Doctors in Trouble

A study of their experience of complaints

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A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

Faculty of Health Sciences

The University of Sydney
Statement of Authentication

This thesis is submitted to the University of Sydney in fulfilment of requirements for the degree of Doctor of Philosophy.

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text.

Elizabeth van Ekert
30 November 2018

Approval of research for submission

As supervisor for the candidature upon which this thesis is based, I can confirm that the authorship attribution statements above are correct.

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The study (Protocol No. 2014/611) was granted ethics approval, Number 1139150, by The University of Sydney Human Research Ethics Committee on August 21, 2014. Documents prepared for the study instruments are in the Appendix.

Interests

I declare my previous employment with the Health Care Complaints Commission from 1994 to 2001, UNITED Medical Protection, which later became Avant Insurance, from 2001 to 2008 and MDA National from 2008 to 2012. I am currently a hearing panel member for the Medical Council of NSW and a community member on the Human Research Ethics Committee (Medicine) at Macquarie University.

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I was delighted to have been welcomed into the faculty and for their providing a place in the corner to set up camp in the Old Teachers College building. Every day I have enjoyed my wanderings through the grounds and gardens and exploring the lovely old buildings of this campus, so thank you to the University for keeping it so beautiful. I have also enjoyed the company of some very fine people in this faculty, and thank you for your friendship. I am grateful to Professor Stephanie Short for her assistance.

I am also very grateful to the former Centre for Values Ethics and Law in Medicine (VELiM), now Sydney Health Ethics (SHE) who offered me my candidature and to those who advised me in the earlier part of my studies. I acknowledge Professor Ian Kerridge, Professor Cameron Stewart (Law), Dr Claire Hooker, as well as Associate Professor Stacy Carter, Professor Henry Kilham and most especially Emeritus Professor Miles Little.

The inspiration for my study came years ago when I participated in the research study conducted by Associate Professor Louise Nash, while I was working at UNITED Medical Protection (now Avant Insurance). She has remained an interested friend, which has been so important in reminding me how essential it is that this story is told. In this, how could the story not be told if it were not for the participants in my study who gave their time, their interest and their candid revelations of what it was really like to be the subject of a complaint, an experience that as a by-
stander in the medico-legal world I could only observe? I am also indebted to the expert informants who gave their time most generously.

Support for my study in its early days was provided by MDA National and Avant Law, most especially Ms Georgie Haysom and the CEO Mr Andrew Boldeman. I would also like to thank Dr Sara Bird, Dr Penny Browne, Professor Geoff Riley, Dr Michael Diamond, Dr Gary Galambos and Emeritus Professor Terry Carney for their kind assistance.

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Abstract

Within the medical profession, disciplinary proceedings and other regulatory mechanisms aim to protect the public by having robust systems to remedy identified problems with doctors’ performance, conduct or health. One in five doctors will have a complaint during their careers, and many of these say it is one of the most stressful events they have experienced, while others carry a fear of complaints even if they have not experienced one. The experience leaves many emotionally and psychologically harmed, some suffer ill-health and many undergo behavioural changes. These effects can cascade down to family, friends and colleagues, and the worry and anxiety can affect their work. This means patients may also suffer, when a doctor who is tired, distracted or anxious can make mistakes and errors of judgement, or is not practising optimally.

The existing literature on this topic, from international and national studies, has consistently found these adverse impacts on doctors, at both the professional and personal level and regardless of the actual regulatory mechanism in place. The purpose of this qualitative study is to build on this knowledge by undertaking an in-depth exploration of the underlying reasons for these impacts for Australian doctors who have experienced complaints, thereby adding to the understanding of what it is about doctors and the process that causes such distress. To find these reasons, the study invited doctors to share their experience and to explore what it was about the process that caused them consternation and distress, and how they deal with it. The aims were:

1. To understand doctors’ experience of complaints;
2. To understand what support, if any, doctors seek during the complaints process and if it makes a difference.

In order to reach a deeper understanding, the study also asked these questions:

1. What can be learned about the complaints process through doctors’ accounts about the impact of complaints on doctors, their health, sense of self and practice?
2. What can be learned from doctors’ perceptions about how law and regulation interact with medicine and the impact of these interactions on medical practice?

These questions were explored through in-depth semi-structured interviews with individual doctors.

Part One of the thesis examines the context for the study, through exploring the reasons for regulating the profession of medicine, and the manner in which it is regulated. A review of the literature will show how this component of the regulatory landscape impacts on individuals who have experienced it.

Part Two presents the empirical component of the study. A qualitative research methodology was the most appropriate method of examining the experience of doctors who have received a
complaint. Using semi-structured, in-depth interviews with seventeen self-selected doctors, a narrative approach enabled a deep examination of doctors’ personal reactions, perceptions and attitudes to the complaints process, and to their values and beliefs in respect of being a member of the medical profession. Speaking of what had brought them into medicine and their aspirations, doctors reflected on how the complaint experience affected them, their practice and their anticipated future. They considered what aspects of the process had been of significance, and how it could be different. They reflected on how they endured the process, whether they told others, whether they obtained informal or formal support, and if it made a difference. The deeper meaning of why the experience had significance for them provided a clue to explaining what it is about the process that these doctors found so distressing and fearful.

For a second phase of the empirical component of the study, five expert informants agreed to be interviewed in order to obtain their professional perspective on how doctors respond to complaints and how they deal with the process. This group consisted of experts who provide professional support to doctors, for psychiatric care or for medico-legal advice and assistance.

The individual narratives told how doctors reacted to the receipt of a complaint, and how they explained their reaction. Initial shock, fear, dismay and distress turned to sleeplessness, loss of concentration, tears and worry, to depression and deep anxiety. Worry about being competent enough to work, fear of what others may think of them and thoughts about giving up medicine endured throughout the process, and for some, well beyond it even if the complaint was not substantiated. Experts’ accounts of how doctors react were very similar, adding terror and fear when facing a disciplinary hearing, and behavioural symptoms such as being belligerent, defensive, and obstructive, and some becoming profoundly distressed or depressed.

Talking about what was so distressing about having a complaint identified many aspects of the process that had contributed to doctors’ concerns. These included the style of communication from the complaints body, delays, uncertainty of the outcome and how decisions were being made, by whom and on what basis, to perceptions of unfairness brought about by these issues. Many perceived that the process holds them guilty until they prove themselves innocent, and is weighted towards complainants. The adversarial nature of the process makes them defensive and cautious, and such defensiveness can be long-lasting, resulting in changes to their practice which are not all for positive reasons.

All participants had told their partners or a close friend, but most had not told anyone else. Those who confided in supervisors, colleagues or employers found it helpful and affirming, but those whose colleagues or employers abandoned them, sidelined them or forced them out fared badly, and recovery was difficult. What was also confronting was when doctors felt unfairly judged by their peers, and especially when this affected how a complaint was assessed and its outcome. Threat to reputation was very real and fearing what others may think of them was a significant reason given
for not telling others. Media exposure was also a real threat, and actual reporting of matters was deeply distressing.

Those whose distress became critical often avoided psychological help, until others stepped in to recommend it. Emotions rose to the surface in the interviews as participants recalled how they felt at the time, and some poignant moments were shared as they spoke of what it was like, how they got through it, and how they felt about it now. Most of the participants continued to work, but it was not quite the same, and the interviews were an opportunity for them to reflect on this. Others had retired early, some were not practising, one resigned and another wanted to.

The value of using a narrative approach was that it was able to identify that there was a deeper meaning to having a complaint. In this way, using in-depth interviews enabled the study to extend well beyond what most previous research had found, reaching into areas that may have been touched on but without the depth that this approach achieved. For participants, this meant not just recounting events and how they reacted, but for some it involved reflecting beyond the allegations raised in the complaint and how they had contributed to the patients’ dissatisfaction, and what they had changed as a result. Others offset these thoughts by considering what it was about that person, on that day, with that presentation, that made them so upset with them. Or, more often, reflecting on what it all meant in terms of their own image of themselves caused some to wonder if they were actually not the good doctor they thought they were, with some fearing the authorities had treated them as one of the “bad guys”. In this respect, a doctor’s moral identity was critical in understanding this deeper meaning, which went beyond fear for their reputation, to questioning their own value and worth professionally, and personally. Threats to one’s moral identity were at the heart of doctors’ consternation.

All participants believed there should be a system for dealing with complaints and a robust regulatory environment to maintain standards of practice and to deal with those doctors who were a risk to the public. They were well aware of who those are, and did not identify with them. Yet there was a doubt for participants that perhaps there was substance to the complaint, even if the complaint had not been substantiated. If it had, participants were aware of their deficiencies, and none believed they were irremediable.

This study has provided insights into why having a complaint is confronting and why the process is so stressful. There is a consistent message that regulatory processes have an adverse impact on doctors, but in spite of knowing this for some decades, little has been achieved to address the underlying reasons why the process causes such a degree of harm. While there is no doubt there is some concern, the focus has been on individuals to cope and to seek support if they cannot. It is now time to look more broadly at what in the process contributes to the distress, and to consider what can be changed to mitigate these adverse effects. The regulators responded constructively to dissatisfaction from complainants by making systems changes and being more communicative.
This study indicates where changes could be made to ameliorate the impact on doctors. This may mean a re-think of the principles behind the approach that is taken in protecting the public. From the time complaints were recognised as an integral component of the regulatory process, for their value in identifying deficiencies and inadequacies in the health system and with health providers, the medical profession railed against the intrusion into their autonomy. The system became part of the regulatory landscape, but the early days of fear and resistance remained, while medical defence organisations stepped in to take care of the “cases” and legalistic procedures took a firm hold. The adverse impacts were little recognised or known about. Doctors suffered silently, or raged vociferously, but all would have to capitulate to the requirements of the system, eventually including the failure to cooperate with an investigation as grounds for disciplinary action as a breach of the Code of Good Medical Practice.

It took some very large studies in Australia and overseas to make it public that doctors suffer from the experience, and that the suffering is so widespread and profound that it was clear that the “collateral damage” was no longer acceptable. It not only harmed doctors, it had the potential to harm patients because people who are not well do not function well. Defensive medicine can harm patients, it can harm the public purse, and it can undermine a doctor’s judgement.

Yet, in spite of this, it is not clear how significantly the process contributes to the reduction of the quantum of adverse outcomes, measured elsewhere, in health care. Complaints are just one element of the regulatory landscape, and they cannot be relied on to improve the general quality of care – the majority of adverse outcomes do not result in complaints, nor do complaints necessarily reveal the worst of care. Certainly, the complaints system has resulted in some positive changes in practice in individual practitioners, and as a risk strategy, taking timely and appropriate action to protect the public against unsafe care is an essential part of the regulatory process. However, the adverse effects and what causes them need to be better understood so that doctors can survive and recover when they are being called to account, instead of their being diminished further.

This study not only confirms the findings of previous research, it provides additional value by explaining the underlying reasons for these findings. The findings are contextualised in today’s medico-legal environment – why it was created, how it was created and by whom – and it is shown that the law, once introduced to protect the profession, now exists to protect the public. The consequences of this shift have enhanced the goals of public protection, trust and confidence, but they have also had a profound effect on those doctors who are directly impacted by it when a complaint is made against them.
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Preface

When people ask me what my thesis topic is, they invariably conclude that I am about to expose another parade of scandalous stories about that privileged profession of doctors who are all in it for the money and status. Everyone seems to have a “bad doctor” story, and they love to tell it. When I tell them I am actually studying what it is like to be a doctor whom someone in the public has accused of being bad, or not good enough, the baffled silence begs the question, ‘Why the interest?’ This is why:

Some years ago, I left my fourteen-year career with the Commonwealth Government, where I had worked as an education officer in Education, and as a regional coordinator in Disability Services. I took a one-year position as policy officer with the NSW Council of Social Service, responsible for the health portfolio. That was the year that heated debates, public meetings, media exposés and furious demonstrations were happening, where the victims of Chelmsford Private Hospital were fighting for justice, and the public of NSW was demanding an independent authority to investigate complaints against health services and providers. NCOS was enjoined in the lobby group, heralded by the Public Interest Advocacy Centre, to advocate for the bill before the NSW Parliament that would pass legislation to provide for such a body. The year passed, the bill was passed, and I joined the newly minted Health Care Complaints Commission in 1994 as a senior investigation officer, the first “lay” person to have done so, and remained for over seven years.

The value of this work cannot be underestimated, in spite of the fear, criticism and sometimes fury that this institution engendered. I took a keen interest in why things go wrong in health care and why people complain, and it was rewarding when we were able to provide information and explanations for events, and had a say in how things could be remedied. But it was a very bureaucratic and largely desk-bound process, and we were often frustrated by the delays caused by these processes and by large caseloads. In those days, the investigator became prosecutor when a doctor was summonsed to a Professional Standards Committee at the NSW Medical Board. This was a precarious procedure as we stumbled through formal proceedings where a doctor’s future could lie in the balance. I was struck by the fear and trepidation that many suffered.

With a reputation for fairness, I was airlifted to the “other side”, and worked for United Medical Protection, later to become Avant, for eight years, as a medico-legal risk adviser and later national manager, risk advisory services. Part of the role was working with doctors in trouble, providing advice, support and advocacy through performance assessments or Medical Board disciplinary interviews. Again I was struck by doctors’ trepidation and apprehension when facing these proceedings. I developed a long-standing interest in doctors’ health and was instrumental in establishing a service for doctors suffering distress whilst the subject of a complaint.

After leaving Avant, I took a position as risk adviser and educator with MDA National, during which time I co-authored the Partnering your Professionalism program, with a particular interest in
leadership in medicine and professional relationships, as well as understanding complaints and how to deal with them. I then left the industry and began my doctoral studies.

While working in medical defence, I completed a Masters Degree in Medical Humanities, with a focus on ethics and law in medicine. I also participated in a large national University of Sydney study led by A/Professor Louise Nash on the psychological impact of complaints and claims on doctors' health and behaviour. The results were so worrying that I wanted to understand what lies beneath the findings of that study, and from what I had observed from my work with doctors. This is why I have undertaken this study, with the added hope that it may make a difference to some doctors who believe they are alone in feeling fearful or anxious when they receive a complaint, and those who prefer to keep it to themselves. I also hope that it may make a difference to those decision-makers who may forget that doctors are human too, and that threats to their livelihood, reputation and career are very real, and very frightening, regardless of being blameworthy or blameless.

I am a community member of the Human Research Ethics Committee (Medical Sciences) at Macquarie University, am a tutor in health sociology at The University of Sydney, and a hearing panel member for the Medical Council of NSW. I will add that having worked in the three arms of the regulatory process, I have a strong commitment to upholding standards in health care, for patients to have access to an independent authority to deal with their grievances, and for health practitioners to be held accountable for their conduct and performance. But I am also committed to the principle that when they are called to account, they are treated with fairness and the recognition that a complaint, per se, does not mean they are wrong or bad. The hard work and commitment that most dedicate to the public deserves to be recognised, and their alleged failures not be cause for blame and shame. This thesis aims to present the doctors’ perspective of what it is like to be on the receiving end.

Elizabeth van Ekert

BA DipEd, Masters in Medical Humanities
Introduction: Yesterday, Today and Tomorrow

“As everywhere else in the universe, so also in society, the yesterday is contained in the today, and the today in the tomorrow. In the sphere of law, justice is the idea of today which has grown out of the idea of yesterday and the idea of tomorrow which is growing out of the idea of today. In order to become a legal proposition, the legal today and the legal tomorrow, born in society, must be given form and shape by a personality who thinks and senses what the future will bring.”


(Brunceilsia pauciflora: “Yesterday, today and tomorrow”)

The lovely scent of Yesterday, today and tomorrow is not what this thesis is about, nor is it about botanicals and what grows in my garden. It is about the narratives that this simple idea unfolds: what happened yesterday affects what happens today, which affects what will happen in the future. It is an account of the law and its impact on the profession of medicine; what shaped and influenced the law; what shaped and influenced the profession of medicine, and how each shaped the other.

This is presented as the backdrop to what has shaped the lives of medical professionals, and in particular, those aspects of legal and regulatory processes that have a direct impact on a doctor’s life and career. While many aspects of law and regulation relating to medicine affect how medicine is practised in order to ensure standards are maintained and the public is kept safe, this thesis focuses on complaints as a means of resolving grievances by patients and as indicators of risk. For the doctor who is on the receiving end of a complaint, this may mean as little as writing an explanatory letter that clarifies a misunderstanding, to being required to face a disciplinary tribunal to answer allegations of professional misconduct, a finding of which may result in the loss of their registration, reputation and livelihood.
The study traces back to what brought a doctor into medicine, their interests, aspirations and values, and how their career unfolded, to the point when a critical incident happened that had the potential to bring this all crashing down. The testimony of doctors relates their accounts of how they reacted when receiving a complaint against them, how they endured what happened next, how they were supported and how it shaped their future. It examines the changes that may have emerged as a consequence of the complaint, how they responded to their patients, their colleagues, how they felt now about themselves as doctors and how it differed from what they envisaged when they went into medicine. It also considers their perceptions of the medico-legal process itself, what was expected of them, how they navigated their way through it, if they thought it was fair, and reflections on how it could have been different.

**Why Care?**

A common question asked of me as a researcher was why I am so interested, and why do I care?

Throughout my career assisting doctors in trouble, whether guilty or not, brilliant or mediocre, “impaired” or just not their normal selves, I became critically aware of the anxiety many of them suffered, and the effect on their families, staff and colleagues. Some were so concerning that I either strongly advised them to seek immediate professional help, or enlisted the intervention of doctors with expertise in managing a dangerous crisis. I am relieved to say that as far as I am aware, most doctors recovered, most continued in their work and most survived, even in the face of possible or actual suspension or de-registration. It is sad to note however that a small number, but far too many, of doctors in this country decide to quit medicine altogether, or even to end their lives. A full account of my own background in relation to this topic is listed in the preface.

My study has revealed that the recovery of many doctors has been a painful one, and in some cases, a protracted one. The critical issue, however, is why the complaints process has such an impact on doctors: is it the very processes themselves, is it more a matter of hurt pride or is there something else that has challenged the very heart of being a doctor?

The next question is why the community might care?

There is no doubt that the public has a right to expect safe care when it is needed and to feel it can trust that those on whom it relies for care are skilled and competent and that they have patients’ best interests at the heart of their practice. We are also aware that things do go wrong in health care, and the public needs to know that such incidents can be learned from to minimise future risk. While many such adverse outcomes can be attributed to errors and systems breakdowns, or just bad luck, some can be attributed to health practitioners. Not everything that does not go to plan is due to wrongdoing, or that someone can be found to be blameworthy, because people do die or succumb to their illness or injury even in the best of hands. But patients want to know and
understand, all the same. Sometimes, the only way to find out is through making a complaint, or lodging a claim for compensation.

Yet many complaints are not about adverse events, although it is often assumed that they arise because of harm or an unexpected outcome. Some complaints arise because people wish to know what happened to them or their loved one, or they wish to understand why decisions were made. Other complaints may have no adverse outcome, yet the patient’s expectations were not met, or they feel aggrieved about the quality of communication, the services provided, the time they were kept waiting or someone’s abrupt manner. The function of the complaints process is to assess all complaints and deal with matters according to how best they can be resolved. Anyone who receives a complaint is asked to respond to it. This may mean a simple letter of explanation that will resolve the grievance or, if the concerns raised in the complaint suggest there is an issue of public health or safety, the respondent to the complaint will face further inquiry.

This means that someone is generally held to be responsible. This does not mean they actually are, or that they are liable or blameworthy, but the role of the complaints body is to find out. To be that identified someone means having to respond to an allegation that generally involves suggested inadequacies in their care, judgement, competence or conduct. This study is about the doctor who may have been that someone.

What is already known is that being on the receiving end is stressful (Bourne et al., 2016; Cunningham, 2004a; Nash, Daly, van Ekert & Kelly, 2013; Schattner & Coman, 1998; Saberi, Sheikhzadi, Joghataei, Mohammadi & Fallahian, 2009), and more than this, for some it can result in depression, anxiety, loss of confidence, and adverse changes in practice and attitude towards patients and to their work. When a complaints process is prolonged, with an uncertain outcome, it can add to the anxiety and become debilitating. What is also known is that doctors suffer mental health symptoms at a higher rate than the general population, and that they tend not to seek professional help nor divulge their anxieties to others (BeyondBlue, 2013; Clode, 2004; Kay, Mitchell, Claravino & Doust, 2008). Doctors who are not functioning properly are more likely to be distracted, pre-occupied, and can make mistakes, overlook essential steps and are not adequately focused on their patients (Fahrenkopf, 2008; Wallace & Lemaire, 2009). In other words, they may not be practising safely. Having a complaint does not mean they are not good doctors, and in fact, of all the complaints against doctors, few are substantiated. Even if they are, there are few doctors whose practice cannot be remediated with support, targeted education and monitoring. A complaint does not mean they are “bad” and should not be practising, and our attitudes should not be tainted by those very few who have brought the profession into disrepute by their notorious deeds. What is important to remember is that complaints, although serious to a complainant, may be of minor consequence in terms of risk to the public, although it is also true that a doctor who attracts several complaints of a minor nature may suggest a pattern of practice worthy of taking more notice of in terms of public protection. These considerations need to bring balance to how complaints are
viewed. Overall, there is no doubt complaints have value in that they bring to notice matters that may mean less than satisfactory practice, and that they play an important part in protecting the public against unsafe care. But it should also be acknowledged that the process of dealing with them may cause harm.

This is an issue of public interest: the complaints process has the potential to harm the individuals involved in it, and if they are harmed, they may harm their patients. A vital question hangs in the air: has the drive to protect the public been at the cost of the wellbeing of doctors, and if so, could there be a different approach to keeping the profession accountable while promoting public safety? The very quality that we want to see in doctors – their humanity – is the quality that I aimed to draw out in this study: where did the hurt that so many feel come from, what is it about and what consequences has it meant for them and their practice and career?

How this is presented is a narrative in itself. As will be explained, a narrative is not just an account, a chronology of events or a simple story of what event led to another. A narrative has a point to it and how it unfolds is how the narrator chooses to tell it, selecting events, ideas and concepts that the narrator deems to have a meaning that goes beyond the incident or idea in and of itself. What gives it meaning is the context in which it occurred, its historical, social and political environment, taking account of how it would have been viewed in its day, not how we would interpret it today.

If the underlying contributors of harm to doctors are better understood, we can more effectively advocate for regulators and complaints-handling bodies to take account of the adverse impacts. To better understand these contributors, and the context in which they arise, the following thesis presents my approach to seeking out an explanation. The thesis is presented in two parts:

- **Part One, Shaping the profession**, provides the background, or the context in which the medico-legal environment was shaped and currently operates, and the impact this has on the individual doctor;

- **Part Two, Why do complaints hurt so much?** presents the findings of my empirical research and its conclusions.

**Part One: Shaping the Profession**

**Chapter One, The law and medicine**, traces the history of the interrelationship between the law and medicine, and the genesis of the profession of medicine and of the regulatory environment in which it functions. While medicine has been practised for millennia, the account presented here commences with the beginnings of the modern profession of medicine in nineteenth century Great Britain and Australia as its colony. It considers the various interests that sought to define the profession, and who was to belong within it, and why the boundaries around medicine became important to address and resolve. This occurred in the social and political context of the developing
industrial economy, where science and medicine offered chances of survival and cure never before possible, and society became increasingly enamoured with what they had to offer.

The guiding principles of the medical profession were not just about the special interests of elite groups vying with each other to be recognised as legitimised doctors with power and prestige. There was another reason for the fight for exclusivity: to protect patients against those “quacks” and other pretenders who might harm patients through their mistaken remedies or by denying patients access to real, legitimate doctors. The outcome was a compromise of sorts, but one that was sanctioned by new legislation which enabled the profession to exist as an elite institution and in doing so, defined who was to belong by virtue of their exclusive training and knowledge.

The decades that followed saw the expansion of the profession into a highly technological and specialised institution with considerable power and influence that enabled it to flourish as an autonomous self-regulating body (McKinley & Marceau, 2002). While it enjoyed the considerable advantages of such exclusivity, society was also moving along, and some important events occurred that meant the profession was exposed to various turning points that challenged these advantages. This chapter traces some of these turning points, of which the Chelmsford Private Hospital scandal in NSW in the later part of the twentieth century was one of the most significant, in terms of challenging the autonomy of the profession, but also challenging the capacity of the existing regulatory mechanisms to recognise and effectively deal with the egregious actions of a few doctors who brought death, harm and lasting trauma to scores of patients. Some big questions demanded answers, and unless these were satisfactory, the confidence and trust of the public in health care providers and the institutions whose role was to protect patients against unsafe care, would be severely at risk. This was a turning point for the people of NSW, and from the judicial inquiry that followed the revelations of what had been happening, the Health Care Complaints Commission (HCCC) came into existence, whose primary objective was to protect the public. It would do so by receiving complaints about health care providers – private and public hospitals and clinics, registered and unregistered health practitioners – and assessing how best to deal with such complaints, based on their significance for public protection. Protection of the public was not assured, however, by this institution, and in NSW as elsewhere, there continues to be a succession of scandals, health practitioners found to be guilty of various misdeeds, poor or dangerous performance, unsatisfactory conduct, and other events that continue to undermine the public’s trust. One thing stands out and that is that doctors are the ones who are most often sued, are most often complained about, and most often have to otherwise account for their conduct.

**Chapter Two, Shaping the profession**, examines the nature of the profession, and what it is about the profession that is held so highly that the public is less tolerant when it breaches its trust. The chapter looks at what is expected of the profession, and what it expects of itself. If a patient is seeking a “good doctor”, what characteristics are they looking for, and is this the same as what the regulators demand, their colleges define and the educators prepare doctors for? Such questions
lead into the next chapter which goes beyond the principles and codes which guide the profession, to how the profession is actually regulated in terms of the standards by which it must practise.

Chapter Three, *The law in action*, describes the mechanisms that provide structure and legislative authority to oblige the profession to comply with regulations, codes of conduct, principles and policy guidelines. The system that until recently functioned independently in each state and territory became a national body, the Australian Health Practitioner Regulation Authority (AHPRA), in 2010 with the aim of ensuring greater consistency and mobility in regulatory processes. This aim has not been fully achieved, with NSW and Queensland retaining different systems although also cooperating in a co-regulatory arrangement with the national body. This is a national study, though it focuses more on the NSW system as this is where statutory authority for complaints-handling was first introduced.

Chapter Four, *The impact of regulatory processes*, sets the foundation for my own study. It presents an overview of what is known about how doctors respond to the regulatory processes that are described in Chapters One to Three. To put it simply, it examines what it is like to be on the receiving end of complaints. What is shown is that many doctors suffer adverse emotional and psychological harms, may suffer physical effects through illness, and may experience behavioural changes that affect how they practise, their attitudes towards their patients, the regulators, their administrations, colleagues and even themselves. It challenges the very core of what it means to be a doctor. The questions are: is it remediable, and why does it matter?

Part Two: Why Do Complaints Hurt So Much?

Chapter Five, *Methodology*, introduces the study, which consists of interviews conducted with doctors with experience of at least one complaint or other medico-legal intervention, whom I will refer to as “Doctors in trouble” (DiTs), and a small group of experts, or informants, in their capacity of providing professional support to doctors. Interviews were conducted in a semi-structured, open and narrative style, transcribed and analysed to identify key concepts which were then constructed into a framework, or structural analysis, which became the basis for a critical interpretation. This chapter explains the selection of methods and my interpretation of narrative.

Chapter Six, *Findings*, presents the outcome of the interviews, in two sections:

*Part One* is a detailed summary of the testimonies of the doctors in trouble, based on the transcripts of their interviews and pertinent observations that I add as the interviewer and researcher, set out in a framework constructed under these broad domains:

- The complaint experience: reactions, responses to receipt of a complaint
- The law in action: perceptions of the complaints process
- Getting through it, telling others: seeking support from others, or not
• Moral legitimacy: being a good doctor, or not, or what the complaint represents

• Changes: practice changes, career changes, attitude changes.

Part Two is a more descriptive presentation of the observations of the expert informants, based on the above framework. They provide a broad perception of what doctors experience, and some of their perspectives of why this is so.

Chapter Seven, Silent narratives, is the Discussion, or critical interpretation, that brings together the concepts and literature introduced in Part One, Shaping the profession, with the testimonies presented in both parts of the Findings, and based on the framework above. This will reach deeper into the underlying causes of doctors’ responses to complaints, to explain the findings of previous research and to add greater depth and understanding to what has already been written about by others. These are the silent narratives that little is known about, probably not thought about, rarely spoken about, but now, I hope, will be cared about.

Finally, the discussion will present a critique of how the objective of public protection is served by the complaints process, and by referring to the perceptions of the participants on this very topic, how it could be different.

The conclusion will bring a close to this study, but I hope not to a continuing recognition of the hidden and unintended consequences of the complaints system. This system grew out of an aim to balance the power of the health professions against the rights and expectations of patients to have not only safe care, but also a mechanism for harms, wrongs and grievances to be resolved, and for the public to have greater trust and confidence in its health system as a public good and necessity. What was not anticipated was that this very system may cause harm, and suggests that the balance may have tipped a little the other way. At least, this is how participants see it, and feeling this way, they feel diminished and powerless. The question about doctors’ personal moral legitimacy then becomes critical, and the value they place on themselves, and that is placed on them by others and the regulatory process, as worthy instead of being forever blameworthy, is a key to how they reconcile and recover.
Part One:
Shaping the Profession
**Introduction: History and Narrative Explanation**

By understanding the past we can better understand the present, and so we may ask what happened in history that shaped our current institutions, laws and regulations. We may also ask what shaped the way we as a society define and then deal with issues that concern us. For instance, we now accept that the public expects greater accountability and effective mechanisms for seeking redress for perceived and actual wrongs; this idea did not just appear, it developed out of a specific nexus of social, legal and professional actions.

Chapter One will discuss the interrelationship of the law, its institutions and the medical profession. It seeks to identify and explain the factors that contributed to the demand for greater accountability by the profession, and how these factors resulted in institutional, regulatory and professional change from being the closed, self-regulating and autonomous profession of the past, to being subject to open scrutiny and public opinion. It is against this background that my study examines how the activities of the institutions that resulted from these changes impact on the individual practitioners who work within this regulatory environment (Mink, 1970, p. 544).

This examination is not just a chronology of events. It identifies events that were significant as catalysts to the changes which are discussed in this chapter. This is presented in the form of a narrative aimed at examining how these events led to the changes that followed. As Polkinghorne states, “Narrative explanation….explains by clarifying the significance of events that have occurred on the basis of the outcome that has followed. In this sense, narrative explanation is retroactive.” (Polkinghorne, 1988, p. 21).

This narrative highlights an underlying theme that identifies the contextual as well as the factual accounts of events, which Polkinghorne (1988) terms as “a process of emplotment”. He says: “By recounting the connections between events and actions that have led to a particular occurrence, the researcher arrives at an appropriate statement of the reasons for the event.” (Polkinghorne, 1988, p. 174). Accordingly, the underlying theme, or plot, of this chapter is to identify why it was that the objectives of law and regulation moved over time from protection of the profession to protection of the public.
Chapter One: The Law and Medicine

The law is a living thing, responsive to changing socio-political and economic needs, but also reactive to challenges brought before it. In the words of the Austrian legal scholar, Eugen Ehrlich, regarded as one of the founders of the field of sociology of the law:

The investigation of the living law will of course render neither the historical nor the ethnological method superfluous; for we can learn the laws governing the development of society only by studying the historical and the prehistoric (ethnological) facts. But the historical and ethnological methods are indispensible, too, for the understanding of the state of the law of the present time. It is true we shall never understand the past but through the present; but the path to the understanding of the innermost nature of the present lies through the understanding of the past. Within every part of the present lies its entire past, which can be clearly discerned by the eye that is able to look into these depths.

In order to understand the actual state of the law we must institute an investigation as to the contribution that is being made by society itself as well as by state law, and also as to the actual influence of the state upon social law. (Ehrlich, 1962, p. 504)

Following this reasoning, the discussion of the law will be presented within a contextual framework that traces how events and societal factors have impacted on medicine as a profession and how the interconnection between law and medicine has effected these changes. Medicine grew as a profession enabled by the law, and with this growth came expectations from within the profession but also external to it. By setting itself up as an institution of exclusive expertise, knowledge and selectiveness, medicine developed great power and prestige (Freidson, 1970). Having both meant much was expected of it and of those who practise within it. Therefore, as the capabilities of medicine grew, so did the public’s expectations of what it could deliver. While law once existed to protect the profession, the pressures of the world outside of medicine to deliver its magic required the profession to become accountable, and here the law responded in the gradual shift of protection to that of the public.

The fundamental issue here is that law does not stand alone, but is responsive to the society in which it exists. To understand the law, what created it and why, we need to understand the historical, social, political and economic circumstances in which new law comes into being, or for existing laws to be revised. In other words, there must have been a reason for laws to be introduced and later amended.

The law is both responsive and reactive: in health care, it can respond to calls for greater safeguards when information is revealed relating to therapeutic goods, diagnostic tools, treatments, safety measures and accreditation standards by introducing legislation and new or
revised regulations. Or it can react when new events and challenges occur, such as laws of consent following civil proceedings\(^1\), or the passage of Health Care Complaints legislation in 1993\(^2\) in NSW following the inquiry in 1988-89 into Deep Sleep Therapy from 1963-1979 at the Chelmsford Private Hospital\(^3\). The law has not branched out on its own to dictate how medicine should function, but as Windeyer (in Jordens, Kerridge, & Selgelid, 2004) stated, “The law marches with medicine but in the rear and limping a little”. It comes along after in response or reaction to events, limping a little behind events that stimulate the need for action.

Nor does the law achieve change on its own – as a living thing, it responds and reacts to what the community and governments deem to be important. As Amsterdam and Bruner (2000, p. 2) explain: “If law is to work for the people in a society, it must be (and must be seen to be) an extension or reflection of their culture”. It is part of society’s culture, but does not define it. Instead, it provides boundaries and protections by which society can flourish.

As responsive in health care, law is protective of public safety by providing legitimate authority to institutions and practices, when for instance the existing authority is inadequate for dealing with actions that have threatened, or are likely to threaten, public safety. The Chelmsford Hospital inquiry, for example, determined that there was major deficiency that needed to be addressed before the underlying problem could be remedied: that of effectively dealing with infamous conduct in the practice of medicine. More will be said of this in the section *The infamy of Harry Bailey* to follow shortly that explains how an identified problem was examined and remedied for the safety of future patients.

**How Does the Law Do It?**

It is important to be mindful that not all human conduct is regulated by the law. Associations within society are kept in order, generally, by social norms which are the understood rules of conduct between people and groups, as well as by moral and ethical norms (Ehrlich, 1962). The law is responsive to situations where social and ethical norms are insufficient to deal with aspects of social behaviour and organisation. Where associations are part of the legal order, they will be regulated according to legal norms, and decisions will be made according to those legal norms.

The rule of law is the basis of legal norms. “One of the most basic principles in the Australian legal system is the recognition of the rule of law” (Raz, 1977, in Kerridge, Lowe, & Stewart, 2013), defined as encompassing two features:

- that all people (including the government) should be ruled by the law and obey it; and

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1. Schloendorff v. Society of New York Hospital, 105 N.E. 92 (N.Y. 1914): it was a judge, and not the profession, that determined the standard for valid consent.
2. Health Care Complaints Act 1993 (NSW)
that the law should be such that people should be able to be guided by it.

The law is therefore both enabling, and protective. There are two main sources of law in Australia: the common law and legislation (Kerridge et al., 2013). Common law is what is derived from cases before the courts, in which judicial decisions become precedents for determining reasons for decisions in other cases that are substantially the same. Legislation consists of laws, or statutes, that are passed by Parliament, or through parliamentary delegation.

What is the Public Good?

The role of the governments of the Commonwealth, states and territories is to protect the public good. The law is responsive to the needs of society, and in respect to health care, it exists largely to protect the safety of the public. Throughout the law and associated regulations are the terms “in the public interest” or “the public good”. But it is not always clear what is meant by that. The question is: what is the public good, how is it determined, and who determines it?

The public good, or the public interest, is not easily defined as it is seen as either representing the rights of individuals or the rights of the collective of individuals, the public.

Former Deputy NSW Ombudsman Chris Wheeler (2006, p. 34) stated that it is “widely accepted that the ‘public interest’ can extend to certain private rights of individuals – rights that in many societies are regarded as being so important or fundamental that their protection is seen as being in the public interest, for example privacy, procedural fairness and the right to silence”. On the other hand, he noted that the common view is that “public interest” extends beyond the community as a whole. His own view was that “public interest must also be able to apply to the interests of groups, classes or sections of a population between those two ends of the spectrum” (Wheeler, 2006, p. 34). A useful explanation comes from the Supreme Court of Victoria (1991) which said:

[The public interest is a term embracing matters, among others, of standards of human conduct and of the functioning of government and government instrumentalities tacitly accepted and acknowledged to be for the good order of society and for the wellbeing of its members. The interest is therefore the interest of the public as distinct from the interest of an individual or individuals⁴.

Johnston (2017) advises that the public interest should not be defined as “It has no overarching definition because it is contextually determined in scope and purpose⁵, which means that “in any particular instance, political, legal and regulatory authorities make judgement calls. And what may

⁴ Appeal Division of the Supreme Court of Victoria in Director of Public Prosecutions v Smith [1991] 1 VR 63 (at 75), per Kaye, Fullagar and Ormiston JJ.

⁵ The Conversation, Johnston, J. Whose interests? Why defining the ‘public interest’ is such a challenge. September 22, 2017 5.42am AEST.
be deemed in the public interest today may not be in a decade; it changes with social mores and values” (Johnston, 2017).

The essential point is that the public interest is at the heart of much of our law and regulation, as a protective and enabling framework that guides not only the law but the administration of the law. As Wheeler (2006, p. 34) stated:

Public officials have an overarching obligation to act in the public interest. They must perform their official functions and duties, and exercise any discretionary powers, in a way that promotes the public interest that is applicable to their official functions.

From this statement, the onus of determining and protecting the public interest is on public officials. However, this relates to the administration of the law, not to its genesis. Does the government act in the public interest when drafting legislation? A statement made in a 1981 judgement of the High Court of Australia stated that “executive Government…acts, or is supposed to act… in the public interest”. This does not mean, of course, that what is in the interest of executive government should automatically be considered to be in the public interest.  

As this decision demonstrates, there may be times when governments determine that their own interests override the public interest, which raises another point: the government may not always be seen to represent the public’s interests. It is therefore important to understand who the public is, because it seems logical to see that the government, in representing the public, stands for the public. However, McKinlay and Marceau (2002) argue that sometimes the state does act independently to shape social behaviour, and increasingly this is on the ascendant, being shaped by the interests of an increasingly concentrated cluster of powerful institutions and individuals. By contrast, a pluralist perspective views governments as acting with neutrality, in the interests of all citizens, and is therefore representing the common good or public interest (McKinlay & Marceau, 2002).

The principle of universal health care is an example, where the public may want or demand free health care, but a government may determine that this is fiscally and/or ideologically unreasonable. It could then be surmised that, while the government has an overriding obligation to protect the public’s interest, it must balance this with a broader interest which is to govern prudentially by protecting the overarching interest of the economy. While some would deem this irrelevant because a healthy society demands a healthy, educated population, others do not share this same value. Politics, then, is a contest between the values held by different parties both within Parliament and in response to representations from external sectional interests to determine, and

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6 Mason J in Commonwealth of Australia v John Fairfax and Sons Ltd & Ors (1981) ALJR 45 (at 49).
7 This matter refers to the disclosure of confidential information, about which the defendant Fairfax contested the view that the documents contain confidential information and that disclosure would be prejudicial to the national interest.
act on, what they deem to be in the public interest. The outcome may not satisfy everyone. As I will examine a little later, when the public has a different view of its interest from what the legislators deem to be the public interest, this can cause significant disquiet. Disquiet can also occur when there is more than one public interest, that one segment of the public benefits at another’s expense. Jaffe (1976, p. 984) concludes that “the proper function of lawyers is to represent significant views that otherwise would go unrepresented in cases affecting the public welfare”.

If we accept that the public interest extends beyond the rights and interests of the individual, then we should consider the role of Public Interest Law, for which Jaffe (1976) provides an explanation. He said this derived from a program introduced in USA in 1970 by the Ford Foundation, with the purpose of providing “representation of the unrepresented and underrepresented” (Jaffe, 1976, p. 982). Although this may be appropriate, it could leave the individual with a sense that they are being overlooked in the interests of the greater good. How the legislation relating to complaints about health care was framed is a good, albeit vexed, example of this. A complaint will be investigated if it presents an issue that means the public is at risk, but it may do little to resolve the complainant’s grievance. This will be explained further as the thesis unfolds.

**Who is the Public?**

For the purposes of this study, I take the view that “the public”, who will be referred to many times throughout this thesis, is the community as a whole, made up of all the individuals within society. The community is not an homogeneous group however, being made up of a multitude of sectional and at times competing interests. But as health affects everyone, and health care is a service essential to the health of the community, the provision of health care is in the public interest.

Being a sensitive issue for the community means that sometimes political parties are compelled to respond to the voice of the community, often represented by various sectional interests. Recent history in the past four or so decades demonstrated how the public’s interest in having safe health care became a political imperative to resolve when the public trust in government’s capacity to provide them with safe care was undermined by the exposure of various scandals. The public can become very agitated when they see that their interests are being neglected, damaged or betrayed, and so it is when the scandals are found to have been dealt with inadequately, or not at all, and fuelled by the media, the public can be unforgiving. McDonald’s (2012, p. 223) examination of how some public inquiries come about as a response to scandals explains that they are a way of restoring public trust: “If the public comes to believe that regulatory agencies are not sufficiently responsive to public scandals, regulators may lose public trust”, without which the regulators may lose their legitimacy. Scandals may then result in public inquiries, which may lead to recommendations for improved safety and risk minimisation, which may lead to regulatory change. The inquiries themselves will enhance the public’s perception of how adequately the regulatory mechanisms have been functioning, which will further question their trust. This may “create a
demand for greater controls to be imposed on the health professions” (McDonald, 2012, p. 224), and in some cases, I would add, on the regulatory authorities themselves. McDonald (2012) adds that inquiries into health-related matters directly or indirectly place the spotlight on health professionals, the health professions and the health professions regulators.

**The Voice of the Public**

This section focuses in on the public voice through examination of the case of Chelmsford Private Hospital in NSW in the period 1960s to 1980s, which saw an emerging scandal slowly played out over decades and grow into a crescendo of outrage. This divided the sectional interests of the public, the regulators, the watchdogs, Parliament and the medical profession, and finally compelled the government to call an inquiry, which led to significant changes in legislation, regulatory mechanisms, and greater control of the profession.

This account provides an example of the political response to the public will, when trust in the government to provide safe care was at a critically low point. There have been numerous examples of scandals and other outrages that have driven the need for change, but the scandal of the Chelmsford Private Hospital was especially egregious. I have elected to discuss this, not for the horrors the story contains, but for the chain of events that became a catalyst for the introduction of protective legislation, greater government responsiveness to public opinion, and for the significant challenge to the traditional power and autonomy of the medical profession. How regulatory mechanisms were framed and subsequently structured in NSW to ensure greater accountability can be largely attributed to this event. The legislation and mechanisms that were introduced greatly influenced similar structures in the other states, and had international influence (Thomas, 2002b).

What follows are the key aspects that highlight the deficiencies in the regulatory process that contributed to the continuing failure to adequately deal with the emerging crisis, and to the eventual actions that contributed to remedying these deficiencies.

**Chelmsford Private Hospital: The Infamy of Harry Bailey**

The psychiatrist Dr Harry Bailey took his own life in 1985, leaving a note that said: “Always remember that the forces of evil are greater than the forces of good. I always tried to be a good doctor, and I think perhaps I was”. Attached to the note was a list of all his degrees and qualifications (Anderson, 1991). The “deep sleep” treatment that he had introduced in 1963 had by 1985 been “completely discredited”, and he was facing criminal charges (John, 1993).

Dr Bailey thought he was a good doctor. Yet 25 people died under his care between 1963 and 1979, 24 died by suicide within a year of treatment, and countless others were irreparably harmed. The youngest who died was only 14 years old. Together with his colleagues, Dr Bailey’s actions became the reason for holding a Royal Commission into Deep Sleep Therapy, conducted by
Justice John Slattery from 1988 to 1989. The 4 000 page report was published in December 1990, and the above note was published a month later in the *New Scientist*.

**Box One: Deep Sleep Therapy**

<table>
<thead>
<tr>
<th>The treatment and its effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>From 1963-1979 deep sleep therapy (DST) was administered to 1 127 patients for such conditions as depression, anorexia nervosa, stress, drug and alcohol addiction, neuroses and schizophrenia. It was not an unknown treatment, having been used internationally but then discarded as ineffective. What was unique about it was the combination and the high level of drugs administered, and by often undertrained or untrained staff (Hansard, 4 December 1991).</td>
</tr>
<tr>
<td>Patients were administered a regime of sedative drugs to render them unconscious for an extended period of time, from several days to weeks. While sedated, patients were given electro-convulsive therapy (ECT). Dosages were increased and some almost doubled from the early 1970s.</td>
</tr>
<tr>
<td>Patients were kept naked and some were tied to their beds to prevent falling out. Bodily excretions collected onto the sheets.</td>
</tr>
<tr>
<td>The first deaths were recorded in 1964: five in that year and thereafter one to two per year. Risks included cardio-respiratory, cardio-vascular and neurological problems. Complications included infections, pneumonia and deep vein thrombosis, much attributable to being immobilised. Patients were often incontinent, suffered falls, had vomiting, skin breakdown and metabolic disturbance, and patients awoke with severe weakness, visual disturbance and hallucinations.</td>
</tr>
<tr>
<td>The main characters were the psychiatrists Dr Harry Bailey, those who assisted with electro-convulsive treatment, Dr John Herron and Dr Ian Gardiner, and Dr John Gill who was a part-owner of Chelmsford. Drs Herron and Bailey stopped practising DST in 1979.</td>
</tr>
</tbody>
</table>

**The Story Emerges: When Action Could Have Prevented More Harm**

There were numerous opportunities for intervention by the authorities over the two-decade period till the Royal Commission commenced in 1988. These are summarised here.

**The coroner**

The first intervention by the state was in 1964, when an inquest was held into the death of a patient, certified by the Government Medical Officer (GMO) as being caused by a coronary occlusion. This was deemed by the Coroner as sufficient in spite of the baffling statement by the GMO that “there were no external signs of any poison having been taken”\(^8\), yet the stomach contents had not been examined. Justice Slattery opined that as this was the second DST death, “Had the coronial system performed properly at the time, it is likely that Health and the medical profession would have been alerted to the dangers of the treatment” (Slattery, 1990, p. 3).

**Publicity**

The first story published was in the *Sydney Morning Herald* on 9 November 1967, reporting a Coroner’s concerns about the amount of dangerous drugs that had been administered to 23-year-old Ronald Carter, who died on 3 May 1967 while undergoing deep sleep treatment (Walton 2013). This had been preceded by a patient complaint in June 1967.

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\(^8\) Extract from Coroner’s report, cited in Slattery, 1990 Vol. 7, p.3
NSW Health

The 1967 complaint led the Private Health Care Branch of NSW Health to conduct an inspection of the hospital the following month. In spite of a report relating to the death of another patient that noted heavy barbiturate dosage, no expert opinion was obtained, and the report noted “No breach of regulations is apparent” (Slattery, 1990, (7), p. 4). A further complaint by a nurse about heavy sedation for 21 days and intravenous feeding was dismissed by the Director of State Psychiatric Services, regardless of his later admitting that DST had “scared the living daylights out of us” when it had been trialled at Parramatta Hospital in 1957 (Slattery, 1990, (7)). That there had already been numerous deaths was not correlated until years later when the Royal Commission pieced it all together.

Doctors’ treatment was not to be questioned

In 1973, a further inspection appeared to have been restricted to comments about the premises, such as the number of beds and labelling of bottles of drugs for patients, though there was no inquiry into the nature of the drugs themselves. The head of the Private Hospitals Branch explained at the Inquiry that their role was to ensure regulations concerning the premises were being complied with, but it was beyond their jurisdiction to question the treatment ordered by the psychiatrists. In short, treatment to private patients was seen as being “quite outside the ambit of Health’s responsibility” (Slattery, 1990, (7) p. 9).

NSW Medical Board

It was Thomas’ (2002a) view that the Medical Board, as the chief custodian of medical discipline, had responsibility for taking action against the Chelmsford doctors. However, interpretations of the descriptors for conduct at that time – “infamous conduct” or “misconduct in any professional respect” – were deemed not to apply to practice issues, meaning that the doctors were safe from being prosecuted for their actions, and “guaranteed the non-accountability of individual practitioners” (Thomas, 2002a, p. 239).

Legal action

A coronial inquiry in March 1982 into the death of a patient found cases of negligence against three of the doctors and referred the matter to the Attorney-General. Dr Bailey was indicted for manslaughter. Committal proceedings began in 1984, were completed in 1985, whereupon Dr Bailey was discharged because his actions did not meet the criteria for manslaughter. However, several more complaints were lodged against him in that year, and in September, he killed himself. Meanwhile, the matter had been discussed in Cabinet in August of that year, and although the suggestion for a Royal Commission was rejected, a sub-committee was formed to consider the issues.
Stirrings of change

A former patient, the forthright Mr Barry Hart spoke of his experience to the media, and in 1976 he commenced civil proceedings against Dr Bailey and the hospital.

The Minister for Health ordered an investigation in 1978 after departmental officers visited the hospital, following a complaint by a nurse that included secretly copied patient files. But “the investigation into Chelmsford from October 1978 to August 1980 was perfunctory” and the few superficial procedures were performed in a “grossly incompetent manner” (Slattery, 1990 (7), p. 160). Meanwhile, politics had entered the fray as the public became increasingly concerned about the emerging stories. “Zombie Deaths Inquiry” headed a story in a Sydney paper on 24 September 1978, following the above investigation. Responding to constituent representations about the mounting death toll and questionable coronial findings, a local branch of the Labor Party called for an inquiry in October 1979.

In 1986, NSW Health formed an investigating committee which found sufficient cause to refer matters against Drs Gill and Herron to a Medical Tribunal, but they applied successfully to the NSW Court of Appeal for a stay⁹, on the grounds of prejudice to them because of the “appalling and inexcusable” delay. Action against Dr Gardiner was also stayed as he had retired and was said to be very ill. Dr Bailey had died the year before.

Public disquiet was not stilled by this decision, and it was then that the Government bowed to public pressure by calling the Royal Commission, which commenced in September 1988. Among many other conclusions, it found that “Deep sleep therapy was an extremely dangerous treatment and was carried out with inadequate facilities, staff and equipment to deal with the risks. It was therapeutically ineffective.” (Slattery, 1990, (1), p. 219, 220). The judge took careful account of the historical context, noting that in the 1960s and 1970s, the public held doctors in high esteem, that they “were admired for their ethics, integrity and practice,” and that nurses held them in “awe, even fear”, rarely challenging a doctor’s decision or conduct (Slattery, 1990 (1), p. 236). Likewise, he held that the Health Department attitude assisted the continuation of the treatment, and the reticence to interfere with the treatment of a doctor’s private patients. It was these and other factors that enabled the three doctors to avoid scrutiny (Slattery, 1990, (1), p. 237). Along with several other recommendations to have come out of this inquiry, the authority of those who may have brought these issues to account was addressed by recommending an independent body to investigate and take action in response to complaints. The failure to have done so prior to these events caused the Justice grave concern, since many harms might have been avoided.

⁹ Herron v McGregor (1986) 6 NSWLR
After the report, further complaints alleged Drs Gardiner, Herron and Gill were guilty of professional misconduct, as defined by s.27(1) and (2) of the Medical Practitioners Act 1938 (NSW). An appeal to the High Court of Australia in 1993 was dismissed because so much more was now known because of the Royal Commission. A consideration of particular significance in their Honours’ deliberations was the public’s interest versus the doctors’ right to fairness. Having concluded that the doctors involved had been engaged in delivering “extremely dangerous treatment” which had harmed hundreds of patients and killed 24 of them, the Decision determined that the public’s interest would prevail. The Tribunal hearings then proceeded.

Public disquiet

The Royal Commission had astonished the public and disquiet continued to brew. The public wanted such incidents to never happen again to others, and the patients wanted justice. The public campaign commenced in earnest when the story was aired on the TV show 60 Minutes in that year, exposing what they declared to be government inactivity. “What followed was a lamentable series of bungles by different parts of the bureaucracy, which ultimately led to the striking out, 11 years later, of misconduct proceedings against the Chelmsford doctors because of this delay” (PIAC, undated).

The above words encapsulate the depth of outrage of the people of NSW, incredulous that this could happen in its day, not in the horror days of the former insane asylums. In 1983, a group calling themselves the Chelmsford Victims’ Action Group had lobbied noisily for an inquiry into the scandal, and supported by the Medical Consumers Association, they accused the NSW Health Department’s Complaints Unit of failing to act because, amongst other assertions, it was “too busy investigating matters such as contaminated goat’s milk.”

What happened next

Public unrest generated sufficient energy to threaten a government in power, and threatened the status quo of a comfortable medical profession that relished its position of power and prestige within the community and that did not wish to relinquish its self-regulatory, semi-autonomous status. The government in power was compelled to act, and finding the existing agencies to be lacking the authority they needed to take significant action, took the matter to Parliament to debate its draft bill to establish an independent statutory authority with the powers to investigate and

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10 s.27 (1) refers to a lack of adequate knowledge, experience, skills, judgement and/or care in the practice of medicine;

s.27 (2) refers to improper or unethical conduct relating to the practice of medicine

11 Walton v Gardiner, Herron and Gill [1993] HCA 77; (1993) 112 ALR 289


Estoppel: “the principle by which a person cannot assert something contrary to their previous statements or to a relevant judicial determination.” (Compact Oxford English Dictionary: Revised ed. 2003, Oxford University Press, Oxford and New York. It could not be asserted the issues were the same in the 1986 case as the 1993 case, so the reasons for granting the appeal to stay the proceedings against the doctors in 1986 did not apply in 1993.

13 Public Interest Advocacy Centre broadsheet Deep sleep tragedy www.piac.asn.au/legal-help/public-interest cases/deep-sleep-tragedy (undated)
prosecute complaints about health care, as recommended by the Royal Commission. This was the first such legislation in Australia, and it was aimed at representing the public interest.

This demonstrates how the law can be characterised as a reactive and responsive living thing, how the functions of government have operated in the past and how they will do so in the future, based on the remedies provided by new or revised laws in response to changing public circumstances and imperatives.

The Inquiry had not only exposed the consequences of self-regulation; it had also identified what was required to expose the dangers of self-regulation when external scrutiny was not available, or was not pursued adequately, to compel individual doctors to be accountable for patient safety. The significance of this exposure for the medical profession was profound, in terms of the challenge to the profession’s powers and its autonomy, and its accountability beyond the profession but also to Parliament, to regulators and to the public. As McDonald (2012, p. 226) states, “The reports of public inquiries provide a narrative that informs public perceptions about whether self-regulation is effective or not”.

Secondly, the Inquiry showed what was needed to overturn the limitations of existing regulatory provisions. Through the systematic scrutiny of the state health department and complaints body at the time, much was revealed about the effectiveness of regulatory procedures and the loss of trust and confidence in these provisions by the public. The Complaints Unit (CU) had been established in 1984 to address the burgeoning number of complaints being channelled through to the NSW Medical Board via its existing mechanism, the Investigating Committee, which had only limited powers to deal with cases relating to medical treatment. The Complaints Unit was to have overcome the deficiencies of existing mechanisms. Its initial functions were to deal with matters relating to fraud and over-servicing, and its staff included police to investigate these matters. In its first year there were 500 written complaints, the majority of these against doctors, two thirds of whom were in private practice (Thomas, 2002a). As the Chelmsford Inquiry later demonstrated, ensuring accountability of those in the private sector was problematic, given that the CU was established within the State government. With the Australian health system fragmented into State and Federal jurisdictions, the State government had little control over activities in the private sector.

The Unit also lacked the independent statutory powers to fully investigate and deal with major threats to public safety, such as the serious misconduct of health professionals, and to effectively deal with the numerous systemic problems in health services. The passage of the 1987 Medical Practitioners’ Act gave the Unit greater power to investigate and refer matters directly to the Tribunal. There is no doubt that the Unit had much success in its years of operation. Under the previous system, between 1963 and 1972, just 13 cases in all were referred to a Medical Tribunal. By contrast, in 1988, the year after the Medical Practitioners Act had been passed, 15 cases were
sent to a Tribunal, and 12 to a Professional Standards Committee (PSC), which was a newly established mechanism convened by the NSW Medical Board to hear cases of lesser seriousness, with less serious consequences for doctors. They were held in camera, could impose conditions, a fine and/or a reprimand, but not suspend or de-register a doctor (Thomas, 2002a). However, after the complaints about Chelmsford burgeoned, the necessity to address the constraints on the Unit identified through the Commission of Inquiry resulted in the recommendation for an independent, statutory body with its own powers to investigate and prosecute complaints in all sectors (Thomas, 2002a; Pierce, 2017; Donnelly, 1990).

At the same time, the medical profession was feeling under threat from these steps towards greater accountability of doctors. In May 1984, Dr Lindsay Thompson declared “we remain a profession under siege” (Donnelly, 1990). The AMA, GPs and surgeons wanted the Unit terminated, or its powers limited, and so began a campaign that continued all the while and into the period of debate about the need for an independent statutory body, which was to become the Health Care Complaints Commission (HCCC). Protests and fierce lobbying came from all sides. Chelmsford victim Barry Hart’s fight for reasonable compensation for the harm he had endured became the focus of the controversy about the purpose and functions of the proposed HCCC. Many, supported by consumer activist groups, cried out for an advocacy function, to fight for just compensation. Others wanted it to be solely for resolution of their personal grievances, while the Unit itself and various public interest groups, whose collective voice was heard through the Public Interest Advocacy Centre, lobbied in favour of a body that represented the public interest, not as a personal advocacy service. On the third attempt to pass the Bill, which by then had seen numerous amendments aimed at appeasing the various interest groups, it was passed by a single vote in 1993.

The early days of the new HCCC saw continued wrestling as the new powers began to take effect. From the consumers’ perspective, many were not happy with what the HCCC could deliver. Yet it was a body established for the public interest, and complaints were a window into what was wrong with health services. Trust in the organisation was problematic to foster, and the HCCC has remained under intense scrutiny for the decades since then.

These decades also saw a continuing sequence of events that have tested the authorities’ capacity to deal with public safety, and to test the public’s trust, and that continued to demonstrate very clearly why regulation of health care is both necessary and expected. The next section shows that parallels with the United Kingdom, and elsewhere, are more than a coincidence. The demand for greater accountability, and the responsiveness to this expectation by governments and their administrations were the common themes for this same period. Not only were there stand-out events that occurred, but there was the common backdrop of emerging knowledge about the quantum of iatrogenic harms in hospitals throughout the western world. The other backdrop was the contemporary rise in consumerism (the rights to have, the right to be heard and the availability
of mechanisms for complaint and redress), and the media's thirst for reporting on contentious issues and for amplifying public opinion. The “closed shop” of medicine was having its doors opened.

**Chelmsford Was Not the Only Turning Point**

In England, the Bristol Infirmary incident in the late 1980s to early 1990s represented a significant turning point in England because it not only led to a major inquiry into the events, it also challenged the very heart of the “closed shop” of the medical establishment by exposing the individual culpability of the practitioners involved. Exposure had relied on the whistle-blower anaesthetist Dr Stephen Bolsin, who was so pilloried for his betrayal that he resigned and moved to Australia. There have been many other serious incidents in UK, particularly the mid-Staffordshire Hospital scandal, but as with Chelmsford, Bristol was a new revelation, and the implication for shaking up the medical establishment was immense. A week after three doctors at the centre of these events had been found guilty of serious professional misconduct, the *British Medical Journal*’s Editorial declared that the judgement would probably prove much more important to the future of health care in Britain than reforms initiated through Parliament. While reform was generally slow to take hold in practice, “the Bristol case is a once in a lifetime drama that has held the attention of doctors and patients in a way that a white paper can never hope to match” (Smith, 1998, p. 1917). The case was described as a tragedy “Shakespearean in its scale and structure”, at the heart of which was the trust that patients place in their doctors. The GMC’s president, Sir Donald Irvine, told the three doctors at the heart of the scandal that:

> A parent placing a child in a doctor's care must have confidence that the doctor will put the child's best interests before any other. A doctor who fails to live up to that expectation will seriously undermine not only his or her relationship with that particular patient or parents, but the confidence of all patients in doctors (Dyer, 1998, p. 7149).

Events of similar consequence have taken place elsewhere that have become the catalyst for major change. In New Zealand, an Inquiry conducted by Justice Silvia Cartwright (the Cartwright Report) in 1988 followed a government inquiry into an “unfortunate experiment” (so-named by Professor David Skegg in a letter to the NZ Medical Journal in 1986) at the National Women’s Hospital. The gynaecologist Dr Herbert Green had followed the progress of women with carcinoma in situ (CIS) of the cervix, aiming to find if CIS inevitably developed into invasive cervical cancer. But the 100 or so women involved in this study received no treatment in order to attain this end,

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14 The Mid-Staffordshire NHS Trust came under significant criticism for its failures to deliver acceptable standards of care to patients, favouring instead to meet business targets, achieve financial balance and to seek foundation trust status. Patients were at risk and medical and nursing staff had poor morale. Even when concerns were coming to light and an investigation commenced, no intervention was initiated until after the investigation was complete. A public inquiry chaired by Robert Francis QC made numerous recommendations, from the: Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry February 2013. www.midstaffspublicinquiry.com
leading to the deaths of several of them. Other allegations were uncovered by the Inquiry, including vaginal examinations conducted for teaching purposes while the women were under anaesthesia for other reasons, and smears taken from baby girls, all without knowledge or consent of the patients (or their parents) (Paterson, 2012).

The outcome of the Cartwright Report was the passage of the Health and Disability Commissioner Act 1994, whose aim was to “promote and protect the rights of health consumers and disability services consumers” (from Preamble to the Act), and the appointment of a Commissioner. As with the experience of NSW, many doctors saw this as “an unacceptable intrusion by the state into the practice of medicine” (Thomas, 2002b, p. 88).

**Significance**

When political sensitivities are touched by events that arouse public outrage, and when existing authority is insufficient to deal with deficiencies, legal remedies are employed to resolve the fall-out. A decade after Chelmsford, the HCCC was itself under scrutiny. An investigation by HCCC into allegations by nurses about conduct at the Camden/Campbelltown Hospitals in 2002 made numerous recommendations about systems issues (Dunbar, Reddy, Beresford, Ramsey & Lord, 2007). Dissatisfaction with this outcome resulted in the Minister requesting a Special Commission of Inquiry into Campbelltown and Camden Hospitals (the Walker Inquiry), to be conducted by Bret Walker SC, to inquire into allegations of unsafe care at the hospitals, into the investigation by the HCCC and into the death of a baby. The HCCC investigation was found to have breached its statutory requirements to inquire into the conduct of named individual practitioners (Faunce & Bolsin, 2004; Wade, 2017).16

The Inquiry led to the sacking of some senior administrators at the hospitals and the former HCCC Commissioner, and the appointment of a District Court judge as acting Commissioner. The final report17 dated 30 July 2004 led to strengthening the obligation of the HCCC to ensure accountability of individual health practitioners, by passage of amendments to the HCC Act. In addition, thirty doctors and nurses were referred to the HCCC for investigation and disciplinary action under the oversight of the new Acting Commissioner.

This incident was not without major criticism, because of the reactiveness of the incident. Retired surgeon Tom Hugh pointed out the paradox of the same minister (The Hon. Craig Knowles) having demanded this action, yet also having established the Clinical Excellence Commission (CEC) just two years before, whose role was to examine systemic issues. He said the success of CEC in bringing about systems change had now been jeopardised by the punitive actions of the Inquiry,

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15 Preamble, Health and Disability Commissioner Act 1994 (New Zealand). Note unlike NSW equivalent legislation, this Act allows for the establishment of a Consumer Advocacy Service.


leaving staff demoralised and anxious about "Walker-style inquiries", and anger in the community intense (Hugh, 2004).

Further commentary by Dunbar, Reddy, Beresford, Ramsey and Lord (2007) reflected on the aftermath, following interviews with people directly involved with this and three other inquiries in different hospitals. In each case, clinical concerns raised by staff had not been appropriately or adequately handled, resulting in concerned staff acting as whistle-blowers escalating their complaints to the authorities. Public inquiries resulted in recommendations to improve public safety, senior administrators were called to account, and regulatory mechanisms were revised and restructured (Dunbar et al., 2007). Themes observed by the authors emerging from these inquiries were the loss of trust in management and among clinical colleagues, and loss of trust from patients and the community. Although the inquiries may have resulted in constructive change by revealing the critical problems within the health system, the demoralisation and fear that this generated were said to be counterproductive in protecting public safety.

**Scandals, Doctors and Trust**

Loss of trust in regulators has pervaded the past decades, not only because of these inquiries. Alleged failures to deal with individual doctors who had stepped over the line of unprofessional conduct have reinforced the public’s opinion that the profession looks after its own, that the regulators and doctors cannot be trusted, and that the public is not safe. The following examples demonstrate the complexities of “bringing to heel” some of the more notorious characters who have both fascinated and appalled public sentiment in recent Australian medical history. What they also show is that in spite of the regulatory changes brought about following Chelmsford, there continued to be gaps in jurisdictional and regulatory capacity to assure the public of its safety. Out of several candidates whose cases could just as aptly have fitted the “notorious character” depiction, I have selected the former Dr Graeme Reeves, obstetrician and gynaecologist, and Dr Jayant Patel, general surgeon, whose notoriety extends beyond Australia to USA whence he came, and to which he was unceremoniously returned.

**Dr Reeves**

Dr Reeves had been found guilty by a Professional Standards Committee (PSC) of serious misconduct in 1997, and was no longer allowed to practise obstetrics. As a PSC was not open to the public, these facts remained confidential. He subsequently moved to Bega on the south coast of NSW and was employed by Bega Hospital as a specialist obstetrician and gynaecologist. The scandal came to light in 2008 when he was charged with aggravated sexual assault, indecent assault of several patients (grievous bodily harm and genital mutilation) during obstetric and gynaecological procedures. He was found to have lied on his application for employment at Bega Hospital that he had no conditions on his practice. He was also found guilty of Medicare fraud offences, and guilty of two of five assault charges. In 2013, he was charged with manslaughter.
following the death of a patient in 1996, and found guilty of negligence in 2017 in that it was found he did contribute to the woman’s death, but it did not amount to “gross criminal negligence” on which a manslaughter finding could be made, or that would require criminal punishment. There were dozens of other cases that never went to hearing, so justice for the patients involved in these was not served. But he could no longer harm any patients (Wells, 2018).

