the same hierarchy as the family, community, society and so on. Understanding this continuity allows one to account for the anomalies of the biomedical paradigm, where the illnesses of a patient are inadequately accounted for within a mechanistic disease framework.

This is an example of a paradigm shift within medicine. Engel introduces a new way of thinking that replaces (in this instance by consuming) an old paradigm and which allows a way of knowing and of researching that knowledge until sufficient anomalies arise that demand the creation of a new paradigm. The importance of the biopsychosocial paradigm shift lies in the call to understand the nature of the person, their contextual situation and of the role of that person within their social hierarchy. The meaning of that hierarchy for the patient lies in the context of their illness. To further explore this we need to examine some concepts from medical anthropology.

1.6.3 The contribution from medical anthropology

A major contribution from medical anthropology has been the notion that there is a difference between disease and illness, and this furthers the application of systems theory that is discussed in the bio-psychosocial paradigm (above). This is fundamental to understanding the nature of the doctor-patient
relationship and highlighting that both the doctor and the patient will have similar and different cultures, and that they will bring these similarities and differences to the consultation. Both patients and doctors will have explanatory models that will be used to explain what has happened to the patient and which will impact on the behaviours observed in response to a disease process. \textsuperscript{26}

In differentiating between the concepts of disease and illness, Cecil Helman puts it simply as “disease then is something an organ has; illness is something a man has”. \textsuperscript{26} The contribution of anthropology, which is concerned with meanings rather than with measurements is relevant both to the doctor-patient relationship and to the nature of this investigation. Not only will doctors give meaning to their patients’ diseases from within the culture of their medical background, but that background itself will alter the ability of doctors to give that particular patient’s presentation meaning. So on both sides of the doctor-patient relationship there is a cultural basis from which the person arises and acts, and a societal and cultural milieu in which they exist.

One of the contributions from medical anthropology has been to answer the “why?” question posed by modern health care systems, when one group of people responds or behaves differently from another. \textsuperscript{27} The idea that lay person beliefs about health may be different from those of the medical profession is a most important one. It has direct relevance to understanding why conflict may occur when either the beliefs or expectations of a patient are not respected or met. Furthermore, as Helman points out, over-emphasis of disease and under-emphasis of the patient’s illness may be a cause of dissatisfaction on the part of
the patient, leading to undesirable patient events such as reduced adherence to therapeutic regimes and undesirable doctor events such as complaints.

1.6.4. The emergence of patient centred medicine

Patient Centred Clinical Method has developed over the last two decades in response to the need for medicine to have a model capable of integrating the traditional biomedical paradigm, its newer replacement the bio-psychosocial paradigm (and its attendant concept of systems theory), with the experience of illness that each patient brings to the consultation that is unique to them. The value of discussing this model is its relevance to our current understanding of the nature of the doctor-patient relationship. It highlights some of the important issues that arise when considering the effect of complaints on medical practitioners. In their 1995 publication Wayne Weston and Judith Belle Brown claimed that the patient centred model is valuable in four main ways.\(^{28}\)

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.

The implication is that it also helps define when effective doctoring has not occurred.
In table 1 the six interactive components of the patient centred process are listed.

**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 and 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

Many of the ideas presented in this model follow from the previous discussion, but are worth in part reiterating. The notion of the disease as an abstraction, and illness as an experience are preserved in this model. There are requirements for effective care that bear a direct relationship to satisfaction, compliance and outcome. If the biopsychosocial paradigm and systems theory is accepted, the first three components of the patient centred process are reasonably straightforward. The last three however are most important in consideration of the doctor-patient relationship and the potential for the negative impact of inappropriate medical behaviour within consultations.

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, (which by implication is not only self-awareness of the doctor but also that of 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”. 28

In this more sophisticated model of the doctor-patient interaction, the place of the doctor achieves increasing recognition. Furthermore, the model does not view the doctor as being solely responsible to patients and patients as being only responsible to themselves. Indeed, 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 in responsibility for their own health care.

The Patient Centred Method model is relevant to the issue of examining the complaint process, in that it incorporates enough components of the consultation to be useful in examining the entire aetiology of a complaint and allows examination of aspects related to the prevention of complaints. In summary, the latter part of this century has seen the development of models for understanding the process of medicine, all of which lead towards rather than away from, the importance of the doctor-patient relationship in the delivery of health care.

1.6.5. Concepts of autonomy, paternalism and beneficence

A brief introduction and discussion of the concepts of autonomy, paternalism and beneficence is warranted in consideration of the doctor-patient relationship. In essence, these terms describe an attitudinal state of the doctor toward the patient, although one might argue that they are also attitudes possessed by the patient, given that autonomy and paternalism are grounded in philosophical principles that lie within the public domain. I believe that it is the responsibility of the doctor to be aware of the influences of these attitudes within the context of the consultation.

The place and relative importance of paternalism, autonomy and beneficence will lie within the cultural fabric of a particular society and as such, they may not be transferable to another culture. Therefore there is potential for
incongruence between the behaviours of doctors and patients based on these attitudes, that could give rise to a complaint. Similarly, these attitudes of paternalism, autonomy and beneficence will influence the response of a doctor to the receipt of a complaint. I shall examine each concept separately, briefly exploring their strengths and weaknesses.

Paternalism as defined by Pellegrino and Thomasma is based on the notion that the physician has better insight into the interests of the patient than does the patient, or, that the physician’s obligations “are such that he is impelled to do what is medically good, even if it is not good in terms of the patient’s own value system”. Autonomy on the other hand is related to independence (implying freedom of action) and authenticity (implying that the motives for action stem from one’s self).

The arguments for and against paternalism and autonomy are complex and specialised. They may differ, depending on the viewpoint (for example medical or legal) of the commentator. Pellegrino and Thomasma sum up the limitation of paternalism as an appropriate model within the doctor-patient relationship as being “the fact that authentic healing can not take place in a paternalistic model since paternalism overrides patient choices. Personal choice is essential to the processes of reintegration which, in turn, is essential to healing”. The argument against autonomy is based around “the need to engage as a society in the pursuit of some common moral goals”. These authors believe that freedom must serve the purpose of the community as well as the purpose of the individual. Even in examination of apparently straightforward issues such as
the allocation of health care resources, reliance on autonomy as a model for behaviour within the doctor-patient relationship would quickly bring the health care system to a halt. This is not however, to undermine the principle of autonomy as a foil to the principle of unfettered paternalism. The concept of beneficence arises from these considerations.

Some of the features of the model of beneficence that Pellegrino and Thomasma suggest are as follows. They believe that beneficence is a prime requirement for medicine and is obligated in the following ways. The physician needs to attend to the patient’s problems and needs, and this takes precedence over all other concerns. Secondly, the physician is to avoid harm to the patient (non-maleficence). Thirdly, beneficence represents a higher plane of moral functioning in which the choice of how the physician acts (as to whether to foster autonomy or act paternalistically) is based upon what most benefits the patient, and sets aside the intellectual and emotional needs of the physician.

Another feature is that it is the existentialist state of the patient rather than the doctor’s professional code that is important. In this way the needs of the debilitated or incompetent patient are accounted for as are the realities of providing care in a particular environment.

Another feature of beneficence is that it respects the individual nature of the patient and the only ethical stance required is that the patient’s best interests are acted in. Furthermore it brings to the interaction the notion of consensus, with
an awareness that the ability to achieve consensus may vary over time and may need to be reviewed.

Beneficence requires the physician to act under the guidelines of general ethical or moral rules.

It is clear from this discussion that the model of beneficence within the doctor-patient relationship allows aspects of both paternalism and autonomy to be combined, and it has the best interests of the patient at its forefront. It sits comfortably with the concepts of patient centred method we have discussed. It highlights again though, the need for awareness that the doctor-patient relationship has two sides to it, and that the role of the doctor must be considered when one is looking at influences on the relationship and on any doctor-patient interaction.

From the history of general practice and the development of biomedical and bio-psychosocial paradigms culminating in the currently favoured patient-centred method, there is evidence that the state of the doctor-patient relationship is an important one to research. There is a call for awareness of the importance of both the culture of the doctor and of the patient within that relationship and of the health beliefs that each brings to it. Both doctor and patient will bring to a consultation attitudes and behaviours that reflect a stance towards paternalism beneficence or autonomy. This has implications for both the genesis of a complaint and its resolution.
1.7 The person of the doctor

Having established the importance of the doctor-patient relationship I will explore the concept of the person of the doctor. This section will consider those characteristics of the make-up of the doctor that, knowingly or not, doctors bring with them to each consultation.

The doctor is not an automaton, an impersonal computer who, if feed the right information, can simply form the correct diagnosis and dispassionately treat any and every patient whom they encounter. Each doctor brings their own psychological make-up to each consultation, and I will explore some of the characteristics that go towards making up the person of the doctor. The implication is that if a complaint has had an impact on the person of the doctor, then that impact will become apparent in a change in the nature of the doctor-patient relationship.

I will explore three separate but overlapping areas that relate to the person of the doctor. The first is an exploration of the concepts that have been promoted of “self”. Secondly, I will explore some of the particular characteristics and vulnerabilities of doctors, using findings that have primarily come from research into the problems of alcoholism, other addictions and marital distress. The third area is an examination of the impact of the medical education experience, leading to an examination of the impact of the professional culture of medicine and of ideas related to role, on the development of the person of the doctor.
1.7.1 Concepts of self

Consideration of the concept of self raises the issue of how one can define self, who should be responsible for defining it and how it can be known. Collins Concise Dictionary defines self as being “one's own person or individuality”. Usually awareness of self is relatively unimportant, although it becomes more important when it is in jeopardy. If the sense of self is challenged or even brought into sharp relief by the process of a complaint, then we need to be open to examining its importance.

Before moving to some of the more psychological writings on self, it is worth considering the place of self-observation. This century has brought with it increasing realisation that it is impossible to separate the observed from the observer. Because the self of the observer is inseparable from the remainder of the system that is being observed, an understanding of self, and of subjective inner awareness, is a valid field of scientific endeavour and of understanding.

I am indebted to Jan Breward's discussion of self, highlighting Carl 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”, meaning that one can approach, but never fully attain true self understanding. Breward also draws attention to our natural fallibility which impedes our true understanding of self if we rely on introspection alone. Breward comments that it is only by interacting with others that we can optimise our self-awareness, by avoiding self-delusion.
These notions, that an understanding of self has validity in all scientific observation, and that an understanding of self can never be perfectly reached by oneself alone, are very important to this discussion. If a complaint and the effects of it are to be analysed in the manner of any scientific inquiry, then there is justification for the analysis of self. Furthermore, the involved doctors by themselves may have difficulty, so to speak, seeing the wood for the trees. The idea that self-awareness requires the participation of others is important when we examine how doctors respond to complaints, and how the process itself may then be influenced.

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 of "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". Turning this statement around, if someone's thoughts and behaviours are examined after an event, and evidence of a lack of awareness of needs perspectives and so on is found, the implication is that there has been significant disruption to that person's sense of identity. By studying the effect of a
complaint on the behaviour of the doctor, evidence can be sought for the effect of a complaint on the “self” of the doctor.

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 clearly important when we consider the effect of a complaint. If the effect of a complaint is to transgress upon that doctor’s boundaries, then there is potential for the doctor to become less aware of their own rights to safety, which could lead to inappropriate acceptance of the behaviours that led to the complaint initially. Or conversely, doctors could inappropriately transgress the boundaries of other patients if they see themselves as being threatened, which ties in to the notion of defensive medicine discussed in section 1.5.3.

Briere describes a third self-function, that of affect regulation, as having two components, modulation and tolerance. When an individual has good affect tolerance, they are able to “experience negative affects without having to resort to external activities” e.g. aggressive behaviours and so on, or the use of psychoactive substances. Affect modulation refers to the individual’s ability to deal with upsetting events internally, for example placing such events into their correct perspective, or being able to soothe, distract or in some other positive
way, deal with the problem. Although this concept does not in itself define self, taken in partnership with the concepts of identity and boundary it provides insight into how internal mechanisms exist to deal with challenges to self. Again, turning this concept around provides evidence of negative coping behaviours as indicators that not only has there been a significant challenge to the self of that person, but that the internal capacity of that person to deal with it has been overwhelmed.

Discussion of the concept of self inevitably leads into the use of phrases such as “self worth”, and “self esteem”. I think these concepts are related to Briere’s idea of identity. They are descriptors of a self-reflective process of understanding. So when somebody says that their self worth or their self esteem has been challenged or affected, they are internally defining their identity as it relates to that event, judging either positively or negatively their ability to handle it. I will explore the development of self in section 1.7.3 as it relates to understanding of self from a professional point of view. But before doing that, I will look more broadly at the psychological makeup of doctors, mainly through the work of researchers who have examined difficulties and failures in the lives of physicians.

1.7.2. Some psychological characteristics and vulnerabilities of doctors

The title of this section is taken directly from the groundbreaking work of Vaillant who showed that symptoms suggestive of psychologic vulnerability are
strongly associated with life adjustment before medical school. For some doctors the very reason that they are drawn towards the practice of medicine is the nature of their psychological selves. This in turn is a function, at least in part, of their upbringing.

Although obtaining psychotherapy is no longer culturally viewed as a weighty symptom of psychological vulnerability, research into the other two areas of marital failure and the use of drugs and alcohol has continued to show that some doctors are particularly susceptible to these problems, because of their upbringing and subsequent psychological characteristics. With respect to this thesis, the importance of this lies in the wider issue of how doctors deal with stress, and why it should be that receiving a complaint is a stressful event. If we examine what we know about the psychological characteristics of doctors and how this pertains to their development of a sense of self, their response to a complaint may become more clear.

Vaillant questioned the accepted values of the day in the 1940s, when the problems of physicians' marriages were chalked up to the demands of patients, the abuse of drugs, to the ready access that they had to them. The use of psychotherapy was seen as a reflection of doctors being less self conscious about its use than the general populace.

By following a cohort of doctors over a thirty-year time course, and matching them with controls of similar socio-economic background, Vaillant concluded that there were particular psychological needs that predisposed physicians to
these problems, that were based upon their childhood upbringing. One of Vaillant’s important findings was that in situations of conflict, physicians were more likely to turn their anger against themselves, than to strike out at the environment. This concept resonates with the “affect regulation” model of Briere. Vaillant goes on to comment that “medicine only becomes a strain when the physician asks himself to give more than he’s been given”. He is referring here to internal resources that the doctor has, and further comments that those doctors who are more psychologically sound by the time they had reached university were less likely to turn towards self-destructive and addictive behaviours in times of stress.

The key finding of Vaillant’s study however, is that “physicians often heal others in hopes that they too, maybe healed”. This could otherwise be paraphrased as “the need to be needed”. For reasons of their upbringing a particular psychological characteristic that many doctors are bringing to the doctor-patient relationship is the need to be needed. Understanding this underlying need to be needed as a component of the self of the doctor, makes the significance of the challenge posed by a complaint more obvious.

In their paper on primary prevention of addiction of the physician, Virshup and colleagues draw attention to the fact that doctors are often self-selected and “having grown up in a dysfunctional family, and having little primary sense of self worth, attempt to achieve it by the secondary means of accomplishment, the esteem of others, and, in the case of the helping professionals, on being a good helper”. They make the point that in a dysfunctional family of origin, the
perception of self worth becomes conditional on achievements and on acceptance and on being a helper. Immediately we see the parallel with the practice of medicine. Again the idea of the “need to be needed” arises, and if one’s sense of self is predicated upon this, the failure of such a reward system will inevitably mount a significant challenge to one’s self.

