Complaints Against Rural Doctors:

The impacts on the quality of rural health care services and on rural communities.

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Abstract

Investigations of health care complaints are assumed to improve the standards of health care but this belief has not been tested. Using a multiple case study in sixteen remote rural areas, this study examined the effects of formal investigations of complaints on the quality of health care services and the effects on the community. Data for the study were obtained from in-depth interviews, documents and observations.

Rural doctors, who struggled to cope with a heavy workload, isolation and many other difficulties, found the accusations of incompetence and the prolonged disciplinary process very threatening. The disciplinary process was more damaging than the findings. The effects of the process were: a few doctors developed a post-traumatic stress like disorder – being unable to cope with threatening situations, some doctors left and were difficult to replace, while others lost their enthusiasm for their work and adopted defensive medical practices. These defensive practices included setting up barriers to access, working more slowly, ordering more investigations and referring more people to secondary care. Other local health workers regarded the disciplinary process as a threat to them also and they adopted similar negative attitudes, as did many distant doctors who heard about the investigation. The fragile local health systems were damaged by the adversarial disciplinary process and became less efficient and less user friendly.

Rural communities became involved in the adversarial process and it appeared some complainants were subjected to community pressure. Complainants also had difficulty accessing further health care services and they appeared worse off for having complained.

There is an urgent need to develop better ways of dealing with complaints so that the complaint process may: find answers to the problems of health care delivery rather than damaging health care services, serve complainants better, and are fairer on health professionals. Many of the answers to a better system of

complaint management are to be found in studies on: quality control in organisations, error control, safe systems in aviation and similar studies.

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Preface

On discussing what form a research report should take, Miles and Huberman (1995, p298) make the following comments:

> *But what form? It's clear that the conventional formats long familiar to quantitative researchers, something like this, are too schematic and constraining: Statement of the problem, conceptual framework, research question, methodology, data analysis, conclusions, discussion.*
>
> *A qualitative study could follow that format, but it looks Procrustean, forced. Normally we would have other expectations for a qualitative report.*

There appears to be no agreed format for a qualitative study but what does distinguish qualitative research from quantitative research is that it does not strive to be the impersonal process that traditional researchers aim for.

> *Rather in Erickson's (1986) terms, the reader is a co-analyst experiencing the original setting vicariously, looking at the evidence, weighing up the writer's interpretations and perspective. (Miles and Huberman, 1995, p299)*

The present research report follows the recommendations of these writers and thus breaks some of the classic traditions of research report writing, which aim for objectivity and an impersonal approach. It is written with the intention that the reader should be a co-researcher who shares all aspects of the research project and who can form their own opinion independent of the researcher. We hope readers will find this an open and honest account of the research process so they can form their independent opinions.

CHAPTER 1: INTRODUCTION

There exists a belief that investigating complaints in health care invariably leads to better health care. This untested belief is the subject of the present study, which was carried out in rural areas.

The present study explores further the findings of a previous study into rural general medical practice, which indicated that the investigation of complaints could be harming rural practice (Henderson, 1999). In this previous study on doctors leaving rural practice, participant doctors expressed their continual anxieties about possible complaints from patients because of their overworked conditions; this fear was a major reason for their leaving rural practice. Concern about complaints was a leading source of dissatisfaction with rural practice and appeared to have far reaching effects on their attitude to patients and to their work. The present study aims to explore further these findings.

Although most of the participating doctors of the previous study had not been the subject of a complaint themselves, they invariably knew of a rural doctor who had had a complaint investigated, and they were aware of the emotional toll the complaint had entailed. Doctors found these accounts very disturbing because they usually felt that the alleged "mistake" their colleague had made, was one they could easily have made themselves. They found the thoughts very threatening.

Emotional burnout and fear of complaints were found to be major causes of doctors leaving rural practice, in the previous study. As doctors had begun to experience burnout and struggled to cope with their workload, they had become increasingly aware of their chance of making mistakes and the likelihood of a complaint. Thought of making mistakes and the ensuing investigation produced anxiety and alarm and became an increasing concern for some doctors.

From these stories of doctors leaving rural practice the researcher was left with the impression that the process of investigating complaints was having adverse

effects that extended far wider than the issue of the complaint. The investigation of the complaint appeared to have a variety of effects on the rural community and other health professionals. In spite of the intention that the investigation of the complaint should be confidential, this was seldom the case in fact, and rural communities became involved in the controversies. Other health professionals working with the doctor were also negatively affected, as were the health professionals in neighbouring areas, and as they took sides their relationship with some community members was negatively affected.

In addition to the negative effects that investigations of complaints apparently had on the health professionals and health care services, they also appeared to have wider repercussions in the local community. It was clear that complaints in a rural setting presented a fruitful area to investigate as a sociological phenomenon. Community members seemed to take an active interest in the complaint and many became involved in the process, some taking the side of the doctor, others the complainant. There appeared to be rich and meaningful social interactions between the various sections and individual members of the community.

The significance of the study

The hypothesis that investigation of complaints was having a detrimental effect on rural health care, required further investigation to determine if it was in fact true.

Considerable amounts of scarce resources are being put into the investigation of complaints in the belief that they will ensure a better health system. If in reality the converse is happening, this needed to be known. It is well documented that investigation of complaints can have a detrimental effect on doctors. The wider effects of investigations of complaints on health services, other health professionals and the recipients of health services are not well known. This study proposed to study these uncertain areas.

THE PRINCIPLES BEHIND COMPLAINTS MECHANISMS

There is a belief that investigating complaints helps to maintain standards of care. Much of the investigative procedure is based on and has developed from the law of torts. The law of torts has the general aim of compensating the person who may have suffered due to the actions of another, but it also aims to act as a deterrent to others. As Fleming has put it,

> *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****. (Fleming, 1998, p10)*

The stated mission of the Health and Disability Commissioners' office is, ***"Our business is service quality improvement through a Code of Rights"*** (Stent, 1996, p1.12). An information pamphlet from The Health and Disability Commissioner's office makes the following statement, ***Complaints: it is OK to complain - your complaints help improve service. It must be easy for you to make a complaint, and you should not have an adverse effect on the way you are treated.***

These statements can be reduced to three main themes.

1. Complaints help improve service quality through the Code of Rights.
2. People who complain should not be subject to any ill effects in their subsequent health care services or any other type of adverse effects.
3. Investigation of complaints should act as a deterrent to providers who do not conform to prescribed standards.

These three principles can be taken to represent the main aims of an investigation. If these aims were met, an investigation could be considered to be a success but if they were not met or if the converse occurred, the success of the investigation must be questioned.

Considerations in selecting a suitable research method

The aim of the study was to describe how formal investigation of complaints affected health services in rural areas, and more specifically to determine whether the effects were beneficial or not to subsequent health care services. An important part of the study was therefore to establish a cause and effect relationship.

ESTABLISHING CAUSE AND EFFECT

True experiments or some forms of quasi-experiments have high internal validity; however, they are not always easy to organise in a field setting (Robson, 1993, p84; Campbell and Stanley, 1963; Cook and Campbell, 1979). As Robson states;

> *A central feature of the experiment is that you need to know what you are doing before you do it. A great deal of preparatory work is needed if it is going to be useful. In other words, an experiment is an extremely focused study - you can only handle a very few variables, and often only a single independent variable and a single dependent variable. (Robson, 1993, p 78).*

With a variable such as complaints it was clear that any form of experiment would not be possible. Some other form of research method would have to be used, that could establish a cause and effect relationship.

A CASE STUDY METHOD

Where it is not possible to do a valid quasi-experimental study, most authorities recommend the use of a case study (Robson, 1993, p101). Although case studies have had a somewhat bad reputation in the past as far as causality is concerned (Cook and Campbell, 1979), the methodology of case studies has become more rigorous in the last decade and validity of the method is now better appreciated (Yin, 1994). The methods of establishing validity are discussed in more detail below. Case studies have the advantage of being more flexible and adaptable to unexpected findings and in a situation where there is not a lot of knowledge about the subject this is desirable. In many respects this was an exploratory study.

THE SENSITIVE NATURE OF THE STUDY

A major difficulty of a study involving complaints is their sensitive nature. For most doctors the investigation of the complaint proved to be an extremely stressful and sometimes painful experience and it was important to ensure that the study did not cause them more distress. Apart from the researcher's desire not to harm others, avoiding distress would be a requirement in obtaining ethical approval for the study.

While there would have been advantages to incorporate in the study all parties involved in a complaint, it became obvious that this would not be appropriate, because this had the potential to re-kindle a controversy that had passed and this would be distressing. For these reasons of not wanting to cause distress and harm in the doctors and others it was decided that the study should be confined to health professionals. Health professionals could be expected to be discreet about the study.

It could not be assumed that all doctors would be happy to discuss their experiences and participate in the study. To avoid any coercion, doctors were asked to volunteer for the study. Interviews were confined to health professionals but before approaching anyone, the doctor's consent to interview a particular person was obtained. As it turned out, only one doctor was uncomfortable about a particular colleague being involved.

PLANNING THE STUDY

Because of these practical and ethical considerations, the study has some limitations. Firstly, the study was confined to cases where doctors had volunteered to participate and secondly interviews were confined to health professionals. In remote rural areas, there can be as few as two health professionals, a doctor and a practice nurse. However, in these situations they often work with the health professionals in the neighbouring towns, sharing an after hours duty roster, attending the same clinical meetings and sometimes sharing patients. The health professionals in neighbouring towns, therefore, often

have knowledge about complaints and so can provide a useful perspective on events.

In addition to the interview with the doctor involved in the complaint, at least one other health professional was interviewed, someone who had a knowledge of health care in the area. When possible, this would involve health professionals other than doctors, in order to acquire a broader understanding of events.

A reasonably workable number of such cases was identified as about ten, but the actual number depended on the number of doctors volunteering for the study. In fact the full number of cases (that is, individual complaints) was 17, with 15 general practitioners having volunteered (two represented two complaints each). Each of the complaints investigated in a community comprised a case study, the study thus being a multiple case study.

Designing the case study

Sound design is crucial for achieving successful results in a case study, a point many authorities have emphasised.

> *Research design is the plan and structure of investigation, so conceived as to obtain answers to research questions. The plan is the overall scheme or program of the research. It includes an outline of what the investigator will do from writing hypotheses and their operational implications to the final analysis of data. A structure is the framework organisation, or configuration of ...the relation among variables of a study. A research design expresses both the structure of the research problem and the plan of investigation used to obtain empirical evidence of relations of the problem.*
> *(Kerlinger,1986: cited in Cooper and Schindler, 1998, p 130)*

Yin (1994) describes a research design thus:

> *A research design is the logic that links the data to be collected...to the initial questions of a study. Every empirical study has an implicit, if not explicit, research design.*
> *Colloquially, a research design is an action plan for getting from here to there, where here may be defined as the initial set of questions to be answered, and there is some set of conclusions about these questions.*
> *The main purpose of the design is to help to avoid the situation in which the evidence does not address the initial research questions. (Yin, 1994, p20)*

In planning the research design, there are four important aspects the researcher must keep in mind while developing each stage of the plan. As Yin describes them:

> *The case investigator also must maximise four aspects of the quality of any design: (a) construct validity, (b) internal validity (for explanatory or causal case studies only). (c) external validity, and (d) reliability. (Yin, 1994, p21)*

THE COMPONENTS OF RESEARCH DESIGN

Yin (1994) recognises five components in case study design; the study's questions, its propositions, its units of analysis, the logic linking the data to the propositions and the criteria for interpreting the findings. These components form useful structures around which to plan a research design and were used in this study as a framework to describe the research design.

Study Questions

When it had been decided in principle what was feasible and practical for the study, the research question was revisited and defined more accurately. After considerable reflection and discussion the following statement of the research question was reached.

The broad question is:

> ***In the rich social context of a sociological understanding of small rural communities, what are the wider effects and meanings of an investigation of a local doctor receiving a formal complaint as perceived by other health professionals of that community?***

There are three more specific questions:

> ***1) What effects does a formal complaint, and resultant investigation by the Health and Disability Commissioner's Office, have on remote rural health care services, as perceived by other health professionals? What are their perceptions of the effect of the complaint on the quality of health services in the area?***

> ***2) What is the impact of the investigation on other persons involved in health services in the community?***

3) What is the perceived impact of the investigation on the investigated doctor as it affects (a) his or her standard of clinical practice and (b) his or her relationship with patients in the community?

Study propositions

Central to the study was the impression that investigations of complaints in rural areas were having significant effects on health care services, effects that were not well understood nor as beneficial as generally assumed.

An understanding of the context of the study would be important, as many contextual factors appeared to have a bearing on the effects of complaints. Those factors would include the circumstances of a small number of health workers, working in a small rural town, often overworked and stressed, who also had a very different relationship with patients to that of most health workers because they lived amongst their patients. These poorly understood factors were not constant but varied from area to area. The relationship between health workers, complainant and community could have an important bearing on the effects of the investigation. The ability of health professionals to cope with and adapt to the events of the investigation would probably depend on the level of stress in health workers, the conditions of work and their integration in the community.

Unit of analysis

The study was a multiple case study. Each case comprised a study of the effects of a single complaint. This meant, where a complaint was relatively minor and did not seem to affect anyone other than the doctor, the boundaries of the case were limited to these effects, but where a complaint was widely known and affected other health professionals in other communities, the boundaries of the case extended to embrace all these effects.

Unstructured interviews with key health professionals formed the chief source of data including the defendant doctor and other health professionals in the same or adjacent rural communities. These health professionals who had knowledge of the health system and community were sought out and interviewed. The

interviews were supported by two other sources of data, observations and documents. Observations included material such as, the isolation, the health care facilities, the size of the rural area and other such observations. The documents concerning the complaint were examined when possible, including official letters, letters by colleagues and comments in the news media. These sources of data are described in more detail in the section on methods.

Linking data to propositions

Yin (1994, p25) advocates a method whereby propositions about findings are subsequently linked to the study findings as a means of substantiating causality.[1] This method involves stating predicted outcomes or "patterns" at the commencement of the study and stating how these outcomes will be interpreted in the study. The final outcomes are then interpreted in terms of these interpretations leading to more robust conclusions.

The present study was based on data obtained from interviews, observations and documents. These data were analysed and consistent themes derived from the multiple cases, which included factual information, such as when doctors left after the complaint, and opinions of the interviewees on events. From these themes, evidence on the effects of investigation of complaints was obtained.

The proposition of this study was that the investigations of complaints in rural areas were having significant effects on health care services, effects that were not beneficial as generally assumed. This proposition contrasts with the aims of complaint processes, which were summarised on page 3 and are restated here:

1. Complaints help improve service quality through the Code of Rights.
2. People who complain should not be subject to any ill effects in their subsequent obtaining of health care services or any other type of adverse effects.

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1 The method was first described by Donald Campbell (Campbell DT, 1975, cited in Yin 1994, p25).

3. Investigation of complaints should act as a deterrent to providers who do not conform to prescribed standards.

These stated aims of the investigation will be returned to when considering the success or converse of the investigation in achieving its aims.

Definitions of terms

A Formal Complaint

A formal complaint was a complaint concerning a registered health professional made to the official complaints authority, i.e. The Medical Practitioners' Disciplinary Committee until 1995, or The Office of The Health and Disability Commissioner after this time.

The Complainant

The complainant was the person who laid the formal complaint against the doctor. This was often the person affected by the doctor's action but in several cases, it was another person, a close relative.

The affected Person

The affected person was the person who was affected and allegedly harmed by the doctor's action. They were usually, but not always, also the complainant.

The (Defendant) Doctor

The doctor was the doctor who was the subject of the complaint to the official complaint body.

Neighbouring Doctor or Other Health Professional

These were doctors or other health professionals who worked in the same community with the doctor or in neighbouring communities. They were the professionals who would be aware of and have knowledge of the health services. They would gain their knowledge about health services from patients and from clinical meetings where practice matters were discussed.

THE RURAL COMMUNITY

The (rural) community in this study refers to the community where the doctor lived and worked and it was thus the community that used the services of the doctor.

RURAL PRACTICE.

The definition of rural practice used in this study is that used by The Royal Australian College of General Practitioners (RACGP).
Rural practice is medical practice outside urban areas, where the location of the practice obliges some general practitioners to have procedural and other skills not usually required in urban practice. This description reflects the common use of the term "rural practice" in New Zealand. In practical terms, it refers to a practice outside of an urban centre and without the immediate support of secondary specialist services. A rural practitioner would therefore have to provide a proportion of the services provided by secondary care services in a city, or be involved in the safe transfer of a patient to a secondary care centre.

REMOTE RURAL PRACTICE

Remote rural practice as defined by the Royal Australian College of General Practitioners is defined as: *rural practice in communities that are greater than 80 km from, or where it takes longer than an hour to travel by road, to a centre that has basic specialist medical services.*

RURAL GENERAL PRACTITIONER

Rural general practitioner refers to a doctor working in a rural or remote rural practice as defined above. The doctors were all solely in private practice except for a small number of doctors who had no more than a two-tenths appointment in some other position such as in a local cottage hospital.

SOLO-RURAL PRACTICE

Solo rural practice was taken to mean that that doctor was the only doctor in the town. Although the practitioner worked on his or her own in the town, the after hours call could be shared with neighbouring towns but in some areas the practitioner was on call all of the time.

"ON CALL"

After-hours call refers to the time between finishing the surgery at the end of a regular working day and the next working day, when the doctor was on call and could be called out to emergencies. This period of time thus refers to week-nights, holidays and weekends. Some doctors covered their own practices at week nights and shared weekends with other practitioners; others shared both week nights and weekends. The on call ratio in this study refers to the total number of weekend days and week nights a doctor is on call in relation to the total number of days in a complete cycle of the roster.

Structure of the thesis

Chapter one has given some background to the study. Chapter two explores the subject further, examining the literature on the effects of investigating complaints and the sociology of small rural communities. Methodology is described in chapter three. The results are presented in chapters four to eight. Chapter four commences with some background information on rural health care and a brief description of each case. Chapter five presents the main themes from the interviews, concentrating on the effects on local health workers and health services. Chapter six describes the complaint as a social phenomenon, how the various parties and community members reacted and interacted during the investigation. Chapter seven concludes the three previous chapters, describing the outcome, two or more years after the event. The wider effects of complaint investigations on health workers are described in chapter eight. Chapter nine builds on the findings in the previous chapters, examining some of the beliefs underpinning disciplinary systems, how these contrasted with beliefs of a rural community and their inadequacies. Chapter ten examines the effectiveness of disciplinary systems and examines alternative forms of quality and error control. Chapter eleven suggests some ways in which complains could be utilised in a more constructive manner. Chapter twelve concludes the study discussing validity, further research and recommendations

CHAPTER 2: LITERATURE REVIEW

Rural Communities and their health care: a review of the literature

Rural towns are not simply smaller versions of cities; they differ in many important respects. They have their own unique subculture, with its own set of norms, rules and values. The rural community has strict expectations of its members, which are based on these common beliefs. Dempsey (1990) suggests that the national characteristics of a nation are usually to be found in its small rural communities rather than in its large international and cosmopolitan cities.

These characteristics and beliefs of small towns are important to any understanding of local events because many of the actions of the local people are based on these communal beliefs. Without an understanding of these community beliefs, the actions of community members would often appear strange or unusual. The following section briefly describes some of the social features of small rural communities based on the work of the main rural sociologists.

Society in small rural communities

Rural communities in Australasia have their origins in the early pioneers. The descendants of the pioneers, the present rural dwellers have a strong sense of identity, and embrace characteristics such as a strong work ethic, friendliness, loyalty and a shared enthusiasm for community. Dempsy describes them:

> *The descendants (of the early rural pioneers) believe in the superiority of their way of life... Whatever their class, they see themselves as resourceful, hardworking achievers, loyal, hospitable, and egalitarian; a people who pull together, look after those in trouble, and strive to repel threats from outside to their community's survival - especially those from politicians and their bureaucrats.* *(Dempsey, 1990, p1)*

The hardship of rural life taught the early settlers that they had to work together and support one another if they wanted to survive. Because of the common difficulties they faced they needed one another. They developed a strong sense of

belonging and a loyalty to their community, which they supported because they knew the community would support them in turn in their time of need.

> *It is as if the people in a deeply felt communion bring themselves together for the purposes of mutual self-help and protection. To this end the community is organised for friendliness and neighbourliness.*
> *(Vidich and Bensman, 1960, p34)*

This willingness to support each other was not confined to material needs but also included spiritual or emotional support.

> *Almost all of rural life receives its justification on the basis of the direct and personal and human feelings that guide people's relations with each other.*
> *(Vidich and Bensman, 1960, p34)*

Small rural communities recognised their own way of life or culture, which was very important to community members. They shared a common identity, an identity which they guarded.

> *In conversations and interviews what is most frequently mentioned is the special quality of relationships in their community and the experience of being known and recognised and of having a sense of attachment to the community...They speak with pride of the fact that Smalltown is a community in which one can be truly involved.* *(Dempsey, 1990, p 41)*

This culture or rural way of life is held to be very important by community members, it is guarded by them and defended from any perceived threat. Community members are expected to support the common values and loyalty to the community and people who do not share these common values are not considered true members of the community. Anyone opposing or breaching these community beliefs will be viewed suspiciously and may be considered a threat to the community. It the breach of custom is considered serious enough community members may consider some form of action against the offending person.

Dempsey (1990) arrived at the view that a rural community is defined not by its geographical boundaries but by its shared values and beliefs. There are therefore some people living in the area who are not considered to be "true" members. This alternative definition of rural communities is probably very important in further understanding the actions of community members.

> *Residents then define themselves through their shared history and their shared future and by their hostility to an external threat. Smalltown exists as a social entity, more than it does as a territory. It exists and reaffirms its existence through engaging in the boundary maintenance activity that distinguishes it from other social worlds, and from the institutions and the people which it perceives as different and often opposed to it. The city is all the bad things that small town is not... Ultimately from this perspective, those who belong to Smalltown are not necessarily those who have lived there a long time but those who identify with the stereotype that it affirms.*
> *(Dempsey, 1990, p 41)*

Dempsey (1990) probed further into community belief and values and has identified some of the cherished values that community members seek to maintain.

> *Among the advantages of assets that may be threatened or perceived to be threatened are economic livelihood, physical security, occupancy of prestigious and influential offices, and less tangible qualities such as a sense of emotional security and a sense of being known and counting for something. In this instance the advantages include their community's reputation as a wholesome and attractive place to live. Those who believe themselves to be under threats may seize upon a variety of attributes to differentiate themselves from those believed to threaten them.*
> *(Dempsey, 1990, p 42)*

The enemies to their community are external and internal. The external enemies are seen to be the big cities and big government.

> *The big city is not only a bad place to live in but is, in many ways, the enemy. It is the seat of big government, which does not appreciate the contribution that communities like Smalltown are making to Australia's prosperity.*
> *(Dempsey, 1990, p 38)*

> *The problems of country life are too many inferior basic facilities, excessive charges for transport, insufficient industry to support the local population, the withdrawal or threatened withdrawal of vital services ... As country people see it, governments use the wealth generated by primary industry to bestow benefits on city people yet reduce their deficits by withdrawing basic facilities that rural people need to earn a living and to make their life reasonably comfortable.* *(Dempsey, 1990, p 39)*

THE PEOPLE WHO DO NOT BELONG

Dempsey (1990) described several groups of people who were not regarded as true community members and were excluded from most community involvement. These people who were seen to be a threat to community were marginalised, a practice that is also called closure by sociologists. These groups of people who were marginalised included the "no-hopers", deviant women, and transients, and these three main groups are described below.

No-hopers and "blockies": No-hopers and blockies are people who are frequently unemployed and on the dole. They are often in trouble with police for petty theft or alcoholism. They often neglect their properties and appear dirty and unkempt. They are often suspected of being on dope. The majority of community members join in criticising these groups feeling that their presence represents a threat to their community. These people threaten the reputation of the community as an honest clean hard working society.

Non conformers: People who flout community values are seen as a threat. An example is "deviant women". Women are judged in the community by their performance as mothers and wives. Women are not expected to drink heavily or to go to bars on their own. Women unaccompanied by husbands are considered to be 'available' and a threat to married women's husbands. Women who break the 'rules' and exhibit such behaviour are likely to be marginalised.

Transients: People who move to the rural community from big cities often present a threat to the establishment because these newcomers are not aware of community beliefs and rules. Newcomers are expected to be enthusiastic about local events and activities. They are however expected to know their place. They are not expected to aspire to positions of influence. They are not expected to challenge any prominent locals, nor to try to be too influential.

> *...newcomers, especially those engaged in upper middle-class occupations, are expected by entrenched members of these classes to participate enthusiastically in community activities. But their enthusiasm must stop short of being 'too pushy' or trying to take over a local organisation or project, or even failing to conform to crucial local expectations of someone in their*

> *position. In other words it is to stop short of threatening the monopolistic rights of 'locals'. It is generally only acceptable for a 'newcomer' to aspire to office if he does not seek a position reserved for long term residents. Also in seeking office he must observe well established protocol by waiting to be asked to stand for office and once in office carrying out his duties according to established practices. This means, of course, not challenging the interests of those who benefit by existing practices and assuming a subordinate position. If he violates any of these expectations, he will be criticised and sometimes eased out of office or even of the town. (Dempsey, 1990, p 49)*

Non locals who remain apart socially and culturally are criticised and described as "not fitting in".

The position of immigrant professionals is more complex than that of never-do-wells or immigrant workers. Professionals have an important role in the community and it is not so easy to exclude them from the society. Professionals who do not comply with the expectations of the community are put in a lower level in the community's social ranking than they would have had otherwise. As Dempsey (1990. P48) describes it,

> *Unlike immigrant workers, immigrant professionals are expected to play a role in community activities as well as excel in their occupational activities. School teachers receive the most criticism for failing to conform to the prevailing image of their profession: people ready to work tirelessly for the community as well as for their pupils and to be exemplary in their behaviour and dress. (Dempsey, 1990, p 48)*

DEALING WITH OFFENDERS

People who fall foul of the community expectations can expect retaliatory measures. They can expect to be ignored and excluded from any position of influence. If this does not work they can be publicly criticised. Some newcomers, according to Dempsey (1990), felt the exclusion so much that they leave town. They felt they had been driven out of town. Even the police are expected to comply with the community's expectations when exercising their duties.

> *There are several cases of policemen's wives reporting that they have had to cope with criticism and anger from local people who have been booked for a minor offence by their husbands. One wife said that, on occasions, as she walked down the main street local women and children chanted 'Pig! Pig! Pig!' as she passed. Smalltownites believe that public name-calling, snubbing and competitiveness falls short of the 'dog eat dog' ruthlessness they believe*

> *characterises life in the city. But does it? The example given suggests otherwise; and it should not be seen as an isolated instance.*
> *(Dempsey, 1990, p 50)*

Dempsey (1990) was left in no doubt about the power of community members and their ability to achieve their aim. The community had subtle and effective ways of making people's lives very uncomfortable or even intolerable.

> *I have been told repeatedly by locals that any policeman who attempts to enforce city rules on locals (for example, booking them for double parking or for not wearing a seat belt, without first being given a couple of warnings) will be driven from the town within three months. As a rule there is no need to petition for the man to be transferred: 'We [the locals] simply make it too hot for him to stay!' This is another example of effective social closure stimulated by attempts of policemen to usurp what 'locals' generally see as inalienable rights of community membership. The punishment of a policeman's wife is, in part, an attempt to restore their rights.*
> *(Dempsey, 1990, p 50)*

Dempsey and the other authorities of rural communities do not appear to have included doctors or other health workers in their studies. It is very likely that much of what applied to teachers also applied to health workers. Health workers would, most likely, be expected to embrace the social values of the community and work tirelessly for the good of the community.

Doctors in the social fabric of small rural communities

Being a doctor in a rural community is undoubtedly a different experience to working elsewhere. For most doctors going into a rural area from a city, it proved to be an educational experience; they soon discovered that there was more to being a rural doctor than simply practising medicine. While communities were kind and supportive, they also had their own opinions of what doctors should do. Doctors and their families had to learn what the communities' expectations were and how to respect these expectations. Their successful integration as a member of the community depended on their understanding of the 'rules' and their adaptations to them. The experiences described below of doctors going into small New Zealand rural communities are drawn from a recent study on doctors leaving rural practice (Henderson, 2000, pp. 58-64).

LEARNING ABOUT THE EXPECTATIONS OF THE COMMUNITY

When a new doctor and spouse arrived in a small community, they were welcomed enthusiastically, giving them a completely unrealistic impression of what life was going to be like in the community. This blissful, unrealistic, honeymoon phase lasted for some months before they became aware of the reality of their lives in the community.

> *Everyone is very welcoming and supportive. You feel elated, and you're stroked at every turn and you rapidly come into an elevated position in the community. And then, suddenly, you realised that the community owns you.*
> *(Transcript 3- doctor)*

The community was quick to lay down rules. Doctor and spouse learnt very quickly that they were expected to fit into the community's idea of their roles.

> *When I first moved to the little town I used to go to the pub because I liked to play pool and there were a few guys who said, "Doc you're a good joker, you're one of us". And all I wanted to do was be one of them but I, sort of learned, that the wives or daughters or families weren't happy and couldn't come and see me because I was the one who drank with dad and dad was actually the problem or drinking was the problem or the hours he spent at the pub were the problem. So I'd identified myself with the element of the rest of the community (and they) labelled me as a pub go'er.*
> *(Transcript 4 – doctor)*

> *.. you know I wasn't myself, people didn't see me as me, they saw me as the doctor's wife* *(Transcript 10 – Spouse)*

They were owned by the whole community but belonged to no section of it. Doctors often found it difficult to socialise with people whom they knew as patients and few people were not patients.

> *You sort of, you're sort of functioning at a strange level. I found it difficult to make friends with patients, and keep them as patients. I found that very difficult. I don't know where to draw the line there and I found that very hard. I mean I think some of the medical legal stuff and some of the opinions from doctors about relationships for instance between doctors and their patients at the moment are obviously come from people working in urban practices and have no comprehension of what it's like living in a small town in New Zealand.* (Transcript 2 – doctor)

Attending functions and meeting patients could create problems, the community expected them as community members to attend local social events but some people saw this as an opportunity to discuss their health concerns.

Loneliness of the Doctor and Spouse

In a solo practice where all the community attended the one doctor the doctor and family might have very few friends. This resulted in considerable loneliness and isolation.

> *I mean outwardly it would seem that all sorts of people would come to you with their most intimate things and so you should be close to these people, but in fact by doing that they have pushed you completely away on a social basis. That makes it very hard, very, very hard.*
> *(Transcript 4 – doctor)*

The result was that, doctors in isolated communities, also became socially isolated as they socialised less and less.

> *Well, actually as time wore on, I wouldn't go. If I was on call I wouldn't go out. I'd get to the point... that my demeanour and my attitude when I was on call - that it wasn't fair to inflict that on other people and so, you know, if people would invite you out, you're going to be sociable and I didn't feel sociable. (Transcript 2-doctor)*

> *Many relationships with people in the community and often their expectations were really quite impossible. We simply withdrew from society and lived life in a little bubble by your self. (Transcript 4 – doctor)*

Doctor Patient Boundary Issues

One of the problems in a small town was that people were expected to be helpful and friendly. Some people thought this friendliness allowed them to bring up the subject of their medical problems whenever they met the doctor socially. This proved a challenge for doctors who did not wish to offend people but who did not

want to have to think about people's problems when they wanted to relax and enjoy people's company.

> *Everywhere I go, virtually every time I go down the street to a shop to buy a loaf of bread or something, someone will come up to me and tell me about their operation or their sore thumb.....We'd go to wedding, funerals, parties, whenever, even church down the street, and where ever we go I get asked about people's health. We left a wedding breakfast early I remember one time and within half an hour I'd had three consultations and in the end we just gave up and went home. I even got approached during a funeral during a prayer, standing there a chap sidled up to me and started asking me about his sore foot. Yeah, you can't escape it anywhere to go.*
>
> *(Transcript 1- doctor)*

To community members, the doctor was adopting an unfriendly or aloof manner. They did not understand the predicament of the doctor. For the doctor and family this reaction meant that the couple felt uncomfortable going anywhere because they would be disturbed and confronted about medical matters.

