



Is imperfection becoming easier to live with for doctors?

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Abstract

Objective: Being involved in serious patient injury is devastating for most doctors. During the last two decades, several efforts have been launched to improve Norwegian doctors' coping with adverse events and complaints.

Methods: The method involved survey to a representative sample of 1792 Norwegian doctors in 2012. The questions on adverse events and its effects were previously asked in 2000.

Results: Response rate was 71%. More doctors reported to have been involved in episodes with serious patient harm in 2012 (35%) than in 2000 (28%), and more of the episodes were reported as required by law. Doctors below age 50 report better support from colleagues, more collegial retrospective discussion on the event and less patient/family blame. In all, 27% of the doctors had been reported to the Norwegian Board of Health Supervision; 79% of these complaints were rejected; 73% of the doctors who had received a reaction from the health authorities found the reaction reasonable, but almost one out of five practiced more testing and referrals after a complaint and 25% claimed that the complaint had made them into a more fearful doctor.

Conclusion: Our results indicate that adverse events are being met more openly in 2012 than in 2000, and that coping with imperfection and patient complaints is less devastating for new generations of doctors.

Keywords

Adverse events, complaints, coping, doctors

Introduction

Although patient injury does not necessarily imply negligence, being involved in serious patient injury and causing unintended suffering for the patient is devastating for most doctors. To decide what is a preventable adverse event is no easy task. Substandard care may not necessarily result in patient harm, and serious outcome may happen in spite of adequate intervention. Doctors are socialized to strive for error free practice, and a medical mistake that leads to patient harm has often been regarded not only as a sign of professional failure, but also as a failure of character in the responsible physician, with subsequent feelings of guilt and shame.^{1–3} Insufficient organizational support and support from colleagues after such events are frequently described, possibly augmenting the feeling of guilt and shame.⁴ Defensive medical practice and a tendency to conceal adverse events may result.^{5,6} Openness about such events, including disclosure to patients and next of kin, should be part of the safety culture.^{7,8} Thus, work to improve the medical establishment's ability to deal with unwanted patient outcomes in an open way and to include support to all involved parties after an adverse

event may be seen as one way of strengthening patient rights in health care.

A Norwegian study from 2000 revealed that many doctors working within the surgical disciplines, including anaesthesiology and gynaecology/obstetrics, had been involved in adverse events with serious patient injury. However, only 37% of the incidents were reported to the health authorities, which is obligatory, and only 68% informed the patient's family after the incidence.⁹ One out of five doctors did not experience any support from colleagues after the incident. Several of the doctors in this study reported that the incident had influenced their private life and had made it more difficult to work as a doctor afterwards.

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A shift in policy

Since 2000, the medical community has gradually seen medical mistakes more as system errors than individual incompetence. This change may hopefully lead to increased willingness to report the adverse event,^{10,11} to improved routines to meeting the patient and next of kin after the event and to better routines to support the responsible health care personnel after the event.¹²

In Norway, several initiatives towards increased openness after adverse events in medical practice have taken place. At the University of Oslo, medical students are offered a 2-day course towards the end of their studies to increase their knowledge of how adverse events should be met, professionally, legally and ethically. A new section in The Health Directorate has been created where anonymized descriptions of serious events that have led to, or could have led to, serious patient harm are reported and processed.¹³ In addition, health care personnel must, according to the Specialist Care Act §3-3a, report every incident with serious patient injury to The Norwegian Board of Health Supervision and to notify patients in cases of unexpected negative or unwanted outcome of health care interventions.¹⁴

The complaint system

When the outcome of a medical intervention is suboptimal or when patient expectations are not met, the responsible health care personnel may experience a complaint put forward to the health authorities. In Norway, filing complaints is now formalized in The Patient- and Users Right law §7-4.¹⁵ The health authorities receive complaints on health care personnel through two channels. Less serious complaints are filed to the County Governor (Fylkesmannen), who may give guidance or propose deliberations between the parties. More serious cases are referred to The Norwegian Board of Health Supervision who processes the complaints with one of three possible outcomes: rejection of the complaint, issuing a warning to the health care personnel or suspending the authorization for a number of years, or permanently. Thus the doctors who experience a reaction have all been involved in more serious events. Even if Norway, since 1988, has had a no blame compensation system after patient injury,¹⁶ a complaint is normally perceived as deeply disturbing for doctors.¹⁷

With increased emphasis on patient rights, it is likely that the number of doctors experiencing a complaint will increase, and with this follows hopefully a need for health care personnel to regard complaints as (albeit unwanted) part of professional life and thus experiencing them as less devastating.

