

Not so random: patient complaints and 'frequent flier' doctors

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Received 11 February 2013

Accepted 11 February 2013

Published Online First

11 April 2013

WHY COMPLAINTS MATTER

Complaints matter: to the people who make them, usually as a last resort after the frustration of trying other avenues without success; to the person complained about, in whom the complaint may provoke a fierce reaction, ranging from shame to indignation; and to the agency required to handle the complaint, charged with resolving a problem when the parties' recollections and objectives may be sharply divergent.

Complaints also matter to society. As long ago as 1644, John Milton said that 'When complaints are freely heard, deeply considered, and speedily reformed, then this is the utmost bound of civil liberty attained that wise men look for.'¹ Complaints are commonly referred to as 'treasure', providing valuable signals from consumers about quality deficits, enabling providers to identify and remedy problems and improve the quality of goods and services.² For safety and quality researchers, complaints may be 'canaries in the coal mine', sounding an alert to deeper problems. Complaints also provide undiluted feedback on a patient's experience, an important measure of quality. Complainants usually want questions answered and problems fixed, and the 'speedy reform' referred to by Milton holds out the promise of resolution for individuals and improvement for the population.

In the early twenty-first century, handling complaints about public and private services has become a veritable industry. Over 70 countries now have an Ombudsman, a 'grievance person' to investigate complaints about maladministration by government agencies. Several countries, including the Australian states and territories and New Zealand, have statutory healthcare complaint commissions to deal with complaints about health professionals and healthcare

organisations. Complaints by aggrieved patients have the potential to be an important window on healthcare quality.³

BISMARCK RESEARCH FINDINGS

The databases of the Australian healthcare complaint commissions are fertile ground for researchers seeking to understand patient complaints. In a national study reported in this issue,⁴ Bismark and colleagues provide some useful insights into the distribution of complaints across the medical workforce and the predictive power of a doctor's complaint history. The study examined around 18 907 complaints made over a decade against 11 148 doctors in Australia.

The distribution of complaints among doctors is highly skewed: 3% of all doctors accounted for 49% of all complaints; and of the doctors who were subject to a complaint, 15% of them accounted for 49% of the complaints. No one with a passing familiarity with the world of patient complaints will be surprised by the fact there is a group of 'frequent flier' doctors who attract a disproportionate share of complaints. What *is* surprising is the extent of the problem. A small minority of doctors accounts for around half of all complaints to official agencies. This is an albatross around the neck of the Australian medico-legal system—and a problem likely to be replicated in other countries, even though the regulatory actors may differ (with medical boards handling patient complaints in many jurisdictions).

Earlier work by these researchers found that, over a similar period, 20% of doctors had been subject to a complaint to the state complaint commission.⁵ No equivalent proportion is explicitly reported in the national study to assist in interpreting the finding that 3% of Australia's medical workforce accounted



► <http://dx.doi.org/10.1136/bmjqs-2012-001691>

To cite: Paterson R. *BMJ Qual Saf* 2013;**22**:525–527.

for 49% of complaints.ⁱ Doubtless many more doctors were subject to a local complaint (made directly to them or their organisation), but the odds of a complaint being escalated to an official agency are modest. This accords with my experience in handling patient complaints in New Zealand,ⁱⁱ and runs counter to the medical myth that all doctors are at high risk of complaint, memorably expressed by the claim that ‘doctors had a greater chance of having a patient complain about them than a World War II bomber pilot had of being shot down over Europe’.ⁱⁱⁱ

The most significant finding from the national study is that a doctor’s complaint history predicts his or her risk of attracting future complaints. By the time of a third complaint, there is a 57% probability of that doctor facing another complaint within 2 years. The complaint-prone doctor was more likely to be male and over the age of 35, with plastic surgeons, dermatologists and obstetricians and gynaecologists at heightened risk of recurrent complaints. Clearly, some doctors *are* complaint prone. The case for early and effective intervention to prevent an escalation of problems is starkly evident.