> *Terribly difficult. It has made us social outcasts really hasn't it? We can't get close to anybody because they are the patients.*
>
> *(Transcript 4 – spouse)*

COMMUNITY PROPERTY

Doctors and spouses were very aware that everything they did was a subject of the public interest and they a favourite topic of local gossip. Attempts to have some privacy were interpreted as being unfriendly or aloof.

> *Yes, when we built the fence for privacy we got a lot of anger that we were shutting ourselves off. We tried to stop people coming and knocking on the door of the house to seek medical help, even on my days off people would come and knock on the door. We just can't escape sometimes and that is why we built the fence and we tried all sorts of things to keep people away.*
>
> *(Transcript 1 – doctor)*

These accounts illustrate some of the difficulties of being a doctor in a small rural town. Apart from being a good doctor and apart from having to learn to be a

doctor in different geographical circumstances, doctors in rural communities, had to learn to meet the community's expectations. The bio-medical training and technical expertise doctors learnt were of no assistance in these tasks. Most doctors were not aware of the community's expectations before entering rural practice nor were they prepared for them. Doctors had to learn various strategies to meet the community's expectations of them, and also maintain a tolerable patient/ friendship balance.

The local health service in rural communities

The rural community health care services were very different from other situations; consequently the work and the conditions of work were different for doctors. Some understanding of the context where the doctors worked is important for this study and therefore the following section reviews the literature on rural health services in New Zealand.

There have been few formal studies on rural practice in New Zealand. A small number of studies consisting of questionnaires and analyses of work in rural practice have helped to produce an incomplete picture of New Zealand rural practice. Many of these studies are now dated and possibly do not reflect the current situation. A larger number of articles describing and discussing New Zealand rural practice have added to the knowledge of rural practice. These articles describe the experiences of the practitioners and are relevant to the locality the doctor worked in but are nor always put in context. Nevertheless, all these articles present similar descriptions of the difficulties of rural practice.

It is important to recognise at this stage, that included under the heading of "rural" are many rural areas that are very different to the remote rural areas of the present study. Rural areas that would probably be different are medium sized towns with a larger number of health professionals, towns adjacent to cities where support is readily available, and tourist towns that are often over supplied with health professionals and where the local population consists mostly of relative newcomers from cities.

Health services in remote rural areas typically consist of one or two doctors, one or two practice nurses, a district nurse and usually a pharmacist. There is usually an ambulance service that is staffed by volunteers who have a basic training in first aid. Occasionally there are other professionals such as a physiotherapist or a midwife. Health professionals are usually attracted to the area by advertisements and start to practise there without any form of training or introduction to working in a rural area. The professionals learn "on the job" trying to cater to the apparent needs of the population as best they can, usually without the benefit of experienced colleagues to advise them.

Seddon and Turnbull (1986) conducted an extensive and informative survey of all rural doctors on behalf of The Royal New Zealand College of General Practitioners in 1986. Amongst other findings the study expressed concerns about the conditions of some practitioners.

> *It would appear that the isolation in physical, cultural and medical terms was a considerable problem for rural general practitioners. This appears to be followed very closely by the difficulty in getting locums and so compounded the first problem. What was painful to the reviewer, was the number of doctors who had found the lifestyle damaging and were continuing to suffer. This number was not large but the pain of their existence was very effectively communicated as was their feeling of entrapment. Some people had already left rural general practice but the questionnaires followed them and they replied. Not surprisingly, most of them had found the lifestyle was intolerable. (Seddon & Turnbull, 1986, p112)*

The College of General Practitioners made a number of recommendations, including education programmes, locum services, and a team to investigate the problems.

Commenting on the study in the same journal, Professor Campbell Murdoch discussed the problems of the rural practitioner (1986).

> *There is little doubt that the country doctor in New Zealand is not now a fortunate man [sic], particularly in these days of rural economical down turn if not disaster. Even in the years previously when there was talk of a doctor over supply, there was little evidence of this reaching the country.*

> *For the country GP there is more work, no relief from A & E departments, the buck stops with him and her and there is little or no reward for the continuity of care.* *(Murdoch, 1986, p87)*

In Murdoch's opinion, there was a need to carry out research into methods to facilitate rural practice. The findings of these studies could then be used to support rural health services. Undergraduate education should encourage graduates to go out into rural areas. Postgraduate education should also be focused on preparing doctors for rural practice.

A short while after this study Barnett (1987) examined the inequality in the distribution of medical graduates in New Zealand in a geographical study, drawing attention to the oversupply of doctors in towns and scarcity of doctors in the country. He also demonstrated that it was the rural and poor areas of New Zealand that tended to be staffed by foreign graduates.

None of the recommendations of Seddon and Turnbull (1986) for research and reforms in rural health were implemented. Instead the health reforms of the late nineteen eighties and early nineties put further strains on rural health services. Holmes (1992) described the effects of the health reforms and withdrawal of services in rural areas. She lists the health priorities rural people have given to the Canterbury Area Health Board. These are in order of importance: primary care, emergency care, maternity care, care of the elderly, terminal care, infant/child health, counselling, Maori health, health education and promotion and rural hospitals. The services provided by rural hospitals such as ambulance services, meals-on-wheels, home help, family support for terminal care, physiotherapy and occupational therapy are also lost when the hospital closes. Withdrawal of services increases the problems facing rural general practitioners, already under pressure. Finding and keeping a general practitioner was difficult and reducing subsidies to doctors was making the rural positions less attractive.

Holmes describes the effect on rural practitioners.

> *Withdrawal of rural health support services would make it more difficult to replace GPs in country areas. By removing an alternative source of medical*

> *attention, closure of hospitals would greatly increase the level of stress on rural GPs as well as forcing the loss of other hospital based services critical to the community, such as meals on wheels, physiotherapy and occupational therapy...*
> *Many patients can't travel to CHEs for treatment and are missing out on important services. Rex Yule says RHA managers appear to be very concerned with delivering services at the lowest price. These managers do not seem very interested in quality. (Holmes, 1992, p121)*

Health workers in New Zealand have few of the support services that other countries, such as Australia, Canada or the United States have (Kamien & Butterfield, 1990; Rabinowitz, 1993; Blair, 1995; Connor, 1994). While in many countries there are rural support systems, in New Zealand by comparison there has been little planning (Hays, & Peterson, 1996; Lewis 1995; Rourke & Rourke, 1995; Stewart, & Bass, 1982; Strasser, 1994).

Burton (1996) wrote on the problems of rural practice in the New Zealand Family Physician after "surveying rural physicians". Unfortunately, no details of the survey or the methodology used was given to enable assessment of the validity of the work. Burton describes how many rural areas struggle to retain doctors and when unable to attract New Zealand graduates have had to rely on overseas doctors to fill the gap. There is often some delay in attracting a doctor from overseas, because of distance and registration processes in New Zealand. The result is a loss in continuity and often the doctors attracted have only stayed for a year or two before moving on. In other areas, difficulty in recruiting doctors has resulted in doctors and their families suffering from over-work. The subsequent medical care suffers as a result, as does the satisfaction of the doctor.

A number of other articles have been published in refereed and non-refereed journals. These articles, London (1991), Loyd (1995), Janes (1994), relying on personal experiences in rural areas, confirm the opinions of Burton (1996).

A recent qualitative study examined the reasons why doctors were leaving rural practice (Henderson, 1999). The interviews in that study revealed some of the

problems rural doctors were experiencing. Doctors were aware that their heavy workload and on call commitment compromised their ability to practise good medicine. Working conditions could be so bad that they knew they were making mistakes but they had no control of the situation. This was a frightening experience. Several doctors suffered severe burnout. Burnout in isolated practitioners was an alarming finding because people with burnout are not always able to recognise it in themselves and an isolated a doctor with burnout may not be recognised. The accounts of doctors give dynamic illustrations of their frustrations.

THE WORKLOAD: The large number of sick patients meant less time for each patient and trying to do the work correctly, without mistakes, in less time was stress provoking for doctors. Stressful, because of the risk of making mistakes, resulting in a sense of insecurity in the doctors. This unhappy situation, participant doctors felt they had no control over.

> *.....Yes I feel like I am rushing, ah, I'm worried that I'm going to make a mistake and if you are seeing multiple problems I get angry with the patient because I want to do a good job... (Transcript 1- doctor)*

> *Well we had odd days where it would get up to 55 and so on, occasionally. I couldn't remember my name after that. I know that some doctors see 60 or 80 a day but if it's 55 of actually trying to examine and make a diagnosis and do investigations and treatment!* (Transcript 1- doctor)

GROWING BUREAUCRACY : Against the background of an onerous workload, the administrative changes of the recent past years were perceived as a source of considerable frustrations. Anger was expressed about increasing administration demands.

> *Yes, there were more and more things to consider. Instead of just sort of meeting with the patient and the context of the consultation and doing your best there, you are having to fill in an increasing number of forms, you are having to be increasingly accountable to managers who are largely from a city background and had no idea of what a rural practice was about and what's more they didn't care. And so yes you had to start collecting statistics and you had to annotate this, your prescriptions with your number and you know basically as time went it would get worse.* (Transcript 4 – doctor)

Rural hospitals were closed with no consideration as to the effects and who would pick up the work. It always seemed to fall on the already busy rural general practitioners to do the extra work.

> *.....after the hospital closed and I said loud and strong," I can't cope, I can't survive with no support structures, please help me". I said it in so many ways to the CHE, the RHA, the Community Trust, the newspapers, open letters to my patients and no one was interested or cared. They said it's your problem. You must find solutions. (Transcript 4 – doctor).*

BURNOUT: After a period of initial enthusiasm in the practice, many of the busier solo practitioners experienced a loss of energy, which in some cases went on to extreme fatigue and burnout. The difficulties of coping with the work and the stresses in some practices were described.

> *That's something that has frightened me a lot this year or even the past two years, is I've gradually... the first three years I had a lot of energy and commitment and we both threw ourselves into the practice building it up and making it more efficient and pleasant and working well and a good service and all that. After three years, it's just like someone flipped the switch and all our energy ran out, the batteries just went flat and we were exhausted. This year particularly, we have not been contending with the demands of the practice. But, we've been contending with, trying to deal with, the community trust who have been unhelpful... We just get so exhausted that I just sit at my desk and I think I just can't be bothered.* (Transcript 1 – doctor)

> *I got to the point, instead of getting involved in the problem and trying to help the problem I was feeling more like fobbing the problem off and that's not really the way to go to do the job properly.*
>
> *(Transcript 2 – doctor)*

THE LACK OF CONTROL OF THEIR SITUATION: Burnout was easier to recognise than to remedy, and as a wife commented,

> *And he's known there have been various stages, that he's been clinically burned out. And he's known, but he's not able to do anything about it, had to carry on working in a burnt out state for weeks or months at a time and that can't have been good for the patients or for the patient's satisfaction or the doctor's satisfaction now. (Transcript 3 spouse)*

Several of the doctors were aware that there were times when they were not competent to do their job but there seemed to be no alternative to the present situation. They were so tired that they had little energy to do anything else other than to soldier on.

> *How do you stop? I mean, you can't just say, " I'm not coming in today". I think that was the overwhelming burden of being a rural GP. You couldn't, not go in today. My husband used to go off to work and he was sicker than the people who were coming in to be treated for sickness, which was silly.....*
> *I could probably name the dates that he's not gone to work and it is only latterly in the last two years that he has had a partner that he's actually acknowledged that he should go to bed and he's taken two days off till guilt's got to him but I think my husband did go to work unwell.*
> *(Transcript 3 – spouse)*

ATTEMPTS TO GET HELP: Exhausted and stressed doctors sometimes felt the answer to their problems would be a break, a holiday, and they tried to get a locum. Trying to get locums could be a very difficult, if not hopeless, task.

> *I phoned throughout New Zealand locum agencies, locum lists, College of GPs, rural GP Network, surrounding practices, everybody I could think of and even though some locums were available, they just simply said, "No! I don't care how much you pay. I am not going out there."*
> *(Transcript 3 – spouse)*

Participant doctors were constantly aware of the consequences of complaints. Fear of complaints added to their anxieties.

> *I just wanted to quit right there and then. I just couldn't take any more. We were just, I just couldn't work during the day. And I couldn't function and I kept making mistakes because I couldn't think straight and, you know it was terrifying. Really, because you always know in the background that you can't escape because you can't leave. I can't tell the boss and say I'm sick, I can't stop people calling at night, I can't do anything to solve the problem. I know in the background that if I make a mistake that isn't going to be any defence. I would be liable for discipline. Apart from the personal fear, of making a mistake, and hurting someone, just the inability to escape an intolerable situation, was absolutely terrifying.*
> *(Transcript 1 – doctor)*

Doctors soldiered on as best they could. They finally reached the conclusion that there was only one answer for them, to leave. If they continued in their present situation, sooner or later they would face a complaint. It was this concern that drove doctors to their decision to leave rural practice.

New Zealand research on complaints against doctors

Changes in the quality of health care services following complaints have not been studied previously, although several studies have examined defensive medicine and the effects of complaints on doctors. To date there has been only one study on the effect of formal complaints on doctors in New Zealand, the study of Cunningham (2000). This qualitative study revealed illuminating effects of investigations on doctors.

Cunningham (2000) used qualitative methods to study the effects of complaints on general practitioners. He confined the study to complaints that did not proceed to a formal hearing and were thus issues considered minor or not substantiated. The study was conducted in the period of the (former) Medical Practitioners' Disciplinary Committee before the establishment of the Code of Patient Rights. The study involved ten doctors who were interviewed over the telephone and these interviews were then analysed using the methods described by Strauss and Corbin (1990).

Cunningham (2000) distinguished between the immediate and long-term effects of the complaint but found the same categories in both periods namely; (1) the effects on the person of the doctor, (2) the effects on the doctor's practice, (3) the effect on doctor patient relationships, and (4) the effects on the doctor and family. Cunningham also identified several sub themes.

The immediate impact of the complaint

Despite their awareness of disciplinary processes, for most doctors notification of a complaint came as a shock.

> *...participants received the complaint as though they had been hit by a thunderbolt.* *(Cunningham, 2000, p66)*

THE IMMEDIATE IMPACT ON THE PERSON OF THE DOCTOR

Cunningham found that there were several immediate effects on the person of the doctor.

1. An immediate and intense negative emotional response.
2. Evidence of feelings of guilt and questioning of self.
3. A discernible intellectual response.
4. The rapid emergence of feelings of depression and associated changes in behaviour, in some doctors.
5. A very rapid emergence of a state of shared understanding with other GPs who have also suffered a complaint.

The emotional responses in doctors were: stress, anxiety and anger and these emotions were accompanied by physical manifestations such as shaking and abdominal symptoms.

Cunningham described a contrasting and conflicting response by doctors to this perceived threat. At times they would intellectually analyse the event, reassuring themselves that they had little to be concerned about but at other times they would have illogical emotional responses characterised by self doubt, loss of confidence and guilt. Some doctors became depressed and considered giving up their work.

> *...looking back and that I couldn't really understand why the hell I felt so guilty. My emotional self made me feel as though I was obviously at fault, and I felt very guilty about it.* *(Doctor 5 in Cunningham, 2000, p67)*

> *I didn't in any way think I was guilty of what I was charged of, as it were, because I didn't, I thought I had done the right thing. I was anxious about it, I mean because I was concerned, although I couldn't see that I could possibly be found guilty of any misdemeanour. (Doctor 7 in Cunningham, 2000, p67)*

THE IMMEDIATE IMPACT ON THE DOCTOR'S PRACTICE OF MEDICINE

The illogical emotional response experienced by doctors seemed to have a far greater effect than the logical analysis of events when it came to practising

medicine following the complaint. An important part of general practice is dealing with uncertainty and doctors found that they could no longer tolerate uncertainty. Their inability to deal with uncertainty had an impact on their practice of medicine and was characterised by a reduction in their ability to practice with speed and confidence.

> *Certainly my working speed declined. My tolerance for uncertainty, which had previously been, well that just went out the door.*
> *(Doctor 4 in Cunningham, 2000, p70)*

> *My decision making process was slowed down. I began to lose a degree of confidence in my ability to assess the situation accurately, and to make proper medical decisions.* *(Doctor 5 in Cunningham, 2000, p70)*

> *Something like this shatters your confidence I suppose. It shouldn't but it does.* *(Doctor 10 in Cunningham, 2000, p70)*

A few doctors felt that their practice of medicine had not changed even though their confidence had been shattered.

THE IMMEDIATE IMPACT OF THE DOCTOR-PATIENT RELATIONSHIP

Doctors felt betrayed by the complaint, they felt hostility toward the complainant and did not want anything more to do with them.

> *If I saw this woman in the street I would be pretty annoyed.*
> *(Doctor 2 in Cunningham, 2000, p71)*

Doctors' attitudes to other patients had also changed, they became suspicious and less trusting.

> *I found that in more subtle ways, how patients were presenting to me and how they were dealing with me was damaged. I was looking at them thinking, 'there is something hidden here' or, 'they're not telling me something' or, 'they're setting me up you know'.* *(Doctor 5, in Cunningham, 2000, p71)*

THE LONG TERM IMPACT OF THE COMPLAINT

The long-term effects of the complaint were less intense than the acute effects but the events continued to haunt the doctor. There was firstly an intellectualising of

events as doctors tried to understand the significance of events. Doctors thought about how they could avoid such events in the future, trying to discover ways to protect themselves from complaints while they continued to practice. There continued to be an emotional element that doctors were not able to control which Cunningham describes as an emotional "baggage" and this baggage affected their doctor patient relationship and subsequent patient care (Cunningham, 2000, p76).

THE LONG-TERM IMPACT ON THE PERSON OF THE DOCTOR

Cunningham found there were three main long-term changes in the perception of self in doctors as a result of the complaint. The three changes were:

1. The type of emotional reaction that persisted after a complaint.
2. Changes in the way in which they saw themselves as doctors.
3. A more general erosion of goodwill towards patients.

Describing the emotional change in doctors, Cunningham identifies a loss of enjoyment in practising medicine or even depression.

> *I date my wish to leave practice from that.*
> *(Doctor 4, in Cunningham, 2000, p77)*

> *You just don't enjoy life quite the same.*
> *(Doctor 3, in Cunningham, 2000, p77)*

There was also anger and cynicism.

> *I think there has been a change in the way I feel about myself now, being a physician. You're just there to be treated as dirt by people who want to treat you as dirt.* *(Doctor 1, in Cunningham, 2000, p77)*

> *You just think, well, this is what I do for a living. You feel more depersonalised in your practice... more robot like. We're all screwed up with the potential for all this drama. It makes you lose your own dignity and rights.* *(Doctor 1, in Cunningham, 2000, p77)*

Cunningham found that for most doctors the enthusiasm to practice good medicine had gone. There had also been a shift in their attitude to patients, the goodwill they had previously felt had been eroded and they did less for their patients, referring more to secondary care.

I will often, with those particular problems say, "it's not worth the hell", just send them on. *(Doctor 5, in Cunningham, 2000, p78)*

I think all of the things that happened of that nature gradually erode your feeling of commitment. A lot of it is the way the patient treats you that has made me feel less enthusiastic about medicine. Of all the hours and hours and hours that I have been on call and got up and helped people and done things for nothing and all the extra time that I have given and how angry it makes you when somebody makes a complaint for something that is not, is really quite trivial, or is difficult and demanding.
(Doctor 6, in Cunningham, 2000, p78)

THE LONG TERM IMPACT ON THE PRACTICE OF MEDICINE

The main change in how doctors practised medicine was an intellectual response delving into how they could decrease the chance of further complaints. They avoided responsibility, referring more to secondary care.

I continue to admit a lot of patients who...probably don't warrant admission. I have adopted a technique with the emergency department of giving a patient a letter and saying, "get on your bike. Go to the emergency department." Then I would ring the emergency department and say, "the patients on their way." *(Doctor 4, in Cunningham, 2000, p82)*

Doctors were also inclined to give the patient what they wanted rather than what was good medical practice because they wanted to avoid conflicts.

It just makes you wary of people and wary of situations, and you think "oh here's one, that you know, these people are going to be difficult and I'll have to handle this one in a more of a cover-my-back type of situations." I will do things to suit these people which I don't necessarily consider to be perhaps the correct way to act in that sense that if you can't do it, it's going to create you more long-term hassle, so you make a decision that is to avoid the hassle, rather than what you would choose as an appropriate thing to do from a medical point of view. *(Doctor 6, in Cunningham, 2000, p83)*

There were specific changes in each doctor's practice that related to the particular incident that caused their complaint.

If I ever get some young woman who looks like this woman and is a similar age and has got similar symptoms, I just see (the complainant) in front of my eyes again. It's awful. You know, it just reminds you so much.
I am certainly less likely to do a smear on a patient who's new to the practice. If I had known that she was a sexual abuse victim on her first visit, I would probably not have touched her with a barge pole.
(Doctor 2, in Cunningham, 2000, p82)

Overseas studies on the effects of a complaint

Studies in the United States have found similar effects on doctors to those of Cunningham. Charles *et al* studied the effects of a liability claim on doctors in America (1991; 1985; 1984). These authors also recognised an acute phase when the doctor feels stunned, misunderstood, immobilised or driven to frantic activity, which are accompanied by intense feelings of anger and rage and betrayal. These feelings the authors describe as normal reactions to an assault on one's sense of self and personal integrity. In addition to these normal reactions the authors describe what they describe as abnormal reactions in some doctors where the coping methods were inadequate. In 33% of doctors there were symptoms of a major depressive disorder. In 26% there was an adjustment disorder characterised by anger, irritability, tension and or somatic disorders. In 16% of doctors there was an exacerbation of a previously diagnosed physical illness such as hypertension, coronary artery disease.

In the long term Charles *et al* found that the doctor's feelings about their vocation and themselves is changed by their experience (1991; 1985; 1984). As the authors comment, life goes on but is forever changed. In the long term doctors became phobic about certain patients, practice situations or procedures. Doctors felt that medicine was no longer fun anymore. Charles *et al* recommend using the support of a peer group or if serious symptoms persist seeking professional help.

The assumption is often made that it is the ability to sue and obtain compensation that distresses doctors in litigious complaints and if this were removed the process would be much less threatening. This was not so according to a Dutch study (Veldhuis, 1994). Complaints were a significant matter of concern for doctors in a survey of 56 Dutch doctors. Concern about possible complaints influenced the behaviour significantly, most doctors using defensive medicine strategies.

Defensive medicine

Defensive medical practice has been defined as, "deviations induced by threat of liability from what the physician believes is, and what is generally regarded as sound medical practice" (Veldhuis, 1994). A second definition is, "medical practice decisions which are predicated on a desire to avoid malpractice liability rather than a consideration of medical risk-benefit analysis" (Dewar, 1994). It has been argued that defensive medicine could be a good thing if it induced doctors to practice more carefully to avoid litigation. This may in part be true on occasions but usually it means pleasing the patient or taking the least risky path. Pleasing the patient means performing any investigation or treatment the patient wants irrespective of whether it is warranted or having regard to its cost. It is said to be more expensive medicine (Veldhuis, 1994). A frequent example cited, of doctors taking the least risky avenue is the use of Caesarean sections. It is almost unheard of for a doctor to face litigation for doing a caesarean section but they can be disciplined for not doing a Caesar soon enough when a baby is born with brain damage. Many people believe that the rising Caesar rate is mostly caused by doctors' concerns about litigation or complaints.

The investigation of complaints

New Zealand has its own unique systems of dealing with complaints because of Legislation. In the first place, there is The Accident Compensation Act of 1972, which prevents most forms of claims through tort law. Prior to about 1995 complaints went to The Medical Practitioner's Disciplinary Committee, a body established by the Medical Practitioners Act 1968 (Collins, 1992, p220). This process was succeeded by The Health and Disability Commissioner Act 1994 with The Code of Health and Disability Service Consumers' Rights 1996.

The overall process of dealing with complaints is generally similar in these two latter systems although with the 1994 legislation, the intention is to deal with more cases by mediation. When a complaint is received by the Health Commissioner's office or the medical practitioners' Disciplinary Committee, it first goes to an assessor who confirms that it is not frivolous. The assessor notifies the practitioner concerned requesting a response and depending on the

response, decides whether the matter should go to a formal hearing before a disciplinary body or to a lower avenue of resolution. An advocate is usually appointed for the patient, and when the case goes to a formal hearing the advocate is usually a lawyer. The hearing before the disciplinary body is a quasi-judicial nature with both sided being represented by lawyers and witnesses are called and heard for both sides.

The Code of Health and Disability Services Consumers' rights (the Code) came into law on 1996, with the aim of establishing a complaints process "to promote and protect the rights of health consumers" and facilitate "the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights". The code confers ten rights on consumers and providers have a duty to comply with the rights. When a complaint is made alleging a breach of any of the rights, it is up to the provider to show that this was not so.

The ten rights in the Code are:

1. to be treated with respect.
2. freedom from discrimination, coercion, harassment, and exploitation.
3. dignity and independence.
4. services of an appropriate standard.
5. effective communication.
6. to be fully informed.
7. to make an informed choice and give informed consent.
8. support.
9. in respect of teaching or research.
10. to complain.

When the tribunal finds a breach of the Code of rights it may:

- Make a declaration that a provider is in breach of the Code.
- An order restraining the provider from continuing or repeating the breach or from engaging in or causing or permitting others to engage in conduct of the same kind as that constituting the breach.

- An order the provider perform any specified acts with a view to redressing any losses or damage suffered by the consumer as a result of the breach.
- Damages up to $200,000 for pecuniary loss, expenses, loss of benefit, humiliation, or other action that was a flagrant disregard for the rights of the consumer.
- Any other relief as the tribunal thinks fit.

Conclusion

Small rural communities are not just small cities; they have their own culture that respects individuality and cherishes personal characteristics such as loyalty, friendliness, honesty and hard work. Communities defend their values against any perceived threats and those people who flout these conventions such as 'no hopers', 'immoral' women, or transients are likely to be marginalized. The communities have their own set of rules and expectations and even people like policemen who disregard these rules, are likely to be driven out of town.

Doctors and other health workers learn to respect and comply with community expectations. Living in a community who are also patients poses many problems. Rural doctors struggle to maintain satisfactory standards of care because they have to contend with a large patient roll, a heavy on call burden, a lack of support services, isolation and many more difficulties. Some rural doctors admitted they made errors because of the difficulties but did not know how to avoid them. Working conditions seemed to have got worse with the health reforms. Studies have found that investigation of complaints can have marked effects on doctors, causing anxiety or depression or physical symptoms.

From the literature, investigating complaints is not as simple as many people would believe. The literature indicates the need for further studies on the effects of investigating complaints, especially in areas such as rural communities.

CHAPTER 3: METHODOLOGY

A multiple case study had been decided on as the most suitable research design for the study, with each case being centred round one complaint, the boundaries of the case extending to include all the effects of that complaint (as described in Chapter 1). Having decided on the method of study there remained the tasks of how to design the study so it would meet ethical requirements, how to recruit participant doctors who had had a complaint, what data to collect and how to collect it.

Ethical issues

Two main considerations appeared most important in this study, firstly that no one would be harmed by the study and secondly participants should be fully informed about the study before agreeing to participate.

The people most at risk of being harmed would be the complainant and the doctor, followed by others closely associated with them such as families and close associates. It was recognised that complaints could be a sensitive and emotional subject, involving personal events that people may not wish to talk about and talking about events again could be very upsetting, opening up old wounds. There was a potential to do harm and this needed to be guarded against. Ideally it would have been desirable to obtain the opinions of the complainant, the defendant, community members and other health workers but there were several reasons why this was inappropriate. The knowledge that both sides were being interviewed would be upsetting to both parties because in a manner it would be a further judgement. Involving both parties or community members could not be done in a small town without it becoming common knowledge and this would tend to stimulate public discussion on the subject at a time when it had probably been nearly forgotten and this would be inappropriate. For these reasons the interviews were confined to the defendant doctor and local health professionals. This was a disadvantage as far as the study was concerned as it would only present one-sided views on events, but studies such as this have to

accept limitations. As it turned out at the time of the study, most of the complainants had left the area and they would have been very difficult to contact.

Having excluded complainants and community members from the study the person of concern was the defendant doctor and it was important to insure that defendant doctors were happy about participating and that they understood all of what participation would involve. To ensure voluntary participation, a plan was evolved whereby a group of doctors at a conference was informed about the study and they were invited to volunteer for the study. It was also important that the participating doctor should be happy about the researcher approaching colleagues for the study as discussing sensitive subjects with some colleagues could be distressing. Accordingly, before any other health worker was approached for an interview in the region the doctor was first asked for his or her approval.

An information sheet for participants was produced. (Appendix A) The information sheet described what the study intended to do, how it proposed to do it and how participants would be involved.

A formal application was made to the Massey University Human Ethics Committee for ethical approval of the study. The ethics committee gave approval for the study and the protocol is attached. (Appendix D) PN Protocol 01/32

Recruitment of participants

In keeping with the aim of minimal harm to participants described above, an announcement was made at a conference of rural doctors inviting delegates to participate as described above. A pile of information sheets was left for anyone to take and read (Appendix A). Interested doctors could approach the researcher during the conference, ask questions about the study and decide on whether they wished to participate.

After the conference, the doctors who had volunteered to participate were contacted again by telephone. Their willingness to participate was confirmed and they were sent a copy of the information sheet for participants together with a consent form. Doctors were also asked to suggest doctors or other health workers in their area whose participation would contribute to the study. These health workers were also contacted by telephone and invited to participate after the nature of the study had been explained. They were similarly sent a copy of the information sheet and consent form (Appendix B) and when the signed consent form had been returned arrangements were made for an interview.

Data collection

As the study had been restricted in that it involved only health professionals and so it was considered important to obtain as much of the available data as possible, accordingly two other sources of data were included, namely, observations and documents. The researcher would visit the rural area where each case study was based and collect the data while there. This however, required some prior organisation and was usually done so with the help of the doctor concerned, who usually gave some outline about the case and suggestions on who else to involve. This allowed some planning as how to arrange meetings with other participants before going to the area. The researcher drove by car to the area and usually stayed one to three nights in the town, depending on the number of interviews. Only one or two interviews could be performed in a day. Staying in the town allowed for observations of the area and community. The rural conference where doctors had been recruited was in the South Island of New Zealand and so the conference delegates who volunteered were mostly from the South Island. For this reason and for the practical considerations of time and travel, the study was confined to the South Island of New Zealand.

Interviews

Interviews were the principal source of data and so considerable thought and effort was spent in attempts to obtain the best data possible. Research of this type

is based on the data collected and can only be as good as the data collected. Qualitative research requires quality data. Anyone who has conducted interviews will be aware that some interviews produce a factual, mechanical account of the subject in question but which is bland, devoid of feelings or thoughts. On other occasions the interviewee speaks with emotion on the subject and is obviously thinking about the subject whilst speaking. This is the essence of qualitative research and what was required. While one cannot force people to give the desired type of interview, there is much one can do to facilitate it. The timing and setting of the interviews was crucial because participants needed to be relaxed and away from any other concerns if they were to express their thoughts and feelings in the desired manner.

Most of the meetings occurred in this type of a desirable setting after work in the evening with the interviewer, the doctor and sometimes the spouse sitting in a relaxed atmosphere in the living room of the family home. Spouses were encouraged to participate, as they tended to be supportive of the doctor and promote a relaxed atmosphere. They also added important data with their interpretation and experiences of events and often remembering aspects that had not been raised. Spouses usually felt less self-conscious about the event and their comments on the complainant were often less guarded than the doctor's. Their views added a valuable depth to the picture of events.

A recording of the interview was made by means of a dictaphone placed unobtrusively between the doctor and the spouse in a position so as not to distract the interviewer or participants.

The interviews were unstructured, participants being asked to explain how they saw the complaint and allowing them to talk freely with minimal interruptions. Towards the end of the interview, a prompt form (Appendix C) was consulted to ensure that all areas of possible importance were covered and any topic that had not been covered in the interview was then raised with the participant. As research progressed, other important subjects were revealed by participants, such

as, “how did the complainant manage to access to health care after the complaint was made?” or "how long the complainant stayed in the area after the complaint?" These important questions were thus added to the list.