In table 2, Edwin Harari lists some of the personality characteristics of doctors in his article on marital dysfunction. These characteristics are consistent with the doctor finding meaning for self in his or her work. Although other researchers have commented on similar personality characteristics of doctors and the destructive effect that it has on marital relationships, the relevance to this discussion lies in predictable responses to stress, especially to the stress of a complaint.

**TABLE 2.**

Personality characteristics of doctors:

- Obsessive traits
- Self doubt
- Guilt
- Excessive fear of failure
- Excessive fear of making a mistake
- Exaggerated sense of responsibility

Harari
It is not reasonable to assume that all doctors have experienced the same dysfunctional background and carry with them to medical school the personality characteristics described. The question now is whether there is a common body of experience likely to impact on doctors as a group, that has relevance to this discussion. The answer of course is yes, being the experience of medical school, the induction of professionalisation, and the development and ideation of one’s concept of the role of the doctor.

1.7.3. The medical education experience, professionalism and the notion of role

The idea of role is integral to the concept of self, and it is not sufficient to rely simply on the previous discussion of the impact of upbringing and subsequent psychologic characteristics, to define self. There is an intense enculturalisation process inherent in medicine that impacts directly upon one’s concept of self because of the way in which the role of the doctor becomes determined. How one’s role is seen, will both determine and be determined by one’s concept of self. This role is then carried into the consultation and will impact directly upon the doctor-patient relationship.

A start to this discussion is to consider the stereotype of “a good doctor”. O’Hagan makes the point that “a good doctor”, is expected to work hard, always be busy, be strong and confident, never reveal weakness or uncertainty, never get sick, always control the emotions, be talented, ambitious, and competitive. Interestingly the same author comments that the profession of medicine carries with it the traditional stressors of “long hours, difficult
decision making against a background of uncertainty, dealing with death, tragedy or traumatic life events, and the need to keep up to date and competent”.

The characteristics of the doctor as espoused here reflect the profession’s attitude towards good doctoring and not just the lay public’s attitude. The characteristics are almost incompatible with the demands of the profession. The conclusion is that failure to always be a “good doctor” is an inevitability.

A similar incongruity has existed for centuries in the perception of the doctor as either the loving brother or as the God-like saviour. This God-like role is one that is particularly important to consider. Although most patients would be quick to point out that their doctor is not a God, Campbell notes that “people want their doctor to have God like knowledge and powers and so they frequently collude in the maintenance of medical dominance”. He goes on to say that “the doctor as God must be replaced by a fallible human being whose knowledge is incomplete and whose will is corruptible”. One must question to what extent an ill patient is prepared to give up placing the doctor in a God-like role, and also question to what extent doctors can resist this role in every situation. The stereotypic representation of the “good doctor” leaves little space for shades of grey, preferring instead the black and white picture.

Experience of medical school and of early post-graduate training appears to have significant impact on the psychological development of doctors. Although arguably the studies on addiction and physicians take an overly negative view of the subject, there appears to be evidence that students in
medical schools across the world are treated in an abusive manner. The point is that the abuse reflects the type of abusive environment that some students will have been exposed to before entering medical school, and will further compound the psychological and emotional difficulties that these students will encounter. Why do such systems continue? The reason is probably two-fold. The first is that for students raised in a dysfunctional family, the only reward system that they know of is intellectual success in demanding circumstances (as typified by the over-achiever). The second (and more frightening) observation is if one uses the model of family abuse situations, abuse is perpetuated across generations and it is quite conceivable that teachers within medical schools may perpetuate the environment that they themselves were exposed to.

A further problem with the medical school experience is likely to be incongruence between the expectations of new entrant students and the reality of their experience. Again, this probably reflects the difference between the public perception of the romantic and omnipotent doctor, and the reality of medical school and professional practice.

It is interesting that some of Vershiup et al’s recommendations for the prevention of addiction of physicians are consistent with several of the perspectives of the development of the self of the doctor already discussed. Some of Vershiup et al’s recommendations for changes in medical school curricula include encouragement to express feelings, improving a sense of self worth that is not dependent on grades achievement or approval, and enhancing an ability to use criticism constructively and accept failure and less than perfect
results. Growth of self-responsibility, which they define as responsibility for
taking charge of filling their own needs by developing an internal locus of
control is seen as important; and finally, learning good social skills.

Against a background of these concepts and recommendations, it is interesting
to examine the response of medicine as a profession in times of stress.
O'Hagan refers to "a combination of denial and collusion which often leads to
late recognition (of problems) and referral". He describes this as "a
conspiracy of friendliness or a collusion of silence". This notion of professional
silence is echoed by David Rabin an American doctor with amyotrophic lateral
sclerosis, who commented on the "deafening silence" of response from his
fellow physicians to his suffering.

These sorts of responses are particularly important if one considers the
characteristics of a profession. Because of the autonomy professions have in
terms of their own regulation, they are relatively free of lay evaluation and
control. The norms of professional practice are likely to be stringent, the
profession's members identify strongly with the profession, and are unlikely to
leave it once they are trained. The profession can be regarded then, as a
particularly powerful socialising and enculturalising force. The problem is, as
Rabin writes, "for an eternity of healers, becoming ill is tantamount to
treachery. Furthermore, the sick physician makes us uncomfortable. He
reminds us of our own vulnerability and mortality and this is frightening for
those of us who deal with disease everyday". If the response of the profession
towards illness in its members is like this, then it is possible that the profession
may respond in an equally inappropriate way towards doctors who have been
the subject of a complaint. The “person of the profession” may be challenged
by its members being complained about in the same way that the person of the
individual doctor maybe challenged.

Hannay defines roles as being our looking-glass selves, meaning how we are
seen by others, and makes the note that those others can be in a general sense, in
a significant sense, or be part of a particular reference group. The important
idea is that (a set of expected behaviours) goes with a particular role. These will
be predicated by particular values and expectations that are likely to be shared
by people within that particular role. Obviously, any one person may have more
than one role: for example, be both a doctor and a parent. It follows that
different roles may either be congruent or in conflict with one another, and
clearly if role is not just defined by the person in that position but also by
another party (for example, the patient tending the doctor) there is potential for
both congruence and conflict within a particular encounter. The patient and the
doctor may define the doctor’s role differently and hold different perceptions of
the role of the patient as well. The concept of role then is important in this
discussion for two reasons. Firstly, how doctors see their role is entwined with
their sense of self in a way that will be particularly deep and meaningful for that
individual. Secondly, role implies interaction with other members of society
and a need to account for the differing perceptions of role that may exist.

A complaint may impact on a doctor’s sense of self by challenging
their perception of role. This study seeks evidence of questioning of
role by participants.
1.8 Shame as an emotional response

Because human beings are capable of a wide range of emotional responses, it seems naïve to focus on a single emotional response apparently at the exclusion of others. However, there is a place for examining the emotional component of the response to a complaint, and to try to understand the content of that emotion and the implications that it has for behaviour. There is a profound impact on doctors from receiving a complaint that appears out of proportion to the “intellectualised” importance of the complaint. One conclusion is that there is a significant emotional response and although there is a risk of over-simplifying the matter, I propose that there is value in looking for an explanation of some of the emotional responses in a way that may not always be generalisable, but may be transferable between situations.

Both doctors and patients will have had emotional responses associated with the complaint and I will discuss some of the published literature which reports how patients may experience shame in a consultation and respond to it with a complaint or litigation.

The emotional response by a doctor to receiving a complaint is directly relevant to the preceding discussion in section 1.7 on the person of the doctor, and to the effect that the complaint has on subsequent doctor-patient relationships.
1.8.1 The concept 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".\textsuperscript{44} It encompasses the whole of our selves; it generates a wish to hide, to disappear, or even to die. Lewis has developed the important 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, about their sense of self, as 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 joy, sadness, anger, disgust or fear can be described as primary emotions. They all require some cognitive activity to be experienced, but they do not require consciousness of self, as do secondary emotions such as shame, guilt or pride. It is consciousness of self that separates primary from secondary emotions, and the importance of this lies in the understanding of the value of an emotional response. The value lies primarily in the self-regulatory role of the emotions. It is the ability to reflect on ourselves, or to have an "object of experience" that allows us to interpret and evaluate our thoughts and behaviours.\textsuperscript{44} This becomes important in considering the effects of enculturalisation and socialisation of medical school and early postgraduate training. During childhood, increasing awareness of self allows the primary emotions to be experienced, and with increasing social sophistication cognitive skills are developed that allow the secondary emotions to be expressed. There is considerable evidence that many of the secondary emotions are experienced
quite early in life, but as understanding of self changes with age, so do the secondary emotional responses. 44

Shame and guilt are experienced as the consequences of the self's failure in regard to a standard or rule. Conversely, pride is an example of secondary emotion that is a consequence of the self's success 44. In other words, the processes of living within a culture and a society give rise to the development of different emotional responses because of the particular standards or rules that are defined by that culture or society. Returning to the notion of the "good doctor" as discussed in section 1.7.3, it becomes clear how a profession can set particular goals and standards against which one measures one's self.

The emotions experienced on failing to meet these standards or goals are guilt and shame. The difference between them 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. This is extremely relevant to complaints and litigation. Because the goals and rules that govern the way people live are able to be learned, and an individual's evaluation of success or failure also involves learning, then it follows that the way that one responds to failures may be able to be altered. Lazare asserts that the experience of shame results from the interaction of three factors, being (1). the shame inducing event, (2). the vulnerability of the subject and (3). the social context, including the roles of the people involved. 31 These determinants may be able to be manipulated to alter both the induction of the shaming response, and the downstream effects of shame.
Responses to shame can be either adaptive or maladaptive. A relatively minor shaming event can be dealt with using humour or laughter. A more meaningful shaming event maybe responded to with a hiding response, which may be in itself protective against further intrusions against the self. Here we find similarity with Briere’s idea of boundary as a component of self. By distancing one’s self from the shaming event, the self is protected. Taken to an extreme however, distancing excessively removes the individual from normal social contact and in an extreme case may result in suicide. The emotional response of shame can itself be protective, but may also become maladaptive.

A further consideration here is in the consequence of prolonged shame. This may involve both 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 one commonly sees, particularly in response to prolonged shame. The implication for this research, is that evidence of prolonged rage or depression following a complaint may signpost the complaint as a shaming event for that doctor.

Lazare suggests that in physicians, shame-inducing events will include: failure to diagnose or treat, in a way that does not comply with one’s own or colleagues’ standards; the induction of shame through “empathic identification” where there is over-identification by the physician with the patient, (who may well have a disorder or circumstances with which the physician can readily
identify) and lastly the experience of disrespectful behaviour by the patient, or the patient's family. This includes threatening to sue. 31

Given that it is possible to be shamed by the action of others, and bearing in mind the power of professions to create value systems, shame as an emotional response will also apply to any (and particularly medical) person that the complained about doctor turns to for help. There is therefore a need for any helper in this situation to be aware of the presence and power of their own emotional responses at these times.

1.8.2 Shame as experienced by patients

This thesis is concerned about the effect of complaints on doctors, but it is worth briefly exploring the way patients experience shame and their reactions to it. In brief, there are three particularly important determinants of shame that may be encountered by patients in a medical setting. 31 The first is the actual physical setting, which although probably of more importance in an institutionalised clinical setting, such as an American hospital, still needs to be borne in mind in general practice as a potential cause of shame in particular patients, whose concept of self is threatened in particular physical situations. Examples might include being seen at a particular clinic (eg. oncology or STD), being kept waiting or feeling rushed. A second determinant is the particular stigmata of disease and the naming labels that are used in medicine such as having a "lazy eye", an "irritable bowel" or an "incompetent cervix". A third determinant is the exposure by patients of their physical and psychological selves to the doctor with its attendant vulnerability.
Patients will respond to shame as previously discussed in section 1.8.1. Several commentators have observed that resorting to litigation and complaint is one of the behaviours that shamed patients are likely to undertake.\textsuperscript{31,40,44} The implication is that awareness of potentially shaming situations in the doctor-patient interaction and the use of responses by the doctor that convey a sense of understanding of the emotional distress involved, may go a considerable way towards preventing litigation and complaints in the first place.

It is also worth discussing counter humiliation/shaming from the doctor which may be experienced by the patient. It is important for the doctor to bear in mind that he or she maybe shamed by the patient in a way that the patient has no control over (for example not responding in the expected way to a prescribed therapy) or by engaging in a behaviour (for example considering getting a second opinion) that was never a shame response in the first place. The doctor should avoid shaming the patient in return.

1.8.3. Shame and the medical profession

Because shame is an emotional response it is specific to individuals, and it is nonsensical to talk about "the shame of the profession". Indeed, it is the very concept of the "I-self" that determines the existence of the shame response.\textsuperscript{44} The role of the profession lies in the enculturising process that sets the values system for an individual. Returning to the self-regulatory role of emotional responses for an individual, there is clearly an advantage to the profession in the induction of some form of emotional response in its members, if they transgress
the norms of that profession. My contention is that the appropriate emotional response to be fostered is that of guilt. Because guilt as an emotional response does not involve global attribution, only a part of the self is seen to be at fault. Taking into account the psychological makeup of some entrants to medical school, with their tendency to derive their sense of self from their achievements, and also considering the way in which perfection is sought by the profession as a standard to aspire to, how doctors tend to experience shame rather than guilt as a response to a complaint becomes clear.

The implication is that those same behaviours seen as protective against developing addictive behaviours that were discussed in section 1.7.3 may also be protective against the development of shame as the significant or only emotional response when some aspect of the practice of medicine is challenged.

In conclusion, Lewis raises an idea that may have direct relevance to medicine. He comments on the current philosophical trend towards the “I-self”, self actualisation and emphasis on personal freedom. Lewis contends that this is exactly the sort of philosophy that encourages shame, because of the focus upon the self and the resulting tendency for transgressions to be globalised. The answer, as he sees it, lies in the development of community and commitment, effectively the development of the “we-self”.

The parallel in a medical setting is to shift the focus of responsibility and the locus of control from the individual doctor to a larger group of doctors or indeed health care providers in the wider community. At the same time this needs to be
met with a sense of commitment from the community (in this case the medical community) towards the individual practitioner, contributing to a sense of self that is not solely dependent on the achievements of that individual person. It is this shift away from the “I-self” towards the “we-self” that may allow the development of the guilt response rather than the shame response to events such as a complaint which would otherwise induce shame.

This study seeks evidence of induction of shame or guilt in participants, to consider its importance in the process of a complaint and to develop strategies that may reduce any deleterious effects.
2. METHODS

Introduction

To research the subject of a human response to a particular event, in this case that of a medical disciplinary complaint, there were several issues that needed to be considered.

There was a need for a method that allowed the meaning of events to be explored. I felt that it was insufficient to simply examine particular behavioural changes without considering the underlying psychological and emotional base of these.

Furthermore, given the lack of an existing research base into the effect of disciplinary complaints in an Australiasian context, I was reluctant to extrapolate from the research from litigious cultures to the situation in New Zealand. I needed to use a method that was open to the range of effects that one might see from a complaint rather than predetermining what those effects would be and attempting to quantify them.

A further issue that had to be considered was the particularly sensitive nature of the topic and the difficulty in accessing participants. I will discuss this further in section 2.2, because the research question places specific constraints on one’s ability to use particular types of research techniques, especially those which
could reduce the personal safety of the participants, for example face-to-face focus groups.

For this reason, a qualitative method using taped in-depth semi-structured interviews was chosen, with transcript analysis and subsequent further participant input.

