Investigations of complaints and quality of health care

RF Henderson,∗ N North** and G Patterson***

Malpractice law is frequently justified by the claim that it improves health care services but this belief remains untested. Using a multiple case study in 16 remote rural areas in New Zealand, this study examined the effects of formal quasi-judicial investigations on the quality of health care services. The study found that the fragile local health systems were damaged by the quasi-judicial investigations of the medical disciplinary body and became less efficient and less user-friendly. A few doctors left rural practice and were difficult to replace. The remaining health workers responded to the investigations in a negative manner, losing confidence, enthusiasm and motivation for work; they performed in a less efficient manner, working more slowly, setting up barriers to access, ordering more tests and referring more to secondary care. Complainants also appeared to have been disadvantaged as a consequence of having complained.

INTRODUCTION

An important aim of malpractice law is to improve or at least maintain standards in health care, generating improvements from which society can benefit.1 One current interpretation of malpractice law sees it as a form of consumer protection, regulating health professions in the public interest.2 Others, however, argue that any benefits of the law are outweighed by the resulting defensive medical practices adopted by practitioners.3 Investigations exact a heavy toll on health workers, who respond by adopting expensive and inefficient practices that are not in society’s interests, especially in today’s

1 Fleming explains: “An award against a tortfeasor served as a punishment for him and a warning to others; it was, in a sense, an adjunct to the criminal law designed to induce anti-social and inconsiderate persons to conform to the standards of reasonable conduct prescribed by law”: see Fleming JG, The Law of Torts (9th ed, Law Book Co, Sydney, 1998) p 10 (emphasis added). An information pamphlet from the New Zealand Health and Disability Commissioner’s Office further clarifies this belief, stating: “Complaints: it is OK to complain – your complaints help improve service. It must be easy for you to make a complaint, and you [sic] should not have an adverse effect on the way you are treated.” (emphasis added). In New Zealand since 1995 health care complaints are regulated by the Health and Disability Commissioner Act 1994 (NZ). The Office of the Health and Disability Commissioner decides how complaints are handled: less serious matters are often sent to mediation, but those matters considered more serious go to a disciplinary hearing, where a tribunal hears the case in a quasi-judicial manner with lawyers representing each side. The tribunal has the powers to impose fines up to NZS$200,000 and restrict or prevent the practitioner from working. Prior to 1995 complaints were heard by a similar disciplinary tribunal under the Medical Practitioners Act 1968 (NZ). See Johnson S, Health Care and the Law (Brooker’s Ltd, Wellington, 2000) p 65.


cash-strapped health systems. With limited funds, more expensive health care means fewer services and longer waiting lists. The lack of empirical evidence on the subject explains why such widely divergent views persist.

**METHODOLOGY**

This study examined the impact of investigations of complaints on the health systems of 16 small rural communities in New Zealand. The case studies used multiple sources of data, obtained by visiting each location and staying one or two nights in the community. In-depth interviews obtained from 33 health workers were transcribed and analysed using the software program ATLAS Ti, according to conventional qualitative methods. The documents used included the doctors’ files of official correspondence and 171 letters from health workers; a content analysis was performed on these documents. Observations included talking to local residents and visiting the surgery.

Causality was strengthened in the case studies by using the pattern-matching method described by Yin. A pattern-matching logic is one of the most desirable strategies for case study analysis, comparing predicted patterns with empirical results. Three outcomes were selected as non-equivalent dependent variables:
1. the quality of local health care;
2. the quality of wider health care; and
3. the complainant’s wellbeing as a result of complaining.

Data were examined in relation to these stated outcomes. Ethical approval for the study was obtained from Massey University's ethics committee.

**RESULTS**

No evidence of improved health care services following investigations was found in this study; on the contrary, there was evidence of deteriorating services. The negative effects following investigations were most marked in the immediate area around the investigation but also spread to neighbouring areas and occasionally, if there had been much publicity, even further through the country. The negative effects of investigations were not confined to doctors but involved all health workers.