The questions concerning the interviewers attitude or how involved the interviewer should become in the interview always present something of a dilemma because a listener's attitude can influence the answers given in an interview. On the one hand, a rigid and impersonal attitude can inhibit people expressing their thoughts especially with a sensitive subject but on the other hand the people being interviewed often try to please the interviewer and give answers they feel the interviewer wants. The traditional method of doing an interview is to be sympathetic and interested but to do no more than this and authorities such as Miller & Crabtree (1992), Bogdewic (1992) and Patton (1987) all suggest such an approach. The interviewer tries to express a neutral attitude to all subjects so as not to influence the speakers. Other researchers such as Fontana and Frey (1994, p369) have questioned this approach and some feminist researchers have gone further maintaining that in many sensitive subjects one has to try to get close to the person being interviewed to allow them to feel confident enough to discuss difficult subjects (Olsen, 1994, p158).

The subject being studied was a sensitive subject, a subject that participants might have difficulties in talking about and it was important to try to get all the rich and deep feelings appropriate to this subject. The researcher therefore tried to assume an attitude that was sympathetic, interested but also maintain a neutral attitude to subjects, allowing the participant to lead the interview. It is possible for an interviewer to show interest and encourage the flow of discourse and thought, without influencing the content or direction. Some time was spent before the interview talking about various unrelated subjects so that participants who did not

know the researcher had time to get to know him a little and not feel too uncomfortable.

In a few cases, interviews with neighbouring doctors could not be arranged in the time available for the visit. Unfortunately, these doctors lived at the other end of the island to the researcher making further visiting difficult. A compromise arrangement was to use a telephone for the interview.

After the interview was completed and we were having a cup of coffee, participants would frequently add another comment on events. This was nearly always something profound and highly significant to the study. When appropriate the participant was asked to repeat their comment again for the tape recorder. On other occasions, the researcher wrote the comments down. In the evenings when the researcher returned to the lodgings, an impression of the interview, observations and comments were written to supplement the interviews. These accounts usually accompanied the other observations of the day.

The tape recordings of interviews were transcribed and copies sent to the doctor and spouse for their examination to confirm that this is what they intended to say and for comments. Copies of the transcripts were also sent to the two supervisors a Massey University. The transcripts were analysed as described below.

OBSERVATIONS

Observations gave a valuable depth to other data and included a variety of subjects such as degree of isolation, community spirit and local health facilities. The experience of driving to the town and making observations such as the distance from the nearest town, the lay-out of the town, its apparent affluence, its facilities and amenities gave the observer a feeling and an understanding for the area. When appropriate, local people were engaged in casual conversation and attitudes of their community and health services could be sounded without reference to the subject of the study.

The local health centres were usually visited and these provided an opportunity to see health workers at work, to see how busy they were, how staff related to patients and how the community approached the health workers. A period of time spent sitting in a waiting room could provide valuable insight into attitudes. A mental note was made of these observations, to be written up in the evening together with the researcher's thoughts about observations and interviews of the day.

Documents

Most defendant doctors had a file of the documents concerning the complaint and were happy to share these with the researcher. These documents included the formal correspondence on the case, including letters of the complainant, the letters of both councils and those of the disciplinary body or cuttings from the news media. Some doctors also had letters from colleagues expressing support and these letters added a further dimension to the process as they gave the views of colleagues who could be at the other end of the country demonstrating how wide the effects of the complaint were. When possible these documents were copied for the study and a qualitative analysis performed on the one hundred and seventy letters.

Analysis of data

The analysis of data was done in three ways and each of these is presented in a separate section to clarify the differences in the processes of analysis. The analysis in Chapter four was a description of each case, what Yin (1994) calls a vertical analysis. Chapters five to seven analyse the common themes of the cases but with one important difference. The analysis in chapter five presents the common themes expressed by participants with minimal interpretation by the researcher, presenting what the participants said. Chapters eight and nine present a further analysis of the same data with some theory building, and are thus more subjective; they incorporate interpretation and input from the researcher. Lincoln and Guba, (1985) maintain that analysis involving theory building and interpretation is more subjective than the primary analysis and they suggest that

the two parts of analysis should be kept separate and not confused. This separation would assist the reader's evaluation of findings.

THE CASE STUDIES (CHAPTER IV)

The first part of the analysis examined each case separately, using all forms of data, observations, interview and documents but presented more of the observations than the other sections. The analysis was largely descriptive and attempted to give a brief account of the complaint in the context of background conditions. The analysis being a descriptive process, no particular method of analysis was needed or used, the descriptions being a synthesis of participant interviews, the notes of observations and documents. These were in fact a summary of the data on the cases. Because of the confidential nature of the study, descriptions were kept general and details of areas and complaints were avoided to prevent identification of places or people. This section represents what Yin would term a vertical analysis of the cases (1994).

THE PRIMARY THEMES (CHAPTERS V TO VII)

This part of the analysis was an analysis between the cases examining them for common themes occurring in multiple cases, what Yin terms a horizontal analysis (Yin, 1994). The analysis method used in this section was a qualitative analysis method, based on the transcripts from the interviews but also incorporating some of the other forms of data.

The theoretical paradigms underlying case study and qualitative study are different (Yin) and these differences need to be clarified and discussed at this point because this study uses both methods (1994). In grounded theory, the most popular form of qualitative analysis used, the researcher attempts to exclude any preconceived ideas on the outcome of the study with the purpose of avoiding bias. Yin on, the other hand, maintains that in a case study one must have some predictions of possible outcomes to enable the researcher to plan the study (1994).

Figure 1

Vertical and horizontal analysis of cases

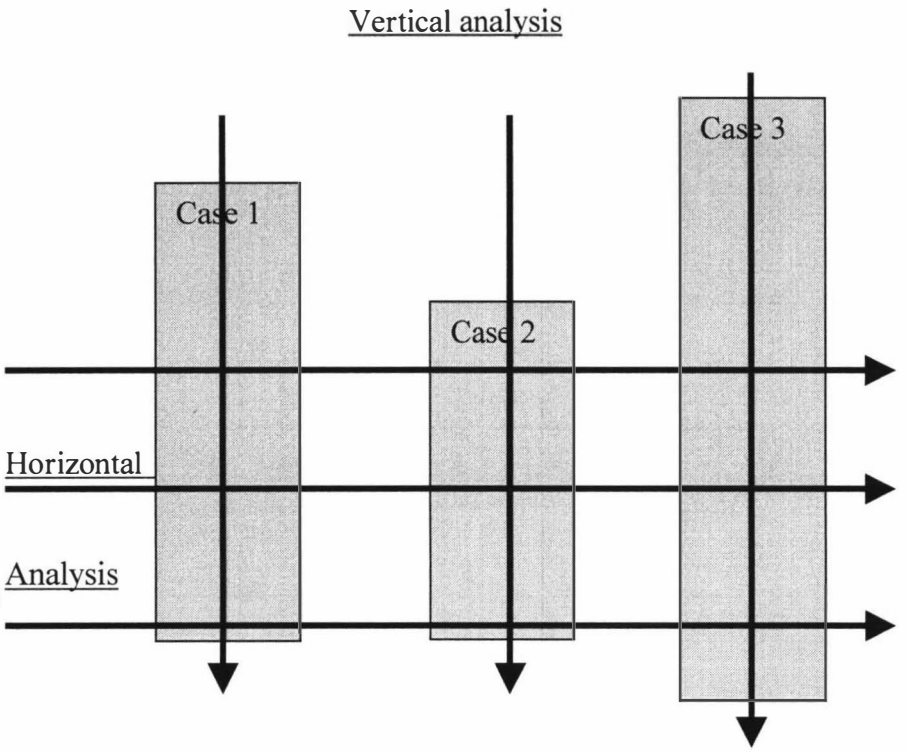

Figure 1: depicts vertical analysis that examines individual cases and horizontal analysis, which analyses themes common to all or several cases (After Yin, 1994).

In practice, these theoretical differences were not so contradictory. A considerable amount of planning was necessary in organising and obtaining the data for the study, and this was done as Yin suggests, but once the data was obtained it could be analysed independently minimising preconceived ideas in the grounded theory manner. This mixing of research methods did not appear to present a serious threat to the validity of the study, on the contrary their combined use appeared the best for the overall validity of the study.

The methods used in the analysis of the transcripts in this section were based on grounded theory as described by Glaser and Strauss (1967), Strauss (1987), Strauss and Corbin (1990) and Miles and Huberman (1994). The software programme ATLAS.ti was used as an aid to analysis (Muhr, 1997). This programme, like similar computer programmes, is little more than a convenient aid to help manipulating data on a computer and uses a form of cut and paste technique. The real analysis of data, interpreting the meanings of data, their similarities, their differences and all the other complexities of analysis, can only be done by people.

The analysis commenced with open coding of the transcripts, using the software programme. Using the conventional techniques, the meanings of the codes were deliberated on, and repeatedly revised, some codes were combined, others changed as they were rationalised and dimensionalised and attempts made to make them more abstract or generic. The result was a smaller number of more meaningful codes. Axial coding was next performed followed by selective coding. These stages were aided by considering the relevance to each of the groups of players i.e. the complainant, the doctor, the community, the neighbouring health professionals and the investigating officials. The constant comparative method was used to repeatedly examine emerging themes in relation to other text. Attempts were made to classify the themes suggested by Strauss into conditions, interactions amongst actors, strategies and tactics, consequences (1987).

Extracting the true and fullest meanings from interviews is fundamental to a good analysis of data and the transcripts were read many times as their contents and meanings were reflected on, using the technique of immersing one's self in the data. Transferring spoken data into written data can result in a loss of some of its meaning because the tone and inflexion in a voice can add emphasis or even change the meaning of words. To ensure these subtle meaning were not lost the transcripts were read through while listening to the audio-tape, together with the notes from the observations and the documents to help understand the context of statements.

Further Qualitative Analysis (Chapters IX and X)

These chapters were a continuation of the qualitative analysis of data in previous chapters, however the analysis went deeper into the same material and was more subjective, involving the interpretations of the researcher. The methods used in this section relied heavily on those described by Miles and Huberman (1994), in that they attempt to explain findings using descriptive models.

Limitations of the study

The writer has practised medicine for about thirty five years, twenty years in rural Southland and two in a remote rural practice. In those times there was no preparatory training for rural practice, doctors learnt on the job and from their colleagues.

The researcher is fortunate in having had only one official complaint, which occurred many years ago. The complaint was not taken to any investigation, as there were insufficient grounds for a complaint. However the process took about three months and it was an anxious time. Such experiences can influence a researcher's view of subjects and a researcher should recognise and guard against possible bias in a study. While such experiences can possibly be a source of bias, these experiences can also help an observer to appreciate better the experiences of participants. Strauss believed that experiences in a field of study could be an advantage and "researchers ought to mine their own experiences" (1987).

One reason for embarking on the present study was seeing the effects of complaints on doctors in the previous study. It would be a hard person who could to listen to the stories of some doctors in this study and not feel some compassion. Compassion too, can be a source of bias. It was appropriate for the researcher to recognise such forms of bias, and discuss it with the supervisors.

Conclusion

Three forms of data were collected for the study: in-depth interviews, observations and documents. Because of the sensitive nature of the subject and to ensure that participation would not cause distress, possible participants were informed about the study and then invited to volunteer for it. To reduce the possibility of harm, interviews were also confined to health professionals. The doctor involved and at least one or more of the other local health professionals were interviewed. Interviews were taped and transcribed for analysis. The first part of the analysis consisted of an examination of each case separately, a vertical analysis (Yin, 1994). This was followed by a horizontal analysis, an examination of the cases for common themes, using standard qualitative methods. The qualitative analysis used a two-tier system, the first part essentially reporting the themes, what participants said and is more objective (Lincoln & Guba, 1985). The second part of the analysis interpreted and built theory on the first part and was thus more subjective. This separation of the less subjective part of the analysis from those more subjective part, aims to assist the reader as a co-researcher.

CHAPTER 4: THE SETTING AND THE CASES

The setting

The small rural towns of the present study were too isolated for people to travel elsewhere for health care so they depended on their local services. Depending on their local health services meant that people valued these services and appreciated the people who worked in them. The local health service would typically consist of one or more doctors, nurses, receptionists and perhaps one or two other health professionals. The smallest towns would have three health care workers; the largest towns seldom had more than ten. Most towns also had a pharmacist, district nursing, and larger towns often had a physiotherapist. None of these professionals apart from the doctor provided after-hours services. Thus, a few health professionals provided all the local health services and they did their best to provide all the extra services of larger centres that were not available, and so when people needed psychological counselling or they had minor fractures they attended the local services and received treatment. Rural general practitioners thus had a far greater range of tasks to perform than their urban colleagues and this entailed more work.

The doctors provided a routine non-urgent service during office hours and an after-hours service on week nights and weekends. During office hours when most of the routine work was done, the whole team was available including a practice nurse and receptionist. Most after-hours problems were not serious but sometimes doctors had to deal with critically ill people with conditions such as heart attacks or motor vehicle accidents and usually doctors had to deal with these sick people on their own or sometimes with the local ambulance service. The local ambulance service was staffed by part-time volunteers, who had a basic training in first aid and so the doctor was usually the first person called to emergencies and then only if necessary would the volunteer ambulance crew be called out. In four localities, there was one doctor in the town, in two localities, there were two doctors and in the other areas, there were three doctors. No town was closer than 40 km from the nearest hospital, and some were more than two

hours away. Any seriously ill patients therefore would have to be carefully assessed and their condition stabilised before they could be transferred to the base hospital. Sometimes doctors would have to accompany a seriously ill patient in the ambulance.

Living and practising in a rural area was a very different experience to any other work doctors had done. This was a far more difficult job than most jobs, with more work, more on call and a far greater range of tasks one had to be knowledgeable about. Most doctors were from overseas and they did not know many other doctors from whom they could ask for help if they needed it. When doctors needed advice with difficult problems, they sought telephone advice from the nearest hospital. Doctors often found some local hospitals very helpful but at other times telephoning a big hospital meant speaking to an unknown doctor, who had little understanding or interest in health problems in rural areas and this was not helpful. Health workers in larger centres frequently had little appreciation of the difficulties rural doctors faced. Rural communities had expectations of doctors, professional expectations, cultural expectations and an expectation that they would conform to their community's way of life.

Doctors usually spoke in glowing terms about their practice nurse and other co-workers, saying they rated them at a hundred and ten percent, that they contributed far more than was expected of them. All health workers praised their colleagues, evidently valuing their help and support. As a small team of workers, they faced many challenges and difficulties together and this produced a very evident unity and loyalty.

The cases

This section describes the individual cases. In contrast, the following chapters present and develop those themes that were common to all or most cases. This individual analysis is what Yin calls a vertical analysis of cases (1994). Brief descriptions give the reader an outline of each case and describe those features of each individual case that were different to the others. Because of the sensitivity

and confidentiality of the subject, descriptions are given in a general manner excluding specific details that might allow identification of participants. The purpose of the study is to examine the effects of the complaints and so the accounts of events are confined to relevant aspects.

If there was one feature common to all of the cases it was their diversity, but despite this diversity, there were still many features common to all cases. Without this complexity, the study would have been simpler and easier but as in most real life situations, uniformity is not the rule. The cases came from the four ends of the South Island, with similar numbers in each province. There were, however, some clusters, possibly due to the particular difficulties of these areas, possibly unknown factors or simply their random nature. This clustering or close proximity meant that some doctors were neighbouring doctor to more than one defendant doctor. In addition, two neighbouring doctors became defendant doctors also when, on being interviewed, they offered to give the story of their own respective complaints. These relationships between participants tended to complicate the pre-conceived ideas on relations between participants but this phenomenon is typical of the complexity of social research.

The study thus had doctors who were neighbours to more than one complainant, doctors who were both neighbouring doctor and defendant doctor and doctors who had received two complaints; these patterns complicated the simple research design. In summary therefore, there was a total of sixteen cases, representing sixteen separate complaints. With two doctors having had two complaints, there were fourteen interviews with defendant doctors.

Another thirteen interviews were obtained from health professionals who had not had a complaint themselves, but a few of these had knowledge of two colleagues who had had a complaint, and in the interview spoke about both these cases. The relationship between participants is summarised in Table 1.

Table 1: The interview participants.

Case (Defendant doctor)	Other health workers interviewed	
	Neighbour doctors	nurses + others
1	2	1
2		2
3	2	1
4	1	
5	1	
6		
7	2	1
8		
9		1
10		1
11	1	1
12		1
13		1
14	3	
15	3	1
16	1	

Notes

1. There were 14 interviews with defendant doctors. Two had had two complaints.
2. Thirteen interviews were obtained from other health workers. Some discussed more than one complaint, as they were neighbour to more than one defendant doctor. Three interviews involved two health workers.

In the oldest case, that occurred twelve years ago, it was not possible to contact neighbouring doctors or other health workers. In another case that occurred ten years ago it was also not possible to contact other health workers (as they had all moved), but the doctor's partner had also worked in the surgery as a nurse and was able to be intervewed. Four cases included in the study did not proceed to a formal disciplinary hearing but the process was time consuming and took a toll on the doctors. One doctor stated during that time he felt like giving up medicine and the other doctor said as a consequence of the stress he felt, he would never report another case of suspected child abuse again. In one case the complainant, the patient's relative, withdrew the complaint when given a more complete account of events. In another case, the complainant disappeared and could not be traced. Both these doctors were referred to The New Zealand Medical Council for a "review of competency", even though they were experienced doctors active in teaching and learning. One doctor decided to give up obstetrics rather than undergo a review of competency. The doctor maintained he only did obstetrics for the benefit of patients would gladly relinquish the responsibility and inconvenience if authorities did not want rural doctors to do obstetrics. To his question, "what happened then when they were called to emergencies" he received no reply. This question remained unresolved, too difficult and no one apparently wanted to think about it. The second doctor went through the professional competency review but found the process very time consuming and stressful. (In the researcher's opinion, this was an extremely good and conscientious doctor.) A patient reminded the doctor of his/her stress when she asked, "are you alright doctor, you don't look well." The doctor took a break of two weeks because of stress. Following the investigation the doctor avoided that type of medical care, leaving it to colleagues.

THE CASES

***Case 1*:** The "attitude" of a doctor in an obstetric delivery constituted the complaint of a woman. There was no concern about the medical care, the doctor was not rough, nor rude, but the woman was unhappy because, in her words, " the doctor did not smile during the delivery." There was a shortages of health

care workers in an area and the busy doctor contended with a workload probably twice that of the average general practitioner, a situation where one would expect a doctor to be tired and stressed. The complaint was not substantiated but took several years to resolve, a time when the doctor felt threatened and insecure. As a consequence of this experience, the doctor was very angry with the people who complained and the officials, who according to him, had nothing better to do but to make a busy doctor's life more difficult.

Case 2: A woman with upper abdominal pain presented to the doctor one evening, attributing the pain to a savoury cake she had eaten. The doctor on finding no abnormalities concluded it was gastric in origin and gave her some antacid. The next day the woman had a recurrence of the pain and whilst attending another doctor on call that day, collapsed with a heart attack. She was resuscitated by this doctor and transferred to hospital where she recovered but was left with neurological damage and was confined to a wheel chair. The family members who now had to care for her vented their anger on both doctors and all health professionals of the area, often being abusive. In spite of the doctor being cleared of any negligence they carried on a vendetta for some years. The doctor found the process very threatening and lost some confidence.

Case 3: This complaint was laid six years after the event which concerned a pregnant woman, who was thought to be in early labour but as she did not progress was sent home from the base hospital about an hour's drive away without informing the doctor. The next night, at about 11 p.m. when labour started the husband came to the doctor's home where the doctor's wife, who answered the door, said he was not on call and she would phone the doctor on call for them. The woman was attended to by the doctor on call and sent back to hospital in the ambulance but delivered on the way.

The disciplinary body criticised the doctor maintaining he should have seen the woman even though he was not on call. The doctor according to his colleagues had a breakdown after the hearing, left his practice and has subsequently moved to Australia. He was very bitter about his experience, feeling he had been unfairly

judged by irresponsible doctors, who had had no understanding of the conditions he had been working under.

All the health workers in the neighbouring areas were very angry about the way in which a hard working colleague had been treated and they felt very threatened by the finding. Two doctors left in the following year, because of events. The other doctors expressed their contempt of the disciplinary process, maintaining it had become an industry, that those doctors on the disciplinary council were motivated by self-interest, and that it was in their interest to see as many complaints as possible as they were on "the gravy train". The local doctors, who were all from overseas, maintained that they were doing the difficult work that New Zealand doctors would not do, and instead of being appreciated they were criticised, criticised they felt by doctors who were biased and had racist views. The people who complained, they perceived, were motivated by the hope of monetary rewards.

An ambulanced officer believed that all health workers felt the complaint was also against them. They worked with the doctor and knew the doctor well and they felt the investigation had been very unjust. The ambulance service relied on volunteers and when people were encouraged to complain the volunteers became fed up and left. A shortage of volunteers was making their work difficult.

Case 4: A man, attending the doctor for an accident certificate, mentioned he had lost weight and was referred to a hospital specialist after the doctor found he had diabetes. The complainant alleged the doctor should have found the diabetes earlier, despite having only attended the doctor for certificates.

The man's action and the investigation angered the local doctors and a relieving doctor subsequently refused to see him, maintaining he could not work with the complainant and he should find another doctor. A neighbouring doctor, married to a farmer, described the community's assessment of the man, a lonely person who had no friends in the community because he had got into quarrels with his neighbours over petty matters that had even gone to court, trying to sue them.

The complaint was not upheld but the complainant continued to harass the doctor and his family until the police were approached to stop abusive phone calls. The complainant then approached the doctor requesting a considerable sum of money ($9000) threatening that if he did not pay the money he would air the matter on a television program. The doctor did not feel threatened by the complaint because he felt there was no substance in it but the processing of the complaint and the subsequent vendetta continued for several years and the doctor found the experiences most unpleasant.

Case 5: A pregnant woman had attended a local doctor and midwife but when she moved to a city, after some delay, she attended a new doctor. She was now found to have intra-uterine growth retardation and her labour was brought on. A complaint was made alleging that the doctor had missed the foetal retardation, but was dropped when the woman, who lived a transitory life, disappeared. It was decided however that the doctor should undergo a review of competence. The doctor objected maintaining that there was ample evidence in the notes of the care given by him and the midwife to confirm that health care had not been compromised The doctor decided it was easier to give up obstetrics than to undergo the review. This event accompanied a number of other complaints in the area and added to the disillusionment and exit of doctors.

Case 6: A woman, attending a doctor for chronic fatigue syndrome, was found to have a lump in her thyroid and was referred to a surgeon. During the operation for removal of the lump, she suffered a heart attack. She entered a complaint against the surgeon and the doctor who referred her. The complaint took several months to be processed and the doctor was cleared of any misdoing in referring her. The doctor was critical of the disciplinary system, claiming a similar matter would be settled by a duty police sergeant in a few minutes because it was so elementary. Having the matter undecided for so long, raised doubts in the doctor that there could be other matters of concern that the doctor did not know of.

Case 7: The police, concerned about public safety, wrote to a doctor asking whether a man was fit to hold a firearms licence. The man, who had recently moved to the small town, had since arrival assaulted an elderly man after a traffic accident and had acted in an aggressive and unreasonable manner with other staff in the medical centre. He was also known to have been in trouble with the law and had been ordered to attend an anger management course. The doctor wrote back saying that in his opinion he was not a fit person to hold a firearms licence.

The man complained against the doctor's action maintaining it was a breach of privacy. The complaint was upheld as it was said the doctor should have discussed the matter with the violent man first. The ruling of the disciplinary body attracted publicity especially when the man subsequently shot someone with a sawn-off rifle.

Case 8: A woman in her fifties attended the doctor one Sunday evening for mild abdominal pain, and the doctor deciding it was indigestion, treated her with antacids. About a week later, she had a recurrence of the pain and a few hours later, quite suddenly, died. The coroner, unfortunately, did not request a post mortem and the precise cause of her death was not known.

The distressed doctor spent some time talking to the husband and relatives and felt they were satisfied with his explanations. However about five months later another relative arrived back from overseas and she was obviously not happy with the doctor. She first tried to turn the community against the doctor by starting a petition but the community members were happy with their doctor, they did not co-operate with the petition and told the doctor about it. When the petition failed the relative laid a formal complaint against the doctor.

The Disciplinary Committee criticised the doctor's management, which the young doctor found very upsetting, however the community had judged otherwise and indicated their support of the doctor. Because of this community support and knowing he was appreciated, the doctor stayed in the area for another twelve years.

The community communicated their displeasure and anger at the family members who instituted the complaint. The family, the only Maori people in the area, were not fully accepted by the community. It appeared their position became uncomfortable by the anger of community members and except for the husband they left the area some months after the investigation.

The husband continued to attend the doctor through the whole process and for many years afterwards. The doctor felt uncomfortable each time he saw the man and tried to talk to the man about the matter but the man who was not a very communicative person said very little and the uncomfortable situation continued.

This case was significant because it had happened twelve years previously and it was evident the doctor continued to think about events, it was still very upsetting, if not painful. The doctor believed he had not received just treatment and this was a deep concern. He bitterly recited a flippant comment by one of the disciplinary committee members, indicating, in his opinion, their casual attitude and insincerity.

Case 9: The parents telephoned a doctor one night when their child had become unwell and vomited and because there were no other symptoms, the doctor advised simple care. The parents phoned again as the child got worse and the doctor, on seeing the child, diagnosed diabetic ketosis and transferred the child to hospital, but not without some delay due to the heavy fall of snow and bad roads. The child deteriorated in hospital and after some hours died. The hospital doctors maintained that if the child had been referred earlier she could have been saved.

Case 10: A child with an injured leg was found to have a small fracture and the doctor, having suspicions on the manner of injury, reported the matter to The Department of Social Welfare. Despite reassurances to the contrary, the mother discovered who had reported her. The mother then laid a complaint against the doctor about the handling of the case. Although there were no grounds for a

complaint, the process took several months to settle and the doctor vowed never to report another case of child abuse.

Case 11: A family member, alleging the doctor was having an inappropriate relationship with a patient, laid a complaint. The other party in the alleged relationship did not wish to pursue a complaint and the matter was settled without incriminating the doctor. The complainant continued to pursue the matter and involved the local press. The events proved very upsetting for the doctor and family, especially as the community seemed to be well informed about events.

Case 12: An elderly woman developed palpitations, while on holiday with her husband. The doctor, who attended her, kept her in the surgery for over an hour doing two electrocardiographs in that time. As the woman appeared well the doctor suggested two options. The woman could either go to the base hospital, where she would be seen but probably not be admitted; or she could stay in the town but should phone the doctor later. The couple chose the latter but later changed their minds and drove the four hours journey, to their hometown, arriving in an anxious and fatigued state at the hospital door. The woman was kept in hospital over night although no heart disease was found. A relative laid a complaint, but when he was told of what really happened, withdrew the complaint. The doctor was however required to go for a Review of Competency. The doctor found the process very stressful and the doctor changed some ways of practice.

Case 13: A woman with chronic fatigue syndrome complained about side effects of a drug she was put on. The complaint was groundless, as a specialist and not the doctor had prescribed it. The woman continued to complain about the doctor and her complaint seemed to be about her not getting home help. The doctor found the process so upsetting that he considered retiring. The woman was not a recognised local and the community did not become involved.

Case 14: An older couple moved some forty kilometres out of town but continued attending their town doctor. However the husband, a diabetic, went

into insulin shock and when the wife called their own doctor he said he could not visit them and suggested calling a doctor from a nearby town. The local doctor arrived from the nearby town and proposed giving the man glucose injection. The, woman however, insisted her husband should receive glucagon, which their doctor always gave him and she refused to allow him to give the glucose. The doctor now faced an ethical dilemma, not knowing whether he should ignore the wife and give the necessary treatment, or should he listen to the woman. The doctor did not give the treatment and a short time later, an ambulance arrived and he was given glucose though a drip. The doctor was criticised for not examining the patient properly, which the doctor felt was inappropriate.

Case 15: A woman had a normal pregnancy and labour but the baby arrived stillborn. There was no apparent reason for the stillbirth and the concerned doctor supported the distressed family, keeping in contact for some months. The family then left the practice and laid a complaint. The subsequent investigations ensued for five years, with the eventual verdict that no neglect had occurred. The process was very stressful for the doctor.

Case 16: The family of a young child phoned the local surgery after six o'clock one evening and the answer-phone message directed them to a doctor in another town. On discussion with this doctor, it was felt by both that the child probably had an upper respiratory tract infection and it was not necessary for them to travel the extra distance to see the doctor. The child died of meningitis that night. The family blamed the local doctors for not being available.

Conclusion

Isolated rural communities depended on and valued their local health services. The local health services generally consisted of between one to three doctors, about the same number of practice nurses, a part time district nurse, and usually a pharmacist. This small team did their best to provide the rural community with primary care services that were equivalent to those of a city. After hours care was provided by doctors, supported by a voluntary ambulance service.

The majority of cases in the study concerned unexpected adverse events that left patients or relatives perplexed and angry. The remaining cases were concerned with issuing of certificates, reporting child abuse and after hours availability (when not on duty). Due to close proximity of a few cases, some the cases overlapped, with the result that a few participants were involved in more than one case and so they discussed both cases in the interview.

CHAPTER 5: THE IMPACT OF THE COMPLAINT ON DOCTORS AND ASSOCIATED HEALTH WORKERS

The players and groups involved in the complaint process

The effects of the disciplinary process went much wider than the doctor involved. A series of events were set in motion that affected the community and neighbouring areas, inciting people to polarise into opposing groups who were in some way antagonistic to others. Several well-defined groups of players emerged during the study and it appeared that a meaningful approach to data analysis would be to examine the role played by each group. These groups of players were: the affected doctor and family, the other health workers, the complainant and their family, the ordinary community members and the disciplinary body.

This chapter examines the impact of the investigation of a complaint on the affected doctor and the associated health workers. The effects on the doctor and the other health workers proved to be virtually the same but varying in degree. Some health workers who worked closely with the doctor seemed as upset about the event as the doctor, others were more detached. Because of the similarity of effects of the complaint on the doctor and other health workers, these are described together but the quotes illustrate any differences. The interviews formed the basic data for this qualitative analysis. The recurrent themes from these interviews are now presented.

The experience of the disciplinary process

Doctors progressed through the disciplinary process in a series of stages, a stage of waiting for the disciplinary hearing, the hearing and decision, the immediate aftermath of the hearing, and the subsequent longer term stage.

Waiting and worrying

NOTIFICATION

For doctors the process started with a formal letter, written in an official legal style, informing them of the charges against them and demanding a prompt response. The unexpected letter came as a shock. The charges against them were accusatory and threatening and it was very upsetting.

Doctors were suddenly thrown into unfamiliar territory and they struggled to come to terms with this new threat. They had no answers to the many questions they suddenly faced. What were their chances of being found negligent? How strict would the tribunal be? What would happen to them if found to have been negligent? What would their colleagues think of them? How should they best defend themselves?

> *The Health and Disability Commissioner wrote to me... I was managing all right up till then, ... That just floored me, that just socked me in the jaw, and yeah, it was much worse... So, I didn't know what to do then,*
>
> *(Doctor – Case 12)*

A waiting period of about a year or longer stretched between notification and the hearing, a time of uncertainty and worry, a time during which doctors wrestled with the many questions they faced. Intermittent correspondence with their lawyer and the disciplinary body helped to remind them of what they faced. They tried to make sense of the complaint by repeatedly recalling the incident, evaluating their actions and discussing the incident with local colleagues.
A nurse who had helped in the treatment of the patient gave her view of events:

> *I thought it was too long, it was too drawn out, far too drawn out, it went on far too long. It allowed too much say on one side without enough redress on the other, in my eyes, and may be I didn't know enough about it, but it just felt like the family were able to say these things without any redress.*
>
> *(Neighbouring Nurse 1 – Case 12)*

SEARCHING FOR MEANINGS

Doctors had not anticipated that these people would complain; worse things had happened to other patients who had seemed to understand and had not

complained. In the doctor's experience, rural people had been very understanding and appreciative of their efforts and they expected this person to be the same. Most doctors had taken the trouble to discuss the incident with the patient or family, and doctors felt they had accepted their explanations and regrets. Doctors believed their conduct had been acceptable and the outcome to be expected but they now began to have doubts, they repeatedly re-examined their actions, they consulted colleagues and tried to understand what it all meant.