2.1 The research method

As conceptual theories started to be developed after initial interviews, and as themes emerged, they were presented to and tested on new participants. This process lead to a more structured style of interviewing for later interviews than for earlier ones. It is the cyclical nature of this type of qualitative research that permits the researcher to progress further into the issues and meanings that exist within the group being studied. A more detailed discussion of this method of qualitative research is made in section 4.2.

2.2 The selection of participants and data collection

Selection of participants for this study was difficult because of the extreme confidentiality in which the New Zealand Medical Council kept the names of potential participants. Once a complaint has been dropped, the New Zealand Medical Council removes any “flag” from its database that would enable identification from their records. At the time of initiating this study, the only person with access to the names of potential participants was Mr Roger Caudwell, the Secretary of the Medical Practitioners Disciplinary Committee (and subsequently for the Tribunal, prior to his retirement). I contacted Mr
Caudwell by telephone, discussed the research with him and enlisted his support.

The proposed methodology of in-depth semi-structured interviews required approximately ten participants, being in line with accepted qualitative methodology. My initial proposal was to use face-to-face interviews with participants mainly in Otago, but this plan had to be modified (due to the wide geographic spread of participants throughout the South Island) to taped telephone interviews.

A letter of invitation (see appendix 2) was sent to participants via the Secretary of MPDC. I enclosed a return envelope addressed to myself, and thirty letters of invitation to participate were sent by Mr Caudwell to doctors who met the study requirements of having received a "non-proceeding complaint" within the last five years. To whom the initial letters were sent is only known by him, and no data are available to me about the non-responders. Thirty letters of invitation were sent, and ten replies received.

On receiving a reply expressing interest to participate, I contacted the respondents by telephone, further discussed the study and arranged interview times. No participants were personally known to me prior to the interview. By replying to me, I became aware of their names and postal address.

Most of the interviews were conducted in the evening via telephone. Oral consent was given at the start of the interview (and written consent was returned
with the transcripts). The participants were encouraged to tell their story. These were often initially about the complaint itself, and then they discussed aspects of how the complaint had affected them. With an increasing number of interviews, as themes emerged, ideas about these themes were able to be discussed with the participants, looking for confirmation or for “deviant” experiences or expansion of existing concepts. An open interviewing style was used with minimal interviewer input, allowing the participants to give their narratives in their own personal style.

2.3 Analysis

Within one week of conducting the telephone interviews the tapes were transcribed and then analysed by reading and rereading, looking for emergent themes and sub-themes. This is “inductive analysis” in which the patterns, themes and categories of analysis come from the data, emerging rather than being imposed upon them prior to data collection. The method used was as described in Strauss and Corbin in which line by line analysis and categorisation allowed a large number of categories to be developed from which more abstract concepts emerged.56 This technique is furthered by returning to reread the original transcript with what is now a heightened sensitivity to the emergent themes to see if new themes emerge or if the categories are intuitively correct.

To assist the participants in this process, four initial thematic headings were developed and quotations from the transcripts were placed under these. The entire transcript and the initial analysis was then returned to the participants for their perusal and comments. The four initial emergent headings were:
1. The immediate effect on the person of the doctor
2. The long-term effect on the person of the doctor
3. Changes in perception of patients, society, and the role of the doctor
4. Strategies developed to prevent or minimise the risk of future complaint

The final level of analysis was to develop a theoretical basis to guide the interpretation of results. This approach allowed the emergence of the doctor-patient relationship and the concept of shame as an emotional response.

Because the subject of the research was on the effect on practice, I searched for evidence of causal networks (as described by Miles and Huberman) which was of particular relevance to in-practice behavioural changes.50

Because of the strictly confidential nature of this research, and the difficulty accessing participants as detailed in section 2.2, I was not able to present demographic data relating to the participants with variables such as age, practice location, number of practice partners and so on.

2.4 Ethical approval

Ethical approval was sought from the Ethics Committee of the Southern Regional Health Authority. Appendix 3 is the letter of approval from the Ethics Committee.
2.5 Consideration of bias

No data are available about the non-respondents against which to estimate bias in participants.

Researcher bias is as follows. My interest in this subject was stimulated by being the recipient of two complaints that did not proceed to a formal hearing during a six-year period in small town New Zealand general practice. The first complaint was essentially one of rudeness and did not proceed after an offered apology to the complainant. The second, also received by my practice partner at the time, related to the admission of a seriously mentally disturbed patient to a psychiatric hospital, was received some 18 months after the event and for which our actions were commended by the Chairman of the Disciplinary Committee. I personally found both of these complaints extremely upsetting, and they have caused reflection on my subsequent wariness of certain patients, especially those with personality disorders.

Disclosure of my own complaint experiences during the interview was only given if directly asked about early in the interview, or if it was felt appropriate late in the interview as a degree of trust and intimacy had developed between myself and the interviewee.
3. RESULTS

Introduction

This chapter presents the results of the study. The findings of the immediate impact of the complaint are presented as sub-themes of the impact on the person of the doctor, the doctor’s practice of medicine, the doctor-patient relationship and on the relationship of the doctor with spouse, family and colleagues.

The findings of the long-term impact of the complaint are presented using the same sub-theme titles. The findings of the impact of the complaint on the participants’ views about patients, society and the disciplinary process are presented with sub-themes examining societal shifts and the role of the doctor, views on complainants and complaints, the disciplinary system and on suggestions for improvements of that system. Positive findings of the impact of the complaint are presented separately.

The Participants

In order to provide insight into the results I will present for each participant, the nature of their complaint and relevant details about the participant and the initial interview. Subsequently, quotations from the transcripts will be referred to “doctor 1”, “doctor 2” and so on.
The Secretary of the MPDC had been asked to send my request for participation only to doctors who had had a complaint that did not proceed to a hearing. However, it became apparent early in interview number 5 that this doctor’s complaint had proceeded to a formal hearing and then the charges against him were dropped. After discussion with doctor 5, we agreed to continue the interview and as his expressed views were similar to the views of other participants, I decided to include his transcript in the study, and analyse it using the same method as the other cases. All quotations attributable to doctor 5 are clearly labelled as such.

All doctors interviewed were still in active general practice and all complaints had been received within the last five years. Some of the participating doctors had a previous complaint that was mentioned during the interview, but the interview was focussed on the most recent complaint.

The participants were as follows:

Doctor 1

This male doctor working in an urban setting received a complaint from a woman who attended him with her granddaughter. The complainant and patient were not previously known to the doctor and were seen as “casual” patients. The complaint related to charges of being impolite, and centred around the reluctance of doctor 1 to support the women in her assertion that the child’s own mother was not taking adequate care of the child. The complaint was dropped after
a written apology. The tone of the interview was frank and explicit with an impression of residual anger.

**Doctor 2**

This male doctor working in an urban setting received a complaint from a female patient, newly arrived at his practice. He had not previously met her. The complaint related to a charge of roughness in performing an internal examination and smear. The examination had been chaperoned by the practice nurse. The complaint was dropped after a written response by the doctor. It later transpired that the complainant had previously been the victim of sexual abuse. The tone of the interview was relaxed and open with doctor 2 appearing comfortable to discuss the experience.

**Doctor 3**

This female doctor working in a rural setting received a complaint from another general practitioner against her. The complainant had previously been in rural general practice as a colleague, with doctor 3. Doctor 3 and other colleagues at her practice had sought help for the complainant via the Doctors Health Advisory Service and the health committee of the Medical Council, believing the complainant’s behaviour to reflect a state of mind not suitable for work in general practice. A somewhat non-specific complaint was received, alleging that a complaint had been made to the Medical Council and that doctor
3 had recruited other doctors in that activity. The tone of the interview seemed open, relaxed and insightful.

**Doctor 4**

This male doctor working in an urban setting received a complaint from the spouse of a patient whom doctor 4 had attended on a casual basis when he presented with chest pain. Doctor 4 had requested admission to hospital, but admission had been declined by the on-call medical registrar. The patient had been followed up by doctor 4 the following day, appeared to be improving, but later died. The complainant alleged that doctor 4 had not taken their needs seriously. The tone of the interview was quiet; the doctor seemed tired and disillusioned.

**Doctor 5**

This male doctor working in an urban setting received a complaint from a female patient who had shifted away from his practice to another doctor about one year prior to making the complaint. The complaint related to failure to diagnose endometriosis as the cause of her infertility. The case did proceed to a hearing and was dismissed. During the hearing it emerged that the complainant’s male partner was infertile with no sperm count. The tone of the interview was open and insightful.
Doctor 6
This female doctor working in a rural setting received a complaint from a patient about a late night call when doctor 6 was on an after hours duty roster. The complaint related to the doctor's attitude towards seeing what the doctor described as "a very demanding patient". The tone of the interview was open and forthright, the participant appearing keen to discuss the case, but still clearly hurt by it.

Doctor 7
This female doctor in an urban setting received a complaint from a longstanding patient of hers, a 43-year-old diabetic and previously infertile patient who had an inadvertent termination of pregnancy at the hands of a gynaecologist to whom doctor 7 had made a referral for further investigation and management of persistent vaginal bleeding. The complaint against doctor 7 was of failure to diagnose pregnancy, and was dismissed. The case against the gynaecologist proceeded to a formal hearing and censure of that practitioner. The tone of the interview was one of keenness to discuss the case and a sense of residual anger.

Doctor 8
This male doctor working in an urban setting received a complaint from a longstanding patient of his who had a long and documented psychiatric history. The complaint centred around the patient being denied access to his notes for the purpose of changing and destroying
parts of them. The patient remained in the practice and had ongoing contact with doctor 8 and his staff during the course of the complaint. The tone of the interview was one of objectivity, doctor 8 having come to terms with the nature of the complaint and having placed it behind him.

**Doctor 9**

This male doctor working in a rural setting received a complaint from the son of an elderly patient, alleging that doctor 9 had not responded appropriately to a call for the patient to be seen again, shortly after doctor 9 had performed a house call. When doctor 9 attended the patient for a second time some two and half-hours after the initial visit, he admitted the lady to hospital with a perforated peptic ulcer. She was treated conservatively in hospital and died from other causes several weeks later. The tone of the interview was somewhat cynical with a feeling of residual hurt and anger.

**Doctor 10**

This male doctor working in an urban setting received a complaint from a middle-aged woman who complained of improper conduct during a consultation. The details were not expanded upon. The tone was somewhat guarded with a degree of reluctance to express feelings about the complaint, but a willingness to discuss the process.
Initial transcript analysis

Transcript analysis initially yielded four themes. It was clear that the complaint had made an initial impact on each doctor, and I explored this in order to compare the initial with long-term effects. In addition to the two themes of initial and long-term effects, most doctors were keen to offer their impressions and insights into the disciplinary process, the role of professional bodies in medicine and so on. This often revealed changes in their perception of patients, society and the disciplinary process, and these insights formed a third theme. The fourth, that of strategies adopted to prevent or minimise the risk of a further complaint, was a useful theme for the purpose of initial analysis and feedback that was ultimately assimilated into the theme of the long-term impact of a complaint. Keeping it as a separate entity initially however allowed subsequent interviews to focus on it, being consistent with the aim of the research. Because of the (overwhelmingly) negative impact that the complaints had on these participants, I specifically sought “deviant” responses in the form of positive outcomes, and these are presented separately.

3.1 The immediate impact of the complaint

Receiving a complaint had a discernable immediate impact. From the moment of opening the envelope containing the complaint, there was a demonstrable effect on the person of the doctor, on their practice of medicine, on the doctor-patient relationship and how doctors interacted with their spouse, family and colleagues. With the exception of doctor 8, whose initial response was to regard the complaint as laughable, all other participants received the complaint as
though they had been hit by a thunderbolt. Despite a degree of awareness of the
disciplinary process and of the experiences of some colleagues, none of these
participants were in any way prepared for the initial impact that the complaint
would have on them.

3.1.1 The immediate impact on the person of the doctor

There were five discernible sub-themes referable to the immediate impact of the
complaint on the person of the doctor. They were:

1. An immediate and intense negative emotional response.
2. Evidence of feelings of guilt and questioning of self.
3. A discernible intellectual response.
4. The rapid emergence of feelings of depression and associated changes in
   behaviour, and for some doctors.
5. A very rapid emergence of a state of shared understanding with other GPs
   who had also suffered a complaint.

The immediate emotional responses were probably summed up in a mixture of
adjectives describing participants’ response to being stressed, anxious and
angry.

> I guess I felt very very upset about it. I was very angry at the time.
> Doctor 2

The physical manifestations were readily recalled:

> And I was shaking ...... you know that knot you get in the stomach? I
   was distressed.
> Doctor 3
You sort of feel real anxious. It makes you a bit irritable and grumpy.
Doctor 1

Several doctors were aware of their feelings of guilt and used that word specifically. They questioned themselves, and their perception of self was clearly related to their perception of their functioning as a doctor.

My immediate feelings before I even researched the information or anything, was this extreme feeling of guilt, which overwhelmed me really. Looking back and that I couldn’t really understand why the hell I felt so guilty, my emotional self still made me feel as though I was obviously at fault, and I felt very guilty about it.
Doctor 5

It makes you do a lot of soul searching. You look at yourself and you think “Oh, my god, I mean I, perhaps I handled that wrongly, perhaps I ah, perhaps I was at fault”. You think “God, I’m the bad person”, or “I’m a bad doctor because someone’s complained about me”. It just creates self-doubt. You feel bad about yourself.
Doctor 6

One of the earliest responses on receiving a complaint was an intellectual assessment of the nature of the complaint and how valid it appeared to be in the doctor’s own mind. There appeared to be little correlation between the intellectual response and the intensity of the emotional response.

I didn’t in anyway think I was guilty of what I was charged of, as it were, because I didn’t, I thought I had done the right thing. I was anxious about it, I mean because I was concerned, although I couldn’t see that I could possibly be found guilty of any misdemeanour.
Doctor 7

These comments contrast with an intensity of emotional reaction from the same respondent.

(I felt) fury with her for “how dare she?” I felt really angry at having that complaint made against me.
Doctor 7
In the case of another doctor, there was more congruence between the intellectual and the emotional responses, although the contradictions between some statements he made reveals the difficulty he had in adequately intellectualising it.

*I did actually think well, I was a bit naughty, I should have gone straight back. You know; it was half an hour since I had been there, but you know, on the evidence I thought it wasn't unreasonable in that I didn't leave her for hours and hours. Because there was a degree of mismanagement, it was just the time delay, I felt a bit more vulnerable about that. You know, a bit more anxious about it.*

Doctor 9

Another set of inconsistencies further illustrates the power of the emotional aspect of the response.

*I never felt too worried because I didn't feel guilty. I didn't really feel that the complaint could be substantiated, so from that point of view I felt reasonably satisfied, although obviously concerned about it all.*

Doctor 10

Contrasting with

*Something like this shatters your confidence, I suppose. It shouldn't, but it did. I was apprehensive, and anxious and annoyed.*

Doctor 10

For two of the doctors, the speed with which they became depressed was noteworthy. Feelings of hopelessness and helplessness were reported by doctor 3 who also said

*I think it just got me down. I think some of my sunny, generally sunny, nature disappeared and you feel a failure.*

Doctor 3
My wife said I'd become profoundly depressed. I didn't actually seek help from my GP, although I suppose, because I thought I probably was depressed, and didn't think that ....... I didn't think any medicine was going to do me any bloody good.

Doctor 4

Although the experience of a complaint led to reflection about the complaints process in general, (I will comment on this in section 3.3) the experience of the complaint led to a shared understanding of the experience of other doctors that serves to illustrate the dichotomy here between the emotional and intellectual responses to a complaint.