The major issue was that Dr Reeves had been able to practise obstetrics and cause much harm, after he had been prevented from doing so. An inquiry, conducted by Peter Garling SC into acute care in NSW in 2008 included this very question in its brief. Garling was reassured that some of the deficiencies in the regulatory system were to be covered by the 2008 amendment to the Medical Practice Act which was to introduce mandatory reporting. This would place the onus on health practitioners and others to report those practitioners who were believed to be a risk to the public18. The Minister, The Hon. Reba Meagher (in Jackson & Parker, 2009), said in a media release of the report (the Garling Report) that this would restore trust: she argued that in spite of the current Code of Professional Conduct that included a professional and ethical obligation for doctors to report others, there remained “the public perception of a ‘closed shop’ culture and of a profession that protects its own”19. Jackson and Parker (2009, p. 37) noted the considerable media interest at that time about the “abhorrent cover-up”20, of which they said “the public outcry is highly likely to have strongly influenced the government’s decision to respond with legislation.”

The NSW Medical Board had to account for its failure to follow up on the conditions that prevented Dr Reeves from practising obstetrics. The Southern Area Health Service was required to account for why it had failed to check the veracity of his employment application in 2002. He was struck off the register in 2004 for breaching the order that he not practise obstetrics. Thereafter, it has been a requirement in medical recruitment to check the credentials of an applicant. A similar failure occurred in the case of Dr Jayent Patel in Queensland, discussed below.

Here was an example of the reactivity of regulatory authorities when existing mechanisms were inadequate, or were applied inadequately, to serve the public interest. “The Reeves saga and consequent events leading to this legislation (mandatory reporting) illustrate how not only individual

18 Medical Practice Amendment Act 2008 (NSW), which amended the Medical Practice Act 1992 (NSW). s71a stated:
(1) A registered medical practitioner commits reportable misconduct in the following circumstances:
(a) if he or she practises medicine while intoxicated by drugs (whether lawfully or unlawfully administered) or alcohol,
(b) if he or she practises medicine in a manner that constitutes a flagrant departure from accepted standards of professional practice or competence and risks harm to some other person,
(c) if he or she engages in sexual misconduct in connection with the practice of medicine.
(2) A registered medical practitioner who believes, or ought reasonably to believe, that some other registered medical practitioner has committed reportable misconduct must, as soon as practicable, report the conduct to the Board.
Note: Pursuant to sections 36(1)(b) and 37, failure to comply with this section will constitute either unsatisfactory professional conduct or professional misconduct.
practitioners, but also the health system, can fail patients, and how politicians may respond to public outcry for action” (Jackson & Parker, 2009, p. 35). In response to the focus on doctors, The Australian Doctors’ Fund declared that “no other health profession will carry this obligation” and claimed that doctors were effectively being made scapegoats for administrative and systemic health failures in New South Wales (Jackson & Parker, 2009, p. 35).

The matter of Dr Jayant Patel echoes similar issues, demonstrating that although such flagrant cases are rare, they continue to cause dismay. Dr Patel was employed by Queensland Health from the USA to take up a position as surgeon in the regional town of Bundaberg on the north coast of Queensland. After a growing list of dead or catastrophically injured patients, and talk of staff hiding patients from him, a whistle-blower went to a Member of Parliament after the local administration refused to investigate. The furore that followed the disclosure caused an enraged Dr Patel to resign and return to the USA. The medical director of the hospital finally checked Patel’s history, and a simple Google search found he had been disbarred for incompetence in the USA. The scandal had broken, and the whole saga played out over years, and finally, Dr Patel was returned to Australia to face charges of manslaughter.

Two inquiries were conducted into this matter. The Morris Inquiry was dismissed due to perceived bias. The Queensland Public Hospitals’ Commission of Inquiry (the Davies inquiry) was conducted between September and November 2005. The inquiry found that more than 20 complaints by staff had been ignored by the hospital administration, which declared the complaints were “unjustified and largely personality driven… when they raised genuine and concerning medical issues” (Davies Inquiry 2005, 3.427(i)). An investigation in 2010 after the inquiry found Dr Patel guilty of three charges of manslaughter and one count of grievous bodily harm and sentenced to seven years’ gaol. But following an appeal to the High Court in 2012, the convictions were quashed and in a retrial, Dr Patel was acquitted of one of the manslaughter charges. There followed a plea deal relating to penalties for the fraud charges, and the remaining charges were dropped. He was de-registered in May 2015, and after the trial he returned to the USA.

The scandal engulfed others. Adverse findings were made against the Director of Medical Services at Bundaberg Base Hospital for multiple failures to check the credentialing and privileging of Dr Patel and for failing to appropriately act on complaints. It was believed that had he acted in a timely way, many of the deaths and complications would have been avoided (Davies, 2005, p. 192). The fallout continued to plague the Queensland Medical Board, which the Davies Inquiry ruled incompetent for its failures in allowing overseas trained doctors, such as Patel, to practise in

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21 At the time of writing, an inquiry is under way into the four hospitals where the repeated instances of proven professional misconduct occurred, of former obstetrician and gynaecologist Emil Gayed, de-registered on 6 June 2018 by the NSW Civil and Administrative Tribunal.

22 The Queensland Public Hospitals’ Commission of Inquiry, September to November 2005, and transcript of proceedings, 29 May 2008 (The Davies Inquiry)
Queensland without meeting the Australian standards. In particular, it had failed to inquire further into Patel’s history, which he had lied about on his application form (Thomas, 2007, p. 406).

**What It Means**

The spotlight through this sequence of events has been on: (a) the adequacy of existing regulatory bodies to maintain standards of care, to protect public safety and to deal with those practitioners whose notoriety caused shame and embarrassment, to restore trust that had been betrayed by these alleged deficiencies; and: (b) the health professions, mostly nurses and doctors, and most particularly, doctors. It was clear from the cases I have outlined as they were examples of misconduct of a most serious and egregious kind. But as will be shown in Chapter Three, most health practitioners are not like this, and most adverse events in health care are not due to negligence, incompetence or wanton neglect. But clearly, there has been sufficient concern that public safety has been a challenge to protect, and regulatory mechanisms have been shown to have their shortcomings. The impact for the medical profession was that its power had suffered a critical blow, and where once the law came into existence to protect the profession, it now existed to protect the public.

The other aspect, alluded to by the fallout from the Walker inquiry into Camden/Campbelltown, was the demoralisation and fear generated from these inquiries that speaking up in a blaming culture could be counter-productive to patient safety. The spotlight on the professionals was beginning to have its effects on those professionals, and not always in a constructive way. For Toni Hoffman, the nurse in the Patel case, being a whistle-blower nearly destroyed her, but when found to have been vindicated, she was rewarded for her diligence. But the law suit that followed was an expensive lesson for the government (Thomas, 2007).

Taking a step back, we will now return to the origins of the profession, and trace its rise through to the levelling that the above accounts allude to, which coincided with other revelations and changes happening in the wider society, such as the exposure of the quantum of adverse events in hospitals, rising consumerism and a rights-based culture, together with the demand for accountability from all institutions.
Chapter Two: Shaping the Profession

Medicine, Professionalism and the Law

This chapter traces the beginnings of the modern medical profession. It does not delve into the practice of medicine itself, much as this is intriguing, given the questions around what medicine is, why it selected certain aspects of what we now know as medical practice, and not others. An excellent account that explores these questions can be found in the work of David Thomas, in his 2002 doctoral thesis and subsequent publications (Thomas, 2002a).

This chapter explores how medicine emerged as a legitimated profession with exclusive membership and knowledge, autonomy and self-regulation. This process of professionalisation is presented in the context of the historical, social and political period in which other professions were likewise emerging with similar authority, such as law, dentistry, and civil administration. As was presented in the introduction to Part One, changes take place for a reason. This account considers why certain events took on such significance that they became the catalysts for change, and what enabled such changes to occur. In considering these changes, we will consider the role of law in the creation of the modern profession of medicine, and how it was that it was established as a profession of privilege, exclusivity, self-regulation and autonomy.

The events and their consequences presented in Chapter One could not have been envisaged in the early days of the profession and in the laws established then to protect the profession. Subsequent events, a changing political environment and a society whose expectations and values had substantially changed to demand greater accountability, safety, and protection of its rights, compelled the profession to adapt through the introduction of measures that now exist to protect the public. This chapter will lead into an examination of what professionalism, and these regulatory mechanisms, mean for practising doctors, in respect of what is expected of them in terms of professional conduct and performance and how this impacts on the medical identity.

A Little History: The Professionalisation of Medicine

The professionalisation of medicine occurred over time in response to and in the context of the contemporary structural, political and social environment, and in relation to other professions including other healing professions (Abbott, 1988). Abbott (1988) states that we should not be studying the history of the medical profession per se, but the work of medicine itself and how the work came to be defined, by whom, what structures enabled it, what intentions motivated those who practised it, and what determined how it should move ahead.

Historical accounts of the trend towards professionalism, therefore, must take account of the wider context: why this trend arose; the influences that saw the practice of medicine distinguish itself
from other healing crafts that existed at the time when other significant societal changes were occurring. Professionalisation is responsive to external influences such as structural, social, economic, and political imperatives, as well as internal forces such as evolving medical knowledge and technology, and changing moral values within the profession.

**Influences on an Evolving Profession**

The regulatory changes that accompanied these influences to enable the professionalisation of medicine have had far-reaching consequences for the structure of health service provision, the working life of the doctor, the law and its many regulatory controls and enablers. These changes saw the move from guilds that protected the surgeons, physicians and apothecaries, to the creation of a legitimised “profession” and its existence as a semi-autonomous, self-regulated body, to the challenges to its status as a so-called closed shop that looked after its own, to the introduction of mechanisms for greater accountability in recent decades that meant the public became more aware of how their health system was performing.

Such developments coincided with the rise in consumerism, commercialisation of medicine, the growing trend towards libertarianism and the awareness of individual rights and egalitarianism – what some get, we all should get, with the media having played a significant role in informing the community what is available. In addition, the quality and safety movement that entered the picture in the 1980s to ‘90s after revelations of the scale of adverse events in hospitals pointed to a health care system in USA, United Kingdom, Australia, Canada and elsewhere that had serious deficiencies and had to do better in order to sustain the public’s trust that their health care would be safe. For instance, the Harvard Medical Practice study of late 1980s to 1990s showed that adverse events occurred in nearly 4% of hospital admissions, most of which were found to have been preventable. Nearly 14% had resulted in a death, and 2.6% resulted in a permanent disability (Brennan et al., 1991). The results were alarming, and the report recommended significant changes. Yet after a decade there was little improvement, as a 1997 study in Colorado and Utah showed, estimating that 44,000 people died each year because of medical errors, the costs of adverse outcomes were between $17 and $29 billion, with over 50% of this in additional care and treatment, as well as loss of employability of patients. “Errors are also costly in terms of loss of trust in the system by patients and diminished satisfaction by both patients and health professionals” (Kohn, Corrigan & Donaldson, 2000, p. 2).

Comparable statistics that generated similar alarm were released in Australia, followed by reports in other countries. The Quality in Australian Health Care Study (QAHCS) by Wilson, Runciman and Gibberd (1995) found 16.6% of hospital admissions were associated with an adverse event, of which 51.2% were considered to have been preventable. This study differed from the Harvard study in that it focused on the preventability of error, and this approach was replicated in other countries including New Zealand, Japan, Singapore, Denmark and the United Kingdom, showing a
consistent rate of about 10% of admissions being associated with an adverse event (Hamilton, 2014).

Three key observations arise from such revelations: (1) that “systems issues” contributed significantly to errors, requiring systematic analysis of adverse events and near misses to be undertaken in order to reveal the true cause of errors; (2) individual practitioners shared responsibility for errors and needed to be more accountable; and (3) the regulators needed to be more vigilant in identifying practitioners whose performance was below standard and in taking appropriate action to remedy sub-standard conduct and performance, as well as collecting and acting on data about injuries, deaths and other harms.

While these studies focused on what happens in hospitals, the principles are applicable in private practice and other health care facilities. Individual practitioners may find themselves needing to account for an adverse event whose contributory factors are inherent systems failures or procedural gaps in their practice\(^\text{23}\).

**Looming Fears, Shifting Power**

The quantum of errors and mistakes became public knowledge from the 1980s onwards. Those doctors who had been identified and singled out for disciplinary action were frequently reported on in the public media, particularly those whose conduct was at the upper end of outrage. The public was becoming more intolerant of a system seemingly beset by the indolence of “the authorities” to allay their fears of risk. Protection of the public became the primary objective of the new regulatory environment. The entry of the law and regulation into the profession of medicine, once mainly protective and enabling of the profession, had now become protective of the public. The message was clear that the public was at risk and the system could not be trusted. That there were new mechanisms to express one’s dissatisfaction, such as the HCCC, added to the view that the public expected better and that the system should become so. This represented a significant shift in power away from the profession to the interests of the public, enabled through the authority provided by legislation and tougher regulation, as well as greater use of tort law to remedy wrongs.

**The Health Industry Adjusts to Pressure**

The past two decades have also seen changes in the structure of the health industry, two of which have significantly impacted on the medical profession. These changes related to greater protection not only of the public, but of the industry itself. By the end of 2000, it was becoming clear that the costs of indemnity through defence of lawsuits and compensation payouts were escalating. The

\(^{23}\) Kite v Malycha [1998] 71 SASR 321 was an example of a doctor not receiving a cytology report from a pathology laboratory after a patient’s needle biopsy. Dr Malycha had arranged for the patient to ring him for the results; she did not ring or attend the follow-up appointment, but as he did not have a system in place in the practice to ensure he followed her up, he had breached his duty of care and was found negligent. (Skene, L. (2014) Legal issues when a doctor’s relationship with a “difficult” patient breaks down. *MJA, 201* (6).)
Australian Health Ministers Advisory Council’s (AHMAC) report of 2002\textsuperscript{24} found an overall significant increase in the payouts for large claims as well as increased costs for all claims. In the previous year, the Simpson vs Diamond case had concluded with a $14.2m damages order to the patient Calandre Simpson, whose birth had been “botched” by Dr Diamond some twenty years previously, leaving her with life-long disabilities\textsuperscript{25}.

This case, together with the collapse of HIH Insurance\textsuperscript{26} and the realisation that the indemnity industry was unsustainable as it had made insufficient provision for future claims, especially if they were to be in the magnitude of Ms Simpson’s, meant a big shake-up was essential. This resulted in the consequent transition from mutual, discretionary organisations to insurers subject to prudential regulation of the industry in 2001\textsuperscript{27}.

One could argue that these prudential changes contributed to the professionalisation of the entire industry, providing better protections for all parties but also bringing the medical indemnity industry into a less club-like, mutual world and into the modern, commercial world of insurance. The other consequence was that it tied the profession more closely to government, for without the arrangement by the Commonwealth at that time to enable United Medical Protection (UMP) to come out of voluntary administration and therefore to save the viability of the medical profession, this would have certainly been a catastrophe.

The other step that was taken was Tort Law reform, including the passage of the 2002 Civil Liability Act, which included caps on damages for loss of earning capacity and for “reasonable and necessary” care. In addition, in NSW the Health Care Liability Act 2001 No. 42 restricted amounts payable for non-economic loss, required all medical practitioners to have indemnity insurance as a

\begin{footnotesize}
\begin{enumerate}
\item Simpson v Diamond & Anor [2001] NSWSC925
\item After the destruction of the WTC on 11 September 2001, reinsurance rates worldwide were significantly increased; the costs to medical defence organisations also increased significantly through the reinsurance of their risks, which meant a rise in indemnity insurance premiums. The collapse of the insurance company HIH in Australia in 2001, and declining investment returns which had till then subsidised premiums charged, meant there were insufficient funds to keep the industry afloat and ensure sufficient future potential costs could be covered. (Luntz, H. (2003) Guest editorial: Medical Indemnity and Tort Law Reform. \textit{Journal of Law and Medicine}, vol. 10.
\item In 2003, the former mutual medical defence organisation, UNITED Medical Protection (UMP), when facing financial catastrophe because of the failure to provide for future indemnity costs, struck a deal with the Commonwealth to underwrite high cost claims in return for the industry being required to comply with prudential requirements under the Australian Prudential Regulatory Authority (APRA). The company became an insurance company, and all doctors in Australia were then required to have medical indemnity insurance in order to be registered to practise. This was a protection for the entire health industry; without indemnified, registered doctors, the health service industry would have been unviable, and without indemnity, individual doctors would face financial ruin without the protection of their indemnity insurer. There remains to this day a residual fear that a doctor’s financial security – their assets – would be lost if they were successfully sued. However, by being indemnified, this is so unlikely except in cases of gross breach of the conditions of their insurance, such as criminal conduct.
\end{enumerate}
\end{footnotesize}
condition of their registration, and indemnity insurers to have risk management and quality improvement activities to contain premium costs.

The Surveillance Society

It is certainly the case that a series of high-profile medical malpractice cases and cover-ups have affirmed the need to reform how medicine as a profession is regulated. As a result, over the last two decades or so, there has been a gradual shift in how medical governance is practiced (Chamberlain, 2013, p. 2).

Alongside these developments, all of which have significantly impacted on the medical profession, are the governance arrangements that accompanied these changes. Certainly, the events that followed Chelmsford saw the establishment of tighter regulatory mechanisms to compel the profession to be more accountable. Chamberlain notes the need to recognise how such reforms are bound up with broader changes in governance in society, which is “increasingly subject to patient-consumerist and managerial-bureaucratic forms of surveillance and control” (Chamberlain, 2013, p. 2). As an example, he points to the performance appraisal mechanisms in state-appointed agencies, such as the National Health Service hospital management.

The Beginnings of the Modern Profession of Medicine

The early days of Western medicine commenced in ancient Greece, and the following centuries of practice were characterised by inconsistent and unregulated training that was confined to certain elites. Legal protection and control of the practice of medicine could be traced back to the days of Henry VIII. As King of Britain, he took overall responsibility for the safety of his subjects, and it was he who demanded greater order in medical practice. He instigated the Medical Act in 1511-12, which opened with the preamble:

Physic and Surgery is daily within this realm exercised by a great multitude of ignorant persons as common artificers, smiths, weavers and women who boldly and customably take upon them great cures and things of great difficulty in the which they partly use sorcery and witchcraft to the grievous hurt, damage, and destruction of many of the King’s liege people.

The professional body of medical practitioners, the Royal College of Physicians, was established soon after in 1523, and was responsible to the King. The College held that it was an offence to practise “physic” or surgery without a licence, although the obtaining of such was questionable (Cartwright, 1997).

The foundations of the practice of modern medicine from the nineteenth century were traced by Abbott (1988) as attributed to other changes in society: (i) industrialisation, and with it the rapid increase in scientific and technological knowledge, demographic shifts, a changing workforce
profile, and improvements in public health; (ii) political changes brought about by the increasing secularisation of the state and its institutions, the democratisation of government and the foundations of parliamentary processes and proceedings, and a growing awareness of people’s rights; (iii) philosophical debate and influence – the appeal of nineteenth century utilitarianism and scientific answers to life’s tribulations contributed to the diminishing relevance of religion; and (iv) access to education resulting in a more educated population as a right and as a need for the advanced skills for the expanding bureaucracy and administrations, and for complex industrial and scientific development. Importantly for the professions, the sectional interests of the trades and occupations, being increasingly protected by the guilds, unions and the rise of professionalism amongst the highly skilled professions, saw the rise of societies and associations to protect the interests of these professions, supported by the law.

Primary amongst the latter was the rise of medicine as a defined, exclusive profession whose access to specialised knowledge was fiercely protected through restricted recruitment, prolonged and advanced training, and special privileges of decision-making power, remuneration and high status. It was not an easy rise to glory, as other health professionals fought for similar recognition and power. In fact, in Great Britain, “medicine” itself did not represent a cohesive body of practitioners: apothecaries were the dispensers of medicine; surgery was a trade until the late eighteenth century when the Royal College of Surgeons was founded; and physicians were the “real” doctors whose professional body, the Royal College of Physicians, was founded in Great Britain in the sixteenth century. After decades of wrangling, these three coalesced under the first Medical Act of 1858, although the apothecaries had rejected the chemists in the process (Abbott, 1988).

This could be said to be the beginning of the modern profession of medicine. The process of working out which bodies were to be included demonstrated how the process of becoming a profession involved not only a claiming of the knowledge and content but determining which jurisdiction each body of knowledge was to be controlled by.

Medicine was a particularly powerful jurisdiction because it laid claim to many areas of health care traditionally performed by others. For instance, control over childbirth by obstetricians in the nineteenth century was largely wrested from midwives because only medical practitioners could prescribe early forms of analgesic pain relief, chloroform, which made heavy sedation and general anaesthesia possible, and therefore forceps delivery and less traumatic caesarean sections. Such activities required the re-location of childbirth from the home to hospitals, where the hierarchy, dominated by the new specialists, was able to take control of childbirth from the disempowered midwives and labouring mothers (Garcia, 1990). While this technology provided the tools, this was not in itself what changed practices or the culture of childbirth. It also needed to gain common acceptance in an “ideologically fertile social field” (Arney, 1982, p. 27), which Arney (1982) traced
to the assumption of control of birth by obstetricians taking charge in hospitals, and because women wanted pain-free childbirth.

Of a process of this nature, Abbott (1988, p.316) states: "History is not a simple pattern of trends and development, but a complex mass of contingent forces. The system model achieves a theory of that contingency". He argued that this model embraces and explains inter-professional conflicts, in that it explains relations between different medical specialties as well as relations with other professions. The model also explains the relationship of medicine to law, in which both professions have high status and recognition, but one in which the law assumes the greater authority. For example, medical practitioners are bound to practise in accordance with the law, and although the profession generally determines its standards of practice, there are occasions when in practice, areas once considered to be the province of medical practitioners are determined by the law. For example, the standard relating to consent was determined by a judge in the Schloendorff case in 1914, and in Rogers and Whittaker in 1992. In cases of irresolvable disputes, the law will make determinations over treatment or withdrawal of treatment. The principles by which courts could make such determinations were spelled out, as below, relating to determination of the relevant standard of care.

Abbott’s model for professions postulated:

1. that the essence of a profession is its work not its organization; (2) that many variables affect the content and control of that work; and (3) that professions exist in an interrelated system. Change in professions can therefore best be analyzed by

28 Schloendorff v Society of New York Hospital, 105 N.E. 92 (N.Y. 1914): Ms Schloendorff sued the hospital after a surgeon removed a fibroid tumour without her consent while she was under anaesthesia for an exploratory examination. She suffered gangrene in her arm which she alleged was due to this surgery. The doctor argued that he removed the tumour for her best interests, but the judge determined this action constituted assault.

29 Rogers v Whittaker (1992) 175 CLR 479: the judgement stated that "The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it (at 490).

30 Cases such as Bland, Schiavo, Gard, Messiha, Wyatt.

31 Rogers v Whittaker [1992] HCA 58; (1992) 175 CLR 479: a High Court decision found in their majority judgement, Mason CJ, Brennan, Dawson, Toohey and McHugh JJ rejected the former accepted principle (“the Bolam principle”), and noted in relation to standard of care:

"In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill ... But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade."

In relation to peer professional opinion:

"...particularly in the field of non-disclosure of risk and the provision of advice and information, the Bolam principle has been discarded, and, instead, the courts have adopted ... the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to "the paramount consideration that a person is entitled to make decisions about his own life” (F v R (1983) 33 SASR 189”.

(My italics: the law has determined that it may be guided by medical opinion, but that it can override it).
specifying forces that affect the content and control of work and by investigating how
disturbances in that content and control propagate through the system of professions
and jurisdictions. The proper unit of analysis is the jurisdiction, or more generally, the
larger task area (Abbott, 1988, p. 112).

The illustration above concerning childbirth shows how this model played out as a profession
claiming jurisdiction over the content of health-related tasks: the task of childbirth, once the
province of women and midwives in the home, was corralled by the medical profession because it
had the tools of pain relief and surgery, and the interrelationship with the hierarchy of the hospital
environment made it possible.

The path to recognition as a unified profession was not a smooth one, but pockmarked along the
way by internecine struggles. These jurisdictional battles continued all the way into the passage of
the 1858 Medical Act. The outbreak of cholera in the mid-nineteenth century made passage of this
Act imperative, given there was no register of qualified medical practitioners. The Act was passed
with its first role to establish a medical register, and the second to establish the qualifications
required to be registered. In spite of continuing arguments about who was to be included, the Act
was the foundational law establishing state recognition of the British medical profession. What it
did achieve was a single governing body for medical practice, the General Medical Council (GMC),
which had the right to discipline doctors, including the power to de-register doctors guilty of criminal
charges or of “infamous conduct in any professional respect” (Roberts, 2009). It also established
an ethical code which raised the social prestige of the doctor. According to Cartwright:

We can now observe the paradox that the 1858 Medical Act, intended to protect the
public rather than the doctors, has in its implementation transformed the medical trade
into the medical profession and benefited the doctors as much as the public
(Cartwright, 1977, p. 57).

Medicine had prevailed, the Colleges flourished, the power of modern medicine assumed
superiority and the mystique of medicine became glorified. The “secret society” of medical doctors
was adept at public relations, in promoting its exclusive and unique place in society with a body of
knowledge and skill inaccessible to common people. In many respects, society lauded this as they
demanded access to what doctors had to offer: pain relief in childbirth; cures and treatments never
before available, clinics and hospitals that enabled such treatments to be offered; and finally, the
chance to beat death and cure diseases never before possible. Freidson (1970, p. 15) asserts,
“The physician is the symbol of healing whose authority takes precedence over all others”32.
Roberts (2009) adds that professional authority rests on more than professional assertion, but also
requires a measure of cultural acceptance. Society wanted what doctors had to offer. He therefore

32 I would add, over all others in health care, except if there is adjudication by the law when the law can take
precedence over medicine.
asserts that the passage of the Medical Act in 1858 represented not only a mediation between divergent strands of the “still fluidly defined profession”, but also between professional and lay conceptions of the role of the medical practitioner (Roberts, 2009, p. 39). The state and the public had an interest in upholding medical privilege because it was given in exchange for the expectation of honourable standards of behaviour, which meant putting the needs of patients before one’s personal advantage, in an inherently unequal relationship by virtue of the possession of knowledge and skills (Roberts, 2009).

Much as Henry VIII had declared that he did not wish to see his subjects exposed to harm by charlatans, the profession argued that their superior knowledge and skill needed to be protected from the quacks who purported to have the same ability to treat and cure. These needed to be kept out of medical practice to keep the public safe from the harm that they may cause, or the indirect harm by denying access to “proper” medical care. Through legitimation of their authority, the medical profession was recognised and protected. This is the fight for jurisdiction of which Abbott wrote, a phenomenon that persists to this day when we consider the fight to exclude complementary medicine, the fight between cosmetic and plastic (the latter being “real” surgeons practising “real medicine”) or between doctors and pharmacists or nurse practitioners, both of whose roles’ duties are encroaching into medicine, such as prescribing, giving limited medical advice and writing medical certificates.

**Legal Protection of the Profession**

As noted, legal protection began with the passage of Great Britain’s first Medical Act 1511-12, which placed overall responsibility for public safety with the King (Henry VIII).

Foucault traces the regulation of medicine in France to the decrees of Marly in 1707 which regulated the practice of medicine and training of doctors. This lasted throughout that century, when “It was then a matter of struggling against charlatans, quacks, and ‘unqualified’ and incapable persons practising medicine” (Foucault, 1973, p. 44). Modern French medicine came into being by the end of that century, when “the gaze becomes objective”, that is to say, medicine became a scientific endeavour, a “clinical science,” and the patient the object of its gaze. The other interesting consideration was the strong social element of medicine’s responsibility to society: a breadwinner who was ill could leave his family destitute, so medicine had a social role in keeping individuals healthy, and as the individual was part of society, Foucault (1973) states, “medicine becomes a task for the nation”. It would be the task of the state “to make sure that a true art of curing does exist”. Here we can see that medicine was accepted as a public good and that it was the task of the state to ensure its security.

Medicine, the law and the state had become intertwined not only in France, but elsewhere. The 1858 Medical Act in Great Britain established a register of legally qualified medical practitioners, and defined who was “legally qualified”. This was the foundational step in transforming the medical
trade as had existed as a former guild into a recognised profession with its own professional regulatory body, the GMC (Little, 1995).

In Australia, the first Medical Practitioners Act 1838 in NSW likewise established a register of medical practitioners so it could keep track of medical witnesses before inquests and inquiries in the colony of NSW (Lewis, 2014b). In so doing, it had to identify who was a medical practitioner, defining as legally qualified those whose qualifications were attained in Great Britain. An amendment in 1855 added qualifications attained from The University of Sydney after it opened in 1850 (Lewis, 2014b). The register was administered by the NSW Medical Board, and from 1838 until 1987, the Board, as a specialised body, was not required to be accountable to Parliament. It regulated its members by defining how it alone could exercise professional discipline.

The autonomy of the profession was sustained by “the dominance of its expertise”, and its strength based on its “legally supported monopoly over practice, which operates through the system of licensing granted by the state” (Freidson, 1970, p. 83). Nevertheless, the profession is not entirely autonomous. The profession may control the content of its work, the knowledge it develops and the training of doctors, but the state retains an interest in the terms under which it serves to protect the profession. In the early days, by determining who would be legally qualified and how they would become so, the profession argued that they were protecting the public by ensuring doctors were highly trained and that they practised at a high standard. This was, in essence, a “social contract” (Thomas, 2002a), though it was somewhat weighted towards protecting the profession, because its main purpose at the outset was to keep those it deemed not suitably qualified out of its ranks, by its own definition and as sanctioned in law.

Explaining the concept of “social contract” further, Cruess (2006, p. 170) traces the granting of licensing laws in the mid-nineteenth century to society granting the profession:

a monopoly over the use of medicine’s knowledge base, autonomy in practice, status, and the privilege of self-regulation. This was based on the understanding that the profession would assure the competence of its members, who would be devoted to altruistic service, demonstrate morality and integrity in all of their activities, and address issues of societal concern in their domain. This was and remains the essence of the social contract, which is based on professionalism.

Trust was fundamental to the relationship between doctor and patient, and as Cruess (2006) explains, patients’ trust in both individual practitioners and in the profession was high from the mid-nineteenth century through to the mid-twentieth century. Trust in doctors relied on the belief that doctors would act in their patients’ best interest and not their own, that altruism was a basic value held by the profession.
In the increasingly complex, sophisticated and expensive health system, providing for a society with diverse needs, values and beliefs, these traditional values were met with competing interests within the profession. For instance, the structure of health care delivery and governance arrangements has changed (Crussess, 2006; Crussess & Crussess, 2008), as well as societal expectations, meaning that the terms of the social contract have had to continuously evolve. Nevertheless, some universal values remain relatively constant (Crussess, 2006, p. 171).

An evolving social contract meant articulating what is expected of the profession beyond the knowledge, skills and competence that are fundamental to their craft. “The new professionalism” was a term introduced in the 2000s to explain the evolving notion of professionalism as distinct from the traditional definitions. It was one concept that attempted to articulate changing values in society which competed with the traditional spirit of altruism in the UK, in which Sir Donald Irvine (2001), as the former President of the GMC, wrote with determination that health systems under the National Health Service (NHS) had been slow to address the quantum of adverse events in health care, a substantial proportion of which were said to be preventable. The quality and safety movement had identified that inadequacies of systems significantly contributed to these harms, but also acknowledged the responsibility of individual practitioners to contribute to the safety of patients, and to be accountable. Sir Donald considered professionalism to be at the “heart of doctors’ relationships with patients and the public”, suggesting doctors should provide their “expertise and reliable, consistent performance” (Irvine, 2001, p. 66). He lamented the “fading” of professionalism in the previous two decades, stating that people wanted more openness from doctors and explicit accountability, though not on their own terms as it had been. He considered that medicine was becoming more like a job and less like a vocation, and he placed the onus onto doctors to change, to be more responsive and to listen better to what people expected.

The other requirement, Irvine (2001) said, was that regulation must likewise change to meet the public’s expectations. In 2001 when this was written, there was pressure for the health system to lift its game and to stand behind it to make sure this happened. He declared that the system of professional regulation was evolving to deliver the new professionalism, which “must be firmly grounded on the public interest – a partnership between the public and the medical profession”.

There is a theme that underlies the above account: that the medical profession had for too long harboured within its ranks some doctors who had breached the public trust, and that as a consequence, the profession had to improve to meet public expectations. The reactions by the regulators in both the UK and Australia have been significant, as we have seen in the examples presented, and the response to this reaction by medical practitioners as equally significant. While some had expressed their dismay that the profession was “under siege” (Donnelly, 1990), there were indications that the tightening regulatory surveillance was having a personal, and sometimes damaging, impact. An alarming report commissioned by the GMC in UK and conducted by Samdrah Horsfall in 2014 discovered that there were 28 reported cases of suicide of doctors
between 2005 and 2013 while undergoing Fitness to Practise investigations (Horsfall, 2014). This prompted a review of the implications for the GMC’s processes, in particular, how it handles vulnerable doctors. In Australia, a report by BeyondBlue in 2013 revealed the worryingly high number of doctors suffering depression and other mental health conditions, from a survey of almost 13,000 doctors and medical students. This study focused on the general stressors of medical work, not just on those undergoing investigations. What is known is that doctors suffer significantly higher levels of psychiatric morbidity when involved in a medico-legal matter. An examination of these and other impacts will be explored fully in Chapter Four.

A more gentle approach can be seen in Canada’s response to the perceived need to identify and embed the qualities and attributes of professionalism into what doctors were expected to be. “CANMeds”, the Physician Competency Framework, was released in October 2015. It identified core competencies of professionalism that extended beyond scientific, clinical skills and expertise, to include the domains of medical expert, communicator, collaborator, leader, health advocate and professional. This concept was adapted by subsequent Colleges in many other countries including Great Britain, New Zealand, USA and Australia. In Great Britain, the GMC published Good Medical Practice, a handbook that aimed to set out what was expected of doctors in terms of their ethical conduct.

In Australia, the Medical Board of Australia introduced Good Medical Practice: a code of conduct for doctors in Australia (the code), which makes it clear what the common values of all doctors must be: Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively. They must be ethical and trustworthy. This document sets out not only what behaviours doctors are expected to demonstrate, but what patients can expect from their doctors. It sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community (The code, p. 4). The code can be used to evaluate a doctor’s conduct, which may have implications for their registration, although legislation and case law will take precedence where there is conflict with the code.

Doctors as Professionals

The word profession has a meaning, and a doctor is meant to be the ultimate professional. (Dr Michael Steiner, President NSW AMA, 27 September 2010.)

In this part of the chapter, we have considered the professionalisation of medicine from an historical and legal perspective. The professionalisation project had begun in order to define and legitimate the modern medical profession, and became an instrument of control, or attempted

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33 Royal College of Physicians and Surgeons in Canada (2015).
34 General Medical Council (2013) Good Medical Practice, UK.
control, over the profession, by which the characteristics of being a professional, of being a “good”
doctor, became the markers by which professional performance was judged.

The questions now concern what it means to be a professional in the world of medicine, and why
being a doctor means being the ultimate professional. Does medicine as a profession define every
aspect of being a doctor, so that doctors know what the rules are, how to behave, how to conduct
themselves, how to be a doctor? We have seen how professionalism has developed as a response
to political and social expectations and that the profession does indeed define certain aspects of
doctors’ behaviour and conduct, which are written into their codes of conduct as essential or
desirable traits on which doctors may be evaluated. Is there another set of behaviours and values
that are expected of them as professionals?

Every doctor will have a sense of what it means to be a doctor, and a sense of themselves as a
doctor, which will influence what choices they make within medicine, how they practise and how
they relate to their patients and to their colleagues. What it means to be a doctor will be influenced
by what is expected of them, and how the individual interprets these expectations, in the light of
their expectations of themselves. The latter is affected by their own personal values, motivations
and beliefs, which all arise from the context in which they chose to become a doctor, who and what
influenced them (Abbott 1981), and what they subsequently experienced. In this next section, I
map out professionalism in a more personal, individual sense, in thinking about where and how the
individual practitioner fits into this world of medicine, with its expectations, obligations and
requirements.

**Profession as Field**

Not happy with the notion that the study of “profession” is about classifications of occupations, and
while recognising the work of Abbott (1981) and others, including Larson (1977) and Freidson
(1986) which see professionalism in terms of the power inherent in these classifications, Bourdieu
(in Schinkel & Noordegraaf, 2011) prefers to replace the concept of profession with “field”. One
way of usefully expressing the placement of the individual within their professional medical
environment or field is by reference to Bourdieu’s concepts of *Habitus*, representing the subjective
element within the objective world. *Field* is that environment, such as the world of medicine.
Schinkel and Noordegraaf (2011, p. 67) regard professionalism as “a form of symbolic capital, the
substance of which is constantly at stake in power-driven contexts, both internally and externally”.
Professional fields relate to other fields as a “general field of power”, whose content is constantly
subject to renegotiation. This seems somewhat akin to Abbott’s (1981) jurisdictional contests, as
above, although while jurisdictional contests are also about content and the power to assume
proprietorship over same, symbolic capital suggests something more: the status that accompanies
each particular field of expertise.
Habitus is the space occupied within the field by the individual and is an acquired system of dispositions. The field structures the habitus by conditioning experiences that help to shape one’s perceptions, influenced by one’s past and present circumstances, such as one’s upbringing and education, but also by one’s dispositions. It explains how people learn to behave in certain ways without reference to obedience to rules. Both concepts are interrelated, explaining in part how the individual relates to their social environment. Practice, or one’s actions, results from the relation between one’s dispositions, or habitus, and one’s position in a field, or capital (Grenfell, 2008, p. 51). Symbolic capital is like a token of status. So if an individual practitioner learns to “play the game” well, this has the potential to enhance their status (Grenfell, 2008). “The better adjusted one’s habitus is to the field in which one occupies a position, the better one’s ‘sense of the game’ and hence one’s ability to acquire symbolic capital and a dominant position in this specific field” (Schinkel & Noordegraaf, 2011, p. 78). Being a doctor and being like a doctor will earn a special place in the field of power. Not being like a doctor can mean the opposite, and such a person may struggle for acceptance. This is demonstrated in the case referred to previously of the whistleblower Dr Stephen Bolsin who became an outlier for having publicly revealed the failings of his own, was shunned and vilified by senior colleagues, and on the point of resigning, sought refuge in Australia, where he remains (Faunce & Bolsin, 2004, p. 44). In fact, to publicly criticise the profession was considered by the GMC in the UK to be “serious professional misconduct” until 1985, when the GMC began to emphasise responsibility to act in patients’ best interest and required that dangerous practitioners be reported to the regulator (Jorm, 2012). Being a medical professional is difficult terrain, understanding one’s place as either “special”, or as a vilified outcast, or as any variety in between.

**Being a Medical Professional**

What a doctor brings to medicine will shape how they respond to the professional environment and culture, and will therefore strongly influence the nature of their practice. Reconciling the autonomy of the individual doctor with that environment may not be straightforward, and likewise, it can be difficult to reconcile what the standard of practice should be in a given circumstance, in the best interest of patients. Moral distress is a phenomenon experienced by doctors (and other professionals) when their judgement about a particular circumstance is at odds with a protocol, a rule of thumb, or the stated standard of practice: “People can experience moral distress when they regard themselves as expected to pursue a course of action they believe to be morally wrong” (Weber, 2017; Monrouxe, Shaw & Rees, 2017, p. 568), which may have far-reaching consequences. The experience of those who had worked alongside Jayant Patel in Bundaberg Queensland showed that it was not only the patients who suffered, some mortally, from his surgical exploits. Staff and colleagues were compelled to do “work-arounds” to hide patients, or to do their best to rescue patients by providing extra care following surgery, all the while being conflicted by the intransigence of hospital management and an unwilling state administration to take effective
action to protect patients from what others believed to be grossly unsafe care by Dr Patel (Jorm, 2012; Pacey, Harley, Veitch & Short, 2012; Thomas, H., 2007).

The significance of social control, of group loyalty and peer acceptance, cannot be understated in such situations. Peer opinion can lead to some vexing disagreements, or alternatively it can help to sustain an individual by providing validation of their unique approaches to problem solving, collegiality and teamwork. The determination of the standard of care, the right decision in any circumstance is therefore not just a formula but is a complex mix of judgement and competency.

**Fundamental Aspects of Being a Professional in the Field of Medicine**

In addition to the skills, knowledge and expertise held by every medical practitioner, there are three fundamental aspects to being a medical professional:

1. The legal aspect: what is expected by the law and regulation;
2. The ethical aspect: what is expected of medical practitioners’ conduct;
3. The moral aspect: the personal qualities and values that the individual practitioner holds, that could be summed up as the moral dimension.

The above discussion sets out how the ethical conduct expected of doctors is articulated. Setting aside the legal and regulatory aspects, we will now consider those other less definable attributes of doctors that accompany the way they practise, the way they relate to their patients, and their commitment to their profession: the habitus that each individual occupies according to their personal values and dispositions. Attention moves to the individual and the moral values they bring to the practice of their profession, as well as how they experience being a part of the professional environment, including how they interpret and enact the ethical aspects. Chapter Three will then examine the legal aspects by describing how the law actually functions: its mechanisms and processes. The focus will be on the protective aspects of regulatory mechanisms, and in this context we will return to the individual who is subject to these mechanisms, when I then introduce my study that examines the individual’s experience. Now, however, the discussion moves to the moral dimension that relates to the individual qualities of medical practitioners.

**The Moral Dimension**

Medicine is a moral community because it is at heart a moral enterprise and its members are bound together by a common moral purpose (Pellegrino, 1993, p. 3).

As a moral community, Pellegrino (1993) opines that the practice of medicine must be guided by a shared source of morality, with the same fundamental rules, principles or character traits that will define a moral life consistent with the ends, goals and purposes of medicine. He traces the source of morality as the character of the physician as it has been through the centuries, providing the
conceptual foundation of professional ethics. Pellegrino (1993) explains that this “virtue ethics” became supplanted by Kant who defined morality in terms of duty, and in more modern times by principle-based ethics proposed by Beauchamp and Childress (1994), which focuses on the principles of respect for autonomy, beneficence, non-maleficence, and justice. Kant defines actions according to fulfilling one’s duty, but principle-based ethics are the more commonly recognised principles of ethical conduct in health care and research because one is deliberating about which principles apply to come to a “right” decision. They have appeal because they tend to spell out how one is to act, they consider the consequences of a decision and are useful in providing a vocabulary and framework for decision-making and “right” conduct. The four principles can also be criticised as being too rigid in that the common values are not accounted for. McCarthy calls it an “ethics of strangers”: they are limited in their ability to deal with clashes of principle, where parties place emphasis on different principles as the basis for a “right” decision. It is difficult to capture the “uniqueness of each moral situation”, or to reflect on the nuances of the interactions between practitioner and patient, with differences in interpretation (McCarthy, 2003).

Without dismissing the value of the principle-based ethics (principlism), here the emphasis is on the moral as a missing dimension, or as a value that underpins the relationship between doctor and patient, and between doctor and the profession. It was MacIntyre (1984) who revived “virtue”, which recalls the ancient art of medicine as a calling, with its emphasis on care and healing beyond the science and evidence-based medicine of today, with its highly regulated framework, where the guidance of principlism has its greatest appeal. “Virtue” however cannot replace rule-based practice, as it is so open to interpretation. Pellegrino (1993) sees that virtue must be linked to principles in an integrated “medical ethics” that draws together as “phronesis”, or practical intelligence, that applies wisdom and good judgement to practical situations. Knowing what is right, what the rules state, and what applies in a given situation while determining how to act in the interests of a patient, and not oneself (avoiding getting into trouble by breaking the rules, for instance) is a vexed issue that has no easy answers, and can be the source of the moral distress to which I referred earlier. The public expects the doctor to be their advocate, to act in their interests, yet doctors also have other patients and other considerations, including their personal values and a life outside.

How the argument is presented suggests that as a profession, medicine is either altruistic, and doctors know how to act because they are “good”, or that medicine has become devoid of moral value, that public expectation of altruism is in conflict with what Pellegrino (1993) describes as the private ethos of self-interest of today’s world. Here he says that medicine is increasingly seen as a commodity, and where moral meaning can become lost in the scientific nature of modern medicine. He suggests that the very foundation of medicine, its moral power, needs to be restored in order to restore it to its true meaning, which is the healing of sick patients, not just by competent performance but by ethical conduct. Quoted in Engelhardt (1977, p. 191), Pellegrino asserts that
“medicine must not only perform well but act well, it must choose what should be done to heal a particular patient whose good is the true end of the whole activity”.

If a community is “a body of men and women bound together by common moral traditions and/or practices around a shared vision of the good life, which allows them to collaborate as moral friends” (Engelhardt, 1986, p. 7), then as a community, the medical profession shares common values. While a picture of all good people collaborating together because they share common values is rather idealistic, the picture is not actually quite so clear. Competitiveness, self-interest, the hierarchy amongst different specialist groups, different cultural and socio-political allegiances and beliefs all add up to a diverse group unified mainly by their recognition as credentialed doctors. MacIntyre makes it a little clearer:

> Every practice requires a certain kind of relationship between those who participate in it. Now the virtues are those goods by reference to which, whether we like it or not, we define our relationships to those other people with whom we share the kind of purposes and standards which inform practices. (MacIntyre, 1984, p. 191).

Therefore, regardless of values, common or not, what is shared by doctors is a commitment to the purpose of medical practice and the standards by which they practise. But how a doctor interprets their commitment does not fit neatly into the dualistic notion conveyed by Pellegrino, as above, of being either the altruistic “good” person or the self-interested, status-seeking individual that promotes medicine as a commodity whose value is defined in terms of economic capital. What doctors bring to medical practice is their own individuality: “in the practice of medicine, the person you are is as important as what you know” (Treadway, 2005, p. 1943).

**Finding Common Values**

Regardless of an individual's personal values, there is a common set of stated values, of standards of conduct and performance, and failure to demonstrate such qualities is not well tolerated by regulators. Coulehan (2001) examines the process of learning such values and behaviour, as part of the socialisation of doctors in training: “An important aspect of this socialization is the transfer of a set of beliefs and values regarding what it means to be a good physician” (Coulehan, 2001, p. 600). Explicit components include the expected activities: the classes, rounds, advice, teaching about what is “good”, including the values of empathy and caring. Yet such virtues may be quite inconsistent with what a doctor observes in those around them: being detached, objective, distrusting of emotions, of patients, of the administration, of insurance companies. This notion is commonly referred to as “the hidden curriculum”, after Hundert. These tacit values can become the more powerful as they relate to what people do, rather than what they say they do, or should do. Coulehan (2001) observes how detachment can lead to the atrophying of affective emotions, leaving the focus on cognitive and technical aspects of practice.
Whose Values Count?

Patients value competence and caring. Complaints can be made when expectations of either or both are not met, and usually, though not always, because something has gone wrong. Yet there is a disjunct between what complainants value in terms of the care they expected to have received, and what the regulatory system deems to be of value. A simple example may explain the difference: the difference in meaning of the word care, providing care or being cared about. The notion of “incommensurability” explored by Hunter (2001) is about patients’ and doctors’ differing orientation (Hunter, 1991). A patient is one who suffers an illness because of the symptoms of disease, for which they want relief, to be healed, and to be released from the disruption to their normal life. Doctors on the other hand are faced with others’ illness as their way of life, their raison d’être: “To the typical physician, my illness is a routine incident in his rounds, while for me it’s the crisis of my life. I would feel better if I had a doctor who at least perceived this incongruity” (Broyard, 1992, p. 43).

The profession of medicine can therefore either be defined purely as one that centres on its mastery of technical knowledge, the status and privilege that accompany this and the capacity to exercise social control, or it can also capture something of the traditional virtue of vocation or calling, evoking a sense of altruism and goodness. Is this not what most people want in their doctor: someone who knows their craft expertly, has wisdom and good judgement, and who cares about his or her patient? Gustafson (1982, p. 501) writes that a “‘Calling’ without professionalization is inept, and a profession without a calling lacks moral and humane roots, loses human sensitivity, and restricts the vision of the purposes of human good that are served”.

A Good Doctor: Best Practice, Best Interests and Being Good Enough

Marrying the expectations of what patients want with what is possible, I will now consider how we may arrive at what a good doctor is. A doctor is expected to serve their patients’ best interest, but they are also expected to serve their profession (not bring it into disrepute), those they work with and for, and their regulatory obligations. It is inevitable there will be competing interests, and without a rulebook that specifies right actions for every circumstance, the health professional is potentially facing some significant dilemmas which are not often acknowledge or thought through (Pellegrino, 1988, p. 73).

The community expects that “good” doctors are generally able to balance all their obligations without sacrificing the integrity of their professionalism. Consider the outrage that follows when the community is exposed to the failings of doctors who have acted recklessly, selfishly or dangerously. So too at the individual level, the patient who considers their doctor is not acting in their best interests loses the trust on which the relationship is founded. Disputes and conflict may follow, associated with loss of confidence and faith and even a sense of betrayal.
At the heart of medical professionalism is trust. How doctors conduct themselves when confronted with dilemmas that have the potential to breach that trust is critical to their ability to maintain their personal integrity and the confidence of patients, the profession and the community. The term professionalism “covers the attitudes and behaviours that promote and maintain the patient’s best interests above and beyond all other considerations. An ethical health professional would put patients’ interests above their own, avoid harm, respect patient autonomy, maintain competence, and work and practise within the bounds of their knowledge and experience” (Walton & Elliott, 2006, p. S62). If patients’ interests are to be served above all else in order to practise ethically, it does not mean that other interests cannot also be served. But it may be inevitable that serving the best interests of a patient may mean compromising other interests. The dilemma for the practitioner is in balancing these competing interests.

Pellegrino (1988, p. 74) opines that without clarity of what is meant by “good”, the emphasis turns to rights, which often leads to an “excessively legalistic framework for moral choice that obscures the distinctions between protecting the patient’s rights and promoting the patient’s good”. When patients or their relatives demand that their rights are respected, but health practitioners disagree that these proclaimed rights are for the patient’s good, then unresolved conflict may ensue, for which a legal remedy may be the only option after others have been exhausted, and it will be for the courts to determine the patient’s “good”.

The Medical Identity

In 1957, Merton described the function of medical education being to “transmit the culture of medicine and … to shape the novice into an effective practitioner of medicine, to give him [sic] the best available knowledge and skills, and to provide him with a professional identity so that he comes to think, act, and feel like a physician” (Merton, 1957). This description implies that the “novice” physician is the passive recipient of all that his educators can offer to mould him into shape, as if there were a template for the model doctor (females are clearly not part of the picture, but this was the 1950s, when authors wrote as if they were not). Nor in this description is there mention of the development of moral judgement, personal and professional values and the unique characteristics and disposition that the individual doctor brings with them into their practice. The term phronesis, also used above, encapsulates my meaning, describing the application of wisdom and good judgement to practical action. Where do these skills come from?

Cruess (Cruess, Cruess & Steinert, 2016) provides an overview of commentary from the past few decades about how these more esoteric characteristics of the professional identity are formed. As medical educators, their interest is in the medical curriculum and assessment of “professional identity”. They refer to the well-known (to medical educators) Miller’s (1990) pyramid or triangle, which consists of four levels of assessment of medical competence: “Knows”, “Knows How”, “Shows How” and “Does.” They argue that this model, while still accurate, is incomplete. Adding
“Is” reflects the presence of the professional identity, with the associated assessment criteria: “the attitudes, values, and behaviours expected of one who has come to ‘think, act, and feel like a physician’ ” (Cruess Cruess & Steinert, 2016, p. 181). Quoting from Hafferty (2009), they explain their reasoning as “the fundamental uncertainties that underscore clinical decision making and the ambiguities that permeate medical practice, require a professional presence that is best grounded in what one is rather than what one does” (Hafferty in Cruess, Cruess & Steinert, 2009). Given that professionalism is now considered to be integral to medical practice, the assessment of professional identity should be used as the basis of the assessment of professionalism, they argue, yet while doctors are expected to behave professionally, there has been little teaching in how to do so. This is considered essential given the failures of medical professionalism, discussed elsewhere, which have caused a re-think and trend towards measuring competencies. But as the authors state, such competencies are evaluated in terms of what doctors do, rather than their values, until, they note, the Carnegie Foundation declared the future of medical education to be “on professional identity formation – the development of professional values, actions, and aspirations” (Cooke et al., 2010).

Yet this still does not adequately touch on what the individual practitioner brings with them into the profession (Cohen, 1994, p. 133). When an individual doctor becomes a member of the profession, there is an acceptance, both conscious and not, of the culture, mores and expectations of ways of behaviour that make a doctor “like a doctor”.

Recognising that identity formation begins from childhood, aspiring doctors “join the community of practice that is medicine” and acquire their sense of belonging and their professional identity through their social interactions, and the sum of their clinical and non-clinical experiences. This process is aimed at developing an identity that is a “fully integrated moral self (one whose personal and professional values are fully integrated and consistently applied)”, yet not static but forever changing as they progress through their careers, in response to changing health care delivery systems and societal expectations (Cruess, Cruess & Steinert, 2016).

The community of practice must have a meaning that is symbolic of what Medicine is all about, how outsiders view this exclusive club, and what many of those who wish to join it aspire to.

Working from a sociological perspective, Freidson’s (1970) early work focuses on the uniqueness of the profession in terms of its prominence and power. Not only is “the physician the symbol of healing whose authority takes precedence over all others”, the profession preserves a common identity in spite of occasional internal disputes over their various areas of work, and sustains a “superordinate” position. He suggests that common identity arises from the visibility of the degree, selective recruitment and common social background. Freidson’s (1970) proposition does not account for the socialisation that takes place during training, where doctors learn how to be doctors. For instance, in discussing the nature of social control in learning, which is often spoken of only in terms of coercive or formal control, Bosk (2003, p. 20) notes Freidson’s absence of
recognition of the process of socialisation: “Totally dismissed is the notion that individual control or group pressure effectively constrains behavior”. Bosk (2003) argues for both a formal system of controls as well as acknowledgement of the considerable control through socialisation, work routines and relationships with colleagues. Nevertheless, Freidson’s (1970) view of this process implies a commitment to an identity which is ingrained in becoming a doctor, incorporating not only the values of the institution in which they are being trained and socialised to serve, but also the values and attitudes of the profession with exclusive membership:

It is professionalism itself that seems to transform the ideal responsibility to serve the good of the general public into limited concrete responsibility to serve the good of one’s personal public, and the ideal of universalistic knowledge and skill into particularistic sectarianism expressed by occupational imperialism (Freidson, 1970, p. 52).

Freidson (1970) proceeds by explaining there are other values as well that account for this transformation, proposing that there are three major sets of attitudes, values or orientations: (1) the professional ideals of knowledge and service; (2) professional occupation and life career; and (3) the character of professional work.

**What is a good doctor?**

Lupton (1999), speaking of western societies, says that risk has “become an increasingly pervasive concept of human existence” (p. 25), which is to be controlled, managed and regulated. In this context, the professionalisation of medicine has been accompanied by a complex set of laws, regulations, codes of practice and conduct, credentialing and accountability, that creates a picture of a profession under constant scrutiny and surveillance. In this socio-political environment that is averse to risk, there may be no other profession that is so under the spotlight, and that has such high expectations of doing, and being, good. The individual doctor, practising within this environment, must navigate their way through, and find their own way of doing their good work, and of being “good”.

In Chapter Three, we will see how the law and regulation actually operate to ensure that doctors are “good”, that patients are safe and that the public can place trust in them and in the profession.

**Patients’ Expectations of the Good Doctor**

In his capacity as the former Commissioner of the New Zealand Health and Disability Commission, Dr Ron Paterson writes: “The ‘good doctor’. Every patient wants one. Every doctor wants to be one. It is widely accepted as a desiratum, something to be desired” (Paterson, 2012, p. ix).

But what is a good doctor? Answer: it depends on who is asking, and it depends on what is expected. External authorities spell out what is expected in terms of Codes of Conduct, accreditation requirements, legislation, regulation and the administration of regulatory practices,
when medical practice comes under scrutiny and what should have been expected is adjudicated. As for patients, this also depends: on the circumstances of seeking medical care, on their personal values, on what others tell them or what they have heard, read about, or have images of. As noted, many patients may not have a picture at all of what they value in a doctor, until their actual experience leaves an impression, perhaps of exceptional care, or perhaps of the opposite.

According to Irvine (2007), former President of the GMC, patients deem a good doctor as one:

whom they feel they can trust without having to think about it. They equate “goodness” with integrity, safety, up-to-date medical knowledge and diagnostic skill, and the ability to form a good relationship with them. For them, good doctors are clinically expert and at the same time are interested in them, kind, courteous, empathetic and caring. All these attributes matter to them because they know that their doctors’ decisions can affect the outcome of their illness – even make the difference between life and death, or between enjoying a speedy recovery and suffering serious disability (Irvine, 2007, p. 256).

With this senior regulator reflecting on what patients want, it feels like a high bar on the scale of ideal to perfect. One could surmise that if all doctors met all of these criteria, then we would have no need of complaints systems. Yet as patients, we have all experienced situations when a doctor is rushed, tired, busy with an emergency room full of anxious patients, or is just having a bad day. How forgiving are we? Coulter (2002, p. 668) reminds us that doctors “remain high in the popularity stakes in almost any poll, compared with other professions or trades”. Indeed, Willis (1993 in Hafferty et al., 1997) reports that public opinion polls in Australia rated medical practitioners as the highest ranking occupation for public esteem and social status. A more recent result shows much the same, in the Roy Morgan Image of Professions Survey 2017, 89% ranked doctors second, after nurses, as the most highly regarded profession in Australia, an increase of 3% from the previous year. These ratings were based on the criteria ethics and honesty35.

This is in spite of the common view that patients are demanding, have high expectations, that there is a loss of trust in the profession and that people’s estimation of the profession has “diminished somewhat” (Lupton, 1997). Lupton’s research involving in-depth interviews with doctors and lay people identified that although some people may not regard the profession favourably, they regarded their own doctor (“my doctor”) as good doctors and treated them with respect. Ideal professional behaviour, rated by both doctors and lay people in the study, focused on good communication, meaning listening to patients’ concerns, explaining medical jargon in lay terms, and understanding the patient’s perspective, and empathy. Technical skill, being up-to-date with their knowledge were valued by both, while doctors added good judgement. By contrast, bad

doctors were perceived as not listening, perhaps dishonest, not communicating well, perhaps “just in it for the money”, lacking good medical knowledge, with poor rapport (Lupton, 1997). Overall, patients rated interpersonal relations and technical skill highly, and humaneness, followed by competence and accuracy, being involved in decisions, and time for care. She adds that interpersonal skills are strongly related to trust, but notes this does not equate to “blind faith” but to honesty in relation to their condition, to treatment options and to being listened to (Lupton, 1997).

The Meaning of Trust

In speaking of trust, Lupton (1997) was building on the findings from Mechanic and Meyer’s (2000) interview study of what trust means to patients. This study found that interpersonal competence, involving caring and dedication, concern and compassion are the most common aspects of trust, with listening as the central focus. Patients with serious illness value not only technical competence, but also the preparedness of doctors to be their advocates in negotiating health care plans and to have their best interests at heart. Trust was something that developed over time, commencing with the initial trust of a doctor’s reputation, based on the recommendation or referral from a trusted other, but over time, respondents would test the doctor’s responses and actions against their own expectations. If the latter were being met, then trust would develop (Mechanic & Meyer, 2000).

Lupton’s (1997) study reinforced this notion of developing trust: “doctors are highly aware that their patients’ trust is now no longer necessarily won by virtue of their occupying the role of ‘Doctor’, but must be earned and worked at continually” (Lupton, 1997, p. 493). Some doctors in her study reflected on the past image of doctors on their pedestals and welcomed being able to come down from it, to be less of an authoritarian god-like figure. As Mechanic and Meyer (2000) explained, this can be attributed to numerous factors that include greater access to information and higher education of the population, which means people are more likely to use their own judgement, demand more for themselves in the age of consumerism and the impact of media on demand for choice in treatments. Mechanic (2003) concludes by noting not only the overload experienced by many practitioners, but also the imperfect or dysfunctional context in which they work, while on the other hand the expectations of medical practice have escalated.

Perhaps, it seems, patients expect too much. At least, doctors appear to think so. Nevertheless, it is not for this thesis to argue who is right, but to explain that there are many factors that lead to discontent in patients, and much of this is related to what expectations they have of their care and treatment. But there are also factors beyond the capacity of the individual doctor that may lead to discontent, as Mechanic suggests, but as the one in charge, the one seen to be responsible, they will often be the one held accountable.

McKinlay and Marceau (2000) discuss this phenomenon at length, while reflecting on what has contributed to “the end of the golden age of doctoring”. Taking an historical perspective, the
authors assert that professional dominance had been acquired by the mid-twentieth century. As written about extensively by Freidson (1970), this depicts the doctor-patient relationship as asymmetric, in which the “imperialism” of medicine gave power and control to the doctor. Although the doctor was there for the patient, acting in their best interests, it was the doctor who took the reins and expected the patient to follow (“be compliant”), given their superior medical knowledge and expertise. Patients had trust then, but now there is wariness.

O’Neill (2002) questioned if there is actually a “crisis of trust”, stating that when people need to trust others, they do. Therefore, she names it a “crisis of suspicion”. This she attributes to the ever more restrictive measures for gaining accountability, which she says have the effect of damaging the professional’s sense of dignity and pride in their work, and replacing it with defensive, risk-aware practices, both at institutional level and individually. This builds a culture of suspicion and low morale within institutions, and given the public is now aware of why accountability is essential and has access to complaints mechanisms, this is the basis for public mistrust (O’Neill, 2002, p. 57).

Katz (1984) said that the “paternalistic sovereignty” that characterised medicine for centuries, when doctors knew what was best for their patients, changed when informed consent became a legal entity in 1957 in the USA as a defence against battery. But Katz argued that this did not mean total self-determination by patients, since although they had a right to be informed, it was doctors who disclosed what they deemed to be relevant in order for a patient to make an informed choice. He argued that this rights model replaced the medical model, yet he was not convinced it made a substantial change in the doctor-patient relationship. Indeed, this was shown in Rogers v Whitaker in Australia. The patient, Maree Whitaker, was almost totally blind in her right eye since an early childhood accident. She consulted an ophthalmic surgeon, Dr Chris Rogers, who advised her that surgery would improve the appearance of her eye and probably restore sight to it. Dr Rogers made a considered decision about what to disclose to Mrs Whitaker in terms of potential risks of surgery in one of her eyes, but failed to disclose the essential source of her apprehension, that she would suffer sympathetic ophthalmia in her good eye, albeit that she had not specifically asked about this condition. This very risk, that her good eye would be affected by surgery to her bad eye, although extremely rare, was precisely what occurred, and now being blind, she successfully sued her surgeon for negligence.

Dr Roger’s defence relied on the “Bolam principle”, that a medical practitioner is not negligent if he acts in accordance with the practice accepted by his peers, which meant in effect that the standard of care owed to a patient is determined by medical judgement. Mrs Whitaker appealed and the High Court decision stated:

The Law should recognise that a medical practitioner has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case,
a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it\textsuperscript{36}.

The meaning of "material risk" became the new foundation of consent, and thereafter changed the foundation of medico-legal judgements: a body of peers deemed Dr Rogers to have been correct in not informing her of the risk, given the high unlikelihood of it happening, but the judgement determined otherwise: that Mrs Whitaker had made it very clear that this is what was most important to her, this was material to her consent to proceed with this surgery. Mrs Whitaker's trust had been broken, and once broken, it was not possible to get it back. The implications of this change to the meaning of consent and the foundation of trust and effective communication in the doctor-patient relationship have been far-reaching.

**Perceptions of Trust**

So far, we have seen that the traditional trust between doctor and patient has been based on a paternalistic relationship between doctor and patient. But while trust may have been challenged, and at times eroded, it has not been eliminated – when people need to trust, they do, but it cannot be taken for granted (Gilson, 2002). It is tested and built up, and once deemed trustworthy, is safe for as long as the trustworthiness is secure. This cannot depend on meeting every patient’s expectations, because sometimes these are unrealistic, or unreasonable, or even unwise. Nor does it mean that the doctor is not a good doctor.

**Being a Good Doctor**

Referring to previous argument about being "good", it was suggested that being good, or even good enough, is a value to be aspired to. It is not clear what we mean by good, but it is more than being technically competent: people want a doctor who shows some humane qualities as well, someone who cares about them as people, who listens and expresses the human virtues of compassion, respect and kindness. Indeed, as Paterson (2012) explains, there is ambiguity in the term "good" in speaking of both the motivation of doctors and also the quality of the work they do.

...this ambiguity is reflected in attempts to define the attributes of a good doctor, and to describe the characteristics of good medical practice. Invariably, the desired qualities relate to both motivation and performance. The duality is also seen in an influential seventeenth definition of a physician as vir bonus medicinae peritus, a good man expert in medicine (Paterson, 2012, p. 2, 3).

This suggests that doctors are expected to be competent, and to have the right commitment, not only to do their job well in terms of technical performance, but to demonstrate those other less-

\textsuperscript{36} Rogers v Whitaker (1992) 175 CLR 479 (at 490).
tangible qualities. Medical competence is the number one quality that patients value in a doctor, according to various studies. Ninety-seven percent of respondents to a 2010 survey of members of the New Zealand public agreed that remaining up-to-date with developments in medicine is essential (Old, Adams, Foley & White, 2011). While this is an obvious response to an obvious question, other qualities were also rated very highly, such as compassion at 89%, and 71% valued doctors who cared about them as well as their health.

Consistent with the latter is a finding from a survey in UK as to whether the doctor makes the care of the patient their first concern. Seventy-eight percent of the respondents rated this as the most important duty (Chisholm et al., 2006).