Making sense of the complaint

The affected doctors tried to assess the validity of the charge against them. They recalled each detail of the event, what they did and what a doctor ought to do in such a situation. Uncertainty is a part of general practice and doctors commonly deliberate over the many complex decisions they have to make. With the benefit of hindsight, often one realises that an alternative treatment could have been better but often there is considerable uncertainty. It was a time of self-questioning and uncertainty, the process was very threatening. Most doctors, however, concluded that, if they were in the same situation again, they would have made similar decisions and actions, but doubts remained.

> *Anyone else would've done no more than that. If I was back in the (same) situation again I would not have done differently, I would have done the same things in the same (manner)...* *(Doctor - Case 8)*

Obtaining Other opinions

Doubts continued to haunt doctors. They consulted colleagues seeking their opinions on their actions. Colleagues usually said that they would have done the same under the circumstances and were very sympathetic.

> *...and I discussed it specifically with one other rural GP and he was helpful and suggested that I actually speak to general physicians about it, which I also did - I went down to (The local hospital) and the general physician I usually refer people to, discussed it with him and he said, the way you did this I am happy that there is no major flaw in your management,...*
> *(Doctor - Case 8)*
>
> *You know, all my colleagues said, oh no of course you did the right thing, of course you did the right thing but the doubts start to come. They all said that you've got nothing to worry about but that doesn't help, that doesn't help when you are worrying and as I say you are examining yourself and sort of*

thinking, well did I do everything right and what could they find big holes in?
(Doctor – Case 12)

A neighbouring doctor described a stressed doctor.

Yes when I first met him the complaint procedure had started and I was struck very quickly by the fact that he appeared very stressed, very eager to tell his story and in actual fact I think I heard his version of events 3 or 4 times and didn't really have the heart to tell him that he had told me it all before, because obviously it was so important to him.
(Neighbouring Doctor - Case 7)

The waiting and uncertainty was stressful and it affected their work.

At that stage, I went to see my own Medical Advisor, GP and asked for time off work. Yes, because I just felt I wasn't going to be working properly,
(Doctor – Case 12)

The doctors worked in areas short of doctors, they worked long hours and were frequently on call and this additional concern added further stress to a difficult situation. The duration and uncertainty of the process took a heavy toll, affecting their confidence and their work.

What did impress me was that the Commissioner for Human Rights Office and the Privacy Commissioner's Office rang me back very quickly and told me what had happened, and that they felt that they saw no wrong in what had taken place and more or less you know said to me, you are fine, whereas the Medical Council or Medical Practitioners Disciplinary Committee, it was very much the other side – it went on for months and months and months and you were very much made to feel guilty until proven innocent rather than the other way around – well that's how I found it really. I thought it was pretty open and shut and cut and dry, but the way it went on, the letters backwards and forwards from Z and that, it just went on for months and months.
(Doctor - Case 4)

In spite of the uncertainty, all doctors felt that they had acted reasonably under the circumstances and hoped that under a fair hearing their actions would be seen as reasonable.

The disciplinary hearing

Appearing before a disciplinary tribunal was an intimidating experience.

I had to go up and see them. I took the whole family up and of course my family were going on holiday with me and I was whipping around to this disciplinary hearing in (Town X) at the same time and it was a great terrible thing for me. *(Doctor - Case 3)*

Most doctors were not prepared for the disciplinary hearing, to be cross-examined in the way they were, and to have their integrity challenged in the manner it was. It was interpreted as a personal attack rather than an attempt to discern facts.

> *The daughter's lawyer was what I would call aggressive in that he looked me in the eye, really I believe trying to intimidate me and saying, "you killed this person" and wouldn't allow me to answer in any other fashion. He was aggressively just saying (this) to make his point - that I had killed a person and it was part of the destructiveness of the whole process - in that him attacking me like that is not leading to anybody's greater understanding or moving on or achieving anything. (Doctor - Case 8).*

In a disciplinary hearing, lawyers could appeal to the emotions of the tribunal and use tactics they would not be allowed to use in a Court of Law.

> *..."this is the photo of this little girl taken at 3 o'clock that afternoon, playing in the snow, before he killed her", pointing at me. The Disciplinary Committee were crying into their handkerchiefs and I'm sitting there feeling like a criminal. That kind of thing would never happen in a Court of Law but it happened at my Hearing (Doctor - Case 9)*

Several doctors felt that they had been poorly represented. Some felt their legal council had not prepared the case, nor did they protect them from aggressive lawyers.

> *I feel that my legal representative really hadn't prepared himself adequately, and didn't support me adequately. I have got to say I was naive in going into it because I had absolutely no experience before, I was a young doctor and yeah, I was just 'eaten by the wolf' really. (Doctor - Case 8)*

One doctor found the hearing reasonably acceptable but still confusing.

> *I was confused about who was who. You get letters from people saying to give you this, that or the other and you wouldn't know really who they were acting for, but I think there was a lawyer present at the disciplinary meeting. There were a couple of doctors and there was a lay woman, something like that. They were very pleasant. I remember thinking at the time, gosh if this woman's husband had been there at the same time and in front of me, it would have been an extremely difficult meeting. Yes I was quite pleased that we just had a chat on our own, (Doctor - Case 2)*

The immediate aftermath of the hearing

The disciplinary threat, that had hung over doctors for a year or two, came to a climax with the disciplinary hearing. Then, suddenly it was all over and doctors were left to simply get on with their job. But, simply going back and doing their job again, was something they could not do, even if they had been cleared of any wrongdoing. Something had happened to them.

> *I didn't have the confidence to make decisions at all. My first delivery that I had I called (Doctor X) in because I didn't feel I had the confidence to do a delivery and I have been doing them for nearly 20 years, with no help at all,...I referred very very frequently.* *(Doctor - Case 9)*

> *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 up and they didn't bother telling me not to send them. They all knew about it too and they knew why I was sending them. They knew I was worried about missing a heart attack. And they would admit them up there and look at them seriously and send them home the same day or next day and say everything checked out and to see your doctor for follow-up which was a great relief to me. I lost my confidence completely....So it was all very distressing.*
> *(Doctor - Case 2).*

Even in cases where doctors were found to have done nothing wrong, they lost their confidence. The accusations, the questioning and stress of the disciplinary process had had profound psychological effects, doctors had lost their ability to make sound clinical judgements.

The accounts of doctors when encountering similar clinical situations, where they described their anxiety, stress, and consequent avoidance, strongly suggests that these doctors were suffering from post-traumatic stress disorder. This inability of doctors to cope with aspects of their work was observed by colleagues.

> *... I can tell you that when I had to go and help him out in a situation, he was sitting in a corner crying. It destroyed him I think.*
> *(Neighbouring Ambulance Officer - Case 3)*

> *...and you are saying he was close to a breakdown and I am saying it was too late for that. He had passed that point, right, and I don't know - luckily*

the patient that we were both with at the time was unconscious so the patient never saw what I saw. *(Neighbouring Doctor - Case 3)*

Most doctors seemed to have experienced some psychological ill effects following the disciplinary hearing; they found attending situations similar to the complaint stressful and they tried to avoid them. They were also unable to make decisions as they had lost confidence. The acute phase of these psychological symptoms, when they were particularly disabling, lasted three to six months.

Doctors found going back and practising difficult after their experience and for a few doctors it was too much. Three doctors left their practice after the hearing, one gave up general practice and two went to Australia.

Wounds that did not heal: The enduring effects

After a few months, life began to settle down and doctors could think about events more clearly. They reflected on their changed career; the future did not appear rosy.

So what the future holds I don't know. I would just like to have some of my life for a change. I don't think that's unreasonable, I think that is the basic right of any and everybody. You (Doctors) have got no rights whatsoever. There is a support group for any thing that you can think of, for people who can bump their toes or any thing but there is no support group for over worked bloody doctors - there is no support. It is a matter of, shut up and go do your job. *(Doctor - Case 3)*

Hurt by accusations and attacks, and perceiving themselves victims of an unjust system, doctors were angry at their treatment. Doctors looked for meanings, how to avoid recurrences and who to blame for their ordeal. Inevitably, some patients were seen to be responsible. Life or work could never be the same again. Periodically, situations arose that could lead to a complaint and these situations would evoke almost a panic reaction. The doctors had lost their sense of security, often not knowing whom to trust or not and some nursed a bitter anger against those responsible for perpetrating what they felt was an injustice.

PARANOIA AND SUSPICION

Doctors became paranoid about complaints. The process of investigation had been so traumatic that they went to extreme measures to avoid complaints.

> *I'm paranoid about complaints. I had a woman just recently who wrote to me after my last weekend on call, ... she rang wanting a Pethidine injection for her migraine and she gets them from other doctors regularly. ...I gave her Pethidine injection. She got a reaction in the arm within 15 minutes, it came up in a big red wheal, I saw her again and gave her antihistamine. I thought it was a very professional service, she wrote to me some weeks later saying I'm not paying your bill, I felt you were rude to me that night, and you should've known not to give the injection in the arm, other doctors give it in the buttocks, I'm going to take this matter further, and I immediately sat down and wrote a letter that says I'm very sorry that you perceived that I was rude, there is no excuse for that, I was tired, you were my 60th patient, but I'm sorry that you thought I was rude, you don't have to pay your bill and please don't take this any further.*
>
> *(Doctor - Case 9)*

> *I mean the next person that came in a campervan I handed over to my colleagues; I wouldn't deal with them, because I freaked out. So, you know it colours your practice altogether, it gives you a different attitude, because you think well who is going to complain and especially with visitors which is a real shame, because most visitors are very appreciative of the treatment that they get...The point is to provide good care and be proud of what you do, not be scared that somebody is going to jump on you and particularly if somebody is going to jump on you and you don't have any forum in which to reply. I mean that's against all natural justice. (Doctor – Case 12)*

Their efforts were observed and understood by colleagues.

> *Well every time doctor gets a complaint he is slightly stressed and sort of always wondering what's going to be the outcome of the complaint. And I guess there is the anxiety. What do I do next? How do I approach this thing? The need to contact the appropriate organisations, and that sort of thing. And even with the um, one of those um, yeah just wondering sort of what effect it is going to have. And that sort of stuff, yeah.*
>
> *(Nurse 1 - Case 2)*

The relaxed trusting relationship doctors had had with patients had ended, they now looked at them with suspicion.

> *I'm not trusting of patients now at all. I write very copious notes. I used to think that my medical records are just a memory aid to help me for my next consultation. I now know that they are the only defence I've got, medico-legally.* *(Doctor - Case 9)*

Doctors feared that in the present system, anyone could make false accusations and they would be believed. Particularly worrying was the realisation that any patient who did not get all they wanted, such as a social benefit form, could retaliate and make a false complaint. It left doctors in a vulnerable situation. One wife got up at night accompanying her husband on night visits in order to protect him from any such false accusations.

> *For instance when he is called out during the night, no matter what time, ten o'clock, two o'clock, three o'clock, I go with him. Because you just can't take chances these days. You know that they may turn around and say that he did this or that or, no doctor anymore is safe. I'm tired too because I accompany him every time, all the time, every time. I have been doing this for years.*
> *(Spouse - Case 3)*

INSECURITY AND CONFIDENCE

Doctors lost confidence in their abilities and were less likely to undertake tasks if there was any risk in them.

> *Well I think it affects your confidence. I mean I think one of the things that people don't really understand about general practitioners as a group is that because we are dealing in a situation where confidence is very much part of the, and trust is very much part of the do-ability of the job. That we are very vulnerable to these kind of, you know this system of complaints is undermining of the trust of the relationship.* *(Doctor - Case 6)*

The more doctors thought about all the things that could go wrong in their work, the less confident they felt about managing certain conditions. A doctor recounted how he felt after admitting a 20 year old with chest pain to hospital - something he would never have worried about previously.

> *I remember thinking well at least I got him to hospital and I am not going to be blamed, if he had dropped dead... Then I started getting panicky...I should be doing ECGs on every single patient who presents with chest pain, which seems a bit silly to me. And should I be admitting everyone anyway?*
> *(Doctor - Case 2)*

The focus of doctors' thoughts was now, not about the patient's needs, but rather how to ensure their own defence against a possible complaint.

Basically I think I've become a lot more aware of my own vulnerability you know. I think I try and be careful about my note taking, I certainly try and make an effort to make a note in the notes if for example I have done a pelvic examination and the lady has declined a chaperone and things like that.
(Doctor - Case 4)

INJUSTICE AND ANGER

All doctors felt they had been unfairly treated, by a system that was biased against them and they could not expect justice in such a system.

I mean this seems to me one of the real problems about the complaint process that its totally swung in the other direction. In the past, the doctor you know couldn't possibly do all these bad things, but now It's swung in the opposite direction and we can do no good. The patient is always right and the doctor is always wrong... *(Doctor - Case 6)*

Doctors felt that people were being encouraged to complain and complaints would become more frequent.

And people are now being encouraged to complain, there is this go ahead and complain, its your right to complain, it doesn't matter if you are partly to blame for the situation or you waited until 3 o'clock in the morning and you had been unwell for 5 days or whatever, it's your right to have immediate service. *(Neighbouring Doctor 2 - Case 3)*

Complaining appeared easy, it cost nothing and anyone could complain about the most trivial things.

if you sneeze wrong someone is going to complain, if you are friendly and touch them on the shoulder, someone is going to complain or accuse you of something, I mean the whole thing is just turning into a fiasco. It's unreal, that's how I feel. *(Neighbouring Doctor - Case 3)*

I mean they haven't defined what a complaint is so therefore anyone who writes to the Medical Council gets you into a complaint process.
(Doctor - Case 6)

What was more worrying, to doctors, was the impression that in the present system, people could falsify claims and they would be believed.

...patients 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)

Doctors felt victims of an unjust campaign against them, which they resented and they felt anger against the people responsible. The satisfaction of work had gone, doctors were less secure, less confident, they trusted people less and the goodwill had ebbed.

Changes in doctors' clinical practise

Finding ways to avoid complaints was now the main concern of all doctors and other health workers. They discussed their worries with neighbouring colleagues who shared similar concerns, and they identified two areas of concern, risky people and risky areas of practice.

IDENTIFYING POTENTIAL COMPLAINANTS

Avoiding or minimising contact with people who they thought were likely to complain, was one strategy used by some doctors.

Yes, it makes them 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 um...
(Neighbouring Doctor - Case 3)

After their traumatic experience, doctors had little sympathy for some groups who they perceived were likely to complain. These people they avoided as patients and then only saw them after hours because there was no other service available for these people.

I'm busy enough with decent people who value what you do for them to have those abusers. I look after them when I am on call, and I don't discriminate at all, look after them, do the best for them. *(Doctor - Case 1)*

Anxious doctors got rid of difficult patients by referring them to hospitals so that they would complain against the hospital, and not the doctor.

I refer, yes I refer them. The moment that I detect that there is a problem, I refer them and then they get into the system and then their frustrations gets diverted from me to the hospital system because they don't get serviced. They don't get service from the system, they don't get prioritised properly and

they don't get service and I just tell the patient that you know I have referred you and for you to take it up with them now.

(Doctor - Case 1)

Doctors thus believed that there were some people who were very likely to complain, other people who were unlikely to complain and those they were not sure about. Those people who they could trust they believed were very unlikely to complain, and doctors dealt with them in much the same way as they had done before. However, those people they felt likely to complain, who could not be trusted, they treated in a cold dispassionate manner, avoiding contact as much as possible. Defensive practices were used to a maximum with this group. Doctors' perceptions on who could be trusted varied, some believing it was only a handful who could not be trusted, while others seemed to be less sure who they could trust.

AVOIDANCE OF RISKY SITUATIONS

Rural practitioners often have to take on many additional tasks because there is no one else in the area to undertake those tasks. Doctors now felt more at risk undertaking many of these tasks and withdrew these services even if it meant there would be no service. They were no longer willing to take any risks to help people. Doctors avoided any practices where they felt things could go wrong, despite feeling it was in the patient's best interest to give these services.

I mean why should you kind of put yourself at risk to that extent, and you know so I mean I think it had a very definite affect on me,

(Doctor - Case 6)

I have become more careful... To me, certain things come before anything else and that is enough. Am I doing the thing in the right legal way. And the last thing I want is to get into problems like (doctor) got into. By doing a public service, he put himself into big trouble.

(Neighbouring Doctor - Case 7)

Defensive practices

All health workers described how they adopted more defensive practices.

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, because it's not nice to be suspicious of people all the time. It's not nice to do things because you think somebody is going to complain if you don't do them. I think I am

spending more time on things that actually you know 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)*

A loss of trust in people was the reason given by a local nurse for adopting negative and defensive practices.

I think it harmed me, 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... No and it's not how I have ever intended to practise. It's like... we worked with an American doctor and I watched his approach to medicine, which is totally different from our model, and we were beginning to adopt that approach and you know cover your backsides all the time, you know. That first, before anything else

(Neighbouring Nurse 1 – Case 12)

Yes, much more defensive I think than I was before...and it makes you...especially things like on the phone when people ring up, that's what I do with a lot of people is telephone triage - I do a lot of that, and I am much less willing to let them go off the end of the phone without making them come in. ...but now I am quite definite about the fact that I want them to come in. I mean still a lot of people say no I won't and that's okay, and I document everything now, I write it all down.

(Neighbouring Nurse 2 – Case 12)

Doctors spent time and effort to document what they did. It slowed down their practice and meant extra work, work that was not productive and of no benefit for patients.

Yes it does, it takes a lot more time... often in a consultation, especially if it is a difficult one, and the patient is not quite happy, I will then sit down after they have gone and write down everything I said. I don't just write advised patients. I tell them what I have advised, and you know, I put it all down.

(Doctor - Case 9)

To protect themselves doctors set up barriers. Prior to the complaint, many rural doctors had made themselves available, even when they were not on call, to those patients who were vulnerable or who had special needs. For example if the doctor on call was in the next town, the frail elderly or ill people often found it difficult and upsetting to have to travel. Doctors also managed conditions like terminal care when not on call for the benefit of these vulnerable people. It had now become too dangerous to maintain these services.

You think about you ringing me today ...I didn't know who you were when you were talking 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)

Doctors felt unwilling to annoy patients who had so much power. They would give these patients what they wanted, even if they knew they should not.

I wouldn't want to argue with him. I wouldn't want to fall out with him. Yes, so it did affect my style of medicine. It made me more cautious with what I was doing and in some ways it's very hard because it makes you practice in a way that doesn't really feel right, you know. I think the instinct was to say that this man wasn't safe to hold a firearm, and is such a threatening character you know, that you wouldn't want to sort of confront him with that.
(Neighbouring doctor - Case 8)

A doctor who reported a case of suspected child abuse immediately received a complaint from the mother. Although the complaint was not substantiated the doctor found the investigation so threatening that he said:

I will never report another case of suspected sexual abuse again.
(Doctor - Case 10)

Several doctors commented that they were now practising a form of medicine, they did not feel was right, yet they found themselves forced to do so for their own protection.

Attitudes to rural practice

The rural doctors interviewed indicated that, prior to the event, they had enjoyed their work; they enjoyed the challenge of running a rural practice, and doing the many tasks that a city general practitioner would never think of doing. They had worked hard to overcome the problems facing a rural practitioner, endeavouring to provide a good service for the people. However, now a fear about complaints hung over them now, they had to question their work, assessing the risks. It was not enough to do your best, the risks were what mattered now. They were no longer prepared to make sacrifices, as these were not appreciated. The enjoyment of their work had gone. They felt frustrated and disillusioned.

Yes that's right, that's right, you do something based on good faith on what you believe is right, as I said before, for yourself and for your community, and for the individual, and have that thrown back and be severely punished in my opinion for that decision. It makes you think twice.
(Neighbouring doctor - Case 8)

Yes, it had a very strong effect on all of us. But what it did underline, personally it underlined the vulnerability of the situation and had a strong role to play in me... looking at getting out of the place. Without that happening perhaps, I would still be there, even though I wasn't specifically or directly involved in it, (Neighbouring doctor - Case 16)

... but I questioned my ability, I questioned the fact whether I should stay in practice. I thought of going - doing anything else. Luckily I didn't make any rash decisions at that stage. (Doctor – Case 13)

Fear of complaints now meant that doctors were unwilling to do all the tasks that they had done previously. They worked 'to rule' becoming more bureaucratic.

Yes, why should one take that responsibility... What they are now saying is that you should not even attempt anything where you don't really feel competent in... And I mean, then 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 doctors working in areas acutely short of doctors were grossly overworked and had difficulties in coping with their work. Their situation became worse.

If you do something wrong to the patient you are breaking the law and I realise that. I am breaking the law because I'm not medically fit to practise medicine. But I ain't got no choice. I cannot walk away and say look "I'm going to rest this afternoon" or I cannot walk away and say "I'm going to take a week's break now"- and I break the law there. If something happens to one of those patients I'm off the road because I cannot tell the Medical Council that I fell asleep. That is not a reason and I don't think that the Medical Council will say, "Poor overworked doctor". They won't.
(Doctor - Case 3)

Doctors in these situations had no answer to the problems they faced.

Attitude to the community

Most community members had supported the doctor in the controversy, so doctors felt they could trust these people and expressed genuine concern and affection towards these people.

That's right and most of the time you can do it because the patients are actually quite relaxed about that. I mean I think people in country practice are really reasonably forgiving about most things. (Doctor - Case 6)

No I didn't become more cynical because the whole time I had the majority of the people I dealt with supporting me. I felt my patients appreciated me, knew me and kept on seeing me. This was somebody who had always decided not to use me but when it actually came to it, did use me. (Doctor - Case 8)

However, doctors were angry with people who complained and their supporters, who they thought were likely to complain. They saw these people as being ungrateful and unappreciative of the sacrifices they had made.

They don't care. No, they don't care. It's the system. You must comply. And, they are encouraged to complain. It's acceptable. You are doing the right thing by the community to complain. (Doctor - Case 1)

They felt little obligation towards such people.

She had to be protected by this bloody system. And the only reason I am still here is because it serves my purpose from my point-of-view of earning potential to get my kids educated through university and get them away to some more sensible environment. (Doctor - Case 1)

Complaints had however made doctors angry and some of the goodwill towards community members was lost.

And I said to them so you tell me why we are still sitting here, why are we still in (this town). You take your complaint and shove it where you want to because you can complain all you like and it means you don't have GP or you can shut-up and you can get one. And that's what I told them in the shop today. But that's how I feel though, there are so many complaints, always complaining about money. (Spouse Neighbouring Doctor - Case 3)

Doctors were, however, quick to point out that these sentiments did not apply to all community members.

Attitude to official bodies

All doctors felt the disciplinary process was unfair and biased against them.

I mean the problem is that the way the legislation is structured there is no justice in the thing, *(Doctor - Case 6)*

Doctors also questioned the impartiality of the people on the disciplinary bodies.

I think this complaints process in itself has become an industry and the people involved say in the Medical Council's Complaints Assessment Committees are a small group of people who I am sure are paid for what they do and they would like to see the System perpetuate and they would like to see complaints taken further and they would like to feed themselves, feed their own process. *(Doctor - Case 1)*

What we have is this bureaucratic stupidity in the Medical Council that treats everyone like an idiot and certainly if you are a doctor. It is almost a kind of - you know - complaint against you - for being a doctor at all. And if you are over the age of 50 and male you have just got no chance. You are immediately suspect, some kind of .... So you know it's a sort of, I find it frustrating more than anything else. (Doctor - Case 6)

Doctors saw themselves as the hardworking genuine doctors who were doing a worthwhile, difficult job under difficult conditions. The doctors on the disciplinary tribunal were seen as political opportunists: These doctors did not do an honest day's work like rural doctors like them did. They were well paid for their easy job and had no interest in genuine patient care, or rather, they were more interested in advancing their own careers.

Totally unrealistic. It would be interesting to see where they come from and what they actually do for a day's work. How many days a year, how many days a week they do work, or whether they are occupying theoretical positions of importance, by being professors of universities, you know, the heads of bloody departments. I was at a university, heads of departments, pretty few of them did much work and if they were working they were working on furthering their own political aims and the political agenda in the academic environment is absolutely amazing and those are the people that actually govern us generally. *(Doctor - Case 1)*

The majority of the rural doctors were overseas trained. For several the rural area was the only area where they had practised in New Zealand. Several doctors felt that they were victims of racial or cultural discrimination and they felt that if they had been one of the "old school" they would not have been treated in this

manner. These doctors saw themselves as innocent victims of the complaints process.

> *So it's a bloody monster that they have created and it needs to be fed, and its going to be fed at the expense of hard working, honest doctors generally speaking.* (Doctor - Case 1)

The medical disciplinary process had been created by people who had no understanding of their work. Doctors ended up bitter and angry.

> *But, in the meantime I will have to give that bloody service and now I'm getting upset as tired as I am, I am forced to give the damn service whether I'm asleep or not. Although you are dead sick you have to provide the service. If you're not available that afternoon it is law in this country that patient can phone up the medical council and say, "this doctor is not giving a twenty four hour service,". You don't see any of these doctors giving up a Wednesday afternoon to go and play golf. It is full time work. All the doctors are working full time* *(Doctor - Case 3)*

Doctors nurtured their grievances and, even twelve years after the hearing, felt anger.

Others were perceived to be involved in the disciplinary process for their own interests too.

> *He was actually instigated by his lawyer to report to the Medical Council. I think he was seeing the lawyer on an unrelated matter and by the way he told the lawyer what had happened and the lawyer instigated him to report to the Medical Council. It would be good business for the lawyer. (Who represented him)* *(Neighbouring Doctor - Case 7)*

Conclusions

Receiving notification of the complaint was a shock for doctors and they struggled to understand why it happened and what the consequences would be. There followed a worrying period of about a year when doctors repeatedly examining what had happened and questioned what they had done. After the disciplinary hearing most doctors had a loss of confidence and an inability to make decisions. Situations similar to that of the complaint provoked anxiety in

doctors when they found they could not think logically, consequently they tried to avoid these situations. Above all, doctors wished to avoid a repeat of the complaint and they now concentrated on a program of defensive medicine. They identified two risk areas for complaints, certain groups of people likely to complain and certain work situations, and so they avoided having risky people as patients or doing work likely to bring complaints. They did more investigations and referred more people to secondary care. They wrote copious notes for their own defence and made sure they could not be contacted when off duty. When issuing certificates they avoided displeasing people.

The other local health professionals observed the disciplinary process and found it very threatening. They knew the doctor and they were aware of the circumstances and most felt they would have done much the same in that situation. Health professionals now recognised their vulnerability and they adopted similar attitudes and defensive practices.

CHAPTER 6: THE IMPACT OF COMPLAINTS ON SMALL COMMUNITIES

The previous chapter examined the effect of the complaint and disciplinary process on health workers, and on health care. This chapter shifts the focus onto the social significances of events. The various groups of players, the health workers, and immediate supporters, as well as the complainant and supporters all lived together in a small town where they were well acquainted with each other. They worked and went about their daily business in a small town where avoiding some contact with another resident was difficult. This closeness meant that many relationships between groups were more intense. The first part of the chapter examines how a controversial matter like a formal complaint affected the lives of those living in a small community. The second part of the chapter examines the position of the complainants within the rural community.

Rural community members maintain strong and intimate interpersonal relationships, relationships that have developed since early childhood. With such close relationships, any significant event within the community, soon becomes common knowledge and community members will enter the serious business of discussing or arguing the issues (Dempsey, 1995, p30). The news-worthiness of events is not the only interest, as community members have a genuine concern for fellow members and like to know if they can assist in needy times, such as bereavements, or the birth of a new child.

Community members, in the present study, felt that a complaint against a local doctor was their business and they took an active interest in it. The controversy divided the community into camps with complex relationships between the groups of players. There were three recognisable groups: the complainant's supporters, the doctor's supporters and people who were non-judgmental, undecided or disinterested. Community members supported these parties with varying degrees of commitment. Community leaders who took an active interest in all community affairs also took an active interest in this matter but those less involved in community affairs tended to play a smaller role. Communities tended

to support doctors more than complainants, especially if the complainant was not a 'true' community member. When the complaint was not from an accepted community member, the community did not seem to take the same interest, unless it was seen to be a threat to the doctor (a community member).

> *I think it didn't really come out in the community. No! I don't think it did. I think probably, I certainly never told anyone and Dr X, I would imagine wouldn't have told anyone. I mean one of our practice nurses was aware. I don't think it went any further than that. And I think, though, he was the type of person who hadn't made friends in the area.*
>
> *(Neighbouring Doctor - Case 4)*

The doctor and complainant.

The person who made the complaint was usually the patient but in a few cases, it was a relative, who seemed to be more angry, than the patient. It was this aggrieved person, who initiated the process and drove the campaign against the doctor. Families of the complainant were usually united against the doctor, supported by a small circle of close friends. However, one family seemed split and in another case, a relative complained against the patient's wishes, the brother of a woman's ex-husband.

The complainant and doctor appeared to have previously had a good relationship until some momentous event occurred that proved upsetting to the complainant.

> *she was badly brain damaged and just a vegetable and in a wheelchair with urinary catheters and all the other things that go with it. So this is a horrifying sort of thing to have happened to anybody...*
>
> *(Doctor - Case 2)*

For the complainants, this was an unexpected and distressing event with enduring consequences that were hard to accept. They were left unhappy and angry.

The aggrieved people usually met with the doctor after the event and the doctor discussed the event, in some depth, explaining how he or she saw it. This does not seem to have satisfied the complainant however, who sought other opinions and decided to complain. This would be accompanied by their switching their

medical care to another doctor and all direct communication broke down, the only communication being through their separate councels. Relatives and close supporters would also switch their health care to another doctor and this was an indication to the doctor of their support.

Avoiding people in a small town could be difficult. The patients could change their doctor but, on occasions, the doctor on call was the doctor complained against and they had to attend that doctor in an emergency. In one case, the husband of a woman who had died suddenly, continued to attend the doctor after his daughter had made a complaint. In some cases, isolation made it difficult to go to another doctor and the patient had to continue going to the same doctor or practice, an arrangement that both parties felt uncomfortable about.

The participant doctors described these difficulties with relatives in a small town.

> *I rang up the father who was obviously the husband of the woman concerned. He wasn't on speaking terms with me at this point but I rang him up anyway and I said "I just want you to know I am going to send your son to hospital with chest pains and I hope that's okay. He did say 'thank you doctor', he didn't say anything else.* *(Doctor - Case 2)*

And after hours, there was no choice of doctors, there was one doctor on call and people either had to accept this doctor or no doctor at all.

> *...and it was difficult because he wouldn't go to (the other doctor) or go to me. But on call one night I got a phone call from this place. It was awkward. There was a prime call to this pub. This guy owns a pub, and I raced up there. I was there quickly. It was amazing. Out in the country there. 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.*
> *One minute looking like he is really, really sick, play acting basically. And so there is a lot of affective disorder there.* *(Doctor - Case 2)*

This was a difficult situation for doctors but far more difficult for a person who was feeling ill and vulnerable. For a person with chest pain, who was anxious and afraid this was not appropriate, having the person they complained about

attending them. This, however, was what happened in small towns when people complained.

Community involvement

The aggrieved persons focused their anger against the doctors responsible for their misfortune, working to ensure they received the punishment they deserved. The complainant tried to marshal the support of others in their campaign against the doctor. They usually had support from their family and close friends and they strove to gain the support of other community members, the medical disciplinary body and even the press. Communities did not always respond in the manner they would like.

> *Um, well the community became quite divided really because there were those in his local sort of immediate area, who were sort of right behind him and feeling his frustration and so-forth.*
>
> *(Nurse 1 - Case 2)*

Doctors became aware of the campaign against them, and they found it unpleasant. They had never wanted a confrontation nor encouraged one. They felt uncomfortable too because they were uncertain what community members really thought or what was being said about them in the community. Doctors in turn, looked for their support; family and friends usually formed their immediate support. Co-workers and neighbouring doctors were usually very supportive and a group of community members particularly their patients were often very supportive too.

Two opposing groups thus formed within the community and their opinions polarised. A very small number of supporters seemed to behave more like football supporters in their actions and taunts, which they directed to the doctor, other health workers, the complainant and opposing groups of supporters. There was controversy between the two groups.