For the first time in my life I understood why (doctor X) had left practice after a complaint. And for the first time, I sort of understood. I visited three colleagues who have been disciplined in a sort of ....... well I don't know what I was trying to do ....... I was trying to indicate collegial support.

Doctor 4

3.1.2 The immediate impact on the doctors practice of medicine

In keeping with the finding that the immediate response to the complaint involved both an emotional and intellectual aspect, one of the early and important effects on the practice of medicine by the doctors interviewed was that the complaint provided the impetus to examine and evaluate their own practice of medicine. In contrast to this more intellectual event, several doctors commented on an immediate change in the way that they practiced medicine that was seen as a reduction in their ability to consult with speed and with confidence. A key feature of general practice is the ability of the doctor to live with uncertainty, and an immediate effect of receiving the complaint was seen
in their perception that they had become less tolerant of uncertainty in the consultation.

An immediate reduction in their capacity to practice medicine efficiently was commented on by several doctors.

_Certainly my working speed declined. My tolerance for uncertainty, which had previously been, well, that just went right out the door._

_Doctor 4_

_My decision making process was slowed down. I began to lose a degree of confidence in both my ability to assess the situation accurately and to make proper medical decisions. I was starting to think about people I’d seen during the day and think “Oh God, was that right?” or “Did I listen to them right?” or “Did I pick up their cues properly?”_

_Doctor 5_

Respondents were also capable of standing back and looking at their overall practice. None of the doctors seemed to think that their overall practice of medicine was faulty, either in the immediate phase of receiving a complaint or in the longer term. The following quotation is representative.

_Here I was doing an exemplary job as a general practitioner and that anyone would have the audacity to say that I was sexually abusing her was pretty horrible to think of really._

_Doctor 2_

Some respondents, even on direct questioning, did not believe that the complaint had any effect on their practice in the short term (e.g. doctor 7). Other respondents denied any effect on their practice of medicine but like doctor 10, admitted that “_something like this shatters your confidence I suppose, it shouldn’t, but it did_”. 


For doctor 8, the patient was a regular attender who continued to repeatedly return to the practice after the complaint. This had a stressful effect on both the doctor and his staff. For this doctor there was an immediate concern that each further interaction with the patient was going to compound the complaint. Although the situation eventually resolved, and the patient departed from the practice, the doctor found himself having to continue to behave (in this case by not giving in to the patient’s desire to alter the psychiatric notes) in the same way that it had lead to the complaint originally. For this doctor it was a source of considerable ongoing stress.

3.1.3 The immediate impact on the doctor-patient relationship

Two aspects to the immediate impact of a complaint on the doctor-patient relationship emerged from the interviews. The first can be summarised as an ongoing sense of relationship with the complainants, despite the complaint. The second is related to the immediate impact on the doctor-patient relationship with patients other than the complainant and the importance of this in the working environment.

For complainants who were either new to the practice or seen as casual patients, respondents had separated themselves from a relationship with that patient to a large extent. They tended to be hostile towards the complainant and did not want anything further to do with them.

*If I saw this woman in the street I would be pretty annoyed.*

Doctor 2
This contrasted with the response of doctors where the complainant was a long standing patient of theirs and where there had been a significant doctor-patient relationship. For most doctors there was a sense of upset that the particular doctor-patient relationship had been damaged by the complaint. Some doctors counted the cost in terms of the effort that they had put into the patient.

*I actually felt a little bit peeved, not peeved; I was a little put out, because actually I had spent a lot of time with this lady, and she was difficult, and you know, over the years I had put a lot of time into her.*

Doctor 9

However for other respondents, the importance of the relationship was paramount.

*You think you have a good relationship with somebody, part of it's that. It is partly the destruction of that that makes you, you know, that is so upsetting; is the kind of loss of your relationship and what you believed was a good one.*

Doctor 7

The loss of the relationship was clearly hurtful to the doctor too, though as the same respondent observed.

*It was simply that people I had cared for and liked should do that to me. That was really the most offensive thing.*

Doctor 7

This immediate impact on the doctor-patient relationship was also observed by doctor 3 who had been complained about by a fellow practitioner.

*And she did this to me... the one who supported her most. And I thought, “well if that’s what happens when you try and help people......” It seemed very unfair.*

Doctor 3

For doctor 8, there was an ongoing doctor-patient relationship despite the presence of a complaint. The negative impact on the relationship was clear.

*I wanted the whole thing dead and just make him go away.*

Doctor 8
There was an immediate impact on receiving a complaint on the doctor-patient relationship as it pertained to other patients. There was a direct impact on the level of trust that the doctor was able to bring to the doctor-patient relationship that is fundamental to the two-way nature of the doctor-patient relationship. This was articulated as:

*I found that in subtler ways my trust of what patients were presenting to me and how they were dealing with me, was damaged. I found I wasn't trusting them so much. I was sort of looking at them, thinking “Oh yeah”, you know, “there is something hidden here”, or “they're not telling me something”, or “they're setting me up”, you know.*

Doctor 5

3.1.4 Immediate impact on the relationship with spouse, family and colleagues

Most participants were aware of an initial response to receiving a complaint that involved seeking or not seeking support, and sharing concerns with their loved ones and with their colleagues. Examination of these initial responses may signal ways that can be used to help doctors deal with complaints in the future. There was a diversity of behaviours related to seeking help with consequences that ranged from being strongly positive through to being disastrous. Although the nature of the support from family and colleagues varied as one might expect, with the personalities of those involved, the most significant finding was the immediate benefit of gaining support from appropriate (and the term “appropriate” is to be emphasised) professional people.
There is evidence that support generally was seen as being positive and desirable whether it came from family or colleagues.

*I shared my experiences with my nurses and wife, and felt supported by them. My wife was very supportive. I think she handled it pretty well.*

Doctor 2

*My husband's a GP and he and I job share so I had the support of him. I got support from one of my colleagues who had been through......; he's had one or two complaints made against him. He was very supportive and I found him helpful, but I mean that was kind of an informal arrangement. It's just that I knew that he had had a charge, so I spoke to him about it. He was very supportive about it.*

Doctor 7

For some doctors it was and remains difficult to speak about the experience.

*I actually felt so guilty about getting the complaint that in fact, I didn't even tell anybody about it for several days, including my wife. You know, I felt ashamed of it and I felt really bad about it; that I had actually received a complaint, and after a while I told my wife. I still haven't told a lot of people about it.*

Doctor 5

There was an awareness of an immediate impact that the complaint had on the family. As one of the participants who was a mother of young children observed

*It took me away from the children. "Mummy mummy, what are you doing? Why won't you talk to me? Can't you throw that stuff out the window?"*

Doctor 3

The same doctor also summed up a frequent observation that sharing the complaint with colleagues often lead to an all encompassing response of affirmation, that in fact provided very little support at all.
I got a little bit of support from work. They said you know, "You're a good doctor" and all that sort of thing that doesn't actually comfort you at all, because it doesn't alter what's happened.

Doctor 3

There was an immediate need for support that had meaning to the doctor who had received the complaint. Doctor 8 commented on the difficulty that his colleagues in the practice had in providing support because they themselves were enmeshed in the process. He said

*My colleagues weren't so much supportive as were part of it. It's sort of hard to be supportive when you're part of what's going on.*

Doctor 8

He commented on the support that he received to help deal with the complaint from the insurance society and also from his psychiatric specialist colleagues.

In contrast to the response of doctor 7 who found general support by discussing her complaint with colleagues who had had a similar experience, doctor 4 did not get the sort of support that he felt he needed from his office colleagues and sought it instead from two senior and respected colleagues. One of these colleagues actually refused to see doctor 4, a response that doctor 4 found extremely hurtful. He felt that his colleague had misinterpreted the nature of the complaint, made a value judgement about it and reacted in a way that had entirely failed to meet his emotional needs.

3.2 The long-term impact of the complaint

Thematic transcript analysis revealed that there were long lasting responses to the complaint that were able to be examined using similar subheadings to that of the immediate impact of a complaint. There was a long-term impact on the
person of the doctor, on the doctor’s practice of medicine, on the doctor-patient relationship and on relationships with spouse, family and colleagues. However, further responses also emerged that are included here, particularly with respect to the practice of medicine, and the doctor-patient relationship. These responses indicate that the doctors interviewed have adopted particular strategies designed to reduce the likelihood of a further complaint.

Some of these responses are perceived by the doctors as representing better or safer practice, but accompanying them, is an attitudinal shift in several cases that carries a negative connotation towards patients.

The pervasive theme that emerges in this section is that the doctor-patient relationship has been impaired by the complaint, and this impairment is carried forward as “baggage” into many subsequent consultations. This is relevant to ongoing patient care. The following sections expand on and illustrate this result.

3.2.1 The long-term impact on the person of the doctor

All of the participants in this study revealed evidence of a change in their perception of self that they considered to have been a direct result of the complaint, and which had persisted over time. The findings were related:
1. To the type of emotional reaction that persisted after a complaint.
2. To changes in the way in which they perceived themselves as doctors.
3. A more general erosion of goodwill towards patients.

Although superficially this last point appears to be more properly included in a discussion of the doctor-patient relationship, the responses show that it is more
fundamental to the doctor's sense of self, and a reflection of a change in that
sense of self.

Of the long-term emotional reactions, the most obvious persistent depressive
response was from doctor 4, who was quite clear about his initial feelings of
depression when the complaint had been received some four years ago, and who
noted that.

_I date my wish to leave practice from that._

Doctor 4

For other doctors, the depressive response was not as marked but was still there.
They made comments such as

_You just don't enjoy life quite the same._

Doctor 3

For other doctors, the persisting emotional response was much angrier. Some
seemed to be aware of this and of the soothing effects of time

_Gradually, with time, the anger has dissipated._

Doctor 5

But other doctors held their anger for longer

_I think there has been a change in the way I feel about myself now. Being a
physician. You're just there to be treated as dirt by people who want to treat
you as dirt._

Doctor 1

In addition to these reasonably straightforward but sustained emotional
reactions, there were also persisting complex effects on the person of the doctor.
Doctor 2 in his written feedback after viewing the transcript and first cut analysis, commented that he was “probably more fearful now of patients generally”. For doctor 3 an increasing sense of vulnerability was expressed as

So I think perhaps I’m hypersensitive now. I think, I’m a little more wary, a lot less naive, a lot less trusting and a lot more careful about saying things to anyone.

The loss of joy was mentioned by several doctors (1, 3 and 5) and seemed to reflect a loss of enthusiasm for the intellectual stimulation of practice.

I will often with those particular problems, say, “it’s not worth the hell”, just send them on.

Doctor 5

Both doctor 1 and 5 were also aware of an increasing cynicism about their practice.

Cynicism. You just think, well, this is what I do for a living. You feel more depersonalised in your practice.... more robot like. We’re all screwed up with the potential for all this drama. It makes you lose your own dignity and rights.

Doctor 1

Some respondents commented on the way in which their goodwill towards patients had been significantly eroded. There was an awareness of the reciprocal nature of the doctor-patient relationship and the sort of attitudinal shift that the complaint had created.

I think all of the things that happened of that nature gradually erode your feeling of commitment. A lot of it is the way the patient treats you that has made me feel less enthusiastic about medicine. Of all the hours and hours and hours that I have been on call and got up and helped people and done things for nothing, and all the extra time that I have given, and how angry it makes you when somebody makes a complaint for something that is not, is really quite trivial, or is difficult and demanding.

Doctor 6
At a less complex level, is the long lasting association between receiving an official letter, and the traumatic emotions that it rekindles.

*Whenever I get a letter with “New Zealand Medical Council” on the outside of the envelope ....... I often sit and look at it for ages – unable to open it. And it’s usually a bloody bill, or something. It’s .... quite devastating.*

Doctor 4

This is a pertinent observation with relevance to this study. The request for participation was sent by the Secretary of the MPDC and this in itself caused a response in the recipient. During the interview one respondent commented on receiving my letter directly thus:

*But, it was such a distressing time that, at first I thought, “I’m not going to open that again”.*

Although I can only speculate on this issue, I wonder if this response was widespread amongst the doctors invited to participate in this study and whether it had a negative effect on the participation rates.

Apart from the effect that the complaint had on doctor 4 who acknowledged that the complaint had a significant bearing on his decision to leave practice, there were other examples of the complaint acting as the instigating point for reflection by the doctor on their own personal sets of values and their sense of self.

*I became a bit depressed about it and stuff, and I really relied on my relationship with my wife as a major support for me and made me examine my emotional self if you like. So it led, coming out of it, to a much greater balance in life for me. I’ve learnt to value some things in life which before, especially in my family and my relationship, which perhaps, like I always thought they were important, but I never really gave them the highest value, and so its made me appreciate those very basic vital things in life. And I’ve certainly, since then, in the last couple of years spent a lot more time in that area of my life, and I have*
limited my life in medicine such as all the bloody committees and all that sort of stuff I was on. And I've just flagged them all really and have tended to concentrate in my free time on other things which I think are of higher value.

Doctor 5

For another doctor, his sense of self had survived the assault of the complaint and he appeared intact in his understanding of who he was, although clearly his sense of self was related to his being a doctor.

I still do what I want because when I have to stop being what I am, I'm not going to do it any more.

Doctor 1

3.2.2. The long-term impact on the practice of medicine

The results indicate that the long-term response to a complaint on the practice of medicine is characterised by the development of strategies that appear (at least to the involved doctor) to reduce the risk of recurrence of a complaint. Although there is blurring of the distinction between the practice of medicine and the doctor-patient relationship, with care the two categories can be separated and examined individually. It appears that an intellectual response has occurred that allows the doctor to recognise situations or contexts that they consider to be risky.

The strategies that are adopted with respect to the practice of medicine can be categorised into those that are “non-situation specific” and those which are “situation specific”. The non-situation specific responses are those that reflect pervasive changes in practice and seem to apply to most, if not all doctor-patient
encounters. The situation specific responses are either specific to the individual complainant themselves, or to the type of condition that the complainant had; or they are specific to the circumstances under which the complaint arose, such as being on call, or attending to an emergency.

The results indicate that there is a long-term effect on the practice of medicine that is carried forward from the complaint to subsequent doctor-patient interactions. These, of course, will almost never involve the complainant themselves.

For some doctors, the non-situation specific responses were quite mechanical, such as making sure that everything was correctly documented (doctor 3). There was also an increasing awareness of technicalities in practice.

*It made me acutely aware that the rules and regulations impact on every part of your practice, even down to the writing of your notes and how you file those notes. And how important it is to preserve the integrity of the notes. And it's made me realise that I mustn't destroy documents just because a patient asks me to.*

Doctor 8

There is also an awareness of the overall behaviour of the doctor despite this perhaps not always being realistic.

*You've got to be Mr Nice Guy all the time, no matter how much pressure is put on.*

Doctor 3

For others there is just a general awareness of a potential downside to any interaction that could be misinterpreted.

*I'm very careful if I'm a bit unhappy about how a patient or family member is feeling about their treatment. I'm very careful about what I say in case it's interpreted as an expression of guilt.*

Doctor 9
One respondent clearly articulated his own feelings in situations that were specific to that of the complaint.

*If I ever get some young woman who looks like this woman and is a similar age and has got similar symptoms, I just see this woman in front of my eyes again. It's just awful. You know, it just reminds you so much.*

Doctor 2

For doctor 2, the residual response is not so much to the complainant as to their condition. Although he did note that he would “not see her again as a patient”, with respect to his practice he commented that.