IMPLICATIONS OF THESE FINDINGS

The public is used to being told, in the wake of inquiries into adverse events in healthcare, that the underlying problem is systemic and will not be fixed by person-centric solutions that focus on individuals. Undoubtedly a systems approach (examining all the factors that contribute to shortcomings in care and communication) offers the greatest potential for improving the quality of healthcare. But the existence of a small group of complaint-prone doctors who loom so large in the corpus of complaints made to external agencies is sobering. However unfashionable it may be to focus on individuals (‘bad apples’), there is clearly a need to do so in this context. Indeed, the fact repeat offenders can continue unchecked indicates a failure of colleagues, employers and regulators to respond satisfactorily—a different kind of ‘system’ problem.

There is now a significant body of research on the motivation of patients in making a complaint.⁶ Most patients want to prevent the same thing happening to someone else. Because complaint handling processes are hidden behind a veil of secrecy, few patients know what, if any, corrective action is taken in relation to the doctor they complained about; and virtually no

patients learn whether others have made similar complaints. Only in the exceptional case of a scandal that comes to public attention, via the media or the findings of a public inquiry, does it become clear whether a patient’s personal experience of a doctor is mirrored in that of other complainants.

Since complainants are isolated from each other, they must rely on the agencies to which they report concerns (employers, complaint commissions and medical boards) to put the pieces of the jigsaw together and detect and respond to a pattern of problems. Distress and dissatisfaction will quickly turn to outrage, and a justified loss of trust in health and regulatory systems, if patients and the public learn that a doctor’s conduct was known to be a problem yet no effective remedial action was taken. How can such doctors have their annual practising certificate renewed and retain employment and visiting privileges? Colleagues who turn a blind eye to such behaviour, employers who respond ineffectually and regulators who take no action beyond mild censure can expect public condemnation when their impotence is exposed.

It is no answer to say that many complaints cannot formally be ‘proved’ or to downplay their significance by categorising them as being primarily about communication. Being an effective communicator is an essential attribute of a good doctor,⁷ and many inquiries into serious failures in healthcare show that communication problems were a warning sign of deeper failures of care.^{iv} In fact, only 23% of the national sample of complaints were categorised as about communication; 61% related to clinical care. Patients’ allegations of problems in care cannot be lightly dismissed as unfounded. Other research by Bismark found that in 50% of complaints to a commission, review of the clinical record showed that there *had* been an adverse event.⁸ This is consistent with research finding that hospitalised patients identify adverse events in their care that may not be documented in the medical record.⁹

PREVENTION

How do we prevent this escalation of harm—the human cost for patients and families damaged by the behaviour of ‘frequent flier’ doctors, and the substantial resources spent by employers and regulators dealing with the havoc such doctors wreak? Bismark and coauthors suggest that ‘(i)mmmediate steps to improve, guide, or constrain the care being provided by these “high risk” practitioners could be a very

ⁱThe authors note that the states and territories whose complaint commission data were studied have 90% of Australia’s 88 000 doctors. In a Supplementary Appendix, details are provided of the complexities of estimating the number of practicing doctors subject to the jurisdiction of the various commissions across the study period.

ⁱⁱThe author was New Zealand Health and Disability Commissioner 2000–2010.

ⁱⁱⁱDr Geoff Shaw reported comments at Association of Salaried Medical Specialists annual conference, Wellington, November 2001.

^{iv}Examples include the inquiries into Dr Jayant Patel (Davies G. Queensland Public Hospitals Commission of Inquiry Report 2005. Queensland Health, Brisbane, 2005) and Dr Roman Hasil (Paterson R. Dr Roman Hasil and Whanganui District Health Board, 2005–2006. Health and Disability Commissioner, Auckland, 2008).

cost-effective way to advance quality and safety, and produce measurable benefits at the system level'.

That is easier said than done. Doctors complained about multiple times to commissions are likely to have been subject to local complaints and unsuccessful attempts to modify their behaviour.^v If peer and employer interventions have failed, and the shock of a complaint to a commission has not been sufficient to provoke genuine reflection and change, it seems unlikely that further complaints will make a difference. Indeed, in my experience complaint-prone doctors are often in denial, and will skilfully use delay and legal tactics to avoid conditions being imposed on their practice. A host of factors (including the reluctance of experts to criticise a peer's behaviour and the 'silo effect' of complaints being looked at in isolation) make it difficult to substantiate concerns and restrict a doctor's practice.