The aim of the present study was to explore the change over time in doctors' coping with serious patient harm, and to study how doctors react to and cope with complaints to the health authorities.

Methods

Since 1992, The Norwegian Medical Association, organising more than 90% of all doctors practising in Norway, has sponsored its own research institute with the main objective to study the health and behaviour of doctors. See www.legeforsk.org for an overview of the publications. An important element of this effort has been to follow a representative panel of approximately 1700 doctors with postal questionnaires. The panel is unbalanced, meaning that new young doctors are regularly added and retired or deceased doctors are removed.

Specialist categories

There are 45 medical specialties and subspecialties in Norway, and for the purpose of optimal statistical analyses, the specialties are grouped into larger logical entities. In this study, we use the following seven categories: family medicine/general practice, laboratory/service specialties, internal medicine specialties (including oncologists), surgical specialties, anaesthesiology and intensive care, psychiatry and community medicine/public health. Specialists in training are categorized according to their future specialty.

Questions

In November 2012, a postal questionnaire was sent to the 1792 panel members, with three reminders. The questionnaire covered several broad topics such as knowledge of and attitudes towards guidelines, priority setting issues and end of life dilemmas.

This article is based on the response to questions on adverse events and their consequences, which are similar to the questions posed in the survey of 2000: 'Have you experienced serious patient injury in connection with medical treatment you have given?' response alternatives: never, a few times/several times/not applicable. The question was followed by eight questions about potential consequences on the part of the doctor (list is provided in Table 2), with response alternatives yes/no/uncertain.

In addition, we asked whether they had been involved in a complaint to the health authorities, followed by a question about The Board's conclusion, and 11 possible consequences of this, including an evaluation of whether they regarded the Board's reaction as fair and reasonable (Table 3).

Statistical analyses

Responses are reported as frequencies across three group variables: gender (female and male), age (30–49, 50+) and specialty (general practice, laboratory/service, anaesthesiology/intensive care, internal, surgical, psychiatry and public health). Where appropriate, the observation of possible overlap between 95% confidence intervals are used to identify statistically significant differences between groups.

Ethics. The regional ethics committee has given the Norwegian physician study exemption from ethics approval (Ref IRB 0000 1870), based on the fact that no patients are involved in the studies.

Results

In all, 1279 questionnaires were returned, a response rate of 71%.

Involved in patient injury

Thirty-five percent of the doctors reported that they had been involved in serious patient injury. The two highest groups were doctors in surgical specialties 51% (43–60%) and anaesthesiology 45% (32–59%). This was significantly higher than other specialty groups (Table 1). Thirty-three percent (29–38%) of all doctors below the age of 50 reported such an experience compared to 42% (CI: 38–46%) of doctors 50 years and over.

Table 1. Percentage of doctors in different specialties who have been involved in serious patient injury.

	Percent of all respondents	Been involved (%)	95% CI
Surgical domain (139)	11	51	43–60
Anaesthesiology (53)	4	45	32–59
Internal medicine (369)	29	35	30–40
Family medicine (309)	24	34	28–39
Laboratory medicine (91)	7	26	17–35
Psychiatry (150)	12	24	17–31
Public health (53)	4	23	11–34
All (1164)	91	35	
Missing (115)	9		

Significant differences from the total (35%) are shown in bold.

In 2012, 35% (32–38%) of the doctors reported to have been involved in incidents with patient harm, compared with 28% (26–31%) in 2000.

Further, 51% (46–56%) of the incidents reported in 2012 had been reported to The Board of Health, compared to 37% (32–42%) in 2000 (Table 2). Likewise, 75% of the doctors who had experienced patient injury reported in 2012 that they had received personal support from colleagues after the incident, compared to 70% in 2000, and fewer doctors reported that the incident had had negative consequences for their private life than in 2000: 12% vs 18%. Also, 7% reported in 2012 that the incident has made it more difficult for them to work as a doctor, compared to 12% in 2000. Although none of these differences are statistically significant, together they suggest a trend towards less negative consequences for the doctors.