*I'm certainly less likely to do a smear on a patient who's new to the practice. If I had known that she was a sexual abuse victim on her first visit, I would probably not have touched her with a barge pole.*

Doctor 2

Although one might predict that being faced with the same or a very similar patient or an identical condition would reasonably alert the doctor or “ring a few alarm bells”, one of the key themes to emerge as a long-term response in this study is that of situation specific responses that relate to the circumstances in which the complaint arose. Clearly the circumstances may be generalisable, in that a blanket approach may be taken by the doctor to a wide range of presentations of illness, in a way that may not always be appropriate. One of the best examples of this was a response of increased requests for admission to hospital and of referral to specialists. One doctor freely admitted that.

*I continue to admit a lot of patients who .... probably don't warrant admission. I have adopted a technique with the emergency department of giving a patient a letter and saying, “get on your bike. Go to the emergency department”. Then I would ring the emergency department and say “the patient's on their way”.*

Doctor 4
A change of practice towards not continuing to investigate and consider the problem by oneself, and to refer onward, was viewed as better, safer practice.

I took quite a lot of pleasure in extending myself a little bit and making sure that I got things right and stuff, and now I tend to practice more conservatively and more safely. Consequently I definitely refer more, and I don't take as much responsibility on myself as I used to.

Doctor 5

A different kind of response was one of wariness and avoidance of difficulty. For doctor 1 this was articulated as “skirting the issue by saying yes sir, no sir three bags full sir”. But for others the complaint seemed to have sensitised them to particular circumstances so that they avoided potential conflict.

It just makes you wary of people and wary of situations, and you think “oh here's one, that you know, these people are going to be difficult and I'll have to handle this one in a more of a cover-my-back type of situation”. I will do things to suit these people which I don't necessarily consider to be perhaps the correct way to act in that situation, just to avoid problems. There are some situations that you sense that if you don't do it, it's going to create you more long-term hassle, so you make a decision that is to avoid the hassle, rather than what you would choose as an appropriate thing to do from a medical point of view.

Doctor 6

Several doctors commented on the need to identify error early and to try to set things right as early as possible. Several doctors mentioned the use of apology and a heightened sense of trying to work with the patient to resolve any adverse circumstance.

There is also a sense of the need to control circumstances that the doctor associated with a complaint.

It also made me try and be careful of those people with long lists.

Doctor 7
Doctor 9 responded in a way that increased his sense of control in situations where confusion may arise.

*I also ring back myself, rather than accept a phone message, then it's all my responsibility. I can't turn round and say, “well I'm sorry, I didn't quite get that message”.*

Doctor 9

There is also evidence that these situation-specific responses had been incorporated into the culture of the practice that the doctor was working in. A good example was avoidance of emergency call outs.

*If there were an emergency call to the surgery, previously I would always say “Yep”. I would go. Now, the staff in actual fact, come to me last because they're aware of the fact that I don't want to go. So obviously, they appreciate the fact that I'm not a ready responder to an emergency call.*

Doctor 4

### 3.2.3 The long-term impact on the doctor-patient relationship

The results indicate long-term changes in the doctor-patient relationship that could be broadly divided into two categories. The first, and again with a degree of overlap with changes seen in the doctor's practice of medicine, was that of a significant attitudinal shift on the part of the doctor towards what the doctor saw themselves bringing to their clinical work and to the doctor-patient relationship. The second long-term effect was a heightening of a sense that the doctors have about patients who might complain about them.

I have already commented on doctor 3's mention of having to be "Mr Nice Guy all the time" in section 3.2.2 and this doctor also made another comment about
the long-term impact of a complaint that is of direct relevance to a consideration of what each doctor brings to each new consultation. She commented on never being free of the influence of the complainant.

*She's just watching, always watching out the back. It zaps you, having that hanging over you, it's quite vexing.*

**Doctor 3**

Perhaps it is that feeling of the constant presence of the complainant that leads some respondents to comment on their degree of suspicion of patients and the need for care over and above what they would normally expect themselves to take.

*I look sideways at every patient, including new patients ..... wondering what the hell they're on about.*

**Doctor 4**

Again the awareness of the doctor-patient relationship is a two way process and was commented on by doctor 6 whose feelings of “erosion of commitment” have already been quoted. She went on to observe that

*I guess the one thing that keeps you going is the fact that you get something back, like an appreciation for what you have done. When people start kicking you, you start wondering why do you bother doing it?*

**Doctor 6**

This need for continuing to get something positive out of interactions with patients was echoed by another respondent when he said,

*Still try to appreciate the nice people that you have.*

**Doctor 1**

A further finding about the long-term effect of the doctor-patient relationship was that not only did several respondents comment on their heightened
sensitivity to the possibility of a complaint, they also commented on the way in which their own perception of the patient in turn determined how likely they felt a complaint could be, and then how they responded toward that patient. The idiosyncratic nature of this response is worth noting. Apart from the generalisations that the respondents made about complainants, which I will discuss in section 3.3, it was clearly difficult for the doctors in this study to articulate exactly what it was about a particular patient that led to their own internal response. Doctor 10, commented on the use of the place of trust.

Doctor 10 - you had trust and they trust. But I don't think that's good enough now.

Interviewer - do you think that trust has been lost?

Doctor 10 - no. I think the trust is still there for 95% of the people. But you're not quite sure who the other 5% are.

Doctor 10

This ties in with the difficulty in establishing a satisfactory relationship with casual patients and again the two-way nature of the relationship is mentioned.

Casual patients. They're much harder aren't they? When a relationship is built up they regard you as a person.... a somewhat valuable person in their life.

Doctor 1

Although having a long-term stable and apparently trusting relationship is clearly not totally protective of receiving a complaint, as was the experience of doctor 7, the feelings expressed by that doctor included a degree of surprise that the complaint should have happened, whereas the experiences of doctor 1 and doctor 6 with casual and out of hours patients respectively, suggested that they were aware of something going awry in the interaction with the patient, and they expressed little sense of surprise that a complaint had happened. The
significance of this observation is that if the doctor perceives that there is an absent or unsatisfactory relationship with the patient, and/or that the required degree of mutual trust is absent, then the behaviour of the doctor towards the patient will alter towards reduced commitment and increasing suspicion.

There is one other important finding with respect to the doctor-patient relationship that emerged during this study. This was the ongoing awareness of the impact of the complaint and the complaints process on the complainant themselves. Despite the negativity generated by the complaint, several of the respondents continued to be aware of how things were for the complainant in a way that suggests that they were still in their role as a doctor with its attendant responsibilities towards that complainant. Two quotes are illustrative of this.

*I don't think that from the patient's point of view, much good came out of it probably.*

Doctor 10

From the respondent who had actually gone to a hearing,

*I've got a feeling she went away from it feeling utterly pissed off. I don't think her needs have been met at all.*

Doctor 5

3.2.4 The long-term impact on the relationship with spouse, family and colleagues

Whereas most doctors commented on the immediate impact of the complaint on their relationship with others, there was very little said about the long-term effect on relationships after the complaint was over. There were no reports of the complaint leading to the dissolution of the marriage, although for doctor 3 it added to the stress of a divorce that was already under way. There was no
mention of feelings suggesting that the respondents had been ostracised by their colleagues or in any way professionally abandoned after having received a complaint that did not proceed to a hearing.

However, several respondents commented that they were aware of a change in their own attitude towards other doctors who had been, or became involved in the complaints process. Interestingly, for one doctor his insight was able to be applied in quite a general sense.

*For some people who go through these things for months and months, it's really horrific I think. It gave me an understanding to some degree of the crisis and the difficulties, particularly when these things have to be defended. They become almost intolerable, I think, for some people.*

Doctor 10

However, others were clearly more discriminating in their support for colleagues. This is an important point when considering appropriate supports and interventions for doctors who have a complaint.

*It's made me very sympathetic to my colleagues who are involved in similar sorts of things. I have to say it hasn't made me incredibly sympathetic to those of my colleagues who have been involved in things which they've been found guilty of. I think it's made me very sympathetic to people who get caught up in either malicious complaints or insignificant complaints or all sorts of other things.*

Doctor 7

### 3.3 Patients, society and the disciplinary process

All the respondents in this study held views about their complaint experience. Although it is not possible from this research to comment on the pre-complaint personalities of the doctors studied, some pervasive moods were discernible in the interviews. Some of these are outlined in the case summary section 3 introduction. These moods seemed consistent with the reported effects on
person, and with the effects of behaviours in response to the complaint; for example the overall angry tone of doctor 1 and the generally depressed tone of doctor 4. Some of the reported attitudes towards patients, society and the disciplinary process may be predicated by an underlying attitudinal shift reflected in the pervasive mood of the interview and possibly consistent with the changes already reported.

The relevance of these comments lies in an understanding that the beliefs that these respondents hold about the process that they have been through will, I believe, have been significantly influenced by their emotional response to the complaint. It is possible that these same doctors held very different views about patients, society and the disciplinary process before and after their complaint experience. This study did not actively seek to investigate the particulars of a change in those attitudes that were directly a result of the complaint, although some respondents commented on attitudinal shifts over a long period of time and I will report these as they stand, noting that particularly in this section, it is not always possible to infer that it was the complaint itself that lead to a particular attitude being held.

Several respondents noted changes in societal attitudes over their practising life times and usually commented on these from what appeared to be a reasonably detached perspective, more as an historical commentator might, rather than an involved participant.
Analysis of the results in this section has then been performed with the differing viewpoints of mood and personality of the participants kept in mind.

The sub-themes that emerged from the interviews were of:

1. Societal shifts and the perceived role of the doctor.
2. Views on complainants and complaints.
3. The disciplinary system.
4. Suggestions as to how the disciplinary system could be improved.

3.3.1 Societal shifts and the perceived role of the doctor

Several of the participants, commented on how they perceived society and how society perceived them when they first started in practice and contrasted this with how they perceived the situation to be now. Whilst none of the complaints appeared to arise from practising medicine in an old fashion or outdated manner, (which would imply that the doctor had not kept pace with professional shifts over a time period), there certainly seemed to be an awareness that there were societal shifts that did not always sit comfortably with them.

The awareness of the two-way role of the doctor-patient relationship was reflected in several of these comments as well.

*People tended to have a heck of a lot of respect for you as a doctor; they tended to have a great deal of respect for the fact that your work was difficult and demanding, and tolerance of things that might not have been quite perfect. You were more inclined to be more dedicated to your patients as well. You were a valuable resource. They respected your opinion and your knowledge. Did you respond to that as a person? Yes, of course you did.*

Doctor 1
The perception of these respondents (as it related to patients and to how society functioned and related to the doctor's role within it), was that patients had become considerably more demanding and less appreciative of the services that the doctor provided. Some respondents put this quite forcibly.

*We're in a time where the doctor has very few rights and the patient has all the rights and basically we are there to be used and abused by patients to a large extent.*  
Doctor 6

*There's a growing tendency for people to regard you just as a convenience, or a commodity rather than a human being or a professional.*  
Doctor 1

The respondents were also able to comment on not only perceptions of their role from the public's point of view but also from within the profession.

*There is no ability to think of the fact that, well yeah, doctors do have to sleep and eat and have families just the same as everybody else, and that nobody pays them to be on-call either.*  
Doctor 6

Enlarging on the difficulties encountered.

*You usually have inadequate time, inadequate facilities. Now days you certainly have inadequate back up from the public sector. Your remuneration is getting worse and yet there's this ivory tower view that the doctor is the servant of everybody who walks in. You get the impression that there is a disciplinary committee that's made up of people whose standard sets they are applying, have no real relationship to the kind of population that you and I have to deal with.... I think it's based on something that is no longer real.*  
Doctor 1

This notion that there has been a professional attitudinal shift that is out of step with the reality of practising was echoed by others.

*You're not allowed to be a human being you see. You're set up as a God and I hate that. They encourage that attitude. You're not allowed to make a genuine mistake, not allowed to do anything wrong.*  
Doctor 3
3.3.2 Complainants and complaints

Analysis of the respondent’s attitude towards complainants revealed a widespread perception that complainants were not like “normal” patients. My observation is that this feeling was held by respondents who seemed to have quite different emotional responses to the complaint, rather than it just being the angry doctors who felt this way.

It’s not very often a normal, reasonably intelligent person who makes a complaint. It’s always somebody who’s a little bit wacky.

Doctor 1

You’re trying to help and it’s being misinterpreted .... by the person. That’s what mad people do. There are some patients who are difficult and I’ve got one at the moment – who’s as mad as a meat axe.

Doctor 3

Other respondents didn’t view it so much as madness, but as the patient being angry and finding the complaints system to be an avenue into which they could vent this anger. The following quotes are illustrative of this.

There are some people in this world who just love to get stuck in.

Doctor 6

I have the impression that most people who make a complaint are angry with the doctor.

Doctor 8

He had some kind of antagonism towards I think, doctors in general, maybe me in particular and this was his chance. The rest of the family came to visit me to tell me they were a bit sad that all this was happening and that I had done everything right. He wanted his pound of flesh of me for whatever reason.

Doctor 9

The person who made the complaint had a difficult personality. I think that’s true. I think the same thing could happen again with that sort of person; because it doesn’t matter how you sort of managed the situation, it was going to be some area that could be misinterpreted and criticised and so on.

Doctor 10
During several interviews, the participants digressed into talking about other complaints that they had been involved with, sometimes their own and sometimes those of close colleagues. Their comments reflected much more intellectualisation about complaints in general, than simply an emotional response. Allied to the notion that it was the nature of the complainant rather than the nature of the complaint that was paramount within the system, there was a widespread feeling that as doctor 1 put it.

*The complaint becomes an open window for anyone who chooses to begin a vendetta against a particular doctor over a particular thing. It's become more a system of bashing us down.*

Doctor 1

There was also a feeling that complaints were quite widespread, but also a feeling that a complaint in itself was still widely perceived as proof that you must have done something wrong.

*I mean that's what you read into it. "Oh God, if somebody's gone to the trouble of writing a letter you must have done something terrible" people aren't very forthcoming in saying "Oh God, well I had one of those two years ago as well, and wasn't it hell". Um, there's a bit of a cover up.*

Doctor 6

### 3.3.3 The disciplinary system

The sub-themes that arose in this section of the analysis indicated the participants' awareness of not only their own complaint but also of others' complaints. Some of the respondents had either a pre-existing *"wariness of the Medical Council"* (doctor 3), or had given the ramifications of a complaint considerable thought.
The funniest thing ... a ridiculous thing .... is, I went through the book .... on how to survive in general practice. A thing I now see as quite ironic.

Doctor 4

The overriding impression from the interviews, was the feeling that the participants had been engulfed by a system about which they had no first hand experience, and over which they had no sense of control. It was an experience for which they were ill prepared. There were two sub-themes that particularly indicated this.

1. A perception that not only did receiving a complaint indicate fault (as I mentioned in section 3.3.2.) but that complainants’ rights out weighed doctors’ rights.

2. The intensity of the emotional response (positive or negative) that was attached to the form and content of the feedback at the time of the complaint being dismissed.

Although difficult to present in quotation form, there was a sense of confusion amongst participants about to whom the complaint had been made, and the role of the person (the chairman of MPDC) with whom they corresponded.

I have already alluded to the finding that receiving a complaint was equated with being at fault, and in addition to this several respondents felt that the patient’s rights were greater than their own.

*The system is totally biased against you.*

Doctor 1

*My own feeling is that patients have much more rights than a doctor. The patient’s rights are far more paramount to any rights that the*
*doctor might have and it's almost a case of guilty till proven innocent rather than the other way around. I think they're bending over backwards to be fair to the patient, or to the complainant and are happy to persecute the other guy.*

Doctor 9

The need for an impartial stance was highlighted by Doctor 10, who felt that the Medical Council had a responsibility to provide this.