**Effects on small rural health services and professionals**

Difficulties in the recruitment and retention of health workers could be a serious consequence following investigations. Three doctors left their practices immediately after the investigation and other local and neighbouring doctors followed them because they now felt vulnerable. Doctors were difficult to replace and when replacements were found, these new doctors frequently joined the exodus after they heard the alarming stories about the investigation:

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9 Yin, n 8, p 106, describes the logic of their use: “The dependent-variables pattern may be derived from one of the more patent quasi-experimental research designs, labelled ‘non-equivalent, dependent variable design’ (Cook & Campbell, 1979, p 118). According to this design, an experiment or quasi-experiment may have multiple dependent variables – that is, a variety of outcomes. If for each outcome, the initially predicted values have been found, and at the same time alternative ‘patterns’ of predicted values (including those derived from methodological artefacts, or ‘threats’ to validity) have not been found, strong causal inferences can be made.” See also Cook TD and Campbell DT, *Quasi-Experimentation: Design and Analysis Issues for Field Settings* (Rand McNally, Chicago, 1979) pp 51-55.
10 This project has been reviewed and approved by the Massey University Ethics Committee, PN Protocol 01/32.
Yes, it had a very strong effect on all of us. But it underlined the vulnerability of the situation and had a strong role in me getting out of the place. Without that happening perhaps, I would still be there.

(Neighbouring doctor – Case 16)

The adversarial process eroded the confidence of health workers, who now found threatening any ambiguous situation that required decision-making. Their response was to shun responsibility, referring more people to secondary care. Three doctors in the study exhibited the features of a post-traumatic stress disorder; they experienced acute anxiety and indecision when confronted with situations similar to the complaint. These doctors did their best to avoid such situations:

I didn’t know how to treat chest pain any more … I went through this phase of about 3-6 months when they [the hospital] would always get a phone call from me, just about every day, I’ve got a chest pain patient and I’ll send [them] up.

(Doctor – Case 2)

I can tell you that when I had to go and help him [the doctor] out in a situation, he was sitting in a corner crying. It destroyed him I think.

(Neighbouring ambulance officer – Case 3)

Critically ill people in rural areas had to sometimes depend on these doctors, who as a consequence of the investigation, were performing below their usual standards.

A sense of vulnerability to complaints made practitioners examine their services for risks of adverse outcomes or complaints. Services that practitioners considered risky were withdrawn because they were no longer willing to risk complaints, even if it meant patients would have no service:

And the last thing I want is to get into problems like [the doctor] got into. By doing a public service, he put himself into big trouble.

(Neighbouring doctor – Case 7)

Yes, why should one take that responsibility? And they are surprised when people don’t want to get into rural practice because you can’t practise in the country without doing these things.

(Doctor – Case 6)

Some people were perceived as more likely to complain; health workers avoided these people, sometimes by referring them elsewhere so that they would complain against others rather than against them:

The moment that I detect that there is a problem, I refer them and then their frustrations get diverted from me to the hospital system … and I just tell the patient I have referred you and you take it up with them now.

(Doctor – Case 1)

Yes, it makes them [doctors] very, very defensive, even to the point of view that you start to defend yourself against certain personalities and personality types. You start to defend yourself against certain race groups and their philosophies, so it actually builds up a rather nasty …

(Neighbouring Doctor – Case 3)

Barriers to access were another measure used by vulnerable health workers to protect themselves from patients:

[T]alking on the phone, … there is no way I was going to let you know where [my wife] was and what she was doing.

(Spouse of neighbouring doctor – Case 3)

Denying patient requests, such as a medical certificate, could be risky, as annoyed patients might retaliate by complaining. Rather than running the risk of complaints, doctors would give what they wanted, even if they knew they should not:

I wouldn’t want to argue with him [the complainant]. It did affect my style of medicine … it makes you practise in a way that doesn’t really feel right … this man wasn’t safe to hold a firearm … you wouldn’t want to confront him with that.

(Neighbouring doctor – Case 8)
A mother who was reported for suspected child abuse, immediately retaliated against the doctor by alleging malpractice in another matter. The doctor commented: 

I will never report another case of suspected sexual abuse again. 

(Doctor – Case 10)

Several doctors commented that, by giving in to patient requests, they were compromising their professional and moral standards.

**Effects on medical practice**

To reassure themselves and to please patients, health workers used defensive medical practices, ordering more tests or investigations and writing down all they did or said, practices which were not usually in patients' interests or in the interests of efficient medical care:

Yes, as I say it has made me slower, because [I am] more obsessional. Not the right kind of things for the outcome or good practice. I am spending more time on things that don’t really contribute a lot, like writing up notes so that I will be able to recall from the notes [if there was a complaint].