Eighty-nine percent (85–93%) of the respondents below the age of 50 reported that the incident was discussed at their workplace, compared with 80% (75–85%) of the doctors 50 years and older. Likewise, 87% (82–91%) of the doctors below 50 reported good support from their colleagues after the incident, as opposed to 79% (74–85%) of the doctors over 50. Also, fewer of the doctors below age 50 reported having been blamed by the patient/next of kin after the incident: 33% (27–38%) vs 45% (38–51%).

Complaints to the health authorities

Twenty-seven percent of the doctors had been reported to The Norwegian Board of Health Supervision, 48% of the family doctors/G.Ps, 33% of the psychiatrists, 23% of the anaesthesiologists and 21% of the surgeons. Thirty-six percent (31–40%) of the doctors who had been involved in serious patient injury had also been reported to The Board of Health, as opposed to 23% (20–26%) of those who did not have such experience.

Seventy-nine percent of the complaints resulted in a rejection of the complaint without further reaction. Other reactions were warnings (13%) and other sanctions (5%), usually suspension of authorisation. Three percent were still waiting for their decision.

Seventy-three percent of the doctors who had received a reaction felt that the reaction was reasonable/fair.

Table 3 shows the reported positive and negative impacts on the complainers. Sixty-two percent reported that they had become more thorough with their documentation, and 44% reported that the complaint had resulted in their giving better information to patients/next of kin. Among negative effects were loss of trust in patients/next of kin and negative influence on the doctor's private life. Seventeen percent reported that the

Table 2. The doctors' evaluation of the reactions after, and effects of, having been involved in serious patient injury through their medical practice in 2000 and 2012.

	2000 N = 366–367			2012 N = 410–413		
	Yes	Uncertain	No	Yes	Uncertain	No
The incident was reported to the health authorities/Knowledge Centre	37	11	52	51	7	42
The incident was discussed at the working place	83	3	15	82	3	16
I received good support from colleagues	70	9	21	75	9	16
The incidence was reported in the media	12	1	87	11	2	87
I was blamed by the patient or the patient's family	32	6	63	32	7	61
The incidence has made it harder to work as a physician	11	6	83	7	6	87
The incidence has had a negative impact on my private life	17	7	76	12	6	82
I have needed professional help	6	2	93	4	2	94

All the values are given in percent.

Table 3. Consequences of having been involved in a complaint to the health authorities.

The health authority's conclusions were reasonable – the 63 who were given formal warnings.	78
The complaint has led me to be more thorough regarding documentation.	62
I have become more thorough with information to patients and next of kin.	44
The complaint has made me a more thorough doctor.	31
The complaint has made me a more fearful doctor.	25
I run more tests/send more referrals now than I did before.	17
The complaint has had a negative influence on my private life.	14
The complaint has made it more difficult to work as a doctor.	12
The Norwegian Medical Association should have supported me more.	12
I have a less trusting relationship to patients/next of kin.	11
I have needed professional help after the complaint.	4

All the values are given in percent.

complaint had increased the number of tests and referrals they made in their practice.

Discussion

Our results must be interpreted with caution. Brief answers and fixed response categories seldom capture the nuances of complex experiences and emotions. We asked whether the doctors had ever been involved in incidents of serious patient injury. The answer is subject to recall bias.

Because we wanted to explore how doctors react when they are involved in interventions that end up

with serious patient injury, we have not included questions about the cause of injury, whether it was a result of an explicit error or just a result of a complicated and risky intervention. It is likely that a negative outcome which is caused by obvious errors may be the most difficult to deal with for the responsible physician. Accordingly, they may need more guidance and support.

One strength of the study is that we can compare the 2012-responses with data from 2000, and show changes in the reporting of patient injury and in how incidents were experienced and followed up. We were also able to find how a complaint to the health authorities may have influenced doctors, which was not possible with the 2000 data.

In 2012, more doctors than in 2000 reported having been involved in serious patient injury. This may indicate more openness; but also that medical interventions are more complicated and risky, in spite of all attempts to increase patient safety. As in 2000, doctors in intervention intensive specialties like surgery and anaesthesiology are more often involved in serious patient harm.