What Complaints Reveal

Turning now to what complaints data tell us, we can deduce that what makes people dissatisfied with their care can provide clues as to what would have satisfied them, had it been delivered. Unless it is articulated in the complaint, such a conclusion is a default one. A perusal of the NSW HCCC’s annual report 2016/17 gives an indication of what aggrieves patients most. After “Treatment” at 41% of the sources of all complaints and “Professional Conduct” at 16.4%, 15.9% of complaints are in the category “Communication/Information”. The latter includes descriptors such as: attitude, manner; inadequate or incorrect information; special needs not accommodated. Similarly, the Medical Council of NSW reports “Treatment”, “Clinical care” and “Poor communication.” The latter includes descriptors such as “insensitive or inappropriate comments; failure to communicate openly, honestly and effectively; disrespectful manner”37.

Complaints are therefore not all about clinical care and treatment, but more about what transpires between doctor and patient, and it can be shown that there is a link between “poor communication” and intention to litigate or complain about an aspect of care and treatment, which may or may not have caused harm. A systematic review by Durand, Moulton, Cockle, Mann and Elwyn (2015) of the literature relating to shared decision-making and intention to initiate litigation, found that while the results are inconclusive about shared decision-making, the general inability to communicate effectively with patients is a strong predictor of malpractice claims: “the relationship itself may be the most powerful antidote to the malpractice crisis that medicine can provide”. While this is a study of litigation, such a finding is mirrored in the above complaints data: when the foundation of the relationship, expressed through the quality of communication, has been breached, it is a strong predictor of motivation to complain.

It is perhaps more complex than this. The seminal study by Vincent, Young and Phillips in 1994, in which 227 clients of five medical negligence firms were interviewed to learn why they were taking legal action, the issue rested not only on the initial injury, but how it was handled and the quality of

communication after the incident. In only 15% of cases were clients satisfied with explanations, if any had been forthcoming, prompting clients to take the matter further. The primary motivation was not compensation, but to have honest explanations provided, for assurance that the matter would be remedied for future patients, for accountability and as well for compensation for losses incurred.

Speaking at the Australian Institute of Administrative Law (AIAL) conference in October 2007, former NSW Ombudsman Bruce Barbour stated: “one of the main reasons people give for making a complaint is to obtain information about what happened, and what has been done to remedy it.” Similarly, 65% of complainants surveyed in a recent Australian study had attempted to resolve a concern locally, but not being satisfied with the outcome, lodged a formal complaint with the authority. This indicates that the majority of patients who have a concern about their health care are primarily interested in having more information about what happened and to have the matter explained to them, and to have any concerns resolved directly. It is only after such an attempt is not satisfactory that they turn to the regulator to deal with the issue (Pierce, 2017). More will be discussed on this issue in Chapter Three, when we examine complaints more closely.

What can be surmised from the above is that patients may not only be dissatisfied when something has gone wrong or because of an inappropriate treatment decision, but because the fundamental starting point of the therapeutic relationship – trust and open and honest communication – has been breached. Where these are absent, a patient is less forgiving of mistakes, harm or disappointment with an outcome, is more likely to be aggrieved, and more predisposed to initiate a complaint. By contrast, when the relationship is founded on trust, the patient is more likely to feel confident they are in good hands. Given that trust is at the heart of the relationship between doctor and patient, failures in this essential ingredient would undermine confidence in the doctor, leaving the doctor open to allegations that they are not what should be expected, that they are not “good”, or at least not good enough.

**Summary**

Chapters One and Two have so far endeavoured to provide the context for my study, to present a picture of the historical, political and social factors that created the medico-legal environment in which doctors practise today. As I have shown, this environment is not a static one but is ever-changing in response to events, medical developments, ideological and political pressures, the structural changes within the health system itself and to the realities of our social world. The move towards the professionalisation of medicine was promoted by medical practitioners in order to safeguard their interests and jurisdiction and was enabled by governments through their legislative powers.

An almost or as equal a pressure came from the public who not only wanted what medicine had to offer and to be able to trust that it would be safely delivered, but when such expectations were not always met, the power of public opinion demanded greater accountability, and in many instances,
redress. Regulators had to step up, and governments responded by establishing the legal mechanisms to ensure greater accountability that included procedures for dealing with institutions and individuals who failed to meet the expected standard. Indeed, standards themselves are constantly being reviewed and revised as gaps and deficiencies have been identified. Complaints became an invaluable mechanism for highlighting such deficiencies.

What we saw by following the progress from the beginnings of the legitimated medical profession, was the usually steady, but sometimes very dramatic, transformation of legal protections from that of protection of the profession to protection of the public. Legislation is now framed around the public interest, public safety and the public good.

Chapter Three that follows will describe how the different jurisdictions function to enable and to protect, to compel accountability, to respond when things go wrong, and will examine how the public is protected by these regulatory processes. Chapter Four will examine how this whole system, the medico-legal environment, affects the individual doctor who has been subject to any of these proceedings, or who fears that one day they may be.
Chapter Three: The Law in Action

Chapters One and Two considered the place of law and regulation in the profession of medicine, and looked into the nature of the profession itself: what is meant when we speak of the professionalisation of medicine, of professionalism and of being a professional, a doctor.

In return for the privilege of being self-regulating, or at least partially so, the profession is required to be accountable by practising within the bounds of a wider regulatory environment, and sanctions exist if it does not. Doctors can interact with the law for all sorts of reasons. As members of the profession, they may be called upon for their expert opinion in a compensation case, a Coroner’s inquest or other inquiry. When a doctor is called to account for his or her own actions or conduct, it is generally because something has gone wrong, or they are required to account for their conduct if it is believed to have caused or contributed to harm.

This chapter will present the jurisdictions that interact with medicine, and examine those that require accountability from the profession, their purpose, and in particular those that take an interest when things go wrong:

1. Jurisdictions relevant to medical practice
2. Accountability in action: When things go wrong
   2.1. The Regulatory framework
2.2. Where complaints fit in the framework
2.3. The complaints processes: understanding what they are for and what complaints are about.

The Relevant Jurisdictions

Purpose: Enabling, protecting, resolving, compensating, punishing

Before the advent of modern medicine and health systems in Britain, Australia, Canada and New Zealand, regulation of health professionals consisted of civil and criminal jurisdictions, and government-sanctioned self-regulation, an arrangement that McDonald (2012, p. 97) refers to as the “regulatory trinity”. With the advent of the modern health system, especially the public health system, the trinity had to accommodate to the medical profession’s professional autonomy in order to ensure that the health system could function. Yet with the demand for greater accountability and the growing pressure to protect the public more effectively, other regulatory instruments were introduced to strengthen the governance of the health system. We have seen how and why this happened, in the account of regulatory change in Chapter One. As McDonald (2012) states, the dominant mode of regulation is no longer the trinity, which now sits within a regulatory framework that encompasses the breadth and complexity of the modern health care system.
The law is also a reflection of society and its changing values. The traditional autonomy and paternalism of the medical profession has been challenged by the greater awareness and recognition of patients’ autonomy. Recognition of patients’ autonomy has been reflected through case law and precedent, which filters into standards of practice thereafter. The legal scholar and social justice advocate George Annas (1990, p. 1) writes:

> Medicine has to do with health, healing, and comfort: the health of the patient, healing the patient, and comforting the patient. The law has little to say directly about any of these, but has much to say about the centrality of the patient’s own view of health, healing and comfort. Because the doctor-patient relationship is inherently one-sided, the law’s direction over the past decade has been to attempt to give the patient more authority over decisions that directly affect the patient’s mind and body.

That “past decade”, the 1980s, coincides with major changes in medical law, through the sharp rise in complaints mechanisms and litigation, and greater demand for accountability by the professions, health service providers and the regulators\(^\text{38}\). Recalling Ehrlich’s (1962, p. xxxiii) conception of the law as a living thing, “the law which governs life must be brought into and kept in touch with life” in this way, we will examine the law in action, how it both reflects the changing social values and expectations, but also its influence on the medical profession and practice.

Civil law

Civil law, or common law, refers to non-criminal law, and is between individuals or groups. There are four categories of civil law: torts, contract law, family law and personal disputes. The areas of contract law and tort law are the most common in matters relating to medical practice.

Contract law concerns breaches of contract in relation to the provision of service and conditions of employment. The doctor-patient relationship is grounded in contract law, either implicitly or explicitly, as is the relationship between the patient and a hospital, with whose employees a patient has a contractual relationship. Remedies in disputes are generally through the award of damages, which is equivalent to the financial loss brought about by a breach of contract (Kerridge, Lowe & Stewart, 2009). An example of contract law in action was the landmark case in Australia of Breen v Williams\(^\text{39}\) which established the propriety right of the doctor to the medical records relating to a patient. It was determined that although the patient’s contract with Dr Williams entitled her to proper care and treatment, the contract did not extend to her owning the medical records.

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\(^{38}\) Mulcahy, L. (2003) notes the advocacy roles played by various consumer groups in England of the 1980s onwards in demanding better conditions and rights in the wider population, with special interest groups being able to exert a lot of political pressure as well as demands to be included in policy development, in *Disputing doctors: The socio-legal dynamics of complaints about health care*. McGraw-Hill, England.

Tort law (case law and precedent) deals with civil wrongs, which give rise to claims for compensation for harm done, or medical negligence (“malpractice litigation” in USA). The interest in the latter is in causation and needs to answer these questions to meet the criteria for negligence: did the doctor owe a duty of care to the patient; has the relevant standard of care been breached; did the doctor fail to take reasonable care; did the breach cause harm or loss as a result of the breach? (Skene, 2008, p. 219; Studdert, 2004). It is important to remember that not all harm is due to negligence. A health provider will not be liable for harm occurring when reasonable care was being taken (Mcllwraith & Madden, 2009).

The standard of proof in civil law is determined on the balance of probabilities\textsuperscript{10} that a court or tribunal must consider. The burden or onus of proof lies with the plaintiff (one bringing the complaint or claim) to prove that the facts are more likely than not to be true (Kerridge, Lowe & Stewart, 2013, p. 116).

While such matters do not directly achieve public protection, the decisions become precedents in similar matters and therefore attract much interest with the profession, the educators and legal advisers. This interest may translate into policy and new guidelines: examples range from the standard expected for medical record-keeping to the revision of the meaning of consent, following Rogers v Whitaker\textsuperscript{41}. This led to a perceived extraordinary increase in litigation (Cica, 1995; Studdert, Mello & Brennan, 2004, p. 283). But not everyone agreed there was actually a “litigation crisis”. Kerridge, Lowe and Stewart (2009) recall the perception of an unsustainable increase in the number of claims and an unsustainable increase in the amount of damages being awarded. This had left many to fear that Australia (not just medical professionals) were “in the grip of a ‘litigation crisis’”, which escalated when United Medical Protection went into voluntary liquidation (discussed elsewhere in Chapter One). Given the consequent consternation, a Ministerial Meeting on Public Liability convened and established a panel under Justice David Ipp to examine the law of negligence. The Ipp Report (2002)\textsuperscript{42} that followed this review resulted in major changes to existing provisions, in particular the assessment of damages and caps on damages claimed. These changes were encapsulated in legislation in each state as their various versions of the Civil Liability Act 2002 (NSW).

The doubts arose because of conflicting evidence of purported increases in litigation. Mcllwraith and Madden (2009) observed that there was little reliable data on the incidence and changes in the level of incidence of medical negligence litigation in Australia. It was known that very few adverse

\textsuperscript{10} This is known as “the Briginshaw test” from Briginshaw v Briginshaw [1938] HCA 34; (1938) 60 CLR 336 at 361-362: His Honour Dixon J stated: The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal.


events translate into a negligence claim\textsuperscript{43}, but reliable data were not available until a study by Studdert (2004), in which he concluded that there was little, and unreliable, evidence that the malpractice system was a deterrent against substandard care, or indeed improved the quality of care. What tort reform did achieve was a containment of costs, rather than greater safety, although it also results in more defensive practice (Studdert, 2004).

**Criminal matters**

It is not common for a doctor’s conduct to enter the criminal jurisdiction for adjudication. The principle is that the offences are so serious that they are considered to be an offence against the community, in contrast to civil law which is about individual relationships. Indictable offences relating to medical practice include significant boundary issues such as sexual assault of a patient or a sexual relationship with a patient, offences relating to fraud such as Medicare fraud or billing, and prescribing offences. Skene (2008) notes that a doctor cannot use as a defence that the patient consented or that the doctor believed they were acting in the patient’s best interests. Because a criminal conviction is so serious, guilt must be proven beyond a reasonable doubt. The accused is presumed innocent until they are proven guilty, putting the onus on the prosecution to establish (Skene, 2008, p. 29).

**Fraud:** Defrauding Medicare, if the misdemeanours add up to an indictable offence, can send a doctor to gaol. In sentencing a doctor in a 2015 case, Justice Estcourt pronounced:

> The Medicare system relies upon the honesty and integrity of medical practitioners who are entrusted with privileged access to the Medicare claims system, based on the premise that they can be trusted to submit genuine claims only. General deterrence is therefore a prominent sentencing consideration\textsuperscript{44}.

Here we can see that the law not only acts to promote compliance with its statutes and to punish those whom it finds guilty of offences; it also serves to make pronouncements about its expectations in terms of standards of morality and ethical conduct.

**Sex and drugs:** (the former Dr Suresh Nair, with a long history of cocaine and alcohol addiction) was convicted of offences relating to the deaths of two escorts in his apartment on different dates and the supply of the prohibited drug cocaine\textsuperscript{45}. Following his conviction for manslaughter, the

\textsuperscript{43} Leape, L. et al. (1991) The Harvard Medical Malpractice Study showed that of the medical mishaps that occurred in hospitals, one seventh would result in a claim for compensation. Incidence of adverse events in hospitalised patients: Results of the Harvard Medical Malpractice Study II. *NEJM*, 324, 377-384.

\textsuperscript{44} The Queen v Humphrey John Polycarp Gomes 7 May 2018: Comments by Estcourt J. in passing sentence.

\textsuperscript{45} R v Suresh Nair [2011 NSWDC 124 (26 August 2011)].
Tribunal cancelled Dr Nair’s registration as a medical practitioner\textsuperscript{46}. Being a doctor made his personal conduct all the more shocking to the public, who relished the scandalous story.

**Murder:** Dr Brian Crickitt, GP, was convicted of murdering his wife in 2016 with a lethal dose of insulin, in order to free him to marry his mistress and to collect his wife’s life insurance. He was sentenced to 27 years in gaol\textsuperscript{47}. That he used his medical knowledge added to the seriousness of the crime. By contrast, the next category of criminal activity is controversial because harm was allegedly caused in the course of a doctor's practice, but without the intent to cause harm, as the following matters demonstrate.

**Manslaughter:** The recent British case of the Dr Hadiza Bawa-Gaba’s conviction\textsuperscript{48} and sentencing of two years’ gaol, and subsequent de-registration, for her part in the death of a six-year-old patient, caused much consternation not only in the UK but in Australia for the meaning that could be derived from such findings. Firstly, this brought issues of medical care and treatment, when not matters of deliberate intent such as Harold Shipman’s history of murder, into the criminal jurisdiction. A finding of “gross criminal negligence” for alleged grave errors in health care, deemed to be “truly exceptionally bad”, could lead to a finding of criminal culpability, and was therefore extremely unsettling for doctors (Schalkwyk, 2018). In Dr Bawa-Garba’s case, what made it particularly disturbing was that there were compounding problems within the hospital that she was not directly responsible for (Dyer, 2018b). Such contributing factors were noted, but they did not sway the judge in his determination about her performance\textsuperscript{49}.

In Australia, there have only been four convictions of doctors for manslaughter in medico-legal history: that of Dr William Valentine in 1843, Dr Frederick Hornbrook in 1864, Dr Margaret Pearce in 2000, and Dr Arthur Gow in 2006. All cases involved inadvertent inappropriate administration of drugs during treatment, and all were found guilty, but the punishment that followed was minimal (Skene, 2004).

**When things go wrong**

In addition to the criminal and civil court systems of redress, the following are standard avenues for responding when something has gone wrong, or if there has been a near miss that could have resulted in serious harm. These take place at different levels of the health system and include Open Disclosure, Root Cause Analysis, and the Commonwealth Professional Services Review Scheme.

\textsuperscript{46} Health Care Complaints Commission: Media Release: 4 December 2013: Dr Suresh Surendranath Nair – registration cancelled by Medical Tribunal.

\textsuperscript{47} R v Crickitt [2017] NSWSC 542.

\textsuperscript{48} An appeal was held on 17 December 2017 that upheld the decision [2018] EWHC 76 (Admin).

\textsuperscript{49} The decision to have her struck off followed an appeal by the GMC that demanded a stronger punishment than a twelve-month suspension, given her criminal conviction, but this was overturned on appeal in August 2018, when the court restored the original Tribunal decision that she be suspended.
Open disclosure: participation in a formal “open disclosure” (OD) for a serious adverse event (or “patient safety incident”). Open disclosure is defined in the Australian Open Disclosure Framework as: “an open discussion or series of discussions with a patient and/or their support person(s) about a patient safety incident which could have resulted, or did result in harm to that patient while they were receiving health care”\textsuperscript{50}. The intent of OD is to provide open communication between patients, families and carers, and aims to identify what went wrong in order to minimise future incidents of a similar nature.

A Framework for Open Disclosure was introduced in 2003 by the Australian Commission on Safety and Quality in Health Care (ACSQHC) as a recognition of patients’ rights to be informed about unintentional adverse events that occur in hospitals (Skene, 2009; Brown, 2008; Finlay, Stewart & Parker, 2013\textsuperscript{51}). An evaluation by Ledema et al. in 2008 of the implementation of OD in 21 sites found a “reasonable degree of enthusiasm for OD among both patients and clinicians”. However, a review in 2012 by the ACSQHC\textsuperscript{52} added non-disclosure protections in order to encourage practitioners to participate openly without fear of what was disclosed being later used in complaints or civil actions. There had been concerns about the legal implications for practitioners, in particular about their indemnity insurance and medico-legal risk, and apprehension that existing laws were insufficient to protect information from ODs being used in litigation (Studdert, Piper & Ledema, 2010).

Studdert and Richardson (2010) called for greater statutory protection and national uniformity of laws relating to apology in which any statements would be legally inadmissible. To clarify the legal obligations imposed on doctors in an effort to promote the adoption of OD, Finlay, Stewart and Parker (2013) summarised the existing, extensive support for OD as evidence of appropriate professional conduct under the National Law. They concluded that it is important to remember that the reason for adopting OD is not to reduce litigation but “to encourage health systems that value honesty and transparency so that errors can be reduced and injured patients can be properly cared for” (Finlay et al., 2013, p. 448).

Root cause analysis (RCA): RCA is a formal process that aims to identify contributing factors in an event, with the aim of ensuring these factors would be remedied and prevent further harm. The Incident Management Policy of NSW Health states that it is mandatory for each NSW Health entity to have a system in place to manage critical and corporate incidents\textsuperscript{53}.

\textsuperscript{51} Brown, D. (2008) Open disclosure: Morally right but is it legally safe? Medico-Legal Society of NSW Scientific Meeting, Sydney NSW.
\textsuperscript{53} NSW Government Incident Management Policy no. PD2014_004 (February 2014).
The purpose is not to find blame but to investigate and understand what contributed to an adverse event. Much of this thinking can be traced to James Reason’s “Swiss Cheese” model of hazards and losses, which considers not just each contributory event but how they have aligned “to cause a mishap or near miss” (Reason, 1990, 2000 & 2008).

The NSW Incident Management Policy sets out the roles of certain personnel and levels of responsibility, and a system for scoring severity of incident, which will determine how it will be managed. The protocol incorporates the principle of Open Disclosure as well as principles of openness, accountability, fairness, a commitment to learning and good communication.

As with the above, there was support for the concept, with the proviso that evidence obtained and opinions sought could not be used in any subsequent legal action. Such provisions already applied under the Civil Liability Act 2002, but as with Open Disclosure, there had been widespread fears about subsequent medico-legal action (Studdert, Piper & Ledema, 2010).

**Coronial Inquest:** Object 3(c) of the Coroners Act 2009 in NSW is “to enable coroners to investigate certain kinds of deaths or suspected deaths in order to determine the identities of the deceased persons, the times and dates of their deaths and the manner and cause of their deaths” (Coroners Act 2009). Most deaths do not require an inquest to be held. However, some deaths are deemed to be reportable due to particular circumstances as set out in s6 of the Act, and include violent or unnatural deaths, deaths of unknown or suspicious cause, and where death is not a reasonably expected outcome of a health-related procedure. The latter means a medical, surgical, dental or other intervention, including administration of an anaesthetic, sedative or other drug.

In order to determine the cause of a death, a doctor may be called to provide testimony about their own involvement in the care of a patient or to provide peer or expert opinion about the actions of another health practitioner. Under s82 (2) (b) of the Act, a Coroner may refer a matter for investigation to the Health Care Complaints Commission, or if under s78 the Coroner has a reasonable belief that a person may be found guilty of an indictable offence, that person may be referred to the Director of Public Prosecutions. Peer or expert review in health-related matters will be an integral part of coming to such a conclusion. Alternatively, it may be the doctor him- or herself who is believed to have caused a death, in which case either scenario may apply.

**Commonwealth Professional Services Review Scheme:** this is “a scheme for reviewing and investigating the provision of services by a person to determine whether the person has engaged in inappropriate practice” (Part VAA, s80 (2) Health Insurance Act, 1973). Inquiries may involve alleged misuse of Medicare, such as over-servicing, incorrect item numbers claimed, inappropriate services or services claimed but not provided. Such inquiries may lead to criminal charges: the Federal Department of Health Annual Report 2016-17 reported that it had successfully prosecuted 29 fraud cases. It also referred 81 cases for Professional Standards Review in that year. Doctors found guilty under these provisions may not lose their Medicare provider number or have
restrictions placed on the scope of their practice, but would face a disciplinary hearing for unsatisfactory professional conduct, or worse.

**Complaints:** From the list above, it is clear that dealing with adverse incidents or events in healthcare is not all about complaints, although they are seen as an important, if not essential, component of the mechanisms for responding to adverse events and matters relating to professional conduct. It is commonly thought that having a robust system to deal with complaints will keep the public safe by enabling identification of those practitioners and health services who are putting the public at risk. The onus is largely on the public to take the initiative, although the actions of other jurisdictions may open a path to an investigation by a health complaints body, so a doctor may find themselves being caught up in more than one process for the same incident. This was shown in the cases mentioned earlier: Drs Bailey, Heron and Gardiner came before criminal and disciplinary jurisdictions arising from the Chelmsford Private Hospital scandal, as did Dr Patel in Bundaberg and Dr Reeves in Bega.

Most commonly, a complaint will be dealt with through a complaints mechanism within a health service, or an independent complaints body. All health care organisations are required under the national standards published by the Australian Commission on Safety and Quality in Health Care (ACSQHC) to have a complaints management system (ACSQHC, 2017: Clinical Governance Criteria 1.13 and 1.4)\(^{54}\). A person with a grievance can therefore expect to have an avenue within the organisation to deal with their grievance.

Most disputes are handled at the local level within a health service, with the assistance of complaint liaison officers (Wilson, 1999, p. 179). This is in contrast to the common belief that the complaints process is about court matters, yet the number of matters that are subject to law suits is small compared to the number of complaints that are dealt with in a variety of jurisdictions and forums\(^{55}\). Wilson (1999, p. 179) sees health service dispute-handling outside of the courts as a “social process of calling the health service to account for perceived violations of the complainant’s expectations”. Lloyd-Bostock and Mulcahy (1994) also add that not fully recognising the importance of complaints understates their value as sources of knowledge about performance and conduct issues, citing examples of the failure to consistently act on complaints by patients leading to avoidable crises and tragedy in health care.

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\(^{54}\) ACSQHC (2017) *National Safety and Quality Health Service Standards*, 2nd ed. Australian Commission on Safety and Quality in Health Care, Sydney, Australia

\(^{55}\) For instance, Avant Insurance reported that of all matters doctors sought assistance for, 50% were in relation to complaints, compared with 18% in relation to claims for compensation. In addition, there were 60 complaints per 1000 members (6%) and approx. 22 claims per 1000 members (2.2%) (Avant Insurance 2017 Annual Report). As Avant’s membership is 75500 doctors in Australia or approximately 65% of all registered doctors, these figures provide a useful picture of the scale of medico-legal matters the profession faces per year. Added to this are 18% of matters relate to coronial inquests, with the remainder being 11% for employment disputes and 6% “other”.
The Complaints Process: Individual Interests or the Public Interest

Reader note: While this study encompasses Australia-wide regulatory mechanisms, the focus is on the NSW system, mainly for the pragmatic reason that space does not allow for an examination of each state’s system and the reasons for differences, and because the study originated in NSW. The purpose was not to analyse the systems themselves, but the impact of the process, in which the underlying principles are consistent.

The network of complaints bodies fits within a broader regulatory framework, and their statutory authority falls within a jurisdictional environment, encapsulated under the term “public interest law”.

Public interest law

This is a term introduced in Chapter One when discussing the interests of the individual versus the interests of the broader public, which sometimes do not coincide. This issue was pivotal in the arguments brought by the various parties and interest groups when the Health Care Complaints legislation was being debated in NSW – whether the new Act would provide for an advocacy service to assist the individual with a grievance to seek resolution and redress, or whether it would exist to protect the interests of the public.

In Australia, a model based on the American model described by Jaffe (1976) was established in the first community legal centre in Fitzroy, Victoria, in 1972, followed by many others including Aboriginal Legal Services. Thomas (2002a, p. 270) quoted Selby (1992, p. 12), “a public interest legal issue [is] one where the results have ramifications which go beyond the immediate parties and affect a broad community of interest either immediately or in the foreseeable future”. It was Thomas’s (2002a) view that the public interest agenda for health care complaints was promoted by the Public Interest Advocacy Centre (PIAC), which focused on the rights of disadvantaged and disempowered groups in contrast to the rights of injured individuals. With a commitment to the public interest by the Complaints Unit, and with an already established legal section with access to resources for prosecutions, two issues were critical for the future: one was the groundwork and expertise for its relationship with the NSW Medical Board to whom it referred matters for prosecution, and the other for the shaping of the future Health Care Complaints Commission (HCCC) which adopted a prosecutorial role, in an eventual co-regulatory arrangement with the Medical Board.

Public interest law and health

Statute law: These are laws passed by Parliament, and as public interest laws they exist as protective legislation. Statute laws include medical practice legislation and associated regulations, and they provide complaints-handling mechanisms, such as the Health Care Complaints Act 1993 in NSW, the Health Practitioners Regulation National Law Act 2009 (the National Law), and Health Services Acts in various states of Australia.
**Professional discipline:** Disciplinary actions are administered under the National Law, and under state-based legislation in NSW and Queensland. The primary objective is public protection, and their interest is in maintaining standards of care, which does not mean optimal care, but accepted practice. There is a process for determining the standard of performance or conduct of an individual practitioner, firstly by determining the standard of care for a particular circumstance, whether the practitioner breached that standard, and if so, to what degree, thence what level of criticism this breach would attract by a body of peers. Departures from the standard are defined under the National Law as when:

the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the health profession in which the practitioner is registered is below the standard reasonably expected of a health practitioner of an equivalent level of training or experience [s3, the National Law].

In NSW, the departure from the benchmark is specified as “significantly below the standard”.

Questions relating to these determinations relevant to my study are:

Q. How is the public protected by holding an inquiry into a doctor’s professional conduct?

Q. Do departures from the standard in respect of one incident mean the public is at risk?

Q. Do alleged or purported “failures” mean a doctor is a bad doctor?

Q. Where does the concept of justice fit?

This thesis explores these questions as we progress further into understanding how the law in action functions and how it is experienced, through both the existing literature and what my study has found.

**Where the Complaints Process Fits and What It Is For**

Here we return to the law in action, to consider the circumstances in which those administering the law decide to act. With criminal acts, which are offences against the state, a prosecuted defendant found guilty beyond a reasonable doubt will receive a prescribed penalty. With state-based laws, including the protective legislation we have been considering, much depends on the adequacy of the agencies operating on behalf of the state to give effect to the legislation. It relies on other parties to draw attention to a potential breach, and in the case of some agencies or individuals, they may fail to act altogether, or to act in a meaningful way. So it was with Chelmsford, where state agencies were indeed aware of problems at the hospital, but either lacked the authority to act, or failed to act more assertively to look deeper into the troubling information that was emerging from that place.
From that circumstance, and the regulatory deficiencies identified by the Royal Commission, the HCCC was born. But the legislation that enabled it to exist and function relied on individuals to draw attention to problems in the health care system through the avenue of complaints. Here I reiterate that complaints are about an individual grievance that expects resolution, and perhaps redress. Therefore, there is inherent tension in the HCCC’s capacity to satisfy that grievance while more pressingly act to protect the public. Nevertheless, there is no doubt the complaints system plays an important role in maintaining public trust through its objectives of public protection and taking remedial action where it is found to be necessary, albeit that satisfaction with the process is less than overwhelming for some. Other studies and reviews have found numerous concerns and criticisms being expressed about such issues in the system as timeliness, transparency, communication and quality of interactions communication, fairness, uncertainties about whose interests were being protected (Pierce, 2017; Snowball, 2014; Health Issues Centre, 2014). These findings will be considered further in the Discussion.

The regulatory framework
The regulatory framework is a complex network of interconnected bodies whose primary aim is to protect the public and maintain standards of health care. It evolved over time from each state having had its own regulatory authorities, referred to as Health Complaints Entities (HECs), each with its own set of legislation and regulations, and each with different approaches to registration and to dealing with complaints and disciplinary matters, to an integrated national framework aiming for greater consistency and mobility between states. Previously, mobility between states was difficult for practitioners because registration was state-based. It was also difficult when undertaking inquiries into a practitioner’s history, usually in the context of question marks about their fitness to practise. This left gaps in ensuring consistency, and in keeping track of those with a blemished or uncertain history. The national framework – the National Registration and Accreditation Scheme (NRAS) - was the response to these and other challenges, and it came into being in 2010 under the Health Practitioner Regulation National Law 2009 (the National Law). The Australian Productivity Commission had recommended in 2005 that there be a national registration and accreditation process, and in 2008, the Council of Australian Governments (COAG) agreed that they would establish a national registration and accreditation scheme. The scheme commenced on 1 July 2010 under the national law that was based on legislation passed in Queensland in 2009 as the Health Practitioner Regulation National Law Act 2009 (Queensland). The Australian Health Workforce Ministerial Council oversees the NRAS, under which there are National Boards for each of the health professions within the scheme (the scheme commenced with ten health professions, and there are now fifteen), as well as accreditation authorities for each

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56 As I have stated earlier, I am focusing on the HCCC but the principles apply similarly in the complaints jurisdictions in the other states and nationally.

57 Health Issues Centre (2014). Setting things right: Improving the consumer experience of AHPRA including the joint notification process between AHPRA and OHSC. A report prepared for AHPRA by the HIC in collaboration with an AHPRA Community Reference Group. Melbourne.
health profession. The Australian Health Practitioner Regulation Authority (AHPRA) provides administrative support to the Boards, and is governed by the Agency Management Committee (Satchell et al., 2016). A comprehensive summary of the reasoning behind development of the national scheme, as well as the consultation that took place in designing the scheme, can be found in the thesis of Suzanne Pierce (2017).

**The Australian Health Practitioner Regulation Authority**

The Australian Health Practitioner Regulation Authority (AHPRA) is responsible for implementation of the National Registration and Accreditation Scheme (NRAS), through its various functions and oversight of the fifteen health professions’ National Boards. The primary and overarching function is protection of the public, and its other functions are to: register the over 630 000 health practitioners in Australia, in fifteen health professions; set national standards of practice; facilitate mobility (by having registration recognised in all states and territories); publish the online register; audit compliance; accredit education and training; and to manage notifications (complaints) about practitioners.\(^{58}\)

**The Medical Board of Australia**

AHPRA provides support to the Boards, including the Medical Board of Australia, at the national level. The Medical Board of Australia is responsible for: the registration of all medical practitioners and medical students; developing standards, codes and guidelines for the medical profession; the investigation of notifications and complaints about medical practitioners (except NSW); conducting panel hearings and referral of serious matters to a Tribunal; the assessment of international medical graduates; and for approval of accreditation standards and accredited courses of study.

As noted, there are two exceptions to the national complaints-handling process: in Queensland, complaints are managed by the Queensland Office of the Ombudsman; and in NSW, the HCCC handles complaints in a co-regulatory arrangement with the Councils for each health profession.

**The Medical Council of New South Wales**

Councils in NSW are statutory bodies which were established under the National Registration and Accreditation Scheme (NSW), and are supported by the Health Professions Councils Authority (HPCA), which itself is an administrative agency of the NSW Ministry of Health. Each Council is made up of practitioners, legal representatives and community members, most of whom are nominated by the Minister for Health and appointed by the Governor of NSW. The Councils work with the HCCC in a co-regulatory arrangement, meeting to consult about which agency should deal with new complaints. The HCCC has an additional role in handling complaints about health providers.

services and unregistered practitioners\textsuperscript{59}. The HPCA also maintains a co-regulatory arrangement with AHPRA and the National Boards for each health profession.

The Medical Council of New South Wales (the Council) has oversight of the performance, conduct and fitness to practise of the 34 255 medical practitioners of NSW\textsuperscript{60}. In consultation with the HCCC\textsuperscript{61}, the Council receives and manages complaints about registered doctors and medical students in NSW. It works to ensure doctors maintain the appropriate standards for the profession and that doctors are fit to practise. Doctors brought to the Council’s attention are managed within the three streams of health, performance and conduct. For each of these streams, there is a program of intervention: the Health Program for doctors and medical students suffering ill-health which may compromise their capacity to practise medicine safely; the Performance Program for doctors whose professional performance may not meet safe standards; and the Conduct Program for doctors whose professional conduct may not meet acceptable standards. The Council is also authorised to take immediate action where a practitioner poses an immediate risk to public health and safety, or to themselves, and this generally means a temporary suspension from practice and referral for appropriate inquiry and intervention\textsuperscript{62}.

The function of the regulatory processes

To reiterate, the National Registration and Accreditation Scheme (the National Scheme) was established in 2010 to oversee the safe practice of health professionals, reporting to the Australian Health Ministers Advisory Council (AHMAC).

AHPRA functions to support the national health practitioner boards in implementing the National Registration and Accreditation Scheme in accordance with the National Law. There is a co-regulatory agreement with the states whereby the states maintain certain regulatory functions, including complaint-handling mechanisms under the various health complaint entities.

In Queensland, the arrangement is different. Allegations that the Queensland Medical Board had failed to adequately deal with cases of misconduct and complaints led to the Board being sacked in 2013 after an Inquiry that involved an analysis of some hundreds of files. A temporary

\begin{flushleft}
60 Medical Council of New South Wales Annual report, 2016-17 (accessed on 23 July 2018).
61 s.144G of the Health Practitioner Regulation National Law (NSW) states that: “A Council must, as soon as practicable after a complaint is made to or by the Council about a registered health practitioner or student, notify the following persons about the complaint or matter-
(a) the Commission;
(b) the National Board for the health profession in which the registered health practitioner or student is registered”;
and
s.139I of the Health Practitioner Regulation National Law (NSW) states that: “A notice under section 130 is taken to be a complaint both for the purposes of this Part and for the purposes of the Health Care Complaints Act 1993”.
Under the Health Practitioner Regulation National Law (NSW), S. 146D states that the “Committee can recommend suspension or cancellation on grounds of lack of physical or mental capacity.” If this occurs, the matter must be referred to the Tribunal.
\end{flushleft}
administration was put in place and the work of the former Board committee was managed by the Medical Board of Australia\(^6\), until the new Board was appointed in early 2014. In addition, the former Health Quality and Complaints Commission was replaced by The Office of the Health Ombudsman in that year.

**What is the Complaints Process For?**

As well as the state-based health complaints entities, such as the HCCC in NSW, AHPRA functions to manage complaints about the health, performance and conduct of individual health practitioners. The National Law refers to complaints as notifications, whose purpose is:

> ... to alert regulators to registrant performance or conduct that may place the public at risk. The notification system is designed to improve the performance of health professionals and safeguard the community by providing – where appropriate – feedback, intervention and more serious consequences to those practitioners who breach professional standards, including deregistration (Snowball, 2014, p. 28).

The role of the complaints mechanism is to “receive and resolve complaints from health service users about health service providers”. However, the objective of the legislation is aimed higher than seeking resolution of or redress for an individual’s grievance. Its primary objective is to protect the public: “to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered” [s1(3) of the National Law]. The individual complaint is a window into possible below-standards of care, for which the legislation is obliged to provide a remedy.

**The Health Care Complaints Commission**

The Health Care Complaints Commission (HCCC) in NSW was the first statutory body in Australia established under legislation to “protect the public” in 1993 to receive, assess and resolve complaints before it, to investigate “serious issues of public health and safety” [(s23) HCC Act 1993] and prosecute complaints of unsatisfactory professional conduct or of misconduct (as defined), or to refer to other bodies if appropriate. The functions of the HCCC arose from Chelmsford, out of the findings of the Royal Commission into Deep Sleep Therapy, presided over by Justice J.P. Slattery, as discussed in Chapter One. Having a strong, independent statutory body was considered necessary in order to more effectively deal with maintaining public protection against identified practitioners and health services that threatened public safety. As “public interest law” in action, the HCCC has the powers to obtain documents, to conduct searches, to fully investigate and to prosecute those whose alleged failings had attracted significant criticism from their peers. At a less serious level, it also assists in the resolution of complaints which do not raise significant issues of public health or safety, but which are significant enough to the complainant to

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\(^6\) Medical Board of Australia Media Release: Board appoints interim committee in Queensland. 23 May 2013.
have taken their grievance to a public authority. Part of the assessment process when new complaints are received is to identify those matters that raise issues of public health and safety, and others that would be better resolved by more direct, and less serious and threatening means (to the practitioner who is the subject of the complaint). The other states do not have similar investigatory functions as NSW; their focus is on resolving complaints, and those matters that require investigation are handled by the relevant health professional board. Some of the latter may be referred back to the state HCE.

The process of complaints-handling in NSW differs from that of the national scheme, while having similar objectives, but for simplicity, the summary prepared by the authors Satchell et al. (2016) presents the national framework alongside the HCCC (NSW) framework. There are five stages to the complaint process as follows:

One: Lodging a complaint. A complaint is to be made in writing, may be about a health practitioner, whether registered or not, or a health service, and is to include particulars of the allegations. The respondent to the complaint is notified of the complaint.

Two: Assessment of the complaint. This is to determine how the complaint will be dealt with: to investigate it; that it be conciliated, referred to another organisation more appropriate for dealing with it (such as Medicare Australia in relation to over-servicing, or the Director-General of Health in relation to prescribing, etc.); or that the matter be declined. Certain additional information may be obtained in order to assess the complaint. Some complaints may be resolved through assisted resolution during the assessment stage.

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64 A note on process: Notification of a complaint may come by mail or email. Notification of a claim for compensation will generally come direct to the doctor from a solicitor. There are other forms of service, such as a subpoena but none of these means applied to the participants so I will not enumerate them here. There were two exceptions, both having been involved in police inquiries.

With complaints, a doctor is required by the terms of their medical indemnity policy to notify their indemnity insurer as soon as they become aware of a complaint, or indeed of a matter that they believe may become a complaint, such as an encounter with a particularly hostile patient, a severe adverse event such as an unexpected death, a catastrophic injury or outcome or a serious allegation of wrongdoing, misconduct or impairment. The insurer then advises the doctor on how to respond to the matter at hand, and there is an expectation that the doctor will comply with directions and advice in order to remain indemnified.

Advice generally involves assistance with drafting letters of response, advice regarding what details to include and what documents and other supporting evidence should be released. If a matter proceeds further, advice is provided throughout the process. Advisers are trained and experienced in providing medico-legal assistance; they are doctors, lawyers or claims managers, or a combination of these professions. For less serious matters (in terms of potential consequence for the doctor), medico-legal advisers handle telephone enquiries, open files for written complaints received, and assist the doctor with drafting letters. A more serious matter, or one that escalates, will be transferred to a qualified legal or medical officer to manage. Medical advisers also provide advice to staff on clinical matters, and IE or peer opinion may be sought to determine the relevant standards of care or conduct in a particular matter.

It is important to have a grasp of these procedures, as all doctors with a complaint rely on the advice they receive and are obliged to accept as an essential condition of their indemnity insurance policy, for which doctors pay many thousands of dollars per year. It means that a doctor’s response to a complaint is generally mediated through the IEs employed or engaged by their indemnity insurer, or less often by a private solicitor.
Three: Investigation. Investigations relate to professional conduct. In NSW, s23 of the Health Care Complaints Act 1993 determines when a complaint is to be investigated. In the course of an investigation, the HCCC may obtain documents or other evidence, may enter premises to inspect, examine and remove if necessary any material, documents or equipment, by compulsion if necessary through sub poena or search warrant. They may also seek the advice of an expert for their opinion relating to standards of care and the practitioner’s conduct, and their opinion may be used in any disciplinary proceedings that arise from the investigation. A practitioner has the right to make written submissions in relation to any proposed action by the HCCC.

Four: Pathways at the end of an investigation. The HCCC may: terminate the matter; make comments to the practitioner; refer to the Director of Public Prosecutions (DPP) for criminal action; refer the matter to the professional Council for performance assessment, counselling or inquiry; refer the matter to the Director of Proceedings for prosecution before a Professional Standards Committee, or to a Tribunal. Performance matters are referred to the Council to be handled under the Performance Program, and concerns about impairment are handled under the Health Program.

Five: Tribunal (a Civil and Administrative Tribunal, such as that in NSW, an NCAT). Only a Tribunal is able to order that a practitioner’s name be removed from the register, or to suspend them from practice for a specified period. This means that the matter is of such seriousness as to warrant such action to protect the public. A Tribunal hearing is presided over by a judge, is generally open to the public, and the decision will be published.

Why Make a Complaint?

Understanding why people complain and what they complain about is an important part of understanding the complaints process, and because it provides some indication of how those who are being complained about may react to receiving a complaint.

Complaints are a means by which dissatisfied people can express their grievances or concerns about a service provided to them or someone they know, with the general aim of having their grievance heard and resolved. Having a formalised system lends weight and authority to the grievance, either because the complainant has not been able to resolve their grievance directly, or because they have not wished to deal directly with the health provider, and want the power of an independent authority to intervene on their behalf. There are many reasons for this, amongst these being fear or wanting the authority to act to prevent further occurrences, to demand accountability, to punish, to remedy, and to seek information or acknowledgement of hurt about an incident of

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65 s23 states that a complaint must be investigated if the relevant Council is of that opinion: if the complaint raises a significant issue of public health or safety or raises a significant question as to the appropriate care or treatment of a client by a health service provider; or, if substantiated, would provide grounds for disciplinary action against a health practitioner; or, if substantiated, would involve gross negligence on the part of a health practitioner; or, if substantiated, would result in the health practitioner being found guilty of an offence under the Public Health Act 2010.
care (Mulcahy, 2003; Lloyd-Bostock, 1994). The main reason given by 80% of respondents to a survey by Pierce (2017) was so the event would not happen to them or anyone else; 75% had a belief that what occurred was wrong, unfair or unjust; 65% said that what happened was unsafe; and 46% believed the practitioner should not be in practice.

Most early studies were about why people sued, but once the visibility of complaints systems became more apparent, studies began to focus more on complaints. The study of Vincent et al. (1994) was foundational as it built on recently exposed knowledge of the quantum of adverse events and a greater awareness of litigation and the costs associated. They undertook their study to better understand litigants’ reasons for suing doctors, and found it was not, as believed, just because there had been an injury but rested on how the incident was handled afterwards.

Respondents in the study survey were clients from major medical negligence firms. What the survey showed was that respondents wanted explanations of what had happened, but only 15% had been happy with the explanations given. They also wanted: greater honesty in knowing what happened; acknowledgement of the effect of the incident on relationships, work, social life and emotional impact; for the organisation to be accountable; to prevent similar incidents happening to others; and compensation for actual losses, pain, suffering and care for the injured person (Vincent et al., 1994).

Lloyd-Bostock and Mulcahy’s extensive work on disputes between doctors and patients reaches back to the 1980s. It laid an invaluable foundation for understanding not only the motivations and expectations of complainants; they set the issue of complaints and complaint-handling into a broader context of how society generally deals with conflict and disputes, and into the social milieu existing in the decades 1980s to 1990s of growing consumer expectations of accountability by health service providers, the medical profession and professionals in general (Mulcahy, 1994; Lloyd-Bostock & Mulcahy, 1994; Mulcahy, 2003). They also succeeded in correcting the impression created by researchers, law reporters and others that complaints are at a “lower level” of the scale, with litigation at the top end of interest and importance. Chapter Four presents earlier research of the 1980s on the impact of medico-legal matters that focused on doctors who had been sued. It was another decade before attention turned to the impact of being the subject of a complaint, which Mulcahy (1994) points out is a very different process, with very different motivations, from taking a matter to court with a claim for compensation.

Lloyd-Bostock and Mulcahy’s (1993) study of hospital complaints and how hospitals responded to them threw light on complainants’ motivations for complaining, and on what outcomes they expected. This study also explained that how the complaint was dealt with, and whether expectations of the process were met or not, would influence what might happen next. Complainants who felt they were not being taken seriously, if they received dismissive, defensive responses, or perceived there was scepticism about their motives for complaining, often meant that
complainants were dissatisfied with the process and would be more likely to progress the dispute to the external regulators, to their lawyers, or to their local MP or the media, as mentioned.

Failure to take a complaint seriously motivates people to take their grievance to where someone with authority will take notice. The Davies Committee report in 1970s England looked back at how investigations had been conducted in the National Health Service (NHS), and found defensive attitudes in response to complaints, low staff morale, indifference to complaints and subsequent little information about complaints procedures and reluctance to introduce appeals procedures\(^6\). As happened in the infamous Mid-Staffordshire scandal in the United Kingdom, Robert Francis QC published his Public Inquiry into Mid-Staffordshire NHS Foundation Trust on 6th February 2013, stating:

> A health service that does not listen to complaints is unlikely to reflect its patients’ needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect others from harmful treatment. … A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint, and undermines the public’s trust in the service\(^7\).

The same applies whether it is a hospital, a clinic, a private practice or an individual health practitioner who is the source of the grievance. What this highlights is that complainants have a genuine desire to express their concern about an episode of health care, not just because they think they deserve better, but to make a difference to their own understanding of an unsatisfactory experience, and so that others may not similarly suffer. Furthermore, what is not generally known is that the majority of those who complain have actually attempted to resolve the matter directly at the point of service. The University of Sydney study by Pierce (2017) found that as many as 65% of complainants had attempted local resolution, but feeling dissatisfied with how the matter was dealt with, wrote a formal letter of complaint to the regulator. Reasons for this dissatisfaction echoed Mulcahy’s (1994) findings noted above: perfunctory or dismissive response; no response; no apology; no assurance that changes would be made. In the words of the psychologist Hugh Mackay:

> We all want our voices to be heard as authentic, legitimate and worthy of attention. We can’t bear to be overlooked, dismissed or belittled. Among the factors that explain why we do the things we do, this one is sovereign. When we know we are being taken seriously, we can relax into that assurance. When we fear we are not, our reactions

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can range from sadness, resignation or disappointment, through envy of those who receive the recognition we crave, to a burning fury of resentment (Mackay, 2013, p. 3).

When the relationship of trust has been tested or broken between health professional and patient, and later between complainant and complaints authority, these emotions can be amplified, because people expect so much more.

Who Makes Complaints?

Complaints may be made by individual members of the public or others on their behalf including public officials. For instance, 62.2% of complaints to AHPRA (“notifications”) about medical practitioners were from patients, their relatives or members of the public, while other sources include a Commonwealth or State Health Department (0.9%) or other Government department (0.7%). These latter sources include regulatory bodies such as Medicare Australia, the Pharmaceuticals Services Branch in NSW or its equivalent in other states, Therapeutic Goods Administration, as well as the police and Coroner’s investigations which may lead to further inquiry by the health complaints bodies and the national regulator AHPRA (see Table One below).

Table One: Source of complaints, HCCC Annual Report 2016-17

<table>
<thead>
<tr>
<th>Source</th>
<th>Number</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer (client, patient)</td>
<td>3 310</td>
<td>51.8%</td>
</tr>
<tr>
<td>Family or friend</td>
<td>1 599</td>
<td>25%</td>
</tr>
<tr>
<td>Other, unspecified</td>
<td>538</td>
<td>8.4%</td>
</tr>
<tr>
<td>Health care provider</td>
<td>349</td>
<td>5.5%</td>
</tr>
<tr>
<td>Professional council/association, regulatory authority</td>
<td>288</td>
<td>4.5%</td>
</tr>
<tr>
<td>Consumer organisation/advocate, carer/employer</td>
<td>184</td>
<td>2.9%</td>
</tr>
<tr>
<td>Department of Health (State or Commonwealth)</td>
<td>58</td>
<td>0.9%</td>
</tr>
<tr>
<td>Government department</td>
<td>45</td>
<td>0.7%</td>
</tr>
<tr>
<td>Legal representative</td>
<td>17</td>
<td>0.3%</td>
</tr>
<tr>
<td>College</td>
<td>4</td>
<td>0.1%</td>
</tr>
<tr>
<td>Court</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Member of Parliament/Minister</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>6 394</td>
<td>100%</td>
</tr>
</tbody>
</table>

The number of complaints in NSW has risen substantially, due probably to a combination of higher population that increases the number of medical interventions, which increases opportunity for things to go wrong; greater knowledge of complaints mechanisms, and/or greater desire for justice and accountability; or the greater difficulty of achieving a successful claim which leads people to its

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68 Medical Board of Australia: Annual Report Summary 2016/17.
alternative. Walton also suggests that the increased numbers are due to patients and families overcoming their reluctance to complain, with easier access and greater publicity about how to complain (Walton, Smith-Merry, Healy & McDonald, 2012). In the 2012-13 year, there were 4 554 complaints to the HCCC, while in 2016-17, this number had grown to 6 319 complaints, a 53% increase in those 5 years. 2 298 complaints were about doctors, or 56% of all complaints (HCCC Annual Reports 2012-13 and 2016-17).

Health service providers are required to have protocols for dealing with grievances or complaints, so that complaints may be dealt with at the point of care. Formal complaints bodies are independent from the health service providers, as provided by the legislation. Object 3(d) of the HCC Act states it is “to provide an independent mechanism for assessing whether the prosecution of disciplinary action should be taken against health practitioners who are registered under health registration Acts” [Health Care Complaints Act 1993]. A health service may refer a complaint to the complaints body about an individual health practitioner whose conduct or standard of care has raised questions about their competence or conduct, as shown in the table under health care provider (5.5% in Table One, above). However, data show that the majority come from individuals directly impacted by an incident or series of events relating to the provision of care (51.8% from Table One) or from a family member or friend (25%).

What Complaints Are About

Complaints data (see Table Two below) show the categories under which complaints are filed, noting that complaints are classified according to the main issue or issues identified by the regulator. It is difficult to provide a definitive summary of the data as the various jurisdictions use varied or inconsistent categories for classifying complaints. In the context of the nationalisation of health practitioner registration in 2010, Walton et al. (2012) lamented that such inconsistencies were a lost opportunity to present an overall picture of what concerned complainants. Having national consistent data would contribute to national policy development that reflects the concerns of complainants, just as exists for the reporting of adverse events.

Harrison (Harrison, Walton, Healy, Smith-Merry & Hobbs, 2016) also noted the value of the patients’ perspectives in adding to this substantial pool of data in order to better inform policy on safety issues. Because consistency of complaints data is not available nationally, Harrison et al. (2016) undertook a study that considered a standard taxonomy from which aggregated data could be derived. Applying a previously developed taxonomy by Reader, Gillespie and Roberts (2014), they undertook a content analysis of 138 serious hospital complaints being investigated by HCCC. They found the complaints could be categorised into three domains of Clinical, Managerial and Relationships, each of which contained categories and sub-categories. For example but not exclusively, under the domain Clinical sits Treatment, with sub-categories of errors in diagnosis, medication or treatment; under Managerial sit delays in admission or treatment, medical records,
grievance handling; under Relationships sit lack of or delays in communication, doctor-patient relationship, shared decision-making, neglect, lack of caring, consent. There was difficulty in defining the categories as many are interrelated – communication problems may lead to a problem in the clinical area. The study was useful in both highlighting the value of the patient perspective as obtained through the avenue of complaints, and the challenges in developing a useful taxonomy that would add to the existing pool of data from adverse events (Harrison at al., 2016).

As the Walton et al. (2012) study showed, added to the inconsistency of data across the HCEs, there is different terminology used when classifying complaints. However, to provide a useful indication, the table below summarises the breakdown of complaints received in 2016/17 by the HCCC. To illustrate, the following shows the categories into which the substance of complaints are filed70. The tables are summarised from the 2016/17 HCCC annual report.

<table>
<thead>
<tr>
<th>Category</th>
<th>% of Total</th>
<th>Details of Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>41.5%</td>
<td>Main categories: inadequate treatment (12.7%); diagnosis (4.9%), complications (4.4%), inappropriate care (4.3%), delay in treatment (3.6%); inadequate consultation (3.0%); results follow up (1.6%)</td>
</tr>
<tr>
<td>Professional Conduct</td>
<td>16.4%</td>
<td>Impairment; illegal practice, competence; sexual misconduct; boundary violation, disclosure of information; assault, advertising, discriminatory conduct, child sexual abuse, financial or scientific fraud, breach of condition, emergency treatment not provided</td>
</tr>
<tr>
<td>Communication Information</td>
<td>15.9%</td>
<td>Attitude, manner; inadequate or incorrect information, special needs not accommodated</td>
</tr>
<tr>
<td>Medication</td>
<td>6.3%</td>
<td>Prescribing, dispensing, administering medication</td>
</tr>
<tr>
<td>Access</td>
<td>3.7%</td>
<td>Refusal to treat, accessibility, remoteness, waiting lists</td>
</tr>
<tr>
<td>Fees/Costs</td>
<td>3.2%</td>
<td>Billing practices, costs; financial consent</td>
</tr>
<tr>
<td>Environment/Management of Facilities</td>
<td>3.0%</td>
<td>Administrative, staffing, physical environment, cleanliness, hygiene</td>
</tr>
<tr>
<td>Consent</td>
<td>2.3%</td>
<td>No or inadequate consent, uninformed consent, involuntary treatment</td>
</tr>
<tr>
<td>Reports/Certificates</td>
<td>2.2%</td>
<td>Accuracy, timeliness of report; refusal to provide certificate, cost of report</td>
</tr>
<tr>
<td>Medical Records</td>
<td>2.0%</td>
<td>Record keeping, access or transfer of records, records management</td>
</tr>
<tr>
<td>Discharge/Transfer arrangements</td>
<td>1.8%</td>
<td>Inadequate discharge, delay in discharge, patient not reviewed, mode of transport</td>
</tr>
<tr>
<td>Grievance Processes</td>
<td>1.6%</td>
<td>No or inadequate response to complaint, retaliation due to complaint, information re complaints procedures not provided.</td>
</tr>
</tbody>
</table>

These figures show that while some categories raise concern or even alarm, many of the complaints are not about harm and injury, and many do not require severe sanctions to keep the

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70 Health Care Complaints Commission (NSW) 2016/17 Annual report.
public safe. This is not to diminish complainants’ grievances in any way, nor to suggest some of these issues do not matter. Indeed, as Gallagher and Maxor (2015, p. 353) state, “Patients who file complaints believe they have been harmed. The harm may not be physical – it may be emotional distress, life disruption or loss of trust. Regardless, the harm is experienced as significant and damaging, and the patient wants it to be taken seriously”.

A complaint can be a window into a broader problem, and an inquiry into it may find a straightforward remedy, or may reveal something more sinister or serious. On the other hand, in the instance where a patient complains that a doctor failed to provide a medical certificate, it may mean the doctor refused to do so because the patient was not unwell, in which case the doctor was doing his or her job properly. In the largest category Treatment, the complaint frequently relates to differences of opinion about appropriate treatment; an example is refusal to perform a caesarean section when the doctor considered it an unnecessary intervention in a normal labour. Therefore, complaints are not all about harm, or fault. The second category Communication can cover all manner of misunderstandings, and not all have had adverse consequences – a gruff manner may have upset someone but it probably did not harm them. On the other hand, a gruff manner that frightens patients or staff may deter them from speaking up, and this could have adverse consequences.

Complaints data, while representing the patients’ perspective (Harrison et al., 2016), actually represents the interpretation of that perspective. The assessment process deals with a complaint in terms of the public interest issues that it raises, as distinct from the human dimension that Gallagher and Mazor (2015) referred to. For instance, the patient’s experience of an episode of health care can be invaluable in alerting “the system” as to how care is being delivered. Quoting other studies, Gallagher and Maxor (2015, p. 353) state that:

patients and family can provide unique and important insights, especially around care breakdowns. When care is complex, fragmented or rife with transitions, patients and family members may be the only ones aware of how care is actually delivered. In many situations, patients and family may be the first to detect lapses in safety or quality, identify worsening outcomes or point out breakdowns in communication that providers have missed.

In situations where patients or family feel dismissed or ignored, this is a missed opportunity to remedy things at the point of care which are causing or may soon cause harm to the patient. It can also be the genesis of a complaint. Gallagher and Maxor (2015, p. 353) add that by shifting focus from efforts to mollify complainants in order to avert publicity and avoid litigation, to taking complaints seriously in themselves as to what can be learned from them, is a more constructive response for which the patient’s perspective is invaluable. By being taken seriously and valuing the
patient’s perspective, it would also resolve those matters that a dissatisfied complainant would otherwise take to an external complaints body, as noted by Pierce (2017).

**Complaints and Public Protection**

Before there was a Health Care Complaints Commission, the public in NSW did not have a remedy with defined statutory powers available to it. The former Complaints Unit within the NSW Health Department was limited in its authority, as was shown in Chapter One when the limitations of its authority were made clear during the Chelmsford Private Hospital inquiry. The ability to protect the public by taking assertive action against errant health practitioners was critically limited, and historically such cases were about gross misconduct including sexual assault or inappropriate sexual relationships, inappropriate prescribing or taking of drugs, and fraud. Prosecuting a doctor for conduct and performance matters was indeed very difficult, relying on a sometimes flawed peer review system which made it difficult to determine conclusively if a doctor’s conduct fell below the standard of care and that a body or peers would agree with such an opinion. This is known as the Bolam test, which became the benchmark for assessing medical negligence, following Justice McNair’s direction to a jury in a high court matter⁷¹:

The Bolam principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care; but the standard of care is a matter of medical judgement.

Reliance on the Bolam test was overturned in Australia following the Rogers v Whitaker case in 1991.

Certainly, civil law has always enabled aggrieved and injured people to claim for compensation. But it could be said that such claims do little to protect the public and future patients against inadequate standards of care, and in many instances a grievance is not about damages for which compensation will follow. In terms of the link between negligence claims and patient safety, Bovbjerg, Miller and Shapiro (2001) argued that there are conflicting cultures between the goals of each, in that in the pursuit of legal claims, lawyers argue that the threat of litigation makes doctors practise more safely, yet the adversarial nature of tort law is antithetical to the strategies of the patient-safety movement, which is more about cooperation, systems and a no-blame culture (Studdert, 2004). For instance, this is the basis on which open disclosure operates, in the spirit of transparency and openness about mistakes, and with which practitioners would not cooperate if it were under the threat of disciplinary or legal action. By contrast, tort law actions target individual practitioners, assign blame, aim to prove negligence and determine compensation. Studdert (2004,

⁷¹ Since 1957, the Bolam test has been the benchmark by which professional negligence has been assessed. It is based on the direction to the jury of a high court judge, McNair J, in Bolam v Friern Hospital Management Committee.
p. 287) therefore argues that “The clash between tort law and the patient-safety movement undermines efforts to improve quality”, and in addition fear of litigation diminishes interest in patient safety, all of which can result in defensiveness, under-reporting and reluctance to be open about errors.

Nevertheless, it may be that knowledge of the outcome of cases gives pause to reflect to other practitioners, which may have a positive effect through being more informed about what can go wrong. Certainly, study of cases and the implications for medical practice is integral to continuing medical education through formal and informal channels.

While there are question marks over the link between tort law actions and patient safety, perhaps the same arguments apply to actions arising from complaints. Elkin (2012, p. 448) says that “Complaints to regulatory authorities are a useful, albeit imperfect, marker of quality”. Spittal, Bismark and Studdert (2015) argued strongly that there is such a link, by saying that important lessons can be learned from complaints to prevent future error. Gallagher and Levinson (2013) support such an approach, arguing that the accumulation of complaints, even if minor, can be a strong indicator of the potential for future problems. By analysing data from a sample of 18 907 complaints filed with Health Care Entities (HCE) over an eleven-year period, doctors at highest risk of future complaints and their characteristics were identified, which would enable proactive rather than reactive intervention, and therefore, would protect patients from potential harm (Bismark, Spittal, Guerrin, Ward & Studdert, 2013). These authors and others built on this analysis and devised an algorithm called the Predicted Risk of New Event score (the PRONE score) which they suggest could be used to assess an individual doctor’s risk of attracting further complaints. “Regulators could harness such information to target quality improvement interventions, and prevent substandard care and patient satisfaction” (Spittal, Bismark & Studdert, 2015). As Gallagher and Levinson (2013) similarly believe, “Our lack of response to individual physicians who accumulate multiple complaints demonstrates an insufficient commitment to being a truly self-regulating profession” (Gallagher & Levinson, 2013, p. 521).

This proactive approach is in contrast to existing reactivity of the medico-legal agencies, that is the insurers, medical boards and complaints handling bodies, which they argue does little to enhance quality improvement efforts that focus on prevention. Identifying future risk would mean an appropriate response in terms of intervention commensurate with the level of risk identified, which they suggest is “particularly novel and exciting because it holds the promise of ushering medico-legal agencies into the prevention business” (Spittal et al., 2015, p. 8). While they recognise the legal and ethical challenges this raises, their confidence in the predictability of their approach justifies the intrusiveness of the intervention.

This reads as another encroachment into the medical profession’s autonomy, and increased surveillance, which raises ethical questions, but I will not venture further to comment on this, albeit
that overall, there is no doubt that patient complaints provide valuable information that can be utilised to inform endeavours to protect patient safety. Protecting patients starts with patient safety, and it does so by aiming to prevent errors, which can lead to harm to patients, thence to a potential complaint, or law suit. But as I have stated before, complaints are not all about harm. The patient safety movement may go a long way to reducing errors, but it is not the whole story.

The regulatory process: the primary objective is protection, but how does it do so?

Elkin (2014) raises the question as to whether medical practitioner regulation is only about protecting the public. If not, she asks what other motivations influence medical regulation, and whether these fit the regulatory framework. She distinguishes between protection of the public and the public interest, as these terms are not interchangeable, and the distinction is important. First, one function of regulation is to protect patients not able to protect themselves against doctors who may do harm, and it does so by having minimum standards of recruitment, conduct and performance and by intervening when doctors do not meet these expectations. Inevitably, these standards impose obligations on practitioners to comply, but they also act to protect the profession through its exclusive membership, the legitimacy of “being special” conferred through regulation. Maintaining its high standards is beneficial to both the public and the profession, provided aberrant behaviour that is a risk to the public is dealt with, which relies on the regulator putting the interests of the public before risks to the reputation of either the individual practitioner or the profession.

Elkin (2015) considers the purpose of disciplinary processes within the regulatory regime. To be effective, the regime must have an “enforcement mechanism” within it to respond to those who fall outside what is expected of them. Yet the focus is on the individual doctor and their failures, not on prevention nor protection, nor on the systems failures that often accompany the incidence of adverse events. However, Elkin (2015) examines the three key aspects of disciplinary actions, aside from registration: a protection of the public; upholding the standards of practice; and maintaining public confidence in the health professions, with the latter two being essential to the first. Upholding standards of practice achieves two things: it protects the public and it protects the profession. High standards and the denouncement of those who breach the standards protect the profession by enhancing public confidence in the profession. This is vital for maintaining the special trust between a doctor and the patient, reiterating Freckleton (2006) who said “mistrust of health professionals, especially medical practitioners, is becoming endemic and has the potential to erode therapeutic relationships” (Freckleton, 2006, p. 17).

Elkin (2015) also considers whether the punitive aspect of discipline can protect the public, or in fact whether punishment is even one of the purposes of discipline: suspension or being struck off the register may be a consequence, but the purpose is to protect the public, not to punish, albeit it will be perceived and experienced as such by the practitioner. A reprimand on the other hand is a signal that the conduct was unacceptable and as such is punitive as well as having deterrent value. Elkin (2015) directed most of her discussion to disciplinary actions and their protective function.
There are other avenues that have a protective role, and could be said to be more proactive than reactive as are disciplinary functions which proceed after the event. These mechanisms exist within the framework as well as the statutory mechanisms we have been considering and include the professional standards and Codes of Conduct that are established by each professional College, as well as the guidelines, protocols and policies published by the Colleges, State and Federal departments and other government agencies, the national and state AMA, and administrative protocols within individual health services. The medical indemnity insurers, with their vast pools of data about complaints and claims, also publish advice and information about avoiding trouble by understanding the main sources of such matters, by interpreting and providing guidance to their membership about current medico-legal issues, and have protocols for managing the risk of member practitioners. The picture is one of a complex network of avenues for providing guidance, professional obligations and maintenance of standards in all aspects of professional practice that aim at maintaining safer practice.

Rather than detailing each of these, as noted earlier all medical practitioners in Australia are obligated to adhere to the national code of conduct developed by the Australian Medical Council (AMC) and issued by the Medical Board of Australia, in consultation with the states’ and territories’ former Medical Boards. The Code’s purpose is to describe:

what is expected of all doctors registered to practise medicine in Australia. It sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community ... The code is addressed to doctors and is also intended to let the community know what they can expect from doctors.72

The code (s.1.2) makes it clear to doctors that they have a professional responsibility to be familiar with the code and apply its guidance. It is to be used to support individual doctors in the challenging task of providing good medical care and fulfilling their professional roles, and to provide a framework to guide professional judgement. It aims, among other things:

to assist the Medical Board of Australia in its role of protecting the public, by setting and maintaining standards of medical practice against which a doctor’s professional conduct can be evaluated. If your professional conduct varies significantly from this standard, you should be prepared to explain and justify your decisions and actions. Serious or repeated failure to meet these standards may have consequences for your medical registration.

Enforcement of this requirement is set out in the national law\textsuperscript{73}.

The message is clear for medical practitioners: breaching the Code may result in a complaint of unsatisfactory conduct. But what is unsatisfactory conduct, and what other aspects of a doctor or their practice may deem a doctor to be a risk to the public? Grounds for considering a doctor to be a “problem” doctor, as defined by AHPRA, as being a risk to the public are for: (i) unsatisfactory professional conduct or professional misconduct; (ii) health problems that may impair a doctor’s capacity to practise safely; (iii) below standard performance.