> *Well there was a lot of controversy. People jumped to conclusions without knowing the full facts. One of our other people (staff), who also works in the bank, has had comments made to her - from one member of the family in particular - every time he goes in there.*
>
> *(Nurse 2 - Case 2)*

The majority of community members, however seemed to have their own sensible balanced opinions on events.

> *And then (there were) other people in the community who weren't exactly siding with the doctors but could just see that the whole reason for his complaint and the newspaper articles and everything else. They saw it for exactly what it was - that he was grieving. He was sad.*
> *(Nurse 1- Case 2)*

The complainant and the community

The people who made complaints did not hold prominent positions in the community, and in the present study, there were suggestions that many of these people were marginalised by the community. In small towns, where everything that a resident did was common knowledge, people were judged on their past activities.

> *He just sort of appeared to make enemies a wee bit. That's only because I live in a small area that you know those details. I mean I don't think I would have known that if I lived in X(The city).*
> *(Neighbouring Doctor - Case 5)*

Community members were quick to form their own opinions on people and events.

> *in fact a lot of people knew the person who was concerned and were quite convinced that it would just go away because there was no way that person could ever afford to complain about anything. (Doctor - Case 1)*

> *She complained about the kids kindergarten and pre-school and yet a Policeman who went to discuss some problems with her kids, knocked on the door and she opened the door with no clothes on, you know underwear. And the Policeman told her to please go and get dressed before he (could) come in to discuss anything. (Doctor - Case 1)*

Complainants did not often find support for their campaign against the doctor in the community. Their approaches to community members was often met with indifference or opposition and complainants found themselves increasingly marginalised by the community.

> *you have this vast majority all saying that they supported me and this small clique really who are finding themselves more and more isolated.*
> *(Doctor - Case 8)*

Communities could exert subtle but powerful pressure on any member who appeared to be acting unreasonably and threatening their medical services.

> *and the community, they had wiped out this petition which never got off the ground, the family were feeling isolated.* *(Doctor - Case 8)*

Some doctors had loyal supporters who had their ideas on how to solve the issues.

> *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)*

Doctors of course did not encourage their supporters to adopt this sort of behaviour.

The complainant and other health workers

The complainant and family often had significant health needs and, having left one doctor, they then had to deal with the other heath providers in the small community. These providers were usually supportive of the doctor and so the relationships with these health workers were usually strained. The neighbouring doctors were not keen to have these people as patients.

> *he was diagnosed with Insulin Dependent Diabetes and so had to have regular contact with the Medical Centre...*
> *... 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)*

> *Unfortunately my partner left and that meant then that we had the difficult situation of having this person as a patient and I didn't really feel I had grounds for not seeing him.* *(Neighbouring Doctor - Case 7)*

Health workers were usually angry with complainants believing they had made unjustified complaints. They also believed they could be the subject of the next complaint from a seemingly unreasonable person. The relationship with the new doctor was usually strained and artificial, not a friendly supportive relationship where a patient would feel comfortable to discuss sensitive issues.

I felt he needed the open door and our medical centre too. So we came to a situation where he didn't see the other doctor. He saw me on the whole, and he read his notes and signed them when he left, so he knew what was said and what was on the notes. We all breathed a sigh of relief, (when) he moved. I don't know where he went..... but he left, probably about 18 months after the complaint and the diagnosis.

(Neighbouring Doctor - Case 4)

Strained relationships meant that some members of the family did not get the medical care they should have been.

I am quite sure his wife is getting very terrible medical treatment. Of course once you have had this sort of thing you need medical care, good nursing care and treatment of things because he is her carer and it is basically as I understand it, only him, he won't let anyone near her, and she 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)

Because of the difficulty in accessing health care, life became very difficult for some complainants and family and this was probably one reason why many complainants eventually left the area. It was very difficult for the complainant and doctor to live in the same small town together after what had happened. Doctors and other health workers were certainly not forgiving after the ordeal.

The doctor and the community

The complaint was an embarrassment to most polite and friendly community members, something that they did not like to discuss with the doctor. This silence was not reassuring for doctors because they worried about what people felt. They were concerned that people would be critical of them and that they would lose their patients. Doctors felt reassured when they did not lose patients and they kept on coming to consult the doctor in the same way. Doctors had to rely on other members on the health team to know what the community thought. Nurses and receptionists had family in the community and were part of the local communication network. Some doctors, however, raised the subject with community members and discussed the matter openly.

The complaint that was laid against me I discussed with everybody in the community without mentioning names. In fact, a lot of people knew the

person who was concerned and were quite convinced that it would just go away because there was no way that person could ever afford to complain about anything. She complained about everything, she was involved in criticism of virtually every organisation. She was a really nasty piece of work. *(Doctor - Case 1)*

When they felt that the issue could be serious and affect their doctor, community members were quick to report their concerns to the doctor.

In a small community the network does work and somebody told me about it, but also came and said, look we're worried about this, and you know, how can we help you and we don't want to risk losing you. So this is what started happening in the community *(Doctor - Case 8)*

Community leaders would intervene to attempt to settle the matter with the complainant.

So eventually that settled down with some leaders in the community saying- you know like, we really appreciate what work I have done and totally support (me), and if anybody had any problems - then this was the procedure; first of all come and speak to me!
(Doctor - Case 8)

Some communities tried to support the doctor in the disciplinary hearing.

Large numbers of the community actually went up to (town X) to support him (the doctor) through this whole thing (The hearing). They weren't listened to though, they weren't heard. *(Ambulance Officer - Case 3)*

Health workers were very close to the community. They were aware that certain members of the community would always be critical of what they did. These opinions would come back to them and could be very unpleasant and had a significant effect on them.

It's quite a problem in a small community as well, because everybody knows everybody else and if one person has a problem or gets sent home and has a heart attack or whatever, everybody knows about it and you immediately get the "don't go to that one, you know they don't know what they're doing" sort of thing. Um, so even without a formal complaint, just general mutterings in the community can be very destructive to people as well, to practices.
(Neighbouring Doctor - Case 3)

The community was composed of a variety of people, some critical but most supportive and appreciative. This appreciation encouraged doctors to continue despite many adverse conditions.

The vendetta

Anger was a major theme of this study. The anger started with a few people and it fuelled their actions, spreading to the other people involved, as they reacted to anger with anger. Anger was evident in all the interviews with health professionals and the documents of the study. Anger in some form was the motivating force behind most actions of the players in the phenomena. The confrontational nature of the disciplinary process appeared to encourage anger. Typical of the anger were the vendettas in some cases.

The interactions of the opposing groups did not end after the hearing, even when a complainant had had a judgement in their favour. Complainants were still unhappy at the end of the disciplinary hearing because the doctor remained in the town and had not been as affected as much as they hoped. In contrast, their life had not been made easier and their loss and unhappiness remained. The complainants were still angry and some continued to wage a vendetta against the doctor, using used the media, the community or any means available.

> *...the husband persecuted me and Dr x in the newspapers and on TV, and there was a feature on the Holmes Show. A picture of me on the "Holmes Show" at one point saying it was a terrible thing that had happened and, someone had to pay for this - this was a recurring thing - that things had gone horribly wrong, and therefore something had to be done, and it was the doctor's fault.* *(Doctor - Case 2)*

> *I'd get phone calls within minutes, within minutes from mum and dad and best friends in Auckland and people all over New Zealand, "saw you on TV, this is terrible", so you had this half hour conversation about it and hung up and the minute I would hang up the phone was ringing again or the call service would call back with a text message. So I remember we got the kids to bed pretty early that night as we didn't want them to see this because we didn't think it would be good for them, because their dad is a hero. It got worse.(It) went through this big long legal process.* *(Doctor - Case 2)*

The vendetta was also directed against family members.

> *We received several abusive phone calls from this man, my wife was absolutely – she really felt quite uneasy about him and reported him to the Police on a couple of occasions for threatening behaviour and the whole thing finally came to an end, (Doctor - Case 4)*

> *The parents said things to their children, those children said things to other children. I know my daughter came home most upset saying, "Dad someone at school said you killed that girl, you killed M." (Doctor - Case 9)*

One doctor's spouse felt that she, as an innocent victim, had been made to pay a high price.

> *I am being further damaged by all of this. I have been severely traumatised by all of the processes that we have had to go through. I have been severely traumatised by the Hearing, by having to live with the situation for four years. It's really taken a terrible toll on me personally and our whole family and our whole extended family. Now how can the Disciplinary Tribunal look at this situation and say that there is one victim and this victim needs to be compensated.*
>
> *There are many victims in all of this. And the longer they carry on with their Hearings and things the worse it becomes, and the more victims there are. So why put one person, the one that happens to be complaining and say well this is a victim we are going to compensate her.*
>
> *(Doctor's Spouse – Case 9)*

It appeared that some complainants had hoped for something more in the form of monetary compensation but they had been disappointed and one looked to other means of getting money.

> *It was probably 18 months after the initial complaint he came along to see me and presented me with a letter of demand and he demanded, if I remember rightly, it was this sum of about $9,500 from me – where he got the figure from I don't know, but it was basically a threatening letter to say that if I did not pay him this sum then he was going to air the whole saga on TV3 and that he had plenty of dirty linen to expose about me, so at that stage everything got handed over to the Lawyers again and that was the last I heard of him, so presumably they dealt with that. It was just a very, very unpleasant couple of years. (Doctor - Case 4)*

The drivers of vendettas appeared to gradually wear out the sympathy and patience of others and support waned. Eventually the complainant and one or two supporters were left on their own with their simmering anger and unhappiness.

Even family members seemed to eventually tire of the cause and they distanced themselves from it. Doctors sensed an indication of this when these people returned as patients. They became tired of the inconvenience of going elsewhere.

Complainants - their status within a small rural society

A frequent question posed by participants was, why did this person complain, because much worse events had happened to other people, who accepted the outcome and explanation without question. What was different about the people who complained?

The complainants, in the present study, were found to be different in many respects to the majority of rural residents. None of the complaints came from what Dempsey (1990) would define as "true" members of the rural community; they all came from those groups who were seen as people marginalised from the community. This marginalised group of people, however, constituted only a very small proportion of the community.

This section examines further these two groups of players in respect to their attitudes to health care workers; the marginalised group that all the complaints came from and the other larger group that did not complain.

The majority of rural residents, who did not complain

The doctors in this study speculated on reasons why this person complained and most believed that only a certain group of people were likely to complain. These people they believed were in some way different from ordinary rural people who were fairly understanding and forgiving and were not seen as a threat to them.

> *I mean I think people in country practice are really, reasonably forgiving about most things. ... I mean this is something that has always fascinated me about general practice. The people who complain are usually people with very little reason for complaining and people whom you really feel some kind of liability towards, are you know sort of so forgiving*
> *There is a lovely story in one of the American journals about a doctor in the States, a rural country doctor – this lady with an arrhythmia who eventually died and everything went wrong, his pager had been turned off when she had her acute episode and he got there late and they weren't able to resuscitate her. I think it finished up that the patient's husband said to him, "we all want you to know doc that you done your best and we are all so grateful to you" – that's the way if often turns out.*
> *(Doctor - Case 5)*

> *No I didn't become more cynical because the whole time I had the majority of the people I dealt with supporting me. I felt my patients appreciated me, knew me and kept on seeing me. This was somebody who had always decided not to use me but when it actually came to it - did use me.*
>
> *(Doctor - Case 8)*

It was not that most people did not complain, because community members did complain. Most people, however, expressed dissatisfaction at the time of the event, they discussed it in a reasonable manner and the matter was usually settled in an amicable manner. What was different about these complaints was that the people had not expressed dissatisfaction directly to members of the health care team but had approached another body instead, that was composed of outsiders.

Most community members knew their doctors as fellow community members. Most doctors had families and like most families, their children attended the local school and the family participated in local activities. Community members knew this side of their doctor and spoke about their doctors as being very busy and hard working. Most community members saw the doctor as a reasonable person who was doing his or her best in a difficult situation and, recognising the realities of the situation, they would probably have been reluctant to complain. The people marginalized, would not have mixed with this social group and would not have this understanding of the position of the doctor.

Part of the culture of small towns is the belief that one can trust community members. As Dempsey put it:

> *In the city you can get away with blue murder, if you are in business, and city businessmen do...Here if you try and charge what they charge in the city for, say a bit of carpentry, it would be all over town in five minutes and you'd lose all your customers. You've got to be honest to survive...any way I couldn't live with myself if I attempted to pull the swifties they do in the city. People aren't like that here. There are more important things than making money. It's the quality of life that counts. This is the best place in the whole world to live!* *(Dempsey, 1990, p 37)*

People in the rural communities seemed to have a lot of trust in their doctors. They would probably accept and trust their explanation of events and not challenge them.

A further explanation for community members not complaining was loyalty to a fellow community member. Most doctors appear to have been accepted as members of the community, contributing to its well-being. The researcher found that local people always spoke well of their local health services - services and facilities they were proud of. The community felt they "owned" these facilities including the people who worked there. While they might be critical of them within the community, to express criticism to outsiders would be unacceptable. Dempsey (1990) describes this loyalty:

> *Smalltownites perceive themselves as very loyal not only to friends and relatives but to the community and its members. This is a correlate of their conception of Smalltown as a 'big happy family' they are concerned about presenting a united front and preserving the unity and harmony of the community;* ***"we don't squeal on one another and we don't let the town down in anything we say to outsiders."*** *(Dempsey, 1990, p33)*

Much the same was found by Voigt (1988).

> *Small town friendliness, neighbourly helpfulness, honesty, fair play, rural hardiness and individuality and the casual pace of life, are measured against a generalised concept of the cities as places where relationships are impersonal, where commercial and political corruption are rife and the anonymous masses are bound up in an unkindly rat race.*
> *(Voigt, 1988, p92)*

However, the marginalized group who were not accepted as "true" members of the community did not feel this loyalty to the community. Aware of the community's critical attitude to them, they were resentful and angry with the "true" community members and they in turn criticised community members as being hypocritical (Dempsey, 1990, p44). This resentful attitude by the marginalized people may have been part of the reason for making the complaint against a doctor who was seen as a community member.

Perceptions of the minority of residents who did complain

Health workers described the complainant in negative terms, and they felt they could identify people likely to complain because they had the same characteristics. Complainants were described in the following terms; discontented and anti social people, often in conflict with others, not integrating well into the rural society, transients without stable occupation, flouting society's norms, and often brushing with the police. The majority of complainants belonged to lower socio-economic groups, who suffered many hardships. Added to these, complainants often suffered mental health or personality problems that compounded their hard life. These participant views of the complainants are described more fully in the following section.

ISOLATION AND EXCLUSION

The complainants did not 'belong' to the rural community because they were 'transients' or people who were not integrated into the rural society.

> *...he was a solo parent, he was divorced and I think probably quite a lonely person and when we first met up with him ,C (my wife) she met him at a couple of sort of Plunket type groups and that, and we both felt quite sorry for him, you know, he came across as a sort of lonely person. He and his ex-wife shared custody of the children and he would see the children at weekends, and he lived miles out on a farm and it wasn't an ideal lifestyle down there, but you know... (Doctor - Case 4)*

> *The majority of the complainants would appear to belong to the lower social group. (Neighbouring Doctor - Case 3)*

> *They are transient people who are coming in and there are incredible problems... (Doctor - Case 5)*

SUSPICION AND CONFLICT

Complainants frequently had a reputation for making complaints about services or confrontation with people they dealt with.

> *I have dealt with the daughters several times and managed to save the hospital from being accused of various things by explaining procedures and things. I was told it was my turn to feel the brunt of their wrath...*
> *(Doctor - Case 2)*

He had attempted to sue several people in the area. When he left the area, this was fairly typical of what sort of person he was. He sold his little small holding and then tried to sue the people for part of the contents on the property. And in a nutshell, what he ended up doing was removing his water tank because he claimed that that was an extra or something like that. So I mean he was just an unpleasant man – one of those people that you hope you never run into again. (Neighbouring Doctor - Case 4)

He, (doctor) tried to make contact with the family but they were resistant. Well actually, the father was potentially physically abusive and was thought to be violent. He is a man with an anger problem with access to firearms so we didn't push the issue. (Neighbouring doctor - Case 16)

She complained about everything, she was involved in criticism of virtually every organisation. She was a really nasty piece of work. She complained about the kid's kindergarten and pre-school (and) there was no way that person could ever afford to complain about anything.
(Doctor - Case 1)

RESPECT FOR OTHERS OR SOCIAL NORMS

The people who complained were described as having little regard to accepted conventions in social behaviour nor did they seem to have much consideration for other people.

I sent him for some physiotherapy, to a very good physio, and she worked on him. She was in tears at the(end of the) consultation. The guy was abusive to the staff, threatening to the staff. Basically he had a confrontation with the Police. Anger management - he had failed to attend his counselling (appointment). He would turn up on his counsellor's doorstep without an appointment, demanding an(Instant) appointment, and really, the whole thing painted a picture of a belligerent and unreasonable person.
(Doctor – Case 7)

Four complainants had known criminal records.

I think he must've been, short of funds and he burnt his garage down and the car in it - and yes (he) was basically found guilty of arson,
(Doctor - Case 4)

PEOPLE WITH MENTAL HEALTH OR MARGINAL PERSONALITY TYPES

The people who complained frequently had other health problems, including mental health problems.

He himself was clinically depressed and when he was my patient, he was certainly on treatment and having great trouble controlling it before this

happened. I am not so sure that he has had proper treatment since...
(Doctor - Case 2)

And I think though he was the type of person who hadn't made friends in the area. He lived on a small lifestyle block. And he had alienated his neighbours with silly quibbles about water and various things and I think someone in the district near him was claiming the unemployment benefit and also earning too much and he dobbed them in. He just sort of appeared to make enemies. (Neighbouring Doctor - Case 4)

Some complainants appeared to have psychopathic tendencies, and they threatened others, trying to intimidate them.

I have witnessed him to be very threatening in the waiting room. On one occasion, he so distressed another woman patient that she actually came in and sat in the office because she didn't want to be sitting in the room with him. She really felt very scared (of him). (Neighbour Doctor - Case 7)

The chemist wanted to charge him $3 for that. He basically bailed up the chemist. There were other people in the chemist - They sort of fled to the back of the shop, huddling together like chicks, and he threatened the elderly chemist, he was 70 years old at the time, with physical harm, threatened to break into his chemist later on and steal the stuff, and he ended up by getting the stuff for nothing. He then took a taxi from the chemist, a few kms. to his house which he could easily have walked, and as soon as the taxi demanded his fare, he then bailed the taxi (driver) up about it. He was extremely aggressive to the guy, again threatening violence. (Doctor – Case 7)

I mean I suspect in this case that the woman was actually being abused by her husband, because you can't say these things,
(Doctor - Case 5)

Some families were well known to the doctors for the multiple social and health problems.

The whole family had had medical problems throughout their whole lives actually as it turned out... (Doctor - Case 2)

The majority of the complainants were unemployed. Of those who were employed few seemed to have permanent work. Some had not worked for many years and relied on social security.

I mean he was very litigious, he had made a living I guess you could say out of the ACC and Income Support in that he actually hadn't worked, he wasn't particularly a youngish man, but he hadn't worked for some years...
(Neighbouring Doctor - Case 4)

Some people seemed to know how to use the systems to their own advantage.

> *Yeah, they normally are an underprivileged group with excessive expectations and with a high degree of resentment of authority, and discipline, and of any restrictions placed upon their perception of what they should be getting for nothing.* *(Neighbouring Doctor - Case 3)*

> *It was probably 18 months after the initial complaint he came along to see me and presented me with a letter of demand and he demanded, if I remember rightly, it was this sum of about $9,500 from me – where he got the figure from I don't know, but it was basically a threatening letter to say that if I did not pay him this sum then he was going to air the whole saga on TV3 and that he had plenty of dirty linen to expose about me. It was just a very very unpleasant couple of years. Where he got that figure from I don't know but that was it in a nutshell, if you don't pay this I have got TV3 and they are prepared to do a story about you and I've got plenty on you doctor – you know you won't believe all the stuff I've got.*
>
> *(Doctor - Case 4)*

The people who complained in the present study demonstrated consistent characteristics and they seemed to belong to a definite marginalized social group. The marginalized people were resentful of other community members and they took delight in finding fault with them. They probably saw health workers as members of the 'true' community and thus, they also criticised health workers.

The marginalized people had very little standing in the community. Dempsy (1990, p43) describes how they where often ignored by 'true' community members and not greeted when the custom in that society was to greet everyone. It is likely these people felt that expressing any dissatisfaction to the local health workers would be futile. They therefore made a formal complaint.

Driving people out of town

The majority of the complainants left the town in the two years following the investigative hearing. Without interviewing these people, we can never be certain of the real reasons for their leaving but it is likely that pressure by the community played a part. Dempsey (1990) describes several cases where people who had fallen foul of the community were "driven out " of the town:

> *If you dirty one of your nests in the city no one but those immediately involved need know and you can get on with the rest of your life as though nothing has happened. But here - if you dirty one nest you have in effect*

> *dirtied them all. The local grapevines work so efficiently; the story of the faux pas is relayed with exaggerations and embellishments at the pub that night and within a day it has spread throughout the community. The offender has nowhere to turn and will face rebuffs and rejections from leaders and organisations he may seek to join because his reputation has preceded him: "don't have anything to do with him, he's murder".*
>
> *(Dempsey, 1990, p52)*

It is clear from the study that some complainants and their supporters were subject to some action by community members, but what these actions were and what effect they had are questions that only community members could answer. They would probably only talk to other trusted community members about them.

Conclusion

The various groups of people in each case, the complainants, doctors, other health workers and ordinary community members, all lived and worked together in a small community, where avoiding contact with members of opposing groups was difficult.

After the complaint had been lodged, the relationship between doctor and complainant was strained and complainants sought another doctor. However, complainants or their family sometimes needed urgent care but after hours, there was usually only one doctor available, and that doctor could be the one they had complained about. Relationships with other health workers could also be difficult as these colleagues were generally supportive of the doctor.

The controversy could split communities but a substantial proportion of the residents appeared to support the doctor. Some complainants were known for their anti social behaviour, and community members were not reluctant to demonstrate their displeasure to these people. Doctors were embarrassed by the complaint and worried about losing community support. The reluctance of the community to discuss the complaint with the doctor, added to the doctor's uncertainty. However, doctors were reassured with time when patients did not leave but continued to attend them.

The anger of complainants was demonstrated by the vendetta orchestrated against the doctor, family members and other health workers. Abusive phone calls, newspaper articles or television interviews were part of the vendetta.

Participants identified two groups of players in rural communities; groups that closely resembled those described by Dempsy (1990, p44). The one group contained the majority of ordinary dwellers with traditional rural values, the other group was a small group of people who did not adhere to these values and who were marginalized by the rest of the community. Health workers belonged to the former group. They became trusted members of this group and, as was customary, if there was dissatisfaction, members kept any dissatisfaction within the group, rather than involving outsiders by making a formal complaint.
The second group of people, the people marginalized, did not belong to the majority group who derided and criticised them. The small group of marginalized people in return were critical of the other community members and did not trust them. The group of marginalized people did not interact well with other community members and were often involved in confrontational behaviour, some having mental health or personality problems. Probably their distrust extended to health workers who they perceived they belonged to the opposing group of people who they distrusted and criticised. These marginalised people had little standing in the community and probably felt that any concern of theirs would be ignored by the other community, leaving them with no hope of resolving a concern within the group. They therefore felt the only alternative was to seek help outside the community and they filed the formal complaint.

CHAPTER 7: THE FINAL OUTCOME

Two to three years after the hearing, the confrontations had died down as community members tired of the issues and turned their attention to other matters. Getting back to their former day-to-day lives or work was not so easy for either the complainant or for health workers. Health services also underwent changes, because of the altered work practices of health workers.

The changes in health services

Health services faced two problems after the disciplinary investigation: recruitment and retention of health workers, and the adoption of defensive medical practices.

Three doctors left their practice immediately after the disciplinary hearing; one moved to a larger town, one moved to Australia and the third gave up general practice. These were well-established doctors, who had been in their practices for between six and twenty years. They had become identities in their communities: they were respected, appreciated and many people had become attached to them. They were not replaced by permanent doctors but by a succession of temporary doctors or locums. Some areas were without a doctor for a few months.

> *Whereas there was previously a self-employed, self-motivated doctor who owned his own practice and was working for his benefit and directly as a result of his working for his own benefit he was working for the community's benefit. He has now gone, so you now have another doctor there trying to do the same thing but finding the burden almost unbearable. They can't get locums on an ongoing basis and they are finding it I think very difficult to provide the care that they should...*
>
> *(Neighbouring Doctor 1 - Case 3)*

Four other participant doctors and three of the neighbouring doctors left in the two years following the investigation. Concern about complaints was cited as a major reason for leaving by these doctors. These were not the only doctors to leave as other neighbouring doctors who had not been interviewed also left in this

period and it is probable that fear of complaints was also a reason for these doctors leaving.

New doctors came to the area but they did not stay. They soon heard about the saga of the previous doctor. They were joining a group of health workers whose confidence had been shattered, who felt persecuted and whose morale was extremely low. Many of these doctors were planning to leave the area. These new doctors were influenced by the attitude of the neighbouring doctors and soon decided that this was not a desirable area to practice in.

> *... one of our doctors is already starting to get pissed off. He has been with us for just on a year now, and he has had to deal with two difficult deaths, and at both scenes he has been accused of 'not looking after the patient properly' and I mean one guy was a heart attack waiting to happen, he had never taken care of himself ever, and the second one was a patient who he had seen after an injury and referred her to the hospital and it was the only time he had ever seen her, and I don't know whether she was an overdose, and alcohol overdose or whatever the story was, but he got it sort of verbally attacked both times and he is now thinking 'well stuff this' ....*
>
> *(Neighbouring doctor 2 - Case 2)*

The doctors who stayed

Three of the doctors who received a complaint remained in rural practice for more than five years and these doctors seemed to retain their enthusiasm for rural practice. What appeared significant with these three doctors is that they had very good relationships with the communities and the communities managed to demonstrate their appreciation to the doctor.

> *That's the thing that keeps me in this town. There's not a month goes by I don't get an e.mail from one of these locum agencies telling me that since my professional interest a year ago, yet another job is available for $150,000 somewhere and all the other extras you get from a country Australian practice but they haven't got any people I know over there and there's the patient who thanks you for a small thing you have done and I suppose that's got something to do with why I stayed. I think so.*
>
> *(Doctor - Case 3)*

> *No I didn't become more cynical because the whole time I had the majority of the people I dealt with supporting me. I felt my patients appreciated me, knew me and kept on seeing me. This was somebody who had always*

decided not to use me but when it actually came to it, did use me.
(Doctor - Case 8)

The support of the community enabled these doctors to brush aside the findings of the disciplinary body. These doctors also seemed to use fewer medical defensive practices, probably because they felt they could trust their patients.

The complainant

As most people became tired of the confrontation, the complainant gradually lost most of the support they had. The complainants found that many of their supporters drifted away and they were left on their own.

No, well I've got the drift that maybe there has been a split in the family and maybe it is only the husband who is really upset with me and the rest may have accepted this, because the rest have just gone on their own ways, to other places to live and so-forth, but he is still hounding me because after the Medical Disciplinary Committee came to its finding
(Doctor - Case 3)

As the complaints became more isolated in an unsympathetic community, they sought other methods of continuing their cause.

...he then decided that they were biased and he wanted them to change their minds - which they have never done in their whole history, so he asked for a full copy of all their notes...I actually attempted them to stop (him) getting a full copy as I knew he was going to find something to nit-pick.... But my reason for wanting them not to get the full copy of notes was I was sure he was going to release bits of it to the news media for the next 50 years, this bit here and this bit here you know, (like) the case with the XXXX murderer type thing – you could just imagine it, in his almost psychotic depressive state I could see him in his dark room, with a candle lit, pouring over his things...
(Doctor - Case 3)

Most complainants left the area after a few years. Life in the community they found was too uncomfortable and the only alternative to was move somewhere else. What this cost them, moving away from family, friends and the town they had lived in for part of their life, one can only speculate on.

He had his business on the market, no-one wanted to buy it though unfortunately, so if he left town it would be a lot easier, but...
(Doctor - Case 3)

Repairing bridges

When a complainant left the area the confrontation ceased but there were still wounds to heal - uncomfortable relationships remained between some supporters and health workers. One doctor described the dilemma the strained relationships presented.

> *...the father continued to see me through the hearing. I did not know if this meant that he did not agree with his daughter's complaint or if there was another reason. I felt we ought to try to resolve issues and I tried to get him to discuss his feelings. He was not the sort of man who said much however and I never knew what he felt. I always felt uncomfortable about it.*
>
> *(Doctor - Case 8)*

The reluctance of people to discuss issues with doctors left doctors with the dilemma of not knowing what people felt.

Conclusion

Two or more years after the disciplinary hearing, either the doctor or the complainant had left the area – it seemed that both could not live in the same town together. Relationships between most people improved however the relationships between complainant supporters and health workers remained strained but tolerable. Health services struggled because of the low morale of health workers and this low morale affected the recruitment and retention of workers. Health workers were also less trusting and adopted many defensive medical practices.

CHAPTER 8: RESPONSES TO DISCIPLINARY DECISIONS FROM THE WIDER MEDICAL COMMUNITY.

This chapter examines a further group of players affected by the disciplinary process, the wider population of doctors and health workers.
The stories about rural doctors and their disciplinary investigation travelled; doctors in the base hospital and town heard the stories from colleagues, some cases were mentioned in the health magazines, and a few were published as the findings of the disciplinary body. Many doctors responded to these stories by writing a letter to the doctor concerned; these letters expressed sympathy but also opinions on the issues. Participant doctors had saved 172 such letters. Many letters were signed by more than one doctor and the number of signatures was well over two hundred. Some letters said that the letter represented, 'the opinions of all of us here', which indicated the letters represented further opinions. These letters thus represented the opinions of considerably more than 200 doctors, possibly even the majority of doctors in New Zealand. The letters were copied and analysed using qualitative methods.

The reason why doctors and others wrote letters was to convey sympathy but also to express their strong feelings: their protest at the actions of the disciplinary bodies, their feelings of outrage, their interpretation of events and their rejection of the disciplinary findings. The following section describes these themes from the letters.

Outrage

Most of the letters were strongly worded expressing their feelings of anger and protest

> *I was incensed at the treatment you suffered at the hands of the Disciplinary Council. It appears there is little a GP can do.* *(letter 3)*

> *Your communication brought forth much in the way of emotion and so I left a period of weeks to think it over.* *(letter 62)*

This situation is beyond belief. I hope you have the energy and finances to appeal. (letter 133)

The decision was perceived as an unjust act perpetrated against all general practitioners, and they closed ranks against the assault. They felt persecuted and vulnerable, when they heard of such decisions.

On reading the report of your case in the New Zealand Medical Journal, I realised yet another doctor had been unjustly treated by the Disciplinary Committee.
(letter 73)

We are appalled that again our Council has seen fit to disregard the rights of a practitioner in disallowing evidence or understating the reality of your situation in order to be seen to be doing the right thing. The council thus appears to have had no guts to stand up for what was the right thing, even if it meant going against an absurdity of any Law.
(letter 118)

Rejection of the disciplinary decisions

Doctors were unanimous in rejecting the decisions of the disciplinary bodies.

(To the Disciplinary Committee)
I am astounded that you can treat such a highly respected and regarded practitioner in this way. With attitudes like you have displayed it is little wonder that doctors like (Dr X) .and many more are considering leaving the profession.
(letter 79)

It strikes me that the disciplinary committee believes in a code that neither the law or ourselves as doctors agree with. I would venture to suggest that the general public would also hold conflicting opinions to the Disciplinary Committee. (letter 62)

It is incredible how common sense has flown out the window in so many of these issues that beset the medical profession in these difficult times. (letter10)

Accounting for poor decisions

The letters discussed the reasons why the disciplinary committee came to what correspondents considered to be "wrong" decisions. For many the disciplinary

committee did not aspire to any justice and so they should not expect any. Other doctors saw the Committee as incompetent.