Two interventions may hold promise. First, above a certain threshold (eg, three or more complaints within 3 years) commissions and medical boards should make the number and nature of multiple complaints against an individual doctor a matter of public record—a move consistent with public expectations of greater transparency of health information and with freedom of information laws. Avoiding public naming on an official agency's list of complaint-prone doctors would undoubtedly be a powerful incentive to settling complaints and addressing the underlying problem behaviour. The current veil of secrecy over most complaints (which avoid publicity by never reaching the stage of disciplinary proceedings) allows repeat offenders to continue unheeded.

Second, as many countries begin to follow the lead of the General Medical Council in the UK, in requiring formal appraisal of a doctor's practice as part of revalidation, medical boards should treat multiple complaints as a screening factor prompting closer scrutiny of a doctor's practice before recertifying that doctor as fit to practise. This is already the practice of some medical regulators, such as the Collège des Médecins du Québec.⁷ In jurisdictions such as Australia and New Zealand, where statutory commissions handle patient complaints, those agencies should be required to notify medical boards of all complaints against a doctor (not simply those upheld in a formal investigation).

The creation of healthcare complaint commissions in Australasia was a response to calls for greater

accountability in the wake of medical scandals in the late twentieth century. Scandals involving 'bad apples' in the profession represent 'a failure in the profession's guarantee that each of its members would be trustworthy as to competence and character' and provoke and legitimise the collapse of self-regulation.¹² The community may be alarmed to learn that a small group of doctors, known to regulators but not to the public, attract half of all official complaints yet are able to continue in practice, often subject only to mild recommendations such as attending a 'communication skills' course. Bismark's latest research on complaints to commissions highlights the need for new and more effective approaches to tackle repeat offenders.

Competing interests None.

Provenance and peer review Commissioned; internally peer reviewed.

REFERENCES

- 1 Milton J. *Areopagitica: A Speech for the Liberty of Unlicensed Printing*. 1644.
- 2 Berwick DM. Continuous improvement as an ideal in health care. *N Engl J Med* 1989;320:53–6.
- 3 Bismark MM, Studdert D. Realising the research power of complaints data. *NZ Med J* 2010;123:12–17.
- 4 Bismark MM, Spittal MJ, Gurrin LC, *et al*. Identification of doctors at risk of recurrent complaints: a national study of health care complaints in Australia. *BMJ Qual Saf* 2013.
- 5 Bismark MM, Spittal MJ, Studdert DM. Prevalence and characteristics of complaint-prone doctors in Victoria. *Med J Aust* 2011;195:25–8.
- 6 Bismark MM, Dauer EA, Paterson R, *et al*. Accountability sought by patients following adverse events from medical care: the New Zealand experience. *CMAJ* 2006;175:889–94.
- 7 Paterson R. *The Good Doctor: What Patients Want*. Auckland: Auckland University Press, 2012.
- 8 Bismark MM, Brennan TA, Paterson R, *et al*. Relationship between complaints and quality of care in New Zealand: a descriptive analysis of complainants and non-complainants following adverse events. *Qual Saf Health Care* 2006;15:17–22.
- 9 Wiessman JS, Schneider EC, Weingart SN, *et al*. Comparing patient-recorded hospital adverse events with medical record review: do patients know something that hospitals do not? *Ann Intern Med* 2008;149:100–8.
- 10 National Clinical Assessment Service. *NCAS Casework: The First Eight Years*. London: NHS, 2009.
- 11 Hickson GB, Pichert JW, Webb LE, *et al*. A complementary approach to promoting professionalism: identifying, measuring, and addressing unprofessional behaviors. *Acad Med* 2007;82:1040–8.
- 12 Dixon-Woods M, Yeung K, Bosk C. Why is UK medicine no longer a self-regulating profession? The role of scandals involving 'bad apple' doctors. *Soc Sci Med* 2011;73:1452–9.

^vEarly remedial interventions in response to local complaints about doctors may be effective.^{10 11}

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BMJ Qual Saf 2013 22: 525-527 originally published online April 10, 2013
doi: 10.1136/bmjqs-2013-001902

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