As to the follow up of adverse events, we see a tendency towards more openness in that the incidents are more often reported to the health authorities in line with legal requirements. Also, the doctors experience more support from colleagues after the event and less emotional stress with impact on private and professional life. Since the numbers are small, the effects are not statistically significant, but we still see a positive development in most of our items. In 16% of the incidents, the event was still not discussed at the workplace. This is not satisfactory and underlines the need to continued efforts to change attitudes in the medical culture towards more openness regarding adverse events. However, it is encouraging that the younger doctors more often report collegial support after an event, more often discuss the event at the working place and

less frequently have been blamed by the patient/next of kin. This may indicate that a new generation of doctors is practicing better coping strategies after serious events.

Being reported to the health authorities

Only 36% of the doctors involved in patient harm have experienced a complaint to the health authorities, compared with 23% of the rest, which means that serious patient injury does not necessarily result in a complaint to the health authorities. This is in line with a study from New Zealand where only a minority of serious adverse events resulted in complaints.¹⁸ A Norwegian study found that only around 10% of patients who have experienced an adverse event filed a complaint.¹⁸ A study from the US found that even in adverse events caused by negligence only a minority filed malpractice claims.²⁰ If the patient/next of kin are met with openness and honest regret in an empathic way after the incident this may reduce the need to 'punish' the doctor.⁶

It is interesting to note that G.P.s/family practitioners and psychiatrists are overrepresented among the doctors who experience complaints, perhaps indicating that many complaints are generated by problems with communication and a suboptimal doctor – patient/next of kin relationship rather than serious somatic injury. Also, G.P.s see more patients during a working week than most other specialists. G.P.s are overrepresented in a New Zealand study of medical complaints as well.²¹ In Norway, the GP has a gate-keeping role, and setting medically sound limits to patients' quests for tests and interventions may cause frustration and possible complaints. Norwegian patients' reporting of adverse events tends to place the responsibility for the event on their GP.¹⁹

The health authorities reject three out of four complaints. Still one in eight doctors report that the complaint has made it more difficult to work as a doctor (Table 3). We find it noteworthy, however, that 73% of the doctors who did receive a reaction, typically a warning, found the authorities' decision reasonable. This may be another indication of contemporary Norwegian doctors accepting patient complaints as part of their professional life. The same goes for having become more thorough with patient information, and in clinical work generally. A Norwegian study from 1993 indicated that having experienced complaints did not influence decision-making, while being threatened with reporting or negative exposure in the media did.²¹ More meticulous documentation may be seen as a defensive, time consuming and stress-generating obligation rather than a sign of improved patient safety. Thus, 17% also report that they perform more tests and make more referrals

after the incident, and 11% report a less trusting relationship to patients/next of kin. Kessler et al. found defensive medicine as an effect of the medical liability systems in Australia, UK and the USA.²³ We have reason to believe that increased collegial support and a scrutiny of what exactly happened may reduce these negative effects of the complaint.¹² Accordingly, not only adverse events but also patient complaints should be met with openness and collegial scrutiny, including ethical and relational considerations.^{16,24}

A recent report on serious events in the health and care services stresses the importance of health personnel opening up for scrutiny of professional practice.²⁴ Our findings are consistent with these societal expectations.²⁵

Conclusion

Increased openness towards health care that results in patient injury is important to meet patients and next of kin adequately. More doctors reported having been involved in adverse events with serious patient harm in 2012 than in 2000, and more of the incidents were reported to The Board of Health. Doctors below the age of 50 describe better follow up of the incident at their workplace compared with their older colleagues. Our study indicates that efforts to improve follow up of intervention causing serious patient injury has given positive results.

Only a minority of the doctors having been involved in episodes with patient harm had experienced a complaint. General practitioners and psychiatrists were overrepresented among the doctors who had experienced a complaint. A majority of the doctors who had received a formal reaction from the health authorities found the reaction reasonable.

Being involved in a patient complaint to the health authorities may be emotionally stressful for doctors. Many complaints may be caused by suboptimal communication and poor doctor–patient relationships. In order to learn and improve practice, it is important to scrutinize episodes of patient complaints and to offer collegial support to the doctors involved.

Authors' contributions

Both authors have prepared the study, analysed the data and prepared the manuscript. OGA has had the main responsibility for the statistical analyses.

Declaration of Conflicting Interests

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