The meaning of unsatisfactory professional conduct or professional misconduct

In Chapter One, we considered the term Professionalism and the inferences of this term in respect of the practice of medicine: not only are doctors expected to be learned, well trained, have expertise and exceptional skills and knowledge in a complex and highly sophisticated field for which they studied hard and endured stiff competition with peers for limited training places; they are also expected to have the more personal, human attributes of being good communicators, leaders and advocates, to be good team players and caring of their patients. In short, they are expected to be good.

If a doctor fails to measure up to or meet the standards required of them, breaches the codes of conduct to which they are committed, their professional conduct may be deemed unsatisfactory, or less than good, and attract sanction and remediation. Professional misconduct implies conduct of a more serious nature, that their conduct is unacceptable, for which the consequences are significant: strict conditions, suspension or even erasure of registration. Such assessments may not meet Sir Donald Irvine’s characterisation of not being good as “dangerous and evil” (Irvine, 2001), nor of Dr Bawa-Garba in UK whose failings were deemed to be “truly exceptionally bad”\textsuperscript{74} by a jury when convicting her of manslaughter, but is certainly conduct of a serious nature that in NSW attracts the significant criticism of a body of peers, defined as:

139B (a) Conduct significantly below reasonable standard. Conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner’s profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience (Thomas, 2004b).

Therefore, while attracting the significant criticism of one’s peers may result in an adverse finding and potential suspension from practice, conditions on one’s practice or being struck off the register for a specified period or even forever, words such as “bad”, “evil” or “dangerous” do not generally enter the lexicon of Australian legal actions. The public may have other feelings, and media like to

\textsuperscript{73} Health Practitioner Regulation National Law Act 2009 (current from 1 March 2018 to date; accessed 24 July 2018 at 14:03).

\textsuperscript{74} GMC v Dr Bawa-Garba [2018] EWHC 76 (Admin).
use such words, and they go to character, which the law is reluctant to broach. Nevertheless, as I have pointed out, a breach of the nationally endorsed Code may bring a complaint against a doctor, because Good Medical Practice expects doctors to be good, but this is only specified as being in the practice of medicine (see footnote below)\(^7\)

**Summary**

In this chapter, I have examined the law in action, as distinct from the historical events and related social and political factors that contributed to the formation the regulatory system that we have today, which took place in parallel with the professionalisation of medicine, as the subject of the previous chapters.

This chapter has considered what mechanisms exist and what the regulatory process looks like in respect of the objectives to protect the public. In the past few decades, demands for greater accountability have meant a major challenge to the autonomy of the medical profession. This was because there was a social shift in society when the new consumer, armed with the language of rights, demanded that the money being spent on health care was being spent wisely and that the promises of safe care were being met. When they were not, the public became less tolerant because they not only demanded more but because they knew more. News of scandals and knowledge of iatrogenic harm in hospitals filtered out and eventually, the authorities had to act because the public was losing its trust and confidence.

The chapter considered what complaints are about, who complains and why, and to whom, and what happens to a complaint. The purpose of a complaints process was discussed in the light of discrepancies in public perception about what a complaints process is for, as a mechanism to resolve an individual grievance or as a vehicle for identifying problems in the health care system.

The next chapter will consider what it is like for a doctor to be the subject of a medico-legal matter. I will present the findings of previous studies which have shown that the impact for some doctors is more often than not a negative experience. Anyone could expect that if someone says negative things about a person or what they have done or not done, it can cause some discomfort or even harm. What follows is an examination of the nature of that harm for doctors, and the nature of any

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\(^7\) Under 1.4 Professional values and qualities of doctors of the Code, it is stated:

While individual doctors have their own personal beliefs and values, there are certain professional values on which all doctors are expected to base their practice.

Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively. They must be ethical and trustworthy.

Patients trust their doctors because they believe that, in addition to being competent, their doctor will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion.

Patients also rely on their doctors to protect their confidentiality. Doctors have a responsibility to protect and promote the health of individuals and the community.

changes they may go through as a consequence. This will lead into my own study which attempts to explain why it is that complaints hurt, and in the final chapters will consider what this means and why it matters.
Chapter Four: The Impact of Regulatory Processes

Introduction

Chapter One introduced the concept of the law as a “living thing” (Ehrlich, 1962), not as a fixed entity, but as responsive to the society in which it was written, and as law in action, being subject to interpretation and challenge. A doctor who finds him- or herself the respondent to a medico-legal action will discover an environment with which most are not familiar, whose language is not their own, and whose thinking is not central to the professional life of a doctor in practice. Interpretation and challenge are not straightforward for the doctor unfamiliar with this language and thinking.

I then presented an overview of what we know about understanding the experience of those who complain about health service provision: why they complain; what complaints are about; and what people expect by complaining. I also presented an overview of the regulatory mechanisms in place in Australia, together with an historical account of how and why the current system came into existence. Far less is known about the actual experience of those complained about when they are interacting with these processes. This final chapter of Part One presents an overview of what is known about the impact of medico-legal processes on doctors’ health and wellbeing. It will focus mainly on the literature from Australia, New Zealand and the United Kingdom, given the similarities and parallels between these countries which derive from their colonial/imperial past, and will give passing reference to literature from other countries as relevant to this study. You will note that although this thesis focuses on complaints and their place in the regulatory sphere, it does not exclude reference to other forms of medico-legal action, in particular claims for compensation and other civil proceedings.

Previous research has found that there is compelling evidence of the harmful effects of having a complaint and the impacts on doctors’ practice, including the impact of defensive medicine and fear of litigation. Defensive medicine, distressed and distracted doctors are a risk to the public, so if there is a concern about such inadvertent consequences, having a deeper understanding of what such impacts may be attributed to and explained by, will better inform decision-makers, authorities, medical educators, insurers and other stakeholders. My study aims to provide this explanation.

Overview: Impact of Medico-legal Interventions

The focus of this study is on explaining the impact of complaints on doctors’ health and practice, specifically:

1. What is stressful about the experience
2. How doctors seek support through the process
3. Perceptions of the medico-legal environment

Having a complaint not only has impacts on a doctor’s health and wellbeing; it can also lead to behavioural changes that may affect their career and attitude towards the profession that they had chosen to enter. This chapter will present what is known about these impacts. What is absent from much of this picture is an in-depth understanding of what contributes to doctors’ unease, why complaints generate such impacts, demonstrated as common to doctors both nationally and internationally, and on why it is important that we have this understanding.

There has been a progression of studies that focuses initially on the American experience of litigation, which later turns towards a focus on complaints in the regulatory environment, primarily in UK with increasing interest in other countries including Australia. Indeed, it could be said that with Australia introducing the first independent statutory body in NSW, the Health Care Complaints Commission (the HCCC), the model for complaints-handling established by the HCCC was influential in other countries’ development of subsequent complaints-handling mechanisms (Pierce, 2017).

The earlier studies acknowledged the adverse impacts on doctors in terms of emotional and behavioural changes, and the remedies recommended lay in suggesting that doctors be offered, or that they seek, professional and/or emotional support during and following a complaints process. While these recommendations remain appropriate, and this study examines this aspect of doctors dealing with complaints, what is largely absent is acknowledgement that it is the process itself that often contributes to doctors’ disquiet. This becomes a trend in the more recent studies, when a link can be seen emerging between doctors’ adverse responses arising from complaints and the way the complaint is handled through the process. This is further confirmed by large studies in the UK which reveal a direct link between having a complaint and suicidality, as well as other morbid conditions such as depression, anxiety and stress, which are shown to be more common in those with a history of complaints than those without. What these studies lack is a focus on the personal experience, which is how this current study fits in with the existing literature.

From litigation to complaints

As noted, much of the earlier literature in the 1980s to 1990s comes from the USA, where the focus was on litigation, as will be shown below. This may have been because the USA favours litigation as a remedy to grievances but it may also be due to the significance of complaints not being recognised. Mulcahy (2003) suggested as much in discussing the common view that there is a hierarchy of remedies associated with their relative seriousness, with litigation at the top and complaints at the bottom. However, this overlooks what a complaint represents: to a complainant it is serious, or there would be no complaint (except perhaps a whinge to one’s friend, family or neighbour); and to the recipient of a complaint, it can mean anything from the inconvenience of drafting a response to the potential for loss of career, livelihood and reputation. In addition,
complaints were becoming more numerous. With the rise of consumerism and its associated rights culture, citizens were turning to making complaints to the authorities as an expression of their dissatisfaction with services. As was shown previously, complaints are not all about money, or harm, and people's motivations for complaining extend beyond what a claim for compensation can offer. This trend accompanied the development of tighter regulatory mechanisms and requirements for greater accountability by health service providers, especially the medical profession. There followed the establishment of formal complaints mechanisms, followed soon after by a flow of research from Great Britain about complaints, hence Australia, New Zealand and others.

**Quality and safety**

Early literature also parallels the beginnings of the quality and safety movement, after the revelation of high error rates, or “iatrogenic” harms, through various major studies and the release of health service data about adverse events in the USA, Australia and elsewhere. The focus turned to the prevention of error by understanding causative factors, the latter of which included the identification of underperforming health practitioners. “In contemporary western cultures, every death, every accident and every misfortune is ‘chargeable to someone’s account’ – someone must be found to be blamed” (Lupton, 1999, p. 45). At the same time, greater accountability of health services and of health professionals was demanded, and dealing with complaints from dissatisfied health service users became one such mechanism for ensuring accountability. Complaints data were an important way of not only identifying underperforming or even dangerous (“high risk”) health practitioners, but of identifying patterns of practice where the source of errors could be isolated (Lupton, 1999; Bismark, Spittal, Guerrin, Ward & Studdert, 2013). Claims data from lawsuits added to this pool of knowledge, and so there grew a vast body of data about medical and other mishaps in health care that was invaluable to the regulators and the professions in terms of policy and systems change and quality improvement, as well as more pointedly identifying and remedying known sources of clinical and medico-legal risk. Here the language of risk and risk management or prevention had begun to proliferate, with the interpretation that it represents the bad, the dangerous, the undesirable (Douglas, 1992; Lupton, 1999), and in Douglas’s (1966) view, extends to looking for who is responsible, or who is to blame (Douglas, 1966). Seeking out who is responsible and therefore who is a risk for the future, then managing that risk, marries well with the notion of protection and also of regaining trust, at least in the regulators, if measures to protect are made public, to which I allude in the next section.

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76 Complaints are attributed to rising expectations and better informed patients, as well as the changing relationship people have with professionals, and what people expect from the doctor-patient relationship (Canadian Medical Association Journal (2012), 184 (16). Complaints rise with expectations.

77 Such as the study by Leape, L. et al. (1991) Incidence of adverse events in hospitalised patients: Results of the Harvard Medical Malpractice Study 11. NEJM, 324, 377-384.


78 The study of error by James Reason was published during this era and had a significant influence on how this phenomenon was conceptualized. Reason, J. (1990) Human error. Cambridge University Press, Cambridge, UK.
Perceptions of the medical profession

Taking a broad perspective of the work of the past 30 to 40 years, there appears to have been a change in thinking about the medical profession. In earlier chapters, I presented an account of the reluc}tance of legal and regulatory authorities to comment on and make judgements about the conduct and performance of members of the profession; it was a closed shop, so to speak, and those outside of it were not equipped nor even entitled to pass judgement.

In addition, the exposure of the extent of iatrogenic harms in health care led to a growing concern about the safety of health care. An expanding body of literature emerged concerning errors and their causes, with consequent regulatory changes that demanded greater accountability through increased obligations of reporting, such as mandatory reporting and open disclosure, and more systematic data collection and analysis (Leape, 1991, 2004; Brennan et al., 1991 (“the Harvard study”); Wilson, 1995; Vincent, Neale & Woloshynowycz, 2001; Bismark et al., 2012; Spittal et al., 2014). While the analysis of the quantum of errors identified that “systems’ issues” were largely responsible for such harms, there was also increasing focus on the individual responsibility of health practitioners, as noted above. There was demand for greater accountability by the heretofore closed shop of the semi-autonomous, self-regulating profession, who it was believed needed to restore public trust. Individual doctors had to be made accountable, they had to lift their game and patients had rights that they were very willing to exercise. “The litigious society” went into action, and there was often little sympathy for those being complained about. Public shaming became commonplace when reports of doctors heading to the law courts made for compelling newspaper stories.

While this is the popular picture, it is actually more nuanced than this. Mulcahy and her colleagues (2003) showed that the motivations of complainants could be more subtly explained than the data appeared to demonstrate (Mulcahy, 2003). Nevertheless, the spotlight has been on doctors to behave, to continuously improve and to keep patients happy, and the regulators continue to find more ways to ensure the profession is accountable and that the public is so protected. For instance, at the time of writing, the Medical Board of Australia issued a draft of revisions of the Code of Conduct (Good Medical Practice) and adds this clause to the existing version: “Behaviour that could undermine community trust in the profession is at odds with good medical practice and may be considered unprofessional”, and doctors are warned not to voice personal opinions publicly so as not to undermine trust79. Such intent is being vociferously resisted, with the new President of the AMA, Dr Tony Bartone, stating that such requirements are “an overreach” of the Board’s authority, and that such conduct does not in itself represent a lack of professionalism nor substandard medical practice (O’Rourke, 2018)80. A further recent step by the Board has been to

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introduce links to Tribunal and court decisions to the publicly available AHPRA registration list on the website, stating that public trust would be enhanced by being open about which doctors had complaints against them. After the outcry that followed which cited this step as being punitive and unfair, particularly when cases resulted in no adverse findings, the Board withdrew its intention to proceed with this move, with the exception of those who do have adverse findings (Wright, 2018)\textsuperscript{81}. These steps by the regulator serve to demonstrate that the medical profession is being required to practise within an ever-tightening of the regulatory reins, in order to win back public trust.

**Focus on complainants, not the respondents**

With the main objective being public protection, earlier studies, as will be shown, were generally about complaints-handling mechanisms and legal procedures and the experience of these mechanisms for complainants. Very little was mentioned about the experience for those complained about – perhaps doctors were such a powerful group they did not need such consideration – until it was becoming increasingly obvious that being the subject of a complaint was for many doctors a highly stressful event, and that perhaps this mattered. From the late 1990s onwards, data began to filter through nationally and internationally that it was not only stressful to have a complaint but it was resulting in threats to health and was leading to negative behavioural changes.

The general response was to put the onus onto respondents to look after themselves by maintaining a healthy outlook and resilience, and to seek counselling if necessary. In more recent times, there is a growing understanding, that: firstly, the medical profession has higher than average symptoms of burnout, fatigue and mental disorders (Clode, 2004; BeyondBlue); that an adverse outcome could distress those involved with the incident as “second victims” (Sirriyeh, 2010; Wu, 2000, 2012; Ullström, 2014); and thirdly, that being involved in medico-legal matters further adds to such distress. In addition, as noted, the solutions were to offer counselling, recommending resilience training or reminding doctors to look after themselves. However, more recently there has been a growing acknowledgement that the distress may not be due to a doctor’s inadequate coping skills; it may be the process itself that is responsible for at least some of the distress. While this does not negate the contribution by an individual’s personal make-up (Nash, 2009a; Charles, 1988), this nevertheless suggests that the process could be more responsive to the adverse impacts.

This is not merely to promote a kinder, more caring bureaucracy that is empathetic to the plight of the suffering doctor; it is also for the more pragmatic reason that if significant numbers of doctors are being harmed by the process itself, then their safety as health service providers is at risk (Shanafelt, Bradley, Wipf & Back, 2002; Mulcahy, 2003; BeyondBlue, 2013; Fahrenkopf, 2008). Sick, distracted, anxious and depressed doctors may not have their minds totally on the job, and

this is when mistakes can happen, as the study by Fahrenkopf et al. showed, in which resident
doctors with depression made 6.2% more medication errors, indicating that patients are at greater
risk of unintentional harm. Doctors’ perceptions of the link between their own stress and lowered
clinical care were examined in a questionnaire study by Firth-Cozens and Greenhalgh (1997), in
which 50% reported lower standards of care due to stress, including errors, taking short-cuts, not
following procedures, even an anaesthetist regularly falling asleep during procedures. Stress was
also attributed to tiredness by 57.4%, overwork by 27.7%, depression or anxiety by 8.5%, alcohol
5.4% and boredom by 1%. Irritability and anger was reported by 40.2%, serious mistakes reported
by 7.4% and there were two patient deaths or 1% attributed to these factors. While these latter two
figures are small, it is still nearly 10% of respondents who reported that their mental state was
related to serious harm or death. A further study by West, Hushka and Novotny (2006) of medical
errors amongst interns found them to be associated not only with personal distress, but also
decreased empathy for patients. Decreased empathy, and the previous study where 40.2%
reported irritability and anger, may not directly cause harm, but suggests strongly that care of
patients will be somewhat compromised as it will interfere with effective, and responsive,
communication both with patients and with members of the team.

In addition, doctors who decide to leave the profession mean society misses the value of their
skills, and this can become critical when there is a shortage of doctors in a district, or a shortage of
those with specialist expertise (Elkin, 2014). Mello et al. (2004) studied the link between
satisfaction with medical practice in the context of the “malpractice crisis” that was believed to be
current at the time and concluded that the crisis was indeed decreasing doctors’ satisfaction, in a
way that was affecting patient care by impinging on the doctor-patient relationship, with a “sizable
minority” stating that malpractice concerns made them less candid with their patients, and losing
warmth within the relationship.

The other aspect that has become apparent in the literature is the recognition that doctors who
have experienced litigation or complaints report changes in their practice (Bourne, 2017; Charles et
al., 1984; Ennis & Vincent, 1994; Verduis, 1994; Summerton, 1995; Jain & Ogden, 1999;
Cunningham, 2000; Studdert et al., 2005; Ortashi, Virdee, Hassan, Mutrynowski & Abu-Zidan,
2013; Nash et al., 2009b, 2010; Kessler, Summerton & Graham, 2006). Such changes include
being more cautious about patients, loss of trust, changing how they practise, ordering tests that
are not medically indicated, and other changes that will be examined further in this chapter. These
effects have also been found in doctors who have not undergone a medico-legal matter, indicating
there is a pervading sense of fear of litigation and complaints within the profession, in some
specialist groups more than others (Cunningham, 2000; Cunningham & Dovey, 2006; Nash et al.,
2010; Bourne et al., 2017). This phenomenon is referred to as “defensive medicine”, which has
implications not only for patient safety, for the cost burden it implies for health care services
ordered that are not necessary, that are not always good practice and are sometimes harmful to patients.

If complaints and litigation cause such emotional, personal and professional impacts, then it is important not only to understand why, but also what it is about the process that makes it so stressful. And what do doctors do about it: are they silent sufferers; do they seek professional or other help and support? The review that follows will also consider what support, if any, doctors tend to seek to help them through the complaints process, and the reasons identified for why they do, or do not, seek such help.

**Being Sued**

Martin, Wilson, Fiebelman III, Gurley and Miller (1991) write that “Malpractice litigation is a major life trauma”. It has been known for a long time that being sued, and being complained about, is damaging. In 1982, Charles published the first of a series of papers reporting on a survey conducted to assess doctors’ reactions to malpractice litigation in the USA (Charles, 1982). To that point, little was known about such impacts, and Charles’ interest followed the increase in the number of doctors being sued at that time. Charles (1984) cites a 1979 study by Mawardi which compared sources of dissatisfaction in two cohorts of doctors graduating in the decades 1935-1945 and 1956-1965 and found the former had identified the stress of litigation and the latter identified stress arising from fear of litigation. This study was about doctors’ perceptions of the impacts on their personal and professional lives. Many doctors reported that they had altered the way they practised, were indecisive and unable to concentrate, and had lost their nerve. Symptoms could last from a few weeks to a number of years. Many were angry about the interruption to their working lives and having no redress for this loss. Mulcahy also discusses this aspect of the process, that doctors felt aggrieved that it was not only the time, but the frustration doctors reported in her study that if a complainant was not satisfied with the outcome of an inquiry, they could seek a review or appeal, yet doctors could not seek redress if the complaint was found to be unjustified (Mulcahy, 2003).

Charles (1984) found that while 54.4% considered litigation to be a part of the practice of medicine and was no reflection on their competence, this did not ameliorate the sense of anger or affront. More than 25% felt alone, although only 10% sought support from their colleagues. The point was made that given the length of the process (average of 46 months in 1978), the prolonged period of stress became chronic: “Such chronicity is considered a factor in physician impairment” (Charles, 1984, p. 565).

Charles, Wilbert and Franke’s next study (1985) considered reactions to litigation by both sued and non-sued doctors. Doctors were surveyed about their reactions to being sued, or if they had not been sued, their reaction to the threat of being sued (which at the time was estimated to be 1 in 4 doctors per year, with a higher number for those in a high risk specialty). Sued doctors reported
significantly more severe depressed mood, tension, anger and frustration than the non-sued doctors. Only 17.9% of all respondents reported no symptoms. For the remainder, symptom clusters were identified, assigned on the basis of DSM-111 criteria: a depressive cluster (affective disorders) and an anger cluster (anger plus at least four of inner tension, irritability, frustration, insomnia, depressed mood, fatigue, headache, gastrointestinal problems). Litigation was identified as the specific psychosocial stressor, applied to both sued and non-sued doctors, although significantly more in the sued doctors (17.2% to 6.0%). Doctors also identified the onset of physical illness or an exacerbation of an existing illness attributable to the stress of being sued or the threat of same. The next study of only sued doctors found 53% were assigned the anger cluster, and included 67% who lost at trial and 48% who won. Just 3% reported the depressive cluster only (Charles, 1988b). This study found that almost two thirds of these sued doctors had decreased satisfaction with their careers, and many questioned their competence.

Such findings were important as they led the way to further exploration of the identified impacts and to the inferences about such findings in the 1984 study as change of practice, the nature of the process itself and whether doctors sought moral support. The 1985 study compared sued and non-sued doctors, and found in addition to symptoms of stress, professional changes which included: ordering more diagnostic tests than were clinically indicated; no longer taking high risk patients or doing high-risk procedures; wanting to retire early. The 1988 study found that it did not matter if a doctor were found guilty or not, in terms of symptomatic and behavioural changes, and although doctors who had not been sued also reported such behaviours, it was significantly more severe if a doctor had been sued.

Charles (1988) observed that what is of interest is that doctors who had not been sued tended to have attitudes similar to the lay public’s, that litigation is an affront to and reflection of a doctor’s professional competence, implying that a law suit is related to negligence or lack of competence and is therefore the doctor’s fault. However, this attitude changes if doctors have been sued, because in their defence they believed their judgement had been good and their performance competent. This change in attitude may explain the anger they felt at a system in which “highly competent physicians” become diminished by a lawsuit (Charles, 1988, p. 359). Anger, the more reported response, is externally directed. This suggested that if anger is expressed, inner directed responses of guilt and shame that “commonly accompany the accusation of being a ‘bad doctor’” would be lessened. Therefore, Charles (1988) suggested, sharing the emotional impact with others would enable doctors to express their anger, which would ameliorate the tendency for anger to turn inwards into depression. Yet she noted that only 10% had shared the experience with their peers (Charles, 1982). Moreover, there was little significance in the scores of those who had won their cases and those who did not, indicating that the emotional or psychological impact of the experience is a function of the allegation, or the process itself, rather than the outcome of a trial. It also leads one to consider that sharing the experience with peers will enhance feelings of
community with other doctors. This may be especially important for those who lose at trial so that they can better recover and return to some degree of equilibrium.

The reason for the focus on Charles’ studies is that they were foundational and clearly set the groundwork for future studies, given they are abundantly cited. By her own admission, they were select samples and the significance of findings may not apply elsewhere, but they led others to pursue further exploration of the issues raised. She wrote a further article in 2001 in which she discusses how doctors react to accusations of malpractice, and some of the strategies they use to cope with the impact (Charles, 2001). I will defer an examination of this discussion until the Discussion chapter. Doctors with depression arising from litigation considered it their most stressful life event (Charles, Warneke, Nelson & Pyskotsky, 1988c). This was in spite of only 1.6% of the sued doctors having an adverse finding from their trial, which suggested that:

malpractice litigation, the chronic character of involvement with the legal process, and the resultant stress on both sued and nonsued physicians may in the long run not serve the public interest or the quality of medicine. It may diminish rather than enhance the integrity and availability of medical care (Charles, 1985, p. 440).

The study by Martin et al. (1991) followed on from Charles’ work, adding the dimension of time for the duration of stress symptoms, which include psychological trauma, job strain, shame and doubt and efforts to cope. These were at their highest for the two-year period immediately following the lawsuit, followed by a period of “active coping”. While these symptoms decrease after two years, they did not return to the level of non-sued doctors, with the exception of shame and doubt. Doctors who won their case reported less psychological trauma, shame and doubt, compared with those whose cases were pending who had more job strain and more active coping. Martin (1991) surmises it is not only the process but the repeated exposure to situations that could lead to repeated litigation. However if the doctor wins the case, this permits a successful integration of the process, which is moreso than if a case is settled out of court.

Saberi’s (2009) study of sued doctors in Iran reported 76% of the 497 respondent doctors who had been sued were found to have psychiatric disturbance at a higher level than non-sued doctors, and the general population at 19%.

**Having a Complaint**

Early studies of the impact of medico-legal matters were focused on doctors’ experience of litigation in the USA. Research into the complaints experience began to emerge in Great Britain in 1990s-early 2000s, where the findings were similar to studies of litigation experience, and while these are significant for my study, it is important to consider the specific impact of complaints. This is because the consequences for doctors are different, and for some, potentially more damaging because: they can directly affect a doctor’s registration; they involve a doctor directly with the
regulator; and their complaints history remains on their record, which in many instances is publicly accessible.

These early studies include those of Jain and Ogden (1999), Allsop and Mulcahy (1998) and Mulcahy (1996, 2003), and as with Charles in the USA on litigation, were foundational for future work in this area. Jain and Ogden’s study was unique in its day because it was qualitative, involving detailed interviews with GPs, and examined emotional responses. Undertaking detailed interviews with GPs who had complaints, the study identified three stages in response to a complaint:

1. Initial: “out of control, feelings of shock and panic, and a sense of indignation towards patients generally”
2. Conflict: the many conflicts generated by the complaint, e.g., anger, depression, even suicide, conflicts around aspects of professional identity including doubts re clinical competence, conflicts with family and colleagues, and about management of the complaint
3. Resolution: sense of resolution such as practising defensively, or planning to leave practice, or no resolution.

This approach was contrasted to Mulcahy’s (1996) early doctoral study which analysed complaints within a sociological framework that emphasised power relationships rather than emotional reactions. Her later work in 2000 was a survey of 848 consultants in UK which considered the emotional impacts, finding that they often have a long-term and significant impact such as: irritation (52%); worry (42%); concern (38%); surprise (38%); annoyance (37%); anger (33%); distress (32%); disappointment (31%); anxiety (28%); and vulnerability (28%). A component of this study included written comments, where doctors expressed fear; feeling a loss of control, powerlessness, being under siege, a sense of futility, feeling that they work so hard but cannot satisfy their patients. The greatest impact was if they thought the complaint was unjustified (five times as many felt anxiety; four times as many anger, annoyance, vulnerability; three times as many felt worried, distressed, surprised). The greater the impact, the more likely doctors were to change their clinical practice, or become more defensive.

Studies in other countries including Australia were soon to follow (Schattner, 1998; Nash, Tennant & Walton, 2004; and publications by Nash et al. to 2013), thereafter in other countries including New Zealand (Cunningham & Dovey, 2000; Cunningham 2004), the Netherlands (Verdhuis, 1994; Verhoef, 2015), Scandinavia (Birkeland, Christensen, Damsbo & Kragstrup, 2013), and Iran (Saberi, 2009). In more recent times, research has extended into issues that are related to the impact of medico-legal matters on doctors and on medical practice. These include inquiries into the nature and consequences of defensive medicine, the growing concern about doctors’ health, mental illness and higher than average suicide rates (Horsfall, 2015; Shanafelt, 2011; Srivastava,
2017). In addition, sophisticated data are being gathered that provide profiles of risk that include profiles of those doctors with complaints (Bismark, Spittal, Guerrin, Ward & Studdert, 2013; Spittal, Bismark & Studdert, 2015). This facilitates more effective targeting of regulatory action where the risk to the public is greater.

The cost of a complaint to doctors’ health and wellbeing has been demonstrated by these studies, and they tell a similar story: being the subject of a complaint is a very high risk for psychiatric morbidity in doctors (Nash et al., 2010). Generally, studies show that stress, anxiety and depression are common symptoms, as are disturbed sleep, increased drug-taking and alcohol use and suicidal thoughts (Schattner & Coman, 1998; Mello, 2004; Nash et al., 2006, 2007; Bourne et al., 2015). Successful suicide attributable to being involved in an investigation is causing alarm now that knowledge of these suicides is available, though the precise numbers are difficult to establish (Horsfall, 2015), and not possible in Australia given how such deaths are recorded. For instance, suicides may not be recorded as such or may not be referred to the Coroner as the death may be attributed to its actual physical cause. In Great Britain, an alarming report was published in 2014 that revealed that between 2005 and 2013 there were 28 reported cases where doctors had committed suicide while undergoing disciplinary proceedings. This was not publicly known until a Freedom of Information request to the GMC released the names and dates of death of those doctors identified as having ended their lives during an investigation into their fitness to practise (Casey & Choong, 2016).

The extent of the harm

The AHPRA annual report for 2016/17 reports that there were 111 166 medical practitioners registered to practise in Australia in that year. Of these, 5 669 or 5.1% received a notification (aka complaint) in 2016/17. A 2010 study of doctors in private practice showed 20.5% of them had at least one complaint against them in the decade leading to the study (Bismark, Spittal, Gogos, Gruen & Studdert, 2011). Added to this number were claims at 1-2% of doctors per year (MIIAA, 200982) or 35 claims per year per thousand doctors (ISA, 2008). When all medico-legal matters are taken into account, 65% of respondents to the national study of 2 999 doctors in Australia had experienced a matter at some time in their career, with 14% having a current matter (Nash, 2009b). While these figures are not recent, they provide a picture that approximately 7% of doctors are involved in a medico-legal matter each year. It is likely that this figure could now be higher, given that the proportion of doctors receiving complaints is consistently rising every year (for example, in 2012 the percentage was 4.3%, and it is now 5.1%).

On 8 October 2013, Beyondblue launched its report on doctors’ mental health in Australia, showing that doctors suffer 10 times the rate of psychological distress as the general population, and that 1 in 10 doctors had suicidal thoughts compared to 1 in 45 of the community. Workplace pressures

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82 Medical Indemnity Insurers Association of Australia
were cited as the highest source of stress for the 14,000 doctors who responded to this survey. This report emphatically warns that having this number of doctors unwell is a significant risk to themselves, their colleagues, friends and families, and significantly, their patients (Beyondblue, 2013). Similarly, a large study of 7,905 American surgeons found suicidal ideation to be 1.5 to 3 times that of the general population, with burnout and depression closely associated (Shanafelt, 2011). As we have seen, being the subject of a complaint is a very high risk for psychiatric morbidity in doctors (Nash et al., 2010). As a work-related stressor, complaints are adding significant numbers to the mental health profile of doctors in Australia. Schattner and Coman (1998) studied metropolitan GP practices in Victoria and while workload pressures and time constraints were the more numerous stressors identified by doctors, the threat of litigation was the most severe.

Fear of litigation and complaints is present even if doctors have never had a complaint, and the fear that doctors feel if they do receive a complaint is pervasive. Mulcahy (2003) stated in her study that the fear arises from potential consequences about disciplinary action under the GMC and courts. Verhoef (2015) wrote about the misery and insecurity during and after the process, the fear of having more complaints and of the fear reviving when in similar situations as the incident complained about.

The immediate response to a complaint can range from emotional reactions to changes in doctor-patient relationships. Short-term feelings of anger, depression, shame and guilt, and decreased enjoyment of practice reduced goodwill towards and trust of patients (Cunningham & Dovey, 2000). The impact softens over time but feelings of persisting anger, reduced trust and goodwill towards patients persists (Cunningham, 2004a). What this means is that there is a significant negative impact on doctors, and on important aspects of the doctor-patient relationship, and the rather poignant “loss of joy of practice” (p. 8). Cunningham (2004) also states that there is no evidence that the receipt of a complaint improves the delivery of patient care, negating the assumption that patient complaints change the behaviour of individual doctors and the profession.

Stuart and Cunningham (2015) conducted a study on dentists in New Zealand, which I include here because it adds the dimension of the impact on families due to a dentist’s pre-occupation with dealing with a complaint, and the anxiety felt by families, and also staff in the practice. The findings echo those relating to doctors, and as with doctors, dentists may be shamed by a complaint. The authors conclude that dentists “need ongoing support that responds not only to the intricacies of the legal aspects of a formal complaint but also to unpredictable interpersonal stress, prolonged anxiety and to feelings of helplessness” (Stuart & Cunningham, 2015, p. 29).

Health professionals interviewed by Verhoef et al. (2015) in the Netherlands reported feelings of misery and insecurity during and after the process, with a fear of receiving new complaints. They found that publication of disciplinary measures online and in newspapers, as well as general media
coverage, enhanced the psychological and professional impact, as did aspects of the process such as the feeling of being treated as guilty before any verdict was reached, the long duration of the process, and an assertion that criminals are treated better because there is more concerted due process. Doctors also reported practising with more cautious care. Although one could say the latter is a positive response, the reason is less than positive when in response to fear. They wrote that in this case, “Although a disciplinary measure is meant to have a corrective effect, our results suggest that the impact that is experienced by professionals might hamper optimal rehabilitation” (Verhoef et al., 2015, p. 5). The authors noted that if the health professional was aware of others with complaints, this had a normalising effect. They conclude that organising emotional support should be considered during the process and after the verdict, to ameliorate the potential damaging effects.

Complaints may go well beyond making a doctor feel miserable. I introduced above the findings of stress, depression and anxiety from the studies of Nash, Bourne, Mello, Schattner, amongst others, meaning that complaints can lead to morbid conditions that are actually harmful, and are perhaps long-standing. The early studies by Charles (1982, 1984, 1985) revealed that it is not just those found guilty of the matter with which they were charged who suffer damaging, and long-term effects. She suggested it was the fact of the complaint, and the process itself, that caused the morbidity. While her studies related to claims for damages due to malpractice, the impacts are as relevant to complaints. In fact, some doctors say that having a complaint is the more worrisome as claims for compensation are about money for damages, handled mainly by the lawyers, and paid for by their indemnity insurance, whereas complaints are about their competence and conduct as medical practitioners, and the outcomes can threaten their livelihood, reputation and career.

Bourne et al. (2015) conducted a very large study in Great Britain in 2012-13 in which 7 926 doctors participated in a survey, along with a sub-set participating in interviews. Those doctors who had a recent complaint or one still current were at significant risk of moderate to severe depression (77%), moderate to severe anxiety (twice as likely) and suicidal ideation (twice as likely to report self-harm or suicidal thoughts). They reported relationship problems, sleep disturbance, anger and irritability, and practising defensively.

**Defensive practice**

Up to 89% of doctors in Bourne’s (2016) study, above, were practising defensively, with doctors avoiding high-risk patients or procedures, and engaging in “hedging” behaviour, which includes such actions as referring more patients to specialists whom they could have managed themselves, ordering tests that were not necessary, or overprescribing. Some who had been whistle-blowers felt victimised (20%) and 38% felt bullied by colleagues or their administration. Some doctors felt they were practising “poorer” medicine (Bourne, 2016).
Common themes identified by Schattner and Coman (1998), Charles (1984), Martin et al. (1991), Jain and Ogden (1999), Mulcahy (1994) and others were the threat or actuality of a complaint or law suit causing emotional and physical disequilibrium, as well as both positive and negative changes in practice (Nash et al., 2004, 2009c). The study by Nash et al. (2009) of GPs in Australia investigated whether having a complaint or lawsuit influenced how GPs practised. They found that it did, in both negative and positive ways. 73% of GPs ordered more tests than usual, 66% made more specialist referrals, 70% introduced systems to better track test results and follow up patients, 49% avoided certain procedures (such as obstetrics) and 68% improved how they communicated risk to patients. 93% overall agreed with the survey question that proposed that inadequate communication is a factor in more complaints, although the proportion was lower at 90% for those who had a medico-legal matter, and 97% for those who had not.

The authors note that greater caution may be a positive thing, but it needs to be balanced against the higher costs that this means for patients and the community, as well the potential risks of having tests that are unnecessary. These findings, and the conclusions about them, are consistent with findings in the Bourne (2009) study, and the study by Nash et al. (2009) which was a large cross-disciplinary study of Australian doctors comparing 2,999 respondents with a history of complaints, claims or any other medico-legal matter, and those without. The results show a similar pattern as the GP study, but the proportions differ, no doubt given the former study reflects general practice in which one would expect to find a higher number of referrals to specialists, and investigative tests. For instance, in the larger cross-disciplinary study, 43% of doctors referred more than usual (66% GPs), 55% ordered more tests (73% GPs), 66% better communication of risk (similar to GPs at 68%), 48% had better systems for tracking patients (70% GPs). Studies by Cunningham and Dovey (2006) and Cunningham and Wilson (2011) also found both positive and negative defensive practices and improved “good” practice, such as reflective practice, greater sensitivity to societal and professional expectations and initiating systemic change. The positive changes were increased investigation and referral rates, more effective identification of potential problem patients, more thorough documentation and consent processes, and adjustments to time and workload. Negative changes involved withdrawing from the doctor-patient relationship and some fields of practice. The authors concluded that while the New Zealand complaints process has the potential to improve health care delivery and to reinforce appropriate standards of professional behaviour, it may cause individual doctors to practise defensively. This may compromise patient care and constrain improvements in health care delivery. An educational process therefore needs to accompany the complaints process.

The larger Nash (2010) study also found that concerns about medico-legal issues led 33% to consider giving up medicine, 32% to consider reducing their working hours and 40% to consider retiring early. Of course, we do not know if they actually did give up or retire early, but this was their intention at the time. But these represent a defensiveness of attitude in respect of doctors’
relationship with the law and regulation. Doctors who had experience of a medico-legal matter were significantly more affected than those who had not (Nash, 2010). Ninety-two percent reported being recently more aware of the risks of medical negligence (Nash, 2009c).

The Stressful Aspects of Complaints

On doctors’ perceptions of the most stressful aspects of complaints, Bourne et al. (2016) found that apart from the emotional distress and feelings of powerlessness, doctors also felt unsupported, victimised, like a failure and incompetent. Negative feelings toward the complainant extended to negative feelings towards the self, and stigma. The most stressful aspects were related to procedural issues, where fear of the consequences, impaired self-image and confidence, feeling intimidated and embarrassed about justifying their actions to seniors or others were all significant. While some participants were aware that a complaint may be justified, others felt that the complaint was unfair or biased towards complainants.

Having a complaint was feared for its impact on one’s career, with a majority of doctors concerned about professional humiliation (80%) and public humiliation (70%), and having a marked record in the future (Bourne et al., 2017). Public humiliation is consistent with Verhoef’s (2015) findings in the Dutch study, where doctors felt that reporters do not necessarily convey the facts, or that readers may not understand the considerations behind decisions. They were also concerned that adverse reporting may affect their reputations, thence their careers (Verhoef, 2015). In Bourne et al.’s (2015) study, 32% also identified that management used the complaints system to undermine them, and 24% that colleagues used complaints to take advantage financially or professionally. These latter have been issues in Australia when in recent times concern about mandatory reporting led many to express fear that threats of mandatory reporting could be used to humiliate or intimidate other doctors (Parker, 2011), or that vexatious complaints could be made by colleagues for competitive or financial reasons. The feelings were so strong that fierce lobbying by a number of doctors resulted in a federal parliamentary inquiry into this allegation in 201783, and, while no substantial outcomes eventuated, it was sufficient to bring the matter into the public and professional eye, and has recently been included in the draft Code as reflecting poorly on the profession84. Having a marked record has also been the subject of a recent outcry in Australia, as

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83 Senate Inquiry: Community Affairs Reference Committee (May 2017) Complaints mechanism administered under the Health Practitioner Regulation National Law.
84 The draft amendment to the Code (Good Medical Practice) includes the section under Professional behaviour:

10.4 Vexatious complaints
Legitimate complaints are motivated by genuine concerns about patient safety. Vexatious complaints lack substance and have other motivations. They are often characterised by an intention to protect commercial interests and/or cause harm to another health practitioner, instead of a genuine concern about patient safety. Good medical practice involves:

10.4.1 Raising genuine concerns about risks to patient safety to the appropriate authority (locally and/or the Medical Board) and complying with mandatory reporting requirements.
10.4.2 Not making vexatious complaints about other health practitioners.
noted earlier, when AHPRA declared its intention to make public the fact of disciplinary action against a doctor, regardless of outcome. The swift reaction that followed compelled AHPRA to retract, although those with adverse findings will still find the outcome is accessible by the public.

**Gender, personality and psychological profiles that affect doctors’ response to complaints**

So far, we have considered the response to complaints that doctors report, and some of the contributing factors to their reported distress. Also considered are the changes in practice that follow a complaints experience or that are reactions to the fear of potential complaints. Differences in responses have been reported that depend on whether a doctor has been sued or not sued, or involved in any medico-legal matter. In addition to these factors, there is also evidence that gender can make a difference, and even a doctor’s personality.

The GP study by Nash and others (Nash, Curtis, Walton, Willcock & Tennant, 2006) introduced these other factors. First, they concluded that those GPs with a current (not yet resolved) or past medico-legal matter have higher levels of psychiatric morbidity, as well as higher disability scores (impairment in family, work and social life). Psychological morbidity was high at 38%, compared with the general adult population of 12%, though comparable with other categories of doctor. However, those who considered the complaint as more serious tended to have higher scores. The study further considered whether a doctor’s personality traits, gender, and type of practice may be related to their history of medico-legal matters (Nash et al., 2008). They found that males had higher disability scores than females, and those who worked more than 48 hours per week had higher scores. There was also a positive correlation between those who work longer hours, being male, being a middle-aged male, and those who drink at potentially hazardous levels. Rural doctors and those who work longer hours are more likely to have a medico-legal matter. What is alarming is that 45% of GPs with a current matter experience psychiatric morbidity, as well as higher disability, or reduced quality of life, and higher alcohol use if they are males.

Drawing on other research that correlates trait neuroticism and mental health problems including high rates of depression, suicide, alcohol and drug abuse, Firth-Cozens (1997, 2007) found that those who are stressed, depressed, exhausted, alcohol dependant, or dissatisfied are more likely to practise at lower standards of care (2007), and have worse patient outcomes (1997). Wallace and Lemaire (2009) emphasised the risks to patients of having doctors who are unwell or who have set their own self-care aside in favour of taking care of their patients.

In summary, Nash et al. (2004) identified that individual and systemic factors have an influence in how doctors respond, particularly the personality and professional identity of the doctor. A key observation was about the influence of the culture of infallibility in medicine, and the inference that errors may be viewed as character flaws: not only are doctors infallible, they must be perfect. A

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The Board may take regulatory action against a medical practitioner who makes a vexatious notification about another health practitioner.
finding of note was that 64% of those with a history of medico-legal matters believed that the law requires them to make perfect decisions, which it does not: care has to be “reasonable,” not perfect (High court decision from Rogers v Whittaker85; Nash, 2009).

**Conclusion: Reflections on Why it Matters**

These findings from the past thirty or so years of research into the impact of complaints serve to provide a picture of the psychological and other impacts on doctors’ health and wellbeing. We have also gained some insight into the perceptions of causes of and contributors to these impacts, as well as personality variables and their impact on how doctors respond to medico-legal matters. As we have seen, a complaint affects not only the doctor whom the complaint is about, but it affects their family, their colleagues, their current and future patients, and their practice. The injurious nature of the impacts is sufficiently severe, and presents a consistent picture across several countries, that the impacts cannot be lightly dismissed as another indicator that doctors need to toughen up and be more resilient. As Bourne (2017, p. 2) stated:

> Litigation, complaints and investigations are part of the processes that are designed to protect patients and maintain appropriate clinical standards. However, the burden and stress associated with these processes are clearly having unintended consequences and it may be argued that when examined as a whole, these structures may be causing more harm to patient care than good. While the regulatory system may protect patients from the misconduct of a relatively small number of doctors, it has a perverse effect on the majority of doctors who become preoccupied by defensive practice.

If doctors are preoccupied, they are not occupied in doing their best, and this is not in their own or their patients’ best interests. This matters. For several decades, regulators have striven to improve public trust by improving patient safety, and they have done so by responding to events where public safety has been threatened. Stronger laws, stronger regulation, more defined Codes of Conduct that focus more on protecting patients than protecting health professionals, and more accessible mechanisms for patients to seek redress for harms and resolution of grievances, have added up to a complex network of mechanisms to monitor and remedy unsatisfactory conduct and performance, to improve safety and reduce errors. The medical profession, with significantly more complaints by proportion than other health professions, has found itself ever more bound by surveillance, data gathering, monitoring and accountability, and the adverse effects are too serious to cast aside as collateral damage. This study builds on the knowledge of existing literature to identify why it is so stressful, and being guided by the testimony of participants who have had direct experience, highlight aspects where it could be different.

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85 “The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment” Rogers v Whittaker (1992) 175 CLR 479 at 483.
In Part Two, I will present my study that builds on the findings of this chapter and seeks to identify the underlying reasons for doctors’ distress, through examining their own experiences of what it was like, their perceptions of what it meant to them, and how it could have been different. It is important to keep in mind that this is not intended to diminish the objectives of regulatory mechanisms in their aims to protect the public. Indeed, it is presented with the acceptance that these mechanisms are necessary because medicine is not perfect, doctors are not perfect, patients are real people and not idealised anatomies, and things go wrong. Patients have a right to complain if they are not satisfied and to seek due compensation if they have been harmed through the negligence of health carers. But it is also important to keep in mind that complaints are not all about harm, but are often about expectations not being met, or miscommunications and misunderstandings. What we do know is that complaints have the potential to harm doctors, and if we better understand why, then we can better ameliorate the damaging reasons for their harm.
Part Two:
Why Do Complaints Hurt So Much?
Chapter Five: Methodology

Aim

Part One of this thesis provided a background to the interactions and interdependencies of the law and medicine to present a picture of the environment in which medical practitioners work, and how the activities of regulatory processes impact indirectly and directly on doctors. Chapter Four introduced studies which explored the impact of these activities on doctors and found them to undergo significant emotional, psychological and behavioural changes. The aim of my study was to build on this existing research and seek explanations for why such changes occur, by speaking with doctors who have been through the experience of having a complaint made against them. I aimed:

To understand what can be learned from doctors’ accounts of having a complaint: their personal responses and their perceptions of the complaints process.

This aim formed the basis of the research questions around which the methodological approach was designed.

General structure

This study was conducted in two parts. The main part is about ‘doctors in trouble’: those who have had direct experience of a complaint against them, or involvement in some other medico-legal context in which they have had to be professionally accountable. It is this part that forms the central focus of the study, as they have first-hand experiential knowledge of the core issue being examined in this thesis.

The second part brings in the perspective of a small number of doctors who provide professional support to doctors in trouble, either psychiatric care, or as medico-legal advisers. They represent those who deal directly with doctors in trouble, who observe how they react to their predicament, and who have perspectives on how doctors in general respond and on the medico-legal environment in which they practise. The purpose was not to privilege their perspectives, but to provide further insight into the phenomena under study. They are referred to as “Expert informants” because they are ‘experts’ who have specialist expertise relating to medical complaints. Their voices are a counterpoint to the main narrative of the doctors in trouble.

Part One: Study Justification

This section describes this study’s approach to explaining doctors’ experience, within the context of the medico-legal environment, which is briefly reiterated here. The medico-legal environment is the objective reality within which doctors practise, while the subjective reality is what doctors actually experience. This dualism is however too simplistic as it infers that there are two distinct realities. Rather, it is a dynamic interrelationship, with other factors influencing how the medico-legal
environment is shaped and changed, and how the individual is affected by and shapes their own interaction with this environment.

This latter point is critical to the study; while it would be easy to call upon a common stereotype of "what doctors are like" or the symbolic image of "The Doctor" that society has created, doctors are as individual as anyone else, though they share some common values and characteristics. The profession expects all doctors to conform to and comply with certain codes of conduct, through a process of socialisation and enculturation alongside the formal learning experience, while every doctor is a person with a distinct personality, motivation, commitment, interest, experience, values, social influences and realities. It is these factors that have a bearing on how each responds and interacts with the medico-legal environment. This notion was explored in Chapter Two.

Similarly, the medico-legal environment is not a static beast that just became what it is of its own volition – it was shaped, reviewed and revised, it was rejected and accepted, cursed and glorified, it was ignored, parodied and feared, all by different interests, preceding laws, regulations, history and tradition, by political, economic and social demands and expectations.

The practice of medicine
The way medicine is practised is determined by:

- The profession itself
- Society's need for health care ("the public interest")

This interdependence is characterised as a "social contract" (Lessnoff, 1990; Rousseau, 1862), which assumes and requires that the profession will provide safe health care, and in return, the profession will be entitled to determine how it will recruit, train and accredit its members and how it will set its own standards of practice ("professional autonomy"). Underpinning the social contract is a foundation of trust, and Chapter One explained how professional self-regulation has been under considerable pressure in recent decades, resulting in an increase in external scrutiny in the form of greater regulatory control imposed by governments.

The law
The profession's ability to exist as an autonomous entity is enabled and secured by the law. The law protects the profession so it can provide a high standard of care without the challenges of competing providers who operate under different standards and interests. The law does this through legislation and associated regulation, and through the bureaucracies established to administer regulatory processes. This is not to say that the profession is then a stand-alone entity that is totally independent of all other obligations. The law requires the profession to be accountable so as to ensure that the public interest is protected. Alongside the law are political
imperatives; in responding to public demand, needs and expectations, governments may act to protect their own interests of economic realities and political survival.

As the history of regulatory change has demonstrated, political interests have stepped in to enforce change where inadequacies in current mechanisms have been identified. When the profession is perceived to have failed in its duty to protect the public, then the private interests of the profession are overtaken by regulatory mechanisms that will protect the public interest. This means that in reality, the profession is not truly autonomous, and that the individual doctor is subject to far more scrutiny than what the profession has determined to be necessary within its own rules, codes and standards, but is subject to written laws that prescribe a certain set of rules of conduct.

The doctor agrees to comply with professional obligations through the oath sworn at graduation and through ongoing compliance with the Code of Conduct - Good Medical Practice in Australia, or the equivalent elsewhere. In return, the doctor is rewarded by status, reputation and by being a highly valued member of the community. This balance is kept in check by one’s peers, colleagues, employers and one’s professional associations (Macintyre, 1984), as well as by the individual’s commitment to moral, ethical and legal obligations. However, when the balance is tipped by allegations of failure or breaches, a doctor may be called to account and may then become subject to sanctions, restrictions, or even loss of licence.

When such failures become public, the image of the profession becomes tarnished, and the individual suffers loss of reputation. This study focuses on how the individual doctor reacts and responds to these instances where they have been called to account: reflections on their experience, their perception of the experience and their perspectives on the complaints process.

**Approach**

Rather than aiming to be objective, impartial and depersonalised, the study aimed to draw out the personal, the lived ‘drama’ and experience of events that had left an indelible mark on participants in the study. This impression provides a picture of the other side of the story away from the language of rights, of the law, of wrongdoing and of failure, and that it may go some way to making a critical difference to how complaints are managed in the future.

Chapter Four provided an account of the ‘objective’ experience of doctors who have had complaints – that is, from a perspective not their own, but based on largely statistical data. To provide the ‘subjective’ perspective of the experience from the doctors’ own viewpoint, a narrative approach was determined to be the most appropriate approach that would complement, and explain, the objective perspective and thus complete the picture. Hurwitz et al. (2004, pp.3, 4), speak of the practice of medicine:

> The objective assessment and intervention is an important dimension in knowing.
> However complete the objective dimension, if we exclude subjectivity and its narrative
expression through dialogue, we remove diversity of viewpoint and impoverish the knowledge we can gain….

While this extract is speaking of clinical practice, the concept could equally apply to how this thesis is presented. The empirical findings seek to not only complement the statistical data, but also to explain what lies beneath it. As is demonstrated in the Findings and is further considered in the Discussion, the testimony of doctors interviewed provided rich examples of those statistical findings almost in their entirety.

The approach taken in the interviews was a key part of creating an environment where the subjective narrative could freely emerge. This was done by briefing participants on what to expect in the interview, and providing a relaxed atmosphere that would encourage free conversation, away from the formal context of medicine and the law. What also made things easier was that although I do not share common membership of the medical community, my background as observer and participant in the medico-legal world enabled a dialogue unencumbered by lack of comprehension of the medical world. As Mishler (1986, p. 11) states, “Interview as discourse is meaningful speech between interviewer and interviewee as speakers of a shared language”.

Using a narrative approach, with the language of narrative being “rhetorically distinct” (Skelton, 2011) from the language of everyday medical practice, of the law and its practices and processes, allowed the person behind the medical persona to reveal their truth and express their vulnerabilities, beliefs and sensitivities. This enabled the interview to go beyond obtaining accounts of events as chronologies and statements of fact.

**What was the most effective way to explore doctors' experience?**

The term “explore” is used in recognition that as an active dialogue, meaning is to be derived from how doctors narrated and explained their experience and how I as a researcher engaged with this and interpreted it. As every participant is an individual, he or she will have responded uniquely to what has occurred. There will be similarities in experience, as there will be similarities in response. However, even in relation to the same or similar phenomena, different people construct meaning of these phenomena in different ways.

Establishing an environment conducive to developing rapport and trust is important to encourage participants to reflect on and interpret their experience through conversation with the researcher. Lofland (1971, p. 76) speaks of the interview being characterised as a “flexible strategy of discovery…Its object is to carry on a guided conversation and to elicit rich, detailed materials that can be used in qualitative analysis”.

Careful analysis was undertaken of each individual interaction to identify the topics spoken about. This was followed by compiling the key concepts derived from the collective of all interviews, and together with notes taken during this exercise and those recorded shortly after an interview,
creating a web of interrelated ‘threads’ of interpretation. The Methods section below provides further detail of this process. As part of the analysis, the constructed web was later placed alongside the chain of events that forms the official protocol for managing complaints, which is described in Chapter Three of Part One.

This exploratory approach was derived from a number of sources, initially from Crotty (1998) who established that meaning is created through a dynamic approach that involves the researcher actively engaging with the participant’s account, as distinct from an objective truth or meaning waiting to be discovered from a participant’s account, as commonly used in traditional grounded theory, such as Charmaz (2006) and as described by Ezzy (2002) and Crotty (1998).

**Truth, facts and stories**

Explaining these foundational questions means eliciting narrative accounts of experience, subjective reflections of the experience and interpretation of the process doctors have undergone. Josselson (1995, p. 33) explains that “narratives are not records of facts, of how things actually were, but of a meaning-making system that makes sense out of the chaotic mass of perceptions and experiences of a life”. In this sense, it is a given that one’s accounts are one’s personal truth, whether or not these truths have been verified through investigation and the legal processes that the individual has been subject to. As Amsterdam and Bruner (2000, p. 221) write:

> Facts are themselves born of interpretation…Facts inescapably derive from the interpretive stance of the knower, for it is the knower who bestows upon them the status of fact. The knower does so by interpreting, by narrating, by making sense of what the knower encounters.

A complaint is the “truth”, or a perception of what happened, presented by an aggrieved patient (or relative or guardian of the patient), the medical records are another truth, and a legal finding is another truth which is the culmination of all these truths condensed and transformed according to statute, legal interpretation and professional opinion by peers and lawyers. In other words, these various truths are versions and interpretations of a sequence of events and facts that are constructed by different parties for different purposes, but that will be held out by those parties as the correct version or interpretation. There is also choice in what facts one chooses to describe what happened. In constructing the narrative of what happened, the account, or story, is not just a “stringing-together” of facts but the choice of facts is constituted by the narrative itself, as what matters in order to construct the narrative. As Amsterdam and Bruner (2000, p. 111) write, “stories construct the facts that comprise them…..much of human reality and its ‘facts’ are not merely recounted by narrative but constituted by it. To the extent that law is fact-contingent, it is inescapably rooted in narrative”.
It is for this reason that a decision was made not to access official documents and findings relating to an individual case, even though these are generally available on the public record. As a researcher, I did not wish to know an “official” account of a case. This would be to distort the participant’s personal account, and for this study, this is what matters. In Arthur Frank’s words (2010, p. 22), “The truth of stories is not only what was experienced, but equally what becomes experience in the telling and reception”.

**Key questions**

Given that the study describes and explains the social reality of doctors, then their lived experience is at the heart of these explanations. The following two key questions provide a pathway to my approach:

1. What can be learned about the complaints process through doctors’ accounts about the impact of complaints on doctors, their health, sense of self and practice?

2. What is learned about the interaction between law, regulation and medical practice from doctors’ perceptions of these interactions and interdependencies?
Part Two: Methodological Approach

Methodology

This study examines how doctors have made sense, or have tried to make sense, of a major event in their professional lives: what happens when the experience has taken on such significance that it has disrupted a doctor’s working life, their personal life, that may have threatened their future, and that has impacted on their composure and sense of wellbeing. This phenomenon has been quantified by others in the previous research recounted in Chapter Four, but the aim in this study was to find out why, and what it has been like for those affected.

Symbolic interactionism

Writing of “symbolic interactionism,” Blumer (1969) introduces the concept that people are not merely acted upon by the society in which they live, nor is their behaviour shaped by their inner world of drives or instincts. People are active in shaping their world, and how they do so derives from a reflective process of ascribing meaning to things.

Recognising that how we construct our own world is frequently symbolic of a greater social reality, it is useful to consider these premises in relation to the participants in the study. The works of Lacan (in Miller, 1988) on the symbolic and the imaginary, and of Macintyre (1984) on virtue provide added insight into how our identities are shaped and influenced by what meaning we attribute to the world around us, and our own perception of who we are and our place in the world. This concept of “narrative identity” has emerged as a central focal point for the unfolding of this thesis.

There are three basic premises in Blumer’s perspective, which provide a useful starting point for unlocking the meaning of narrative identity, in the context of doctors’ experiences:

1. Human beings act towards things on the basis of meanings they ascribe to have for them

   As a doctor, what does it mean to be a member of the medical profession? What expectations does society have of doctors, what are the expectations that doctors have of themselves and the people who care about them? What does the profession and what do the regulatory authorities expect? How do doctors respond to the authority of the law and regulatory processes?

2. The meaning of such things is derived from or arises out of the social interaction one has with others

   How have these expectations shaped a doctor’s career? Why did they become the subject of a complaint: how did they fail to meet the expectations of others? How did their involvement in the complaints process affect them? How did others react? Did their reactions affect the doctor?
3. These meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he or she encounters.

Did these responses make a difference to how doctors saw themselves then, and how they see themselves now? To what do they attribute these changes? Is it about them, about complainants, or about others? What is it about the regulatory and legal process that has contributed to these responses?

A narrative approach to the inquiry

How else to explore these questions than to engage in a conversation, not to obtain answers to set questions, nor chronicles of events or statements of fact, but to encourage reflection on these fundamental perspectives about the self as a member of the medical profession, in its relationship with the regulatory processes constructed by society through the law, and in response to social and political needs and expectations?

The conversations began with the first contact with participants, through phone calls and emails to establish understandings about the nature of the study and to negotiate arrangements for those who wished to proceed, or if indeed they were to be included as participants. In this way, a relationship had begun before the more formal interaction of taped interviews. This is important as the approach relied on establishing trust with participants, as noted above, so they could feel at greater ease in speaking candidly about the more personal aspects of their life as a doctor in relating an event through the natural form of telling a tale, a story, or constructing a narrative, as is now elucidated in the following section.

What Narratives Contribute

What are narratives and what can they contribute?

Taking an approach that uses doctors’ narratives as the primary, though not only, source of data, there are various approaches to narrative that could have been selected, as well as an array of interpretations of “narrative” and “story”.

There is no one method or tradition for conducting a narrative-style study, nor are there agreed definitions of Narrative, Story or Discourse. The distinction between them is sometimes unclear and the terms are frequently used interchangeably.

A story is about what happened: a sequence of events which generally has a chronological order as related by the story-teller. Story is a component of narrative discourse, which has a form in which the story is told (Abbott, 2009), which is generally accepted as having a beginning (“once upon a time”), a middle (“then this happened”) and an end (“and this is how it all ended up”).

The study of stories is less about finding themes and more about asking what stories do, which is to inform human life. Stories inform in the sense of providing information,
but more significantly, stories give form – temporal and spatial orientation, coherence, meaning, intention, and especially boundaries – to lives that inherently lack form (Frank, 2010, p. 2).

Stories, therefore, have a form, one that Frank suggests is more than the mere structure of beginning, middle and end. Labov (1975) asks why a story is worth telling; as a narrative it will have a point, a point that is revealed in how it is told and what is to be told. As Greenhalgh (1999) explains, while narratives generally have a framework, a beginning, middle and end, they have a structure that is reflected in:

1. The story: the sequencing of events, the timing of events, the history of events, the experience of the event, making sense of what happened

2. The plot: reflecting on the experience, finding meaning and imposing a perspective on the experience.

Nelson adds another element in the exploration of identity through narrative: “I make sense of myself or others by arranging what I care about into a story” (Nelson, 2001, p. 81). She presents the following as the key features of stories which together construct an identity as:

- depictive, as representations of human experience
- selective, in what is depicted
- interpretive, in how the acts, events and personae are represented
- connective, creating relationships among their own elements, and with other stories. The connective features work together to give it meaning and to convey meaning.

These features distinguish a story from a chronicle, which is an historical or chronological account of events, but which lacks the interpretive element that the above features represent.

Ricoeur (1984) presents a three-stage process of interpretation, and adds the concept of temporality. The latter draws out the events that have shaped a person’s identity, so that it is not just a string of events that happened along the way but an event or series of events that have been of significance. An isolated experience in a person’s life is only significant if seen in relation to other events in one’s life, pieced together via the process of emplotment to form one’s personal narrative. A personal narrative includes what has happened in the past, the present and the future, as each aspect impacts on the other: what happened in the past affects what is now in the present, which impacts on what will happen in the future. How people act in relation to these events reflects who they are as people and what their motivations are, and in this way, their identity is revealed, or at least becomes more clearly apparent. The other aspect of temporality is that some events have more significance to one’s life than other events, in terms of what shapes a person’s sense of self.
and identity. The memory of past experiences, of the present and the imagined future experiences coalesce into a constructed self-identity (Ricoeur, 1984).

**How useful is the narrative approach?**

Most approaches to narrative are consistent with the straightforward structure of beginning, middle and end, although the analysis of this study’s interview material allows for greater flexibility, for it is unclear from this structure where a story began, what is the middle and where it ends, if indeed it could be said that there is an end. In this study, the latter becomes an anticipated future, whose end is uncertain. This definition is therefore somewhat confining, though it is not to be dismissed as it has relevance, because generally the story does commence with an account of the defining event of the complaint. However, during interviews it became clear that the story began much earlier than this, at a point when a doctor made the defining decision to become a doctor. From this perspective, the complaint can be seen as a disruption to a life story, one that changed the course of that life story, in the sense of a “biographical disruption” (Bury, 2001). So it could be said that the narrative begins with the start of a career as a doctor, the middle as mid-career experience, and the end as what happened as a consequence. The story becomes a narrative when the point of the story becomes apparent, which is the life-course-altering event of the complaint. This latter interpretation of narrative resonates with Ricoeur, as briefly summarised above, which allows for greater depth by emphasising the element of deliberative selection of significant events in accordance with one’s personal construction of their identity.

This inquiry goes beyond an account of what happened and its focus on the event itself, to become not only an examination of a picture of where the event was placed in a person’s life story and its impact on their identity, but also an examination of perspectives on the broader social, political and regulatory context in which such events are constructed. Nevertheless, Nelson’s description of the key features of “story” are useful for the later examination of identity as a critical part of the analysis. Throughout this thesis however “account” or “testimony” is preferred to Nelson’s terminology “story”. Accounts or testimonies include stories (of what happened) which for this study are the catalyst for the broader narrative inquiry.

Narrative, in summary and for the purposes of this study, consists of an account of what happened, but more importantly focuses on the reasons for giving the account, on the significance of the event or events that motivated the giving of the account, and the attempt by the narrator to explain the significance of the event or events in the broader context of their lives, careers, values and aspirations. This is achieved through in-depth interviews and is set against an examination of the contextual features in which doctors practise.

**Narrative inquiry**

For this study, I have undertaken a narrative analysis, or “Narrative Inquiry”, which Polkinghorne (1988) describes as being an examination of “lives unfolding temporally as particular events in an
individual’s life”. I make a distinction between narrative analysis and analysis of narrative. The latter is not what I chose to do. The latter requires an examination of the structure and content of the narrative as text, identifying themes and categories and in some cases the actual use and structure of language.

This is not to say the tools and methods of analysis of narrative have been abandoned, for there is indeed a partial identification of themes in the later analysis of data. Following the former concept, referred to hereafter as Polkinghorne’s term Narrative Inquiry, enabled other contextual factors to be drawn on that create a sense of the continuity of “lives unfolding”. Here the works of Frank (1995), Ricoeur (1984), Clandinin (2007), Dewey (1938) as well as Mishler (1986), Riessman (1993, 2008), and Denzin (1989) have all contributed to the understanding of narrative as a way of gathering, exploring, interpreting and presenting the data in this study.

Connelly and Clandinin (2006, p. 375) state that:

People shape their daily lives by stories of who they are and others are and as they interpret their past in terms of these stories. Story is a portal through which a person enters the world and by which their experience of the world is interpreted and made personally meaningful. Narrative inquiry, the study of experience as story, then, is first and foremost a way of thinking about experience.

Narrative inquiry is also a collaboration between researcher and participants in order to understand the experience:

Beginning with a respect for ordinary lived experience, the focus of narrative inquiry is not only valorizing of individuals’ experience but also an exploration of the social, shaped, expressed, and enacted – but in a way that begins and ends that inquiry in the storied lives of the people involved. Narrative inquirers study an individual’s experience in the world and, through the study, seek ways of enriching and transforming that experience for themselves and others (Connelly & Clandinin, 2000, p. 20).