(Doctor – Case 12)

Health workers adopted these negative practices but they felt uncomfortable about them. They had previously taken pride in their work, endeavouring to provide a good service for people but now they were disillusioned and felt little motivation. Patient-centred care had shifted to a health worker-orientated care:

I think it harmed my approach; loss of trust in people and loss of trust in the system and faith and all the things, and how we deliver it. We deliver to the best of our ability with our heart totally in it and I felt quite knocked back … and we were beginning to adopt that approach and you know cover your backsides all the time. That first, before anything else.

(Neighbouring nurse 1 – Case 12)

As our ability to continue to have an honest relationship with our patients is eroded, the job satisfaction dissipates. So my disillusionment increases.

(Letter 47)

Underlying all the negative changes adopted by health workers was their feeling of vulnerability: their belief that they faced a biased disciplinary system that always favoured patients. They believed it was too easy for any disgruntled patient to set in motion a process that would be extremely stressful and one in which they had little confidence:

I think if somebody wants to have a go at you they are going to do it successfully. If they have got a good enough lawyer he is going to find something in your management and I think 90% of cases if somebody wants to have a go at you they will do it successfully.

(Neighbouring doctor – Case 3)

[P]atients have all the rights and I’ve seen a system where they can reconstruct what happened and you’ve got no defence.

(Doctor – Case 9)

Health workers felt that in the present system there was no limit to what they might be expected to do and even if they tried to improve health care, it would be impossible to prevent complaints. Negative defensive practices were the only way open to health workers to avoid investigations.

**Effects on complainant**

The people who complained exhibited a number of consistent characteristics. They were known to the community for being prone to disputes and frequently belonged to a group that Dempsey described as being marginalised.11 One characteristic amongst this group was a need for health care, and a problem for complainants and their supporters was continued access to health care, since health workers were uncomfortable or reluctant to deal with them following the complaint:

The other doctor who did the locum for that time refused to deal with him outright, just outright refused. [He] said “I’m not letting that man in my practice while I’m here.”

(Neighbouring doctor – Case 4)

Even when they did find a doctor, the doctor they complained against could still be the doctor on call:

One night I got a phone call from this place. And there's the owner of the pub, lying on the floor, looking like he is having a heart attack. So I was very professional and felt his pulses and he took one look at me, jumped up and went down the corridor, “you’re not seeing me” he says.

(Doctor – Case 2)

The relationship between complainants and all health workers who treated them often became dysfunctional. The confrontational process bred distrust in both parties:

I am quite sure his wife is getting very terrible medical treatment … [S]he is stuck out in this hotel on the way out there through the Gorge and the District Nurses say they are not allowed near her, they are not trusted and so she is probably actually suffering from neglect which is also is a cause of great concern.

(Doctor – Case 2)

Communities became involved in the controversy and everyone had their own ideas on solutions.

There was evidence that complainants were subjected to subtle but effective pressure:

My patients too, the impression is just about the same “we will go and lynch them for you doc, you know”. That's the sort of things that would come out – “we’ll go and sort them out and rough them up”, you know, because they don’t want to lose the town’s doctors.

(Doctor – Case 2)

A consistent finding of the study was that, after about two years, either the doctor or the complainant left the area. It appeared that both of them could not live together in the same community. Usually it was the complainant who left, giving the impression that the process had taken a heavier toll on the complainant than on the doctor.

DISCUSSION

There is no doubt that investigating complaints can improve the quality of services, as many effective organisations demonstrate, but whether they lead to improvements depends on the process.12 Businesses concentrate on improving services rather than disciplining workers. Realising that unhappy customers are bad for business, they expend considerable effort in analysing customer dissatisfaction, incorporating complaints into quality control systems. Ultimately, the quality of services depends on the performance of people, the employees who deliver services, and to improve services, an organisation needs to know how to improve the performance of its employees. Improving the performance of workers has been the subject of much research in organisational studies, and there is now a considerable body of empirical evidence on the subject.13

Improving the performance of workers requires a system that informs workers how they are performing, when their work is satisfactory, and when it is below standard. However, delivering negative feedback can be difficult because it is not welcome and people may respond in undesirable ways, leading to reduced performance.14 To minimise undesirable negative responses, it is important that negative feedback is delivered in a non-threatening manner, that is, it is non-judgmental, consistent and credible. The response of workers depends on their expectations, their belief that they can improve. Most workers want to perform well and if they believe they can do better they will try harder, but if they do not know how to improve or do not believe they can do better, they become disillusioned and frustrated and their performance declines. They react by blaming the system,

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...believing it to be unfair; they become resentful. Resentful workers respond with reactance; they adopt secretive and dishonest measures such as falsifying data.\(^\text{15}\) Such reactions are counter-productive or even damaging to organisations. Managers take precautions to ensure that employees do not wish to damage the organisation by using appropriate feedback systems and by providing support for their workers. They also monitor the effects of feedback systems.

