

# Supportive networks, healthier doctors and ‘just culture’

## *Managing the effects of medico-legal complaints on doctors*



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### Background

When an error leads to possible patient harm and a complaint, the impact on doctors and patients can be profound. Doctors may respond in ways that risk harm to themselves, colleagues and patients, including withdrawing from peers, risk-avoidance practice and even suicidal ideation.

### Objectives

This article discusses current research and public discourse on the impact of complaints on doctors' personal and professional lives, as well as the way complaints and the fear of complaints affects doctors' clinical practice. It suggests strategies to ameliorate these effects before a complaint is made.

### Discussion

When colleagues support one another and collectively reflect on their practice within a culture focused on patient safety, doctors facing complaints or presented with an error are less likely to isolate themselves and fear the worst. Using a common adverse event, the author discusses how analysing minor errors and near-misses can benefit patients, practitioners and practices.

**WHEN AN ERROR** leads to possible patient harm and a complaint, the impact on doctors can be profound. The common ways in which doctors respond to adverse events and complaints (including withdrawal from peers, risk-avoidance practice, increased anxiety and even suicidal ideation) indicate that the current mechanisms that doctors use to deal with these occurrences could be improved. Consider the following scenario, based on claims experience to date. Details have been altered and de-identified to preserve privacy and confidentiality.

### SCENARIO

Lisa attended a routine mammogram screen. While the screen was negative, Lisa reported some nipple changes, and the report was flagged for follow-up with her general practitioner (GP). Her usual GP, Dr K, received the results of the screen and marked Lisa for a recall. Lisa made an appointment at the practice for an infected laceration to her leg, but she saw a different doctor. Neither she nor the doctor mentioned the recall. She returned to the practice several times over the next few weeks for wound dressings and review of the infection. She saw different doctors over these visits and the recall was not



mentioned until she finally raised it when she returned some months later to see her usual GP. Dr K explained the missed recall and apologised to Lisa. They discussed symptoms and she was referred for testing. A breast cancer was discovered, and although Lisa was distressed, she continued to see Dr K during her treatment, which was standard and progressed well. However, as she neared the end of her treatment, Lisa reflected on the delay in diagnosis and decided to make a complaint to the regulator.

### Complaints change doctors

This example is a clear case of delayed diagnosis – a common scenario even in a well-organised practice. Often, as in this case, it is not clear that an earlier diagnosis would have made any difference to the patient's treatment or outcome. Nevertheless, such misses can be devastating for both practitioner and patient, with both left wondering 'what if'? Complaints to regulators are becoming more commonplace. Australian Health Practitioner Regulation Agency (AHPRA) data indicate that over 6300 complaints were made to the medical regulators (AHPRA and the NSW Health

Care Complaints Commission) in 2017–18 about medical practitioners. Just over 40% of these were related to clinical care.<sup>1</sup> The number of complaints has risen from just over 4100 in 2010–11, the first year for which AHPRA reported.<sup>2</sup>

The impact of complaints and claims on doctors' professional practice and personal lives is widely documented. In calling into question doctors' judgement and decision-making skills and their ability to care for patients, complaints can deeply affect a doctor's sense of self.<sup>3</sup> The belief that their actions may have harmed a patient can compound the impact. Professionally, doctors have reported an increase in defensive practice or avoiding treating certain conditions.<sup>4–7</sup>

Behavioural changes have also been observed in doctors who had not experienced a complaint themselves, but observed a colleague experiencing one.<sup>8</sup> Bourne et al found that 72.2% of doctors with no previous complaints reported changing their practice after observing a colleague's experience; 81.7% reported 'hedging' (being overcautious to an extent that may lead to overprescribing, over-investigating or referring too many patients); and 46.1% reported 'avoidance behaviour' (which might result in not taking on certain patients or avoiding particular procedures or particular issues).<sup>5</sup>

Fear of litigation has long been recognised as a significant stressor for doctors.<sup>8</sup> Research has also documented the significant impact that complaints, and fear of complaints, can have on doctors' health<sup>5</sup> – including having feelings of anger, frustration, anxiety, and depression, functional impairment and even suicidal ideation.<sup>3,9</sup>

Much of this research has considered the way in which the process of investigating complaints can increase the negative effects of the complaint. Issues such as length of time taken to resolve complaints; bureaucratic and opaque processes; and lack of parity in time frames, style and tone of communications have all been cited as aggravating the impact of complaints.<sup>9,10</sup> There have been many calls for changes to the regulatory process.<sup>3,9</sup> There is no doubt that such changes are important.

### The danger of isolation and the panacea of peer contact

Some of this same research highlights another key element of the distress that doctors experience through the claims process: professional and/or personal isolation. Avant's experience<sup>11</sup> mirrors that of researcher Elizabeth van Ekert, quoted in an article on the impacts of the complaints process.<sup>12</sup> She noted themes of fear and loss common among doctors she spoke to, particularly fears of being stigmatised or ostracised. 'Very few confided in their colleagues, and few opted to tell anyone else beyond their partners.'

According to van Ekert's research, doctors speak more positively about surviving a complaint when they say they felt supported.

'When a doctor's sense of worth is threatened, what helps to mitigate the shock and shame is the collegiality of those around them — affirming that they're okay, that they are worthy of their care and support, and knowing that it is normal to feel unnerved.'<sup>12</sup>

Her findings echo findings from the UK that doctors are best able to manage the challenges and stresses of a complaints process when they are supported by their colleagues.<sup>10</sup>

### Protect and prevent: Now, not when

While this research presents a positive opportunity, it is also important to recognise that building a collegiate support network from a position of distress, at the point of receiving a complaint or claim, is likely to be very difficult.

