Lessons from complaints: implications for medical education

Ron Paterson

What have I learned from a decade as New Zealand’s Health and Disability Commissioner (HDC) reading and handling thousands of patient complaints, and undertaking hundreds of detailed investigations? And what are the implications for teaching future doctors?

The following is a summary of some insights gained from a unique perspective on the health and disability system.

Communication

An effective doctor needs to be an effective communicator. A breakdown in communication often sets the stage for a complaint. But good communication is not important simply because it is protective against complaints. Good communication matters because it is strongly correlated with better outcomes for patients.

There are many systems barriers to good communication, especially in our hospitals—pressure of time, lack of continuity of care (with constant changes of shift), the increasing acuity and complexity of cases, etc. Even in the stable GP-patient relationship, communication is highly variable. Do patients feel that their doctors are really listening to them? Can they confide their fears? In HDC files, doctors who are truly open to their patients—listening to them, engaging them in conversation, trying to answer their questions—are seen infrequently.

A recent United Kingdom “Consensus Statement on the Role of the Doctor” noted that “patients are increasingly better informed and act as partners in their own health care. The doctor serves as advisor, interpreter and supporter in this endeavour.”

Courtesy, kindness and empathy

Patients have very good antennae for whether a doctor is genuinely interested in them and their health problem. It is no accident that Robyn Stent, the inaugural Commissioner, placed “the right to be treated with respect” first of the 10 Code rights. Patients understand that they may be kept waiting—but if the doctor is brusque when they finally get seen, the patient will naturally feel aggrieved.

In a complaint in 2009 from a mother whose son died in a hospital emergency department after an intracerebral bleed—where the family had only a few hours’ warning of the man’s sudden collapse and hospitalisation—the mother described finding her son on life support: “The staff on the early shift were amazing, professional, caring and efficient… We were treated with respect and caring…”

But at 7pm “there was a change of staff. A new doctor introduced himself, [a] big man…brusque, arrogant.” That doctor’s lack of compassion fuelled the family’s complaint about what happened when life support was withdrawn and the suction
equipment malfunctioned, leaving them with horrible images of their loved one’s death.³

In 2009, HDC reviewed the Act and Code, which involved a lengthy public consultation. Forty-four of 122 submissions supported adding a “right to compassion” in the Code, with compassion defined as “the humane quality of understanding suffering in others and wanting to do something about it”.

In my Review Report to the Minister of Health (June 2009) I did not recommend the addition of a legal right to compassion.⁴ However, it is clear that patients and doctors perceive that it is a quality increasingly absent from clinical interactions. As educators, we should teach medical students about the nature of suffering and the value that patients place on courtesy, kindness and empathy.

**Self-reflection and openness to criticism**

The doctors who appear before HDC are a defensive bunch. Perhaps this is to be expected. What is striking is the degree to which a minority of doctors who are subject to patient complaints are unwilling or unable to move beyond technical justifications for their diagnosis and treatment, to reflect on why the patient was so unhappy that they made a complaint.

Some doctors are very good at pointing the finger at others (including the previous doctor who treated the patient—setting the stage for a complaint by casual innuendo and implied criticism) but poor at self-reflection or accepting constructive criticism from peers. The standard motto seems to be “Offence is the best form of defence”. This sort of approach is sometimes fuelled by the Medical Protection Society.

But it is not confined to complaints and litigation. The negative reaction from many quarters of the medical profession to credentialling by employers (in the 1990s) and to proposed 360 degree assessment by the Medical Council⁵ testifies to an unwillingness to submit to review of one’s practice by peers, colleagues and patients.

**Teamwork**

In its landmark report on “Doctors in Society: Medical Professionalism in a Changing World” (2005), the Royal College of Physicians described “working in partnership with members of the wider healthcare team” as a key attribute of the modern doctor.⁶ The days of the brilliant solo operator in medicine are gone.

From primary to tertiary care, health care is delivered by teams, and the ability to be a team player is essential for the team to function well for the benefit of patients.⁷ Yet we still see the old medical hierarchy at play, with junior doctors, nurses, pharmacists and technicians feeling unable to speak up and question the treatment being provided to the patient. Research confirms that bullying of junior doctors is a problem in New Zealand hospitals.⁸

Interestingly, the Code of Rights contains a provision, right 4(5), that to my knowledge is unique in codes of patients’ rights—yet it goes to the heart of modern health care: “Every consumer has the right to cooperation among providers to ensure quality and continuity of care.”
Teamwork is not just important with fellow health professionals—it extends to clerical staff, managers and employers. There is a risk that the current emphasis on clinical leadership will overlook the critical importance of effective teamwork between clinical leaders and managers.

Quality improvement

Troy Brennan, a US physician and lawyer who was part of the landmark study of adverse events in New York Hospitals in 1988, says that “we are at a critical cusp of time in which we have a last chance to retain our professional role and to do so [doctors] must become protectors of quality”.

A key aspect of quality improvement is understanding the role of systems problems and human factors in reduction of preventable harm to patients. Patient safety has been a major theme of my work as Commissioner. Making health care safer demands a new set of skills from health professionals—adverse events will not be prevented simply by focusing on individual performance.

Competence

I have left to last the issue that was once seen as the starting point for any discussion of adverse events in medicine—the competence of the individual doctor. Despite the appropriate emphasis on teamwork and systems, individual skills and competence remain critical.