ABANDONMENT OF JUSTICE

Most doctors were convinced that the Disciplinary Committee did not aspire to any form of justice and doctors should not expect any.

I came to the conclusion, having also decided not to appeal, that this is a political machine designed to produce a certain number of victims for sacrifice each year to satisfy an increasingly vociferous aggressive public. I feel they need to prove they are being tough on doctors and the more aggressive the approach to them the more sure you will be found guilty. It is not fair, biased against us and we have no rights in the situation.
(letter 76)

I'm only sorry no one has previously warned you that the last thing you can expect from the Medical Disciplinary Committee is JUSTICE! If you had gone in the knowledge you would be found guilty - no matter what - you could have taken a more relaxed attitude to their findings. The whole process is designed to be "seen to be fair to the lay person" - in effect the MPDC will find you guilty and that is that. Justice does not enter this process and there is no real chance to "defend" as that is not what they want to hear.
(letter 41)

Correspondents believed that in the disciplinary process, the aim was to show the patient was always right and doctors wrong. Some doctors rationalised that the reasons for the "bad" decision were political.

Personally I have not gone through this process yet, but several of my colleagues have. It seems that evidence counts for little and the Disciplinary council is there purely to be seen to be defending the masses from those awful beasts called doctors.
(letter 83)

a committee which appears to have fallen over backwards to try and prove it will "get tough" on alleged breaches of this Act. *(letter 5)*

It is becoming more and more alarming to many good New Zealanders that common sense is rapidly declining

in the middle of stupid bureaucratic politically correct judgements. *(letter 118)*

OTHER REASONS GIVEN FOR CONTENTIOUS DECISIONS

Other doctors felt that the reasons for what the saw as the "wrong" decisions were the lack of expertise of the committee, the quality of people on the committee and the lack of accountability.

Some doctors felt those doctors who were on the Disciplinary Committee were so far removed from the situation of ordinary doctors that they could not understand the issues.

It simply confirms my long held view that medical discipline in this country is in the hands of people who are out of touch with reality. *(letter 45)*

Some doctors felt that the doctors on the Disciplinary Committee were not ordinary doctors but had personal attributes that accounted for their "wrong" decisions.

Which leads me to the Medical Council. This body is made up of individuals, possessing personality traits which incline them to define standards for, and sit in judgement of, their peers. More correctly,, I should say they "sit in judgement of medical practitioners" because sometimes Medical Councils are individuals who have clearly gone out of their way to avoid actually practising medicine. *(letter 128)*

These "ivory tower" people lose sight of those of us working in every day practice where decisions such as yours have to be made. *(letter 48)*

The disciplinary Committee is supposed to be a group of "peers", yet appears to be "holier than thou". *(letter 80)*

" Artificial intelligence will never replace natural stupidity". *(letter 133)*

Other doctors felt that part of the problem was the lack of accountability.

The Disciplinary Committee are a law unto themselves because there is no accountability to any organisation or body. One chairman of the Disciplinary Committee admitted they

treated doctors more severely than the courts.
Even judges can be taken to court but not the Disciplinary Committee.
(letter 73)

One would assume that the individual members of the medical Council, being persons expecting the highest standards of honesty and integrity, will hold themselves accountable for any failures in performance of the Council that may be demonstrated. I look forward to seeing that this issue is thoroughly investigated, and that the Council ensures that appropriate disciplinary action is taken against itself and its members should a failure of duty be proven. (letter 128)

What such judgements meant for the doctors

Doctors knew that with the ever-increasing frequency of complaints they were probably due to face a complaint some time and they found the thought very threatening especially if the decisions of the Disciplinary Committee were questionable.

As doctors we all have to accept that at some stage of our practising life, circumstances will occur that bring us to answer to the Committee.
We hope for the Committee to dispense wisdom and justice, they have badly failed you in that expectation.
(letter 62)

They invariably support the complainant with total disregard to a practitioner's efforts to do his/her best, and the appropriateness of their actions. (letter 97)

The decisions of the Disciplinary Committee left doctors in a quandary. They found them illogical and unpredictable. They were confused about what they were expected to do. It seemed that they were likely to be dammed whatever they did.

I can think of at least two or three other cases, similar to yours, published in the Medical Journal in recent years. On each occasion, the practitioner did what was almost certainly the best thing for society but was found wanting when judged by his colleagues. (letter 29)

I have taken a particular interest, for reasons which I cannot go into here, in the way the disciplinary method is applied to medical practitioners. I believe that the decision of the MPDC was fairly predictable under these

circumstances *(letter 29)*

We are reaching a crazy phase in medicine and here's hoping the pendulum will swing back to some sensible/ balanced position, in regard to "patient rights'. (letter 119)

As GP's we often find ourselves in legal no-mans-land when acting in the best interest of our patients and the community. (letter 10)

It seems that the profession has limitless responsibilities with very few rights to balance these responsibilities. (letter 29)

The consequences of vulnerability and confusion

Doctors were worried about the apparently illogical and unpredictable decisions of the Medical Disciplinary Committee. These decisions put a different perspective on their work. Doctors felt confused, disillusioned and less motivated in their work.

Doctors felt that these decisions came between them and their patients and was destroying trust in both parties.

As our ability to continue to have an honest relationship with our patients is eroded. The job satisfaction dissipates. As College increases its power over us all, and as the NZMA and GPA appear to collude in the Government's controls over general practice, so my disillusionment increases. (letter 47)

The majority of GP's, of all doctors, have only the best interests of their patients at heart. It is hard enough making a correct diagnosis and obtaining a correct diagnosis and obtaining the necessary investigations and treatment in these times of economic restraint but having to cope with such unnecessary repercussions of just doing your job is too much. (letter 53)

They did not see the Disciplinary Committee was upholding and promoting what is morally good or correct.

The implications of their judgement are very worrying. The possible consequence is that fear of reprimand may deter doctors from honestly (and Legally) stating facts... How extraordinary to avoid doing what is morally correct and

legal for fear of idiosyncratic reaction by the disciplinary body - who, while they exist to uphold the profession's moral and ethical standards ostensibly do so for the public's good. (letter 72)

A few doctors felt that the answer was cynicism, to accept there was no justice and not to worry about it.

Take heart - sit back and say - they will do whatever they want - and don't take it personally - it is not worth it. (letter 41)

All doctors seemed to loose their respect for the official bodies.

The fact of the matter, in my view, is that painfully few persons in authority deserve to be respected, because (as the old saying goes) "the higher the monkey climbs the tree, the more you can see it's bum". (letter 128)

A few doctors advocated more active strategies to counter the political bias.

I think you probably need to get along side a member of Parliament, who can take up your case. (letter 10)

The more the injustice is exposed the better it will be for all. (letter 76)

Sometimes we do need to stick together, understand each other and help each other. (letter 11)

The sense of vulnerability and confusion sapped the enthusiasm for their work. They thought about retiring or working less.

I know the same could happen any day to me (or anyone) and I'll just hang up my stethoscope and quit - I don't care enough (letter 72)

I used to see myself enjoying general practice well into my sixties. Now I am looking hard at ways of decreasing my involvement, though I think I am too set in my ways to move. Nevertheless I suspect I will retire considerably sooner than originally planned. (letter 48)

These letters demonstrate what effects investigations of complaints could have on doctors. Some of these issues were critically discussed in the medical magazines.

Conclusion

Investigation of complaints in a rural town could have widespread effects on health care because the cases were discussed in magazines and journals or the contentious news spread by word of mouth. The reactions of these doctors, living far from the rural area, were similar to that of the neighbouring doctors and the letters showed their strong feelings on the subjects. Doctors rejected the findings of the disciplinary body, believing it was biased or politically motivated. Their distrust of the process made them cynical; they believed it was pointless to make any changes in their practice as there was no way in which they could avoid complaints because in the present system they could be found wrong whatever they did. Doctors no longer believed they lived in a just society and they lost faith in official bodies.

CHAPTER 9: DIFFERING PERSPECTIVES ON COMPLAINTS

Complaints are invariably controversial affairs and in this study, as is typical in such cases, the various parties took opposing sides, arguing for one side or the other. As usual, in such situations, there is never a simple answer because the problems are complex, poorly understood, and the solutions depend very much on one's perspective. The Hon. Justice Kirby describes this complexity:

> *Debates such as I have outlined have their parallels in every part of the world where the common law system of recovery for torts (civil wrongs) and breach of contract bring the two professions into litigious conflict. As is usually the case, neither side has a monopoly of wisdom. Each side makes valid points. Each party is voicing reasonable perspectives. One lesson that is quickly learnt as a judge is that, complex problems rarely yield simple solutions. Justice, Janus-like, ordinarily has a dual face. Discovering truth is often a highly subjective exercise, the outcome of which depends on one's starting point.* *(Kirby, 2001)*

The present study examined complaints and their investigation from a quality of health care perspective, arguing that the purpose of bodies such as disciplinary bodies, which are paid for out of public money, should be to benefit to society.

> *The good of the people is the chief law.*
> Cicero.

The issues concerning the investigation complaints are not simple. This chapter examines some of these complex issues, with particular reference to rural practice.

Complainants had originally been happy with their doctor, but then some momentous event occurred that left them shocked and disappointed; an event that they felt should not have happened and someone must held be responsible. The offended people listened to the doctor's explanation but rejected it; there was now a lack of trust. They were then to spend the next one to six years on a campaign to obtain redress, bringing themselves into conflict with the doctor, other health professionals and some community members. This conflict harmed them as well as the defendant and other parties involved. Complainants appear to have been dissatisfied at the end of the investigation.

Rural community members did not generally understand or support the disciplinary process, which they were not allowed to observe or comment on. The rural communities were invariably left with a health service that was worse than previously and so they derived no benefit from the process. The problem was that members of the Disciplinary Committee failed to identify the real problems of the local health service such as inadequate numbers of health workers because the process sought to find someone to blame and took no interest in unsafe working circumstances. From the community's point of view, the resources spent on the process could have been better used.

As the present study demonstrates, there were no winners at the end of the disciplinary process, as the defendant doctor, other health workers, community members, and the complainant were all worse off. The changes to health care services were the most disturbing consequence, changes resulting in cynical, disillusioned workers who adopted defensive medical practices. The present study found that in rural communities, the present disciplinary process was not an effective instrument for improving quality in health care services.

Patients' expectations and the conflicting duties of doctors

A frequent concern of doctors in the present study, who were trying to satisfy everyone, was conflicting interests between patients. Conflicting duties often arose when trying to help an individual patient, but helping that patient might compromise the interests of the community. When the interests of parties did conflict the needs and rights of each party had to be considered and balanced with those of the other party. Conflicts of interest arise in such areas as: certification of fitness, reporting dangerous behaviour (such as child abuse) and resource allocation. When an individual, in these situations, did not get what they wanted they could be unhappy, and even complain.

A typical example of conflicting interests is issuing a medical certificate for an older person to drive a car. There are many good reasons why an older person should retain their licence; there is often no public transport in rural areas, or

taxis. Frail people need transport for shopping for food or visiting friends. Not being able to drive is a serious restriction for most elderly people and doctors would not want their patients to suffer in this way. Unfortunately, frail elderly people have slower reaction times and are more likely to have accidents, which may harm others. Allowing an unsafe driver to drive puts other people at risk of harm, infringing their rights to safety. A doctor has to balance the needs and rights of both parties, and do what a reasonable person would do in these situations.

When people do not get what they want they are sometimes angry and they express their anger by complaining. They often find a more plausible reason to complain about rather than the certificate refused. With the disciplinary system so accessible to people doctors felt vulnerable in such situations.

> *I think if somebody wants to have a go at you they are going to be able 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, you know especially like if they have a good lawyer.* *(Neighbouring Doctor – Case 3)*

Doctors could not rely on understanding from the disciplinary bodies.

> *The disciplinary bodies seem to now take the attitude*
> *that a doctor is guilty until proven innocent, rather then vice versa.*
> *(letter 86)*
> *Like many other GPs, I am very concerned at the arbitrary*
> *and unfair way you have been treated by the Disciplinary Committee.*
> *(letter 37)*

The threat of discipline changed the decisions of doctors, something they felt uncomfortable about.

> *... it certainly does continue to affect the way I practice. I feel less happy about medicine in comparison to what I used to. I feel more at risk, I do look at the possibilities whereas once upon a time I just trusted my patients and now I don't completely and I realise that the process, I mean I knew that the process was wrong.* *(Doctor – Case 14)*

After one investigation, a neighbouring doctor described her feelings; she found the complainant so intimidating, she said she would never disagree or argue with

him, she would have simply given him what he wanted. She felt unsafe in his presence and would not have liked to be alone with him in the surgery. Another doctor said he would never report another case of child abuse again. In two cases complainants were known to be violent and have firearms, one of these threatened to use them on the doctor.

Two cases in this study resulted from such conflicts of interest. One was a case of suspected child abuse, the other was in the case of a firearms licence. In a third case, the person seemed to have multiple complaints among which was one blaming the doctor for arranging home help. Not all patients are reasonable, some have an unreasonable expectation of their doctor in catering to their wishes to the detriment of others and some even expect doctors to be dishonest. Sometimes these patients can be intimidating. Use of the disciplinary process by patients as a means to intimidate doctors, compromises the public good and safety.

Community expectations and contrary professional codes of practice

The values and expectations of community members often clashed with the professional codes of practice of doctors. These clashes constituted a dilemma for doctors because it meant they had to make compromises – compromises that they felt uneasy about because whatever they did they risked criticism from one side, either the community members or the professional bodies. Neither side had much knowledge or understanding of the beliefs of the other group but each had clear, and sometimes uncompromising views, on what they expected from a doctor. Doctors, particularly young doctors, or doctors from overseas and in isolated areas, were left with considerable uncertainty regarding what they should do in certain situations. This section explores some of these dilemmas faced by rural doctors.

THE RURAL SUB-CULTURE

Friendliness was the personal attribute that rural small town residents valued most in people, according to Dempsey (1990, p31). Rural communities saw themselves as caring communities where:

> *People here are willing to help someone in need. If somebody's house gets burnt down, even if it is their own fault, we'll all pitch in and see they soon get a roof over their heads. (Dempsey, 1990, p33)*

Community members were expected to help anyone in trouble. The whole community was seen as one big "happy family" where all community members are considered friends who help one another.

Dempsey (1990) further enumerated the personal attitudes that community members held as desirable (*Gemeinshaft*). These attitudes were: relationships are personal and enduring, relationships are intimate, relationships involve people totally, relationships are unlimited and unspecified, members are seen as trustworthy and honest, relationships involve the whole community, and members are very loyal to their community. These personal attitudes, expected of community members clash with the accepted professional code of practice expected of a health professional. For example, expectations of 'intimate and unlimited personal relationships with all community members,' clashes with the Medical and Dental Council's directions for health workers.

All rural community members are expected to support local functions and activities, which are very social events, and those who do not join in are considered unfriendly or 'snooty' (Dempsey, 1990). For doctors, however, socialising with patients can be difficult, especially because much of what they knew about people was confidential. Conventional medical ethics discourages doctors socialising with patients because of their fiduciary duty to patients. The doctor patient relationship is considered an unequal relationship, in the traditional medical code of practice – and doctors are expected to take care not to take advantage of the unequal relationship. To ensure doctors do not take advantage of patients some advocate no social contact between doctors and patients but such anti social behaviour would be totally unacceptable in a rural community.

Because of these contradicting expectations from different parties, doctors faced many dilemmas living in and practising in a small rural community.

In addition to beliefs on social relationships, rural communities had their own ideas on how government and other officials should behave. Dempsy (1990) describes how even the Police were expected to behave in a manner that was acceptable to them.

> *I have been told repeatedly by locals that any policeman who attempts to enforce city rules on locals (for example, booking them for double parking or for not wearing a seat belt, without first being given a couple of warnings) will be driven from the town within three months. As a rule, there is no need to petition for the man to be transferred: 'We [the locals] make it too hot for him to stay'.* *Dempsey (1990, p50)*

Doctors were aware that similar pressure could be put on them, making it hard to be objective when executing official tasks expected of them, such as issuing sickness or disability certificates or certification of fitness to drive a car or hold a fire-arm. A few locals expected their local doctor to be a "good mate" and be sympathetic and lenient on them, the locals. If doctors did not do as they expected, they could take exception and make life difficult for them.

The place of trust in health care services

Few actions evoke stronger emotions than a betrayal of trust - feelings of betrayal were expressed by all complainants in this study. Feelings of betrayal fuelled the anger of complainants, driving them in a campaign against the doctor that was to last years. To appreciate the place of this sense of betrayal in social dynamics of complaints we need to understand something of the place of trust in health care. Fugelli (2001, p570) has studied the place of trust in health care and emphasises its importance:

> *Sick people have always had a particular need for trust, because to fall ill implies a loss of trust in yourself, in your body, in your social role, in your future. This loss of trust fortifies the need to trust others; among them the doctor.* *(Fugeli, 2001, p 571)*

Trust is based in a belief in the sincerity, benevolence and truthfulness of people but it also involves a transference of power. This transference of power and the

subsequent feeling of vulnerability and betrayal probably account for the intense emotions expressed by complainants.

> *Trust is an individual's belief that the sincerity, benevolence, and truthfulness of others can be relied on (Siegelman, 1997, "The problem of trust", cited in Fugeli, 2001). Trust often implies a transference of power, to a person or to a system, to act on one's behalf. (Fugeli, 2001, p 571)*

> *Trust is divided in to two categories: personal trust and social trust. Personal trust is the trust you have in an individual - such as your spouse, your friend or your doctor. It evolves between people with names, identities, feelings, and faces and must be actively gained.*
> *Social trust is trust in societal institutions; for example, the government, the military, or a health care system. It is the type of trust that develops between a person and a faceless, abstract organisation, that does not possess human feelings. Social trust is often passive and inherited. (Fugeli, 2001, p571)*

We cannot go though life without trust especially when we are unwell.

> *What do we need trust for? We need it for the following reasons: To cope with existential angst, To make sense of complexity, To reduce risk, and To function as a 'chaos pilot' in life and society. Trust is the 'social vitamin' that enables us to live. As Graham Green writes in his book, 'The Ministry of Fear': 'It is impossible to go through life without trust, that is to be imprisoned in the worst cell of all – oneself.' (Fugeli, 2001, p 571)*

Vulnerability and trust go hand in hand. When people are ill they feel vulnerable and they have to rely on the help of others to get better. People who feel vulnerable need to feel sure they can trust those they depend on and if things go wrong they question those whom they depend on. In dealing with complaints, it is important to appreciate the feeling of vulnerability by complainants and their sense of betrayal. Complaints systems that encourage distrust may not help complainants because they may still be in a position where they need to trust someone.

Probably a lack of trust was the underlying reason behind all complaints. Trust is essential for a person's health care and so one of the services a complaints process could do for the complainant would be to restore their faith in the health care service. The faith of the complainant could be restored by demonstrating that, either there was a fault in the system and this has been remedied, or

alternatively that there was no fault and that further regrettable events were unlikely to happen again.

The origins of fault disciplinary systems

Fault or disciplinary systems did not originally intend to address quality but rather "bad Practice" and they have evolved over the centuries as part of the justice systems, slowly developing with changing medical practice, social conditions, and societal beliefs. Sir William Blackstone, described *Mala praxis* in 1769 as, *Injuries ... by the neglect of unskilful management of physicians, surgeons or apothecaries... because it breaks the trust which the party had placed in his physician, surgeon of apothecary,* (*Commentaries on the Laws of England*, 1769, cited in Mohr, 2000). The law, in those times, served to protect people from such bad practices but also to provide relief to people harmed by bad practice. In those times there was no national health services or other income benefits and a maimed person needed some monetary assistance. The Law of Torts was a remedy open to them but only if a health carer had made an error. The focus was on demonstrating error and so the approach was adversarial, where the doctor had to defend his or her actions and not admit to anything that could be incriminating.

From its rather obscure origins, medical malpractice grew in the nineteenth and twentieth centuries with the expansion of tort law, especially in the unregulated climate in the United States. The stated aims of the law, was to protect patients' rights, protecting patients from exploitation or substandard care. Medical malpractice law has based many of its dicta on ethical norms as Hoffmaster explains:

> *The dominant approach to medical law ...has been a highly rational ethical consumerism. It sees medical law as unified around ethical concepts such as respect for autonomy and self-determination, truth-telling, confidentiality, respect for people (including their dignity), and justice. It sees one of its key tasks as redressing the imbalance of power that exists between expert medical practitioners and lay patients by establishing ground rules for the relationships between them. It also worries that important moral judgements are being clothed with mystique of professional expertise and appropriated by medicine from their proper place as social and political problems.*
>
> *(Hoffmaster, 1994, p1156).*

No one would argue with these aims. However, it is the implementation of these aims that is the reason for concern. The present study found no evidence that disciplinary systems were an effective method of implementing these ideals. The following sections will argue why this was so and what is necessary to prevent adverse effects on health services.

Inadequacies of the present disciplinary systems

There were five reasons why the disciplinary system had adverse effects on health care services in the cases of the present study. These were:

- poor decisions,
- a failure to ensure solutions,
- adversarial processes,
- indeterminate norms
- and a lack of credibility.

POOR DECISIONS

Determining the exact causes of adverse events is paramount to their prevention and improving subsequent health care. Determining their cause means examining all possible causes and not just a few possible causes, otherwise one will miss important contributing causes. Aircraft accident investigators usually examine human factors, mechanical factors and environmental factors in their investigations. Ignoring one group of factors would mean missing things like instrument failure or poor visibility due to fog.

Health care investigations have confined their attention to people because their purpose was to obtain money by showing negligence and all other factors were ignored. With more than twice as many patients as the average general practitioner, rural doctors could not be expected to perform as well as doctors in ideal conditions. Most doctors in the present study worked in extremely unsatisfactory conditions; they were always rushing, with never enough time for each case. Frequent night duty, meant disturbed nights after which they faced a

heavy day's work in a sleep-deprived state. Apart from the stress of their work, they had to contend with a wide range of conditions on their own and they did not always get a lot of support from secondary services. Holidays, or refresher courses for their continuing education, were luxuries they seldom experienced. Any person who is rushing, working long hours, deprived of sleep and stressed would be expected to make errors. The doctors on the disciplinary body appear to have had no knowledge of or ignored the situation of these doctors. There are three main factors that make a rural practice more difficult: the degree of isolation, the number of people to be cared for and their socio-economic status.

FAILURE TO ENSURE SOLUTIONS

Investigators of adverse events in most situations, such as in industry or the military, have the responsibility to finding solutions to the events, so they do not happen again. If these adverse events do recur, the investigators and their processes are themselves investigated to see why their investigations are failing. If these investigators suggested workers who were working sixty to seventy hours a week should work harder or people who were not getting adequate sleep should sleep less, their decisions would probably result in more adverse events. Their competence would be questioned. These were the sorts of consequences of the decisions made by investigators in the present study. It was a case of power with no responsibility.

With these types of decisions, doctors faced a dilemma because they did not know how to avoid complaints in future. They knew that the manner in which they had to practise was not ideal at times, because of the workload. This was something that concerned them - as they were always rushing and could not always give the service they would have liked to. They did not know how to change their circumstances. They needed solutions to their unfortunate predicament - answers that would help them avoid errors and complaints. But the disciplinary process made no attempt to tackle this problem. The reality was there was no simple answer short of extra funding for additional staff, but it appeared no one wanted to recognise this.

Left with no solutions to their situation, doctors anticipated that sooner or later they would have another complaint and come into conflict with the disciplinary body again. They felt sure that whatever they did, they would be found guilty and the decisions of the disciplinary body were seen as so arbitrary they were incomprehensible. There was a sense of hopelessness and doctors concluded it was best to ignore the inevitable and do what was best for themselves and for their patients. The alternative was to give up rural practice. Enthusiasm and dedication to a practice were replaced with defensive practices, setting up barriers to patient access and reduced patient services. Morale fell as doctors who had been altruistic and dedicated became disillusioned and cynical. The reward for all their hard work and sacrifices was this punishment. They became bitter.

Doctors could see no solution enabling them to avoid complaints in future except by avoiding those situations and people likely to result in complaints. They also tended to give people what they wanted to avoid confrontation. In these ways, they adopted defensive medical practices; they ordered more tests and investigations, they referred more cases, and they avoided accepting responsibility. In a time where the costs of health care are a major concern, such inefficient practices are not beneficial to a budget constrained health care system. As is predictable when a few outcomes are focused on, health workers changed their work practices to focus on those outcomes being measured. Concentration on a few outcomes meant other factors were neglected and the total quality of care deteriorated. Difficult cases they sent elsewhere, they made copious notes and they sometimes gave patients what they wanted, not what was necessarily best.

Such negative practices are well recognised in organisations and would be expected in these circumstances from studies on human behaviour.

> *Control systems can become dysfunctional... When standards are unreasonable and when controls are inflexible or emphasise single, bottom-line figures to the exclusion of other standards, people can lose sight of the organisation's overall goals. They become motivated to literally "lie, cheat or steal" to meet performance standards. (Robins& Mukerji, 1994, p 480)*

ADVERSARIAL PROCESSES

For doctors the disciplinary process was an added source of stress, distracting them from their work, making their difficult situation worse. An anxious period of waiting, dragging on for about a year, eventually culminated in the hearing. For several doctors this proved too much; they experienced a crisis, losing the confidence to practise effectively. This crisis of confidence had all the features of a post-traumatic stress syndrome, which itself was a concern for patient safety. Previous studies have shown that doctors in these situations are frequently not good at recognising their limitations (Henderson, 1999). An isolated doctor with little support in such a condition must be a cause of considerable concern. Once again, the disciplinary body appeared to have no awareness of the stress defendant doctors were under, stress that was exacerbated by the isolation and unsupported context they practised in.

For doctors, the worst implication of the process was the attack on their integrity. For them to work effectively, doctors needed to be trusted by patients and they also needed to be able to trust patients. This seemed no longer possible. The situation that the Rt. Lord Denning warned about in *Hatcher v Black*[2] seemed to have become a reality:

> *It would mean that a doctor examining a patient, or a surgeon operating at a table, instead of getting on with his[sic] work, would be for ever looking over his shoulder to see if someone was coming up with a dagger – for an action for negligence against a doctor is for him like unto a dagger. His professional reputation is as dear to him as his body, perhaps more so, and an action for negligence can wound his reputation as severely as a dagger can his body.* *(Hatcher v Black).*

Lord Denning goes on to comment:

> *I remember how anxious the doctors and nurses were. It showed on their faces.* *(The Rt. Lord Denning, 1970, p244).*

Some of the worst affected doctors were those who had been found to have made no error, indeed the process of the investigation exerted a far more profound

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2 *Hatcher v Black* (1954) Times 2 July (QBD)

effect on doctors than the outcome. Even if exonerated, doctors subjected to the process were as adversely affected, as were those found guilty.

INDETERMINATE NORMS

David Collins makes the following statement in his book *Medical Law in New Zealand*:

> *It is not acceptable that members of the medical community, devoted to the care of the sick, should be put in the dilemma of not knowing whether their conduct breaches the requirements of the law.*
>
> *(Collins, 1992)*

Doctors desired clarity and lucidity in these areas but the disciplinary process left them more confused than before. The dilemma faced by doctors was situations where the rights of patients came into conflict. It was relatively easy to produce a code of rights, but in real situations, the rights could contradict each other or the rights of one individual contradict the rights of others. In many of these situations one breached the right of someone whatever one did and someone could complain that their rights were breached. As the doctors said, "you are dammed if you do and dammed if you don't."

These problems of a moralistic approach or applied ethics are discussed by Hofmaster:

> *The notion of applied ethics spawned by this philosophical conception of morality suffers from two familiar and related failings - incompleteness and indeterminacy. When a moral theory contains a single basic principle, that principle is invariably too vague and amorphous to be practically helpful. And when a moral theory contains multiple norms, conflicts inevitably arise. A common conflict is between autonomy and beneficence, doing what is best for the patient. When there is conflict between moral norms, judgement is needed to prioritise which norms are more important and should be followed. But this is often only a matter of opinion and opinions will differ. Some people have argued that more discussion amongst various community groups is required to develop practical moral theory to find answers to these problems (Brodie, 1988, cited in Hoffmaster, 1994). Others have turned*

> *away from applied ethics proposing alternatives such as casuistry[3] or narratives. (Hoffmaster, 1994, p1156).*

With such a fatalistic attitude doctors abandoned trying to understand the codes of patients rights and did what they felt was right. Doctors frequently quoted a former Health and Disability Commissioner's statement that in the present law, patients had rights but doctors did not, doctors only had duties. Doctors felt the legislation was enacted to set them up so they could be disciplined whatever they did.

The use of vague objectives rather than specifics are criticised by Hoffmaster for the following reasons:

> *Ambiguity and vagueness are the enemies of analytic philosophy and consequently of applied ethics. Much of the time in practical ethics, they are objectionable as well, largely because they serve to cloud responsibility. (Hoffmaster, 1994,p1162)*

Hoffmaster (1994) cites Wolfgast giving two examples of the use and effects of ambiguity[4]:

> *People avoid putting things clearly in writing. They try to make group decisions so that responsibility is not always clearly defined. Thus, if I tell you what to do, I can't bawl you out if things don't work out. And this is why a lot of bosses don't give explicit directions. They give a statement of objectives, and then they can criticise subordinates who fail to meet their goals. (Wolfgast, cited in Hoffmaster, 1994,p1162)*

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3 Casuistry "the reason of the casuist; the resolution of cases of conscience by the application of general rules to particular instances, frequently disclosing a conflict of duties", (The New Shorter Oxford Dictionary, 1993, pp349).

[4] The second example is a military situation:

The more chilling military example is the Malmedy incident in World War II, in which a German unit, pressed to move quickly, massacred its prisoners of war, many who were later found in the snow, frozen with their hands up. Wolfgast cites the testimony of a German soldier, according to which the order given by their commanders was that 'we should behave towards the enemy in such a way that we create amongst them panic and terror'. (Wolfgast, cited in Hoffmaster, 1994,p1162)

An example of such ambiguity was given in Case 7. The disciplinary body ruled that a doctor was wrong for not first consulting with a violent man before answering a police enquiry on the man's fitness to hold a firearms licence. The violent nature of the man was demonstrated when he was later convicted of shooting a man with a sawn off rifle as he was running away. The man is also alleged to have said he would use his rifle on the doctor. The disciplinary body was surely acting in an irresponsible manner by making rulings that put a doctor at risk of serious harm in such situations; a doctor whose actions were intended to ensure public safety.

Medical law has traditionally based its paradigm on medical ethics as Montgomery (2000) has stated:

> *Traditionally, medical lawyers have seen the relationship between ethics, law, and medicine as a hierarchy. The purest discipline is ethics, the substance of which should be reflected in the law, which in turn should use its coercive aspects to bring medicine into line. Medical law is thus a species of applied medical ethics. This paradigm implies that the law should lead the medical profession towards more ethical practice. (Montgomery, 2000, p399)*

Both legislation and common law claim to have their basis in medical ethics. While this intention is laudable, it would seem that the present law has strayed a long way from the ethics it claims to be based on.

> *A metaphysics of morals is therefore indispensably necessary, not merely for speculative reasons, in order to investigate the sources of the practical principles which are to be found 'a priori' in our reason, but also because morals themselves are liable to all sorts of corruption, as long as we are without that clue and supreme canon by which to estimate them correctly. For in order that an action should be morally good, it is not enough that it conform to the moral law, but it must also be done for the sake of the law, otherwise that conformity is only very contingent and uncertain; since a principle which is not moral, although it may now and then produce actions confirmable to the law, will also often produce actions which contradict it.*
>
> *(Kant, 1990, p37)*

Immanuel Kant continues to describe his fundamental principle of morality:

> *A good will is good not because of what it performs or effects, but by its aptness for the attainment of some proposed end, but simply by virtue of the volition, that is, it is good in itself...*

> *Even if it should happen that, owing to special disfavour of fortune... this should wholly lack the power to accomplish its purpose, if with its greatest efforts it should achieve nothing, and there should remain only good will, then like a jewel, it would still shine by its own light, as a thing which has whole value in itself.* *(Kant, 1990, p45)*

A process that was so devastating, that it appears to have caused post-traumatic stress disorder in some people, is of questionable morality. The majority of people, whom were later, found to have done nothing wrong.