In this way, the interview is more than hearing and recording someone’s story. It involves participation by both the interviewee and the researcher in seeking an understanding of the phenomenon under study, together with contextual factors and influences. The outcome will ‘enrich and transform the experience’ and the collective of experiences for not only the individual who wished to tell their tale, but also for the benefit of others. Indeed, as will be seen in the Findings, the majority of participants had both purposes in mind: to tell their story but as importantly, to contribute for the benefit of others.

A person’s experience of a phenomenon is made meaningful by the telling of it. Each interview aimed to examine the story as it was constructed through its telling, and to build on it so that where
possible, the emerging narrative would anticipate a future. As I have noted earlier, this may be compared with other theories about narrative structure which identify a beginning, middle and end. In these interviews, we did not seek the end but rather looked to the future to consider what impact the past has had on this future. In this sense, the narrative creates the sense of there being a flow in the life story of a doctor impacted by a complaint, where the interview is a moment in time in that life-story. Who knows where the future will take them?

What is known is that the life-story as it was anticipated had been interrupted, and in the process of telling what this interruption was like, the doctor reflected on how it has affected them when it happened, throughout the duration and in the aftermath, at which point they reflect on what it means for them now, and in the future. As Ricoeur (1984) would define this process, or *mimeisis*, they refigure what the past event means for the future. There is a thread, the process of *emplotment*, or the underlying theme or point of the story. Mimesis extends beyond the story itself, to a way of examining a life. Hence, what happened before influences what is happening now, which affects what will happen in the future. There is a plot that holds these threads together, based not only on a linear series of events but of how we respond to them and understand them, and how we do so is not static or fixed, but may change over time (Ricoeur, 1984). Telling the story will likewise not be a static account. It may be told differently tomorrow, or to a different person, but there will be a point to it and that point will constitute the narrative. The analysis of findings that will follow will be seeking what this point is.

**An ontology of experience**

This study centres on doctors’ experience of complaints, so there is now a need to explain what “experience” actually means in the context of exploring others’ experience through the means of a narrative inquiry. Narrative Inquiry begins with an ontology of experience, one that emphasises continuity. The inquiry, through the medium of an in-depth interview, is an act in itself within the stream of experience that has led to the moment of the interview, that generates new relations and understandings and that then becomes a part of future experience. It is a moment in time in the continuum of that experience. In this way, the inquiry itself alters the phenomenon that is the focus of this study.

Clandinin and Connelly’s (2000) view of experience has its roots in Dewey’s pragmatic philosophy (Experience and Education, 1938). Salient features of Dewey’s (1981, p. 251) concept of experience, as set out in Clandinin (2007), are:

Experience is the fundamental ontological category from which all inquiry proceeds (not just narrative): a notion of the inexpressible. It is a “changing stream that is characterized by continuous interaction of human thought with our personal, social, and material environment. Because every experience is constituted by interaction between “subject” and “object”, between a self and its world, it is not itself either merely physical
nor merely mental, no matter how much one factor or the other predominates…. [experiences] are the products of discrimination, and hence can be understood only as we take into account the total normal experience in which both inner and outer factors are so incorporated that each has lost its special character. In an experience, things and events belonging to the world, physical and social, are transformed through the human context they enter, while the live creature is changed and developed through its intercourse with things previously external to it (Clandinin, 2007).

Clandinin (2007, p. 4) adds that “Narratives are the form of representation that describes human experience as it unfolds through time….they are the most appropriate form to use when thinking about inquiry undertaken within a pragmatic framework”.

In relation to “experience as data” in qualitative research, St Pierre (2008, p. 326) writes: “Narrative goes hand-in-hand with another concept that grounds qualitative inquiry, experience, as in the common phrase, ‘the everyday lived experiences of participants’. Participants often embed their experiences in stories they tell us in interviews. Experience thus becomes data and then foundational evidence that warrants our claims.” However, she disputes that experience is data. She quotes Scott (1992) who explained that “it is not individuals who have experience, but subjects who are constituted through experience”. Experience is not the origin of the explanation, nor the authoritative evidence, “but rather that which we seek to explain, that about which knowledge is produced” (Scott, 1992, pp. 25, 26). In other words, experience, per se, is not the data, or the evidence. It is the explanation of the experience that is the data. As St Pierre (2008) explained further, “experience is not simply material, what ‘happens’; it is also discursive. Of course, this is not to say that nothing happens, but that what happens is recognized and made meaningful only through available discourses that ‘systematically form the objects of which they speak’” (Foucault, 1972, p. 49), including identities.

This suggests the reason for someone wishing to tell their story as an experience of the past that has had significance is that it would provide the opportunity to articulate what that experience meant to them.

Under conditions of adversity, individuals often feel a pressing need to re-examine and re-fashion their personal narratives in an attempt to maintain a sense of identity (Bury, 2001, p. 264).

It is this examination, not the experience itself, that forms the basis of this inquiry.

**What illness narratives contribute**

Illness narratives speak of the disruption to one’s life and to one’s identity caused by the onset of a disease, injury or chronic illness, and the role of narrative or story in seeking to re-establish a
sense of self or identity when so much has changed. Bury (1982) called this concept a "biographical disruption" because the event disrupted the predicted course of a person's life.

When illness seriously disrupts a person's life, especially following the onset of a life-changing disease, injury or chronic illness, it can result in what Goffman (1963) spoke of as the "spoiled identity" which is associated with stigma because the image of the person is different, either because of physical changes or that the individual believes they are no longer the same to others. The person they thought they were is now different because it may have changed their capacities, appearance, status in the world, dreams, and potential future achievements. Frank (1995, p. 60) explains it thus: "the present is not what the past was supposed to lead to, and whatever future will follow this present is contingent".

Just as illness interrupts one's normal existence, so it is with complaints, and has effects that reach beyond the event itself:

Illness alters life plans and projects. And it provokes a response, however difficult and tenuous. Illness matters because real things are on the line: self-identity, physical and mental health, life chances, social status, employment, finances, religious aspirations, or personal relationships. Seen this way, illness and treatment are embedded in the local moral experience of a particular network, neighborhood, or community (Kleinman, 2006, p. 834).

Broyard speaks of the "crisis of (his) life", making a narrative or story out of his illness in order to detoxify it (Broyard, 1992, p. 21). In much the same way, the experience of a complaint can also be perceived as the crisis of one's life. It is a disruption, one that threatens one's identity. Doctors undergoing an event of significance, such as a complaint that threatens their self-image, how others see them or how they see themselves, their reputation and their future, are similarly affected.

Denzin (1989, p. 70) writes of illness as an epiphany, as "interactional moments and experiences which leave marks on people's lives. In them, personal character is manifested. They are often moments of crisis. They alter the fundamental meaning structures in a person's life". However, it is important not to take on the "Phoenix"-like metaphor of a new person arising from a spoiled identity via illness. For instance, a change in physical or mental status via illness may affect one's image to the world, and may interfere with or prevent continuation of lifestyle and livelihood. Having a complaint is different: it is often silent, not known about or not spoken about. It is generally not obvious unless it has been in the news or people around know about it. This invokes Goffman's (1963) stigma theory: actual overt stigmatisation can occur if the event is visible, or self-stigmatisation otherwise. Alternatively, there may be no radical change at all, as one learns to live
with it (Frank, 1993). Nevertheless, this still suggests some conscious reckoning has taken or is taking place.

A story worth telling
Whatever the root cause, as Labov (1967) writes, a story has to be worth telling: there has been a precipitating event from which “an implicit canonical script has been breached, violated or deviated from in a manner that has done violence to it”.

The precipitating event, whether illness, complaint or other, can be significant enough in a person’s life that their identity and sense of self are so disrupted as to cause a fundamental shift in their life course, and therefore, a fundamental shift in their belief in who they are. A re-assessment is what then occurs, during which the meaning of the event and its consequence are contemplated (Frank, 1995; Charmaz, 1990; Bury, 1982). Part of the impact of the complaints process is the waiting, not knowing what the outcome may be, and therefore, what the consequence will be in terms of the future.

An interview is an opportunity to express the evaluation of their current status, which anticipates a future that can be the positive result of a reconstruction of one’s identity. Nelson (2001, p. 6) calls this process a production of a counter-story that addresses the former narrative of the spoiled identity. Ricoeur would call it the configuration, and then the reconfiguration phase of a narrative (Ricoeur, 1991, 2008). Overall, I will borrow from Nelson’s term “Narrative Repair” to explain this process, for which people use narratives to explore how they seek to undergo such repair (Nelson, 2001) to reconfigure their identity.

The social dimension
It is important to acknowledge the social dimension in narrative inquiries.

Narrative inquiries explore the stories people live and tell. These stories are the result of a confluence of social influences on a person’s inner life, social influences on their environment, and their unique personal history. Narrative Inquiry is an approach to the study of human lives as a way of honouring lived experience as a source of important knowledge and understanding (Clandinin, 2007, p. 7).

This inquiry takes account of the social dimension, as well as the historical and political. How a person constructs their story is influenced by what they want to tell, which will in turn be framed by the “who” they wish to portray, and that “who” is the creation of a history of a self-made and other-influenced identity.

A picture of that milieu is described in Chapter One as an exploration of the creation of professional, personal and social identity in the context of the legal and regulatory environment in which medicine is situated. In this regard, it is important to keep in mind that this environment is
constantly changing in response to events and influences in the social and political environment. Clarke (2003, p. 365) recognises that as situations are unstable, influenced by social worlds that are constantly changing, methods are needed that capture the complexities of such situations and identify participant positions that acknowledge what perspective they are speaking from.

**The moral dimension**

Nelson introduced the concept of “master narrative” (Nelson, 2001). From master narratives, identities are formed, drawing on the values, acts, characteristics and experiences that mean most to the individual. As Nelson (2001, p. 82) said, “I make sense of myself or others by arranging what I care about into a story”. We seek our identity in terms of “plot templates” and character types which surround us in our lives, and which are often shared by others. The self’s master narrative could be another term for identity. But as a narrative, it extends beyond identity (“I as a doctor”) to an exploration of how identity is created, by whom and why, what influences this creation, what maintains it and what threatens it. Lacan (Miller, 1988) conceptualises this as the symbolic and the imaginary – what is symbolic of being a doctor (what a doctor is like; how the image of a medical practitioner is portrayed in society) and what the individual doctor imagines him/herself to be.

Let us say that being a good doctor is a doctor’s “master narrative”, or their imagined self. This is what all doctors are expected to be, what they pledge an oath to be, and what society demands of them. But of course, the degree of commitment to such a virtue is as variable as there are doctors. Regardless, there are common characteristics, and standards that have to be met, and so it becomes a search for moral legitimacy that is not about right and wrong, but about virtue, worthiness and values. As Hunt and Carnevale express it,

> Moral experience encompasses a person’s sense that values that he or she deems important are being realised or thwarted in everyday life. This includes a person’s interpretations of a lived encounter, or a set of encounters, that fall on spectrums of right-wrong, good-bad or just-unjust” (Hunt & Carnevale, 2011, p. 659).

Wortham (2001, quoted in Neimeyer, 2005, p. 70) comments on how “we subtly position ourselves as characters of moral worth in the stories we tell to others. The underlying assumption is that narrative conveys a moral sense of life”. The analysis of this study therefore focuses on how subjects positioned themselves, how they spoke, how they manifested their interests and moral beliefs, and how their talk reflected moral understandings.

Memory of past experiences, experiences of the present, and imagined future experiences coalesce into a constructed self-identity. Hence, at interview, the past is recalled; the present is deliberated on as it was shaped by the past; the future is contemplated for what this all may mean. The self-identity that was shaped in the past may no longer hold the same value when the significant event of having a complaint throws this into question. The master narrative, the
imagined self, has been set off course, and the moral question emerges as critical: is the master narrative as it was in the past retrievable, has its interruption interfered with the self as imagined and as lived, has it altered the future life course, and does it matter?

The purpose of interpretation was to explore how a doctor's career trajectory was shaped by events, such as having a complaint, what this meant at the time, what it means now, and what it means for the future. By looking back, there is a connection between events that is constructed by what they now mean, and by looking forward, this construction anticipates what the future may become. This study presents the testimony of doctors in trouble in such a way that their experience was not just a series of events that upset them, and perhaps changed them, but that has caused them to reflect on a bigger world they did not create (the medico-legal environment) and what this has meant for them, not only in terms of what they went through, but how it impacted on shaping their future.

The value of such understanding is expressed by Scott Fitzpatrick (2014, p. 64):

By exposing us to new possibilities of being, narrative provides us with ways of reflecting on and structuring future actions in light of our past and present lives, and of giving unity to that life. In this view, narratives not only become something to be lived out, they also act as one of the primary ways by which we come to understand our identities.

**Interpretation of the interpretation**

As discussed earlier, the interview itself is a joint enterprise that reflects on an event which continues to have resonance and emotional significance. Meaning is drawn from explaining events, perceptions and feelings. The result or “product” of this process is a transcript which will be further analysed and interpreted, with a product that is of the making of the researcher, based on the interaction between interviewer and interviewee. The record of an interview is a representation of the talk. Mishler (1986, p. 11) writes that, “How we make that representation and the analytic procedures we apply to it reveal our theoretical assumptions and presuppositions about relations between discourse and meaning”.

Neither the interview nor the analysis that followed involved verifying the “truth” of an event, since for the purposes of this study, the truth was not relevant. What was important was the account of an experience, and this account would be constructed according to what the interviewee wished to tell and how the interview or conversation itself unfolded. To reveal the truth would not be possible, if viewed in this way. Narratives can only achieve “verisimilitude”. Bruner (1991, p. 7) states that “Narratives, then, are a version of reality whose acceptability is governed by convention and ‘narrative necessity’ rather than by empirical verification and logical requiredness, although ironically we have no compunction about calling stories true or false”.

Bruner (1991) explains the components:

The loose link between intentional states and subsequent action is the reason why narrative accounts cannot provide causal explanations. What they supply instead is the basis for interpreting why a character acted as he or she did. Interpretation is concerned with “reasons” for things happening, rather than strictly their “causes”.

Hermeneutics implies there is a text through which somebody tries to express a meaning and from which somebody is trying to extract a meaning: there may be a difference in what is expressed, and what it means.

**Summary**

This section of the chapter provided an overview of the value of narrative inquiry as a method for examining doctors’ experience of complaints. For this study, those devices, tools and methods that would best facilitate obtaining, analysing and interpreting the very rich material were selected. By adding the account of the political, social and regulatory environment in which doctors’ practise would heighten the understanding of “where doctors are coming from”, when a complaint against them threatens to unravel the careers and lives they have made for themselves.
Methods

To develop an understanding of why doctors respond as they do to complaints, it was preferable to seek methods that would be fluid, dynamic, relatively unstructured yet consistent in their overall approach so that similarities and differences in doctors’ responses could be identified. The methods also needed to acknowledge personal perception, context and experience, so there was to be no concern about identifying or verifying the official facts of a case, for reasons that have been explained earlier.

As no one traditional approach was satisfactory in meeting the epistemological stance taken for this study, it was decided to draw on several methods from qualitative research methodology and the methods of narrative inquiry. These were the most appropriate as they provided the scope to explore subjective experience as distinct from the objective realities, and to elicit subtleties, nuances and meaning through interaction with the participants. Rather than making assumptions based on my own observations, experience and reading, I aimed to obtain doctors’ accounts of their experience and perceptions, achieved by subtle exploration of their accounts and their perceptions of the complaints process. I believed that the most effective way to obtain the explanations I was seeking was to have doctors, as experts in their own experience, tell us.

Approach to Interviewing

The interview method was used as the primary source of data collection (Charmaz, 2006). For the main part of my study, semi-structured interviews were conducted with seventeen doctors who had the experience of a complaint against them. A narrative style is a non-intrusive way of having participants relate their accounts and tell their stories. However, given there were specific questions, there needed to be some direction and structure so that all topics would be covered. In so saying, these directives were subtle, rather than imposed, so that questions would be answered, though posed in an unstructured way. A consistency in the method chosen was therefore achieved, and the topics covered, while the conduct and flow of each interview varied. Most interviews became more like a conversation which allowed the participant room to speak without interruption, with occasional prompts and incursions when going off topic or to introduce a new topic, to explore a response or to return to expand on points made earlier. If a participant was less forthcoming, the interview was more directed, at least initially until the interviewee became more at ease.

Recruitment

Main group: Doctors in trouble (doctors with experience of complaints against them)

Recruitment came from various sources:

1. Through negotiations with medical indemnity insurers to place notices in their membership publications
2. Recommended by participants’ colleagues who knew of the study

3. Doctors attending a conference at which I presented.

Medical insurers
Meetings were held with the two larger medical indemnity insurers (MII) in Australia, Avant Insurance and MDA National. The purpose was to obtain support for the study, primarily in order to facilitate recruitment of their members for participation, and secondly, to inform them of the study with a view to the findings being of benefit in designing appropriate support for members through the complaints process. Both organisations agreed to place advertisements in their publications to members seeking interest in participation. These advertisements were placed four months apart in order to space the subsequent interviews.

It was made clear that my study was being conducted independently of their organisation, so interested doctors were to contact the researcher directly. Names of doctors who came forward were not provided to the MII.

Inclusion criteria were that participants were to be currently registered and practising, or recently retired medical practitioners, with the experience of at least one complaint against them. Age, sex, speciality, nature of complaint and outcome were irrelevant for recruitment, as the focus was on their experience in their own terms, not as defined by “the process”. For instance, to select by any of these criteria could be seen to pre-empt that there would be a correlation between that criterion and how they responded. I did not wish to make such an assumption.

A number of enquiries was received, each responded to with a personalised letter, participant information and a consent form. Doctors were invited to phone or email if they had enquiries prior to providing their consent. Some doctors phoned to say they would like to have their say about the process but did not wish to proceed with an interview as they did not wish to “go back there”. One doctor emailed to say he would like to participate but did not feel safe to do so. After a lengthy conversation, he was reassured that his participation and the data derived from this would be entirely confidential and not-identifiable in any subsequent publication. He agreed to go ahead.

A few doctors received the information but did not respond further. Reminders were sent but no one was pressed further unless they replied to the reminder. For a few of the latter, there was to be another follow-up by email or phone call, as fitting in around busy schedules proved difficult for a few doctors. One doctor postponed her interview several times, explaining later that she had not felt quite ready to talk about her experience. Sadly, one doctor died by suicide some months after our initial contact, which I came to know about through a media report.

Some doctors had been informed of the study and had expressed an interest in being interviewed. I either declined, or they did, because of the expectation that the study would be used to advocate
for their cause. The exception was one other doctor who had been put into contact with me whom I did interview, but in later consideration, I decided not to include the data from this interview in the main analysis. Hers was a very controversial case, well known in her specialist field, and as with those mentioned, I considered that her motivation was to express her profound sense of injustice at how the medico-legal system managed her prolonged case through various jurisdictions rather than to understand her experiences more broadly as I was aiming for. While this did not make her ineligible, she expected that her name would be published, which is contrary to my protocol of ensuring anonymity of all participants in the primary group. Setting the disaffected group aside, the motivation of doctors during our initial contact was not generally raised. It was not a question that had been included in the original plan, but after conducting the first two interviews, it was obvious that this question needed to be asked. As an iterative process, it was apparent that the interviews were to be more than an account of “what happened” and doctors’ perceptions of this. It also became clear that the interview was also to be an exploration of the moral dimension of their experience, which I will explain later in the next chapter.

Suggested by colleagues
Other potential participants came forward after being suggested by their colleagues. It was this group who tended to make demands of the conduct of the study.

Conference attendees
Interest was expressed in the study after presenting a paper at the Australasian Doctors Health Conference 22-25 October 2015. Prior to the conference, Ethics Committee approval was obtained to distribute flyers, announced at the end of the presentation. The flyers could be obtained from me directly and by agreement with the MDO Avant, from a supply displayed on their marketing table. Within hours, I had five approaches and over some weeks, other email contacts following the conference.

Second group (the “expert informants”)
Five expert informants who provide professional support to doctors, in various capacities including private psychiatrists and medico-legal advisers in medical defence organisations, were invited to be interviewed. These practitioners were specifically invited because of my familiarity with their work through my previous employment experience. Given they are actively involved with doctors in trouble (DITs) during the complaints-handling process, they have a perspective that extends beyond the individual to a broader view of what doctors in this situation go through and how they respond. As with the first cohort, scheduling the interviews was difficult and prolonged as few have a spare hour or two without several weeks’ notice.
Final numbers
By the end of sixteen months, 17 extended interviews had been conducted with doctors in NSW, Queensland, Victoria and Western Australia. There had been 26 enquiries. Of the “Expert informants”, all but 2 proceeded to an interview. One doctor, a medico-legal adviser, was interested in an interview but 2 follow-up contacts did not receive a reply; the other, a doctor in private practice who writes medico-legal reviews, was likewise interested, but did not follow through.

The following table presents the basic demographic profile of the participants. I have not added further personal information, to protect their identity. Each is designated as a DiT (doctor-in-trouble). The demographic details of the expert informants is included in Section Two of the Findings (in Chapter Six).

Table Three: Doctors in trouble

<table>
<thead>
<tr>
<th>Identifier</th>
<th>Gender</th>
<th>Specialisation</th>
<th>Location</th>
<th>Type of practice</th>
<th>Career</th>
</tr>
</thead>
<tbody>
<tr>
<td>DiT1</td>
<td>M</td>
<td>Gynaecology</td>
<td>City</td>
<td>Public</td>
<td>Mid-career</td>
</tr>
<tr>
<td>DiT2</td>
<td>F</td>
<td>Obstetrician/ Gynaecology</td>
<td>Regional</td>
<td>Private group practice/private hospital</td>
<td>Mid-career</td>
</tr>
<tr>
<td>DiT3</td>
<td>M</td>
<td>Psychiatrist</td>
<td>Regional</td>
<td>Community</td>
<td>Resigned mid-career</td>
</tr>
<tr>
<td>DiT4</td>
<td>F</td>
<td>Physician</td>
<td>Regional</td>
<td>Mixed: Solo practice; public hospital</td>
<td>Mid-career</td>
</tr>
<tr>
<td>DiT5</td>
<td>F</td>
<td>Emergency Physician</td>
<td>City</td>
<td>Mixed: Public/private hospital</td>
<td>Mid-career</td>
</tr>
<tr>
<td>DiT6</td>
<td>M</td>
<td>Obstetrician/ Gynaecology</td>
<td>Regional</td>
<td>Mixed: Public/private hospital</td>
<td>Late career</td>
</tr>
<tr>
<td>DiT7</td>
<td>M</td>
<td>Psychiatrist</td>
<td>City</td>
<td>Private solo practice</td>
<td>Mid-career</td>
</tr>
<tr>
<td>DiT8</td>
<td>F</td>
<td>GP (hospital)</td>
<td>City</td>
<td>Public</td>
<td>Mid-career</td>
</tr>
<tr>
<td>DiT9</td>
<td>F</td>
<td>Psychiatrist</td>
<td>City</td>
<td>Solo practice</td>
<td>Late career</td>
</tr>
<tr>
<td>DiT10</td>
<td>M</td>
<td>Psychiatrist Registrar</td>
<td>City</td>
<td>Public</td>
<td>In training</td>
</tr>
<tr>
<td>Identifier</td>
<td>Gender</td>
<td>Specialisation</td>
<td>Location</td>
<td>Type of practice</td>
<td>Career</td>
</tr>
<tr>
<td>------------</td>
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<td>----------</td>
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<td>------------</td>
</tr>
<tr>
<td>DiT11</td>
<td>M</td>
<td>Gastroenterologist</td>
<td>Regional</td>
<td>Solo practice; Public/private hospital</td>
<td>Early-career</td>
</tr>
<tr>
<td>DiT12</td>
<td>F</td>
<td>Psychiatrist</td>
<td>City</td>
<td>Mixed</td>
<td>Mid-career</td>
</tr>
<tr>
<td>DiT13</td>
<td>M</td>
<td>Anaesthetist</td>
<td>City</td>
<td>Mixed</td>
<td>Mid-career</td>
</tr>
<tr>
<td>DiT14</td>
<td>M</td>
<td>Psychiatrist</td>
<td>City</td>
<td>Solo practice</td>
<td>Late career</td>
</tr>
<tr>
<td>DiT15</td>
<td>F</td>
<td>GP</td>
<td>City</td>
<td>Private group practice</td>
<td>Mid-career</td>
</tr>
<tr>
<td>DiT16</td>
<td>F</td>
<td>Emergency Registrar</td>
<td>City</td>
<td>Public</td>
<td>In training</td>
</tr>
<tr>
<td>DiT17</td>
<td>F</td>
<td>Geriatrics</td>
<td>City</td>
<td>Mixed</td>
<td>Late career</td>
</tr>
</tbody>
</table>

**Demographics**

**Doctors in trouble (DiTs)**

Participants are categorised as: *In training* (as specialist); *Early career* (recently qualified as specialist); *Mid-career* (well-established in area of specialty); *Late career* (towards or after retirement age, still working either full-time or part-time).

**Setting**

Participants were invited to nominate their preferred venue for the interview. This was in recognition that, as difficult subject matter may be touched upon, they should feel as much at ease as possible without being in unfamiliar territory. Venues therefore included homes, offices, private rooms in hospitals or private surgeries, and this meant I as the researcher needed to travel to them. Given this was a national study, this had logistical challenges. For the most part, it was possible to accommodate the travel requirements, but in one instance, the challenge of distance and expense prevented travel to a more remote district. Instead, a telephone interview was suggested but the doctor was not happy with this and so he declined. Three interviews were conducted within the university campus, as finding another suitable location proved difficult for the participants, one because he was travelling from interstate, one because she was fearful for her privacy if close to work or home and the other wanted to reconnect with the university environment. These arrangements were not ideal, as it was either unfamiliar territory for them and they felt unease, or it was very familiar and there was much reminiscing of student days. On the other hand, an arrangement with one participant to meet in a large public park proved impossible, as on the day it poured with rain. A nearby café served as a retreat, and with the buzz of music and background chatter, the interview appeared as a pair of friends having a lengthy catch-up over
coffee. The recording device was secreted behind the sugar bowl, and the mobile phone was placed on the table, as is usual in modern life. Even towards the end of the interview when she became weepy, this was managed as a “normal” occurrence between acquaintances, although we walked for a while afterwards while she regained her composure and more confident self. In this instance, I consider that the apparent normality of the situation enabled me to achieve one of my most successful interviews.

The interviews with expert informants followed much the same format as the main group, although with different questions which were more structured than the other set (see below). These interviews were conducted in their workplace: an office, a meeting room or clinical rooms.

The templates for the sets of questions are in Appendices 6 and 7.

**Interview Questions**

The full version of the guide to the interviews is in Appendix 6. Box 2 below is a summary of the questions. The following interview guide demonstrates that the main topics to be covered were identified prior to the interview, and each interview included these topics. Motivation to participate was added after the first two interviews, as it became clear this was relevant as doctors spoke about why they were interested in being interviewed, a topic that arose naturally during introductory conversation.

**Box Two: DiT interview questions**

<table>
<thead>
<tr>
<th>Introductory questions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self, practice</td>
</tr>
<tr>
<td>The complaint and you</td>
</tr>
<tr>
<td>Experience of having a complaint: What happened, what did you do, feelings at the time</td>
</tr>
<tr>
<td>Process of dealing with the complaint: advice, communications with AHPRA/HCCC</td>
</tr>
<tr>
<td>Support</td>
</tr>
<tr>
<td>Telling others: family, colleagues, medical insurer</td>
</tr>
<tr>
<td>Formal, informal, professional support during the process</td>
</tr>
<tr>
<td>Changes to you and your practice</td>
</tr>
<tr>
<td>Changes to self or practice during or after the complaint-handling process</td>
</tr>
<tr>
<td>Attitudes to patients, profession, colleagues</td>
</tr>
<tr>
<td>Attitudes to self by others</td>
</tr>
</tbody>
</table>
Impact on your perception of medicine
Why they chose medicine, what they expected
Whether the experience of a complaint change their perception, feelings about being a doctor
Perceptions of the whole process
Overall perceptions of the whole process
The most challenging aspects of being complained about
What could have been different

**Box Three: Guide to interview questions for the experts**

<table>
<thead>
<tr>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introductory questions</td>
</tr>
<tr>
<td>Role as a doctor providing support to doctors, and in what context support is provided</td>
</tr>
<tr>
<td>Experience of complaints</td>
</tr>
<tr>
<td>Comments on how complaints impact on doctors’ health and wellbeing, and why</td>
</tr>
<tr>
<td>Observed changes in doctors: practice, emotions, behaviour</td>
</tr>
<tr>
<td>Obtaining support</td>
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<tr>
<td>Why many doctors do not tell others or ask for support</td>
</tr>
<tr>
<td>The complaints process</td>
</tr>
<tr>
<td>Impact of the complaints process on doctors</td>
</tr>
<tr>
<td>Perspectives and reflections</td>
</tr>
</tbody>
</table>

**Reflections on the interviews**

All interviews were recorded using a digital recorder and a mobile phone as back-up. Recordings were sent to a professional transcribing service, given the length and nature of the audio files. Before commencing the analysis of transcripts, I replayed the recording with the transcript and made corrections as necessary. Utterances, pauses, emotive sounds such as coughs, tears and laughter were noted in the transcript in square brackets, as were interruptions. For each transcript, I added some observations of my own about the setting, the conduct and tone of the interview, and any unusual or noteworthy events and incidents. This became valuable in later analysis as it
provided contextual material that added richness to the construction of the unfolding narrative of each participant.

The interviews were conducted in a way that encouraged free expression, prompted at times to bring a participant back from meandering, to overcome hesitations and insecurity, or to ensure that all intended topics were covered (see Interview Guide in Appendix 6). Each interview was an interchange, and whether intended or not, how I as an interviewer responded to the participant’s talk affected how the interview progressed.

By having consented to being interviewed, the interviewee had agreed to share their experience. They had varied motives for volunteering, and while this may have influenced why they attended, it did not appear to have made a significant difference to what they chose to speak about during the actual interview. For instance, some came prepared with a file or even dossier of “their case”, as if to launch into an examination of what occurred and analysis of how they fared at the conclusion of their medico-legal matter. As the focus was more on the process, the outcome of the complaint was to become secondary, and in most cases, these prepared dossiers stayed in their briefcases. But once this was understood, all participants freely opened up about the more personal. By steering participants in this way, the desired subject matter was covered while avoiding being prescriptive in the order of topics and the manner in which participants could express their thoughts. This was not to say the interview was dismissive of their desire to tell what happened, how they felt about it and if they had a need to justify and reason. However, if an analysis of the legal case opened up, then the interview would become engrossed in a critique of the judicial or official decision, which would be a distraction and not appropriate as this would draw the interview into a commentary about justice served or denied, in their specific case. It was for this very reason that certain individuals were declined from being interviewed, as they wished to use the study to advocate for justice they felt had been denied them in other jurisdictions.

In this way, while there was control of the boundaries around which our discussion would proceed, yet as with most interchanges, the participant as narrator was able to select and edit those elements according to how I as the listener responded. As Greenhalgh (1999) writes, “The choice of what to tell and what to omit lies entirely with the narrator and can be modified, at his or her discretion, by the questions of the listener”. The conduct of the interview affected how the interviewee responded to this opportunity to be selective in what they chose to relate, and how they would do so. In some cases, an interviewee’s uncertainty meant that they would check back periodically to see if this was what was needed, or wanted (“Is this what you’re after?”). Reflecting on experience was more of a struggle for some than others. Some embraced the opportunity, and needed very little input from the interviewer. Others, who came prepared to relate the facts, were less relaxed or were even surprised that there would be interest in them as people with a subjective story to tell about how those facts came about and their perception of the process that dealt with these facts.
As this account shows, the context of the interview is a very important element in the data collection and my analysis pays special attention to the exchange between teller and reader (or interview participant and myself as interviewer) and the social purposes and conditions in which narratives are embedded (Eagleton, 1997).

As the interviewer, I was acutely aware of how the interviewees appraised me and the situation, as to how much they were willing to share with me. For instance, every participant wanted to know my credentials and the basis of my interest in this subject. I would find myself telling them the story of how I came to be doing this doctoral study and what it was that had caught my interest. More importantly, they needed to understand that I had sufficient experience and authority to be trusted to talk with me about their professional and personal life. There was universal surprise that I am neither a doctor nor a lawyer, so my interest in this topic raised a lot of curiosity.

It is interesting to explore further the nature of the relationship of myself as interviewer and the interviewee as participant. First, I needed to gain the trust and confidence of my participants, so I needed to establish the worth of my own identity, before we could proceed with the interview. When there is a differential in power and status between interviewer and interviewee (Fontana, 2003), in this study it was they who came with the credentials and who chose the setting for the interview. But as I have noted, I needed to establish my credentials, which are clearly not as privileged as those of a doctor. Yet I did hold control of the interview – how it was arranged, its purpose, its content, its conduct.

Each doctor’s account is not just a story of what happened, but is the telling of how they see themselves as doctors and also as normal human beings responding to a critical event in their lives. For these doctors, their identity is so much tied in with their professional selves that as a reader, you will see that their personal narrative is the thread that underlies each interview, and that this thread is the common thread that binds the findings into the principle of “Moral Legitimacy”.

The findings that are presented in the next chapter present the testimony of doctors in trouble in such a way that shows their experience was not just a series of events that upset them, and perhaps changed them, but that has caused them to reflect on a bigger world they did not create. They reflect on this bigger world – the medico-legal environment – and what this has meant for them, not only in terms of what they went through, but how it impacted on shaping their future. By also presenting the testimony of the expert informants who present a variety of perspectives depending on their role in working with doctors in trouble, we will gain a clearer picture of what this environment is that DiTs have to navigate through.
**Ethical Challenges**

The conduct of this study presented some challenges beyond the expected range of ethical considerations, and needed to be adequately addressed prior to gaining Ethics approval.

1. **Confidentiality**

Not only was it essential to protect participants’ identities; attention was to be paid to not refer to any other identifying facts, even if these were not named. Some matters can be identified by those “in the know” merely by recognising the story, because these tales are part of the “insider knowledge” that every profession carries. It was certainly an issue of significant concern to those considering whether to participate. Care has been taken to anonymise accounts to ensure confidentiality.

2. **Disclosure of illegal activity**

Complaints data and various studies reveal that taking drugs, medication for non-therapeutic purposes, exists and can be either a cause of complaint, a reason for an adverse event, or a consequence of stress relating to practice or to involvement in a complaints process. Doctors were therefore forewarned about revealing this information in an interview, since although not being a health practitioner with obligations to make a mandatory notification if there were to be a belief of potential impairment, as a researcher there would be a duty of care to ensure the safety of the practitioner and of patients.

3. **Protection of the participants**

It was anticipated that doctors may find the recall of events distressing, and care needed to be taken to both forewarn participants and to handle this appropriately in the interview, to prevent further inadvertent harm. A statement to this effect was included in the participant information, as well as assurance that my many years of experience of working with doctors in trouble had equipped me to deal with many disturbing events and emotionally-charged situations. In addition, professional advice and opportunity to de-brief were sought from my mentor and supervisor, the psychiatrist Professor Garry Walter.

**Narrative Analysis**

**Introduction**

Beneath the telling of other people’s stories, there is no denying that my interest in this topic has had a profound impact on how I chose to conduct my study, and on how I now choose to explain what was found. My background in relation to the topic was described in the preface, but I need to also explain how I dealt with the vast pool of data I had collected from the participants in the 22 extended interviews, and in particular, how I found I needed to deviate from traditional methods of data analysis in order to preserve and respect the character and integrity of each account. While it
was tempting to re-create the stories as testimonies to a set of unique experiences, I erred away from doing so for these reasons:

1. Preserving their confidentiality. Some “cases” are well known or have sufficient clues that someone “in the know” would be able to identify who the participant is.

2. The limited value of “stories” per se in responding to the research questions. Stories of “what happened” provided interest and context but were not central to the exploration of experience and perception.

3. This study is not a study or analysis of narrative per se. Narrative-style interviewing was instead a tool to encourage free and open dialogue.

There are, however, common threads that can be identified throughout these testimonies and it is these that the analysis focuses on.

What are common threads?

Common threads are not themes, because “themes” can be fixed labels imposed on the analysis. Themes are what are contrived by the researcher, who identifies and imposes them on the basis of coding transcripts, which has the risk of taking the life and individuality of the testimonies and treating them as disembodied “data”. Themes can remove the individuality of participants, except to use them as extracts to support and exemplify a decision about naming the theme. This thinking aligns with that of Jackson and Mazzei (2009) who argue that:

...qualitative data interpretation and analysis does not happen via mechanistic coding, reducing data to themes, and writing up transparent narratives that do little to critique the complexities of social life; such simplistic approaches preclude dense and multi-layered treatment of data. Furthermore, we challenge simplistic treatments of data and analysis in qualitative research that, for example, beckon voices to ‘speak for themselves’, or that reduce complicated and conflicting voices and data to thematic ‘chunks’ that can be interpreted free of context and circumstance.

Common threads can be interwoven, do not have boundaries, and they can link the thoughts and ideas of participants, binding them together but enabling them to remain distinct and individual. For this study, the aim was to present how participants thought about their experience beyond providing a description of “what happened” and how they described their experience.

Speaking of narrative inquiry, Polkinghorne (in Clandinin & Murphy, 2007) describes it as philosophically different from other qualitative methodologies. In a conversation with Mishler, he says:
I think in qualitative research there is a general push to provide taxonomies and conceptual systems and so on which sort of look for commonalities across interviews and other things. And my own point there is, I think that narrative is quite different, that it really deals with individual lives. I come at narrative more than from a philosophical perspective in terms of it’s the way we understand human existence. He looks for how people have responded differently to similar events in their lives and how they’ve responded in some similar ways. But that when you use narrative as a kind of data which is sort of equivalent to any other kind of interview data and you analyze it and the way qualitative analysis normally looks at things I think it misses the significance of what narrative is about. That it can capture in this kind of temporal development of lives, of the unique histories of people.

Likewise, Riessman (1993) speaks of her reluctance to using traditional methods, when she found that looking for themes became difficult to categorise when narrative accounts “knitted” several themes into long accounts that had coherence and sequences which she did not wish to fragment into distinct thematic categories.

**Management of interview material**

Instead of undertaking a thematic analysis, I was guided by authors who allow for a more iterative process, dealing first with the vast pool of transcript material, then sorting and building a conceptual scaffold (Ritchie & Lewis, 2003) that builds on ideas, beliefs and concepts that go beyond descriptive accounts of what happened. What happened becomes the centrepiece around which these concepts can be explored, not the raison d’être of this thesis.

This iterative process involved three steps which commenced with a holistic “sweep” of each interview transcript, then a more in-depth identification of the topics spoken about, to an identification of the underlying concepts that these topics represented. Josselson (2011) and Lieblich (1998) have a similar approach and my analysis began with this. Josselson (2011, p. 226) explains:

> What is perhaps unique to narrative research is that it endeavors to explore the whole account rather than fragmenting it into discursive units or thematic categories. It is not the parts that are significant in human life, but how the parts are integrated to create a whole – which has meaning.

Josselson (2011, p. 226) frames this approach around the concept of the hermeneutic circle (from Friedrich Schleiermacher), “in which an understanding of the whole illuminates the parts, which in turn create the whole”. Analysis from this stance means gaining an overall sense of meaning, and examining the parts in relation to it.

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Initial handling of the material involved an adaptation of the “framework” method of analysis, from Ritchie and Lewis (2003). This enabled a structure within which to manage and organise data, by which is meant the contents of the transcripts from the interviews. While there are three stages involved in this approach, it was more useful to represent analysis following Ricoeur’s (1976, 1984) three-stage process of interpretation:

1. Naïve interpretation
2. Structural analysis
3. Critical interpretation

This commenced with an analysis of each transcript one by one, and then the transcripts as a whole (Ricoeur, 1984).

First, taking a step back to consider what constitutes “data”, this study includes as primary data the audio recordings of interviews and the transcripts from these interviews. As supplementary data are included observations relating to participants. This includes file notes documented following an encounter with a potential participant by telephone or email that adds to the picture of a participant’s experience.

Following each interview, notes of incidents or observations about the interview were recorded, such as how it progressed, and peripheral and other issues that may have had a bearing on how the interview was conducted or how a participant responded to the situation.

Management of primary data

The interviews generated a vast amount of material, contained within verbatim transcripts for each participant. After checking the transcripts for errors, the first step was to identify broad “domains” of topics spoken about, such as the experience itself and perceptions of the experience, leading to reflections on the meaning for each participant. Groupings of the nature of experience and perceptions were generated, and a reflexive process enabled reflections on meaning by seeing patterns, similarities and common threads, as well as identifying anomalies, gaps and unique experiences. To complete the picture, a process of analysis considered what insights had emerged that had not been anticipated, whether explanations could be found for these in the data, in documents referred to, or in the literature.

These steps represent the first two steps of Ricoeur’s (1984, 1991) approach, while providing a straightforward method of dealing with the data. This completed the picture and brought the analysis together, allowing the analysis to move on to the critical interpretation presented in the Discussion chapter.
This approach is consistent with the method “Framework Analysis” (Gale, Heath, Cameron, Rashid & Redwood, 2013) which was followed as a process that enabled identifying, capturing and articulating what was common to the collective of interviews, without the necessity of reproducing the entirety of data, which runs into thousands of pages. For each interview, the concepts were identified, and extracts of text that articulated how the participant addressed those concepts were highlighted. In this approach, Gale (2013, p. 1) describes how to manage data for the purpose of analysis: “The framework creates a new structure for the data (rather than the full original accounts given by participants) that is helpful to summarize/reduce the data in a way that can support answering the research questions”. The analytical framework consists of a set of codes (“a descriptive or conceptual label”) organised into categories, with “analytic memos” which investigate particular concepts, themes or problems that emerge from the data. Categories consist of codes grouped into clusters, which starts the process of abstraction of the data. Themes are explained as interpretive concepts or propositions that describe aspects of the data. While Gale (Gale et al., 2013) built a matrix for entering the summarised data as codes and cases, my approach differed by producing tables of these grouped concepts, did not match cases to these groupings, but instead, marked the raw data according to the concepts that had been identified. These will be shown in the next chapter, the Findings.

The approach taken may differ in certain elements but it draws a certain consistency from Ricoeur (1979, 1984) as well as Gale et al. (2013), Ritchie and Lewis (2003), and Josselson (2007), and was useful in dealing with the vast volume of data obtained. As Gale stated in recognising that there exists a number of approaches to qualitative data analysis: “The Framework Method, however, is not aligned with a particular epistemological, philosophical, or theoretical approach. Rather it is a flexible tool that can be adapted for use with many qualitative approaches that aim to generate themes” (Gale et al., 2013, p. 3). Following Ricoeur (1976, 1984) as explained above, there were three steps, as follows:

**Step one: Naïve interpretation**

Each “raw” transcript was set up in table form to provide a column for notes. With this document, errors and misheard words were systematically corrected while listening to the recording. For each such document, the notes taken immediately following the interview were incorporated, which provided additional contextual information and observations.

The first step of analysis was to re-visit each interview transcript and accompanying notes to identify the topics that were spoken about, highlighting particular phrases or words that appeared to have significance. In the adjacent column, thoughts and reactions were noted, and for each transcript key concepts, thoughts or ideas that became apparent were noted as each transcript was traversed.
A separate notebook noted observations of a more conceptual nature. This was a way of extracting the key topics from each interview, which would be used as the basis for the Structural analysis of Step two.

In undertaking this “sweep” of the transcript and related data, a holistic approach was taken. As explained earlier, rather than dissecting out sections or parts that may fit into a category that may be common to many or all of the participants, the story told (What happened) became the unifying thread within an account, around which a picture of a doctor’s reactions, perceptions and perspectives was built. Out of this were attached labels of meaning, the concepts which define the underlying narrative for each doctor. In other words, sections of the text were identified and interpreted in the context of other parts of the narrative. This latter is what has been referred to in the methodology as the “plot” of the narrative, or the thread that holds the account together, and the process referred to as “employment” (Polkinghorne, 1988).

**Step two: Structural analysis**
Step two meant creating a method that would gather the observations from Step one in such a way as to build a framework that would reflect the concepts that were being identified in Step one. This step would identify the significant phrases and statements that would support or challenge the concepts that had been highlighted in Step one. The idea was not to find all the statements that were consistent across the data but to offer a picture of the range of experiences and responses that would challenge some common beliefs about how doctors react to complaints and about how they endure the process. This may ultimately lead to a more meaningful and useful insight into how to most effectively acknowledge and respond to doctors’ needs throughout and after being involved in a formal complaints process.

**Step three: Critical interpretation**
Apart from some interesting observations and glimpses into the lived experience of a group of doctors who volunteered to participate in this study, there is little relevance unless this material is used to build an understanding of the phenomena under study so that others may benefit. This data aims to provide an explanation of what lies beneath the previous studies referred to in earlier chapters that show many doctors suffer adversely from being the subject of a complaints inquiry.

If we keep in mind the significance of this revelation, in terms of the consequences that reach further than the individuals directly involved, it is with this focus that I present my interpretation of not only the findings from my study, but how it relates to that previous research and to the theoretical and contextual framework in which the study is situated. This step in the analysis drew together the analyses which arose from all sources. The Discussion compares and contrasts data from the doctors in trouble with each other and the expert informants. Do they have insights that may explain some of the doctors’ responses, behaviour, and values?
Conclusion

I have described here a methodological approach which focuses on drawing out experience, perceptions and reflections on meaning of the experience of a small number of self-selected doctors who responded to notices in the medical press and at a doctors' health conference in order to share their experience of complaints. A narrative inquiry method was identified as being the most appropriate and useful way to achieve this aim, drawing on various methods presented in qualitative research literature. The design of the study was influenced by my prior experience of working with doctors in trouble, and this enabled me to consider how doctors may best respond to this approach.

The testimonies of doctors could have been obtained with other approaches, and could have been analysed in many different ways. As a researcher familiar with the statistical evidence of the impact of complaints on doctors, and who observed it in my career, although from an entirely different perspective, this approach made sense as a way of drawing together my own knowledge, my learned understanding of narrative inquiry as a way to reach beyond the objective data to gain a greater understanding of doctors' personal and subjective experience. What this approach has achieved are significant meaningful insights into the thoughtful contemplations of a small number of doctors who have had a sufficiently vexed experience in their careers as to wish to share that experience for the benefit of others.
Chapter Six: Findings

Section One: Doctors in Trouble

The Framework

In the previous chapter, Gale’s Framework Method (Gale et al., 2013), Ritchie and Lewis’ “conceptual scaffold” (Ritchie & Lewis, 2003) and Ricoeur’s (1984) three-step framework for analysis were introduced as key tools to structure the analysis and results. Using Ricoeur’s terminology, the three steps to analysis are Naïve interpretation, Structural analysis and Critical interpretation.

This chapter will present the first and second of these steps, with the third forming the basis of later critique in Chapter Seven, the Discussion Chapter. The current chapter will follow the progress of analysis from the management of the primary data that involved 1) undertaking a “broad sweep” of each transcript to identify the main topics discussed, the emergence of the underlying concepts and then the key categories or domains (the “naïve interpretation”), to 2) a more in-depth analysis of the categories, using participants’ accounts as testimony to support the analysis (the “structural analysis”).

Each domain has an introduction, followed by presentation of selected relevant testimony, and the chapter will conclude with a summation of the significance of the Findings. This will lead into the Discussion chapter, which will bring the thesis together through a critical interpretation of the findings.

Naïve interpretation

The main topics arising from the naïve interpretation of the data are grouped into key concepts and set out in Table Four. These are set out in logical order in the table that starts with What happened? through to How could it have been different? These are the “common threads” introduced and outlined in the Methods as a way of expressing the concepts that were most apparent from this first step of the analysis. The second column provides notes and questions which led to the more refined conceptualisation. For each interview, the concepts were identified and extracts were highlighted that emerged from participants’ accounts. As an example, under “Moral legitimacy”, there is a line item “Being a good doctor”. Not one participant actually said they were a “good doctor”, yet they were all in various ways focused on validating their own self as a person and professional of worth, of recognised value, of competence or of good character, conveyed variously in terms of their own values such as being a great leader and mentor, being recognised for their expertise, or being dedicated towards their patients and their profession. It became clear that this concept was central to the narrative, and if there is to be a core theme that underlies doctors’ accounts, it is this.
Concepts identified from examination of transcript data from Doctor in Trouble (DiT) interviews

The following Table Four represents the identification of the concepts that arose from undertaking the "broad sweep" of transcript content, which are then grouped into categories, following Gale et al. (2013) and as described in the Methods. Taken as a whole, the preliminary naïve analysis presented in this table can be structured into five categories of experience and meaning, including a preceding category that describes the complaints experience itself. Questions are in the first person from the perspective of the doctors in trouble (DiT) because they signal the thoughts and reflections that typified their interviews. The notes suggest what needs to be explored, examined and interpreted from my initial analysis, which were followed up in the structural analysis.

Table Four: Key concepts

<table>
<thead>
<tr>
<th>Concepts and categories</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The law, the process and me</td>
<td>Initial reactions, perspectives on interacting with legal processes. Is it fair? Interactions with the authorities; working with their advisers.</td>
</tr>
<tr>
<td>What was it like: what I went through</td>
<td></td>
</tr>
<tr>
<td>The reckoning Neutralising the threats</td>
<td>Am I to blame? Did I do wrong? Justifying: finding causes, finding reasons (law seeks causation/interviewees seek reasons): Why did the patient complain? What was their motive; what was their story? Do doctors have to make perfect decisions?</td>
</tr>
<tr>
<td>How could it be different?</td>
<td>Reflections on how the process could be different, and why.</td>
</tr>
<tr>
<td>Getting through it: telling others</td>
<td></td>
</tr>
<tr>
<td>Whom did I tell? What made a difference</td>
<td>Personal, professional, legal</td>
</tr>
<tr>
<td>Moral legitimacy: the good doctor</td>
<td></td>
</tr>
<tr>
<td>Being a good doctor: Why I went into medicine: what were my aspirations; what were my expectations; who influenced me?</td>
<td>The drive to be seen as a “good” doctor, not a “bad” one. “Good” as a virtue? The external standards and the more personal: a calling, or vocation, or self-created? Where does professional identity come from - self, others; the social, political, historical construction of the profession?</td>
</tr>
<tr>
<td>Perceptions of self: before and after the complaint: what has changed, in what way, why?</td>
<td>The critical point: was I a good doctor? Am I now a good doctor?</td>
</tr>
<tr>
<td>Concepts and categories</td>
<td>Notes</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Perception of self by others: what have others said or done in response to the complaint event?</td>
<td>How important is collegiality to the individual: in developing the professional self; in being part of a sub-culture of common interests; in validating oneself as okay or not okay, in getting through a complaints process and beyond it.</td>
</tr>
<tr>
<td>The inside self and the outside self: compares what I think about me, what I think others think about me, and what others think about me (or what has been said about me).</td>
<td>The scapegoat, the whistle-blower, as some participants found themselves being marked.</td>
</tr>
<tr>
<td>Threats and challenges to identity because of the complaint</td>
<td>Threat of loss: reputation, career, status, income. How my attitude and expectations changed over time and with the reality of working life; how it changed since having a complaint. How needing to be good at something is important to self.</td>
</tr>
</tbody>
</table>

Changes

<table>
<thead>
<tr>
<th>How the experience affected me</th>
<th>In retrospect, on balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>How this changed my practice</td>
<td>How and why changes in attitude towards patients, in practising more defensively or cautiously, knowing they are doing so, and why.</td>
</tr>
<tr>
<td>Did it affect my attitude to my profession and career?</td>
<td>Is my commitment to medicine as it was before?</td>
</tr>
<tr>
<td>Has this affected my future?</td>
<td>The past, that has led to the present, that impacts on the future</td>
</tr>
</tbody>
</table>

The next step was a structural analysis, which enabled a closer examination of the participants’ accounts of the complaint experience. This was based on the notes and questions that arose from my naïve reading of the data. These could be grouped as the common threads from the first step of the analysis, and they would become the subject matter for this more structured analysis. This step examined each of these five categories, presented as Parts 1 to 5 of this chapter:

1. The complaints experience
2. The law in action: the law, the process and me
3. Getting through it: telling others
4. Moral legitimacy: the good doctor
5. Changes.

Part one is an overview of “The complaint experience” which is a descriptive account of what happened and how doctors reacted when receiving a complaint. The remainder of the chapter presents the findings of each of the other four key categories. The Discussion in Chapter Seven
will present a critical interpretation of the participants’ responses to and perceptions of the complaints process.

How the findings are presented

Keeping in mind that DiTs were the focal point of my study, the data from this group provides the basis for the analysis. Each section starts with an introductory text, followed by data from participant DiTs presented as quotes from their transcripts, accompanied by explanatory notes and my own observations. The findings are set out as free-flowing text, which allows for the development of conceptual ideas and description, and in boxes for longer quotations. Each of the following categories is presented as a dedicated Sub-chapter or Part, commencing with Part One: The Complaint Experience.

Part One: The Complaint Experience

Why did doctors wish to participate in the study?

Seventeen doctors with experience of at least one medico-legal matter were interviewed for the main part of this study. The reasons they gave for participating ranged through altruism to a desire to tell their story, to a desire for justice. One doctor stated that he became involved because of curiosity about qualitative research as well as having a desire to explore his own reactions to the complaint experience.

Knowing why doctors wished to participate adds to the overall picture of how a participant presented their narrative, or to articulate this in terms of their individual “plotline”, what it adds to an understanding of whom they present themselves to be. For instance, having altruistic reasons so as to benefit others could contribute to a picture they create of themselves as a good or worthy person, instead of as the bad or unworthy person with a complaint against them.

Wishing to participate

Throughout this chapter, doctor participants are referred to as a ‘DiT’ with a number, as per the table below which identifies their assigned code, their specialty and a summary of the medico-legal history. The predominant reason was to speak of a distressing incident in their lives: “I’ve had a recent complaint which came to nothing but was very upsetting and I was so distressed by it” (DiT15). DiT3 participated “...mainly because it was the most devastating thing that happened to me in my career”. DiTs 2, 12, 13, and 14 were interested to be involved with the issue in the formal context of a university research study, and for this to be conducted by someone who had the credentials to have fostered a degree of trust and confidence (my background in relation to the topic is explained in the Introduction). There was also a sense that by speaking about their experience through the medium of a later publication, this may help others going through, or who may one day go through, a similar experience. It was interesting to note that a couple of doctors said that while their matter may not have been serious, they knew that the process had a
significant impact on others. DiT9 spoke of the experience of a former female colleague and friend whom she said had been publicly humiliated and treated unfairly in a judgement against her because the panel that heard the matter failed to take into account the circumstances in which that doctor had acted. The friend subsequently gave up medicine because of this incident, and as a fellow female colleague, this participant identified strongly with her and felt a strong sense of unfairness on her behalf. This is what motivated her to come forward to be interviewed, more than an incident which she had experienced some years earlier in which she too had felt unfairly treated by the process.

Making time to meet was problematic due to doctors' busy schedules and because of practical considerations of the research project. Limited funds meant that interviews in different states were arranged within the one trip. But for some doctors, there were several months of delay between consenting and the actual interview, with repeated postponements due to hesitation about revisiting a difficult time in their lives. DiT3, for example, delayed making a time to meet by over seven months, eventually telling me she had to gather the nerve to participate in the interview as the complaint experience had been a highly emotive event for her.

The complaint experience

What happened

As noted earlier, the account of what happened became secondary to a doctor’s account of how it affected them and their reflections on the event itself, why it may have happened, and the complaints process. I will therefore not provide a detailed account of what happened. The other reason for my reluctance is that some of the doctors are readily identifiable because the events are well-known either within the profession or their specialist area of practice, and/or they were well publicised at the time. While the loss of story potentially diminishes the description or summary of key events that explain the way doctors responded during the interview, it would be a breach of their privacy and confidentiality to speak in detail of their account. It was a condition of their consent that this study would not identify the participants.

This noted, Table Five sets out basic summaries to give the reader a picture of the type of matter that preceded their participation in this study. For “Outcome”, see Chapter Three “The Law in Action”, which summarises the complaints-handling processes in Australia.
Table Five: Complaints history of DiTs

<table>
<thead>
<tr>
<th>Participant</th>
<th>History of complaints</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>DiT1</td>
<td>Gynaecology: complaint from husband re post-operative complications in another country; not substantiated but complainant appealed, leading to a full investigation. Dr had been accepted for work in Australia but the investigation held up his registration in Australia for a considerable period</td>
<td>Not substantiated. Doctor likes working in this country but wishes to leave the profession</td>
</tr>
<tr>
<td>DiT2</td>
<td>Obstetrics and gynaecology: one complaint</td>
<td>Lengthy investigation; forced out of job; suspended by Medical Board; restrictions: overturned on appeal. Much local publicity and matter was subject of controversy within the profession. Not substantiated. Doctor no longer practises as a doctor</td>
</tr>
<tr>
<td>DiT3</td>
<td>Psychiatrist: one complaint</td>
<td>Not substantiated after three years of inquiry, and much publicity. Doctor quit medicine after this</td>
</tr>
<tr>
<td>DiT4</td>
<td>Physician: one complaint</td>
<td>Not substantiated</td>
</tr>
<tr>
<td>DiT5</td>
<td>Emergency physician: two complaints</td>
<td>Not substantiated</td>
</tr>
<tr>
<td>DiT6</td>
<td>Obstetrics and gynaecology: one complaint from a staff member</td>
<td>Not substantiated; moved cities to “escape toxic peer relationships”</td>
</tr>
<tr>
<td>DiT7</td>
<td>Psychiatrist: Medical Board suspension due to criminal charges</td>
<td>Criminal matter found guilty but no punishment; much publicity. Medical Board imposed conditions and doctor now works in restricted part-time private practice</td>
</tr>
<tr>
<td>DiT8</td>
<td>General Practitioner: Complaint of discrimination; another complaint related to a drug-seeker</td>
<td>Neither substantiated</td>
</tr>
<tr>
<td>DiT9</td>
<td>Psychiatrist: history of complaints; some minor; one major</td>
<td>Most minor matters were no further action NFA; major complaint substantiated; appeals; restrictions on practice; publicity</td>
</tr>
<tr>
<td>DiT10</td>
<td>Psychiatric registrar: one complaint from intern</td>
<td>Not substantiated</td>
</tr>
<tr>
<td>DiT11</td>
<td>Gastroenterologist: one complaint</td>
<td>Not substantiated</td>
</tr>
<tr>
<td>Participant</td>
<td>History of complaints</td>
<td>Outcome</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>DiT12</td>
<td>Psychiatrist: complaint and claim for compensation from parent of failed-suicide adolescent left severely brain-damaged</td>
<td>Complaint not substantiated; settlement of claim agreed</td>
</tr>
<tr>
<td>DiT13</td>
<td>Anaesthetist: no complaint; Medical Board intervention due to impairment (drug use)</td>
<td>Criminal matter dismissed Medical Board imposed strict conditions</td>
</tr>
<tr>
<td></td>
<td>Criminal allegations: Medical Board notified by police with allegation of misconduct in relation to a death</td>
<td>Lost job</td>
</tr>
<tr>
<td>DiT14</td>
<td>Psychiatrist: one complaint about the content of a medical report</td>
<td>Not substantiated</td>
</tr>
<tr>
<td>DiT15</td>
<td>General practitioner: two complaints: one about failure to diagnose, the other an administrative matter</td>
<td>Not substantiated</td>
</tr>
<tr>
<td>DiT16</td>
<td>Emergency Registrar: two complaints about alleged unsatisfactory professional conduct</td>
<td>Not substantiated</td>
</tr>
<tr>
<td>DiT17</td>
<td>Physician: complaint about management of patient, plus two other minor matters</td>
<td>Not substantiated; resolved directly, one conciliated. Doctor holds complaints responsible for onset of a medical condition, so she took leave then retired</td>
</tr>
</tbody>
</table>

**Reactions: Response to a Complaint**

This section presents participants’ responses to receiving a complaint, and reactions to the process. As explained above, the results are presented here rather than in table form. This is because the extracts selected are descriptive accounts that speak for themselves, and do not require interpretation at this stage. They provide a picture of how participants reacted when first receiving a complaint, and what went through their minds.

**First reactions**

The respondents reacted with surprise, shock and dismay when they received the complaint. Three accounts from the interviews represent this reaction. The first is from DiT3, whose complaint was not proved, but after which he asked to have his name removed from the Medical Register: “It was not what I went into medicine for”. His account is presented at length because it encapsulates the reaction that so many of the participants expressed:

> The complaint landed on my doorstep on the day of my partner's birthday in 2012. So, the timing was just hideous. Um, and interesting from an emotional perspective, I can still clearly remember, we'd been for a fantastic dinner, gone home, I hadn't gone
through the post before we went out for dinner. Got home from dinner and kind of opened this letter from the [complaints body] and I read this incredibly vitriolic, highly personalised, accusatory complaint on a multiple, alleging multiple levels of incompetence. Um, one only had to read through the complaint to understand that this was vexatious. So thereupon ensued essentially a week of hell. I was really actually quite terrified, because even though you’re a psychiatrist, even though you’re a rational being, seeing something highly personalised like this, you have immediate images of losing your livelihood, losing your reputation. Um, what are colleagues going to think of you? Are you going to lose your private practice, because the system is the outcome of complaints will be published? So, the risk of personal reputational loss is – the perception of that risk is very high, and the potential consequences of that, both in terms of income, livelihood, quality of life, standard of living, all of those kinds of things, you just see that vanishing out the window, instantly.

The second is from a junior registrar, DiT16 in an emergency department, whose email letter arrived from HCCC during her tea break.

I first didn't realise – I thought what – like I was very confused. I was like, why – nobody has called me? I didn’t remember this patient at all and then I started to remember a little bit. Um, and it was a long complaint and there was a lot to unpack. And reading it the first time around it was literally like a kick in the guts, it was a very sort of physical reaction. Um, especially because there was a lot of quite personally hurtful statements, she used very personal language to describe me. And then it was really hard for me to think that there was somebody out there in the community who hated me that much – like who had such a skewed idea of who I am and that seemed to really vehemently dislike me. And so that was hard and then I was just so scattered because I had to go back and start working and it was really hard to just compartmentalise that (DiT16).

The third is from DiT15, a GP with two minor matters that were not substantiated, but which left her so distressed she had to seek professional help after months of not sleeping and worry:

I think it's just, um, it's like a – a grieving, you know, it's a – it's the same sort of process that you go through [emotional], you – you've been grieving - - - the loss of your confidence and, um, and you, sort of, do this, um, projected grieving of, you know, gosh, you know, what if I lose my – my career, my employment, my income, my standing, my reputation, my, you know, all these potential losses that are in your head - - - there is a – a real grief reaction that – that these are all the things that you are risk – at risk of losing and, gosh, if I lose my income how am I going to support my family, my parents, what am I going to do, what – what job am I fit to – what job am I fit to do, you know? Who wants a dud doctor [laugh], you know – [pause] – you can’t be a doctor
anymore but nobody else wants you either if you, you know, were found to be incompetent and you know; why would you do another job competently? So just your employability is, you know, is at risk as well. And, you know, how am I going to pay for my kid's school fees and all that sort of stuff (DiT15)?

As outlined in Chapter Four, doctors are aware that one of the risks of their profession is that they may be sued or complained about. This may seem remote, and seems unlikely it will happen, but when it does, it takes many by surprise.

These participants eloquently describe the surprise and shock they felt upon receiving a complaint. The first respondent quoted above relates the stream of fears that poured through his mind: loss of his job, career, reputation, standard of living; and for both, the suddenness of the transit from ordinary life to this state of terror or disbelief. For the second, a check of emails during a short work break leaves her reeling, yet she must gather herself together ("compartmentalise") and return to work. As she later said, she had to ask her supervisor if she really was the person described in the letter of complaint as she did not recognise herself in what was said about her. She also said she continued to have these doubts for long after the matter was finalised, some months later, even after the complaint was not proven.

These stories were told in hesitant phrases, incomplete sentences, using strong emotive vocabulary, and from my observation from having been present, the words are spoken in rapid, highly charged speech. Yet I have used the term "eloquently" because it was how they expressed themselves, as well as what they said, that left an impression of such strong emotional shock and disbelief. This was observed in several other interviews as well (DiT1, DiT2, DiT5, DiT8, DiT9, DiT14, DiT17).

Some participants spoke about the grief they experienced after the initial bad outcome that later gave rise to a complaint, for example: "I was very upset this had happened. I was very upset I'd had such a bad outcome" (DiT12). A complaint compounds this emotion – feeling sad for the patient, and then for themselves, but responding to the complaint creates a duality – having to defend one’s actions sometimes means losing sight of the patient. This same doctor later recounted how she was happy the patient received money as compensation just to “make it go away”, but also because she felt bad for the patient who had such a terrible outcome (DiT12).

DiT5 was particularly upset about a complaint because she felt that she and the nursing team had 'gone above and beyond' for the patient:

...they all remembered the patient, so a number of them were really distressed about it, they were distressed that I was undergoing a complaint, they were really distressed that the woman had complained about me when, like, we’d actually gone above and beyond. We’d made so much effort to address her pain, and everyone was so upset
about the diagnosis because she was so young and it was so unexpected that you
know (DiT5).

Others spoke about how the impact of receiving a complaint infiltrated their lives, from difficulties in
concentrating to penetrating fear of what may happen. For instance:

I think – I think – I think as soon as I got the complaint, my practice was different. I
would look at things differently. I would be – initially I couldn’t focus on what I was
doing for weeks (DiT1).

Being a sort of person, you know, like many personalities most probably in medicine,
we’re Type A, we like to dot the i’s, cross the t’s, get everything right, be all things to all
people, and then suddenly to have number 1, a complaint and number 2, I was just
painted so black that it was extremely confronting (DiT17).

Complaints do make you feel bad whenever you receive them, even a small one like
that because you always think the worst (DiT1).

You can imagine how this devastates the operating day when you’re trying to
concentrate (DiT6).

After sensing she was about to receive a complaint because of a patient’s unexpected adverse
outcome, DiT2 said tearfully, “And it felt, you know, it felt like the hurricane was about to come
down on my head and there was nowhere safe to run to, and I couldn’t do anything to prevent the
disaster from arriving”.

For many participants, being “incandescent” (DiT3), angry, horrified and awful, or “the most
distressing thing that had ever happened in my career” (DiT2) were typical responses recounted
during interviews.