Despite the best efforts of workers, adverse events occur, usually due to situations or factors out of their control. Studies in aviation found that 90% of quality lapses were judged blameless.\(^\text{16}\) Other studies found that the same set of circumstances tends to be associated with the same adverse event irrespective of the people involved – concluding that adverse events depend on circumstances rather than people.\(^\text{17}\) Many studies have shown that stress, fatigue and sleep-loss are associated with much higher levels of errors or mistakes.\(^\text{18}\) In remote areas where there were few doctors, fatigue and sleep-loss were frequent. In order to avoid some adverse events, therefore, it is more productive to correct the situation rather than to try to correct the person.

Organisational theory explains many of the findings of this study. When subjected to a prolonged, personal and threatening process, health workers in this study reacted in the same manner as other workers: the quality of their work deteriorated. Investigators paid little attention to the context of the workers – the understaffed and isolated rural areas.\(^\text{19}\) Although prescribing high standards of care for health workers, the disciplinary process left the workers with no remedies to enable them to reach prescribed standards. Health workers themselves could find no answers to these difficulties and they responded in a predictable manner with disillusionment and decreased performance, responses that were not in the interest of good health care. Health workers did not find the disciplinary process credible: they found it prejudiced against them and so they dismissed its findings.

Litigation and disciplinary investigations do have a place in quality control, but only where wrongdoing or reckless behaviour is suspected.\(^\text{20}\) Such wilful behaviour is under the control of the perpetrator, and can thus be controlled or at least reduced by discipline. Other causes of adverse outcomes, such as incompetence, ignorance and mishaps, are not generally under the control of workers and do not respond positively to formal discipline. Incompetence is often due to factors such as illness. Ignorance is due to a failure of education systems; and mishaps are usually a matter for better organisation. Most of these factors are outside the control of individual health workers and are more in the realm of administrators.\(^\text{21}\) Genuine improvements in the quality of health care can only be achieved when all the factors contributing to adverse events are identified and addressed. Stanhope et al\(^\text{22}\) have described a protocol for investigating adverse outcomes that examines all possible contributory factors.

“No-fault” systems are promoted as desirable alternatives to the tort system: they are cheaper to administer; they are fairer, as more people who suffer losses are covered; and they are thought to be kinder on health professionals. With a less threatening system, doctors could be more open and honest.

\(^{15}\) Ilgen, Fisher and Taylor, n 14.
\(^{22}\) Stanhope et al, n 17 at 1225.
about errors. However, without having to establish loss and causation, the number of cases has been calculated to increase three to sixfold, with a corresponding increase in costs. A no-fault system would thus be more expensive overall, but this is not the major cost: the real costs are the consequential defensive medical practices. “No fault” is a misleading term because, although the claim for damages is reduced, the adversarial disciplinary process still remains, at least in the New Zealand system. The belief that no-fault systems are less traumatic to doctors was not supported by this study and there was no evidence that defensive practices decreased. On the contrary, the increase in complaints might have resulted in more defensive practices than would occur under a tort system. A disturbing finding of the study was the reluctance of health workers to report suspected child or elder abuse because of their fear of the disciplinary process and the easy, unrestricted access patients had to it.

All interventions in society can have unintended effects in spite of their plausibility. In an age of accountability, it is important to monitor the effects of all interventions, and not to rely on assumed outcomes, thereby ensuring that interventions are not harmful to individuals or to society.

CONCLUSION

This study found considerable evidence of deteriorations in the quality of health care services following formal quasi-judicial investigations of complaints based on an adversarial process. Health workers left and were difficult to replace. Those workers who remained lost confidence and a few were so traumatised that they developed symptoms of post-traumatic stress disorder. In order to avoid future complaints, health workers reduced services and adopted tactics that were inefficient and expensive, including defensive medicine and unnecessary referrals. These findings are not surprising because they are consistent with a large body of research in organisational studies showing that all workers respond in a similar manner to personal and accusatory investigations of their work. The study also found that the people who complained were usually worse off for having complained, due to the pressure applied to them by some community members and difficulties they experienced in accessing subsequent health care. If the purpose of investigating complaints is to improve health care, there needs to be a rethinking of the present systems to take into account the large volume of scientific evidence on the subject in organisational studies, psychology and error management.