LACK OF CREDIBILITY

Participant doctors believed they had been treated unjustly as did their colleagues – and they questioned why.

> *It appears that yet again, absolute nonsense has been perpetrated on an innocent citizen, carrying out a duty.* *(letter 118)*

Various explanations for the injustice were proposed by other doctors.

> *I find it very concerning that the Medical Council has achieved such a high state of political correctness that they are prepared to put an honest professional through this prolonged anguish in order to give satisfaction to what sounds like a very difficult patient. (letter 30)*

While doctors could accept that many people would be prepared to sacrifice doctors for their own ends, they found it hard to accept that doctors on the Disciplinary Tribunal would do so. They could only do so for devious reasons, political aims, bias or ignorance.

> *And furthermore I know of several situations where the MPDC seems to make judgements that are only understandable if one accepts that upholding the establishment, and/or satisfying the clamouring public are the aims of the exercise. Particularly is this so where there is a case like yours where a charge pits common sense or the GP's safety against rules dreamed up in an ivory tower of the demands of the public, particularly the public of the cities.* *(letter14)*

> *I suspect that those who sit on the committee are so far removed from the daily realities of medical practice, that they are totally unsuitable for the job of judging their peers.* *(letter 68)*

Doctors produced a variety of theories to explain a decision they believed to be wrong; it was political, those in authority were looking after their own ends, there was an "old boys club" that looked after its own and used them as scapegoats, or they were racist. The rural doctors had very little respect for these doctors. Interestingly doctors blamed the people in these positions not the system.

Such illogical and arbitrary decisions meant there was little hope of ever having a clear understanding of what one should do.

> *You have my sympathy; for falling foul of an Act, which contains so many contradictions and vague clauses open to interpretation...* *(Letter 5)*

As studies in organisations have shown, adversarial approaches stimulate adversarial reactions (Taylor, 1988). People resent criticism and do their best to refute it, blaming other factors such as the situation or the integrity of the people criticising them. If people do not accept criticism, they do not respond in an appropriate manner to them and in some cases, there is reactance; people do the opposite to that which is desired. This is what happened in the cases of this study.

Conclusion

Rural doctors faced many challenges, living in a community where most community members were also patients. The needs or wants of their patients sometimes conflicted with those of other patients and pleasing everyone was not possible. The code of practice laid down by the Medical Council conflicted with the code of practice expected of rural community members and doctors could not always comply with both. Maintaining the trust of community members was an essential but difficult task for doctors practising and living in a small community.

Medical disciplinary systems, following their origins in the laws of torts and doctors' codes of practice, focus on possible faults by health workers. This narrow focus in examining adverse events meant that the many other factors

causing or contributing to adverse events were not considered and the real reasons for events were often not discovered. These disciplinary systems also provided no solutions to prevent adverse events recurring in the future. The adversarial process and the confusing indeterminate norms imposed on health workers damaged the trust between patients and health workers. Health workers were left feeling insecure and in a dilemma, because they did not know how to avoid such events in future. They also felt that such a disciplinary system served to benefit only those on the disciplinary bodies who were perceived to have no interest in justice or improving health care.

CHAPTER 10: RE-EXAMINING COMPLAINTS AND QUALITY

This chapter continues the discussion of the previous chapter on the complex issues concerning complaints and examines further complaints and quality of health care. The first section examines the success of the disciplinary process in achieving its aims. The subsequent section then examines other approaches to error: quality control in organisations, human error models and error management, and studies on factors predisposing to errors such as, stress, fatigue, sleep deprivation, micro sleeps and sleep inertia.

The success of the disciplinary process in achieving its aims in the light of the case studies.

Investigating complaints is assumed to advance several socially desirable objectives. In the introduction, three of these objectives were selected as non-equivalent dependent variables, to form a pattern by which the results would be interpreted in the study. These non-equivalent dependent variable objectives were used to interpret the study findings, to determine whether the assumed outcomes of the disciplinary process did occur.

These aims were.

1. Investigation of complaints help to improve service quality through the Code of Rights.
2. People who complain should not be subject to any effects in their subsequent obtaining of health care services or any other type of adverse effects.
3. Investigation of complaint should act as deterrent to providers who do not conform to prescribed standards.

A pattern matching logic is one of the most desirable strategies for case study analysis, comparing a predicted result with empirical results (Yin, 1996, p106). Yin describes the logic of their use:

> *The dependent-variables pattern may be derived from one of the more patent quasi-experimental research designs, labelled 'nonequivalent, 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.*

The findings of the study are now examined in a pattern matching exercise, comparing them with the above stated aims of the disciplinary process.

AIM 1: TO HELP IMPROVE THE QUALITY OF HEALTH CARE SERVICES

The effects that investigating complaints had on health services can be examined from four perspectives: the complainant, the complainant's supporters, the community members and neighbouring community members.

THE COMPLAINANT AND SUPPORTERS' SUBSEQUENT HEALTH CARE

The majority of complainants experienced difficulties in obtaining health care services after the incident. The other doctors were not happy to have dealings with a person who had complained against a colleague, feeling that this person could also complain about them. Doctors tried to find excuses for not accepting the complainant. When complainants did find a doctor willing to accept them, the relationship between the complainant and the new doctor appeared artificial, strained and uncomfortable - not a satisfactory doctor patient relationship. Although during office hours they could attend another doctor, after hours they had no choice, they had to go to the doctor on duty. When the doctor on duty was the one they had complained about, this proved very upsetting for someone who was feeling ill and vulnerable. The complainant's immediate family and supporters seem to have had similar difficulties in accessing satisfactory health care.

THE EFFECTS ON THE COMMUNITIES' HEALTH CARE.

Retention and recruitment of doctors: Ten participant doctors left the rural area in the two years following the disciplinary hearing and all these doctor said that fear of complaints was the major reason for leaving. Several other doctors who were not interviewed also left, probably for the same reasons. Under-serviced local health services became shorter of workers and they struggled to attract replacement doctors. The local people had to attend other doctors in

neighbouring towns, doctors who were overworked and did not want an additional load of patients. The new doctors coming to the area would see the demoralised health workers and hear the story of their predecessor and they would not stay. There followed a period of uncertainty, when health services were frequently interrupted by changing doctors.

Impaired doctors: Some of the doctors in this study suffered from a post-traumatic stress like syndrome in the immediate four to six months following the disciplinary hearing. Doctors lost confidence in their diagnostic abilities, they were unable to make decisions in difficult situations and they avoided these situations. An impaired doctor in a remote rural area must be a matter of grave concern, as doctors frequently work alone, have important decisions to make, decisions that can affect people's lives. The health care of the whole area is put at risk in such a situation.

The health care of marginalised groups: The people who belonged to marginalised groups had a hard life, because they had a high incidence of health and social problems, and few resources allowing them to access health services. Often described as "no hopers" by the locals, they received little support from them. These low socio-economic people needed the services of a local doctor most; however, because complainants often came from their group, doctors became less sympathetic towards the group as a whole.

CHANGES IN PRACTISING MEDICINE

Defensive medicine: To avoid, or defend themselves against complaints, doctors adopted many defensive medical practice measures, practices that doctors recognised were not good medical care, but were necessary for their protection. They ordered more investigations, not because they were necessary but because ordering more investigations made them feel more secure. Doctors referred more cases to secondary care, not because they felt it was necessary but because it reduced their risk of complaints. Doctors paid more attention to their note keeping, not notes that improved patient care but records that would assist them

in defending a complaint, working slower and less efficiently as a result. Health workers changed the focus of their attention from what was necessary for the patient to what was necessary to defend themselves from complaints.

Doctors reduced their range of services, being reluctant to do any tasks if they saw a possible risk in doing them. This was important for health care, as doctors in remote rural areas often have to undertake tasks that general practitioners would not do in a city, because there is no one else to do them. People now had to travel to a larger town to have these services, go onto a waiting list, pay to go privately or not have the service at all. Doctors set up barriers to protect themselves when not on call so no one could contact them. Previously many doctors would see some of the needy and frail when not on call but this was now seen as too risky.

Because of the threat of complaints, doctors would not do anything to annoy patients even when it meant doing things they felt were wrong. They complied with patient requests, as they knew they were safer giving patients what they wanted. One doctor claimed he would not report another case of child abuse after the child's mother responded to his action by laying a complaint against an aspect of his treatment.

AIM 2: PEOPLE WHO COMPLAIN SHOULD NOT SUFFER ADVERSE EFFECTS.

Many community members were angry with the complainant because the local doctor was their doctor and a complaint against the doctor was a complaint against the community. The complainants were usually not seen as 'true' community members and there were many indications that the complainants were subjected to the community's ire. Many of the complainants left the area in the year following the complaint hearing and community pressure is likely to have played a part in their leaving. The people who had laid complaints and their supporters subsequently encountered considerable difficulties in accessing health care as has been described above.

While there was no evidence the complainants suffered adverse effects from the defendant doctor, there were nevertheless consequences of complaining.

AIM 3: ENSURING COMPLIANCE WITH PRESCRIBED STANDARDS OF CARE.

There was no indication that any doctor changed practice in a positive manner after the disciplinary hearing; rather standards of care deteriorated. The reason for the negative change was because the doctors did not work in ideal circumstances where they could choose to work in a manner that they wished to. They were overworked, and doctors knew they could improve some aspects of their work, but this would mean taking more time for it and this could only be done at the expense of some other equally important work. To be told by the tribunal that some aspects of their care was not ideal, without addressing working conditions was not helpful. They knew the deficiencies already, what they needed was support, not criticism.

The study thus found no evidence that the investigation of complaints improved the quality of health care or that they helped to ensure that health care workers complied with prescribed standards of care. There was also evidence that complainants did suffer adverse effects because of their action in lodging a complaint. On the contrary, the study found that the effects of the investigation were: The health care services to the community got worse, the trust and working relationship between the doctor and the community deteriorated, and doctors felt disempowered and unable to do the duties society expected of them, such as reporting child abuse. Doctors also lost respect for the disciplinary system. Neighbouring doctors and health professionals were affected in a similar manner to the defendant doctor.

In conclusion, the present study found that none of the stated aims of the disciplinary process were achieved, on the contrary, the converse occurred in all three aims. The assumption that investigation of complaints lead to improved health care was not supported by this study.

Quality control in organisations

To survive in a competitive environment, commercial organisations need to produce quality goods and to do so they rely on quality control systems; systems based on the considerable volume of academic research demonstrating the best ways of implementing quality control systems. Some of this knowledge on quality control is now being used in other disciplines like health care.

Employees perform most of the work in service organisations and how well the organisation performs depends on how well the employees do their work. In a competitive world, organisations need to ensure workers do their work well, and in a manner, that furthers the organisation's aims. The importance of workers' performance is reflected in the resources devoted to control systems in organisations, helping their workers to perform better.

Most workers endeavour to do their work well, but they are often not clear about what is wanted, how to do it or how well they are doing. They need systems to give them this information (Taylor, 1987). Feedback can be a valuable mechanism to direct the behaviour of workers so that the aims of the worker approximate those of the organisation (Ilgen, Fisher & Taylor, 1979). Feedback systems have been shown to assist individuals to become effective in high-levels of performance, to influence their beliefs about personal competence, their attitudes towards their work and towards others in the organisation (Ilgen, Fisher & Taylor, 1979).

A classic description of a feedback system is that of Miller, Galanter and Probrom (1960) who described a test-operate-test-exit (TOTE) sequence. The following briefly describes this system. The system starts when fed some information, this is compared to a standard and if a difference is found, the system signals some remedial operation. The cycle is repeated, until the test and the standard concur. The classic example of this TOTE feedback control system is a temperature regulation system.

Controlling human beings is not as simple as machines because many psychological factors complicate the system. To understand any complex system we need a basic model to start with, and in spite of being over simplistic, the cybernetic model has been found to be an appropriate basic model for human control systems (Taylor, 1987, p 193). Four basic requirements are needed to operate the control system; (1) standards of performance, (2) feedback on performance in relation to standards, (3) an understanding of how to improve performance and (4) regular reviews of the feedback system (Taylor, 1987).

Standards: The requirements of the organisation are translated into standards to allow workers to understand what is expected and to enable meaningful assessments of workers' performance.

Feedback: Data concerning the performance effectiveness of individuals is fed back to workers but presented in the least threatening manner as individuals have a tendency to avoid assessing discrepancies between performance and standards especially when there are threats to self-esteem. Workers find feedback less threatening when the information is presented in a confidential or impersonal manner, e.g. the number of customers served, or their output. Presented in this manner, workers will not feel that they are continually being watched by others and there is less chance of reactance. (Taylor, 1987, p 199).

Knowing how one can improve: Workers need to know how they can improve their performance. Often they require assistance to identify the barriers to better performance and help to overcome the barriers. Taylor describes how this can be done:

> *Administrators should encourage managers to hold staff meetings where the primary goal is improved unit performance. Individuals should be asked to discuss performance difficulties and the relative utility of various performance strategies under different situational conditions. High performing staff members might be encouraged to allocate a portion of their work time to assisting other staff members on an individual basis, resolving performance-standard discrepancies. Emphasis should be placed upon helping employees made attributions for the causes of unfavourable feedback, e.g., whether discrepancies are caused by using inappropriate strategies, not devoting enough effort to particular tasks, a lack of ability in certain areas, etc. Performance attributions are more likely to be accurate when feedback sources are careful to give consistent feedback over time and*

> *when feedback is made specific enough to identify what the source perceives is the major course of performance.*
> *(Taylor, 1987, p 199)*

Regular reviews of the feedback system:

Finally, quality control systems need monitoring themselves to ensure success. Monitoring of workers' beliefs is needed: (1) their attitudes to the systems, (2) their explanations for performance differences and (3) their expectancies of improved performance.

PSYCHOLOGICAL RESPONSE TO FEEDBACK

Feedback of information induces complex responses in an individual. The nature and manner in which the feedback is delivered can produce undesirable as well as desired effects. Inappropriately delivered feedback can discourage workers, cause resentment or a sense of injustice. The resultant behaviour may be the reverse of what is desired. It is important therefore, that the feedback is delivered in a manner that does not have detrimental affect for the organisation. An understanding of the psychological effects of feedback are therefore important when designing and implementing feedback systems.

Affective responses: Individuals accept favourable feedback without question but unfavourable feedback will be examined and evaluated, especially when attributed to personal causes affecting esteem rather than non-personal causes such as a difficult task.

Cognitive responses: Expectancies, or an individual's beliefs in their ability to meet standards, are critical in the way they respond to feedback. Their understanding of the reasons for poor performance, determine these expectancies. They will have high expectancies when they believe the factors for poor performance are easily changeable (unstable), such as trying a bit harder or using the right technique. They will have low expectancies when factors are difficult to change (stable), such as one's innate ability (Carver & Scheier, 1981; Weiner, Nierenberg & Goldstein, 1976, cited in Taylor, 1987). When individuals see the standards being too difficult to achieve they become discouraged, less motivated and may leave their job.

Even favourable feedback may have dysfunctional effects on performance if it causes individuals to believe that they have lost the freedom to perform the job as they wish and are being overly controlled by others in the work environment. *Reactance* is the name for this phenomenon in psychological literature (Brehm, 1966, Cited in Taylor, 1987). As part of reactance individuals attempt to restore lost freedom. Such attempts may include performing in the same way despite negative feedback, behaving exactly opposite to the manner expected, or encouraging other employees to violate organisational standards (Taylor, 1987).

Individuals may also react against the feedback organisation.

> *When systems are viewed as unfair because standards are applied inconsistently, or they were never communicated, etc., employees may retaliate in a variety of ways, sometimes falsifying data, sometimes withholding information, and sometimes by evaluating organisational supervisors poorly on attitude surveys, etc. (Dornbush &Scott, 1975: DeNisi, Randolph & Blencoe, 1980, cited in Taylor, 1987).*

> *Like the tail wagging the dog, controls can wag the organisation. Two potential problems that work against the long-term interests of the organisation are (1) efforts by employees to look good on the control criteria, regardless of the actual impact of organisational effectiveness; and (2) manipulation of control data.*
>
> *(Robins and Mukerji, 1994, p 477).*

Human error models and error management

There are two basic ways of viewing human errors: the personal approach and the systems approach. Each has a model of error causation and each has an approach to managing errors (Reason, 2000).

The 'bad person' approach is the traditional approach to errors – attributing all errors to acts such as forgetfulness, inattention, poor motivation, carelessness, negligence and recklessness (Reason, 2000). The remedy for these aberrant mental processes is to reduce the unwanted variability in human behaviour.

> *These methods include poster campaigns that appeal to people's sense of fear, writing another procedure (or adding to existing ones), disciplinary measures, threat of litigation, retraining, naming, blaming, and shaming.*

> ***Followers of this approach tend to treat errors as moral issues, assuming that; bad things happen to bad people - what psychologists have called the just world hypothesis.***
>
> *(Reason, 2000, p1).*

The systems approach accepts that humans are fallible, that even in the best organisations errors will occur and are to be expected. Since we cannot change our basic human nature, which is to make errors, to prevent errors we have to develop safe systems. Situations most prone to accidents are concentrated on, with strategies developed to prevent these accidents. The factors associated with errors are examined and altered, e.g. a 'black spot' in a highway may need better lighting or straightening of the road to allow better visibility. When an adverse event occurs therefore, the important issue is not who blundered but why the safety system defences failed.

In health care the personal approach remains the dominant approach and has its attractions because blaming an individual is emotionally more satisfying than blaming a system. People are seen as free agents and if something goes wrong the person who administered the treatment must be the one responsible. It is convenient for managers and funders to have someone to blame to relieve them of any responsibility. **The person approach nevertheless has limitations if the object is to reduce errors.** If human error is inevitable, a personal approach may be satisfying in some respects but it does not have the ability to prevent most human errors.

Although a proportion of human errors are due to carelessness, the vast majority are not. A study in aviation maintenance found that 90 per cent of quality lapses were judged as blameless (Marx, 1997, cited in Reason, 2000, p 768). By focusing on the person two errors are made; firstly errors are not the sole domain of the careless as the best people sometimes make the worst errors, and secondly errors are not random. **The same set of circumstances tends to be associated with the same error irrespective of the people involved.**

Hazardous circumstances need to be identified if they are to be guarded against and they become evident over time as more and more accidents occur. Accidents are wasteful and in healthcare often have a human toll but, for every accident in a hazardous situation, there are often several 'near misses'. Thus by examining near misses it is often possible to establish strategies and safeguards to prevent accidents before they happen. Hence, the reporting of near misses, mishaps, incidents and minor accidents plays an important role in detection of hazardous areas before accidents happen. Trust is necessary for a reporting culture and this in turn requires a just culture - knowing where the line should be drawn between blameless and blameworthy actions.

Defence systems against errors

The systems used to guard against accidents include technical, human or operational protocols. Technical measures may include alarms, barriers and automatic shutdowns. Human barriers may be formed, such as requiring more than one person to check a dangerous activity. Protocols may ensure that the safest methods are developed for a hazardous activity. A hazardous activity will have more than one defence system and may have several defence systems. No defence system is complete, there are usually gaps in it. The analogy has been made to Swiss cheese: there are holes in the barrier (Reason, 2000). The holes are not constant; they are opening and closing, and moving. It is only when all the holes are in alignment, in all the defences, that an accident can happen.

There are two types of failures or holes in the barriers to errors: active failures, and latent conditions. Both forms of failure are present when accidents happen. *Active failures* are human errors such as slips, lapses, fumbles, mistakes and procedural violations. Active failures have a direct and usually short-lived effect on the defences. Proponents of the personal approach look no further than the human error and fail to see the latent defects in the system that also contributed to the error.

Latent conditions are the underlying conditions within the system. These arise from decisions made by designers, organisers, procedure writers and top-level

management. These erroneous decisions may be mistakes but need not be, but they have the potential to introduce latent weaknesses into the system.
Latent conditions are of two kinds: the first kind are error provoking conditions such as time pressure, understaffing, inadequate equipment, fatigue or inexperience; the second kind are weaknesses in the defences against accidents such as untrustworthy alarms, unworkable protocols and construction deficiencies. Both these conditions may lie dormant for a long time before they combine with an active condition and an accident occurs. Latent conditions should be discernible. An active risk management should be able to identify these latent conditions, unlike active failures, which are mostly inevitable.

Error management

Studies on error management have shown that one can never eliminate human errors. Error management has two components, firstly prevention and secondly, damage control when accidents happen. Programmes to manage accidents are aimed at several targets; the person, the team, the task, the workplace and the institution as a whole (Reason, 1997).

Safety studies have examined organisations that have been successful in achieving a good safety record. These organisations include aircraft carriers, air traffic controllers and nuclear power plants. Traditional management systems attribute human unreliability to unwanted variability and strive to eliminate it. In organisations requiring high levels of reliability, such as aircraft carriers, human unreliability is recognised and in addition to error control, error recognition and response is taught as one of the safeguards of the system. Reliability has been described as a "dynamic non event" (Weick, 1987, cited in Reason, 2000). It is dynamic because timely human adjustments contained the error. It is a non-event because successful outcomes seldom attract attention. High reliability organisations have the ability to function in two modes. In normal times they function in the usual hierarchical system where

Figure 2. Swiss cheese model of multiple safe systems

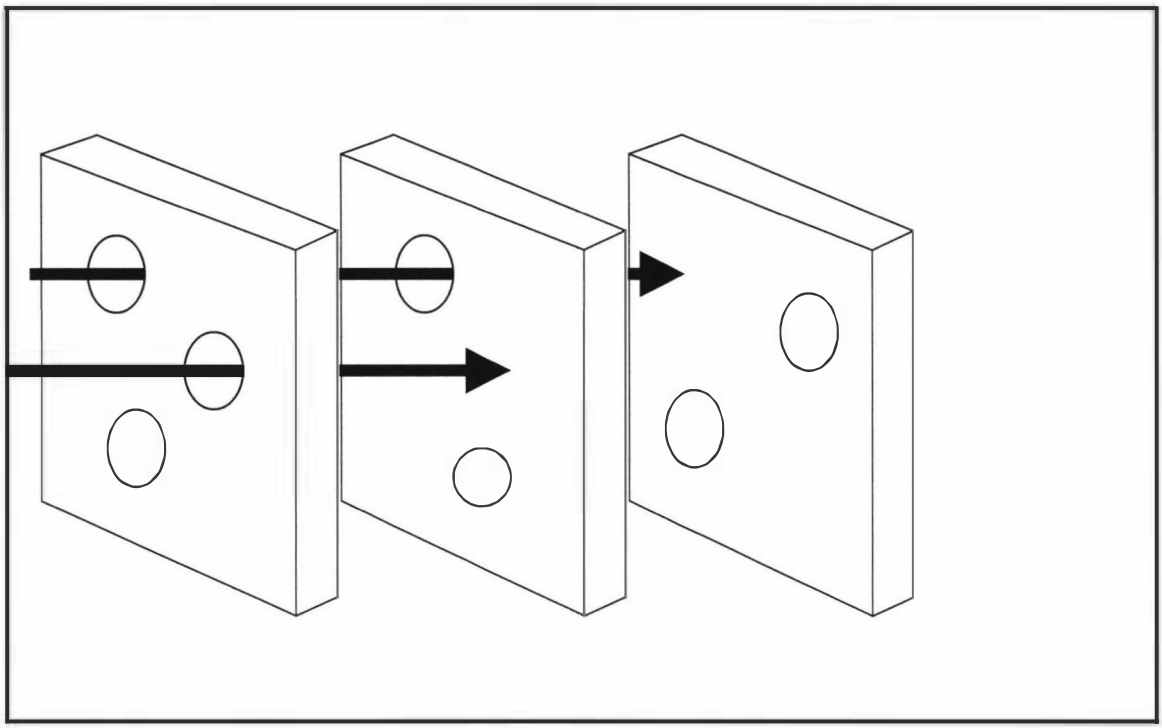

Figure 2 demonstrates the "Swiss cheese" concept of multiple barriers to errors. No single defence system against errors is infallible and deficiencies (or holes) occur. The deficiencies or holes in defence systems are not static, but may open, close or move. With multiple defence systems it is only in the very unlikely event of three holes lining up at once will the defences fail.

everyone does his or her job as expected. However, in times of threat or impending accident, the person on the scene becomes the expert and using their initiative does what appears to be the best remedial action. High reliability organisations expect to have failures and train their staff to cope with them. Staff are taught to have a wary eye to recognise pending failures before they happen. Accident scenarios are rehearsed and staff becomes prepared to deal with accidents. Staff search hard for unusual and unexpected forms of possible accidents so they can train to deal with them. The organisation as a whole develops a culture of a consciousness of accidents and how best they may be contained.

The impact of factors such as: sleep loss, sleep inertia, micro sleeps, fatigue, and stress on errors.

Over the last few decades, a considerable body of evidence has been accumulated on the factors that make errors or slip ups more likely (Kreuger, 1989). Both sleep loss and interrupted sleep are well established factors in errors (Bohnen, & Gaillard, 1994; Dinges, Orne, & Carota Orne, 1985; Johnson, 1982). Prolonged periods of work without rest have the same effects in decreasing concentration (Ellingstad, & Heimstra, 1970; Grandjean, 1968; England, & Kreueger, 1985). The more difficult or complex a task is, the more likely people are to make errors when affected with fatigue or sleep loss (Craig, 1997; Mathews, & Holley, 1993; Bohnen, & Gaillard, 1994). For the first three minutes after being woken from deep sleep, that is level three or four sleep, people can be confused and disorientated and may take up to thirty minutes to perform at their usual level. These factors are summative, that is when two or more factors occur together, such as when sleep deprivation is combined with stress, the risks are worse than when only one factor is operative (Ellingstad, & Heimstra, 1970; Angus, & Heslegrave, 1985; Spurgeon, Harrington, Cooper, 1997).

The conditions that many rural doctors worked in were far worse and the problem solving tasks they faced were more difficult than those of the experiments, yet no consideration was taken of these factors in the cases of the present study. None of the people involved in the disciplinary process were apparently aware of these

factors. This suggests that there is a need for people to have training to investigate adverse events in health care, as occurs in aviation.

Conclusion

The present, adversarial and moralistic form of investigating complaints was not a good method of ensuring quality of services, in the light of the present study where the quality of health services deteriorated following investigations. These negative changes could be predicted from studies on quality control in organisations where there is ample evidence to suggest that: inappropriate standards produce reactance in health workers; a failure to find solutions reduces the expectancies of workers resulting in them adopting negative, defensive and inefficient practices; and excessive concern about people initiating investigations could affect doctors' issuing of certificates.

Studies on errors prevention demonstrate that eliminating human errors is not possible and the best approach is to recognise their inevitability and to concentrate on developing systems to reduce them. The study of errors reveals that they often occur in similar situations and for every error there are usually several near misses, thus if these situations can be identified, and safety checks developed to guard against their occurrence, errors can be minimised. When errors do occur, workers are trained to recognise them early and to take measures to limit the damage. Error control requires openness and honesty; it cannot operate in an environment where a moralistic disciplinary system is in place, as people would be afraid to talk about errors for fear of discipline. Studies in aviation and other organisations have demonstrated some of the human factors determining the incidence of errors – they show the incidence increases dramatically in situations where there is sleep-loss, fatigue, sleep inertia and stress.

Investigating errors is not a simple matter; investigators need to have expertise in the subject. There is a need to train people to enable them to investigate adverse events competently in health care, as occurs in aviation.

CHAPTER 11: REVISIONS OF COMPLAINT PROCEDURES

Investigating complaints did not generate improvements in health care services according to the findings of the present study, however this does not mean that complaints should not be taken seriously. No one could doubt the need for a complaints system after the exposure of Dr Shipman in the United Kingdom and Dr Fahey in New Zealand (Pringle, 2000). These revelations shocked both doctors and the public. People need to know that they can trust health professionals and health systems, and when they have doubts, there are systems in place to heed of their concerns and act on them, so hopefully maintaining the quality of health care systems.

The question is how can complaints be used in a way that benefits health care rather than damaging it. Part of the answer lies in recognising that complaints cover a wide variety of events and each of these areas of complaints needs a different approach. Some form of classification of the events evoking complaints is needed before appropriate ways of dealing with them can be determined. Cunnigham (1999) suggested classifying events into: wrongdoing, errors and mishaps. This classification is helpful but too simplistic and it focuses on the doctor, ignoring the other factors responsible for errors. The classification does not make it clear where ethical issues or professional competence fit in the classification.

The first distinction to be made in complaints, is to distinguish those events involving intentional wrongdoing or reckless behaviour, because these events are under the control of individuals and should thus, be addressed by disciplinary processes. All the other events, that is, those that were neither intentional nor reckless, are better managed by some other system of quality control, because disciplinary processes tend to have detrimental effects on quality in these situations.

The problems of distinguishing between these two categories has been discussed and deliberated at length by lawyers and it is unlikely that anyone could improve on their expertise on the subject. A standard textbook on criminal law will discuss in detail the subtleties of this distinction.

> *Although the view has been expressed that it is impossible to ascribe any particular meaning to the term 'mens rea', concepts such as those of intention, recklessness and knowledge are commonly used as the basis for criminal liability and in some respects may be said to be fundamental to it. Generally, subject to both qualification and exception, a person is not to be made criminally liable for serious crime unless he intends to cause, or foreseen that he will probably cause, or at the lowest, that he may cause, the elements which constitute the crime in question. (Halsbury's Laws of England, 4th Ed, para 10., cited in Garrow & Cadwell)*

A small but important number of complaints will result from wrongful or reckless behaviour and will warrant misconduct focused or blame based disciplinary approaches. Other adverse events that are not intentional or reckless will be better addressed through alternative solutions.

Ethical issues

Ethical issues need special consideration because they do not usually involve wilful wrongdoing nor do they fit comfortably under the heading of quality control. The handling of ethical issues by the disciplinary process produced much controversy and anger in the present study, as in case seven, the case where the police asked the doctor about a man's fitness to possess a firearm. If the purpose of the disciplinary process was to direct doctors to adopt certain ethical views, the outcome was the opposite – they disagreed with and resisted these imposed views. They argued passionately against them. Instead of these ethical issues becoming more open, doctors became guarded and more secretive about them. As the Jewish Dutch philosopher Baruch Spinoza maintained in *Ethics,* (1675) (following his family's experience in the Spanish Inquisition), "minds are not conquered by force, but by love and high mindedness." Nor were the minds of doctors conquered by discipline – more subtle approaches are needed if one wants to conquer minds.

There needs to be a better way of handling ethical issues with more understanding of the issues as seen by health workers and communities in these situations. It is naïve to assume that a small number of people who were largely ignorant of the context and complex social issues in rural areas could go in and tell doctors and community people what was right to do. Ethical problems often deal with conflicting ethical norms or rights and decisions on ethical issues reflect the values of those on the disciplinary body. People's judgements are matters of opinion and opinions depend on a number of factors such as that individual's sex, age, race or culture. There is seldom unanimity on these questions and an individual is not necessarily a bad person if they did not come to the same opinion as others.

It is important that lay people discuss medical ethical problems together with health workers to try to reach consensus in ethical questions, which are seldom black and white issues and on which there is frequently intractable disagreement on the issues. Decisions are made on the weight of priorities favouring one avenue rather than the alternative but changing the context slightly can shift the balance to favour another avenue. To make judgements, when neither the context is understood nor the individuals concerned are known, is simplistic and is inviting controversy. There needs to be more education and discussion to gain an understanding of ethical issues.

Competence

Most complaints hinged on professional competence; the complainant alleged that, had the doctor done something else, the adverse event would never have happened. The allegations of incompetence by complainants and their lawyers were responsible for so much damage to doctors, even to doctors who were later found to be very competent. The question of professional competence as grounds for a complaint needs to be reviewed, as the public needs to know that health professionals are competent and professionals need to be protected against false allegations.

The traditional way of becoming a health professional, is by undergoing training and passing a proficiency examination, plus a stipulated period of experience. On completion of these requirements, they could then be registered as a health professional and unless there was some challenge to their abilities, could continue to practice until they died. Over the past decade, this premise has changed and most professionals are required to undergo some form of continuing education, which is determined by the professional body. What is usually required is attendance at a certain number of lectures and courses and sometimes an audit. There is considerable discretion as to which sort of lectures a professional may attend; indeed, they may not be relevant to professional competence, or the attending professional could sleep through the lecture. The effectiveness of the continuing education in not monitored and the system is not objective.