A better approach may be for doctors to try to create such support in their everyday practice. The culture of the workplace is an essential part of this. Workplace cultures in which staff are supported and encouraged to raise concerns about patient safety, and admit weakness and concern (sometimes called 'just cultures'), are increasingly seen as essential to patient safety and staff wellbeing.<sup>13,14</sup>

The concept of a just culture, as explained in a 2001 report for Columbia

University,<sup>15</sup> is that in order to reduce errors and improve patient safety, organisations also need to make it safe for employees to report errors. In a workplace with a just culture, individuals are accountable for their actions, but know that they will not be blamed for system faults.<sup>13</sup> When doctors are working in a practice with a just culture, issues can be managed collectively, reflected on and learned from, benefitting all in the practice.<sup>13</sup>

The impetus for creating just cultures in healthcare was patient safety. However, as recent work by Professor Sidney Dekker indicates, the benefits for staff wellbeing are perhaps even more profound.<sup>14,16</sup>

For doctors, working within such a culture can help ensure that if a complaint does arise, they have more experience in identifying, reflecting on and addressing concerns and discussing them with their peers. This, in turn, can help provide a different perspective on complaints.

While complaints will always be confronting, particularly where they are based on some kind of error, they are likely to be much more so in practices where the prevailing culture has been to keep silent about incidents and errors for fear of being blamed. Isolating oneself after an adverse event or complaint seems to increase doctors' tendency to catastrophise and imagine the worst possible outcome. AHPRA CEO Martin Fletcher recently commented that 'practitioners tell us they worry that a notification (or complaint) will lead to loss of their registration'.<sup>17</sup> However, the reality is that 'last year, less than 1% of notifications about doctors resulted in suspension or cancellation of registration. And in about 80% of medical matters, the board took no regulatory action.'<sup>17</sup>

### Dealing with delayed diagnosis within a just culture

Consider the case of the delayed diagnosis. The practice in this scenario has been cultivating a culture in their workplace for some time where all staff in the practice are encouraged to speak up at their regular practice meetings about near misses and adverse events and reflect on what could be improved.

**SCENARIO CONTINUED**

During a practice meeting, Dr K undertook an open, reflective analysis of the incident. As a practice, they collectively unpacked what took place and why. This revealed that each doctor in the practice treated recalls differently. They brainstormed mechanisms to develop greater consistency and a more fail-safe system. As a result, they have implemented the following changes.

- The practice will make sure a recall consultation is specifically marked 'recall' in the appointment screen, with a note to explain the purpose of the recall. This means reception staff are also alerted to the recall appointments, and any doctor seeing the patient, even for a different reason, will be alerted. From doctor to the reception desk, everybody is involved.
- The practice has established a recall list that is reviewed regularly by the practice nurse. Patients are not to be removed from the recall list until the recall issue has been taken care of.
- The practice now aims to have the same doctor follow through on the same issue where possible so there is greater continuity and less likelihood of issues falling between the cracks.

**Building a just culture**

'This happened to me too' can provide very powerful support for someone experiencing a complaint or even when discussing an error. Creating a just culture in practice can both reduce errors and increase practitioner resilience if something does go wrong. Key to a culture where doctors can open up is:<sup>13</sup>

- trust and honesty
- genuine respect for all members of the healthcare team, as well as for the challenges of working in a general practice environment
- a non-blaming environment
- practitioners' preparedness to reflect on their own clinical practice as well as those of others and an opportunity to do this regularly

- sound systems and mechanisms to support all practice staff – uniform systems that are consistently applied
- good practice analysis that involves critically reviewing systems and procedures that could prevent problems
- people being alert to potential system issues, and good communication about what is working and what is not.

**Better outcomes for the GP****SCENARIO CONTINUED**

Later down the track, when the complaint came in, Dr K was better equipped psychologically for the medico-legal process, having already aired the issue with peers and having gone through that critical-thinking process. In addition, Dr K was able to explain to the regulator the actions the practice as a whole had taken to address the incident. The doctor was able to already show:

- the error was recognised and communicated to the patient and that the patient's medical care was managed
- the GP had conducted a critical analysis of their practice with peers
- both the GP and the practice have made changes and implemented mechanisms to reduce the risk of this happening again.

In our experience, the regulator will likely look favourably on a doctor who has been through this process, as it shows insight and acts to reassure the regulator that the doctor does not pose an ongoing risk to the public. In a recent update, the Medical Board of Australia confirmed that 'in the vast majority of cases, the Board takes no further regulatory action on complaints. This can be because the doctor has already made practice or other changes that manage risk to patients or the complaint does not raise issues of risk and therefore regulatory action is not needed'.<sup>18</sup>

**SCENARIO CONTINUED**

Importantly, Dr K was supported by practice colleagues and is less likely to be psychologically affected by the process of responding to a complaint.

**Where to start**

Collectively analysing common near-misses or minor errors is a good way to reduce risk and improve safety. Errors and near-misses include:

- incorrect dosage on medication, which is picked up by the pharmacist
- incorrect file opened (wrong patient's name)
- abnormal results overlooked but picked up the next month (near miss).

Talking about minor errors makes doctors more familiar with the routine of analysing their practice. It will allow them to implement changes that will reduce the risk of future errors and improve patient care.

It is also likely that working through near-misses in a collaborative way helps model to junior colleagues that doctors are humans who can also make mistakes. It is what they do when those mistakes happen that makes all the difference.

By conscientiously creating this culture in healthcare workplaces, doctors are better looking after their patients, themselves and each other.

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Competing interests: None.

Funding: None.

Provenance and peer review: Commissioned, externally peer reviewed.

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