

Complaints, shame and defensive medicine

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ABSTRACT

While the complaints process is intended to improve healthcare, some doctors appear to practise defensive medicine after receiving a complaint. This response occurs in countries that use a tort-based medicolegal system as well as in countries with less professional liability. Defensive medicine is based on avoiding malpractice liability rather than considering a risk–benefit analysis for both investigations and treatment. There is also evidence that this style of practice is low quality in terms of decision-making, cost and patient outcomes. Western medical practice is based on biomedicine: determining medical failure using the underlying, taken-for-granted assumptions of biomedicine can potentially contribute to a response of shame after an adverse outcome or a complaint. Shame is implicated in the observable changes in practising behaviour after receipt of a complaint. Identifying and responding to shame is required if doctors are to respond to a complaint with an overall improvement in clinical practice. This will eventually improve the outcomes of the complaints process.

INTRODUCTION

One of the aims of the complaints process in medical practice is to deliver better healthcare to society. However, the emergence of defensive medicine as a response to receiving a complaint represents an unintended outcome of the process. To understand why doctors might change their practice towards defensive medicine, it is helpful to consider the underlying rules and assumptions of modern medical practice, and how these beliefs are shared by both medicine and society. We will then outline research into the response of doctors after error or on receipt of a complaint or disciplinary process, then make the links between biomedicine, shame and defensive practice. Finally, we will offer some thoughts on how to address these issues for future practice.

BIOMEDICAL PARADIGM

Since the 19th century, the dominant underlying paradigm or belief system of medical practice in the Western world has been that of ‘biomedicine.’ Over several hundred years, this system arose in conjunction with the emergence of the scientific method and the application of those principles to understanding the human body. Biomedicine is focused on disease—its cause, the characteristics of the organ involved and the current treatment for a recognised pathology. A useful metaphor is that the body of the patient is a machine and that the doctor is a mechanic, fixing the broken part.¹ The corollary is that the doctor is a scientist or ‘detached observer,’ and that by applying correct medical understanding—history taking, examination and investigation—he or she can know the best way to treat each disease.²

This biomedical approach underpins research, practice and medical education, and it has been, and is, a very useful paradigm. It is responsible for the major medical advances in diagnosis and treatment over the last few hundred years.³

Philosophically speaking, biomedicine is located within a ‘positivist’ understanding of disease (empirical knowledge is gained from scientific testing leading to generalisable laws of nature).⁴ However, many observers have outlined the difficulties in applying these principles to human illness and behaviour, more accurately theorising medical practice as a social construction.^{5 6}

McWhinney’s seminal critique of biomedicine in 1984 identified the following taken-for-granted ‘rules’ that underpin medical practice: patients suffer from ‘diseases’ that can be categorised in the same way as other ‘natural’ phenomena; a disease can be viewed independently from the person who is suffering from it and from their social

context; mental and physical diseases can be considered separately; diseases follow defined clinical courses that are altered by medical interventions; the doctor's effectiveness is independent of gender or beliefs; the doctor is usually a 'detached neutral observer'; the patient is usually a 'passive recipient' of the prescribed treatment.⁷

These usually unstated assumptions of biomedicine imply that identifiable truths about diseases can be discovered by research, that diseases exist independently of persons, and that the correct attitude or 'stance' of the doctor is that of objective scientist.

While the 'body-as-machine' metaphor has been a useful one, most doctors do not critically examine these underlying assumptions; many still take this metaphor quite literally. The unstated implication is that given sufficient knowledge, doctors should almost always be able to make the 'correct' diagnosis or provide the 'correct' therapy. These uncontested assumptions have led to a black-or-white dichotomy between correct and incorrect medical practice, without consideration of each patient's ideas, beliefs or particular context, and how these factors can impact on disease outcomes.⁸

DOCTORS' RESPONSES TO COMPLAINTS AND/OR ADVERSE OUTCOMES

The relationship between quality of medical care and complaints from patients is a complex one: an adverse event does not necessarily lead to a complaint, while complaints can arise even if the standard of care has been exemplary.^{9–11} There is also considerable emerging evidence from around the world indicating that both adverse outcomes and complaints have a significant impact on doctors.¹² Research in New Zealand, for example, indicates that doctors respond in both emotional and intellectual ways, the intellectual appraisal being usually based on the principles of biomedicine outlined above.¹³ Complaints also impact on the "person" of the doctor and on the doctor–patient relationship. Personal emotional responses can include feelings of anger and depression, reduced levels of enjoyment of the practice of medicine, and feelings of guilt or shame. While some of these feelings appear to soften over time, many doctors remain angry and/or report feelings of depression, guilt, shame and loss of joy of practice many years later.¹⁴

This emerging body of research indicates that receiving a complaint can reduce trust, goodwill and commitment towards patients. Doctors report a reduced ability to tolerate uncertainty and reduced confidence in their clinical judgement, responses that can persist into the long term.¹⁴

In summary, doctors' personal and emotional responses to errors and/or complaints are highly

significant, but this has only been recognised as impacting on their professional work in the last decade. As Wu observed in 2000, '...although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.'¹⁵ More recent research has indicated how different doctors tend to 'recover' from these events.¹⁶

DEFENSIVE MEDICINE

Defensive medicine has been defined as: 'deviations from what the physician believes is ... sound medical practice'¹⁷ and 'medical practice decisions predicated on a desire to avoid malpractice liability, rather than a consideration of medical risk–benefit analysis.'¹⁸

Defensive medicine may be either positive or negative. Positive defensive medicine is expressed by an increased use of resources, both to reduce the risk of receiving a further complaint and to increase doctors' ability to defend one: this could be called 'augmented' or 'extra' medical practice. Negative defensive medicine refers to withdrawal of medical services; doctors may cease providing care if they believe particular types of patients or diseases place them at greater risk of receiving a complaint: this is 'diminished,' 'inhibited' or 'contracted' medical practice.