The present systems are inadequate to demonstrate professional competence to sceptics. Closed forms of self-regulation are open to the criticism that professionals are looking to their own self-interest rather than the interests of patients. In a time when knowledge is increasing at an exponential rate, practitioners are having to change practices at an ever increasing rate because of new discoveries or evidence. Experience, which was once considered very important for practitioners, is now less important, because scientific evidence is playing an ever increasing part in health care. The problem for health workers is keeping abreast of the expanding fields of knowledge and to enable them to do so they have to confine themselves to part of the large mass of knowledge concerning health care - they become partialists rather than generalists. Concentration on a part of healthcare enables practitioners to become expert in that field but at the price of being less expert and less aware of developments in other fields. Competence in groups of professionals, generalists and partialists has traditionally been determined by each professional body. Professionals who work in isolated or specialised areas of health care need to maintain a basic knowledge of the changes in the rest of health care and they need the assistance of other professionals to help them with this. Having other professionals and lay

people on the bodies that govern certification processes will help ensure that they do not become too narrow in perspective.

There have been two major public enquiries into aspects of health care in New Zealand, both concerning cervical screening. Both of these enquiries were in part due to professionals not keeping abreast of changing health care practices and ethics. All professionals need periodic re-testing to confirm their competence.

THE BASIC REQUIREMENTS OF A CREDITABLE CERTIFICATION SYSTEM

Continuing education of professionals to refresh and update their knowledge is in the interest of both patients and professionals. Education however must be combined with an assessment of professional competence that is creditable, even to suspicious people. To be creditable, competency assessments must be: open, independent, objective, and assessments must be made at regular intervals.

An Open system: To be creditable certification systems must be open, so others can see the process, how it works and what the standards are and who successfully completed it.

Involving others: While health professionals probably have the best understanding of what they need to know, they need to be guided by other perspectives. Patients or consumers have a different perspective to health care; Carol *et al* (1998) found factors such as listening, access, an ability to sort out problems and seeing the same doctor were important to patients. Funders and administrators place more emphasis on cost constraints (Lawson *et al*, 1996). It would be wise to involve other professionals and suitable lay people in the management of the system because these independent people would add assurance to the integrity of the system.

Objectivity: Schemes for the assessment of competence of professionals should be a true test of competence and not simply attendance at courses. Attendance at conferences or lectures may well benefit doctors but does not demonstrate or enhance competence. Some form of examination is far more reliable. One form of such examination is *'Check'* run by the Royal Australian College of General Practitioners, which assess knowledge by means of a multiple-choice test. A

similar form of test could be developed, that together with some practical assessment could set a minimum standard for health workers. Any person attending a doctor or other health professional could be assured of a basic standard, if that person had passed a competency test.

Regular re- assessment: Competent health professionals may not always remain competent. Decline in competence may result from failure to update, or be the result of health related developments. Older people may lose their faculties but Alzheimer's disease may present in people as young as 30 years. Re-certification at regular intervals would detect some people who for medical or other reasons might be falling below acceptable standards.

Part of the objective of competency testing would be to protect professionals who had passed tests their of competency from accusations of incompetence, when unintentional adverse events occurred. These competence assurance systems should not be structured in a way that health professionals see them as a threat because their aim is to set the minimum requirements of competence that any competent professional would easily satisfy. There are probably many health professionals, however, who would resist these types of certification and so it would be inappropriate to enforce them in any confrontational manner. The "carrot" of almost certain protection from claims of incompetence, would, in time, encourage many health workers to adopt certification tests.

Quality Assessment of Health Services

Quality improvement should be a priority when investigating complaints, but this study has shown that investigations can harm health services. This harm was caused by damaging accusations from the complainant, their supporters, and their lawyer, and from the threat of discipline that hung over defendant doctors for about a year. This damage was particularly undesirable in those cases where the doctor was eventually found to have acted correctly. Damage could be minimised if suspicion and accusations on the professional could be dealt with as quickly as possible.

To minimise the damage to health care systems, the question of professional competence needs to be settled as soon as possible. Competency could be rapidly assured if all health professionals who had passed their competency exams were on a register available to the complaints investigating officer. Intentional or reckless behaviour would be relatively easy to establish in most cases and health workers could be freed of blame. The doctor or health worker, having been freed from suspicion, could co-operate with others to ascertain if something did go wrong and how to remedy it.

Suspicion, hopefully, having being removed from the health professional, the investigation could concentrate on finding out: (1) if the event was something that should not have happened, and (2) if it was unacceptable, why did it happen? The investigation would follow the manner advocated by Stanhope et al (1997), examining what was well done and what was not well done. Experienced health professionals would assist in assessing the situation. The aim would be to determine how far the incident was due to poor performance, lack of knowledge or a simple slip up. Often, there may be a combination of these factors. Poor performance does not always indicate blame, as there are other causes such as lack of sleep or stress or an inability to attend further education. Thus, the investigation should aim to discover the root cause of adverse events and recommend solutions: a doctor may need more assistance with the workload, or opportunities to attend education sessions, or simply need a holiday. Stanhope et al (1997) describe an excellent "Checklist of background factors" (Appendix E) that could be modified to assist assessment in all complaints.

A Better System?

Complaints have a place in the prevention of future adverse events but they need to be integrated into a wider system of quality control. Adverse events play an important part in quality control but complaints only represent the tip of the iceberg because many more adverse events occur that are either not complained about or not recognised by patients. There are also several near misses for every adverse event and these near misses need to be studied with actual adverse events

in order to develop systems to avoid them recurring. The co-operation of practitioners is essential in the reporting of unrecognised adverse events and near misses, and practitioners will only report adverse events if they can be sure that they will not be disciplined.

Practitioners are now being encouraged to examine these adverse events and near misses and develop solutions to them.[5] This system, while valuable, has limitations, as many practitioners are too busy to learn how to implement such a system or too busy to give the time to work out solutions to the events and implement them. Solutions are often not under the control of the doctor – also implicated are the needs for better continuing education or better health planning. A central reporting system used to analyse and to monitor adverse events or near misses could reveal much information on adverse events. Such information would tell us the situations where adverse events are more frequent: in day time or late at night, by newly trained doctors or older doctors, in high socio-economic areas or low socio-economic areas, when doctors have been on call for a long time or just a short while or what parts of the country have the highest or lowest rates of adverse events. Much more information could thus be collected and analysed, allowing more rational planning of health care systems.

Some adverse events occur infrequently and are seen by only a few practitioners; these rare events are not generally recognised. One such important event occurred in two cases in the present study, when heart disease presented as upper abdominal discomfort and was not recognised by the practitioner. Such rare cases would be instructive to most general practitioners and could be included in their continuing medical education.

When teaching is based on adverse events, it must be recognised that there are limits in what can be learnt and so it is necessary to prioritise teaching taking into consideration the severity of events and their frequency. A technique used in

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[5] See *Significant Event Management A General Practice Guide,* Wellington: The Royal New Zealand College of General Practitioners.

industry is to score events on a scale of one to five on their severity, and also on their frequency. These two scores are multiplied and a weighting obtained. Thus, an infrequent event of little importance would have a score of one on severity and frequency, resulting on a weighting of one. A very serious event that was also frequent would have scores of five on both accounts and a weighting of twenty-five, which would indicate its importance in education.

The distress and suffering caused by adverse events could be reduced by the rational use of complaints together with practitioner reporting of adverse events and near misses. With appropriate reporting and analysis of these events, strategies could be developed to prevent them - lessons from them could be incorporated into continuing education and also into health planning. Such a system would have the potential to maximise quality control.

A further advantage of this system would be a reduction in wastage. Most participant doctors reported they practised some form of defensive medicine, and this is a waste of precious resources. The extent of defensive medicine is likely to be very wide in the presence of an adversarial and punitive complaints system. A less adversarial complaints system could reduce the practice of defensive medicine and free up further resources for a resource strained health care system.

> *Cooperative discernment of why things may have gone wrong, and how they can be improved, is no bad basis for learning from complaints.*
> *(Bullough and Etchells, 1999)*

Attending to the needs of complainants

Quality care systems should attend to the needs of complainants, who having suffered because of an adverse event, were unhappy and dissatisfied. They felt their loss was something that should not have happened, they wanted answers. They wanted their concerns to be taken seriously, and they wanted someone to look into it to ensure that the same event would not happen to anyone else. They had lost faith in the local health system and in health professionals and they needed to restore some faith if they were to continue to living in that area.

The adversarial disciplinary system encouraged conflict between complainants and other health professionals or community members. After the disciplinary hearing, complainants were abandoned and complainants often felt let down especially when the findings were not in their favour. They were left worse off for having complained. Some complainants were suffering from acute grief reaction and may not have been entirely logical, wanting revenge rather than facts, but they still needed someone to examine the case for them. Some grief counselling may have been helpful in some cases and helping in a constructive investigation, may also have helped the complainant's resolving of the event. Perhaps much of the anger of the complainant could be diverted into an investigation of the complaint. A more open system as this would be more likely to satisfy most people who feel they may have had sub-standard care.

MONITORING

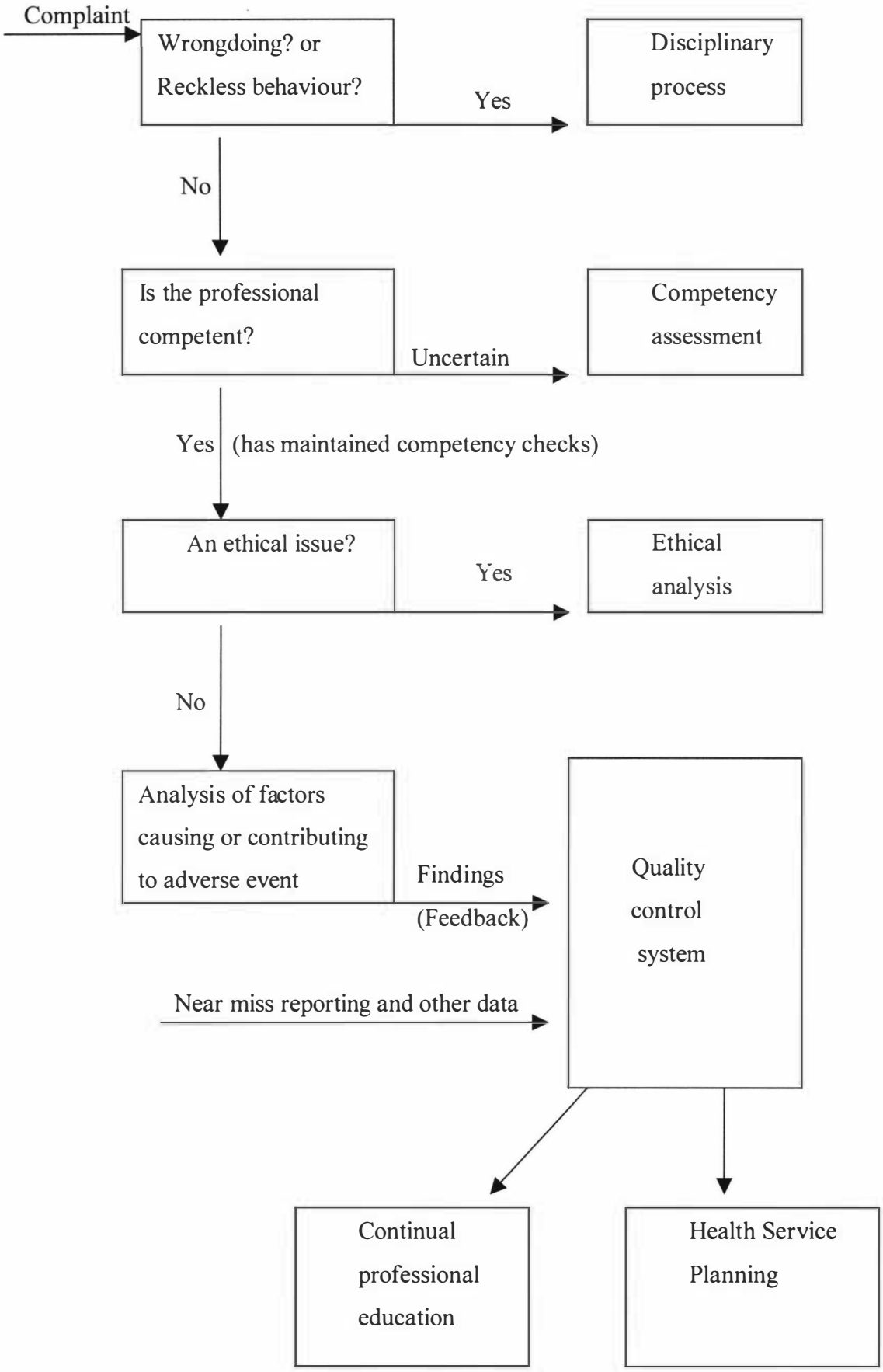
Interventions like the quality control one described above will hopefully improve health services, but this is only a plausible assumption and, as many studies have shown, it cannot be relied on. A form of audit is essential to confirm that the aims of the process are being achieved. It would be irresponsible to implement a system without ensuring that it is not doing harm.

Conclusion

Complaints systems should serve to reassure people who have concerns about the quality of health care services, providing an avenue where their concerns can be investigated. Complaint systems should also utilise their findings to find ways of improving services; but to minimise possible harm to health services, the damaging phase of suspicion on health workers, ascertaining whether there was wrongdoing or incompetence, should be completed as soon as possible. Once the health professional had been freed of blame, they could co-operate in the investigation contributing valuable information that they would not dare to give under an adversarial system. The manner of investigation would be based on that

described by Stanhope et al (1997), examining all aspects of the adverse event, including what was well done and what was not so well done. The examination of adverse events would involve experts similar to air accident investigators. The findings of investigations would form part of quality assurance systems and would be combined with other data such as adverse event reporting. The data on adverse events could be used to facilitate further training of health professionals and health planning. Figure 3 summarises this process.

Figure 3: A schematic representation of a complaints handling system



CHAPTER 12: CONCLUSIONS AND RECOMMENDATIONS

The assumption that investigating complaints improves health care was not supported by the present study, a study that rather found health services deteriorated after an investigation. Investigations were followed by doctors leaving their practice or adopting defensive medical practices that were less efficient. Other health workers also adopted the same inefficient practices because of their fear of having to go through the same disciplinary process. Of the cases included in the study, three doctors left their practice immediately after the disciplinary hearing; one moved to a larger town, one moved to Australia and the third gave up general practice. These were well-established doctors, who had been in their practices for between six and twenty years. Four other defendant doctors and three of the participant neighbouring doctors left in the two years following the investigation. Concern about complaints was cited as a major reason for leaving by all of these doctors. Other neighbouring doctors who were not interviewed also left, presumably for the same reasons. There followed a period when recruitment of doctors to that rural area was difficult and shortages of doctors usually occurred.

The defensive practices adopted by health workers included: setting up barriers to prevent patients accessing them when not on call, a reluctance to accept responsibility resulting in more referrals to secondary care or reduced services, ordering more tests - not because they were needed but because it made doctors feel more secure, working slower and writing copious notes - not for the patient's sake but for their own defence in the event of a complaint. These defensive measures resulted in health workers doing less work and the health system becoming less efficient. Other health workers, observing the ordeal of a colleague, also felt threatened by complaints and adopted similar defensive practices. Investigating one doctor affected many other health workers: in the same town, in neighbouring towns, and sometimes doctors across the country.

The investigations of complaints had other effects on the quality of health care. So traumatic was the experience of the investigation to some doctors that they

exhibited a post-traumatic stress-like syndrome, experiencing acute anxiety when faced with a similar situation, and losing the confidence to make simple clinical decisions such as diagnosing chest pain. Doctors tried to cope by avoiding these situations, referring these patients to secondary care, and taking extreme measures to avoid upsetting or confronting patients. One participant doctor said he would never report another case of child abuse again and another doctor said she would sign any form a complainant wanted rather than annoy him, so threatening she found him.

A dilemma health professionals faced was, not knowing how to avoid such complaints in future. No solutions to the problems faced in a difficult practice were offered; the disciplinary process produced only criticism and it seemed to many doctors that whatever they did they could be found at fault. They felt they were in a hopeless situation and many doctors saw the disciplinary system as an avenue designed to allow any patient to "have a go at them". Doctors referred to pamphlets issued by The Health and Disability Office that encouraged patients to complain and doctors frequently quoted a previous Health and Disability Commissioner's statement that patients had rights and doctors had duties. Doctors and others workers were resentful of such attitudes and they only tolerated the conditions that they worked in because of their good relationships with patients and goodwill towards the community. However, the goodwill towards the community was affected, and doctors became more selfish in their attitude to work: their trust in a just society was undermined, they lost respect for many people in positions of authority, and they lost faith in the justice system.

In a small rural town, community members considered a complaint was their business and people entered the controversy, debating the issues. Both sides were well known to community members but some complainants were known for anti social activities, such as aggressive behaviour or confrontation with the police. These complainants did not receive much support from the community, on the contrary, they appear to have been subjected to community pressure or even anger. Having made the complaint, the complainant and family had to seek health care elsewhere, and finding alternative health care could be difficult and often the

substitute service was unsatisfactory. Most complainants in the study seemed to have moved away from the area a few years after the disciplinary hearing and their move seemed to be due to the difficulties they faced in the community following their complaint. Most complainants seemed worse off for having complained.

The process of the disciplinary investigation was more damaging than the outcome in the cases of this study. It was the threat of the investigation hanging over the doctor for a year or more that did the damage; damage to doctors who were often found to have made no errors. The most threatening part of the inquiry for doctors was challenging their competence. Professional competence is not something that should be assessed only when someone makes a complaint; if doctors had regular checks on their competence, there would be little need to challenge their competence when someone laid a complaint. However, for assessments of competence to be creditable, they need to be open and objective, probably including a few people from other professional and lay people in their governance. If creditable professional competency checks were implemented, complaints following adverse events could be approached in a less blaming manner and the damage to health systems avoided.

Validity and limitations of the study

The aims of the present study were twofold: firstly to examine the effects that investigations of formal complaints have on the quality of health care, and secondly to explore the social impact of complaints in a rural community. The first aim looks for a cause and effect relationship between investigating complaints and the consequences for quality of health care services, and the second aim explores the wider social implications. The effects of complaints is not a subject that lends itself to any form of experimental or quasi-experimental method, therefore a case study was used, the best alternative when a quasi-experimental method cannot be used. A case study is also a preferred method for exploratory studies. The use of multiple cases adds to the validity of a case study;

this study used sixteen cases, which helped to enhance the robustness of the study.

Using remote rural areas for a setting had the advantage of making the effects of any intervention such as the investigation of a complaint much easier to detect because of the simplicity of the local health service. Health care in big centres is very complex, with large numbers of workers and many variables, and in these large complex health systems, the investigation of one complaint is a relatively small event which is not likely to have a measurable effect on the total health care system. In a micro health system, as in a small rural town, a complaint affected all health workers and the effects on health care were far more discernable.

The selection of cases for the study was determined by participants volunteering, and those who volunteered may not have been representative of complaints in general. There is no way of knowing about those who did not volunteer but it appears that, out of those doctors at the rural health conference, most who had had a complaint did volunteer. There were sixteen complaints in this study and they came from a wide area of the South Island of New Zealand. The professionals in each area were aware of the complaints investigated in their area and of a few doctors not at the conference and who had not volunteered but the local doctors' accounts of these complaints did not suggest that they were very different from the cases of the study. Thus, the cases of the present study were probably representative of most complaints.

The in-depth interviews of the study were limited to health professionals and this important source of data was restricted to their perspective. The views of complainants, their supporter, and independent community members would have given an alternative interpretation of events. Nevertheless a wide range of health professionals were interviewed, including nurses, managers, neighbouring doctors, and ambulance officers. Some of the health workers such as nurses were only part time workers – the rest of the time they were mothers, doing all the things that mothers do in a rural community. Others had grown up in the area and

had their family there. These health workers were thus part of the rural community and they generally knew what the community thought. The researcher was also able to speak to community members on unrelated health matters and thereby sound their attitudes to health matters. Observing patients in waiting rooms and listening to the conversation added to an understanding of the attitudes of community members to health care. Thus, in spite of the limitations, the study was able to obtain data concerning community opinions.

The restriction on interviews may not have been important when assessing the quality of health care services, because while the patients and community members have valuable contributions to make in the manner in which health service are administered, it is questioned whether they are qualified to judge the quality of health services, as they often tend to judge services on factors such as appearances – expensive and imposing décor of units rather than the quality of services (Carroll, Sullivan, & Colledge, 1998). The opinions of community members therefore, while helpful in understanding many issues, would not be of great value in assessing the quality of health care services.

Health professionals associated with the defendant doctor were chosen for in-depth interviews on the basis of who would be available for an interview at the time the researcher visited the area. It was not practical to interview all associated health professionals but at least one associated health professional was interviewed in most cases. There was consistency in the views expressed by most associated health workers despite their coming from different cases - they gave a more detached perspective on events, often more critical of the disciplinary process than defendant doctors and more critical of complainants. Similarly strong opinions were expressed by the many letters written by over 170 doctors and claiming to represent many more doctors. Other documents, such as letters by complainants, lawyers and official bodies retained by some defendant doctors gave depth to their account of events.

The study, therefore, used multiple sources of data: interviews of various health professionals, documents such as letters of support, letters by complainants,

lawyers or official bodies, and observations. These multiple sources of data enabled triangulation to be utilised, that is, to use each form of data to confirm the validity of the other forms of data. Triangulation was also used in the qualitative analysis of the interviews. The researcher's formal analysis of the interviews was checked by two supervisors who also read the transcripts of interviews. Further confirmation of the analysis was obtained by presenting the findings to a group of rural doctors at rural conference and asking for criticism or confirmation.

Bias in the interviewed health workers was a potential weakness in the study - health workers, resentful of the disciplinary process, could exaggerate the negative sides of discipline and understate any advantages. This form of bias is very hard to confirm or discount but it was the researcher's opinion that participants were genuine in what they said. In a long, unstructured, and unprepared interview, it would be very hard to maintain pretences. The researcher has tried to present relevant quotations from the interviews so readers can form their own opinions on possible bias. Many of the descriptions, such as the doctors who experienced a post-traumatic stress-like syndrome, are too vivid to be anything but accurate. The facts of the cases, however, are not in dispute, facts such as doctors left and were hard to replace.

The researcher has endeavoured to maintain an audit trail – describing how the research was done so readers as co-researchers can tell what was done and how, so they can evaluate the research themselves and form their own opinions. A study such as this has uncertain external validity in areas of health care that might be very different to those of remote rural areas. An understanding of the study and its setting will aid readers in deciding whether to apply the findings to other settings.

The findings of the present study on quality of services were consistent with the many studies on quality control systems in organisations and this concordance with the findings of other studies gives credibility and validity to the present study's findings on quality of health care services.

Further research

The present study was carried out in a small area of health care, which was different to many other areas of health care and so the study needs to be repeated in other areas of health care. There were also limitations on which data could be used in the study due to ethical considerations and further studies using other forms of data may give added understanding of the phenomena revealed in the present study.

Several aspects about complaints were uncovered by the present study, aspects that had not been appreciated before. It was not possible to explore these areas fully in the study and there is a need for further research in these areas.

1) There were repercussions for complaining and the majority of complainants appeared to have been worse off because of their lodging of their complaint. There is a need for research onto the effects of the disciplinary process on the people who complained, especially from their and their supporters' perspectives. There was an impression that some form of grief counselling would have benefited people. The disciplinary process appeared not to be effective in dealing with grief and anger because it appeared to intensify feelings of loss and anger rather than help people to overcome these feelings.

2) There is a belief that defensive medical practice is not significantly or widely practiced in New Zealand. This belief was not supported by the present study as doctors used considerable amounts of defensive practices and further studies on defensive practices are needed in New Zealand.

3) Fatigue, lack of sleep and stress, all played a part in the adverse events in the present study. Very little is known about these factors and probably many other factors that make errors more likely and there is an urgent need to understand how they affect safety. We need to know, for example, how many patients a doctor can safely see in one day, or how many hours a doctor can work before the chances of making an error becomes unacceptably high.

4) The present study found that social factors played a part in the decisions to lay complaints. A lack of trust appeared to underlie the decision to complain – a lack of trust in sections of the community and institutions. If there are inappropriate levels of distrust by certain sections of the community, understanding the reasons for distrust and addressing it would help these people more than the present moralistic disciplinary system. There is a need for more research into the reasons why people complain. The reasons for complaints are more complex than the assumed ones and to understand these reasons more research is needed.

5. The ethical issues that resulted in complaints caused much controversy, most of the ethical decisions of the disciplinary body being rejected by doctors and other health workers. There appeared to be a genuine belief among health workers that these decisions were inappropriate or wrong and there is a need for more research into the ethical beliefs of doctors and other health workers.

6. The law of torts is assumed to benefit society in many areas other than health care, but these assumptions are untested. These beliefs now need to be tested.

Recommendations

1. In a rapidly changing world where scientific evidence is becoming as important as experience, the competence of professionals needs to be regularly assessed and should not have to wait until complaints are made.

2. The credibility of the certification process should be beyond doubt and to ensure this it should: contain a component of other professionals and lay people, the process should be open, and should involve objective assessment rather than passive learning.

3. Professionals who have undergone competency certification should not have their competency challenged when a complaint is laid, unless there are unusual circumstances.

4. Monitoring the effects interventions have on health care is essential and this includes monitoring of disciplinary and quality control systems. The effects interventions have on health care systems, complainants, and health workers need to be monitored.

5. If complaints systems are to play a part in error prevention, they need to be based on the evidence of studies on quality control and error containment. Complaint systems need to be part of quality control systems. Disciplinary systems would need to be retained but only for intentional wrongdoing or reckless behaviour.

6. Members of disciplinary bodies or quality assurance panels must have the appropriate experience to enable them to understand the situations where errors occur, such as: a large workload, a high patient to doctor ratio, frequent on-call duties, isolation and a low socio-economic population. Too frequently, doctors end up on these panels because they do not have enough work in their own practice and these under worked, part time doctors have little understanding of the situations where errors occur. Investigating officers should have expertise similar to that of aircraft accident investigators, that is, they should have expertise of human factors that cause accidents such as sleep inertia, micro sleeps and divided attention.

7.The continuing education of health professionals should include instruction on recognising those situations where errors are likely to occur such as in sleep deprivation or prolonged periods of work. Health professionals, who work in such dangerous conditions by choice rather than necessity, should be liable for discipline.

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APPENDICES

Appendix A: Information Sheet for Participants

Dear .....

I am an older general practitioner who worked for twenty years in rural Southland. I am doing this study with Dr N North and Ms G Patterson of Massey University. I have an interest in what can be done to help rural health care. One way to help rural health care is to do research.

This study is part of a Masters in Business Studies at Massey University. The study is examining the following question: *In the rich social context of a sociological understanding of small rural communities, what are the wider effects and meanings of an investigation of a local doctor receiving a formal complaint, as perceived by other health professionals of that community?* More specifically the study will examine the effect of the investigation on local health services, the effects on other health professionals and the effect of the investigation on the standard of care exercised by the doctor. The study is not considering the rights or wrongs of any issues being investigated but rather the effects of the investigation. Your participation in the study would be very helpful.

Other health professionals in the rural area, who could assist with the study, may be asked to participate. This would only be done after discussing it with you and obtaining your full agreement and their informed consent.

Interviews would take one to two hours and could be conducted at your home or other convenient place. Interviews will be audio-recorded and transcribed onto paper. Transcripts will have all references to names places or other identifying references omitted so it will not be possible to trace who said what. Audio tapes will be destroyed. The anonymous paper transcripts will be shared with the supervisors and kept in a safe place for a few years in case someone wishes to challenge the research findings. They will be destroyed within seven years. Participation is entirely voluntary and you can withdraw at any time. If any participant found that during or after the that it was distressing to them assistance could be obtained from the Doctors Health Advisory Service Wellington (04-4792654) or assistance could be arranged by the researcher. This study has been reviewed and approves by the Ethics Committee of Massey University

If you have any queries or questions please feel free to contact:

Rob Henderson or
1 12 Don St.
Invercargill.
03-2147740 day
03-2141458

Dr N North
School of Health Sciences
Massey University, Palmerston North.
06- 3505799 ext. 2794

Appendix B: Consent Form

1. I have read and I understand the information sheet dated 1st February 2001.
2. I understand that taking part in this study is voluntary (my choice and that I may withdraw from the study at any time and this will in no way affect me.
3. I understand that the participation will be stopped if it should appear harmful to me.
4. I understand that my participation in this study is confidential and that no material, which could identify me, will be used in any reports on this study.
5. I have had time to consider whether to take part.
6. I know whom to contact if I have any questions or concerns about the study.
7. I Consent to the interview being taped YES/NO.
8. I wish to receive a copy of the study summary YES/NO.

I.....here by consent to take part in this study.

Signature:

Witness:

Date .....

Appendix C: Prompt Sheet

1. What are the problems you and other professionals face here in providing a health service?

2. In what way do you think the investigation effected health services?

3. Do you think health services got better or worse after the investigation?

5. Are you aware of other people who have different opinions?

6. What do other community people think about the investigation and the health services?

7. Do you have any final comments on how rural health services can be better supported and improved?

Appendix D: Ethical approval

Massey University Human Ethics Committee: Palmerston North (MUHEC: PN)
Room 2.02, Main Building, Turitea
http://www.massey.ac.nz/~muhec
Telephone: 64 6 350 5799 extn 2625
Fax: 64 6 350 5622
Email: M.Tolich@massey.ac.nz

Massey University

Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099

21 June 2001

Mr Robert F Henderson
24 Herbert Street
INVERCARGILL

Dear Robert

Re: MUHEC: PN Protocol – 01/32
The effects on other health professionals and health services in rural communities of investigations of formal complaint against rural doctors, as perceived by health professionals

Thank you for your fax received 8 June 2001.

The amendments you have made and explanations you have given now meet the requirements of the Massey University Human Ethics Committee and the ethics of your protocol are approved.

Any departure from the approved protocol will require the researcher to return this project to the Massey University Human Ethics Committee for further consideration and approval.

A reminder to include the following statement on all public documents "This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 01/32".

Yours sincerely

Dr Martin Tolich, Deputy Chair
Massey University Human Ethics Committee: Palmerston North

cc Dr Nicola H North
Management Systems
TURITEA

Appendix E: Checklist of background factors

(After Stanhope et al (1997), adapted to allow general use rather than just obstetrics)

- Were the case notes available, legible, attributable and complete?
- Were there language/ cultural problems or misunderstandings between staff and the patient or relatives?
- Was there agreement regarding the interpretation of test results?
- Was there adequate and reliable information from all equipment?
- Were the case notes adequately flagged to alert you to all risk factors?
- Was communication between yourself and other members of staff effective?
- Did the working environment (e.g. heat, noise) affect you?
- Did all the equipment you used work adequately and effectively?
- Did you have enough medical and nursing supplies?
- Did you have to spend time on non-clinical duties?
- Was help/advice from another member of staff available at all times?
- Do you feel management showed appropriate care and concern?
- Did staff agree about who was in charge of operations?
- Did you have enough time to spend with the patient explaining procedures, possible complications and outcomes?
- Did you have adequate supervision and/or support?
- Did you have to rely on a new (locum) doctor or (agency) nurse whom you had not worked with before?
- Were routine tests carried out and the results documented in the notes?
- Was the appropriate person consulted when necessary about the management of care?
- Were there any delays in carrying out clinical procedures?
- Were test results quickly and easily available?
- Did you feel tired, hungry or unwell?
- Did you feel appreciated and was your morale high?
- Was the patient/were visitors helpful and cooperative?
- Do you feel your opinions and competence were accepted, appreciated and unquestioned?

- Did you feel you had enough knowledge and experience to deal with the problems/complication?
- Do you feel your orientation time in your work prepared you for this case?
- Was your training in using equipment/protocols sufficient for this case?
- Did you have to prioritise more than one patient needing care simultaneously?
- Did you have to look after more than one patient simultaneously?
- Did you have an unexpected or sudden increase in workload?