As the analysis proceeded, these reactions reappeared many times as participants sought to
recover from the fears that the first notification heralded for their immediate and longer-term future.
Some also feared that it would affect their practice, whether they could continue doing their job well
and safely while distracted by fearful thoughts. As discussed above, DiT16 had wondered if they
even had the right person, as she said she could not recognise herself in what was said about her:

Do they [the HCCC] have my – like are they getting me confused with someone?
Really? This doesn’t sound like me at all. So there was a lot of disbelief initially and
then I read the letter and, I was like, okay, she mentions my name a lot so it must
actually be me.

After being accused of being condescending and dismissive, DiT16 said:
... it made me look at myself and to see whether I am condescending or I am dismissive and, um, yeah and I think it made me – I guess it just made me angry at the system for not giving me that time to spend with people.

Yeah um, because often, you know, there's always a little part of you that goes, oh, you know, I – maybe I am like this and it, it makes you second guess things and it makes you, um, yeah – it makes you question how you practise, um, and yeah, and so, and so that, I think that's one of the more difficult things about getting a complaint against you (DiT16).

The feelings expressed in these quotations suggest that a complaint raises doubts for a DiT about the person they had thought they were. Their self-image appeared to have been shattered, questioned and challenged. Most participants engaged in a process of self-reflection: am I really this person, did I really do such things; or is there another explanation: did the complainant identify the correct person?

Other thoughts voiced during interviews were as if to neutralise the complaint, to find reasons for the complaint that deflected blame away from themselves: was there a problem with the patient or did the complainant wish to find blame in the doctor as if to explain their own state of mind or behaviour? In DiT16’s case, an anxious mother had been kept waiting for an extended period in the hospital waiting room and was agitated and annoyed, especially while overhearing nurses chatting about their love lives. For DiT12, a mother sought compensation for injuries caused by a daughter’s self-inflicted drug overdose and attributed this to DiT12 who “failed” to identify suicidal ideation some days before this event. This notion of blameworthy or blameless self-perception, and “good” or “bad”, will become a core part of the discussion in a separate section.

Overall, there was an underlying fear, whether justified or not, of loss of income, reputation, career, status, all of which suggest a fundamental shift in participants’ sense of confidence and security. This may undermine trust as well as their own sense of competence. These sentiments echo on a broader scale those expressed by the DiTs in the section above, where shock and disbelief, fear and loss of confidence were frequent descriptors of their reactions to a complaint and the process that followed.

**Conclusion**

This section has paid little attention to the nature of the complaint or to the potential seriousness of the outcome for doctors. The focus has been on how having a complaint has affected the participants – their actual emotional reactions and symptoms of emotional impact, of behavioural or attitudinal change. It has also been on how they seek to find reasons to neutralise the impact, how it has raised questions in their mind about their own confidence to keep working, to be competent.
while suffering the anxiety, distress, uncertainty for their future or even to deal with a deeper level of disturbance.

The next part explores the nature of the process, to delve deeper into what some of the contributing factors are to these emotional and behavioural impacts.
Part Two: The Law in Action

As described in Chapter Three, the law in action is about process: how it works, what actually happens, the mechanics of administering laws and regulations through the statutory bodies charged with these responsibilities. As the naïve interpretation of the data revealed, one of the key categories emerging from the participants' accounts of being a respondent to a complaint is the process itself. Their accounts describe such aspects as the receipt of letters from the authorities, the style and nature of the communication, how doctors meet the obligations required of them, and their understanding of what is happening while traversing the process. They speak of their perspectives – whether it is fair, whether the rhetoric of public protection is reflected in the actual conduct of matters by the authorities, their interactions with the law and lawyers. The next section is more speculative, where DiTs reflect on why they had been complained about, if it was really about them or was there something else about the context or the complainant, and whether having been blamed, they are really blameworthy or not. These thoughts have been intrusive and at times threatening, and they appear to be a way of neutralising the threats of such thoughts. Nelson (2001) likens this to the counter-story that a "damaged identity" creates to neutralise the effect of a threat to the self and self-respect. Finally, most reflect on how it could have been different, and these may provide insight into how procedures and protocols may be amended in the future to take greater account of the adverse impacts on those involved in these proceedings.

The law, the process and me

This section follows the process of how a complaint is dealt with and what doctors experience throughout the process. This is presented in narrative form, as various thoughts and impressions are revealed, interwoven with comments, interpretations and explanations.

Receiving a notification

Earlier participants’ emotional reactions to receiving a complaint were described. This section describes how they received the complaint. DiT8 recalled how she had received a phone call from the regulator while driving with a sick child in the back of her car. The caller demanded that she respond to various questions about a patient accusing her of racial discrimination. Knowing the patient was a very dangerous person with a lengthy criminal record, DiT8 responded by urgently trying to warn the caller of the risk of being in the same room as the patient, as she was when making the call. Undeterred, the caller pursued vigorous questioning over the phone. DiT8 later had to attend a hearing, where the complainant’s issues were examined at length, but DiT8 had no opportunity to raise her own concern about the unusual manner in which she was called to answer to a complaint. This was not a typical case and all other participants received notification by mail or email. Some spoke of the persisting fear and trepidation that accompanied the arrival of any subsequent mail. DiT16, introduced earlier, received her letter by email during the work day, and it was very disorienting. DiT3, also introduced, had his special day concluded by the letter awaiting
his arrival home. For these participants, the letter becomes a symbol that associates official correspondence with fear.

Ongoing communication with the complaints body had a similar effect. DiT5 received her first and only complaint after 23 years of service, and it took her by surprise. Communication with the complaints body had her in tears every time, even though she knew she had done nothing wrong and was aware that the complainant had been devastated by the news that DiT4 had delivered to her. She recalled:

> Every time they would call me, I'd go weak at the knees and practically collapse and burst into tears and all of it saying, you know, you have no case to answer, but, you know, she was, oh, I mean, I can understand why she was very distressed because I was the one who first delivered the news (DiT5).

**Responding to a complaint**

… for a week or two couldn’t eat, couldn’t sleep, um, and while we worked through with the solicitor putting a letter together and pulling, you know, the hours that were involved in me responding to this (DiT15).

Responding to a letter of complaint is challenging because so much depends on what they say and how they say it. Some doctors are confused about what they are responding to, and need to rely on the advice of their medico-legal adviser. So it is not just a matter of providing the clinical facts of a medical event and of their reasoning; it can also be a carefully constructed account that protects the doctor’s interests. “I was quite frightened by the legal stuff”, said DiT1. DiT5 said:

> … it’s just like you’re being judged here and every now and again you’ll get a little letter which will tell you where you’re up to. There’s, sort of, no ongoing contact and therefore you just sit there wondering [laugh] am I about to be, like, struck off, which I know is catastrophising again, but like, is it going to be the worst case scenario because, you know, with all these scenario possibilities and when you don’t know who’s making the decision or what factors they’re taking into account or you don’t get to write another letter or – it’s just they’re all dealing with the first pieces of information so there’s not even a second response written. It just goes to the Medical Board, [sound effect] and the letter comes back [sound effect] (DiT5).

The confusion and uncertainty generated by this part of the process leaves a lasting impression: doctors are not in control and are not certain of what is expected of them. For some, needing to relinquish some of the control to their medico-legal adviser does not always sit comfortably. DiT16 describes how she pondered the preparation of her written response:
I had quite a conciliatory tone and I was happy to sort of make concessions even though I didn’t quite agree with them, um because I knew what would be expected and because that’s what was told to me when I called up the [complaints body], so I called up [Medical Indemnity Insurer] and they said something like to show that you’ve reflected – they want to see evidence of you reflecting and basically like, they want to see that you’ve learned something from it (DiT16).

A response to a complaint may make a difference to how it is assessed and subsequently dealt with. Doctors such as DiT16 learn that taking the advice of their adviser will give them a better chance of being assessed favourably. Yet it does not always accord with their perspective of what happened.

The process itself
For some, the process is confusing and uncertain, because doctors do not know the end-point and how they will get there, and do not know how best to navigate their way through because of uncertainty about what they are responding to and how it will be assessed. Adding to the uncertainty is trying to understand the procedures of a large bureaucracy, whose role is sometimes unclear. As DiT12 said: “It’s like walking down a highway full of potholes” (DiT12).

Responding to a complaint may also mean responding to issues identified during the assessment or inquiry phase of complaint-handling, which may not be directly about the complaint. Participants felt this makes them uneasy and puts them into a defensive mode, as it is not clear what the basis for this request is and where it may be leading them. They would have liked the opportunity to explain, to provide reasons for their own judgement and conduct at the time but they are being told how to structure one’s response which is not always what a doctor thinks is a logical way forward. What a doctor thinks is relevant or superficial may not accord with how the regulator sees it. As DiT4 said:

It’s the forensic detail of the reply that elevates each of these small things into something, so each small thing becomes elevated in importance ... I responded only to the complainant’s messages. It went into a very different trajectory (DiT4).

Time is important to doctors
Many doctors spoke of the delays in the process, when they had no idea what was happening and at what stage of the process the complaint was. Time is important and adds to the pressure – preparing responses within a short timeframe; the lengthy time waiting for a reply, and later, to hear of the outcome. Nor were the doctors provided with information about how a decision was made about the outcome of a complaint. These points are illustrated in the following quotations:
I was given 14 days to provide a response; it was months before I even got a reply (DiT8).

You just wait and you wait and you wait (DiT13).

It took a huge amount of time. My spare time was all spent photocopying the file which I had to do myself and writing reports. I didn't type then, I had to do everything by hand (DiT12).

I must have spent, like, a shitload of time going through all the notes and getting help from all these people and gearing myself psychologically to deal with it. And then, actually sitting down, going through the letter, taking away the personal feeling so that I could look at it in a very detached manner and just respond to it as factually as possible. It took a lot of time to do that (DiT16).

Doctors are generally busy people with tight schedules. It is not just the time itself but it is the inconsistency in timeframes that adds to the anxiety and the irritation. They are expected to meet statutory timeframes, but the regulator is not. In addition, waiting for the next step builds up the unease and tension.

The power of the law
Failure to respond to a complaint may lead to further action against the doctor as cooperation with complaints processes is expected in the Code of Good Conduct87.

[T]here's nothing else you can do because they've got you over a barrel (DiT8).

The whole legal process is very persecutory and I know the law a little bit – enough to know that just because you're right doesn't mean you win. You can still lose even though you're right. I didn't lose. I just wanted to – end it (DiT12).

From the participants’ perspective, the legal process is very adversarial (DiT14), showing little regard for the time it takes, and the anxiety provoked, while responding to matters put to them. At times, this seemed like a never-ending process as new matters were brought up and compounded by lengthy delays.

The nature of communication with the authorities
When dealing with AHPRA or the HCCC, participants described how they were dealing with a large bureaucracy with complex procedures, statutory requirements and timeframes, and to many of them it seemed like a faceless (some were not sure if they were dealing with doctors or with junior administration staff), de-personalised monolith that has a logic that is not one they can relate to, yet has considerable power in respect of their futures. Their unease translates into a sense of

87 Medical Board of Australia: Good Medical Practice: A Code of Conduct for doctors in Australia.
unfairness, because the reasons for what it asks of respondent doctors is not made very clear. For instance, the process allows a complainant to seek a review of the decision, which is a reasonable right in respect of any legal decision. However, the effect is that it is “not over”, and in addition, the complaint will remain on the doctor’s registration record, even if a complaint has not been substantiated. DiT15 expressed it thus, but it was an issue that several doctors remarked on:

The letter back says “we don’t find that there’s enough evidence, to uphold this complaint against you”, but it’s still open to the patient to complain again if they’re not happy, this is not the end of the matter. So I found that quite upsetting that I still can’t completely rule a line underneath that, now, you got away with it this time, but the patient can still complain and we can still have you back on the carpet, and I think that, if it’s finished it should be finished (DiT15).

DiT5 said much the same: the letter at the end of an inquiry told her that her matter was not found proven, but the fact of the complaint would be on her record forever. This extends to when applying for a job, and having to answer the question about ever having been referred to the complaints body or Medical Board, “and I have to answer yes, yes, forever, for the rest of my career. So, you know, a career will span 50 years – and hopefully they’ll be my only two complaints (in 25 years so far) – will sit with me forever. That’s pretty unfair” (DiT5). The after-effects of a complaint reverberated for the years since a complaint and would for a long time ahead for DiTs. In response to a friend with experience of the authority, who told her “I think you should just cop it”, DiT5 said, “But, like it says at the bottom of the letter, this will be on my file forever, there’s no way of removing this blemish. That’s what it says if I’m ever referred to the Medical Board again this file will come up again, so it’s – it hangs over me forever. I think that’s pretty unfair” (DiT5).

Communications from the authority could also be so brief or insufficient as to invalidate the personal toll of the process on DiTs. As DiT8 said, “Communications from AHPRA are very brief”. DiT6 said there was a long delay between the decision being made and being informed. He was cynical about what the letter said, that AHPRA acknowledged the stress that was caused to him. DiT5 also said that a delay of 6 weeks in being informed “there was no case to answer” added to her grievance about the way her matter was managed. Changing the tone of the correspondence such as acknowledging that this may be a difficult time and to contact their medical indemnity insurer would make it less impersonal. “The anonymity of the tone (of letters), the guilty till you’ve proved yourself innocent, the denial of justice in effect, or the denial of the usual judicial process, where you’re innocent and they have to prove you guilty” (DiT6).

Participants found the lack of information added to their confusion. DiT16 had hardly heard of the HCCC and there was no brochure or link to further information. On accessing the website to obtain information, she was alarmed at the potential courses of action a complaint may take. As DiT5 said:
There’s no ongoing contact and therefore you just sit there wondering, am I about to be struck off, which I know is catastrophising, but is it going to be the worst case scenario because with all these scenario possibilities and when you don’t know who’s making the decision or what factors they’re taking into account.

**Just doing their job**

Participants see the regulator as the adversary rather than protective of their interests. DiT8 said of AHPRA, “they are all just people following a process, so do I hate them? No, they’re probably just doing a job and they don’t realise the effect”. DiT4 said: “I had the feeling from the Medical Council that they wanted to give me this sort of response because in a way they had to placate two parties (the complainant and AHPRA). I felt that quite strongly”. This was after being given recommendations to improve how she communicated with patients and their relatives. She felt the accusations were unjust as she had had a torrid time with this patient’s relative, and that the Council had assumed she was in the wrong because there was a complaint, but did not take account of the context. Yet she later admitted that she took this message seriously and passed it on to the team.

As these perceptions illustrate, DiTs experience confusion and a variety of emotions throughout the process. The bewilderment many felt was not just from the complaint itself, but from not knowing what was happening and how the bureaucratic process was handling their matter. DiT6 even viewed AHPRA as “the enemy” and referred to his faith to assist him come to terms with his experience:

> I’ve come to terms with it now, um, because, ah, I realise – because I’m a sort of practising Anglican and I believe in you’ve got to forgive your enemies. It’s not for them, it’s for you. I don’t have any resentment about it because – because that just makes me sick, and there’s nothing I can influence – these are all just people following a process. And – and they’re probably just doing a job and they don’t realise the effect and you’ve got to forgive them for your sake so you don’t let that have power over you (DiT6).

Another manifestation expressed by some DiTs was the ‘catastrophe’ ahead of them. They had seen others before them suffer from the public exposure, the unfair judgements, the humiliation, the loss of jobs, and feared this may happen to them. They now had to “face the music” so to argue, fight, blame, and accuse would do no good. Interestingly, one doctor said when asked about the ‘catastrophe’ she had thought was about to befall her, and subsequently didn’t happen: “it was the fear speaking, but it was all gone now” (DiT12).

**Was it fair?**

Participants conveyed a strong sense of injustice or unfairness with the system and its processes. They acknowledged they are afforded procedural fairness, which is written into the legislation and
procedures, by being given the opportunity to respond to complaints made against them and to decisions arising from inquiries into the complaint. The sense of unfairness arose from how the process actually worked as, what I have termed, *The Law in Action*. In the previous section, delays, brief and sporadic communications which relayed little information, mystery about how decisions were made, were not just annoyances; they were also perceived as being unfair to them. Other aspects of the process added to this perception, as follows.

**Access to relevant information**

Participants spoke about their frustration in being unable to access records, which they need to have in order to respond adequately to complaints. Medical records are not only a factual record of a medical encounter, but are also a useful reminder to the doctor about the patient and their issues. Some complaints may be made some time, even several years, after an incident, and doctors may struggle to recall either the patient or the event referred to in the complaint. DiT9 was required to respond to a complaint dating back 12 years. She could not recall the patient, but was told to do the best she could as the patient file had been archived several years before.

DiT15 was refused access to the medical file by the complaints body for several months, and was unable to remember with certainty what she had done; this raised a doubt that perhaps she had neglected to perform expected assessments of the patient. She said this added to her distress significantly, as there was a doubt about her competency. Once the file was provided, it was clear that she had performed the tests, and the matter was closed very quickly after that. She felt her anxiety could have been avoided if the complaints body had provided the records with the letter of complaint. During the interview, this participant thumped the table in anger at what she perceived was the unfairness of an aggrieved patient with a trivial issue taking up so much of her time and emotional energy:

> … the hours that were involved in me responding to this and all the patient had to do was write a letter of complaint to our clinic and “cc” to Complaints Commission [thumps table], that’s the only effort he had to make to make my life utterly miserable for the next month or more … because he didn’t get what he wanted … [it] cost me – I don’t know – a total of maybe 12 hours’ work or more to respond to this complaint that took him 10 seconds [laughs] (DiT15).

Going back to the origins of a complaint, some participants spoke of the dilemma they faced when there was an incident in providing care that resulted in an adverse outcome to the patient, or even death. They spoke of how their first desire is to provide appropriate care for the patient, and loved ones if need be. At the same time, they are dealing with their own dismay or even grief from a lost or damaged patient. As a professional, they also wish to identify what went wrong and what were the contributing factors. However, this may be curtailed if the incident becomes managed by
others, or by an administrative process or protocol, such as a complaint, an open disclosure process, or because of perceived “damage control” by administrators or senior staff.

**Peer opinion: It's slippery ground (DiT4)**

DiT4 now does some medico-legal work and commented on the implications, based on her own experience, of the reliance on peer review to make judgements about other doctors’ conduct and performance. The inference is that giving such opinions from the outside and out of context can have deleterious consequences for those being judged, and can therefore be unfair or even precarious:

> It’s so easy to be critical in retrospect and it’s slippery ground to be criticising other people in retrospect. I don’t think that’s reasonable to say that they would have absolutely made that decision at that point in time, only because now it’s this decision and you can see whether it does line up. The view is easy from the cheap seats; they’re in an office now reading a thing where they get the end story as well as the beginning story, the person that was in the firing line was doing it in a different sequence (DiT4).

**Reflections on blaming and being blamed**

DiT1 commented on the fallout from the investigations into the scandal at mid-Staffordshire Hospital in the UK in 2012\(^8\)⁸. The fallout meant that everyone was blaming everyone else, and by speaking about this issue, implied that this tendency to blame, and to be blamed, is all-pervasive. While mid-Staffordshire was a particularly extreme case, the sense that being a good doctor doing a good job does not protect one from blameworthy by others:

> … lots of patients died and it was felt to be due to the lack of care within the hospital and the doctors blamed the managers and the managers blamed the doctors and, you know, the nurses … – it was a whole hoo ha with all people blaming another…It makes you very uncomfortable as a doctor if you know that – as an honest doctor, I think – if you know that you’re – when something goes wrong, which inevitably will do even if you take the greatest care – if something goes wrong, you could be held accountable in the same way that somebody in the street could be held accountable for doing a – a criminal activity. Makes you feel uncomfortable (DiT1).

**“Nonsense” or anonymous complaints**

Some participants could not understand why all complaints are accepted by the authority without vetting or triaging them. There was a belief that “Nonsense complaints [are] taken at face value” (DiT8), while DiT8 wondered why AHPRA appeared not to “have a mechanism for weeding out bulldust type complaints”.

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\(^8\) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013.
A member of the health care team made a complaint against DiT6. He knew who it was, but it was never officially divulged. It became so toxic for him that he relocated to work elsewhere. He declared it to be:

... such a flawed process. The anonymity of it got me, the fact that you could – it was like Stalin’s Russia and Hitler’s Germany that you could make an anonymous accusation and never be held to account. I thought it was absolutely despicable and underhand. You know, to me, if you have a complaint about someone, you make it to their face. It goes against every part of my philosophy, so that was why it offended me (DiT6).

Some DiTs considered the process is weighted towards complainants. This was not only in accepting complaints at face value regardless of being trivial or “nonsense”, but also because some felt they had no opportunity to put their side of the story, to provide reasons and their own perspective. “The patient has the main voice. You only respond to their complaint, that’s what people tell you to do. You don’t draw a picture from the other perspective at all” (DiT5).

The frustration of dealing with “nonsense” complaints added to the perception of unfairness. Doctors are aware that some complaints are very serious, and will be investigated. Most complaints are not investigated, but are finalised with no further action or with a non-disciplinary pathway to resolve them (see figures in Chapter 3). Some doctors could not see why the complaint against them, being a “trivial” or minor matter, had either not been dismissed on receipt by the authority or that it was treated as if it were a serious matter. They felt as if the process considered them to be one of the “bad guys”. Such minor matters could still take many months to be finalised, and they did not understand why. As DiT5 said, “Me, it felt like, you know, me the Butcher from Bega, which I know is catastrophising the whole thing, but I did sort of feel that he and I were at the Medical Board at the same time” (DiT5). She felt she was being judged at the same level, reinforced by the statement at the end of the letter from the Board, when it was all over, that this would remain on her record “forever”\(^\text{89}\).

**Fairness at the end of a complaint**

Perceptions of the issues discussed above not only left participants feeling disgruntled; they also added to the feeling that the process is unfair. For instance, once a complaint had been finalised, many participants did not feel vindicated, even with a finding of not guilty, or the complaint not

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\(^{89}\) This latter point was noted in Chapter Three as causing significant consternation amongst the profession. A doctor’s medico-legal history of matters which have attracted conditions is indeed able to be accessed through the online register of health professionals on the AHPRA website. It had been proposed by AHPRA that all complaints be available, with the rationale of being transparent and enhancing the public’s trust, but this caused such an uproar that the proposal was withdrawn. The effect however has been to reinforce doctors’ view that the process is weighted towards complainants.
being substantiated\(^90\). Others expressed their dismay that complaints stay on their record forever. DiT12 said of her matter that was settled\(^91\): “You can still lose even though you’re right”. DiT4 was also upset that her matter would stay on her record forever: “When it’s over, it should be over”. DiT13 accepted his conduct was “less than ideal”, but as the complaint related to activities in his own time (recreational drugs) he felt it was unfair, as he had never had a patient complaint nor caused injury. Not only did doctors retain a sense of guilt after the complaint was finalised, they felt that the whole process had treated them as if they were guilty and that the onus was on them to prove otherwise. DiT8 stated: “But just going through that process and you just sort of feel – you feel guilty from the moment that that letter rocks up”.

DiT6’s views were very clear, when speaking about the role of the regulator:

> And I think that these people are meant to be protecting you and – and helping you but they’re actually your adversary, you know – and it’s a false feeling. I have a feeling with all these boards that you’re always guilty ‘til you prove yourself innocent. It’s the reverse of what’s normally the case in other realms of the law – … because you have to disprove an allegation. It’s not that they’ve got to prove it.

This sense of injustice was amplified when comparing the system with the criminal jurisdiction, where the presumption of innocence is a fundamental principle. The other aspect is the perception of the role of “their” Board, as the authority that exists to protect the profession, when in fact it is there to protect the public. As DiT8 said:

> The thought too that these people (i.e., the Medical Board) are meant to be protecting you and helping you, but they’re actually your adversary, and it’s a false feeling. I have a feeling with all these boards that you’re always guilty till you prove yourself innocent. It’s the reverse of what’s normally the case in other realms of the law, because you have to disprove an allegation, it’s not that they’ve got to prove it. You’ve got to disprove it (DiT8).

Some participants felt that when facing the law, they have little power even when giving an opinion, adding to the sense that the system is adversarial. DiT14 endured a long court hearing resulting in no case against him being found; however, the legal argument was prolonged and largely fruitless and the judge finally called a halt to it. DiT14 viewed the regulatory system as adversarial, and he felt powerless and distressed throughout its duration.

DiT8 wondered what would have happened if he had ignored “the whole thing”, until he looked into it and found the authorities have the power to search a doctor’s records, their house and examine

\(^{90}\) See Table Five Complaints history

\(^{91}\) A compensation claim may be settled, not because a doctor was liable, but because a commercial decision is made because of some foreseen difficulties in defending a claim in court.
their bank account. Procedural matters interfered with a perception of procedural fairness for these participants. While doctors do have a right of reply, sometimes they are unable to effectively exercise this right without access to sufficient information, such as medical records. Many participants felt that the delays and length of time it takes to finalise a matter, added to the sense that their interests are secondary to the process, that the presumption of innocence does not apply to them and that they must comply with requests for information and reports within restrictive timeframes, yet the authorities appear to have no such pressures to respond to them in a timely manner. Therefore, several doctors felt that the very process itself assumes they are guilty, unless they can provide sufficient evidence that will clear them of accused wrongs. As DiT15 said, “the process itself is like a punishment”, for an assumed wrong.

**Does the type of matter make a difference?**

As explained in Chapter Three, not all complaints are handled in the same way. First, a complaint to a complaints body comes under the regulatory provisions of public protection legislation. Serious complaints are investigated and may result in conditions placed on a doctor’s practice, a suspension from practice, or de-registration. Such matters impact directly on a doctor’s career and reputation. A claim for compensation comes under civil law dealing with wrongs, and is about finding fault, causation and monetary compensation. Payouts for claims, as well as the costs of defence, are included in medical indemnity insurance. As DiT6 explains: “Well, in negligence generally – we’re all comfortable with the whole, sort of, concept of negligence and the legal system around that, so if someone is going to sue me for negligence then – then fine, I’ve got my defence organisation” (DiT6).

Many participants said that although claims are stressful because doctors still have to face the processes of being accountable for their actions, complaints are more so because of the link with their professional status. Even within complaints, there are different types of complaint. Some are viewed as “nuisance” complaints, others go to the heart of a doctor’s competence and commitment. Two DiTs spoke about the type of complaint making a difference. DiT15 had two complaints: the first was about her clinical care; the second was about a patient who had a grievance about an administrative matter. While she was disturbed and annoyed about the administrative matter, she was highly distressed about the other as it touched on her competence as a doctor. She said:

> So it wasn’t really about my medical expertise, it was more an administrative complaint … and so I wasn’t as upset about this. … I didn’t feel like it was my medical competence or my expertise or, um, you know, didn’t feel like my career was threatened… (DiT15).

DiT12 was sued and avoided court because a settlement was agreed. She was “fine” about this because the patient’s “life wasn’t very good” after a failed suicide attempt left her severely brain...
damaged and compensation would have helped her. Even though DiT12 was not considered guilty of negligence, and believed that her actions to look after the patient had actually “saved” her from an adverse finding, she was pragmatic about the settlement, knowing a court case would have made her very anxious.

These results demonstrate that some doctors can be pragmatic about the compensation paid out when a patient has been catastrophically injured. It is what they pay their insurance for. For complaints experiences such as DiT15’s, an administrative misunderstanding over a Medicare entitlement was upsetting to receive, but dealing with it was more annoying. The other matter was about her clinical care, and it was this matter that sent her into a very distressed state requiring psychological support.

**Summary**

These results have shown that when traversing a complaints process, many participants feel like perpetrators of a wrongdoing, even though there is no fault apart from making someone unhappy which could have been resolved in a more conciliatory way. They then feel under threat, which results in having to defend themselves against the threat. This is a different perception of “defence”: defence as a part of the process means explaining and accounting for their actions, and procedural fairness ensures they have a right of reply in which to do so. Due process ensures things are done in a systematic, ordered way that is about protecting the process against challenges about its fairness. However, due process meant that participants sometimes felt alienated, so they are defending themselves against the threats that the complaint represents to their future, as well as the inference of moral culpability.

The results show that there is a strong sense of loss of control that enters the doctor’s life when a complaint leads into a process requiring them to account for their actions. This is made more difficult when access to vital information, such as DiT2’s patient’s file, has been withheld, and this can be compounded over time if the subject matter of a complaint occurred several months or even years before. Therefore, while doctors acknowledge there needs to be a system to manage complaints and to catch out “bad” doctors, and recognise that the system ensures they have a right of reply to complaints and decisions made about them, they also perceive the process to be unfair, with some believing it to be weighted in favour of complainants, and therefore not just. The other aspect is the process, described above as being “punishment in itself”, because of delays and silences in communications with the regulatory authorities. Contributing to this is how they are required to respond: not to tell their version of events, but to respond to issues raised in the complaint, which many believe do not correspond to what really happened. This adds to the sense that the complaint is accepted as it is, without any vetting or triaging.

Neutralising the threats
Am I to blame?

An observation from the interviews is that participants went through a process of rationalising the complaint. Some of this was the weighing up of being right, or being wrong, or perhaps being partly to blame. But even if a participant took full responsibility, there was a justification for their actions at the time, or an attribution of at least partial blame to the complainant or to other people. In some cases, complaints that were not substantiated naturally left doctors feeling relieved, yet they would say “but there is always a doubt” and “I must have done something wrong that someone was unhappy with my care” (DiT11). There is also the dilemma that if doctors remain adamant about the treatment they propose as the right course of action, they may still upset people who do not agree with them. Each of the participant interviews contained one or more such stories, and in each case the doctor weighed up their actions. Following are some examples of how participants rationalised some of the blame.

A mother demanded antibiotics for her child which DiT16 believed to be incorrect, not helpful and potentially harmful. DiT16 reflected on why the mother was so angry:

I was the sole doctor in the paediatrics department at the time, and so you have to deal with every child that comes in. I think she was annoyed before she came in the room because there were extraneous circumstances as well – she had waited some hours in emergency department before her son was seen, and she overheard two nurses discussing their love lives and so obviously she was annoyed before she even met me, and it was like she was taking that annoyance out on me.

A patient made a second complaint against DiT16 after a car accident. The patient was constructing a compensation case that was not just about the accident, but also about the alleged poor care she had received in the hospital. DiT16 summed it up by stating “it sometimes reveals more about them, rather than what it tells about you. I felt like I was a bit part in someone else’s story”.

DiT12 “failed” to schedule a patient who was not suicidal at the time, and was sued as well as complained about, because several days later the patient took an overdose and was catastrophically injured as a result.

In another case, a very elderly patient, with underlying co-morbidities, underwent abdominal surgery. The patient’s daughter had insisted on active treatment because the patient had been fit and healthy prior to surgery. She survived the operation but had a difficult course of recovery over a prolonged period, during which DiT17, a physician, was called in to help manage her. The daughter blamed DiT17 for her mother’s subsequent death, yet DiT17 had been brought in post-surgery with the patient already in intensive care and not recovering well.

DiT17 reflected on what lay behind the complaint and expressed her thoughts as:
Each one of these (complaints) is usually a difficulty coming to terms with not a good outcome. Somebody has to get blamed for this bad outcome, and whether it was some guilt feelings about having gone ahead with this surgery, which maybe in hindsight was not a good thing to do. But you know, I have the perspective of looking and saying, “Look, these people are the ones suffering; they’re just making other people suffer along the way”. You know, that’s what happens sometimes when people are aggrieved, as opposed to when there’s a clear case of somebody doing something very wrong.

DiT4 knew she was going to receive a complaint after a vexed phone call with a very difficult relative of a patient: “She had her agenda. She wanted to ram it down my throat, um, and that she didn’t want to listen to what I had to say and so one of her complaints was that I said that ‘I didn’t want to speak to her anymore’, whatever”. She felt that whatever the agenda was, she was never going to please this angry person.

These are examples of the bargaining that became a feature of some participants’ moral deliberations: perhaps they were at fault, but perhaps it was more about the complainant who had another agenda, or who could not come to terms with a bad outcome. Perhaps it was about participants needing to find fault in others so as to deflect total responsibility from oneself, which would ameliorate the impact of the accusations.

When constructing her response to the complaint, DiT16 met with her mentor and former supervisor. They went through the complaint “forensically”, and the more they went through the notes, the more they realised that the complainant had misrepresented events, a lot of the details were confused, and some things were “blatantly untrue” and didn’t make medical sense. Her mentor told her that “she’s made some really terrible allegations against you and you have the right to defend yourself”. So from being initially conciliatory in her response, DiT16 went through the complaint step by step and refuted everything that the complainant had said, “providing really good evidence for why these allegations were being refuted”.

The above accounts suggest that participants felt under threat and needed to gather the forces to defend themselves. This behaviour fits with the general perception by participants that the system is weighted towards complainants, with the perceived adversarial nature of the process compelling them away from conciliation towards defensiveness and taking “sides”. They used the resources at hand, material and emotional support from a mentor or supervisor, the power of their medical knowledge and any evidence that they could gather, to repudiate the accusations. But without collegial support and access to evidence, other participants’ experiences suggest that they fare less well. This is illustrated in the experience of DiT2 whose colleagues abandoned her and she was refused access to the medical files.
What could have been different?

Some doctors, though not all, reflected on what could have made life easier for them while they traversed the complaints process. Not one doctor denied that there should be a complaints system, as all recognised that people have a right to complain, that health care is not always safe and that not all doctors, and other health practitioners, do the right thing or are entirely competent. Most doctors recognise that they themselves are not perfect, but that even if they could have been better, there should be room for doctors to improve without being blamed for everything that goes wrong or that could have been better: “good enough” medicine could replace “perfect” medicine. Nevertheless, when faced with a complaint, they know they are accountable, yet in being accountable, they then feel the system assumes they are guilty.

Doctors agreed there should be a system for managing complaints and that people have a right to complain but that it should not be so hard for the respondent: “There has to be a process but the process for the doctor is the punishment even when you have done nothing wrong, it’s a punishment” (DiT15). Some doctors considered other ways of being accountable that do not generate the fear that has been described, or the defensiveness that will be described in the last part of this chapter, Changes. How to achieve a balance was considered in detail by DiT15, whose reflections are set out in Box Four.

**Box Four: There needs to be a balance: DiT15 reflects**

}[E]verybody knows you have to have a complaint process - - - and God knows the doctors do make mistakes and that sometimes doctors do… practise poor medicine, not just make inadvertent mistakes, so there has to be a process but the process for the doctor is the punishment even when you have done nothing wrong, it’s a punishment….the fact that I would even think about I can’t continue in medicine when I’ve done nothing wrong – what does that do to your workforce if the balance is too far to the complainants?

}[Y]ou lose doctors, you make doctors insecure, in some ways you make their practice worse, if they are practising too defensive medicine so … there’s got to be a good balance and, I don’t think that complaints should be that easily made, I think they should require some energy on the patient’s behalf, if it’s important enough to make a complaint then they should, you know, be required to devote some energy and thought to it. I’m not saying that doctors – are gods and shouldn’t be, you know, have a – a proper complaints process - - it’s got to be even-handed, but regardless of how even-handed you make it, the mere fact of having a complaint about you can be utterly devastating - - - no matter how minor it is, yeah (DiT15).

DiT15’s thoughts reflected what others also said: that a complaints process is necessary, but it appears to be weighted towards complainants, whose effort in writing a complaint is far outweighed by the effort, time and resources required by a doctor to respond to it. It also appeared to have little regard for its impact on participants, given the perceived dismissiveness with which the authorities communicated with them, which some perceived as perfunctory, lacking in information and explanation, and bureaucratic. In addition, that the complaint will remain on their record “forever”
(DiT5) was both threatening and unfair, especially if the complaint was not substantiated or was of a relatively minor significance.

Being experienced as punitive has a negative impact not only on the doctors themselves; it can also promote the risk of defensive medicine. Protection of the public, as a given, may be more effective if the adverse impacts can be ameliorated. Suggestions for how to achieve this ranged from process changes to the manner of communication between the authorities and doctors, to suggested alternate resolution practices.

**Communication with the authorities**

DiTs’ impressions of the nature of communication with the authorities ranged from being very brief (DiT8), to having significant delays in receiving letters, the anonymity of the tone (DiT6), and the lack of acknowledgement of the process being stressful, being “detached and a little too devoid of emotion or any acknowledgement that this might be difficult” (DiT16) all added to the grievance about the process itself.

DiT16 said that a phone call to her before the complaint arrived by email during her break may have helped, and she wondered what would have happened if the email had never reached her and how the system would respond to her lack of response that would follow. She added that the letter gave little information about what would happen next. Having more personal contact was also noted by DiT4, who suggested that their insurer have a contact person or support person allocated who could be like a supplement to medico-legal advice. She also commented that the nature of the communication is “like a postal service, back and forth” between the Medical Board (Council, as it is now) and herself:

> And so it's just like you're being judged here and every now and again you'll get a little letter which will tell you where you're up to. Yeah, there's, sort of, no ongoing contact and therefore you just sit there wondering [laugh] am I about to be, like, struck off, which I know is catastrophising again, but like, is it going to be the worst case scenario because, you know, with all these scenario possibilities and when you don't know who's making the decision or what factors they're taking into account or you don't get to write another letter or -- it's just they're all dealing with the first pieces of information, so there's not even a second response written. It just goes to the Medical Board, [sound effect] and the letter comes back [sound effect] (DiT4).

The frustration and sense of bafflement of dealing with the big bureaucracy represented quite a contrast to the busy, organised lives of the DiTs as medical professionals. This manner of communication was anathema to how they would prefer to resolve problems, yet they had no say in how this could be achieved.
Not all participants were of the view it would be preferable to deal direct with patients when there is a dispute or grievance, although it was a more common view. Some doctors believed that if they could just sit down with an aggrieved patient and sort it out, it would provide the opportunity to resolve a grievance before it escalated. DiT2 felt she was denied the opportunity to do so by her hospital administration that intervened and prevented her from being with the patient after a critical incident. DiT1 was caught up in a dispute with an aggrieved husband which escalated to a formal complaint, but when he then picked up the phone to explain the situation to the husband, the acrimony was immediately dispelled. Others were not so certain that a direct approach was a good idea. DiT16 said she would not be happy to do so, though it would depend on what the complaint was about:

I think a written forum is a much better way to express yourself, especially when emotions are heightened. You would want a mutual third party there, just in case they make another complaint against you because obviously you’re not their favourite person, which is why they’ve made a complaint against you and they might not be reasonable in the way that they approach you. I wouldn’t be comfortable just walking into a room with just her and go chat about it amongst yourselves (DiT16).

She acknowledged that for some doctors, this may be feasible if they have had a long-term relationship with a patient, but the complaint about her was “out of the blue” from a person whom she had known for only a very short period of time.

While a doctor may say it is in their nature to want to solve problems, they are faced with a bureaucratic process that removes them from control and from direct communication, which becomes a process mediated by others in a manner sometimes unclear to doctors, whose frustration became clear when talking about how it affected them. While this may appear to be a challenge to participants’ professional autonomy, nevertheless it gives pause to consider whether there are aspects of the process that could take more account of the perceptions of it as unfair and unnecessarily unwieldy, confusing and unsympathetic, which undermines trust in the regulator and which brought some participants to ponder how these processes serve to protect the public.

Although not one participant denied there should be a system to deal with serious matters of public interest and safety, when reflecting on the role of the process itself, some participants expressed the view that in today’s world, patients expect too much from health care, and it is not possible to either keep everyone happy, nor is it feasible. DiT4 said:

I think it is the direction of health care, I mean, people’s expectations just get higher and higher, and maybe the legislation just says protect the public, but the general sense is that the patient has to experience excellence and have no complaints almost
at the end. I don't think it's in the public interest, I think expectations just seem to be becoming just way over the top (DiT4).

People expect a lot. Our whole society expects a lot. In my life time when I was a little girl, doctors couldn't do anything wrong and now, ah, it's almost that the consumers know what's best and if they want something, they should get it (DiT4).

**Summary**

The overall impression from the participants is that many of their observations about dealing with the medico-legal process could be avoided if greater acknowledgement were made of how the process is experienced by those on the receiving end.

There were differing opinions about whether it would be better to resolve complaints more directly with the aggrieved person, which would de-escalate a potential formal complaint, or if this would be too confronting and uncomfortable (DiT16). Direct resolution is a process offered by the HCCC for less serious cases, although like DiT16, some parties are not happy to take up this opportunity. The Medical Indemnity Insurers advise doctors not to deal directly with complainants unless mediated through the MII, given that sometimes, a participant’s anger or defensiveness can escalate a grievance. While this is done to protect the doctors, some doctors such as DiT1 feel it is unnatural that they cannot follow through with a patient, even if the patient is unhappy with them.

In summary, there are many aspects of the process that participants found to be problematic. There is a belief that having a permanent record disadvantages doctors when applying for work elsewhere, and may damage reputations. There is also a belief that while the public has a right to know of instances where they are placed at risk by “bad doctors”, the doctors who are not “bad” feel they are being treated as if they were as bad or even worse than criminals, whose criminal record will be wiped after so many years, or not recorded at all for minor matters.

Finally, there is an impression that the balance is weighted towards a public that expects more than the profession is able to give, and that they, the doctors, bear the brunt of this. A common view was that there should be a more refined process to handle complaints. Many considered that there should be a better way of separating the minor matters from the serious, rather than treating them all much the same. It has the effect that doctors who previously were considered competent, dedicated doctors have a stain on their professional career.

**Conclusion**

The complaints process has evolved over time to more effectively protect the public against the risks inherent in a health care system that allows health professionals to practise below standard, to perform poorly and demonstrate unacceptable conduct, and to deal with complaints by those dissatisfied with or harmed by their care. The findings of this study so far have identified that doctors’ experience of the process has left many of them metaphorically battered and bruised, and
certainly not experiencing the system as caring and sensitive, nor even acknowledging that the process is stressful.

Participants have offered some thoughts on how it could be different. The changes considered do not suggest radical change, but a greater sensitivity to how the messages conveyed by the bureaucratic handling of the complaints process can be improved. While these perceptions are open to challenge, because the system is designed around the principles of procedural fairness, the legalistic tone does not marry well with the values inherent in care for others that participants said the medical profession stands on. Dealing with this dissonance, and its emotional toll, is the subject of the next section of this chapter: *Getting through it, telling others.*
Part Three: Getting Through It, Telling Others

Whom did I tell?

The focus here on the question ‘whom did I tell?’ comes about because it is known that many doctors do not seek professional, collegiate or personal support when they are experiencing distress for whatever reason (BeyondBlue, 2013; Nash, 2013). Yet the incidence of psychological and emotional harm is known to be significant, and in some cases prolonged, and can affect a doctor’s attitude to their profession, the way they practise, and their personal wellbeing. The reasons for doctors not seeking help when suffering mental illness have been well documented in the BeyondBlue (2013) survey. These include practical reasons such as insufficient time, lack of access to available help, and more personal reasons such as embarrassment, shame, fear for reputation and fear of stigma affecting career (BeyondBlue 2013). However, not everyone needs professional support, or they may prefer support from those closer to them, in terms of friends, partners, colleagues and others in the workplace. This section aims to provide greater insight into why doctors chose to tell others, or not to, about receiving a complaint and whether this made a difference in their handling of the process.

The analysis here does not delve into doctors’ coping skills or techniques for maintaining their wellbeing such as diet, exercise, work-life balance. These techniques are amply covered in other literature and advice to doctors generally92. For the purpose of this study, the interest is in seeking an understanding of what makes some doctors reticent to tell others, whom they decide to confide in and whether sharing with others makes a difference to them. This will reflect on later deliberations about reputation and trust, as well as dealing with the uncertainties of the future triggered by the complaints experience.

The following table explores one participant’s account of sharing what was happening for her at the time. This is to convey a sense of the deliberations about whom to divulge their experience to and under what circumstances.

<table>
<thead>
<tr>
<th>Box Five: A Doctor in Trouble: One participant’s story (DiT15)</th>
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<tbody>
<tr>
<td><strong>Telling the interviewer</strong></td>
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<tr>
<td>I’ve never had any mental health problems, I’ve never had anxiety or – or depression or anything like that and always considered myself … fairly…sort of, strong, get on with it, sort of, person - - - I was just nobbled by this happening. I was dreading going to work [emotional] … you know, crying all the time and like this [laughter] … just [emotional] – I just couldn’t function properly.</td>
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92 MIs, the Colleges, AMA, medical newspapers, the Australasian Doctors Health Advisory Service, BeyondBlue, all offer articles, resources and advice to doctors, including such publications as “Keeping the Doctor Alive”, a self-care handbook.
**Telling her partner**
My partner was with me and ... I had that – all that sort of support, but he’s very sensible and he just kept saying, “You know, don't you think you should go and talk to someone about all this?” Oh, no, no, I'm fine, I’m a doctor.

**Telling her solicitor**
And the solicitor from [MII], he was in fairly regular contact with me ... and he was really good and he eventually said, "Look, you know, if you’re so upset, go and see someone.” I was impressed with [MII], you know, also I – I, kind of, knew that they had the counselling service as part of it but ... but the remaining aware of how you’re going and prompting me - - - doing something about, you know, yeah.

**Professional help**
DiT15 was selective about whom to see: not a young person but an older person with experience of medical professionals.
I said, “Well, I don't see any point in going and talking to anybody, it is what it is, they can’t change it, it's, you know, I’ve just got to wait until this process is – is done with and I don't see how a counsellor can change anything, you know, all he can say is, well, yeah, [laugh], you know, that is what it is and, you’ve got a good ... partner supporting you and, you know, just have to hang in there until it's finished”. But somehow unloading it all to the psychologist, ah, was helpful.

**Telling the boss**
“Look we know you’re good, we know you’re competent, we don’t have any problems with it and we’re sorry you’re in this position.”

As noted, doctors who receive a complaint are required by their indemnity insurer to notify them about a complaint, and to heed the advice of the adviser who is allocated to their “case”. DiT15 dealt directly with a solicitor, who recognised that her ongoing distress was of concern, for her own sake but also because it made it difficult for him to work with her in dealing with the complaint. Both her partner and the solicitor entreated her to get professional support, and after resisting for a long time, she eventually took their advice, and it “helped”. Taking this advice was not easy, and it did not sit well. After all, she argued, what could anyone tell her who wasn’t a doctor? This seeming belief in the superiority of her knowledge resonated with her seeming disbelief in receiving a complaint, and the shock and distress that followed once the reality set in.

Receiving reassurances from her boss about her competence did little to assuage the long-standing grief that accompanied her to the interview. DiT15 was a good example of intrusive worrying and fear that led to severe anxiety, loss of sleep, long-standing fear of recurrence of the event, and of others knowing about it. Her boss only knew because she had to access the records in order to respond to the complaint.

**Telling others**
Other DiTs responded in varying ways, not all as traumatised by the event, but as deeply reflective. Confiding in others was helpful and some participants felt it was critical to enduring and surviving
the process. While all the DiTs interviewed had told at least their partners, not all immediately shared it with others. When they did, rather than feeling judged, they felt supported, and not only this, they felt validated and this helped to maintain a degree of confidence.

DiT16 confided in family (medical doctors), her fiancé, friends and colleagues, and her supervisor:

I got a call from the boss … to see how I was, which was a big surprise, like, it's really lovely. It's really nice to see people take an interest in your wellbeing because a lot of how you see yourself as a doctor is based on your terms of success, like treating patients well or having good outcomes. One of the things that really struck me was when my boss said “I'm really sorry this happened to you, this sucks”. Nobody had ever acknowledged it had caused me distress. I can't underestimate the importance of having the support of people around you because I think that completely changes how all of this – because I know – there's a lot of shame attached to it and I know that some people would be so ashamed that they wouldn't want to tell anyone about it … the negative feelings that were attached to this were only mitigated when people said stuff like, oh that really sucks and I'm so surprised and that's not my experience with you and I can't believe that somebody complained about you. And so it was like I needed five positive reinforcements for every negative (DiT16).

The more common response was to tell only one's partner. Not everyone wants to tell others or get professional support, and telling colleagues takes courage. Yet when participants did confide in colleagues, it made a difference as they could relate to the experience as a peer:

I've got quite a good friend who's a colleague I've talked to about a few things. That was nice. He thought I'd probably done nothing wrong. I did that once. I didn't need to do it again. They said they had this support program - - - I didn't use it. I didn't need it. I just had to beaver away and get through it. So I did. I'm used to complexity and uncertainty which I think really helped (DiT12).

But if a doctor tells no one, it can add to the stress. DiT11 did not tell anyone apart from his wife, yet once it was all over, he confided in his former supervisor. He was surprised how much better he felt, and relieved, when his former mentor told him he too had had a complaint: “When I was going through dealing with it, nobody knew. I brought this up, yeah, at our meeting when it was completed” (DiT11).

After the initial shock of receiving notification of the complaint in the mail, DiT3’s partner thereafter intercepted every envelope that arrived. DiT14’s wife remained his confidante and support throughout his lengthy process and court case: “My wife is wonderful. She’s always been totally behind me” (DiT14). Similarly, DiT8’s wife stood by him throughout the ordeal of his complaint,
supported his move to another city, and at the time of the interview was reluctant to leave his side. For both of them, they had lived through a trauma and this was a part of that narrative.

Telling friends and colleagues was often conflated: the friends chosen to confide in were fellow doctors. DiT4 confided in a friend, who is also a doctor:

I talk to her about things but that’s the only person. It would not help if you didn’t speak to a doctor. People would not understand what you’re talking about, you know. They just wouldn’t understand. I’ve discussed some things with people outside and the questions they ask you, it’s quite clear that they don’t really understand what it is that you’re trying to convey or what you’re talking about. It’s – I don’t know, they just don’t understand what it is to be a doctor. I don’t think it’d help to speak to anybody else. It might help to speak to other doctors but I just haven’t got that relationship with anybody else. And her values are similar to mine and things like that. I think that means a lot too (DiT4).

This was interesting, as it shows that DiTs needed to not only “offload” their story but they needed someone who could identify with them and understand how they may be feeling and why they may be feeling that way, that is not to have to explain why they had such anxiety, fear or whatever their emotions were. Telling colleagues was much the same, though the risk was higher if they feared being judged. On whether to appeal a decision that arose from an administrative error, a colleague said to DiT5: “I really think – of course if you wanted to and I’d support you and I’d help you – but I think you just need to cop it. And think of it as something unfortunate that’s happened in your career”. To which DiT5 responded “But I don’t think of it as something unfortunate, I think it’s like a terrible blemish really. I think of it as something awful” (DiT5).

She had a nervous time and was so fearful of the hearings, she was accompanied to them by a friend: “[I] managed to have someone who could go along and hold my hand and drive, because I was not in a fit state to get myself down and back” (DiT2).

**Getting medico-legal advice**

As has been noted, doctors are required to notify their insurer if they receive a complaint and, for participants in this study, most found them helpful. DiT15’s lawyer went beyond providing legal advice and intervened to arrange emotional and psychological support for her:

And the solicitor, um, from [MII], he was in fairly regular contact with me, um, and he was really good, um, and he eventually said, “Look, you know, if you’re so upset go and see someone”, because I'd be crying on the phone saying, you know, “It’s so distressing” and, you know, [emotional], look, he probably hears from every person he speaks to but, um, and he was probably dealing with things that were way more, um,
worrying that my little matter, um, and I can, sort of, see, you know, you’re just one little droplet in the whole thing, but for me it was everything [emotional] (DiT15).

DiT14 found he was well supported by his solicitor, and though this was focused “on the legal stuff, I don’t recall deep and meaningfuls, but it felt supportive. He was terrific during the hearing and we would meet every morning before we went to court. And we’d review the day at the end of each day” (DiT14). The DiTs who mentioned their lawyers and advisers were generally appreciative of the support and advice they were given, although DiT2 spoke of differences of opinion with her adviser, who was a peer in her specialty. She felt he was less sympathetic to her situation because of this, and it added to her anxiety.

Getting professional help
As noted in Chapter Four, Nash et al. (2013) and BeyondBlue (2013) found that very few doctors seek professional psychiatric or professional help, nor even tell their GPs, when they are distressed by having a complaint. Not one of the participants had sought psychiatric care. One signed himself into a rehabilitation centre to assist with addiction problems. As for obtaining psychological support, it took some time before DiT15 agreed to see a psychologist. Although she said to her partner “I’m fine, I’m a doctor”, she was in hindsight not at all fine. She was reassured only because her medico-legal adviser, whom she trusted, referred her. But she was choosy about who would help; it would not be a 25-year-old who would not understand why it would be upsetting, but a middle-aged man who, she felt, would be sensible because of their maturity and experience. What she found helpful was having someone who was “used to talking to doctors”, who would listen to her story, and encourage her not to think in terms of the worst possible scenario when the outcome was uncertain. This reinforced what she had told herself. Although she had recounted her story to her partner, it was “some kind of validation” to have someone else listen. Others had said they would not see a psychologist because “What would they know? They're not a doctor," which is reminiscent of BeyondBlue's findings (2013).

Summary
Having someone hear their story, to support them throughout or to validate their worth were of value to each participant. The exception was DiT11 who did not tell anyone apart from his wife, until by chance his former supervisor revealed in a public forum his own experience with a complaint. His was a back-story of high achievement, and a minor complaint had weighed heavily on him. Having colleagues or other doctors as support people was of great value, as the participants trusted that they would understand. DiT5’s experience was a little different however. The colleague she sought advice from was engaged by one of the authorities and had “insider” knowledge of how the system worked, so the advice was to “just cop it”. This was not what DiT5 wished to hear as she felt her experience was “awful, a blemish” on her career.
What was apparent was that some doctors wanted to better understand their own emotional reactions to a complaint; for example, DiT10 wrote a journal of his unfolding experience. Some participants also wanted to understand more of the process, and its impacts, by becoming alert to medico-legal events and taking more notice of others in a similar situation. Others admitted to having “tuned in” to media reports and medical-legal literature after having had a complaint. An issue that might otherwise not have been of interest to them now became one that they related closely to. DiT1 for instance had an impressive knowledge of recent cases, was aware of data in the UK and Australia relating to the numbers of complaints per year, suicide rates of doctors undergoing investigations, the names of inquiries into hospitals and individual doctors, and an understanding of procedures, rights of appeal and review, beyond his direct experience.

The next part of the analysis focuses on the ‘moral’ dimension revealed through some of the deeper insights given by participants as they recounted their reasons for going into medicine, what they thought it was going to be like and what it was actually like, particularly following their involvement in a medico-legal matter. It was not anticipated that they would ponder so deeply about what this all meant.
Part Four: Moral Legitimacy

This section introduces reflections on the underlying reasons for participants’ reactions to the complaints process, which appear to arise from the deep-seated values they hold. The experience they had was not just an event; the recollection and the reflection that accompanied the recounting of it showed that the event also had a personal, moral significance. It was more than whether they had been accused of a wrongdoing and been found guilty or innocent; it was about questioning whether having a complaint meant they had to reassess the values that they held about themselves. Hunt and Carnevale (2011) stated:

Moral experience encompasses a person’s sense that values that he or she deems important are being realised or thwarted in everyday life. This includes a person’s interpretations of a lived encounter, or a set of encounters, that fall on spectrums of right-wrong, good-bad or just-unjust (Hunt & Carnevale, 2011, p. 659).

This section of the findings focuses on the moral significance of having a complaint. It presents the deliberations of participants and what mattered most when they reflected on the complaint. The interview was an opportunity for participants to explore what it meant to them to be a doctor, why they went into medicine, what they expected of themselves, and what others expected of them. It was important to also understand that this ‘created identity’ may have been subject to various threats and challenges during the complaint process. While there are commonalities of experience imposed by the regulatory process, it was expected that not all participants would react in the same way. This would depend on how they saw themselves in their professional role of ‘doctor’, the values that they held, and their own personal characteristics and circumstances. As stated by Hunt and Carnevale (2011, p. 659): “We regard moral experience as a contextualised experiential phenomenon that is best understood from the subjective perspective of the person living the phenomenon within his or her local social context”. The interview was an opportunity to explore the subjective perspective of participants’ individual experience of having a complaint, and the values relating to who they held themselves to be. These deliberations are presented from the perspective of the ‘doctor in trouble’, beginning with why they went into medicine and their aspirations. Establishing their moral legitimacy is explained through their reflections on their values about what it means to be a good doctor, whether they saw themselves as such, and if they still did after having a complaint. Being a member of the medical community, what did they feel that others thought of them after having a complaint? Participants had various ways of dealing with these questions and the other threats and challenges from having a complaint, and what this meant in terms of restoring a sense of worth.

Choosing medicine

This question was included in the interview to give a perspective of what doctors aspired to when they chose to enter medicine as their career, and how their career eventuated and unfolded, to set
the scene for how their early expectations may have been affected by the experience of a complaint.

Some participants came from medical families (DiT11, DiT16), and it was either expected or natural that they continue the family tradition. Some ‘got the marks in high school’ so went into medicine (DiT3, DiT4 and DiT11), while others had more altruistic motivations: a cure for cancer for a relative (DiT5), or a desire to help the community (DiT6). DiT8 was the first doctor in the family and her grandfather’s advice guided her “… have something at the end of your working days you can feel [you’ve] contributed, and haven’t been a drain on society”. DiT5 spoke of not knowing what she wanted to do and went along with a friend to a talk on studying medicine at the university where she was later to study: “So I went to this introduction thing and the chancellor was speaking and she said the word “vocation”. I practically fell off my chair. I hadn’t heard that since I was at school, you know, I – I still do think there’s a strong element of that”. DiT4 also spoke of medicine in terms of vocation: “I was very idealistic and had no experience of the world – I came from a Catholic school with nuns and I wanted to do the best I could for people in the world and I just imagined that was the way to do it. And I believe very strongly in vocation in that sense”.

DiT11 entered medicine because he got the marks, and found he enjoyed it. Others spoke of what it meant to them: “I loved medicine, I loved talking to people, I loved to explore people’s stories (DiT14). DiT7 admired a senior with whom he worked and aspired to be like him and take on his specialty, psychiatry:

The [hospital] had always and has always done very well in terms of getting psychiatry registrars through the program and getting them…with a high pass rate….and I think part of that was because [supervisor] told us we had to. [H]e was a – pretty tough like that … he didn’t suffer fools. So you got used to him. He was a real professor. Not in a fuddy-duddy way. He was a commander-in-chief.

Doing well at school opened up choices. With her high marks, DiT2 was encouraged by others and her parents, “You should do medicine”, but not the school:

I topped the high school, no-one kind of realised that I was actually quite clever, even though I was a girl. So my guidance counsellor at school kind of scoffed at me when I said that I was thinking of doing medicine, and said “Teacher or nursing would be much better … you shouldn’t really aim for something that’s impossible to achieve. So I thought – well I’ll teach you, you bastards [laughter].

DiT2 had in mind to be the perfect doctor with the qualities she most admired: “I’ll be the nice obstetrician who supports women’s choices, who supports women to give birth at home, who doesn’t treat them badly”. These ideals characterised the first decade or more of her practice, until there was a tragic outcome which led to her complaint. DiT2’s experience will be examined in more
detail a little later, but when looking at her aspirations for her career when she set out, and what happened after this tragic event, she said wistfully that she “would not go into medicine now … no”. Her experience, which was prolonged and traumatic, left her so disillusioned that she no longer practises and has taken up a different career where she said she can once again feel she can be “good at something”. Participants commonly expressed this pervading sense of wishing to restore some sense of purpose and worth.

**Establishing moral legitimacy**

Participants were not asked to speak of their perceived values or virtues, whether they were “good” or “bad” doctors, whether they were blameworthy or blameless. Nor were they questioned about the truthfulness of the complaint or the veracity of their accounts. The concept of a moral legitimacy emerged as a common thread in close analysis of the transcripts, which revealed that each participant appeared to be seeking to establish that there was “good” in them, and what that good might be. For many, there was a pre-occupation with wishing to be seen, and believed, to be good at their job, or at the least that they had been so. The struggle was to hold onto that belief. What follows is an interpretation of what participants spoke of, not as what was expected of them by external standards, but what they expected of themselves.

**What is a good doctor?**

Participants did not specifically define what they meant or understood about being a “good” doctor. Some spoke of how they believed others saw them, that there was an expectation that as a doctor they were held out as different from the rest of society, and this expectation affected not only how they behave, but their place in the community. Patients were told by their GP that “I was a ‘whiz-kid’. I’ve never said that. I’m just like any other person”. (DiT11). Some felt scrutinised: as doctors at work, they had to be “superhuman” and were not allowed mistakes, while outside of work their conduct as a citizen could be suspect. DiT1 trained and worked in the UK before coming to Australia. His complaint related to his work in UK. He said:

> Doctors are held to higher standards than the general public, even in their personal lives; there’s a perception that as doctors, we have to behave in a certain way, but that invades every aspect of our lives. And you do feel that – because having had no interaction with the GMC before, I didn’t feel those eyes on me as much, but now I’m much more aware of how your behaviour is considered and, you know, at any time, even though – even if it’s nothing to do with your practice, you could be picked up for doing something that is considered a no-no by AHPRA (DiT1).

He reflected on how this affects relationships with patients such as having a “normal” conversation with them, use of social media, even having children at the same school as patients and meeting up at the soccer game; while such conduct is discretionary, others may have a different perception of it, which may attract critical opinion. He says:
I thought I could just be myself, but you can’t – you can’t just be yourself. You have to be yourself within a very strict confine of conduct and, ah, accountability. ... We’re expected to be a certain level of superhuman and we’re not, we’re just normal people. You can’t make a human level of mistakes (DiT1).

When a participant’s worth was brought into question by a complaint and the process that followed, there was a lingering fear that this meant they were not the ‘good doctor’. As a ‘good doctor’ they thought they were immune from complaints and could not get into trouble. DiT2 believed she was “immune” from complaints because she believed she had all the attributes of being a good doctor:

I’m female, that tends to protect you, because people tend to not dislike female doctors as much as they do male doctors. I’ve got good social skills, I usually manage to make the patients like me. I don’t get abusive and yell at people. I don’t get drunk and turn up at work. I practise safely. I’m an obsessive auditor, unlike anyone else I’ve ever worked with in practice. I can tell you exactly what my [surgical] rates are, and I knew that it was better than everybody else’s at the hospital … so it was just very interesting when somehow you get painted as the dangerous one (DiT2).

DiT1 also thought he was immune:

Never thought it would affect me, never thought I’d be involved. That’s one of the things, I thought I was a good doctor and I thought good doctors don’t get put in front of the GMC. And then suddenly … since then I’ve had this, you know, dramatic realisation that you can be a good doctor, a careful doctor, yet still your dog bites the postman, you know? Even if there were no issues of competence, all the same, someone has been aggrieved by something I did. You don’t realise you’re vulnerable until you’ve been through the process” (DiT1).

DiT5 had never had a complaint before, in 23 years practice: “I felt I'd done a really good job”. DiT4 likewise could not relate herself to being like some of the notorious “bad” doctors but thought the system treated her as if she were, saying, “I am not like that. There are some bad doctors out there, I am certainly not that. It upsets me that they should lump me in alongside Graeme Reeves as if I was as bad as he is” (DiT4).

From being a “good” doctor, a turning point occurred when the complaint letter arrived: “‘Cause you’d read these things, and, um, it won’t happen to me. Why would it, yeah. I’m – I’m trying to do the right thing. Of course. That’s being a doctor. You’re trained to it. In Medicine you’re meant to do no harm” (DiT8). She then felt guilty when she received the notification: “You think, ‘what have I done wrong?’”

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93 This latter reference is a story DiT1 related about a friend who was walking his dog which attacked but did not injure the postman, who complained to the GMC because the friend was a doctor, and should know better.
DiT4 took the event as an affront on her competence:

But to us, it’s, ah, almost an attack on our capabilities as clinicians. Um, because I think as medical health professionals we’re always trying to improve, always trying to be better and learn more and improve on our practice. Um, and when something like that happens, whether you get sued or a notification that it’s saying to you – it’s almost like it’s saying to you, “well, you’re not good, you’re not trying hard enough or you’re not, or, you know, that’s wrong what you’re doing there”. So I – I think that the normal response would be to, sort of, bristle up at that and get quite sad (DiT4).

What will others think of me?

When doctors express fear about their reputation, it goes to their sense of their good self, and that their future may be at stake. DiT5 said: “You know, you’re not a bad person. It seems so trivial to say that, but it did make me feel like I was a bad person”. After a complaint by a drug addict in which she, and her senior, believed she had acted appropriately, she was instructed by the Board to read the Code of Conduct, the inference of which caused her much offence.

It’s terrible [cries] to think you’re breaching the Code of Conduct, which is the basis of good practice. It is ridiculous how much it upsets me [cries] considering it was, like, years ago [silence]. It upset me dreadfully for the first six months. I couldn’t sort of speak about it without becoming a howling mess. It went with me the whole time, everywhere. I tried the whole time not to catastrophise the whole thing but um, it really goes to the core of being a good doctor (DiT5).

DiT2 was distressed by how, after a complaint, she thought potential employers would react to her and, in her case, the complaint went public through the media so she became acutely aware of how others in the community viewed her, as well as the profession and hospital:

I thought that if anyone saw that I had an investigation underway, that they – my CV would immediately go into the round circular filing cabinet underneath the desk and that they wouldn’t consider me. That I’d be immediately branded as being bad ... [it also] became difficult, ‘cause the general public knew. So every time I went to the supermarket, I felt like people were looking at me. “She’s that axe-murderer” – I used to be in the Local [Community] Group, and I turned up at a meeting once and had people say, “Oh, I saw you in the paper”. So not only had I lost my professional reputation, but it was spilling over into my personal social life as well (DiT2).

Another DiT felt very exposed: “It’s not nice to have your name in the paper” (DiT8). This was a matter before a Tribunal open to the public, with a reporter and photographer present. Many people commented on the case, as the complainant was a known person with a past that drew
public attention to the matter. There was a fear of matters going public, of being reported in the media, and a distrust about how it would be done as it is often sensationalised. Once it was in the media, there was no right of reply: “Even if you could, but even if you do, people have already made their minds up, haven’t they?” (DiT6). DiT14 was critically aware of protecting his reputation during his trial where he was found not guilty of scientific fraud:

And after 12 days of hearings, and honestly it may even make me teary now, but I remember coming out of day 2 or day 3 when they were still having legal wrangling and ringing my wife in tears and saying, “You know, they’re accusing me of being a fraud”, and it still brings tears to my eyes thinking about it and, you know, that’s dreadful – and it really – I could give up medicine if that were to be established – I didn’t think the chances of it being established were strong but it is such an attack on your absolute being and essence as a doctor (DiT14).