Positive defensive medicine is linked to perceived reduction in confidence, reduced ability to make decisions and patient pressure. Other changes are increased referrals and admissions to hospital, pre-emptive identification of problem patients, excessive documentation and consenting, and changes in consulting times.¹⁹

Negative defensive medicine is characterised by specific changes in response to particular complaints; ceasing clinical practice in fields such as obstetrics and intensive care, shifting from rural to urban practice or withdrawing from patients with particular conditions who might pose an increased risk of a complaint.¹⁹

These New Zealand doctors' responses are similar to those of doctors practising in tort-based legal systems. Research from the USA, the UK and Australia indicate that positive defensive medicine such as increased referrals, test ordering and prescribing are all responses to litigation.²⁰ These common findings from disparate cultures (with respect to complaint and litigation procedures) suggest that doctors' responses arise more from internalised mechanisms, rather than from an externalised modifier of behaviour. We contend that the link between the biomedicine, complaints and defensive medicine (as observed in these doctors' responses) lies in the notion of shame.

SHAME

Shame is characterised by a desire to run away, hide, disappear or withdraw. It is an internalised emotional response to an actual or perceived assault or threat to one's sense of self. Shame results from what has been described as a 'global attribution of failure.'²¹ A judgement of failure is made, and the person believes that they themselves are a failure.²²

In medicine, some doctors respond with shame rather than guilt when they perceive they are being judged to have failed in their clinical practice; for example, 'I am a bad doctor' (shame), rather than 'I practised badly' (guilt). This internalised judgement arises from the complaint itself or from the doctor's own analysis of the events, and here lies the problematic link with biomedicine as the underlying medical paradigm.

After an adverse outcome or on receipt of a complaint, many doctors look rather simplistically for where they went 'wrong': what did they not know, or if they had made an error in diagnosis or management. In these situations, doctors appraise their practice using the biomedical paradigm, as does the complaints process itself. Judged by themselves or others to have 'failed,' doctors can internalise this failure and experience shame.²³ Arguably, this shame response drives the observable changes in attitude towards patients and changes in practising behaviour.²⁴

Because the underlying rules of biomedicine are based on 'external truths' about disease that doctors need to know, the possibility of judgement is always present. By considering that the disease is independent of the person of the patient, the "person" of the doctor and the doctor-patient relationship, judging adverse outcomes by the rules of biomedicine will almost always find that the doctor has fallen short of the mark. Because the self of the doctor is closely linked to 'being' a doctor,²⁵ and because a failure of judgement can be perceived by the doctor to be a failure of self, the practice of biomedicine can quite readily induce a shame response, with its potentially damaging outcomes.

In contrast to writings from researchers in countries using a tort-based system, we contend that defensive medicine is less driven by any external 'litigious' environment than by these internal responses arising from within the doctor.

On being shamed, doctors change their way of practising. They use the default setting of biomedicine, ignoring the shades of grey of practice, and (mistakenly) polarise medical practice as though it only existed in a dichotomy of black or white. This response, however, fails doctors, patients and the communities they serve. If complaints are to be used as 'a 'window of opportunity' to improve health services,'²⁶ it is essential that the

profession and society are cognisant of the maladaptive learning processes that can characterise doctors' current responses to complaints.

The key to effective learning from a complaint is to minimise the induction of internalised shame responses that can overwhelm doctors' emotions and interfere with their ability to correctly appraise and respond to the complaint.

SOME WAYS FORWARD

In New Zealand, a readily accessible counselling service has been created to provide support for doctors in times of self-identified stress.²⁷ Designed to respond to the emotional needs of stressed doctors, we believe this could serve as a model for a rapid and coordinated professional service for doctors when they receive a complaint. Doctors would meet with trained colleagues acting in a mentoring capacity to review the biomedical basis of the complaint, set against the context of that particular practice, doctor-patient relationship and personal responses. This supported reflection could assist doctors' intellectual appraisal of their practice and mitigate the potential effects of any shame response. It would significantly reduce the dependence of doctors on their own intellectual appraisal or on the usually delayed reports of expert advisers who are prosecuting or defending the complaint.

Shame is a very powerful emotion that can overwhelm the intellectual analysis of any event or incident; in turn, this can lead to 'maladaptive learning.' Taking the time to review the circumstances of a complaint or adverse event in this way would allow the doctor's personal feelings to be considered, and any sense of failure to be fully aired. Guided intellectual appraisal allows learning that is not wrapped up in shame.

CONCLUSION

Although the complaints process can discover systems error and occasionally uncover doctors' unethical or criminal behaviours, we believe its potential to improve medical care is underutilised. The emergence of defensive medicine suggests that an unintended outcome of the complaints process can be reduced patient care. We propose that the profession institutes a rapid collegial response to complaints that is mindful of both emotional and intellectual responses, and seeks to minimise the maladaptive learning that is characteristic of defensive medicine.

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