There was a range of responses to the feedback that the participants received at the end of the process. There was an intensity of response, that indicates the emotional strain of the whole situation. For doctor 8 there was an amusing note as the quote indicates.

*I got a nice letter from the Chairman of the Council and I got an indirect indication that he understood how I was, very well, because he was the next one in the firing line.....(the complainant) had turned his attention on the Chairman of the Council!*  

Doctor 8

For doctor 5 who actually went to a hearing and was able to speak to the Committee members afterwards, the way in which the result was delivered was clearly important.

*The Chairman said he thought I had behaved impeccably. So my feelings about how I handled it were given an enormous boost by that statement. If I hadn't received that, if I had just received the official legal thing, I might have had a different feeling about it.*

This insight was confirmed by doctor 6, which illustrates the importance of the process here.

*When I finally got the letter back from the Secretary where they sort of say "you're a naughty girl and you shouldn't have done that" you know that blah de blah, I think when you get that sort of letter you realise how ridiculous the whole thing is, and that almost enables you*
to shut it away and think “Oh well, you know, if they are going to take that sort of attitude how can you take it too seriously”. The whole thing was worded in a punitive type of way with very little support that came through. I think it had the effect of turning me off really.

Doctor 6

She too was aware of the impact of this on both patients and doctors and further said.

You’re talking about the patient welfare and the doctor welfare. I mean, you’ve got to think of both of these two things.

Doctor 6

There was a range of opinions, both positive and negative, on the role of the defence society. For doctor 9, who viewed corresponding with the complainant as adding fuel to the fire, having to enter into a legal pathway over which he had no control was very difficult.

It really was the involvement of the insurance company that turned it from a laughable thing into something quite serious. The last think I wanted to do was to justify myself, but that is what my insurer insisted on. As I had not the means to fight this character myself, I had to do it the insurer’s way. What I couldn’t understand was my insurance company was always taking sides with the complainant, and making me justify everything that I had done.

Doctor 9

However, the same doctor also found the individual people he dealt with at the insurance company to be very supportive, implying that he was quite able to make the distinction between different aspects of their involvement. Several other doctors commented on the supportive role played by lawyers from defence societies and commented positively on the availability of the societies. They recognised that as medical doctors they were now entering a legal world that was outside their area of expertise, and that they were in need of professional
assistance. However, there was still a feeling that while the complaint remained unresolved there was still a lack of understanding of what was going to happen on a day to day, week to week basis and this in its self was stressful.

*Once these things get into the bureaucracy you don't know what's going to happen.*

Doctor 10

In general, the involvement and role of the defence societies did not create much emotional impact on the respondents, but there was significant intellectual realisation of the importance of professional legal assistance and the fact that they were not involved in a sphere of expertise that was their own.

### 3.3.4 Suggestions for improvement

After the fourth interview, I actively sought the participation of the doctors in suggesting ways in which the experience of having a complaint could be improved. In general the doctors appeared to have given little consideration to this issue. The question often took them by surprise and they took a few moments to reply. There was general acknowledgement that there was a need for support of the recipient of the complaint, but there was a diversity of opinions as to who should provide it. Suggestions involved some form of counsellor or someone from within the medical profession.

One insightful comment was:

*It's nice to have somebody who understands I think, understands how you, you know, what you're going through. But you see if I've done something that was kind of awful, then well, who knows?*

Doctor 7
Another participant suggested a list of confidential mentors, but there was concern you may not want to talk a doctor who works close by but recognised that:

_Because sometimes people don’t know people outside their own area well enough to ring them up and say “well hey, this is what’s going on”._

Doctor 9

An insightful response from doctor 8 was.

_I wouldn’t like to suggest any changes and the reasons for this are that in the end it worked out well for me. I’m well aware of how we appear to make an improvement from one person’s point of view, and it just ends up creating problems from somebody else’s point of view._

Doctor 8

Only one respondent suggested that a conciliatory or facilitated meeting with the complainant would be of any value (doctor 5) which is interesting in view of this being the favoured first step, not only of the Office of the Health and Disability Commissioner, but of many practice organisations around the country.

A key notion was forwarded by doctor 3 who said.

_I think we need more information about procedure, and they need to be more aware of what an awful effect it has on you._

Doctor 3

By “they”, doctor 3 was referring to whoever is responsible for administering the disciplinary process.

Doctor 4 put the above comments into a practical setting by discussing the formation of a “crash team”. He referred to one of the lawyers from a defence
society who had visited him and suggested the idea of the crash team in the following manner.

*I think that what I'd really like is a “crash team” of Chris Hodgson (a well known medical defence lawyer in New Zealand) and a respected colleague, to come round the day after and say, “right, you've had this letter, the shit's hit the fan, can we talk about this? Because we still think you're quite a good doctor, we'd like to help you through this.”*

Doctor 4

The key notions which I will expand on later, are that there is a lawyer well versed in medicolegal matters, that the professional colleague is respected, that there is an immediacy to the response and acknowledgement of the impact of the complaint, and that the self of the recipient, embodied in the concept “good doctor”, is integral to the whole process.

3.4 Positive outcomes of the complaint

After the generally negative tone of the first three or four interviews, I actively sought evidence of positive experiences. In general, the tone of the interviews was summed up in the following quote.

Interviewer - *Can you think of any positive things that have come up from this, from your point of view?*

Doctor 7 - *Nothing at all. Not one thing.*

Doctor 7

However, two positive sub-themes emerged. The first is more than simply a comment on the nature of feedback. It is a reflection of the complaint being a type of summative assessment of one’s practice performance; an examination which had been passed and which was then valued.
One of the positive things that I got off it if you like, was that my practice was reinforced as being appropriate and that they said it was considered to be that of an experienced general practitioner, and that it was appropriate. 

Interviewer - Did you find that sort of feedback useful? 
Doctor 7 - I did. 

The second sub-theme, emerged from doctor 10, who said.

*I think that it was quite a useful experience. But not one that I'd want repeated. I think it was good that I went through the experience of it. You know, at least you know that you can be in the gun regardless.*

Doctor 10

It is unclear to me from this response as to whether he is referring to affirmation of his practice as being satisfactory, or affirmation of himself as having survived a sort of “trial by fire”. Certainly this response is consistent with previous discussion on the medical education process, induction into a profession and the often-held ethos of survivors of punitive processes that it “made a man out of me”.
4. DISCUSSION

Introduction

In this section I will discuss the results, the strengths and limitations of the research method, solutions to the problems raised in the study, and make recommendations as to how these solutions should be put in place.

With respect to the short-term effects of receiving a disciplinary complaint, the results of this study are consistent with the findings from the literature as discussed in section 1.5. However, this study also found a profound impact on both the doctor-patient relationship and the doctor’s practice of medicine that is sustained in the long-term.

This is a crucial point. If the doctor-patient relationship and/or the doctor’s practice of medicine are negatively affected, there will be an impact on other patients who will seek care from that doctor, months and even years down the track from the time of the original complaint. The risk is that the standard of care for those patients may be adversely effected.

These results have been derived from analysis of a complaint regarded as being more “minor” than complaints which lead to litigation or a full disciplinary hearing. This study examined only complaints in which the doctors were found “not guilty”. None of the changes in participants’ behaviour were prescribed for them by any external agency, and none of these doctors had been asked to do remedial study or undertake any form of reflective self-evaluation. All such
evaluation and behavioural change has been a result of some form of internalised process.

There is a need to develop theory to understand why the receipt of a complaint of this nature should have the effect that it demonstrably has. Results indicate significant short and long-term impact on the person of the doctor involved. The effect on the person of the doctor, which is one side of the doctor-patient relationship, underlies the changes seen in both the doctor-patient relationship and in the doctor's practice of medicine.

One of the striking things to emerge from analysis of the interview transcripts was the distinction between intellectual and emotional responses. From the onset of their description of the complaint, the respondents often alluded to how at an intellectual level they were able to justify themselves, but how there was an enormous emotional component to their response that virtually engulfed them. I have interpreted the emotional response as shame. The discussion of shame in section 1.8 has direct relevance to the real life experience of receiving a complaint and the impact of it on the person of the doctor involved. Shame is the emotional response that both underpins and in many ways undermines the response of the doctor to a complaint. An understanding of shame is pivotal in understanding why a complaint should have the impact that it does. The importance of developing shame as an interpretation of the response to a complaint, is that it allows us to consider what might happen when a doctor receives a complaint and to develop both some primary and secondary prevention strategies.
I will start the discussion of the results by summarising the findings under six headings, the first three dealing with the person of the doctor, their practice of medicine and the doctor-patient relationship, and the last three which arise from the observations made on patients, society and the role of the doctor. From this discussion I will develop a theory-enhanced interpretation based around the role of shame as an emotional response.

4.1 Discussion of the results

There are six key areas evident from the results. These are:

1. The person of the doctor.
2. The practice of medicine.
3. The doctor-patient relationship.
4. Relationship issues with spouse, family and colleagues.
5. Societal shifts and doctors role.
6. The disciplinary system.

Some of the results are based on statements about an emotional experience; other results are based on an intellectualisation of the experience albeit, for example, strategies employed to reduce the likelihood of a further complaint, were predicated by an underlying emotional drive.

Some of the results are based on the participants’ talking about themselves, whereas other results are based on participants talking about other people, such
as the complainants whose viewpoints cannot for obvious reasons, be cross checked to those of our interviewees.

This diversity of findings encourages the interpretation of the results in a lateral rather than a linear manner. Contradictions and inconsistencies are part of the human condition, but are found to be less oppositional if one is prepared to place them in their appropriate context. With this in mind, the following sections discuss each of six key areas.

1. Person of the doctor

The short-term effects on the person of the doctor were by and large in keeping with those proposed in the American literature. Noteworthy, is the intensity of the responses that are reported by Charles in response to the threat of litigation. Here in New Zealand where the threat of litigation is substantially less, a similar intensity of emotional response on receipt of a complaint was observed. This helps to validate the results of this study as it suggests that the group of doctors studied here responded to a receipt of a complaint in a manner predicted by the literature. Apart from doctor 8 who initially found the complaint "laughable" and who denied it for a while before getting round to dealing with it, all the respondents had an immediate and intense negative emotional response. The terms "immediate" and "negative" are of key importance in considering what should be an appropriate response to a complaint.
The rapid emergence of a depressive response as related by doctors 3 and 4 contrast with the Charles' findings which suggest that anger and rage are the expected responses. It is the speed on this effect of the self of the doctor that is impressive. Given that one of the clinical characteristics of depression is a reduction in insight, of awareness that one's self may in itself be depressed, this is a substantive finding.

Another finding from this study was the rapid emergence of shared understanding of the experiences of colleagues who had been in a similar situation. Here the intellectual and emotional distinction becomes blurred and unnecessary. Of most significance in this observation about shared understanding, is that despite the level of "emotional shock" being experienced, the complained about doctors were actively seeking to make sense of the situation and to give it meaning. Going hand in hand with the immediacy of the emotional response, was an immediacy of need for assistance.

As in the short-term, the long-term effects on the person of the doctor of receiving a complaint are reasonably consistent with the effects of litigation. The most congruent responses were from doctor 3 and doctor 9 who expressed a loss of confidence in themselves and a heightened sense of vulnerability. This is certainly in keeping with the overseas literature. The sense of being "more fearful" of patients generally (doctor 2), is probably predictable. Less predictable, and certainly noteworthy with respect to the person of the doctor was the "loss of joy" that the several of these respondents claimed to have experienced in their practice of medicine. Combining this with expressions of
cynicism (e.g. doctors 1 and 5), the complexity of the effect on the person of the doctor becomes evident. For this group of doctors, there is no suggestion that receiving a complaint has been "water off a duck's back".

An important finding was a significant erosion of goodwill towards patients. This occurred even when the complaint was received from a fellow general practitioner (doctor 3). I think the significance of this lies in the concept of role. Doctor 3 saw herself, at least in part, in a "helper-healer" relationship with the doctor who subsequently complained about her. Thus the complaint impacted on her sense of self and even though she had not been in a traditional doctor-patient relationship with the complainant, the impact that the complaint had on her sense of person was such that it carried over into changes in her long-term attitude towards patients.

In this group of doctors, the emergence of prolonged depression and anger as emotional responses to receiving a complaint was observed. These are significant long-term effects on the person of the doctor. I will develop discussion of these emotional reactions further in section 4.1.2.

One of the most positive changes prompted by a complaint is also to be found under the heading of long-term changes in the person of the doctor. I observed that the complaint acted as an instigating point for self-reflection. The re-ordering of the priorities of family and of self-care over the needs of the practice were viewed as positive changes. To do this had taken some redefinition of self and the concept of "others", so that "others" was not exclusively or predominantly defined by patients or by the profession, but was widened in
what may be a more appropriate and healthy way. The converse was evidenced by doctor 5 who dated his desire to leave practice from the time of receiving his complaint. This is an important consideration in times when a significant number of other pressures are likely to impact on doctors and to influence whether they choose to remain in practice. Not only may the receipt of a complaint be the figurative straw that broke the camel’s back, but the way in which complaints are dealt with by the profession may come to be viewed as a factor in remaining in practice in the same way as income and conditions of employment are currently viewed.

2. Practice of medicine

The ability of this group of doctors to practice medicine in the short-term was adversely affected. There was an immediate negative impact on their ability to function on a day to day, consultation to consultation basis as they were used to doing. The two most important immediate effects were on their ability to practice quickly and there was a significant loss of confidence in their own decision-making ability.

At face value, an inability to work quickly does not seem to be a major issue. In fact, to patients who sometimes feel rushed this may appear to be a positive thing. The down side is an associated loss of efficiency, and the inconvenience to other patients that occurs when there is a loss of work speed in the face of an ongoing and unchanged workload.
More ominous was the reduction in confidence that several of the respondents identified. Confidence in practice is closely allied to the joy of practice, and loss of confidence was immediately followed by changes in the way that several doctors practised medicine. This was probably best summed up by doctor 9 in his comment of "it's not worth the hell", describing his reduced tolerance of uncertainty and reduced willingness to try to work with the patients to solve problems or issues, preferring instead just to push the problem away by referring elsewhere.

I've outlined in some detail in section 3.2.2 the sorts of non-situation specific and situation specific strategies employed by this group of doctors to try to avoid or minimise the chances of a complaint happening again. The discussion point is whether these changes in practice represent the adoption of defensive or of defensible medicine.

For two of the doctors who had had complaints from female patients relating to sensitive examinations, the use of a chaperone clearly made them feel much more comfortable about the complaint initially. They were already practising what one would consider to be acceptable medicine (defensible) and the impact on the practice of medicine for these doctors was obviously lessened because of this.

For most of the other doctors however, their practice of medicine was altered more in a "defensive" direction. The most positive behaviour or change was that of being open and honest with patients immediately, if there was any
suggestion of there being a mistake or wrongdoing. Such behaviour fits comfortably with the profession's concept of acceptable patient-centred medicine, using a beneficent rather than a paternalistic consultation model.

There were a group of responses that fell between self-preservation of the doctor and concern for patient welfare. These changes mainly involved heightened awareness of the potential for difficulty, such as taking care when patients have long lists of problems, responding in person to telephone messages and, like doctor 3, of being more aware of the interpersonal interactions happening during a consultation and "bailing out" of the consultation if it is perceived as being dangerous to the doctor. These responses may reasonably be viewed as having a positive outcome for the patient, although it is interesting that they were not put in place by the doctors in this study for that purpose, but to safeguard the doctors against further complaints.