**Weighing it up, feeling responsible**

Several participants engaged in a process of reckoning which they spoke about as having occurred during or after the event, and even during the interview, when they looked back to consider what their contribution was to the incident that became the subject of the complaint. Even when not substantiated, some considered that there was a reason for the complaint, and searched for what that reason could be. In this sense, they felt responsible for the complaint, even though not liable. The account of DiT1 is included here at length to demonstrate both their feeling of being a good doctor and questioning this through consideration of their responsibility:

I’d always considered I was a good surgeon and a good doctor and anytime you get a complaint – which you do get complaints – anytime you get a complaint you always feel like shit. You do – whether it’s spurious, justified or not. I think there is always some degree of truth in a complaint – in the words. It may be that – that most people would consider it a spurious complaint – but within that, the reason it's arisen is because somewhere along the line the person, the complainant has felt aggrieved. So there is a reason why they feel aggrieved – they may have perceived things wrongly, but they still feel aggrieved because you’ve allowed them to perceive things wrongly. It's part of our job unfortunately as well, to make, I think, make the patients – recipients of our care – relatives understand why we are doing something and sometimes we don’t always do that. It’s not always that easy to do – you do get complaints even when you've done everything – you think you’ve done everything right, but in there will be a lesson to learn that you may have not communicated what you’re doing correctly or you may have missed the fact that somebody has not been happy and you've not had the chance to address it with them. I still feel like a good doctor, but I don’t feel as confident maybe, as I might have done before. I feel diminished (DiT1).
DiT1 also felt a degree of responsibility for the complaint:

You would be a very egotistical, ah, big-headed bastard if you didn’t take anything from a complaint. And, look, well, there’s a few of them out there [laughs]. And look, you know, people will complain and I, by no means, do I want to be pleasing everyone all the time, because that’s impossible. But they would have complained for a reason. You’ve got to think about how you behaved there as well and see if there’s anything there that you did wrong (DiT1).

The opinions of peers and colleagues

Participants not only reflected on their worth as doctors, but many were critically aware of the opinions of their peers.

**Peer review**

A matter sent for peer review in the course of an inquiry will influence, if not determine, how a complaint will be dealt with, and therefore its outcome (see Chapter Three). But a participant may find criticism by a peer very troubling for their own sense of competency and worth.

DiT1 commented: “At the end of it, a report was sent out to one person, so you’re in the hands of that one person really, as to whether or not you’re considered to be acceptable or not” (DiT1). In DiT1’s case, a peer made adverse comments about the care of the patient, and much of which DiT1 said should have been attributed to other people in the team. In addition, the comments were accompanied by a degree of criticism, stated in terms of departure from the standard, as interpreted by the peer. If the degree of departure is significant, then further action against the doctor will ensue. Of this DiT1 said:

I’ve not got any, you know, significant below standard comments anywhere – and therefore the likelihood is – they’ll say there’s no case to answer is the overall outcome anyway. But I still felt bad because there’s a report that says that I fell below standard. Just the fact that I’ve fallen below standard, you know, makes me feel terrible because I have high standards and when none of those three points are either related to me directly or one is actually false – but if you then argue, you are just going to prolong the outcome when you know the outcome will be that there’s no action. So that was – that was distressing as well (DiT1).

**Collegial peers**

One’s collegial peers can have a big impact on how well a DiT gets through the process. After a terrible outcome, DiT2’s professional partners with whom she had a long-standing relationship turned her out of their circle. The nursing team also were instructed by the hospital administration not to speak to her. She felt abandoned at all levels:
No-one contacted me at all to see how I was, and I was devastated … people that I thought actually would offer some form of support were very keen to just wash their hands and walk out and not associate themselves. I’d like to come and join the club again.

When asked why she thought they responded as they did, she said:

I think that the message that was going around the hospital was that it was my fault, that I was dangerous, and I think they didn’t want to be guilty by association with me, that they might also somehow or other be bad practitioners because they supported me in some way (DiT2).

DiT1’s hospital was asked to provide a report about him:

So the letters that came back from the hospital were extremely supportive, as expected, they basically said, this guy is a good doctor. Um, doesn’t make you feel that much better though. [Laugh]. Makes you feel better to a degree, but you know there’s still this complaint and therefore a feeling that you’re shit. No, not only that, that you are so bad, you’re as bad as those people you read about (DiT1).

Nevertheless, he said that his team stood by him the whole way through, and he felt validated by their support. Looking back, he felt that this was crucial in dealing with a prolonged and acrimonious process.

**Good or bad, worthy or unworthy**

As can be seen in these results, while the participants tended not to press the point that they were “good” doctors, some spoke of not being “bad” or not wishing to be judged as “bad”. Participants expressed themselves variously, alluding to images of themselves as having valuable and valued skills and attributes. This can be seen in the quotations from DiT4 “… as medical health professionals we’re always trying to improve, always trying to be better and learn more and improve on our practice”, or DiT1 who has “high standards”. DiT14’s allegation of scientific fraud was so antithetical to who he was and how he had built his career in service to the public and the profession that he found it “incredibly confronting and distressing” to be considered as anything but a person of his high moral standards.

When asked about how they felt now and on reflecting about feelings of guilt or responsibility for a complaint, most expressed a sense of doubt: that even though a complaint may not have been substantiated, they must have done something to have upset the patient to the point that they lodged an official complaint. If there were adverse findings, or perhaps a claim that was settled rather than dismissed, then this weighing up of being blameworthy or blameless, unworthy or worthy, bad or good, was a strong preoccupation throughout the interviews. The ‘good doctor’ they
used to be was perhaps no longer quite as worthy. Exception came from two participants, DiT7 and DiT13, who acknowledged that their behaviour even through medical school was eccentric, outlandish or troublesome and they never declared they were “good” as in virtuous or having particularly worthy moral values. It was interesting however that in speaking of their more eccentric professional lifestyles and experiences, both were at pains to tell me of their academic brilliance and achievements, as if to neutralise their aberrant conduct which later brought them so much trouble with the law or regulators. This is a presumption, but it is consistent with observations made in the interviews; it was a universal theme that participants spoke of their credentials and their positive or “good” qualities. For DiT7 and DiT13, their good qualities included having been very bright and having achieved top of the grade academic results, and reference to various activities and roles they had played in the past as mentor, leader, professional committee work and medical education.

**Being blamed, being blameworthy**

Being blamed does not always lead to feeling blameworthy. A doctor may be blamed for an adverse outcome, but they may not actually have contributed to it. As DiT1 explained, “If there is an adverse outcome, people will try to use this to blame you even though that particular thing didn’t contribute to the outcome”. However, they are required to account for their actions, and even if found not responsible or guilty for the adverse outcome, there may be other factors picked up through peer review (as discussed in The Law, the Process and Me) that the doctor will have to account for, or the complainant may seek a review if dissatisfied with the outcome⁹⁴. While these actions are in the interests of public protection and complainant rights, and doctors generally accept this, nevertheless, as DiT4 said “If it’s over it should be over”. Yet it will remain on their registration record forever. The sense of injustice was so strong in DiT1 that even though he enjoys his work, he announced as he was leaving the interview that he “really wanted to give up medicine”. DiT3 actually did, as soon as he received the report that cleared him.

In reflecting on these issues, doctors were weighing up whether they were blameworthy, or whether other factors were also at play, such as fault with the patient/complainant, other people, or the process itself that pre-judged them or judged them unfairly. Adding to this introspection were thoughts about how others did or may view them. The stigma of media exposure (DiT1, DiT2, DiT5, DiT7, DiT13, DiT14), being cast out by those whose support she relied on (DiT2), or gossiped about (DiT16) were not only a threat to these doctors’ futures (DiT2 was “unemployable”) but represented the struggle to regain a sense of their good self. Such deliberations are reflections on their moral status, as it was before, as it is now in the telling, and what it means for the future. Redeeming that sense of worthiness gives them pause to reflect if they indeed deserve it: “it’s like a seed of doubt” (DiT11).

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⁹⁴ The role of peer review and complainants’ rights of review have been explained in Chapter Three “The Law in Action”.
An existential crisis

A doctor’s feeling of self-worth, their status in the community and their sense of who they are, are all threatened by having a complaint, and this existential crisis is what DiTs spoke about of their own experience. It can be damaging if it happens early in their career, as DiT16 alluded to when as a junior registrar she felt her future was under threat because of the damage to her reputation, or DiT6, who as an early-career specialist was seriously contemplating giving up medicine. On the other hand, DiT3 had enjoyed a blemish-free long-standing career at a senior level up until the time of the complaint; DiT2 also as a senior specialist who believed she would never again be “good” at her craft; and DiT14 as a very senior specialist who would not retire while his reputation was at stake, indicate that for some doctors the fact of their long-standing service, and status, has been challenged can likewise be “incredibly damaging”. People respond differently, and this is partially accounted for by their different values and sense of identity as a doctor.

Conclusion

There was agreement among participant accounts that being a doctor carries with it an identity that defines to varying degrees how they see themselves. A complaint represents a moral challenge to this identity. Participants provided a picture of some of the influences that brought them into medicine and what they aspired to be: good doctors, whose sense of self as doctors in their professional and personal roles is very much who they are. Having a complaint brought these doctors to reflect on what sort of doctor they truly are: a bad doctor like others who have attracted the contempt and ire of the public and the profession, or someone who always considered themselves to be good and are hanging on to the thread that they are still that person. The next part of the chapter will look further into the threats and challenges to this thread of hope.

Just as doctors sought to neutralise the circumstances contributing to the complaint, so they also sought to neutralise the impact. Participants were deeply affected because of what a complaint represented in terms of threats to their reputation and the fear of loss that a complaint may result in. It gave them pause to consider what it meant to them as a person who identified as a good and worthy doctor which, in turn, was a reflection on their worthiness as a person. For these participants, neutralising the impact of such considerations appeared to be a natural part of the process of recalibrating the sense of self and the threats to it.

There was no suggestion by participants that the process of recalibrating was able to fully restore their former sense of self, their attitudes towards their own career, to the profession, to their patients and to their commitment. Most spoke of how it had changed them, changed the way they practised, and changed their attitudes towards the profession. The next section will also explore what these changes were, and doctors’ reflections on why this may have been so.
Part Five: Changes

The previous section considered how participants attempted to make sense of the complaint, what may have been the motivator or “hidden agenda” behind it, what it meant in terms of their own practice, and more significantly, whether the complaint raised questions about their values and worthiness; that is, their moral legitimacy.

This section considers how doctors in trouble reflected on the experience, on balance, in both a personal and a professional sense. There was a range of responses, from one who saw the experience as a positive one because it made him consider how he may better relate to his patients (DiT11), to the doctor who declared he did not go into medicine “for all this” and had his name taken off the medical register (DiT3). These thoughts infiltrated the participants’ thinking about medicine, medical practice and their place in it, and how this may have consciously or unconsciously translated into changes in their practice, attitudes and behaviour.

Reflections on the experience

The DiTs reflected on their recovery from the complaint experience in different ways. DiT14 pondered over how long it took to recover from the ordeal of a 12-day trial, which was dismissed by the judge. Sometime later, at interview, he was still teary about its impact on him:

You can see it in what I tell you now – it’s something that’s still there and it doesn’t take much to stir it up, but I’m by nature a reasonably optimistic person and, you know, my way of dealing with a lot of stuff is to say “Shit happens.” But it doesn’t mean it’s not there – I can still become quite emotional about it and I don’t pretend otherwise. I think as I’ve got older, I’m more ready to acknowledge being emotional about things than the abrasive young man that I may have been in my 30s [laughter] (DiT14).

Recalling the experience brought up strong emotions for many of the participants, and their candid responses provided some insights into how it affected them. DiT1’s admission of his own vulnerability extends to a universal recognition of people’s vulnerability that becomes evident when undergoing a process that is traumatic. But DiT5 was more optimistic: “I’m just hoping I can stay where I am ’cause I really enjoy what I do. Despite all the things that have happened” (DiT5). DiT13 spoke about the process changing him: “I’m a completely different person to the one they were talking about, then and there.” He was reflecting on how he was described at his Tribunal hearing, as quite a different person from who he was three years previous to that (it took three years to bring his matter to a hearing). The consequences meant he could no longer work, but he felt he was being judged as the person he was at the time of the complaint, not who he was at the hearing, nor who he is now. He reflected on this at length:
I was just so acutely distressed after being told I couldn’t work, that I was some sort of bad doctor, you know, that just totally floored me, and, um, you know, I just, as I said, I was ready to kill myself, I thought oh this is terrible, you know, what’s my life come to?

I think I could have been treated with a bit more compassion, because the irony was for the six months up until that day, I’d been working without any event – even though I was quite distressed, you know, and then suddenly they say, “No, you’re unsafe now to practise”. Well, what’s happened? What was it yesterday when I did those [procedures at hospital]? Why was it okay to work then and now suddenly I can’t? Don’t you think you can have an investigation and let me continue to practise? (DiT13).

He then mused: “The public is well and truly safe from the likes of me at present. You know, he said I am not a bad person, I was a sick person and I’m getting better”. At the time of the interview, DiT13 had recovered from drug and alcohol addiction. He was able to return to work with conditions, but while undertaking rehabilitation, he was stood down. So even though he is now sober, he is virtually unable to obtain sufficient employment to make a living, and his future is uncertain.

Other participants, regardless of the outcome of their inquiry, did not come out unscathed either. Even DiT10, who had a very minor matter relating to his supervision of a junior resident, realised that, having dwelt on it from time to time ever since, it affected him more than he acknowledged at the time. For DiT1, it was important for him to have his story heard, as he grappled with conflicting thoughts about enjoying his job, yet not being “as confident”, and as the interview drew to a close, declaring that he wanted to give up medicine. DiT9 was happy to say she still enjoyed her job in spite of what had happened.

It could be surmised that as a self-selected cohort of participants, the participants would not have volunteered to be interviewed if they had not wanted to speak about it to a stranger because it had affected and unsettled them, even in some cases several years after the event. For DiT8, the event had taken place some 12 years before the interview, and she was cleared of any wrong-doing, yet the event clearly unsettled her still at the time of the interviews. Whatever the outcome, participants found that not only had they been affected by a complaint, it had changed them.

**How it changed my practice: thinking defensively**

Some participants felt the experience made them think defensively and be more cautious about patients, how they interacted with them and how they treated them. DiT1 noted how his manner towards patients changed: “I was a little hesitant, I’ll say, in talking with patients, much more formal. I don’t think I was as friendly with the new patients as I would have been, had I not got that letter” (DiT1).
What came across was that there was a certain caution about some patients and a generalised belief that there will always be difficult people they may have to deal with:

The nice patients are still nice patients. The-not-so-nice patients I've been suspicious of. So if I don't get a nice rapport with people now, I'll walk them out the door without asking them if there's anything else that they're not happy about (DiT1).

DiT4 avoided the not-so-nice patients altogether: “I've moved out of that pool of very difficult patients”. DiT8 took a more pragmatic approach to patients:

Well, I work on the principle that most people are very reasonable and I heard this statistic, that 97% are reasonable and there are 3% turkeys out there and whatever you did, there would be some people, they'd complain. So no, it doesn't affect me with patients. In fact, people that have had a problem, um, usually, as long as you take an interest and are not seen to be walking away – they often turn out to be very grateful and they – and they become almost friends or they become friends because they realise it's not a perfect world but if you try your very best to try and sort them out they're appreciative. What they don't want is being abandoned or people try to bluff that there's not a problem when there is (DiT8).

DiT17, who stopped practising to preserve her health after being diagnosed with a chronic medical condition attributed to work stress said, “I think you need a bit of a thick skin sometimes, and my skin wasn't thick enough, and I think it was starting to affect my health” (DiT17). DiT16 said:

I guess I’m less likely to hold my ground now about things like investigations and antibiotics. Like if [a patient] is adamant or if a patient's mind would be put at ease and I'm more likely to work with them, even though I disagree with what they want (DiT16).

DiT16’s inclination was to give in to patients’ demands, against her clinical judgement, and she was aware this was not ideal. It can cause problems either way, as DiT15 experienced when she was blamed for over-servicing, while DiT16 was blamed for not doing so.

When a patient of DiT8 was seen to be obtaining a copy of the notes and the discharge summary, it made her think “whether he would find something in that that he could complain about”. She thought this because she was aware he was not happy with how she had treated him, and was not surprised when she later received a complaint. She reflected on how this had changed how she recorded her notes, and why:

I must admit I tend to write my notes these days with the view that the person who you write about could always have a look at them, but it does mean sometimes you can’t put down really what you’d like to say because the notes really are not for the patient
as such. They’re for other doctors who are going to be picking up the key. So they need to know certain things, and if you can’t put them down, it’s not good. When I was a little medical student, I just wrote down everything that the patient said to me and everything that everybody else said to me … write it down verbatim. I filter a lot more now …

Flashbacks and feelings of nausea when seeing patients with the same condition as the one who complained, fears of another complaint, caution about patients’ motives permeated some DiTs' daily practice since having a complaint. For DiT5, encountering patients with similar symptoms as the patient who complained about her triggered defensive thoughts:

It wasn’t that difficult to go to work, but I’d get a sick feeling if I had to see someone with back pain. And back pain is incredibly common and I’d have this, sort of, nausea feeling and then I’d, sort of, think what tests do I want to do, stop thinking yes and no, all decision making you know, because that was one of the huge complaints that I should have done an X-ray, which is actually never a test indicated except if there was trauma – so this would, sort of, swirl in my head for weeks afterwards – you’ve got to put that out of your head – it’s so ridiculous … It’s like a seed of doubt. Even though I knew that it was silly but I couldn’t stop this, sort of, second guessing. It was like being in a whirlpool. It sort of permeated every interaction and I have to break bad news all the time, and whether I had done something wrong was just like a cloud, was really hard to get out from under (DiT5).

Just as DiT5 became wary of patients with similar symptoms, DiT8 became similarly fearful:

Each case you look at, you know, when you’re going through you think, God, could this be one? You think no, this doesn’t seem to be and you get to – well, perhaps it’s the next one. You know, each case you look at you think, oh no, this might be my – my Waterloo, you know. You just wonder (DiT8).

For DiT4, there were reasons for her fear that arose not just from the interaction with the patient that had resulted in a complaint, but it was the continued focus on the alleged deficiencies in her care that reinforced and then embedded the fear. Although she said the litany of issues raised in the complaint was readily refuted, they were given greater weight by having to respond to each in detail. So it is not only the complaint that sowed a seed of doubt, it was the “forensic detail” of each component of care, treatment and decision-making required to respond to the complaint that gave it significance. Knowing how she responded would affect how the matter would then be dealt with in the inquiry, such as how it would be assessed and what would happen next. Even though she believed her actions were correct and defendable, there was uncertainty about whether the authorities would agree. This deliberative thinking carried over into everyday care of other patients;
that decision-making became laboured and she had to again question her own judgement which for years she knew had been sound. It appeared like that seed of doubt had grown roots.

Fearing another complaint, DiT5 found herself spending extra time with difficult patients. For DiT4, there was an emotional toll that affected her personal as well as her professional relationships:

When things start to build up, they have consequences to me in my personal life – I might get more irritable about things, more angry about things, more unreasonable with other people, personally I mean. I just do more, I just take on more, I do more and then after it, that’s when irritation builds up and anger builds up and things like that. Probably I was much more – I was more tetchy with staff as well, like I was more what I might call exacting (DiT4).

**Complaints can make a positive difference**

The above accounts indicate that participants had reflected on how the experience motivated them to think about themselves as doctors. While most related how complaints affected their behaviour in negative ways, DiT11 alone felt the complaint made a positive difference. Looking back at the complaint, he considered how he could have done things differently to prevent the complaint, which was basically about his manner of communication with an older patient. As a result, he had improved his consultations, and although he acknowledged that it is not possible to please everyone all of the time, “it’s the way you go about not pleasing people that’s important”, and having clear documentation. In retrospect, DiT11 felt that the complaint had made him reassess his own self:

My inherent personality is not going to change. I felt that it had been, ah, brought down a peg. Oh, I’ve learnt from it. I’ve improved what I do consciously. And I think, you know, now it’s, sort of, ingrained into what I do all the time. So I think it’s made me a – a better person, um, but also it’s, ah, um – oh, it was bloody stressful for those few months [laughter] (DiT11).

As these reflections show, participant doctors generally recognised that they had changed the way they practise since having a complaint. What some did not so easily recognise was that even if they had not consciously made practical changes, their attitudes had shifted and this was reflected variously in loss of confidence and commitment, and in caution about some or all patients. Loss of trust in one’s competence appears to have underscored some doctors’ confidence in themselves, and loss of trust in patients appears to have explained some doctors’ caution.
Changes in attitude to profession and career

Weighing it up: what is reasonable?

Earlier it was shown that some participants felt that being a doctor put them in a position of not being seen as “normal” and not being able to lead a “normal” life, that they are held to a standard above that of the general population. They also expressed the view that there are high expectations of them that are sometimes not achievable, and there is little tolerance for perceived error. The DiTs expressed fears of not being “good” doctors, but they ponder if they can be “good enough”. Looking back over the experience, some reflected on what is reasonable, both for the profession at large, and for them as individuals. The experience of a complaint left a profound impression on DiT16 as a junior doctor, saying “The first thing you get pretty upset or a bit angry about what people say about you, but then you have to address exactly what it is and realise that just because you think what you’ve said or what you’ve done is okay, doesn’t mean that other people think it’s okay”.

Asked if she had actually absorbed the complainant’s dissatisfaction with her being less than perfect, DiT4 said:

Hopefully I learn from these things but there’s something about me which caused this. Because certain things about me would provoke reactions in other people and there are things about all of us which if I look at myself and my colleagues, we’re all quite different in personality and all those sorts of things. The system deals with the person who makes sporadic errors and in a way systems demonise people too as well, because it’s sort of saying this is a shocking thing that they’ve done but their whole life’s not shocking. But at least at the time, it must feel to them like that’s the case.

DiT4 and DiT16 recognised that even if they think they are doing a good job, not everyone will agree. Having said that, she acknowledged that if she could upset one person, she may upset others. However, because a doctor had done one “shocking” thing did not mean it applied to their whole life.

Will it ever be the same?

As has been shown, for many participants, life and practice will never be the same after a complaint, and for a few the change was significant. DiT3 is no longer a doctor as he resigned, DiT1 wants to resign, DiT2 cannot face being a doctor again so has taken up a different profession, DiT13 is virtually unemployed and DiT17 retired early due to stress-related ill-health. Unfortunately, as noted in Chapter Five, one doctor who wished to be interviewed suicided before this could be arranged. Others remain in practice and some of them remain profoundly disturbed by their complaints experience, while others see it as one of those experiences that they would rather not have had, but did.
After a court hearing, DiT5 wondered if life would ever return to normal:

I kind of expected I’d walk out and the world would suddenly be right again, but it’s still not. I mean, I still have to write every time I apply for a job, have you ever had restrictions on your practice? Yes. Have you ever been investigated by AHPRA? Yes. So it’s never going to go away, and it still feels like I have to apply for seven jobs before I get one.

DiT14 said “the experience still left a little bit of its toll. But I think all these things do over a lifetime don’t they; it’s one of life’s experiences. Just caution, plus, plus, plus”. Thinking about his views on medicine, he said:

Ah, a bit more cynical but in the end, I just decided that you could only be true to your own standards and – and in the end there’s – have you seen that great poem called The Man in Mirror? No. There’s one, ah, it’s called The Man in the Mirror and he’s the one you’ve got to please. You know, because he’s with you to the end and you – you can fool everyone else but you can’t – you can’t fool that guy. So that’s, um, you know, what I’ve sort of – the philosophy I try to work – work through with this, you know, and you can only do your best in good faith. So it’s made me cynical about these sort of investigations, these procedures. It’s not really affected my practice in a sense because you can’t practise looking over your shoulder the whole time, otherwise you would never get anything done (DiT14).

DiT1 was being partly fatalistic, partly pragmatic that it was inevitable there would be more complaints: “Even a small one makes you feel bad because you always think the worst”. While liking his work, he intends to resign from medicine as soon as he is able.

Being realistic about the potential for further complaints, DiT11 reflected:

I don’t think it will stop me from doing what I do. But I think if it happens again and again, you have to think either I’m not dealing with it properly or there’s something going on. Um, yeah, I don’t think that specifically will make me stop working. Because it was right at the start of my career, it’s – you, sort of, roll with it. If there was notification that something happened really late in the career you might just think, well, you know, stuff it, why put up with the stress, you know, whereas at the start you are a bit more self-deprecating, I think (DiT11).

DiT4 thinks age gives one perspective on the implications of complaints and errors on doctors:

I think the more you get of these things the more at my age you normally feel look, do I really want to do this? Do I really want to put myself through these risks and that’s one
thing I’ve noticed as I’ve got older, I think if I made some error at the end of my career which put a blight on it, it would be something which would be pretty well impossible to get over. I mean a complaint which went really seriously, and all complaints have got some truth in them. I do think that, you know, it’s not even if you don’t agree with it, if you think it’s unfair or whatever, and it would be really difficult to get over that. I guess it’d be hard to get over it any time if you had some legal case, a high profile case, all over the news (DiT4).

Reflecting back on a bewildering experience with a complaint, DiT5 spoke about why it took her a long time to arrange the interview (it was put off a few times over a period of nine months), saying she thought she had put away her feelings about the matter into a “little box” and was now ready to talk about it. Although the patient was not known to her prior to the incident, she had felt she and her staff had gone to extra lengths for her as they had made a devastating diagnosis and they felt distressed for her. The case therefore stood as exceptional, and when there was a complaint, it was very distressing. She thought she had recovered sufficiently to talk about it, but surprised herself in the interview that the raw emotion quickly returned to the surface, out of “its little box”, so she wondered if she would ever be able to put it away, back into that box:

I did actually think it was in its box until this morning and I burst out crying again. It is funny because I thought actually when I replied to you the first time, um, well, I think actually your letter said that, you know, that this can reawaken things and I thought, no, no, I’ve pretty much [laugh] got that sorted now [laugh]. I think it’s your consent forms said that, I think, I remember reading something in the long thingy – in the information. Yeah. I remember reading that and thinking no, no, I’ve got that one pretty done and dusted now [laugh].

But it was not “dusted”:

It is funny because, um, I have, ah, one of my colleagues who works at (regional city), I mean, she was so invested in the process, when the Medical Board letter came she sent me a bunch of flowers which had a card that said, “Don’t let the bastards get you down.” [Laugh]. And she often says, “Oh, you know, I had to do something today. All I could think about was your letter” [laughter]. But I think she was more damaged than I was in the end, it was, like, God, you have to let that go, it wasn’t even your complaint [laugh].

Ridiculously since that day I – and I actually received many letters of thank you and I have never saved any of them and since that day I now actually save letters of thank you to, sort of, say, you know, you’re not a bad person [laugh], you have that little stack. I mean, it – it really upsets me to even talk about it [cries].
Asked if this helped her put it into perspective, she said: “It was very nice. I kept the card on the noticeboard for about a year and a half” (DiT5).

Still young but not able to work, DiT13 became philosophical about his “long journey” as a doctor:

You know, I’ve had some good times and I’ve had some bad times, but, you know, there’s more to life than work. So, and but more importantly hopefully I can help others recover from their illness. But in some ways, it is the best thing that’s sort of happened to me, because now I’m living, you know, living a life of sobriety and I tell you what, that’s fantastic. To get up every morning and I don’t feel guilty about what I’ve done the night before.

Summary
A sense of vulnerability is evident in some of these accounts as they relate how the experience of a complaint changed the way they thought about how they practised, their patients and their future. Many made changes that they knew were not in their patients’ best interests, or at least, they contemplated such changes. Caution about patients, revived fear when attending a patient with a similar presentation as the complainant, cautiousness when making decisions about ordering tests, or about diagnosis, treatment and care. Some make more meticulous notes or are more cautious in what they actually record, others are now more conscious of how they communicate. Such actions are often positive, for the good of patients, as well as being more protective of the doctor. But when defensiveness and fear get in the way of sound clinical judgement, it can have other costs.

The recovering addict DiT13 had seen four of his fellow addict doctors in rehab take their own lives, and he is the one remaining of his cohort. He knows how close he came to the same end, but while there’s life, there’s hope as he contemplated a life that can only improve from now on. But the process of managing his addiction by the authority has left him scarred and bewildered: while being grateful for having been a catalyst for recovery, the process left him without income, without work, and with a tarnished reputation. His words: “But my journey is my journey, and I always wonder, you know, sliding doors moment, what might have happened that night if I hadn’t gone out\(^\text{95}\), but, um, you know, things happen and you can’t change the past and you’ve just got to deal with it”.

DiT5 now keeps all the complimentary letters, cards and notes from satisfied patients, which she would have once appreciated and then discarded, in a special box that she opens when she has doubts about herself. Her tears flowed when speaking of such memories, and surprised her as she thought she was over that now. DiT15 wept throughout the interview, as her emotions caught her during recollections of what the process was like for her, and DiT4 had to pause as she recalled

\(^\text{95}\) He had gone out that night and became embroiled in a police matter, which led to an AHPRA notification.
dealing with a letter from the authority requiring a response to a complaint within a few days, at the same time as her father passed away. DiT14’s tears welled up as he recounted how he had called his wife during a break in court proceedings, to share with her the horror of being accused of fraud, which if found to have been proven, would have spelled the end of his career. But not only that, such an accusation was so contrary to his personal values, it was unthinkable.

Fear lasts a long time. The incidents recounted by some of these doctors happened many years ago (for DiT8 12 years, though most were in the 3-6 year range). What stood out was that unresolved emotion from that time remains under the surface ready to bubble up during the recall of the event. For some, the fear of a repeat of such an event was intolerable, sufficient to give thought to retiring early, or even quitting.

The future
How a doctor reconciled their situation affected how they saw their future, as above. DiT3’s future had begun, when he announced before the interview that he had quit medicine, just after the final report came that found him not guilty. He had been considering this for some time. When asked how it felt, he said:

I can go and be really mad and get away and not have to worry. And it’s actually – it really is – it’s interesting. I’m in the process, I’m still going through the process you know, and it’ll probably take a year before I can settle down to that new identity. But it’s – I’m much happier – much more relaxed, energised. All of those sorts of things (DiT3).

While he was not in a position financially to give up medicine, and although he enjoyed his work, DiT1 said medicine was no longer the same, he had lost the joy. “You know, I really want to give up medicine and do something else.” DiT8 was profoundly affected by what happened to her friend and colleague, whom she thought had been treated grossly unfairly by the regulator: “I’m still happy to be in medicine but I do think of my friend who just threw in her towel and said enough’s enough. She went and became a potter.” DiT17 presented as a doctor who felt quite comfortable that she had not been judged as “bad”, nor that the complaint had any substance to it. But she said the complaint spoke of her as a person she did not recognise, and nor did anyone else (her peers). So she retired. She said how much she missed her work, feeling restless and having a good brain that she wasn’t using enough. “It’s still hard to get used to. It’s still hard, because I’m still young” (DiT17).

At the time of the interview, DiT2 was contemplating giving up her medical registration, but could not quite resolve herself to not ever doing clinical work again. She reflected on the disjuncture of the complaint:

This has literally stopped me in my tracks, I’m no longer practising, I’m effectively unemployed and I don’t know what to do with myself. It still feels slightly dangerous.
So, you know, every time I walk through the front doors of a hospital, anything I can do at any point in the future, could turn back into this process again. I was going to drop my medical registration ‘cause I didn’t want to have to do this again. Honestly, if they had designed something as psychological torture, it would look like what I’ve been through. I have to find the reality for myself as to how I’d define myself as a professional success and whether clinical work is in there or not. The initial thought was, oh, well, they’ll investigate it, I’ll get an answer as to whether I can practise or not, and then I’ll move on, but that – none of that had happened, so I had to figure out what I was – who I was and what I was doing (DiT2).

So she took up teaching as she had to be good at something.

Do I really want to do this? pondered DiT4, the doctor who was so committed to medicine as a “vocation”, but for whom as a school-leaver could have taken up a profession in music. Now she spoke of returning to her music, reducing her hours in practice and performing once again.

Looking at how a complaint may have affected a doctor’s future, it could be said that as the interviews took place a few years, or at least several months, after the complaint was finalised, the future had already begun to unfold. As a moment in time in the continuity of a doctor’s life, it is difficult to predict what may actually happen to a career trajectory, but the interview was an opportunity to explore the participants’ thoughts following the event and how it had already shifted the lifetime trajectory they had anticipated before the event. During this time period, participants had indeed moved on with their lives, having adapted to their altered sense of self, albeit not necessarily accepting it. In such cases, one can only surmise that they will continue to function, they will continue to practise, and as DiT2 said after her first tentative steps back into medicine following the traumatic experience of an unanticipated death and subsequent standing down from practice, “I did two weeks and that was okay and no one died, and that was gratifying”: the catastrophe that she thought may happen because it had happened before, did not. But it changed her all the same.

There is no doubt that some doctors’ lives were significantly changed, from those who resigned (DiT3), retired (DiT17), felt forced out (DiT2), or were on the edge of employability (DiT13 and DiT7). Others doubted they could go through this again (DiT5), or whether continuing in medicine was really what they wanted (DiT2), though DiT5 and DiT8 still loved their jobs, in spite of all that has happened.

Conclusion

Returning to the reasons the participants went into medicine, it was not to be the doctor that this chapter reveals. Even one such as DiT11 who “got the marks” and was known as a “whiz kid” by his referring GPs, had a strong commitment to excellence in his practice, and took the complaints
experience as a call to reflect on how to improve his practice and his communication with patients. DiT2 was to be a “good doctor, a caring doctor” and could never have foreseen that later in her career, she found that being a good doctor was not good enough. Others such as DiT6 never believed a complaint would be made against him, until it happened.

This snapshot is not sufficient to conclude that complaints destroy doctors’ lives or that they have been so catastrophic as to permanently damage them; however, these doctors had a reason for telling their story on this occasion and they were all variously affected, some in positive ways, others in more negative ways. But it cannot be presumed that all doctors would react in the same way. In the next section, the testimony of industry informants provides useful insights into how the complaints process affects doctors, and why this may be so.
Section Two: Industry Informants

Introduction

Seven industry informants (IEs) who provide professional support to doctors in various capacities in the complaints process were invited to participate in the study. These included private psychiatrists and medico-legal advisers in medical indemnity insurance companies. The purpose was to obtain their perceptions of what doctors experience, their insights into why this was so, and their perspectives about the complaints process. This is positioned as a counterpoint to the DiT narratives. Of the seven invited, only five proceeded to interview: one did not respond to two follow-up communications; the other became unavailable.

The role of IEs 1 and 2, as non-practising general practitioners, is in medical indemnity insurance handling claims and complaints. An important part of their role includes advocacy and advising the company on medical matters, but an essential function each has adopted is a more pastoral role in supporting doctors through the complaints process. This may involve being attuned to doctors’ emotional states while they are assisting with medico-legal matters, or being available to advise when a claims manager or solicitor senses that a client member is in need of emotional or psychological support. Their roles mean being alert to potential or actual problems, and taking appropriate action if necessary. The latter may be offering the chance to talk, giving advice about seeking professional help, or actually intervening if a doctor is at risk, such as referring them to a psychiatrist. In rare instances, a mental health team may be asked to attend a doctor at serious risk of self-harm.

The role of IEs 3, 4 and 5 is as psychiatrists, whose patients include doctors who are suffering mental distress or illness. Some of the latter will have been referred to them by the Medical Council and is a condition of their continuing registration. Others are voluntary patients who have either initiated treatment themselves or professional, clinical or personal associates have recommended it. The goal of these relationships is therapeutic. A third source of doctor-patients are those referred for forensic psychiatric assessment for court or Tribunal matters, with the purpose being to assess psychiatric disturbance, other related conditions or drug and alcohol dependence that may be affecting capacity to practise or that is believed to have been associated with a competency, conduct or criminal issue. These doctors will often be called to give expert evidence in matters before the court or disciplinary proceedings.

It is on the basis of these roles that these IEs were invited to participate, and from their perspectives that they provided the following observations and insights.

The interviews

Participants were invited to nominate their preferred time and location for the interview. This was usually in their workplace: private practice rooms, in a hospital or clinic, and in the offices of
medico-legal advisers and solicitors. One participant was interviewed by telephone as the distance was prohibitive. A full guide to the interview questions is provided in Appendix 7. Box Six contains a summary of the key topics covered.

**Box Six: Guide to interview questions with IEs**

<table>
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<th>Introductory questions</th>
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<td>Role as a doctor providing support to doctors, and in what context support is provided</td>
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<td>Experience of complaints</td>
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<td>Comments on how complaints impact on doctors’ health and wellbeing, and why</td>
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**Analysis**

Interviews were prolonged and at times went “off topic”, given that interviewer and interviewee had common history in the industry, anecdotes and topics not directly relevant arose during the conversations. These peripheral topics are not included in the analysis, which is confined to the key categories identified from the testimony of the DiTs. The exception was that experts were neither asked nor offered insights into how the experience changed doctors. Other insights pertinent to the core objective to understand doctors’ experience of complaints are also included.

To reiterate, the key concepts that are included here are:

- Part 1 The complaint experience
- Part 2 The law in action
- Part 3 Getting through it: telling others
- Part 4 Moral legitimacy: the good doctor

Analysis for this group relied on these four concepts, so presenting the data involves identifying text from the transcripts which “fits” these topics, and where there are anomalies, these are addressed as this process proceeds.

**Motivation to participate**

IEs were not specifically asked why they wished to participate; each gave their time willingly and generously, so it was clear they wished to contribute. Each was expansive on how their role contributed to the support of doctors, and in some cases, how their role contributed to advocacy for greater recognition of the impact of medico-legal processes and procedures on doctors’ wellbeing.
and health. IE3, a psychiatrist, spoke of earlier days of the investigations process when it could take four or more years to finalise a matter:

I became aware more and more of the impact that it had on doctors. And I saw a number of doctors who were sent to me for treatment because they were depressed, they were distressed, their alcohol problem had exacerbated, their relationships were in trouble, they were suffering the effects of being involved in what, in those days, was a far more prolonged process of investigation and prosecution (IE3).

As professionals who have worked with DiTs, the IEs were motivated to share the benefits of their experience and expertise, with the view that by sharing their insight into the reasons for doctors' distress, they may indirectly influence how the regulators may ameliorate the adverse impacts.
Part One: The Complaint Experience

IE3 viewed the event for doctors as “an existential crisis”, “traumatising”, “overwhelming”, and “distressing”. He stated that “It’s just all covered by this big, black event, and over time it never goes away so you’ll never be the same”. IE2 stated that “Some of them get really angry” and that DiTs experience a great deal of fear: “they are actually at a fundamental level worried that they’re going to lose their house, or their life savings or whatever. The other big one is the loss of face and the publicity”. IE2 explained that in spite of being covered by their medical indemnity insurance, potential loss still causes anxiety. She said that doctors are also fearful about the peer review process and that any criticism will reflect badly on them96. Speaking of how they react to a performance assessment97, IE2 said: “So how do they take it? Badly. Do they get the shits? Yes. Do they get depressed? Yes, they are depressed, they are miserable”.

IEs1, 2 and 4 stated that doctors fear having conditions placed on their registration, and that this will be known to the public since conditions are listed on the medical register which is available on the AHPRA website. Loss of confidence was a major concern, for example: “Doctors need to have confidence in their own decision-making skills to get through the day-to-day work” (IE2). She said when a matter is prolonged, this loss of confidence, and the “threat to their core self” is especially significant: “You need confidence in your decision-making and you need to be able to trust the doctor/patient relationship”. She felt when DiTs encountered a major complaint, “that trust is eroded for a period of time – and how long depends on the nature of the complaint and the doctor’s own persona, their ability to see it for – you know, to get a perspective on it and their ability to compartmentalise” (IE2).

IE4, a psychiatrist, said that some doctors get very distressed, and that he can only treat them symptomatically while they perceive themselves to be under attack. He considered that those who have been through the process end up with a level of post-traumatic stress disorder, characterised by intrusive worrying that it is going to happen again, that they become hyper-vigilant with panic attacks, sleeplessness “because they fear the environment is dangerous”. IE3 commented on the experiences he had witnessed in those who seek treatment from him as a consultant psychiatrist:

I think individuals respond very differently. I mean, some people go down the pathway of feeling shamed and becoming depressed and withdrawn, embarrassed and unable to face people in their community or beyond. They don’t tell their wives, they don’t tell their husbands, they don’t tell their children; it’s based on shame and with that becomes self-incrimination and embarrassment, and it can be to a profound extent.

96 The peer review process, as described in Chapter Three, can play a pivotal part in the determination of what action if any will follow in an inquiry into a complaint: serious criticism may lead to an adverse finding against the doctor.

97 A performance assessment is a non-disciplinary pathway involving an assessment of a doctor’s practice in situ by a group of peers appointed by the Medical Board. A report sets out issues of concern that need to be addressed by the doctor within a given timeframe. Failure to meet conditions may mean that they will be referred for disciplinary action.
Other doctors become quite belligerent and they don't look at what the issue is, because they don't know what its implications might be. They don't have a sense of balance or appreciation of what might happen. So they see themselves under extreme attack when they may not be, and the response is an aggressive belligerent one. The notification (of a complaint) can be a tipping point for them (IE3).

While experts observe various responses to the complaints experience, there are some common threads that accord with other findings. Shame, embarrassment and fear are expressed as anger, distress, sleeplessness or becoming withdrawn, and such responses can overwhelm doctors' capacity to deal with the complaint. They are reasons not to tell others or to face their community.
Part Two: The Law in Action

Advisers are integrally involved in the process as they guide doctors through their defence, and they describe how doctors respond. IE1 stated:

So sometimes they will quite – almost consciously – sabotage the whole process, and in that way they won’t meet deadlines, they won’t answer your phone calls; they turn up to some hearing and be surly and difficult, whereas if you could just get over where they were at, they could present in a different way. I think it’s part of their distress about the process and maybe it is their shame that they can’t face what’s going on and they can’t interpret it, they can’t make sense of it, they’re confused – they’re a bit like a rabbit in a headlight, so, they will resist the journey, if you will, unless you can make it clear and understand where they’re coming from, and acknowledge it.

IE3 described a client/patient who was facing a Tribunal hearing:

And I have a case of a doctor I’m treating at the moment who is filled with terror – he really is out of his depth in this environment and the amount of fear and the amount of anxiety and the effect of this investigation upon him because of personal vulnerabilities that he carries, it’s really been awful to witness, and a lot of time I’ve spent with him trying to get him to understand the process that he’s involved in, and put it into some sort of reasonable perspective. I mean, it’s almost like a public execution was going to follow and he was going to be in the forefront of every publication, the whole world would be looking at him, he would be disgraced, humiliated, all of his standing as a good practitioner. Clearly what he did was wrong, he had no problem with that. But he still was terrified. He is terrified about the process, and if that had been managed along the way, I’m sure he will never offend again. I’m sure of it, and I’m sure his skills are pretty adequate. So the public protection issues are almost non-existent.

The sense of powerlessness and bewilderment with the process is expressed in these accounts of how doctors progress through the process.

An adviser’s role is to advise and assist with defence, but they find they cannot do so effectively if emotions are getting in the way, so their role is also to recognise distress and handle it. As they are not the treating doctor, there are limits to this role. But being experienced in their primary role, they are “following that narrative and you can pick the clues” (IE1). They may then arrange appropriate
referrals for psychiatric care if especially distressed, or to one of the specialist doctors' health services available, such as the Doctors Health Advisory Service.\textsuperscript{98}

The perception of unfairness

DiTs' accounts presented a picture of aspects of the process that left an impression of unfairness. The IEs have a broader perspective as they have all worked within the system for many years in various capacities. But there were some similarities. IE4 said:

The system is stacked against us. There are multiple levels of – that are grossly excessive, expensive, overkill level of scrutiny and legalistic bodies there to, you know, punish doctors. Look at New South Wales: AHPRA, Health Care Complaints Commission, the Medical Board’s now called Medical Council of Australia. Then you’ve got other bodies. You know, there was recent instance of psychiatrists where the Police were involved. About – about boundary violations, alleged. You know? There’s these consumer type groups: the Mental Health Commission. There’s no other word for it. It is clearly anti-doctor.

IE4’s perspective is at odds with IE3’s, who did not at any time express a view that the system is anti-doctor, and in fact, he is highly supportive of the system. This, however, did not detract from his perspective that doctors fear the process and are profoundly affected by it. There was a view that lawyers misunderstand that doctors are not like them, that the process is adversarial, which is counter to the culture of medicine. As IE4 stated:

If someone’s in the middle of litigation, you can only treat them symptomatically. You can’t expect recovery while they’re under attack. Or they’re perceiving themselves to be under attack, or they are under attack, you know? Litigious processes are adversarial. And it’s counter culture to doctors. Doctors feel like their work and their patients and they are under attack by the legal system, by an adversarial process, which is trying to work things out in a non-medical arena.

A complaint may raise other issues

The issue that triggered a complaint may not have been proven, but in the course of an investigation, other issues may have been identified and attract a peer’s criticism, which will have a significant bearing on how the matter progresses. Participant DiTs perceived this as unfair as they do not know what they are dealing with, and this adds to the sense of the unknown. IE3 comments on this phenomenon:

\textsuperscript{98} This is a panel of on-call doctors who take phone calls from doctors for advice on a range of personal, professional, financial and emotional problems, or doctors are advised to see their own GP. This is part of a national network under Australasian Doctors Health Network that also includes New Zealand.
I mean I think that, you know, the thing that might have triggered the investigation is the substantive issue. But then to hang off a whole lot of other criticisms because of other things that come to mind, but that is a questionable outcome. You do read some of those peer review reports where it’s a case of not only do you do that badly but you did this, this, and this and then says “I’m very critical or severely critical”, they use those magic words that set the level of misdeed; so the commission is in the position that they are compelled to read those words in particular and then bring that into the hearing, where in their own right, they would never have reached that threshold. I think that’s a failing or I would criticise in some of the peer review reports where there is this idealised view of what safe practice is. It’s not about total and utter best practice, it’s about the issue of public protection and that gets lost. And it then triggers a whole series of other criticisms and I’m quite sympathetic to the doctors in that case. You know, there is an element of unfairness in that.

IE3 has a long history of treating doctor/patients, of providing expert opinion in forensic and disciplinary matters and of advising in Medical Board conduct and impairment matters. In the above quote, he speaks of the inherent unfairness when peer opinion is highly critical of a doctor for failing to meet a standard of performance or conduct that is well above the accepted standard. The effect is that the doctor so affected will be judged unfairly, and what follows will be a much harsher path.

The other theme that emerges is about cultural dissonance. This is about how the culture and language of Law and Medicine are so different, to the point of clashing in an adversarial context. While IE3 sees the law as a “game” to those who practise it, the values which characterise medicine are antithetical to this.

There is also a perceived difference in the impact of a claim compared with a complaint. When considering if the type of matter makes a difference to doctors, IE1 said that:

I find my doctors don’t get particularly upset about claims, not in the way they will about a complaint, and it’s because a complaint goes to who they are, you know, in a way that a claim doesn’t, and maybe it’s because a claim is dressed up in a whole lot of legal mumbo-jumbo, so it doesn’t make a lot of sense to you, but, you know, a complaint is a very personal thing; I don’t like who you are, I don’t like what you did – it really does cut to the core of people.

**Why complaints upset doctors**

Many of the aspects of the complaints process expressed by DiTs in Section One are amplified by the expert informants. As a psychiatrist, IE4 has worked with many doctors who have had complaints, and also with the Medical Council. His view is that most doctors are caring, reasonable
and do a good job. It is a “blow” to them to think they have done harm, when their “key value” is not to do so. Then the doctor is faced with a “factory conveyor belt process”, which is “skewed” against them (IE4).

He then described the lengthy process where a doctor spends a considerable amount of time poring over the file, thinking about it, writing down responses and having the MII look at it, tweak it. The doctor is left feeling scrutinised and vulnerable, not knowing what will happen, whether they will be judged harshly. He believes that even the Medical Council is acclimatised to that adversarial lens. The doctors are scrutinising the patient file, which “is quite sacred”, with sensitive information, which is “a level of intrusion and kind of defiling of the therapeutic relationship. So there’s a very ugly sense of defilement as part of the experience” (IE4).

You know that the whole design of it is, uh, let’s find something wrong. What have they done wrong? They don’t look at what’s been done right. But there is this sense that you’re having to defend yourself. There is a sense that yes, you’re the accused.

If they’re going through it and ending up with PTSD or being anxious and depressed, then it’s working against the community. Because then you’ve got more and more defensive doctors.

You can’t be engaged and defensive simultaneously. You can’t. You’re one or the other. So when I’m defensive and the defensive thoughts come in, I’m not engaged with that patient. I’m distracted. But I think it is excessive, in the current way of doing things. And if someone has been through the system, I’ll tell you now, that it will recalibrate them not in the direction you want (IE4).

While the above encapsulates much of what the DITs said, it adds another dimension. First, this IE speaks of the breach of trust between patient and doctor that he believes occurs when a medical file is handed over for the scrutiny of others, which he declares to be like a “defilement” of that trust and an intrusion into the relationship. He also raises the spectre of post-traumatic stress disorder syndrome which may explain the defensiveness and ongoing anxiety that many doctors admitted to in their interviews. This, he believes, “recalibrates” them in a counter-productive way, one that does not serve the public interest. Could it be done differently, he asks? We will return to this consideration shortly.

**What could have been different**

The IEs saw the issue from a more global and less individual perspective, as would be expected. When asked if they had any insights into how it could be different, IE1 considered that a “proper” regulatory process is necessary and that can identify the group of unsafe doctors and deal with them; what is also needed is a process that enables a doctor to resolve a complainant’s concerns.
It is difficult to have both in the one system, and how it is phrased in terms of statutory definitions of conduct is “not how a complainant thinks” so is unlikely to meet their needs.

What IE1 is referring to is that to a complainant, a complaint needs to be acknowledged and resolved. In other words, the purpose of the system is not clear to those who provide the input (the complainant), nor the recipient (the doctor).

A common view expressed is that there should be a more refined process that is more discerning about what matters are minor and what are serious; what will resolve a complaint, and being clear about how the doctor should respond accordingly. IE1 considered there should be a better way of separating the minor matters from the serious, that the process treats them all much the same. It has the effect that those doctors who are good, dedicated doctors have a stain on their professional career, and also does little to resolve the concerns of the complainant. DiT4 stated:

While public protection is a recognised necessity, we do need to have mechanisms to ensure that patients are well treated. I’m just not convinced that an adversarial one is necessary. First, maybe we can find some hybrid, where doctors don’t feel like it’s stacked against them, feeling like the system is actually equally interested in both sides. I think that it’s overkill at the moment. Number two, how do you develop a culture where the doctor is not presumed to be a bad guy, just because someone’s complained about them. If they are, we need to find out. But to presume that is destructive; it makes doctors defensive. You can’t practise well if you’re defensive. You’re asking does it improve on patients? If I’m lost in defensive thoughts and worries, I’m not with a patient. I’m worrying about my own arse. That’s not what you want when you go to the doctor.

I think the system needs to trust that most doctors are reasonable. That should be their assumption, and the presumption of fairness. Doctors need to feel that it’s not stacked against them. If there are warning bells to be looked at, fair enough. But I think that that would help doctors feel less defensive. I think that the way that the system interacts with doctors should be considered, to be more sensitive, more caring (IE4).

Adding to this, IE1 thinks that doctors should not feel so rushed and stressed and that there is not time to be polite, to sit with patients and be respectful – a health care system that has a kinder, gentler way of doing things, with the inference that it may lead to less dissatisfied patients, fewer complaints, and less distressed doctors.

Summary
The complaints process has evolved over time to more effectively protect the public against the risks inherent in a health care system that allows health professionals to practise below standard, to perform poorly and demonstrate unacceptable conduct, and to deal with complaints by those
dissatisfied with or harmed by their care. The findings of this study so far have found that doctors’ experience of the process has left many of them metaphorically battered and bruised, and certainly not experiencing the system as caring and sensitive, nor even acknowledging that the process is stressful.

Participants have offered some thoughts on how it could be different. The changes considered do not suggest radical change, but a greater sensitivity to how the messages conveyed by bureaucratic, brief correspondence, by lack of personal contact, by the anonymity of those who are making decisions about their future, strongly suggest to the respondents of these messages that they have a case to answer, that they are perceived as guilty. While these perceptions are open to challenge, because the system is designed around the principles of procedural fairness, the legalistic tone does not marry well with the values inherent in care for others that the medical profession stands on. Dealing with this dissonance, and its emotional toll, is the subject of the next Part of this chapter: Getting through it, telling others.
Part Three: Getting Through It, Telling Others

Knowing that most doctors will be disturbed by receiving a complaint, knowing that most people in a stressful situation turn to others for support, but also knowing that many doctors who do not do so may be at risk, advisers are alert to how their client is faring. IE1, as a medical adviser in an MII, generally asks a doctor “How are you feeling about this?” followed by the critical question “Who else have you told about it?” She explained:

If the doctor has told no one, then I will immediately know this is someone who’s going to find this a very difficult process to manage, and I think that comes from that sense of absolute shame, that they can’t tell anyone. I mean, I’ve had people who have been, and what seem to have been, incredibly happy relationships for 30 years, who share everything, who cannot tell their spouses and/or their families - - - what’s happening to them, and that leaves them incredibly – you know, that issue of building that resilience around you is gone because you’re missing that whole part of it. So one question I will always ask is who else have you told, apart from me?

She also asks “what are you most worried about?”:

It’s difficult for a doctor who generally is in control of a lot of things, not everything - - - and so you’re putting them in that really vulnerable position. So in terms of trying to manage them and enabling them to be able to manage that process is giving them control. So you can say to them, well, you can’t control, you know, what the outcome will be, when you’re going to be asked to provide a response, but you can control and decide who you want to share this with, who you want to choose to have as your support person, who you’re going to have – in some ways I describe it as a journey with them. They’re not going to manage it on their own (IE1).

IE2 puts it this way: speaking of doctors in the performance “merry-go-round”, if a doctor is depressed, “we get them involved with all the people that can support people, crank up the rest of their support network and try and get them out of there as quickly as possible”.

It is usual also for advisers to remind doctors to see their GPs, to inform them what has happened, and that they are under stress. This is common advice for all doctors: the doctors’ health services, Beyondblue, who advise doctors to have their own GP and to see them regularly. As a psychiatrist, IE3 explains:

… some people go down the pathway of feeling shamed and becoming depressed and withdrawn and embarrassed and unable to sort of face people in their community or beyond. They don’t tell their wives, they don’t tell their husbands, they don’t tell their
children. It's based on shame and with that becomes self-incrimination and embarrassment, and it can be to a profound extent.

Other doctors become quite belligerent and they don't look at what the issue is, because they don't know what its implications might be. They don't have a sense of balance to it or anticipation of what might happen. So they see themselves under extreme attack when they may not be and the response is an aggressive belligerent one.

It's because they feel confronted. And they add fear to it because they don't understand what might happen. And then you get this response which is to attack the complainant and to attack the investigation body and to sound off, and it's completely out of proportion and those doctors are often acting out of fear, they've never been confronted in this way before, they had no method for problem solving – you know, you see these behaviour patterns. A lot of it is fairly indicative of the individual.

Other doctors are intrinsically bad in the sense that they've been serious offenders for a long time and it's now come to light and they are very defensive and they are very abrupt and their response is to attack the informant and the institution.

It's very situational and personality dependent. I mean, some of the most difficult people to deal with in the medical board, medical council setting are very accomplished doctors. Doctors who have fairly impressive careers and are accomplished people in their field, um, but who have things like an addiction and the idea of being identified as susceptible to an addictive illness, it's so hard to incorporate that. They go to the most extraordinary lengths and they are the most difficult people to get into proper treatment so they can recover and they don't. They go down a completely different pathway which is to fight the authority tooth and nail; and just end up in the most terrible state. They can fight their lawyers and their advisers all the way - - - and it makes it very difficult to – to look after them (IE3).

IE3 considers that while it is difficult to generalise, doctors avoid other doctors or doctors avoid being patients for lots of reasons, from believing themselves to be the best expert on their own health, which IE3 said is completely misguided, to embarrassment, social stigma, and fantasies that they should as a doctor be a paragon of good health. To a doctor, having to admit to not having good health is really an indictment of their skills, which to IE3 is a bizarre way of thinking. He added, "there are lots of psychological and practical reasons why doctors might just take that choice step of either convincing themselves that whatever's happening isn't that serious, which is the denial, or taking the short cut and saying, well I know what's needed and so I'll just treat it.
myself. Um, because it’s so available, you know, and that is a significant cause of doctors going down those paths. But neither of them are acceptable (IE3).

This is reminiscent of BeyondBlue’s findings (2013), and will be considered further in the Discussion. It is also reminiscent of DiT15 who resisted psychological help for her distress because she said as a doctor she knew what was wrong with her. Although she said to her partner “I'm fine, I'm a doctor”, she was in hindsight not at all fine.

The message from the IEs is that DiTs’ fears for themselves, their reputations and their futures can be overwhelming and although some may resist, manifesting as rage, anger, withdrawal, refusal to cooperate, or as various forms of anguish, what they recognise is that having professional or personal support is going to be necessary because “they are going to need it”.

Part Four: Moral Legitimacy

Establishing moral legitimacy: IEs speak of what it means to be a doctor

The testimony of the IEs supports my interpretation of DiTs’ testimonies that having a complaint touches a doctor at a deeper level than responding to questions about the medical care of a patient. It goes deeper than having an identity as a doctor; it goes to who they are. IE3 acknowledges there is a doctor identity, and for some it’s the foremost thing that they are. And if you took that away, they would feel that they were nothing. However, for other people they feel quite comfortable in their own self and role and being a doctor is just part of their identity and it’s not the whole identity. You see variables but if you threaten that, people respond differently.

Speaking of that identity, the IEs comment:

Well, it’s an identity that that person views into that role. You look demographically or socio-culturally and you’ll see very different perceptions of what it is to be a doctor (IE3).

Doctors invest a lot of themselves in being a doctor; they are a doctor, so part of their person – being a doctor is very much who they are. You’re never off duty, it is who you are. Work is their identity. ... If a doctor has a strong sense of identity before a complaint, it can help. If it happens early in one’s career, it can be incredibly damaging (IE1).

You know, like, all of that is about – you know, you accept those responsibilities but it also goes to defining who you are. It gives you your status in the community, it gives you your sense of self-worth (IE2).

As the IEs said, a doctor’s feeling of self-worth, their status in the community, their sense of who they are, are threatened by having a complaint, and this existential crisis is what DiTs spoke about of their own experience. IE1 says it can be incredibly damaging if it happens early in their career, as DiT16 alluded to when as a junior registrar she felt her future was under threat because of the damage to her reputation, or DiT6 who as an early-career specialist was seriously contemplating giving up medicine. On the other hand, taking account of DiT3 who had enjoyed a blemish-free long-standing career at a senior level up until the time of the complaint, of DiT2 also as a senior specialist who believed she would never again be “good” at her craft, and of DiT14 as a very senior specialist who would not retire while his reputation was at stake, indicates that for some doctors, the fact that their long-standing service, and status, has been challenged can likewise be “incredibly damaging”. As IE3 notes, people respond differently, and this is partially accounted for by their different values and sense of identity as a doctor.
In conclusion, there is agreement that being a doctor carries with it a “doctor identity” that defines to varying degrees how they see themselves. A complaint represents a moral challenge to this identity. The DiTs provided a picture of some of the influences that brought them into medicine and what they aspired to be: good doctors, whose sense of self as doctors is very much who they are (IE1). Having a complaint brings these doctors to reflect on what sort of doctor they truly are: a bad doctor like others who have attracted the contempt and ire of the public and the profession, or someone who always considered themselves to be good and are hanging on to the thread that they are still that person. So we will look further into the threats and challenges to this thread of hope.

A complaint questions doctor’s capability to do the right thing for patients. As the experts explained:

Medicine is such a different profession to any other profession ‘cause we’re dealing with something that is absolutely core to the human condition which is (people’s) health. You know, and doctors take that responsibility very seriously, in the main, and believe to themselves and to the external world – well, it’s the external world – that they’re doing everything in their capability to do the best thing by the patient. So when that’s questioned via a complaint or a claim – it actually goes to the very core of what they think they’re there on this planet to do. And it's more than – this is half the reason doctors can’t retire as well, apart from the fact they’ve got [laughter] poor financial management, is that it actually defines who they are. It much more defines who they are than many other professions (IE2).

Losing a sense of competence, a complaint subsumes everything else you’ve ever done. I think that’s why it really cuts to the core, ‘cause it cuts to the core of who they are; it’s quite an existential crisis in a sense, you know, when somebody says to you you’re crap at what you do and they’ve invested a lot of themselves in it (IE1).

A complaint is a very personal thing; I don’t like who you are, I don’t like what you did – it really does cut to the core of yourself (IE2).

Doctors often feel great responsibility and so they take that seriously. And then they feel like that their sincerity or their competency has been challenged, you can’t help but take it personally (IE4).

There is a perception that lawyers see complaints and claims as not personal: “Legal people think it’s a game. It’s their bread and butter” (IE4). It is about conduct, behaviour, judgements, and if it is a claim for compensation, it is about money for harms and injury, which is what doctors pay their indemnity insurance for. The words set out in these results tell a different story: it is indeed personal. As IE4 said, “For us, it's not a game, it's at the heart of the calling of medicine”. As IE2 explained, medicine is dealing with the core of the human condition, people’s health, and the
burden of responsibility becomes ingrained into the very core of a doctor’s life and being. And so, it is indeed personal.

Summary
Expert informers provided a picture of doctors’ responses to complaints that is largely consistent with participant DiTs’ accounts. Given that they are dealing with doctors “in the moment”, it adds an additional dimension that confirms that the individual accounts are not unique to this small group of self-selected individuals, but that what they spoke of represents a common picture of what doctors in general experience when they are dealing with a complaint against them. The expert informants also provide a perspective of the legal process as they perceived it, as one that is antithetical to medical practice, and, together with dealing with a complex and at times mystifying administrative process, is a reason for doctors’ feeling alienated and confused.

The expert informants provide additional insight into reasons for doctors’ reticence to speak to others about having a complaint, and how they respond to this by initiating conversations around who doctors confide in, or if they do not, how to manage this signal that may mean the doctor is at risk of a morbid reaction to the process. This is useful for identifying strategies for overcoming doctors’ tendencies not to seek support, and more will be said of this in the final chapter.

Conclusion
Participant doctors provided their time, their thoughtfulness and their candid perspectives on how they responded to and dealt with having a complaint. From the accounts they have provided is derived rich testimony of their experience, which to most was an ordeal that had an irrevocable effect on their practice. Not only this, it had an irrevocable effect on how they saw themselves as doctors, changed from the picture of themselves when they first went into medicine and pursued their careers, to being more cautious, more defensive, less trusting, sometimes angry, sometimes profoundly sad.

The key reasons for these effects has been identified as the sense of unfairness that arises from the process itself, and the underlying threat to a doctor’s sense of worthiness, encapsulated as their moral legitimacy.

The next chapter will examine what this means, not only from what this analysis has presented, but how it reflects, amplifies or diverges from what other studies have found. Accepting that there needs to be a robust mechanism to deal with errant conduct and performance, and deriving from the thoughts of Doctors in Trouble and Expert Informants, the chapter will consider what could be done differently to avoid or mitigate some of the adverse impacts on doctors, who may, or may not be guilty of a whole range of misdemeanours, disappointments and failed expectations that they have been accused of.
Chapter Seven: Discussion

Silent narratives: Finding the Common Thread

Critical interpretation

This final chapter is what was referred to in the Methodology as the third step in Ricoeur’s (1984) three-step process of narrative analysis, which he termed “Critical interpretation”. This brings together the literature introduced in Part One, *Shaping the Profession*, with the narratives of the study participants’ experience, the perspectives of the expert participants, and a critical interpretation of what this means for doctors, how the law in action impacts on them and the inferences that can be drawn from this interpretation in terms of how the profession is regulated in order to protect the public.

As will be shown, the Findings generally confirm the results of previous research, with many consistencies in the results, regardless of the mechanics of the medico-legal processes and their state or country of origin. But apart from some interesting observations and glimpses into the lived experience of a small number of doctors in Australia, there is little relevance beyond what was already known unless this material is used to build a deeper understanding of the phenomena under study, so that others may benefit.

The findings not only support what other national and international studies have found, they provide additional insights that have universal value in explaining the contributory reasons why many doctors suffer adversely from being the subject of a complaints inquiry. These insights are derived from the analysis presented in the Findings, and the key ones that emerge, as the “plotlines” described by Blumer (1969) and Ricoeur (1984), are that:

1. the legal process is perceived as unfair; and

2. the threat to moral legitimacy is key to a doctor’s plight.

This chapter will trace the consistencies and the anomalies, then explore these primary insights through how doctors reacted not only when receiving a complaint, but how they endured what happened next, how it affected their practice and their sense of self, and how it shaped their future.

Part One traced the origins of the present-day regulatory environment in which doctors practise. The history of the emergence of the medical profession has parallels with other professions, but its history is also unique because of the unique nature of the profession. Its uniqueness lies in its position of expertise, privilege and status, and for most of the profession, it has been driven by a profound sense of duty, altruism and commitment. It has also been driven by expectations of the community in its demand for safe health care in a rapidly advancing technological world. This history identified some defining events that steered a course which began with a drive to define the profession, enabled by legislation to protect it, through a changing social, economic and political
environment, to the current complex system that aims to maintain standards of practice, ensure doctors are accountable, and with the overarching aim of protecting the public.

Being accountable is linked with patients’ rights to complain, recognised after decades of the relative powerlessness of individual patients to seek redress for grievances, aside from the previously only available legal recourse for harm through the courts. But being accountable to the public meant the profession having to answer to statutory authorities for its conduct, and having to answer to authority independent of the profession meant having to relinquish some of its professional autonomy. This required doctors having to account for their actions, decisions and judgements in a sometimes very public arena. Chapter Four showed how many doctors find this is a confronting experience and one that has lasting consequences. This study has aimed to identify the underlying reasons why, when called to account, doctors find the process so stressful, and at times frightening.

The complaints experience

Receiving a complaint

Capturing recollections of first reactions provides a picture of the surprised entrée into what was to follow in terms of being swept up in a process over which many doctors felt they had little control, and the beginnings of the disruption of the narrative of pursuing one’s career. Common responses in this study and those reported in the literature were the thoughts that went flooding into their minds, envisaging catastrophe, the end of one’s career, livelihood, fear for reputation, and disbelief. When the reality begins to settle in, sleeplessness, loss of concentration, worry and distress intrude into their lives. The doubts begin to creep in and doctors worry that perhaps they are as guilty as they feel they are being made out to be, and what this means.