As noted by the Federation of Women’s Health Council in its submission to the “Doctors in Training Workforce Roundtable” (2006), consumers expect a “high level of medical competence—good up-to-date medical knowledge and diagnostic skills, sound technique for medical procedures and awareness of limitations”.

Patients assume that their doctors are competent—as noted by Donald Irvine, “although patients can judge a doctor’s personal qualities, they have to take clinical competence on trust because they cannot assess it satisfactorily”. So the public relies on medical authorities (medical schools, colleges and the Medical Council) to ensure that doctors are properly trained and fit and competent to practise.

Patients assume that doctors have to maintain their professional skills and that this is checked, much as a car must have a valid “warrant of fitness” to stay on the road. In fact the current Medical Council requirements for recertification are light, based on a fairly soft CME model. There is too much mileage given to attending update conferences and not enough focus on participation in audit, peer review, and quality improvement activities.

Ethical blindspots

The final category is one that I have called “ethical blindspots”. Of course all the issues I have raised thus far have an ethical dimension. But there are also some classic ethical issues. Examples include areas of financial dealings with patients or with pharmaceutical companies, sexual relationships (with patients and colleagues), terminating a doctor-patient relationship, prescribing for family, lack of sensitivity to patient confidentiality, limited understanding of a health professional’s obligations in
a pandemic, ignoring the cultural and health needs of different ethnic groups, and a blindness to population health issues.

Doctors often fail to see beyond their own consultation or waiting room to the population as a whole. As the UK “Consensus Statement on the Role of the Doctor” notes (as does our Medical Council in its guidance on practising in a resource-constrained environment), “Notwithstanding the primacy of the individual doctor-patient relationship, the doctor appreciates the needs of the patient in the context of the wider health needs of the population.”

**Cartwright Report**

What did Judge Cartwright say about teaching medical students in her “Report of the Cervical Cancer Inquiry” (1988)?

“It is important to stimulate student thinking on ethical issues…The public does not see medicine purely as a scientific pursuit. Increasingly, it is demanding evidence that doctors think through the many dilemmas which surround its practice and that they involve the public in ethical decisions.”

Judge Cartwright saw the need to “improve the teaching of ethical principles and communication skills at all levels of the medical degree”. It is also noteworthy that Judge Cartwright was very critical of the failure of the curriculum on gynaecological malignancy to reflect current research or practice, calling the use of 20-year-old lecture notes evidence of “intellectual impoverishment”.

**Teaching of medical students**

What are the implications for the training of medical students? I am not an expert in medical education, but I offer a few thoughts.

First, *how* we teach may be as important as what we teach. Our behaviour as educators matters. Do our tutorials and lectures (and later our ward rounds and teaching sessions) model good communication? Do students see courtesy and kindness in the approach of teachers?

Are lecturers, Professors and Heads of Department and School open to constructive criticism? Are we willing to reflect on our own practice? Is it appropriate for a medical school to invite the Medical Protection Society to talk to medical students? Do we model teamwork in the way we organise our courses?

In the area of quality improvement, does a school take a systems approach to developing and refining the medical curriculum? How do we tackle issues with staff performance? Would we know if lecturers are using outdated lecture notes? How do we respond to ethical issues involving medical students?

Secondly, are our medical schools silo institutions or do they model teamwork with other schools? A number of pressures are leading to some secondary care services being moved to primary care settings. It is essential that any barriers to collaboration (e.g. between schools of Medicine and General Practice) are removed and strong links developed. Likewise, links with other professional schools (e.g. Nursing and Pharmacy) must be maintained and strengthened.
Finally, in terms of what we teach—we need to draw on the best of medical education in New Zealand and overseas, in areas such as communication skills, teamwork and patient safety. A good example is the two-day interprofessional “Quality and Safety” learning module (led by Professor Alan Merry of the University of Auckland) for third-year medical, nursing and pharmacy students, who take the programme together. This enables the teaching of critical material (patient safety and a systems approach) while modelling interprofessional teamwork.17

In my view, there is also a place for more teaching of medical ethics and law in the academic programme. I note that the General Medical Council requires each medical school in the UK to provide adequate teaching time and resources in this area, and that the Institute of Medical Ethics has recently revised its 1998 Consensus statement by teachers of medical ethics and law.18

Conclusion

Many of these lessons are well captured in a recent article on “Transforming health care: a safety imperative”.19 International patient safety leaders Lucian Leape, Don Berwick and colleagues identify reform of medical education as one of “five transforming concepts” and write:

“Medical education needs to be restructured to reduce its almost exclusive focus on the acquisition of scientific and clinical facts and to emphasise the development of the skills, behaviours and attitudes needed by practising physicians. These include the ability to manage information; understanding of the basic concepts of human interaction, patient safety, healthcare quality and systems theory; possession of management, communication and teamwork skills.”

Undergraduate, specialist and continuing medical education in New Zealand are already well advanced on these paths. My experience as Commissioner confirms that we need to continue to maintain a balance between teaching (and updating) technical skills and developing and maintaining the broader skills essential to be a good doctor in the 21st Century.

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2. The Code of Health and Disability Services Consumers’ Rights.
3. HDC complaint file 09HDC00849.
5. The “Performance evaluation programme” piloted by the Medical Council in 2005–06.


12. The Medical Council’s proposed reforms to introduce regular practice reviews will, if enacted, be an important step in the right direction. http://www.medschools.ac.uk/AboutUs/Projects/Documents/Role%20of%20Doctor%20Consensus%20Statement.pdf