The alarming feature of the findings of this study on the long-term effect on the practice of medicine of a complaint, was the use of avoidance behaviours by these doctors in situations that appeared to be specific to the context of the original complaint, either with respect to the complainant themselves or their condition, or to the circumstances in which the complaint arose. The inability to shake off the mental image of the complainant when a similar patient consulted doctor 5 is worrying, because this sort of response completely fails to see the person in the patient who is now presenting. The new patient of course has absolutely no responsibility for the previous complaint, and is unintentionally evoking the memory of it in their doctor.
Similarly, the avoidance behaviour that relates to the circumstances of a complaint such as night calls, home visits or emergencies are not the responsibility of any patient other than the original complainant. However, these doctors started practising negative defensive medicine (section 1.5.3) with withdrawal of their skills and participation in the practice of medicine. It is a response that at an intellectual level is out of keeping and overstated with reference to the original complaint, especially when viewed by a third party. These behaviours are as irrational, for example, as an anaesthetist who will no longer anaesthetise patients for one type of procedure because of a complaint, but who would continue to anaesthetise patients for a similar risk procedure about which he or she had not received a complaint.

The notable finding here is that the type of changes in the practice of medicine seen as a result of a complaint in this study group, represent the least desirable components of defensive medicine, with withdrawal of services, a tendency to under investigate and over refer. There is no evidence from this study that the response to complaints lead to a shift in biomedical aspects of practice that was in a desirable direction.

3. The doctor-patient relationship

For all of the doctors interviewed, the doctor-patient relationship was adversely effected in both the short and the long-term. Again it is important to stress the two way and contextual nature of the doctor-patient relationship. For respondents who had had a long-term relationship with the patient who made
the complaint, there was an overwhelming sense that trust had been lost. The trusting relationship that they thought they were in, had been broken. For the doctors who were seeing patients on a casual or out-of-hours basis, in their role as a doctor they entered into a relationship with that patient with at least a sense of commitment towards that patient's wellbeing. The complaint shattered the sense of commitment and for the doctor, this hurt was carried into subsequent consultations. One of the distressing themes to emerge from these interviews was a progressive loss of regard for patients and a concomitant rise in the need for self-preservation of the doctor. Considering this in terms of the psychological makeup of doctors, their altruistic tendencies and their "need to be needed" (sections 1.7.2 and 1.7.3), the complaint and the process of the complaint has the potential to make a profound impact. For the doctor whose sense of self is intimately enmeshed in their relationship with others, the threat of further complaints poses such challenge that behaviours previously seen as quite unthinkable, (such as not responding to an emergency or making potentially wrong assumptions about the person of the patient and their likelihood to complain), becomes an acceptable way of preserving self.

4. Relationship issues with spouse, family and colleagues

The findings of this study indicate the need for significant initial support for doctors involved in a complaint. There is a need for immediacy. There is a need for the availability of support from those whose love is not conditional and of support from respected and trusted professionals, both within and outside the medical profession. The need for the support diminishes over time. No doctor who responded to this study commented on a need for further assistance for
themselves at the time of the interview. This was a possibility that I had anticipated in my ethical approval application (section 2.4).

It is significant that for several doctors there was an attitudinal shift away from the demands of colleagues and the profession, toward the needs of spouse and family. This sort of shift is seen as being desirable in terms of professional maintenance, but has yet to be adopted by the wider profession. It is tragic that it takes an event as depressing as a disciplinary complaint to initiate this process.

There was also an attitudinal shift towards colleagues who have been through a similar complaints process. At face value, there is significant positive attitudinal shift that appears to be supportive. However, on closer inspection, this support may well be conditional on the context of the complaint, as perceived by the "helping" doctor. This emerged clearly in the interview with doctor 7, who is quite unsure how she would respond towards a colleague who had "done something really bad". This finding has implication for the selection and training of colleagues who may be able to assist doctors through the process of a complaint.

5. Societal shifts and the doctor's role

Receiving a disciplinary complaint was clearly an event that caused the doctor to question his or her role in society (section 3.3.1). For some doctors, the complaint brought the historical shifts that they had witnessed into sharp relief. They were aware of the changing place of a doctor within a community
structure. They noted that doctors and medicine in general, had become a "commodity" that was no longer as valued, either within a community or in society generally as it had been. No solutions were offered to this. In the words of doctor 1 "I do what I do" can be taken not only as a comment on his style of practice but of a belief in the role that he continues to play despite the challenges to it.

6. Disciplinary system

The two major discussion points to come out of the results of the respondents views about the disciplinary process, are of the importance of appropriate feedback, and the recognition that doctors being complained about are engulfed and overwhelmed by a disciplinary system for which these respondents were completely unprepared.

For other doctors, the complaint really seemed to heighten the existential "why?" question that perhaps could be viewed as a positive outcome of the complaints process. The important point here lies in the nature of the complaints process and specifically in the nature of the feedback and closure of that process. Considering how doctors go about defining their role, and the medical education and professionalisation processes involved in making of a doctor, (Section 1.7.3) it is not surprising that these respondents attached so much significance to the feedback that they were given. This point cannot be overstated, given the impact of a complaint. The point of closure is not (and was clearly not seen to be by many of these participants) the same as a point of vindication. At the point of closure of any complaint process there is going to
be a degree of input from some significant external "other". This may take the
shape of the person of the complainant, of some form of medical professional
comment (in this case it was from the Chairman of the disciplinary committee)
or from some legal or judicial process and its representatives. From wherever
the point of closure comes, there needs to be an awareness of the impact that it
will have on the person of the doctor. This is an important finding from this
study.

In the same way as I express caution in assuming that doctors' experience of
complaints prepares them adequately to assist other doctors, giving prior
consideration to the possibility of complaints is not necessarily protective either.
It is noteworthy that having heard of other doctors' complaints and even, in the
case of doctor 4, having considered a document on how to deal with such issues
in general practice, these doctors all expressed their feelings of being engulfed
in the system, a sense of loss of control, and a sense of impotence to
meaningfully change the outcome once the system had been set in motion.

This finding is consistent with the reported experience of American doctors and
the legalities of litigation. The implication from this is that preparedness is
not the answer and that assistance after the event is a necessity. This comment
in no way diminishes the need to practice safe and appropriate medicine as a
means of reducing the likelihood of a complaint in the first place.

Of relevance to this discussion of the disciplinary system, is that this group of
doctors were highly supportive of the legal assistance that they received from
their medical defence society. Even doctor 8 who did not like having to “do it the insurer’s way”, was satisfied with the outcome and in retrospect saw no other way of dealing with the situation. The level of support for appropriate legal assistance is a significant finding of this study.

4.1.2 The role of shame as an emotional response to a receipt of a complaint

This study has provided insight into the depth of the response to a complaint at the level of person of the doctor, and has demonstrated that there are both immediate and long-term effects of the doctor-patient relationship and the doctor’s practice of medicine.

The question to consider is why there should be such a profound response to a complaint, because without consideration of this question, it will be difficult to find adequate solutions as to how the response might be modified. So far, this study has provided insight into what happens, so it is now an understanding of why that is needed. I propose that the notion of shame (as an emotional response) meets the requirements for an explanatory model that is capable of providing insight into the question of why doctors respond in such a way on receipt of a complaint.

Has a failure to meet one’s own or other’s standards occurred? (section 1.8)

The standard is an internalised abstraction that is personal to the doctor involved. The standard may of course be widely held by others amongst the
profession, and in the wider community. It may on the other hand, reflect a particular values system held only by that doctor.

Quotes from two doctors illustrate the key issues involved. From doctor 1, "because of the complaint, you've done something wrong" and doctor 5 "my emotional self made me feel that I was obviously at fault". For doctor 5, his own internal standards have been breached. His failure came from within himself and he recognised that there was an emotional reaction clearly related to transgression of this standard. For doctor 1, standards were breached that, although obviously internalised, originated from without. They are the standards of "a significant other". Furthermore because the complaint was seen as having come through a professionalised and presumably authoritarian structure, it was perceived as implying criticism and failure from the profession itself.

Is there evidence from the participants' responses that the perceived failure/transgression has resulted in a global response? (section 1.8)

The shame response is a global response, the guilt response only affects a part of the self. 44 Sometimes these exact terms may not be used but, the results of section 3.1.1 clearly show that the complaint resulted in a global response that was attributed to the whole of the doctor's selves not just to a part. Doctor 3 uses the term "guilt" in referring to her shame response. She notes "the utter hopelessness. You feel a failure." Doctor 6, feels like "a bad person" and notes that she must be "a bad doctor because someone's complained about me".
Given the relationship (explored in the introduction) between the perception of one's role as a doctor and the self of one's person, the presence and the intensity of the global emotional response should not come as a surprise. I think this is borne out in the finding that the level of the emotional response is disproportionate to the intellectualised perception of failure. It is this degree of disproportion that needs to be recognised at a professional level. Denial of the intensity of the emotional response and its global nature will inevitably lead to the failure of any helping system that is put into place.

Is there evidence of long-term shame as seen in the development of a shame/rage or shame/depression axis? (section 1.8) This study lacks any baseline measurement of the precomplaint characteristics of the doctors’ personalities. All that is available is a perception of change that comes from the participants themselves. This study has shown that there is a long-term sustained emotional reaction for some of these participants that is either in a direction indicating depression or a direction indicating rage. The implication is that these are the effects of experiencing significant shame. The importance of this lies in the documented attitudinal shifts towards patients. The emotional and intellectual dichotomy is exemplified by doctor 7, who describes her initial fury with the patient for making the complaint and feeling “how dare she?” Later on in the interview, there is a degree of softening, “I was surprised how vindictive she was towards me. I mean it makes you feel the crunch; she really hates me that much”. Later again, “I mean of course it wasn’t that she hated me, it was just that she hated what had happened and I happened to be there”. This response represents a good example of another characteristic of the shame,
being that it changes over time. It is not necessary for a shaming event to have a permanent and fixed emotional and behavioural outcome. Unfortunately, especially when the response follows the depression axis, there is potential for the response to be prolonged and probably deleterious to both doctors and patients.

Is there evidence of an absence of the shame response as evidenced by a different outcome? For doctor 2, who was adequately chaperoned and whose practice was perceived by him (presumably by the Chairman of MPDC also) as being defensible, he felt more “right” about the complaint. Apart from being a little bit more cautious in his approach to examining women and new patients in particular, the complaint had significant short-term impact, but not so much impact in the long-term.

Similarly for doctor 8, there was much less “whole of self” involvement. The behavioural changes described were largely procedural changes with greater care with note keeping and so on.

Considering the difference between defensible and defensive medicine in the context of a shame response, avoiding or minimising a shaming response in the doctor may lead to a more desirable outcome from a professional viewpoint. The more significantly shaming the complaint is, the greater the risk of less appropriate behaviours and attitudes emerging.
This study was not specifically designed to address the subject of the shaming response in the complainant themselves, but it is appropriate to mention it as an important consideration in the education of doctors about complaint avoidance. In some of the complaints described, the question of humiliation or counter humiliation by the doctor towards the patient needs to be considered. Doctor 1, faced with patient demands that he saw as being inappropriate got "kinda peeved off". For doctor 4, the widowed spouse of the patient had the feeling that the doctor had been more interested in chatting with her husband than in dealing with his medical condition. For doctor 6 who had a "difficult person" on a night-time call, one wonders whether this perception was relayed to the patient and of course doctor 2's patient had previously been the victim of sexual abuse, and would have been highly at risk of being shamed in a medical encounter.

Shame in the medical education process needs to be addressed. It is essential that those responsible for teaching medical students are aware of the possibility that their actions may induce shame in students whose psychological vulnerability towards this response is high. There is a need for students to become increasingly self-aware of their own emotional needs and responses, and to work with medical educationalists to shift from competitive to collaborative models of learning and from persecutory through to participatory models of teaching.

It is important to recognise that shame will exist within the medical community. It is often said that the actions of an individual have "brought shame upon us all". I contend that this response in itself is inappropriate and that the medical
profession needs to recognise that its response towards doctors with a complaint will parallel the types of responses that we have seen from doctors towards patients, if the shame response is not recognised and adequately dealt with. If it is not possible to change the perception of the entire medical profession, then it is essential that doctors involved in helping those who have had complaints are aware of the possibility that they themselves may be shamed by the actions of that doctor. They as helpers must be adequately prepared to deal with this.

4.2 Strengths and limitation of the method

This section presents 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. A wider view, as we see in Table 3, is the notion that there are different ways of knowing depending on the intent of the researchers.
TABLE 3.

RESEARCH STYLES

<table>
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<th>Characteristics of Style</th>
<th>Experiment</th>
<th>Survey</th>
<th>Documentary-Historical</th>
<th>Field</th>
<th>Philosophy</th>
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<td>Casual hypothesis</td>
<td>Probability sample</td>
<td>Artifacts</td>
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<td>Generalise to population</td>
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<td>Holistic, Establish realistic underlying principles</td>
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Source: Miller & Crabtree

Jackson makes the following rather cynical comment, that “the dominance of biomedical 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.” An interesting reflection is that the argument between qualitative and quantitative research maybe less related to its validity, and more related to the people who hold power in a medical culture at a point in time.

Where then has qualitative methodology came from and for what purpose? Initially, qualitative research probably formed the basis of the natural sciences when “the natural world was initially described and chronicled by narrative researchers”. Since then it has been increasingly used by sociologists and anthropologists as they study issues related to human behaviour and relationships.
Perhaps even this is slightly too narrow in that qualitative research usually expresses in words rather than in numbers some insight or understanding into the word that is being observed. This concept of describing in words was furthered by the anthropologists whose discipline developed in the study of people who were generally 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.\textsuperscript{48} From this sort of study two important concepts emerged, firstly that of distilling out certain universals of human behaviour and secondly the description of unique features of a particular group. This concept remains valid in a modern context. Obviously, the study group is likely to 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 particular aspects that are only of relevance to those particular circumstances of the study.

Recalling that our concept of culture is one of a shared world view (although recognising that an individual may have a culture of their own) it is by describing in words what has meaning for a particular group that we may come to understand the consequences of that meaning in the behaviour of the participants. In a medical context, there is little argument that the cultural and subcultural practice of medicine can influence the quality of health care that is provided to patients.\textsuperscript{48}
It is interesting to draw parallels between the nature of general practice itself and of qualitative research. 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 GPs we take account of the context and individuality of our patients as does qualitative research." 47 Returning to the biopsychosocial paradigm and of patient centred clinical method the parallel between a research methodology that inquires into the nature of meaning within a culture or subculture, and the clinical practice of medicine is apparent.

When then should qualitative research methods be used? In straightforward terms, "qualitative methods are particularly appropriate when researching a previously unexplored topic, or one that is poorly understood or ill defined." 49 When one is exploring new territory there is a basic need to find out what the relevant issues actually are. From this understanding, it is then possible to use other research styles to test hypotheses, to enable generalisation to the wider or other populations and so on. Qualitative methodology then, is directly applicable and appropriate to the study of the effect of disciplinary complaints on general practitioners in this country, as there is simply no available evidence and the need is for the generation of concepts and of theories.

Roger Jones quoted TS Elliott in asking, "where is the understanding we have lost in knowledge? Where is the knowledge we have lost in information?" 51 I do not think there is a simple answer to this question, but perhaps part of it resides in the concept that there is a range of different ways of making sense of the world. 49
The clinical relevance of qualitative research methods examined from the point of view of disclosure of information and patients views on what is appropriate disclosure and provision of information and what is not, is dependent upon details of circumstance. Furthermore, not only are there differences between individuals for “disclosing” about the same issue, but there are differences in willingness to disclose between different issues for the same person. Thus information may result in different ways of knowing and different ways of knowing, may result in different ways of understanding.

In the field of health services research there has recently been a call for qualitative research to be based on an underlying theory. Harding and Gantly indicate that there is a need for “theory informed” research leading to “theory informed” analysis which in turn leads to “theory enhanced” interpretation. They call for analysis of qualitative research that does not simply identify themes in the responses and narratives that participants give, but question why a particular pattern of responses is found and not another. These researchers are critical of a tendency to use “common sense” perspectives, believing that to do so is risking the perpetuation of widely held assumption rather than critically examining and questioning them. This concept of the theory-ladeness of facts has also been discussed by Guba and Lincoln who comment on the need for objectivity in an inquiry but note that theories and facts are inter-dependent and that “facts are facts only within some theoretical framework”. Griffiths also draws attention to this when he comments that to develop an answer one needs to start from a particular theoretical perspective in order to provide insights and
from which one can find a way of testing them.\textsuperscript{55} 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.

Part of the answer to this issue lies in the development of the notion of “grounded theory” by Corbin and Strauss.\textsuperscript{56} There are two important requirements of grounded theory. The first is that the account should be “clearly recognisable to the people in this setting”. 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 based on.

What then are the characteristics of “good” qualitative research? Accepting that all research is selective and that all methods have their own particular strengths and weaknesses, qualitative research relies in part upon identifying informants who will allow a particular aspect of relevant behaviour to be researched. This means that the sampling method used will be systematic and non-probabilistic. The purpose as Mays and Pope clearly state, is “\textit{not to establish a random or representative sample .... but rather to identify specific groups of people who either possess characteristics or live in circumstances relevant to the social phenomenon being studied}.”\textsuperscript{57} To do so, one identifies key informants who have information that the researcher wishes to access.
Having gained access to this information, it is important to establish the validity of the information. One method for establishing validity in qualitative research is "triangulation" which refers to acquiring data by using difference sources and/or using different analytic techniques. The validation strategy used in this study was to feed the findings or interpretations of the research back to the participants and to search for "deviant" cases where the evidence appeared to contradict the emergent themes or the researcher's explanation of it.57

The issue of bias is an important one in all research. Armstrong makes the point that "humans will respond to the fact that they are being observed".58 The concept of bias also needs to include the bias that researchers themselves take to the interaction, 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, cross over, placebo controlled, quantitative study) but in recognising where bias may exist and confronting it in an explicit manner. I did this by detailing personal bias in section 2.5.

This study has met the requirements of the method imposed by the topic of inquiry. Its strengths lie in the grounded hermeneutic nature of the method that largely overcomes the limitations of single researcher involvement.

4.3 Solutions to the problems

This study specifically examined the effect of receiving a complaint from the Medical Disciplinary Committee on the doctor involved. Societal beliefs, issues of patient education, help seeking and complaint related behaviour by patients,
are not addressed. Neither is the wider issue of the overall role of complaints
or of the different types of issues about which complaints are made.

What this study does enable us to do however, is to examine the effect of
complaints under the system of the Medical Practitioners Disciplinary
Committee, on the assumption that some form of complaint system will
continue to exist, either as a procedure of the Office of the Health and Disability
Commissioner, the New Zealand Medical Council, or in a more litigious
American style system. This study has shown that the effect of receiving a
complaint is to impinge upon the doctor's sense of self. The resultant emotional
response underpins significant attitudinal and behavioural shifts in both the
short and long-term that have potential to be deleterious to patient care.

4.3.1 Objectives

An underlying objective in a search for solutions to the problems shown by this
study, is to increase awareness of the importance of the role of the person of the
doctor within the profession. This awareness needs to infiltrate every area of
medical practice and education, starting with examining its role in the selection
procedures for medical schools, in undergraduate and early postgraduate
training and in postgraduate education at all levels.

The specific focus of this study was on the effect of a complaint in both the
short and long-term in a group of general practitioners. From the results it is
apparent that there is a need for a process that helps doctors deal adequately
with a complaint *at the time* of its receipt and during the process of resolution of the complaint.

4.3.2 **Defining a positive outcome**

Following from the findings of this study, a positive outcome would be seen as a reduction in the impact of the complaint upon the person of the doctor. This would be evidenced by:

1. A reduction in the negative effect of those changes on the doctor-patient relationship and the practice of medicine.
2. An enhancement of positive changes in the doctor-patient relationship and the doctor's practice of medicine (when indicated).

In essence, there would be a positive outcome, defined as an increase in the practice of good or "defensible" medicine.

The question to be answered is whether such outcomes are measurable. General practice in this country currently lacks usable outcome tools. We do not reliably or consistently measure our reasons for encounter\(^{59}\) and our measures of interpersonal skills and of patient satisfaction although valid for the tasks they purport to do, remain crude at best. However, positive outcomes might be able to be studied in terms of doctors' attitudinal shifts in response to so called difficult or heartsink patients.\(^{60}\)
4.3.3. The crash team

Doctor 4 suggested the need for a crash team during his interview. I was able to discuss this idea with other participants and with a large number of colleagues, who have considered it favourably.

In essence, the crash team would consist of a doctor and a lawyer providing a near immediate response, visiting the doctor on the receipt of a complaint. The characteristics of the crash team for general practitioners receiving a complaint would be as follows:

**Characteristics of the doctor**

- Colleague. The doctor would be a general practitioner, experienced and with reference to the specific complaint, seen as being contextually appropriate. By this, I mean that they would be likely to have some experience in a field that was relevant to the complaint, for example general practice obstetrics, rural general practice, industrial medicine and so on.

- Esteemed. The results suggest a need for the doctor to be respected by the doctor receiving the complaint (and this may be different from respect endowed by a professional body such as the RNZCGP or the Medical Council), and not personally connected to the doctor receiving the complaint.

- Clinically competent. The results indicate overwhelming distrust of “ivory tower” professional attitudes which are seen as being out of step with clinical practice reality.
• Aware of impact of a complaint. Clearly from this study there is a need for professional assistance from someone who is aware of the impact of a complaint on the person of the doctor. This would require specific training for the role, ongoing support and evaluation.

Characteristics of the lawyer

• From the Medical Defence Union or Medical Protection Society. These are the only medical defence organisations operating in New Zealand.

• Dedicated. A handful of medical defence lawyers involved in a crash team would lead to the acquisition of greater depth of experience quickly, than with larger numbers being involved.

• Conversant with the process. The results indicate that unfamiliarity with the process, lack of information and lack of a sense of control are major stressors for the doctors involved. The legal representative must be capable of imparting this information and sensitively dealing with the needs of the client doctor who feels disadvantaged by being outside of his or her own field of expertise.

Characteristics of the crash team

• Timing. The crash team must visit the doctor with 24 to 48 hours of being notified of the receipt of a complaint. The results indicate the significance of the immediate impact of a complaint and the
delivery of support needs to be timed so as to reflect the acute nature of the event.

- Space. There is a need for protected time away from the doctor’s practice for the meeting to take place. Given the intensity of the emotional response, at least a half-day away from the practice should be made available by the doctor (although the meeting with the crash team would probably not take this long).

- “Brokers of care”. The results indicate that after receiving a complaint, the doctor will seek assistance from many different sources. It is also clear that this haphazard process provides significant emotional support from spouses, but dubious support from professional colleagues. The crash team should be the primary point of contact for the doctor for all formal issues related to the complaint, so that no decision is made by the doctor about attendance (or non-attendance) at meetings or hearings, and no decision is made about the provision of reports or other correspondence, without direct consultation with the appropriate member of the crash team.

Furthermore, while the medical representative of the crash team is not to assume the role of primary physician to the complained about doctor, part of the role of this crash team member is to be aware of the health needs of the doctor and facilitate access to appropriate help. This may require the involvement of the doctor’s own general practitioner, of their mentor, Balint group, supervisor, or of independent professional counselling or psychotherapy.
The key point about the crash team is that it forms part of the overall process of the complaint, and is not just seen as being there at the start. This approach would be seen to acknowledge the importance of the long-term effect of a complaint on the person of the doctor and on their ongoing practice of medicine.

4.3.4 Responsibility

The point has already been made that an individual doctor is most unlikely to be prepared adequately for the receipt of a complaint, and their need is to be assisted with it. Despite an awareness of the possibility of a complaint, it will be perceived as “a bolt from the blue”. With this in mind, and noting that this study is with reference to general practice, I will discuss the professional institutions that exist in New Zealand with respect to their suitability for taking responsibility for improving the system that we have, and secondly providing a mechanism such as the “crash team” to provide that support.

The alternatives are:

- The New Zealand Medical Council. This study indicates the perception that doctors hold of the NZMC as being a prosecuting body. Receiving support from the same body that was seen as an integral part of the complaints process, may not sit comfortably with either doctors in receipt of a complaint or patients making complaints. The contrary argument is that given the deleterious long-term effect on patient care, the Medical Council may have a responsibility to support initiatives in this direction.
- The Office of the Health and Disability Commissioner (HDC). The Commissioner operates under the Health and Disability Commissioner Act 1994 and the Code of Patient Rights contained within it. The Code clearly states that those in receipt of health care have rights, and that providers of health care have responsibilities. This model arose as a reaction to paternalism, and is grounded in the flawed philosophic principal of autonomy (section 1.6.5). To place the onus for change on the Office of the HDC would require not only a philosophical shift towards the model of beneficence, but a legislative change as well. My feeling is that, although possible, the creation and maintenance of crash teams would be unlikely to be instigated and continued by that Office.

- Universities. In this country, universities take the responsibility for undergraduate and some postgraduate medical education. I do not think that they would be seen as the appropriate administrative bodies for crash teams. To do so would carry the risk of being viewed as elitist and “ivory tower”.

- Independent Practitioner Associations. These associations of general practitioners are commercial organisations whose primary role lies in negotiation with health care funders for the provision of health care services. They are regionalised, becoming increasingly fragmented and I doubt whether they would be able to provide the required commonality and uniformity of response that this proposal would require.
• The Medical Defence Union and Medical Protection Society.
These organisations are the major providers of legal assistance to
doctors in this country with respect to disciplinary matters. The
results of this study clearly indicate the high level of support that
they provide to doctors in receipt of a complaint. The proposed
model requires their involvement and I believe that there is
potential for improved long-term outcome from the point of view
of the defence societies with a reduction in the number of
complaints and the nature of them.

• The Royal New Zealand College of General Practitioners
(RNZCGP). I believe that this organisation is ideally placed as the
vehicle for the instigation and running of crash teams. It currently
has widespread membership and has a stated interest in both the
welfare of doctors and of their patients.

I see the ideal situation as being a liaison between the RNZCGP and the
Medical Defence Societies to establish crash teams and run them on a
nationwide basis. The issue of cost needs to be considered, but it is noteworthy
that most general practitioners are already paying both college membership and
malpractice insurance.

4.4 Recommendations

1. That crash teams are established by liaison between the RNZCGP and the
   Defence Societies on an appropriate geographical and population basis. That
   the teams meet, train, and share a commonality of purpose.
2. That the doctor on receipt of a complaint contacts the crash team (via either the insurers or the RNZCGP), and the team visits that doctor within 24 to 48 hours of notification.

3. That the crash team then represents the point of primary contact for all matters relating to the complaint, and is available to the doctor involved for the duration of the process.

4.5 The significance of the findings for other specialities

There is a need for similar research to be conducted in other specialities, and also in general practice, over a range of "severity" of a complaint. There is a need to establish whether the effect of a complaint is:

A. Similar between doctors practising in different specialities

B. Similar between complaints of different type (for example sexual abuse and fraud) and whether the perceived severity of outcome for the patient or complainant has a different outcome on the nature of the response of the doctor.

If the findings of this study based in general practice are supported by studies in other specialities, then the establishment of parallel crash teams under the auspices of the respective colleges of each specialty may be appropriate.
5. CONCLUSION

This study has shown that receipt of a disciplinary complaint in general practice has a significant short and long-term impact on the person of the doctor, the doctor-patient relationship and ultimately, on the doctor's ability to provide the highest standards of patient care. A theoretical basis for this effect appears to be the induction of a shame response in the doctors involved and this has implications for both the selection and training of medical students and for the way in which the profession responds towards doctors who are in receipt of a complaint.

The results indicate a need for an immediate, appropriate and co-ordinated response to meet doctors' needs for support throughout the disciplinary process. In the opinion of the author, this study indicates that the responsibility for providing such support lies with the Royal New Zealand College of General Practitioners and the Medical Defense Societies that operate in New Zealand.
6. REFERENCES

1. Health and Disability Commissioner Act 1994


55. 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. *Family Practice* 1996; 13 Supplement 1: S27-S30.


### Medical Disciplinary Complaints and Their Outcomes to the MPDC 1992-1996

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### Outcomes

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### MEDICAL DISCIPLINARY COMPLAINTS AND THEIR OUTCOMES TO THE MPDC 1992-1996

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Information Sheet

This letter has been forwarded to you by the Secretary of the Medical Practitioners Disciplinary Committee, at the request of Dr Wayne Cunningham, Department of General Practice, Dunedin Medical School. He has no knowledge of your name or address or of any details regarding any previous encounter with the Disciplinary Committee.

Dear Dr,

I am a practising General Practitioner and a Senior Lecturer in General Practice in the Department of General Practice, Dunedin Medical School Ph 03 4797430, PO Box 913 Dunedin.

For my thesis in the Master of General Practice degree, I am conducting research into the effect on practise of receiving a complaint from (what was until recently) the Disciplinary Committee. Specifically, I am looking at those complaints that did not proceed to a formal hearing.

Better understanding of the effect of a complaint on doctors will lead to improved self care of the doctor, and quite possibly to improved patient care. Receipt of a complaint has considerable impact on the lives of GPs. I would like to investigate the effect on the way that we as GPs practise, looking at feelings attitudes and behaviours, as reported by GPs themselves. Our shared experiences will be of value to all of General Practice.

Getting down to the nuts and bolts, this is qualitative research using taped interviews, transcribed and analysed to describe the themes that emerge. Your transcripts will be returned to you for scrutiny and comment. A copy of any resulting publications will be sent to you. I am expecting most interviews to take 45-60 minutes, and they will be conducted at your convenience.

No information allowing personal identification of participants will appear in any thesis or publication. Transcription of the tapes will be in the Department of General Practice, and supervision of the study will also be within the department. The transcripts will be coded so that I am the only one able to identify the participants, and all tapes and transcripts will be stored in a locked cabinet within the Dept of General Practice, and you will not be identified on the tape or the transcripts. Although the participants have been approached with the help of the Secretary of the MPDC, that is the limit of the MPDC’s involvement with the study. Patient confidentiality is required to be maintained.

If you would like to participate, please indicate this by completing the reply sheet and return in the post-paid envelope and I will be in touch.

Thank you for considering this request.

Yours faithfully,

Wayne Cunningham
9 June 1997

Dr W K Cunningham
Senior Lecturer
Department of General Practice
Dunedin School of Medicine
PO Box 913
DUNEDIN

Dear Dr Cunningham

The effect of disciplinary complaints on General Practitioners
Investigators: Dr WK Cunningham, S Dovey
Protocol Number: 97/04/027

Thank you for your letter of 12 May 1997 in which you respond to the queries raised by the Committee in regard to the above study. This study has now been approved in full.

Approvals granted to protocols are for 12 months. If, after 12 months the study is not completed, it will be necessary to forward to the Committee a brief report on progress made to date and a request for an extension. Please quote the above protocol number in all correspondence relating to this study.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Please advise the Committee on the completion of the study or if, for any reason, you decide not to complete it. On completion of the study a brief report should be forwarded to the Committee.

Yours sincerely

Carol Algie
Ethics Committee Administrator