The recollections of participants in this study are consistent with those summarised in the literature. These include the initial feelings of being out of control, panic, shock, anxiety, misery, anger, distress, shame, guilt, insecurity, fear and powerlessness being common reactions (Charles, 1984; Mulcahy, 1996; Jain & Ogden, 1999; Schattner & Coman, 1998; Shanafelt, 2002; Cunningham, 2004, Cunningham & Dovey, 2006; Bourne et al., 2016; Verhoef, 2015; Nash et al., 2007, 2009, 2010, 2013;). Psychiatric disturbance (Saberi, 2009, Nash et al., 2006), stress, anxiety, disturbed sleep, suicidal thoughts and continued feelings of distress can become prolonged for the duration of a complaints process and beyond. This has been likened to post traumatic stress disorder by the experts interviewed, explained as being characterised by intrusive worrying that the event is going to happen again, so doctors become hyper-vigilant with panic attacks, sleeplessness and irrational fears of danger. Death by suicide occurs for a small but disturbing number (Horsfall, 2014; Casey, 2015; Milner, Maheen, Bismark & Spittal, 2016). Increased alcohol and drug taking was a finding from Nash et al. (2010), although this factor was not discussed by the participants in my study.
Martin (1991) found that stress symptoms were at their highest for the two-year period immediately following a lawsuit, then decreased but never returned to the level of non-sued doctors. She surmised that it was not only the process itself while in the workplace, but that the repeated exposure to situations that may lead to further litigation added to long-term effects. Some of the participants in my study reported this feeling as well, with one speaking of the dread she felt when patients with similar presentations arrived, bringing flashbacks of the case that had resulted in a complaint against her (DiT5). Others actively avoided such patients (DiT1). The irony of such reactions is that they may expose the doctor to further complaints, and more will be said of this later in the chapter in Changes. Added to the long-term impact was a feeling of being under siege, a sense of futility, never being able to satisfy patients in spite of hard work, loss of control and powerlessness (Mulcahy, 1999).

Grief for the loss that the complaint represented often added to the grief some expressed over an adverse outcome when a patient had suffered badly, or had died, leaving some doctors feeling deep sympathy for these people. The phenomenon of “second victims” has been described by Wu (2000) and Wue and Steckelberg (2012), Sirriyeh (2000) and Ullström (2014). Harrison (2014) writes that when an unexpected adverse outcome causes not only the grief of the person harmed, it can also leave those treating the patient in a state of dismay and grief. Yet, few supports exist for doctors, who are expected to just get on with it. In this study, participants had varied experiences of this phenomenon, with one team sharing their shock and sorrow about a catastrophic outcome (DiT5), while another doctor, devastated by the death of a patient, was excluded from the staff debriefing sessions that followed, leaving her alone and bewildered (and later blamed, then finally exonerated) (DiT2), and yet another who was actually pleased for the patient’s compensation payout because of harm she suffered, although very distressed about having been blamed for it (DiT12). This can be summed up by the English neurosurgeon Henry Marsh who wrote:

> Everybody accepts that we all make mistakes, and that we learn from them. The problem is that when doctors such as myself make mistakes the consequences can be catastrophic for our patients. Most surgeons – there are always a few exceptions – feel a deep sense of shame when their patients suffer or die as a result of their efforts, a sense of shame which is made all the worse if litigation follows (Marsh, 2014, p. 154).

The experts, who see doctors when they are undergoing an inquiry into a complaint, observed similar reactions, finding some of them overwhelmed, fearful of loss – of house, reputation, livelihood, loss of face – and some very angry. While in these states, they can be difficult to assist because their emotions can be an obstacle to preparing their defence, until the emotions are acknowledged and their greatest fears addressed. But certainty cannot be guaranteed, and it is this state that keeps many doctors distressed and anxious for the duration of the process, since they can perceive they are under attack, and if this is prolonged, may result in post-traumatic
stress disorder. Above all, the experience was summarised as an “existential crisis” by participants and experts. Experts see doctors when they are at their most vulnerable and when their emotions are raw, so experts’ testimony added confirmation that participants’ recollections were not unique, but echoed the experts’ observations of common emotional responses.

**What is stressful about complaints**

The critical question is why doctors suffer from these symptoms, and why they are so enduring. The mental health of doctors is known to be in a more vulnerable state than the general population (BeyondBlue, 2013). The stress, and fear, of litigation and complaints is a known contributor to mental illness and is rated by doctors as one of the most stressful of all stressors in medical practice (Schattner & Coman, 1998) and malpractice litigation is described as a major life trauma or the most stressful life experience (Martin, 1991; Charles et al., 1984). This was reflected in the comments of doctors in my study, even if a complaint was not substantiated, as occurred in a majority of the participants’ complaints⁹⁹. Yet they suffered a range of the symptoms during the process and well into the future, to the point where tears flowed while recollecting their experience, up to several years after the event. This accords with Charles’ (1988) finding that there was little significance in the scores of those who had won their cases and those who had not, suggesting that it is not the outcome that is most feared, but the process itself. The next section will look at how the process has such an impact, and related factors that the process gives rise to.

**Is it fair?**

While it is generally understood that legal processes are lengthy, doctors are afforded procedural fairness in that they have a right of reply to decisions being made about a complaint, and are generally provided with access to evidence that supports a complaint, such as access to the medical records, copies of peer reviews and the like, as noted in Chapter Three. However, participants identified multiple ways they felt they were treated unfairly, relating to the process itself, and for example, the delays in dealing with “nonsense” or minor matters. As identified in Chapter Four, these may not have been labelled as “unfair” as did several of the participants in my study, but the effects were much the same – that aspects of the process itself contributed to doctors’ distress and to defensive practice (Cunningham & Dovey, 2000; Nash et al., 2010; Bourne, 2017). These aspects included prolonged timescales and “poor process” which were identified in Bourne et al.’s (2017) study, which found it was the interruptions to their working lives which were taken up with meetings, hearings, and responding to matters, with no redress for this loss (Charles et al., 1984). Mulcahy (2003) said it was more than just the time being engaged in the process; it was the fact that complainants, if not satisfied with an outcome, could seek a review or appeal, yet doctors could not seek redress if the complaint was found not proven. DiT1 was one such doctor whose matter was re-opened and subject to a lengthy investigation, before being

⁹⁹ AHPRA’s 2016/17 figures showed that no further regulatory action was needed on 76% of the 3 557 complaints closed, indicating that the participants were not an unusual group in this respect.
closed with no adverse finding against him. Observations about delays, the quality of communication, the lack of compassion or consideration in the process and the feeling of powerlessness were also identified by Horsfall (2015).

Overall, there is an impression of incommensurability between the law and medicine, leading to an added feeling of frustration and uncertainty. Expert informants had a view that the law misunderstands that doctors are not like them, that the process is adversarial and is counter to the culture of medicine. As IE4 said: “doctors feel like their work and their patients and they are under attack by the legal system, by an adversarial process, which is trying to work things out in a non-medical arena”. Being captive to the power of the regulatory process added up to a sense that it is the process itself that is the punishment, and that participants had to prove themselves innocent. It was not only some of the participants who said this, but McGivern and Fischer’s interview study (2010) found the process made them feel guilty until they are proven innocent, and they begin to practise more defensively thereafter. Doctors under Fitness to Practise inquiries in the UK reported the same perception (Horsfall, 2015).

Enduring the complaints process

As well as feelings of powerlessness and emotional distress, Bourne et al.’s UK study of 10 390 doctors reported on the most stressful aspects (2016), and found doctors felt unsupported, victimised, like a failure, and incompetent (Bourne et al., 2015, 2016, 2017). The most stressful aspects related to procedural issues in the process such as prolonged duration, unpredictability of procedures, managerial incompetence, poor communication and perceiving that processes are biased in favour of complainants, fear of the consequences, embarrassment about having to justify their actions, fear for career, humiliation – professional and public – the latter of which was also reported by Verhoef (2015) as affecting reputation and career, and having a marked record. As noted, this has been a current issue in Australia. In my own study, these fears were apparent and underscored their experiences for the duration of the process. Here, “walking down a highway full of potholes” characterised the feelings of confusion and uncertainty that began with the notification of the complaint. Not knowing what may lie ahead, what the outcome may be, what impact it would have on their reputation and career, and how decisions are made that would affect their future, were all reflections of this uncertainty. One expert described “the long haul ahead” for doctors receiving a complaint, but could not provide the reassurance that doctors need, nor give false hope that it will come out well.

What compounds the issue is that the complaint may raise other issues, determined in the course of the inquiry, when peer review may be critical of another aspect of the respondent doctor’s treatment or care, or the quality of medical records or other matter of which they are critical, and the doctor will be required to respond to these further issues. This not only prolongs the process, but adds to the sense of powerlessness – they are in other unseen and unknown hands – “there is an element of unfairness in that”, said an expert. Some participants found this aspect very
confronting, to be held in judgement by one’s peers when it may have been more a matter of
differences of professional opinion than actual departures from the standard, and although they
have a right of reply, they feel the system has the greater authority. It is perceived as weighted
“towards complainants”, as was also found in Bourne’s study (2016). As an expert said, it is “an
adversarial process” that leaves doctors feeling vulnerable.

The Findings also describe the process issues that compound the uncertainty – the long wait
between communications, yet being given little time for doctors to respond – and the impersonal
nature of correspondence, with little information about how decisions were made and delays in
progress, and in resolution of the matter. While some participants recognised that the people who
are administering the system “are just following a process”, participants believe they have little idea
of what effect it is having on the recipient. These findings reflect the “procedural issues” identified
in Bourne’s (2016) study of what is stressful about the process. While the procedures in the UK are
not the same as Australia, the frustrations expressed relating to procedural issues were very much
alike.

**The significance of this**

*Liminality* is a concept that comes to mind when reading these accounts. Liminality is an existential
state that places its subject into an uncertain space, the boundary of which commenced, when
speaking of participants’ experience, with the receipt of a complaint. The ending is never certain,
and so the space in between is one where the doctor wonders what is going on, how will it end,
and most significantly, what will it mean for them. Each communication from the complaints body,
Medical Council, medical indemnity insurer or lawyer can be a reminder of the uncertainty that
these communications represent and symbolise. Speaking of the state of liminality in respect of
life is also the existential life, separated from other lives only by the symptoms and disabilities of
the illness, and a cultural agreement to validate the transparency of the existential issues in times
of “normality”. So it could be said of these doctors, being separated from other lives, not here by
symptoms and disabilities, but by their own sense of unease about the future, by the inferences of
their being not only accountable but having to justify their actions, and in so doing, feeling guilty
and accused. With a reduced sense of control, they wait it out, responding as required to the
occasional missives from the authorities, while “sitting in the cheap seats” (DiT3) as some
unknown person makes critical decisions about them.

While waiting it out, most are back at work, trying to be normal, but every letter, phone call or email
brings back the process going on behind the scenes. As simple as being fearful of mail arriving that
can be a reminder of the shock endured on first receipt of the notification of a complaint, and so
was symbolic of the fear, or the feeling of ever-presence, when a trip to the supermarket or any
other normal event could be interrupted by a phone call from the regulator, recalling the underlying
anxiety carried constantly. The process therefore was not merely a series of actions, interspersed
with periods of normality; it was a constant in doctors’ lives, yet whatever was happening behind
the scenes was silent to the doctor. This again evokes the sense of existential uncertainty
characterised in the “illness narratives” or “biographical disruption” (Kleinman, 1988; Bury, 1982;
Charmaz, 1990), in which a person living their normal life while having a chronic illness or a cancer
in remission, may revert from being that person to being a patient. How one plays the “sick role”,
as Parsons (1951) described it and as explained in Chapter Five, may have adverse
consequences depending not only on their disease, and on how they play that role. The doctor with
an open complaint is a doctor at work, a member of the community with a social life, but is also a
respondent to a legal process, which carries legal and regulatory obligations, again with potentially
adverse consequences depending on the seriousness of the complaint, but also on how they play
their “role” as a respondent, or defendant. They cannot just ignore it, because “they’ve got you over
a barrel” (DiT8). The powerlessness and loss of control that participants in this and other studies
(Mulcahy, 1996; Jain & Ogden, 1999; Bourne et al., 2016) reported can be explained by this
phenomenon. While at work, there is the doubt that a complaint implies, that they are less the good
doctor than they thought they were.

Just as a cancer patient in remission fears an uncertain future, part of the fear for the participants
was the catastrophe that some saw ahead of them, which generated the angst and dread. They
had seen others before them suffer from the public exposure, the perceived unfair judgements, the
humiliation, the loss of jobs, and feared this may happen to them. But to argue, fight, blame, and
accuse would do no good, for they still had to “face the music”. Interestingly, one participant said
when asked about the catastrophe she had thought had been about to befall her, and
subsequently did not happen, “no, it was the fear speaking, but it was all gone now” (DiT12).
Additionally, just as illness interrupts one’s normal existence, so it is with complaints, and has
effects that reach beyond the event itself:

Illness alters life plans and projects. And it provokes a response, however difficult and
tenuous. Illness matters because real things are on the line: self-identity, physical and
mental health, life chances, social status, employment, finances, religious aspirations,
or personal relationships. Seen this way, illness and treatment are embedded in the
local moral experience of a particular network, neighborhood, or community (Kleinman,

The impact extends beyond the individual as well, and can affect staff and one’s team members
and colleagues. Stuart and Cunningham (2015) found anxiety spread into the practice, and DiT5’s
team became distressed at the complaint because they were part of the care of the patient but also
in sympathy for the doctor who received the brunt of her anger. DiT1’s team felt the complaint was
very unfair and gave him significant support, which he recalled later helped him endure the long
process of investigation and appeals that followed.
Family members are also affected. Participants’ partners invariably supported them, although DiT13’s partner had long been troubled by his conduct and the future of their marriage was uncertain. Clode’s (2004) study of general practitioners highlighted that partners of GPs suffer psychiatric and psychological morbidity at a greater rate than the general population as they carry the effects of their partner’s stress and anxiety. My study did not venture into this territory beyond the participants’ acknowledgement of the support their partners gave during and after the complaints inquiry, but it suggests that further research would be beneficial in gaining a full picture of how doctors maintain or restore their equilibrium.

Shame, stigma and reputation

Participants found it a challenge dealing with their own emotions, but thinking about what others may think of them made it very troubling, particularly if their case was reported in the paper, as was discussed in the Findings. Verhoef (2015) reported on the fear of such exposure. Participants spoke of this fear when first receiving a complaint and what happened when the press did report on their matter, such as DiT2’s experience (see Findings) when her photo was printed in the paper, and she became acutely aware that the public as well as the profession knew and were judging her. To reiterate what she said:

So that became difficult, ’cause then the general public knew. So every time I went to the supermarket, I felt like people were looking at me. “She’s that axe-murderer.” I, you know, I used to be -- I used to be in the Local [Community] Group, and I turned up at a meeting once and had people say, “Oh, I saw you in the paper”. So not only had I lost my professional reputation, but it was spilling over into my personal social life as well (DiT2).

The stigma for her was too great, and she ceased attending her community group, she no longer attended her specialist College conferences, and eventually she stopped practising as a doctor. Feeling blamed, she felt unworthy, and although she was eventually cleared of any wrongdoing, the shame that she endured never completely receded.

Writing about disasters, Wells (1995) distinguished between events that give rise to blame and those that do not, much of which is attributable to how it is reported, which can bias public perception. “There is a complex relationship between public reaction, media responses, risk perception and causal attribution” (Wells, 1995, p. 9). Misfortune due to “natural” causes is not blameworthy, while blame can be attributed to “man-made” causes. Quoting Lee (1981), Wells added: “The awfulness of a catastrophe may lie not merely in the loss of life and suffering involved,
but in the violation of people’s sense of justice or moral rightness” (Lee, 1981\textsuperscript{100}, p. 7, in Wells, 1995, pp. 9, 10).

Similarly, Bosk (2003) made a distinction between “technical" errors and “judgmental" errors, the latter of which are “moral in nature” (Bosk, 2003, p. 168) and are dealt with more seriously than errors in techniques. Examples of the differentiation between technical error and moral error abounded in the participant accounts, with the difference in how they were handled and how the participants perceived them being evident. DiT15, for instance, had two complaints. The first was about a “failure to diagnose”, and because of the potential seriousness of the illness, and the risk to the public if she were found to be an unsafe doctor, there was an investigation. This was finalised with no finding against her, but the complaint itself and its inferences were sufficient to produce such severe shock and depressive reactions that she had to obtain professional psychological support. The second was about an administrative matter that the patient was annoyed about, and was quickly dealt with and closed by the regulator. DiT15’s reaction to this, after the initial shock and tears of receiving another complaint, left her irritated and angry with the patient, but without the soul-searching, the agonised analysis of what she may have done wrong with its moral undertones, and the distress.

The case of DiT2 demonstrated very clearly that technical error is forgivable, while moral error is not. As an obstetrician, babies sometimes die before, during or after their births. DiT2 had her share of “adverse outcomes” over her twelve years of specialist practice and without a suggestion of wrongdoing or error. She was one in a group of partners running a practice and seeing patients in the local private hospital. After a prolonged shift dealing with a lengthy delivery, she spent her next evening at home on call and was ten minutes away if needed. She left instructions to be called if needed, and expected a low-risk delivery. She telephoned a few times during the night to check progress and was assured that all was well. She left early for the hospital to be there for the delivery. When delivered, the baby was dead, and had been for some hours. The mistake was not hers – during the mother’s labour, the midwives had misread vital signs. DiT2 was blamed, sidelined by the hospital administration, isolated from staff, excluded from her partners’ practice, eventually suspended from medical practice, and publicised in the press as the one who had refused to attend for the patient. Her alleged failure was unforgivable, and her exclusion was her punishment. The midwives were sent for re-training, but kept their jobs. DiT2 was found not guilty, was reinstated to the register, but has not practised again. In Bosk’s (2003) terms, the hospital’s and team’s failure to forgive DiT2 for her alleged moral lapse would mean that she was excluded, whereas the technical error made by the midwives was forgiven, remedied and they were brought back “into the fold”.

In this way, Bosk (2003) explains the consequences of technical error as more forgiveable and that individuals remain part of the work group, and their performance is not seen as “nonnormal”, unless of course this becomes a pattern of practice, in which case questions will be asked (and I add, sometimes reluctantly\(^\text{101}\)). The occasional technical error is accepted even if the patient suffers harm – “these things happen” – and the problem resolved by re-training, as in this case. When good faith is brought into question, lapses in moral performance are less forgivable. Bosk (2003) writes of a collective conscience in the occupational group, with its own morality, and a moral lapse is not tolerated, and the individual may be scorned, humiliated or even excluded, which is precisely what happened to DiT2. Bosk argues that forgiveness bonds the team:

Forgiveness removes the stigma of uncertainty – by allowing people to confront their error, it can therefore serve to limit self-criticism and prevent an individual from being immobilized by guilt. Forgiveness helps individuals mobilize for action after failure has stripped them of a sense of mastery. It is a necessary part of group life which sustains commitments and mobilizes actors in the face of inevitable failure (Bosk, 2003, p. 179).

The absence of group forgiveness can leave a doctor exposed to their own doubt and uncertainty, of which DiT2 was left with so much she could not return to practice. DiT14 was one who could not forgive himself had it been found true that he had been guilty of medical fraud, and he would have given up medicine.

Lewis (1971) opines that shame is a deeply painful negative appraisal of oneself, as defective, and therefore a bad person. Shame is different from guilt in that the person appraises oneself, while guilt involves appraisal of the specific behaviour, and as such, shame is more associated with psychological pathology. For doctors, if they felt their treatment was not up to standard, or if a patient does not do well, then it can give rise to shame, which Davidoff (2002) associates with the culture of perfectionism. This starts in medical school, when lack of knowledge implies a shortcoming and in later training implies a lack of dedication, in itself implying a moral failing. When a doctor has done something wrong, or who is accused of same, this invokes this deep-seated sense of shame, and self-forgiveness is not easily remedied.

Carlsson (2016) examines further the nature of guilt, associating it with blameworthiness, yet distinguishing between being blamed by someone else, and blaming oneself. The latter, he argues, “necessarily involves suffering” (Carlson, 2016, p. 89), but one is only morally blameworthy, and therefore should suffer guilt, if the issue were under one’s control. This is not just to speak of guilt as found, or not found, in a Tribunal of court of law. This is about the sense of blameworthiness and shame that participants spoke about, regardless of the finding in relation to the complaint. It

\(^\text{101}\) We could see this in the Patel case where prolonged efforts to raise the alarm about the shocking outcomes of Patel’s efforts were disregarded, as were Dr Harry Bailey’s at Chelmsford, the cardiologists at Bristol, etc., because peers were reluctant to voice critical judgement about their techniques.
certainly appeared that some participants had been “immobilised”, as Bosk (2003) argued, when forgiveness was not forthcoming or if one could not forgive him or herself for their alleged shortcomings or failures. This is about taking moral responsibility, which is beyond the blame attributed by a complainant, and beyond the liability attributable by the legal process. In this sense, Carlsson (2016) argues that being blamed by someone else is not necessarily harmful, but to blame oneself certainly is, and one suffers. He also argues that blameworthiness is associated with an inference or perception of ill will, which may explain why participants reacted so strongly at the “personal” nature of many complaints, and the underlying hate expressed in some. For instance, what disturbed DiT3, DiT4, DiT5, and DiT16 was the attack implied against them as people, not just what they had been alleged to have done. Allsop (1999, p. 160) observed, in her examination of more than a hundred complaints, that rather than expressing complaints in terms of precise allegations, complainants expressed them as “stories which put an emphasis on doctors’ obligations, (so) the professional identity of the doctor comes under attack as well as their clinical competence”. This implies that once trust is breached, and the doctor’s perceived lack of moral responsibility has betrayed the patient, the response is unforgiving and the doctor becomes the villain. As IE1 said, “it is personal”.

Therefore, I would argue, when doctors receive a complaint, they react emotionally as a defence against the moral imputations. But being advised by their medico-legal advisers or lawyers to “stick to the facts”, what is missing is an avenue for expression of the imputation of a moral lapse, leaving the blamed one feeling uncertain and morally guilty, under attack as IE3 said, and with the emotional load that was so abundantly evident in the Findings.

**We’re just normal people**

With this in mind, and as noted in the Findings, the key underlying theme emerged as the principle of moral legitimacy. During interviews, doctors appeared to feel compelled to restore a sense of themselves as moral, or “good”, in response to the inferences in a complaint, and how it was handled by the authorities, that they were blameworthy, guilty, not good doctors but bad, or seen as bad, and that they now had to redeem a sense of their good self. This was not only to restore their own moral values, but reflected what many felt was expected of them. As DiT1 articulated, “Doctors are held to higher standards than the general public, even in their personal lives: there’s a perception that as doctors, we have to behave in a certain way, but that invades every aspect of our lives. … We’re expected to be a certain level of superhuman and we’re not, we’re just normal people. You can’t make a human level of mistakes”. A complaint meant they had let the side down (the “social contract” discussed in Chapter Two), that they could not meet this externally imposed expectation. The extrinsic rewards of medicine – the financial security, esteem, recognition and even fame – are ideally balanced by the intrinsic rewards – the satisfaction of doing a meaningful
job well (Riley, 2010) – but this balance can be disturbed when the inference of not having done a job well, which may then extend into doubt about the whole of their practice, can contribute to this sense of no longer being the “good” doctor one thought they used to be. Even DiT11, who did not ever consider himself to be a “bad” doctor, said the experience “brought (him) down a peg”, and he then made a conscious effort to improve, although “it was bloody stressful for those few months”. DiT1 likewise said he was “still a good doctor but not as confident”. DiT11 reflected on the process and why it affects doctors so much compared with lawyers, who do not see it as an emotional thing, but a black and white process of dealing with facts. This was an important observation because some felt there was a general lack of empathy for doctors’ plight. Even with a sense of his good self being relatively intact, DiT11 found this a challenge and felt there was always a doubt, while going through the process, suggesting that what is missing in the process is an avenue to express emotional responses, as the experts also identified. It was interesting that DiT11 told no one except his wife, and it was not until some time later, when he encountered a former supervisor who revealed he had had a complaint, that he felt ready to share his experience with others, albeit within a closed circle of that person whom he trusted and admired. This suggests that the “shame response” discussed by Cunningham and Dovey (2000) did not fit his image of a highly competent specialist who had excelled in his education and training, and the hesitancy revealed in his thoughts in the above quote is indicative of the discomfort he felt in thinking that there had been something wrong with him, that he was not good, or good enough. In this way, Wilson and Cunningham (2011) contend that doctors respond both emotionally and intellectually to a complaint. The intellectual appraisal that will follow a complaint (what went wrong?) uses the biomedical paradigm as does the complaints process itself. “Judged by themselves or others to ‘have failed’ in the ‘dichotomy between correct and incorrect medical practice’” (Wilson & Cunningham, 2011, pp.450, 451), the failure becomes internalised, leading to the experience of shame. They argue that this shame response is what drives the changes in attitudes towards patients and to changes in practising behavior.

The shame response is an underlying emotional response to a complaint (Cunningham & Dovey, 2000, p. 464), as are depression, anger, guilt and loss of joy (Wilson & Cunningham, 2011). Shame is also listed as a common symptom by Charles (1988), Martin (1991), and Stuart and Cunningham (2015). As DiT16 said: “there’s a lot of shame attached to it and I know that some people would be so ashamed that they wouldn’t want to tell anyone about it”. It is explained by IE1 and IE3, who said:

... some people go down the pathway of feeling shamed and becoming depressed and withdrawn and embarrassed and unable to sort of face people in their community or

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102 Riley, G. (2010). Professor Geoff Riley, AM, is a psychiatrist and Professor of Rural and Remote Medicine at the University of Western Australia. He was speaking at a conference of the Royal Australian College of Surgeons (Rural Surgeons), in Broome, WA on 1 September 2010.
Shame is attached to feeling blameworthy, yet they may not be. “But there is always a doubt” as DiT11 said, because a patient was unhappy with his care.

Embarrassment, easier to handle than shame (Lewis, 1992, p. 126), is about self-consciousness, uneasiness, awkwardness, while shame is a deep-seated feeling of self-mortification, humiliation and guilt. Lewis describes some of the ways people deal with shame, such as by deflecting onto others or other circumstances, denial of the issue that caused the shame, substituting shame with anger, sadness, self-blame, or confessing the source of shame. Any of these may be attributed to the participants, but I will avoid making interpretations that enter the psychological realm, being ill-equipped to do so. However, the term was used by both participants and in particular by the experts, as reasons for doctors’ angst and reluctance to tell others or for others to know, and in the findings of others’ research (Cunningham & Dovey, 2000; Cunningham, 2004; McGivern, 2010).

The other aspect is that shame is closely related to stigma. Goffman (1963) explained the early meanings of stigma as being signs of visible deformity or blemish, but the more recent meaning refers to disgrace, which he states is a reflection of the more recent psychologisation of experience, expressed as distress and other mental problems. Visible stigma discredit people, but the invisible stigma are those where bearers discredit themselves, and become internalised, leading to a change in the conception of self. This change can be associated with feelings of shame, deviance, being inferior, or “discreditable”, representing the “spoiled identity”. The person who has discredited oneself anticipates the reactions of others, even if these never happen. Kleinman writes (1988, p. 160), “By that stage, he has thoroughly internalized the stigma in a deep sense of shame and a spoiled identity. His behaviour, then, becomes shaped by his negative self-perception”.

While Goffman (1963) and Kleinman (1988) are writing about illness and disease, I posit that their interpretation of stigma applies similarly to the self-stigmatising that occurs when doctors in trouble anticipate that others will shame them because they have failed to measure up. This is supported by a recent study by Clough, March, Leane and Ireland (2018) of what prevents doctors from seeking help for stress and burnout that cited time, or lack of it, as the greatest systemic barrier, but the most consistent reason was stigma. Perceived structural stigma was fear for being disadvantaged or discriminated against at work; perceived stigma from others and self-stigma were about perceived devaluing and discriminating beliefs.

The DiT who feels shame believes they are less than worthy or that they may deemed by others to be less worthy. So they tell no one, or just the few trusted ones, and have difficulty forgiving
themselves, even if the outcome of a complaint has found them not guilty. Stigma are a “public violation of what is considered normal” (Lewis, 1992, p. 195), but the question is, in relation to who or what? This brings us to the concept of identity, and the notion of what Goffman (1963) describes as a “spoiled identity”. Kleinman (1988, p. 5) writes of cultural orientations, being “the patterned ways that we have learned to think about and act in our life worlds and that replicate the social structure of those worlds”, which can be likened to Bourdieu’s (1993) “field”, or the particular culture of medicine into which new doctors become socialised and internalise the customs and culture of being a doctor. Becker (1961), in his book Boys in White, describes the acculturation process that takes place in medical school of 1950s America (where girls apparently do not enter), in which medical values become assimilated beyond the learning of clinical skills. An example was of exercising responsibility and to handle “one’s opportunities to do so skillfully and well, are important signs of one’s personal worth and hence symbolic value beyond the actual experience involved” (Becker, 1961, p. 255). Such expected competencies have become in more modern parlance part of the “hidden curriculum” of medical training, where doctors learn how to behave like doctors, and in this there is a common identity. But while the profession may appear to act as a unified institution, or as a collective, to the outside world, within it there are the same rivalries, competitiveness, hierarchies of status and prestige as are common in other large institutions. Nevertheless, the granting of the right to the wearing of a white coat was to Becker the material symbol of acceptance into the tribe, and one worn with pride as the sign of being accepted into the inside (Merton, 1972). When this is challenged if accused of incompetency, for instance, and this opinion is generated or supported by one’s peers, the sense of self is disrupted and challenges the security of being part of the collective. When a doctor lets the side down by being complained about, the identity of being one of them, of being a good doctor, is thrown into question, and there is a risk that they may symbolically, or actually, be forced out of the club, or humiliated and excluded, as Bosk (2003) intimated, and as DiT2 experienced. Safer not to tell them, but then, the identity is already spoiled, through self-stigmatising ruminations. It was these ruminations that were expressed during the interviews when thoughts went from “am I one of the bad guys”, to “what will others think of me”, to it being “an attack on your absolute being and essence as a doctor”.

Telling others

Shame and embarrassment, and perceived stigma in nearly half of the respondents, were identified by the BeyondBlue (2013) study of doctors as reasons for not seeking help or support, yet 25% of doctors were found to have some degree of psychiatric disorder. As discussed in the Findings, participants tended not to tell others beyond their partners, and not to seek support beyond obtaining medico-legal advice. Those who sought professional psychological support only did so when they were in a state of high distress, such as DiT15, whose partner and lawyer both recognised she was not coping, not sleeping and was acutely anxious. This accords with the experts’ opinions, who all said that doctors in a state of distress were frequently handling it alone, and BeyondBlue’s (2013) finding that 30.5% either chose not to tell anyone, or to rely on
themselves. As professionals, the expert informants felt it very important to address this critical need and if necessary, guide doctors to obtaining professional support.

Bury (1982) stated that the "overall effects of stigma affect the individual's ability to mobilise resources to advantage" (Bury, 1982, p. 180) which gives some insight into this reticence, and supports the experts' opinion that guiding them towards support is a critical need. The Findings set out some of the reasons for participants' reticence to seek support – shame or embarrassment were evident, with worries about what others would think of them a key reason. Another reason was the sense that none other than a doctor would understand what they are going through. DiT2 saw a nurse/counsellor but found this of limited value. Others were reluctant to use the free psychological service available to doctors, although some of them who did found it useful, while others did not know of the service. Cunningham and Cookson (2009) undertook a survey of the use of a similar service in New Zealand and amongst their conclusions, the service was valued and effective, but that it was not well known about. The Canadian Medical Association’s study (2003) found that only 2% of doctors sought support, in spite of 18% being identified as depressed. A systematic review by Kay, Mitchell, Claravino and Doust (2008) found reasons for not seeking support included time constraints and lack of availability of services being primary, as well as embarrassment, which accords with Clough (2018) that lack of time is the primary structural reason. The survey by Nash, Daly, van Ekert and Kelly (2013) found that of those who had contacted an independent counselling service, 47.5% had contacted the Doctors Health Advisory Service and 73.4% had sought independent counselling. What this suggests, as with Cunningham and Cookson's (2009) study, is that doctors have a strong need for support, and that they need a variety of sources of support, but lack awareness of what is available. Nevertheless, given the additional awareness of doctors' mental health needs in recent times, there is growing interest in and education in the need to be more responsive to doctors’ vulnerabilities. This is especially so given the recent exposure to news of doctor suicide and mental illness, especially amongst junior doctors.

**What made a difference**

What made a difference was not just having professional advisory and therapeutic services available, though these were important, but also having a trusted person in whom to confide, whether this was family, friend, colleague or senior, someone who was not there to judge, defend or challenge but to accept that the experience was difficult and emotionally distressing. The most significant aspect, however, for assisting a doctor feel they are valued as doctors and that they remain accepted as part of the circle is to be in a supportive collegial environment. This largely depended on how one’s colleagues respond to the doctor in trouble, and as stated by Amsterdam and Bruner:
The sense of identity … relates us to the groups on whose good opinions we rely for self-esteem, and fixes us to the roles and statuses that those groups assign us as a condition for holding their good opinion” (Amsterdam & Bruner, 2000, p. 234).

When a doctor loses that good opinion, it can have significant consequences – for DiT2 who had been actively sidelined and excluded by her colleagues came seriously unstuck. Writing for the Medical Observer, psychiatrist Dr Helen Schultz, whose interest is in the high rates of suicide amongst doctors, would like to see doctors being kinder to each other, as IE1 had similarly said. She says: “With every conversation we have with a colleague, we have the power to make or break that colleague” (Schultz, Medical Observer, 2018). Being kinder, more forgiving, enabling time to de-brief are all important to the preservation of self-esteem, while loss of colleagues’ good opinion can be devastating and add to one’s doubts about one’s own worth.

Those who chose not to disclose to others for reasons of their shame and embarrassment can feel very isolated, and as DiT15 found, she suffered until psychological support was finally obtained. Cunningham and Dovey (2000) suggest a rapid response “crash team” organised by a doctor’s professional college to minimise the adverse effects of a complaint, while Nash et al. (2013), having asked respondents to nominate what support they would want if they were to experience another medico-legal matter, found 88% wanted someone to attend court with them, 76.5% wanted more information about the medico-legal process, 78.3% wanted more information about what services were available for them, 81.8% wanted someone available within their medical defence organisation for contact when needed, and 75.6% suggested a peer support program. These services would complement the activities of the defence team. Certainly the participants in my study identified the lack of information about the process as a large contributor to their apprehension about what was happening, where it was headed, and on what basis, so the provision of additional information, and support outside their actual defence, would relieve some of this uncertainty.

**The emerging plotline: Challenge to moral identity**

What emerged as the underlying plotline to the collective of doctors in trouble narrative, was how participants’ sense of identity had been challenged by having a complaint. As the Findings established, the biographical disruption (Bury, 1982) of having a complaint, which represents a significant or even catastrophic event in a doctor’s life, was sufficient to disrupt and potentially forever change the anticipated course of a doctor’s life, and each account represented the struggle to recalibrate and re-establish a sense of equilibrium that would see them restored, not as the same, but as ‘good’. Williams (1984) wrote about narrative re-construction while Nelson (2001) referred to “narrative repair” and Walker (2006) to “moral repair” as ways that people whose lives have been disrupted in significant ways seek to “reconstruct a sense of order from the fragmentation produced” (by the event) (Williams, 1984, p. 177). Telling the narrative in an
In neutralising the threats described on the occasion was said, the future process, cannot become Plummer even if good had come of the experience. Bury (2001) expresses some caution in the "overdetermined nature" of these analyses. In this respect, the translation of the concepts behind "the illness narratives" and the disruption so caused, into the biographical disruption of doctors' experience is valuable, but it is not determinate. To provide a more nuanced conceptualisation, Plummer (1983, in Robinson, 1990, p. 1177) describes experience as "a stream; a flow; social structures are seamless webs of crisscrossing negotiations; biographies are in a constant state of becoming and as they evolve, so their subjective accounts of themselves evolve". In this way, the event that gave rise to a complaint may certainly have disturbed many, as we have found in the participant narratives, to the point of chaos for a time; it disrupted their daily working and family life while going through the process with a sense of dread for what may or may not eventuate, but it cannot be said to determine the eventual future because the future is not yet here. During the process, the future may have looked bleak and uncertain, but even in the telling during the interview, that future had already arrived as they were present to tell the tale. But it was clear, the future when going into medicine was not to be what had been anticipated. As Frank (1995, p. 55) said, "The present is not what the past was supposed to lead to; the future is contingent". There was no doubt, however, that the process had left an indelible mark, and the interview was one occasion to attempt to retrieve some of the valued anticipated future. This, to Riessman (1990), is the "moral stance" taken in understanding a significant event in someone's life. The unfolding reflection on the experience by participants revealed this to be at the heart of their narrative – described by Ricoeur as the emergent plot that underlies each account of the experience.

Neutralising the threats

In unravelling this moral dilemma, participants made attempts to neutralise the impact of the threats to their moral stance, by findings reasons for the complaint (see Findings in the section

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Neutralising the threats: Am I to blame?). While these will not be repeated here, it is useful to recall how rationalisations, justifications and other reasons were contemplated as ways of mitigating participants’ perceived blameworthiness, as if they were bargaining their way to seeing themselves, and being seen as not so bad, or even good. Nelson (2001) likens this to the counter-story that a “damaged identity” creates to neutralise the damaging effect of a threat to the self and self-respect. Most reflect on how it could have been different, and these insights may provide a guiding light into how procedures and protocols may be amended in the future to take greater account of the adverse impacts on those involved in these proceedings.

This, of course, is natural, and is consistent with doctors wanting to understand the underlying reasons for a complaint that go beyond the causes identified in the legal process. It also sheds further light on why many participants feel the process is unfair, as they have not had the opportunity to express their deliberations throughout the process, and if they do, it can be interpreted as defensiveness. It feels that the system, which listens to complainants, does not listen to doctors, adding to the perception the process is weighted towards complainants.

Responding to the threats: Changes

Part Five of the Findings summarised how participants reflected on what difference, if any, the experience had made to them, their practice, attitudes to their patients, their practice and their career. Some felt the experience had overall been a positive one as it had made them think more deeply about how they practised and what could be learned from the complaint. Others weighed it up and “still love their job”, in spite of seeing the complaint as a challenging intrusion and the experience of dealing with it unpleasant. Others were less forgiving, and carried a burden of ingrained distress and anxiety that flowed through their everyday lives and affected their attitude, perspectives and behaviour.

Some changes could be said to have made a positive difference and provide for safer care, such as writing more detailed notes, being more attentive or being more cautious about demanding patients. This is similar to the perceived practice changes identified in the study by Nash et al. (2010), including the introduction of improved systems for tracking test results (48%), for identifying non-attending patients (39%), for auditing one’s practice (35%), referring patients more than usual (43%), ordering tests more than usual (55%), and prescribing medications more than usual (11%). Respondents also reported improved communication of risk (66%), increased disclosure of uncertainty (44%); 33% considered giving up medicine, 32% considered reducing their working hours and 40% considered retiring early due to concerns about medico-legal issues. The latter results were all significantly greater for doctors with experience of a complaint, compared with those who had not. While many of these steps may indeed lead to safer patient care, they may be unnecessary, be costly, and may even cause harm, such as ordering imaging technology unnecessarily (Studdert et al., 2005). Importantly, if they are done as a result of fear instead of one’s good clinical judgement, they are known as “defensive medicine”, such as ordering tests and
treatments, undertaking procedures and referring to specialists more than necessary, primarily to protect the doctor from liability and complaints, but as not to be beneficial to patient care. As many as 96% of doctors in high risk specialties in the USA reported practising defensively (Studdert et al., 2005), and 78% in a UK study (Ortashi et al., 2013).

Avoiding certain procedures was another aspect found in Nash (2010), such as no longer practising obstetrics or other high risk procedures, and seeing every patient as a potential litigant. Another worrying finding was that only 26% said they now relate empathically to patients. Participants in my study likewise began to avoid certain patients, especially those with similar presentations as the complainant, or responded differently to those patients they did not like. Bourne (Bourne et al., 2016) found that doctors in their study began to practice more defensively, were practising “poorer medicine”, and engaged in “hedging behaviour”, which relates to avoidance of certain procedures and high-risk patients. The significant impact on the doctor-patient relationship was also a worrying aspect of changes that occur (Cunningham, 2004a). Several other studies have noted that defensive medicine is a common reaction to the fear or reality of being involved in a medico-legal matter, and they paint a similar picture (Charles, 1984; Ennis & Vincent, 1994; Verdhuis, 1994; Summerton, 1995; Jain & Ogden, 1999; Nash et al., 2009).

Two issues come to mind here: one is that the fact of a complaint has power. It can influence not only how one sees him- or herself as a doctor of worth, but it can lead to significant changes to how one practises, and not all of such changes are of benefit to the patient. The other is that the objective of a complaints system, to protect the public by identifying instances of unsafe care, is perhaps missing the mark if it inadvertently causes further harm. Finally, a complaint has the power to make a doctor feel that the system has identified the “shocking thing that they’ve done, but it doesn’t mean their whole life is shocking; but at least at the time it must feel to them like that’s the case” (DiT2).

Conclusion
This thesis did not set out to advocate for those who feel unjustly done by, although there are many doctors who feel this is the case. Their voices can be heard through such publications as Ann Daniel’s (1998) book Scapegoats for a profession: Uncovering procedural injustice, or the activities of the recently formed group of disaffected health professionals, the Health Professionals Australia Reform Association (HPARA)104 which advocates for the reform of health care regulation, and justice for all health practitioners. Nevertheless, this study shows that there is a space in how the best interests of the public are protected that has not adequately taken account of how the complaints process, as it has been conceived and administered, affects those who are deemed to be a threat to the public.

104 //www.hpara.org.au/
While there is a growing recognition that regulatory processes do impact on those caught up in them, and that they can be stressful, the onus has largely been on the individual to take care of themselves. The participants in this study have shown what it is actually like and what it is about the process that has affected them. These provide some important clues as to how it could be different so it does not have such damaging and lasting effects.

The history of regulation showed that regulatory processes had to respond to the changing face of health care, which brought new threats to safety at a time when public awareness coincided with rising expectations of accountability. Transition from self-regulation to externally imposed systems for the governance of health service systems has seen the imposition on the health professions to comply with those external processes. Pressure on the former social contract meant that the terms of this contract needed to be renegotiated, and efforts to do so have been demonstrated through the “new professionalism”, the revision of Codes of Conduct that take greater account of patients’ interests, and the ever-tightening activities of the regulators to oblige health practitioners to behave. Promotion of confidence in the health system and in the regulators has been at the forefront of the message to the public, in order to restore the trust that for the past decades has been under threat by a wary public suspicious that yet another bungle or scandal meant that the health practitioners were not worthy of the trust once taken for granted, and that the regulators were not doing their job.

Public confidence had to be restored by improving patient safety, and also by identifying how things go wrong. Complaints-handling was partly intended to “create an effective bridge, at a national policy level, between the complaints management system and the quality management system” (Hsieh, 2011). This would explain the emphasis on systemic reforms in the health system and preventive measures which would become the foundation for the risk-based approach of protecting the public. This would be at the expense of addressing individual grievances, although as Carney (Carney et al., 2016) points out, the focus of some complaint systems is on resolution, while others have both regulatory and prosecutorial functions, as does the HCCC, in a co-regulatory arrangement.

This risk-based approach has exerted pressure on the individual professionals to explain themselves in the context of an environment that is perceived as assuming they may be in the wrong. What this does not achieve is a restoration of trust in the individual doctor-patient relationship. As Allsop (1994, p. 178) observed from her study, each party to a dispute has a different perspective, having interpreted what happened from their own view of the experience. “For complainants, by the time a letter is written a threshold of intolerance has been passed and the doctor-patient relationship is likely to have been broken. … Equally doctors, once faced with such an eventuality, will wish also to be heard.” What then happens is that the complainant’s

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version is interpreted by the complaints-handler in terms of the public interest it may or may not represent, and the response is mediated through a legal process that addresses those public interest concerns. Neither party is truly being heard. This recalls my earlier understanding, based on the findings, that what is missing is the expression of the doctors' personal response to a complaint, and the meaning this has for their personal and professional identity. This is the silent narrative to which the title of this chapter refers, and this is what is at the heart of their moral anguish. What the participants of this study showed, through their powerful and candid testimonies, was that the process of dealing with complaints is distressing, and that aspects of it contribute to a sense of guilt and shame, that they feel blameworthy even if they are not, and that they are less than the doctors they believed themselves to be.

Cunningham questions whether having a complaint improves the delivery of patient care, and there have been several indications that if anything, it has a negative effect in terms of defensive behaviour, and impacts on their health, which in turn affects their ability to practise safely:

Some effect is expected following a complaint. The profession’s regulatory processes are intended to ensure doctors do change their practices. However, the change is expected to be positive, to remedy dangerous or disrespectful care, and to ensure that future patients benefit from the process. The study suggests there is doubt as to whether these expected benefits actually accrue (Cunningham & Dovey, 2000, p. 467).

Vincent’s (1994) study of why people sue doctors likewise doubts if litigation has any beneficial effects on standards of care. What the process does achieve is reduced goodwill towards patients (Cunningham, 2004), loss of joy (Riley, 2004; Cunningham 2004a), and all the other impacts that have been so eloquently expressed by the other studies which sit beside my own.

It could therefore be argued that to reduce adverse impacts and to achieve improvements in the quality of care, an educational process into the experience may reduce the possibility of defensive practice becoming normalised. This could be achieved through a more collaborative approach between the profession and complaints authorities (Cunningham & Dovey, 2006). Cunningham (2015) also recommends that there be a reflective process, one that is currently missing in the complaints process, as the “opportunity for careful structured reflection allowing learning and change” (Cunningham, 2015, p. 29), which would be a role for the professions. The other aspect is to ameliorate the distress, in order to assist doctors regain a sense of emotional equilibrium while undergoing the process (Charles, 2001). This can be achieved by enhancing knowledge of what is already available, that doctors be generally more aware of the potential impact of complaints and that they be encouraged to seek help from the outset. In addition, the simple question “whom have you told”, asked by those advising a doctor in trouble, is a useful signal to how they may travel, and how to intervene in order to “guide them towards support”. At the least, pastoral care is necessary
to support doctors during the process, and to prevent long-term emotional consequences (Cunningham, 2015).

The difficulty for doctors in this regulatory environment is that professional regulation is perceived as discipline and sanction, whereas the regulators see there is a positive correlation between their interventions and the safety and quality of care (Quick, 2011, p. 5). In regulation, therefore, he said it is not reasonable to expect total compliance, that the pursuit of perfection is not possible, and that the focus should be on “governing rather than erasing” the gap between expectations and performance. Unfortunately for most doctors who come under the net of disciplinary processes, the perception of punitive intent is common. Regulating doctors is perceived to be designed around the assumption that all doctors are potentially at risk and surveillance is necessary to prevent calamity. As a consequence, there is an underlying fear of trouble, of being sued or complained about if they do not measure up and they will be regarded as one of “the bad guys”. The complex process of regulation, to McGivern (2010, p. 606) is thus:

Spectacular regulation focuses on rare but high profile cases of malpractice, which tarnishes the reputation of doctors and suggest that more regulation is needed, rather than its impact on the day-to-day practice of the “invisible majority” who have never been found guilty of medical malpractice.

But most doctors are not “bad guys”, and even if they have complaints, it does not mean they are bad or that it is acceptable that they should suffer morbid anxiety and distress. As DiT3 said, after he had resigned:

If knowing that other reasonable people can have complaints as well, it kind of neutralised it to a certain extent but it also made me think, you know, in terms of practising, if we go through this really quite dreadful emotional angst every time there’s a complaint and it’s happening to all of these people, why the hell do I want to remain in clinical practice (DiT3)?

The challenge is how to prevent the process from even causing a doctor to think like this (unless there are good reasons why they should no longer be doctors).

In summary, a complaint casts a shadow of doubt over a doctor’s practice. Most have said that they still harbour such doubts, even if a complaint was not substantiated. Being a “good doctor”, and being seen to be good, is important to doctors. Being accused of not being a good doctor is very threatening, and they find that recovery is very hard, even years later. It is not sufficient to blame the individual for not being resilient or not coping, because there are factors outside of their control but that are inside of the control of regulatory authorities that add stress and uncertainty to an already confronting event such as receiving a complaint. What many doctors need is validation that the profession (colleagues, peers, team members, administrators, managers) will not rush to
judge, will acknowledge that the process is stressful and that they may need some human understanding and empathy, even if they are guilty or are suspected of being so. Most doctors are good or at least good enough. Even if they are not, how can the process better contribute to their recovery instead of diminishing them further?\footnote{From author’s address to the Australasian Doctors Health Conference, 25 October 2017.}

**Limitations**

The study was based on a small group of self-selected few doctors. They had their reasons for participating, which was to speak about what it was like. Those who wanted this to serve to advocate for their quest for justice were not interviewed as this was not the purpose of the study. Nor were the otherwise disaffected not interested in having their voice heard, or those who were not bothered about having a complaint, or who had nothing to say. Being a small group, no inferences could be drawn about patterns emerging from demographic groups, such as more mature, experienced doctors being more reflective, or that younger ones were who felt they had more to learn. No effort was made to draw out fine distinctions of this nature, nor whether gender makes a difference, or type of specialty. Such information would be very useful, and suggests further research.

The other limitation was that although it was tempting to offer suggested changes in the system, other than presenting the drawbacks, frustrations, confusions and delays in the bureaucratic process itself, it is for the administrators of these procedures to give thought to how they may better communicate with respondents and to address these problems without compromising fairness and the public interest. The incommensurability between law and medicine has been referred to, with their different language and culture, as well as the notion that the process is very legalistic and alien to medicine, and perceived to be adversarial. Procedures in other jurisdictions can be less daunting, and therapeutic jurisprudence (Wexler, 2000) is one such approach that may suit the resolution of many disputes in health care that would avoid the punitive flavour of existing processes. However, space does not allow such deliberations, nor the limits of my own experience in pursuing such options. It took a Royal Commission to bring about fundamental change. All I can do is present some very powerful accounts of what being complained about is like, and what it means, to provide greater insight into why it hurts so much.
Epilogue: a Personal Perspective

This thesis has identified some aspects of the complaints process that have been shown to contribute either directly or indirectly to doctors’ distress. The two key findings reveal that the process is perceived as unfair, and that the threat to moral legitimacy is the foundation of doctors’ fear, distress and consternation. These findings suggest the reasons are intangible, existential responses to a system that digs at the fibre of what makes a doctor who they are. The value of a narrative approach in being able to identify these reasons, and the factors that led to these conclusions while undertaking this study, cannot be underestimated. Such issues have implications for change, not only in the process itself, but in the foundational principles on which the process operates. This is not to suggest that there should not be a complaints system, nor that it is not necessary. History showed us very clearly that these presumptions are now a given.

Legal history has also demonstrated how the law responds to changing circumstances, community values and expectations, and political imperatives. Such changes may shed light on how current systems and institutions are functioning, giving us pause to reflect on their adequacy or appropriateness and whether they meet changing expectations. The recent inquiries into financial institutions and child sexual abuse by the clergy are examples of how identified problems that have a significant impact on the community need to be examined and remedied. In this way, my thesis showed how the Chelmsford Private Hospital judicial inquiry was instrumental in identifying major structural problems in health care governance and lack of accountability of the medical profession, and how these problems may be remedied. As a consequence of this latter, an institution (the HCCC in NSW, and equivalents in the other states) was created that would deal with complaints as both a window into problems in the health system and an avenue for the resolution of personal grievances. It was created on the basis of a model deemed appropriate at the time of its instigation. Originally envisaged by Justice Slattery, who oversaw the inquiry, that the NSW body would be a sub-division of the Supreme Court, but after much debate about its purpose and who it was serving (the public interest or as an advocacy service for members of the public), it was almost inevitable that it would have a strong legal base that echoed the language and procedures of existing legal processes. For an individual to be brought before such an authority with its newfound powers was the source of much consternation, as it continues to be.

This study has been a reminder that the consternation has not gone away and has brought back into the spotlight what has been known for these past decades, that complaints processes may cause harm to those complained about. This is set against the recent reporting of the unacceptable loss of doctors to suicide due to the unsustainable pressures that many endure. Some of these pressures are due either directly or indirectly to involvement in a medico-legal matter, an event which for some may mean loss of their career, and certainly threats to reputation. The language of the medico-legal world is not that of medicine, where failure can mean catastrophe and is therefore not part of the lexicon. “Failure” in the medico-legal world means a breach of a rule, a regulation, a
code, a failure of judgement, a failure to be good enough by established standards. It is a retrospective examination of what has passed, and is assessed and judged by those who were not there.

This is at the heart of the consternation. Doctors fear they will not be believed, that they must defend themselves, for the very nature of alleging a failure of some sort sets the tone of what is to follow. They perceive this process as adversarial. To allege a failure, shortcoming, mistake or deficiency, leads to the natural desire to defend oneself. This leads to many of the behaviours described by the experts, which they then need to be able to manage in order to assist. It does not suggest a spirit of resolution, but how to come out unscathed and unblemished. Yet the legal process denies it is adversarial, asserting that it is inquisitorial, that it is educational and restorative. Few participants acknowledged any of these applied to their own experience, albeit that all agreed a complaints process is necessary. What doctors also perceive is that the process is taken out of their control. This may be to protect their interests, but there is a sense that they cannot tell their story without it being manipulated, and the parts of the story that matter most to them are carefully put to silence. These are the personal and human reactions to an event, or to the complaint itself. This they must deal with on their own. An astute adviser, such as those whom I interviewed as experts, will recognise these reactions and if they appear as “obstacles”, then they are dealt with before the real business of defence can begin. Such a question as what do you fear most seems simple, but it could open up a conversation that means someone has heard and acknowledged the human reaction, as does whom have you told as opening up a conversation about deeper feelings of shame, stigma and loss of reputation, or career and livelihood, which are the common responses participants spoke about, and that have been identified by previous researchers.

This suggests that to minimise distress, doctors not only need medico-legal advice, but that the personal reaction to receiving a complaint, to the limbo state while the process takes its course and to the last stage of finalisation, need some acknowledgement and timely intervention, where it is needed. Not all doctors need this attention, nor want it, but many do, or they suffer in silence, bewilderment and perhaps distress. Whose responsibility should this be? As we know it is more common than not for doctors to avoid seeking professional help, we should not leave it to them to recognise and act on their own symptoms. Lawyers and medico-legal advisers are not trained to provide psychological support, nor would this be appropriate. But those simple words, as above, may be sufficient to bring to the fore what may be needed to provide more holistic support to doctors during this anxious event, and for a protocol to be developed to take over from there, depending on the response.

The other aspect is how to aim for restoration to one’s normal competent self. The process then also needs to provide an opportunity for reflection in a non-judgemental way to appraise the event and their practice. If the shame of alleged failure gets in the way of restoration by being judged, or
judging oneself through the norms or standards of practice, then it can impede the learning opportunity provided by such appraisal. Therefore, the objective of the process to be educative is curtailed and replaced by defensive practice, which in itself is counterproductive.

The question asked in the thesis was does it matter? I argued that it does. The question we can now ask is should it be different? And then, if so, how can it be different? I do not wish to imply that the authorities are not aware of these issues, or that they do not care. In fact, many changes have been introduced to lessen the focus on investigations and more onto enabling those less serious matters to be resolved more expeditiously, to acknowledge that the process may be stressful and to encourage doctors to seek support. Greater emphasis has been placed on doctors’ health in general, and resources to support such services are available. The medical insurers are well aware of the personal impacts and aim to educate and support doctors through the process. However, the onus still resides with the individual to look after themselves, to learn to be resilient, to cope. My view is that the system should not be so threatening as to lead doctors into this state of mind in the first place.

There is another dimension that is missing from the picture. This is the moral dimension that was discussed in the thesis. Threats to reputation are real, as are the shame and stigma associated with complaints. These are the key reasons doctors do not seek support, tell others, or obtain professional help if they need it. Doctors need to feel validated that they are worthy, and that they remain worthy in spite of an allegation that they are not. While they are afforded procedural fairness, this is only the beginning, for it does not mean they feel the process is just, that they will be heard nor that anyone will be really listening. They feel the process is weighted towards the rights of complainants, and that the system assumes they are guilty until they can prove otherwise. They lose control over their professional life and future, until they can win it back, a process that is mediated by the lawyers. This is why it feels adversarial, and being in such a dependant position is not a comfortable place for a doctor who needs to feel in charge, to be confident to assume leadership and to exercise sound judgement. Given this system, it is essential that such defence and support be provided, since too many doctors have fallen over the edge from attempting to navigate the process on their own.

Validation, acceptance, collegiality are all essential to one’s personal and professional wellbeing. When this is threatened, it can be the source of much distress. Therefore, the system and those within it need to be better balanced and less judgemental. To judge a person by one mistake negates the good they have done. It needs to help a doctor hang on to that good or to return to a time when their vision for an exceptional and fulfilling future may return to them. This is compromised when all the focus is on the wrongdoing, a prolonged and tortuous wait as the process unravels itself towards a conclusion. These are the elements of the process that participants perceive to be “unfair”.

The suggested improvements identified in the chapter “How could it be different” are a guide to what can be done within the system to mitigate the harm. I suggest that these be used to identify the basis for another conversation, this one with the regulators, as to what could make a critical difference to a doctor’s survival. These can be listed as:

Style of communication, being less bureaucratic and being more informative about the basis for decisions;

Being more informative in general about the process, given many have the impression that complaints are being assessed not by their peers but by non-medical administrative staff, and so have little trust in the decision-making process;

Timeframes for assessment decisions and key steps in this process need to be better articulated to remove some of the uncertainty;

Timeframes for doctors to respond are often unrealistic when access to documents and records is delayed or denied, or due to the complexity of a matter requiring significant time to construct a considered response;

Dealing with less significant complaints more expeditiously, and explaining why they must be dealt with.

I would add that communication could not only advise respondents to seek advice from their medical indemnity insurers but could forewarn doctors that the process may be stressful, that it may take some time and make suggestions about self-care. When a matter is finalised, letters generally acknowledge that the process may have been stressful, but this is often perceived as patronising and tokenistic. It is like telling someone that we know we have hurt you, but we accept no responsibility for having done so.

While the regulator AHPRA believes in transparency and that it will enhance trust if the public has the right to know about doctors who have been disciplined or who have conditions, this adds significantly to doctors’ distress and sense of unfairness. It adds to the sense of guilt to a wrong-doing, which may not have been a wrongdoing at all. The public does not have “insider knowledge” of how the disciplinary process works and will therefore have a biased view based on the fact of a complaint and its outcome, without having the contextual background. Therefore, doctors’ perceptions that their reputations are at stake are understandable, and they have no right of reply to this public disclosure. This aspect needs to be reconsidered so it provides a more balanced view to the public.

**Summary**

I was asked to provide my own perspectives of what needs to change in order to prevent or minimise the damage caused by the receipt of a complaint. The first point is that hurt doctors may
harm patients, which compromises the aim of protecting the public by having a complaints system. It is not sufficient to advise doctors to look after themselves or seek professional help as it is akin to holding them responsible for not coping or not being resilient enough. The second point therefore is to identify what can be changed to prevent the hurt in the first place. This thesis provides several areas where the process could be improved to minimise the factors that contribute to distress and anxiety.

The third is to reconsider the very principles on which the process was constructed: an adversarial approach that is perceived to assume guilt by its very nature that must be proven otherwise. If we fail an exam, we are not guilty of failing an exam; but if we make a mistake, why are we guilty of doing so. We may do better next time if we understand it better, but this process is not about learning, it is about blame. This is very damaging, because it establishes a dualistic frame of mind that evokes such values as unworthiness, blamefulness, badness, incompetence, or just not being good enough, which can be generalised to a doctor’s whole image of themselves. Such values are antithetical to the values instilled in a doctor’s professionalism, such values being the groundwork for everything a doctor aspires to be and is trained for. Somewhere in the process, somewhere in a doctor’s life, there needs to be a way of restoring one’s sense of worth and value, for a doctor to be restored to their sense of equilibrium in order to continue as a fully functioning, competent doctor, not the diminished one that this process leaves many in a state of being. These are conversations that need to be had, that I alone cannot provide the answer for. The principles of therapeutic jurisprudence may provide some of the answers to a way forward, as will the demonstration of greater empathy and kindness.

Lastly, while this thesis is about medical practitioners, the same principles apply to any other professionals who have been called to account for their actions, particularly those in the helping professions – dentists, psychologists, veterinarians, physiotherapists, nurses, paramedics, and all the other allied health professionals – as well as the lawyers, engineers, architects, police and so on. Most of such people do not set out to cause harm, but to use their skills and expertise to help people and society. Doctors need support in dealing with the more challenging aspects of their work, and the opportunity to learn from mistakes and make improvements when they need to, but do not need blame for not coping when they cry or fall to pieces.

Elizabeth van Ekert
9 April 2019
References


Health Issues Centre Inc. (2014). Setting things right: Improving the consumer experience of AHPRA including the joint notification process between AHPRA and OHSC. Melbourne: Health Issues Centre Inc.


Medical Board of Australia. (2014). *Good medical practice: A code of conduct for doctors in Australia*. Canberra: Medical Board of Australia.


Srivastava, R. (2017). To stop doctors ending their lives, we need to hear from those suffering. Australian Doctor, March 21.


Appendices

Appendix One

Doctors’ experience of complaints against them

PARTICIPANT INFORMATION STATEMENT

(1) What is this study about?

This research study is about understanding doctors’ experience of complaints against them, and about the effectiveness of any support obtained during the complaints process. The results will be used to inform complaints-handling bodies and AHPRA, providers of support services, the Colleges and the medical defence organisations about the impact of complaints from the doctors’ perspective. The knowledge will also contribute to a greater understanding of the nature and impact of the regulatory environment on the profession, so that medical educators and curriculum developers may better prepare student and junior doctors for what may lie ahead.

You have been invited to participate in this study because your experience of complaints will provide a valuable contribution to understanding why doctors respond as they do. This Participant Information Statement tells you about the research study. Knowing what is involved will help you decide if you want to take part in the research. Please read this sheet carefully and ask questions about anything that you don’t understand or want to know more about.

Participation in this research study is voluntary. So it is up to you whether you wish to take part or not.

By giving your consent to take part in this study you are telling us that you:
✓ Understand what you have read
✓ Agree to take part in the research study as outlined below
✓ Agree to the use of your personal information as described.

You may keep this Participant Information Statement.

(2) Who is running the study?

The study is being conducted by Elizabeth van Ekert as the basis for the degree of Doctor of Philosophy at the Centre for Values, Ethics and Law in Medicine, Faculty of Medicine, The University of Sydney. This will take place under the supervision of Dr Claire Hooker, senior lecturer, Centre for Values, Ethics and Law in Medicine, Faculty of Medicine, The University of Sydney.

Auxiliary supervision is being provided by:
- A/Professor Ian Kerridge, Associate Professor in Bioethics, Centre for Values, Ethics and Law in Medicine, Faculty of Medicine, The University of Sydney
- Professor Garry Walter, Professor Child and Adolescent Psychiatry, The University of Sydney
- Professor Cameron Stewart, Professor of health, Law and Ethics, Sydney Law School, The University of Sydney
- Dr Jennifer Fleming, Postdoctoral Research Associate, Centre for Values, Ethics and Law in Medicine, Faculty of Medicine, The University of Sydney.
(3) What will the study involve for me?
The study will build on previous studies concerning the adverse impact of medico-legal matters on many doctors’ health and wellbeing and aims to understand the reasons why there is an adverse impact.

You will participate in a face-to-face interview with the researcher that will be conducted at a venue, time and date to suit your convenience and comfort as we are mindful that you may wish to keep this confidential.

All that we ask is that you have undergone the experience of at least one complaint against you, that is now closed, and that you will be happy to talk about your experience. The interview will not be focused on the complaint itself nor on its outcome but on your personal experience of the process including any support you may have received. If your matter went to a formal hearing, the researcher will not access the decision unless you think it may add to an understanding of your experience. This will be discussed with you before or during the interview.

The interview will be audio-taped and transcribed. If any identifying details are inadvertently included in the tape, they will be removed from the data before it is analysed. The transcriber will have signed a confidentiality agreement prior to having access to the data.

(4) How much of my time will the study take?
The interview will take from 60 to 90 minutes of your time but in preparation for the interview, it will be helpful if you reflect on your experience.

(5) Who can take part in the study
In this phase of the study, only doctors who are currently practising or recently retired, and who have experienced at least one complaint against them, may participate. This may be a complaint to a complaints body or AHPRA, or a claim for compensation. The complaint must have been finalised and if it went to a formal hearing, any appeals period must have elapsed. This latter stipulation is to protect doctors against the remote chance of discoverability while a matter remains open.

(6) Do I have to be in the study? Can I withdraw from the study once I’ve started?
Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect your current or future relationship with the researchers or anyone else at The University of Sydney.

If you decide to take part in the study and then change your mind later, you are free to withdraw at any time. You can do this by informing the researcher, Ms Elizabeth van Ekert, on 0401997537 or elizabeth.vanekert@sydney.edu.au.

You may refuse to answer any questions that you do not wish to answer during the interview.

You will also be free to stop the interview at any time, and proceed after a break or at another time, or withdraw completely. If the latter, we will not collect any more information from you. Any recordings will be erased and the information you have provided will be removed from our study records and will not be included in the study results.

(7) Are there any risks or costs associated with being in the study?
Aside from giving up your time, we do not expect there to be major risks or costs associated with taking part in this study. However, you need to be aware of the following:
Emotional risks
There is a chance that memories may be stirred up that may not have been pleasant, or that were quite distressing. If you are hesitating now about this, you may wish to discuss this further with Ms van Ekert. Alternatively, the medical defence organisations have been informed that the study is being conducted, so you may wish to speak with your medico-legal adviser. [Name of MDO] has also nominated [name of contact person] as liaison between the researcher and [Name of MDO] members, and she is willing to discuss any concerns participants may have about the study.

If during the interview you feel unnerved or distressed, we may break for a moment or resume on another occasion. On the other hand, if you wish to withdraw at any time, you may do so with no consequence. If you wish to stop the interview altogether, the audio-recording tape will be erased and any other information you have provided will not be included in the study.

At the end of this information sheet, there is a list of support services you may wish to contact before, during or after your participation in this study.

Disclosure of illegal activity
You need to be aware that if you are engaged in illegal activity, the researcher may be under an obligation to notify the authorities. The most likely activity that may come up during an interview relates to the acquisition, possession and/or use of illegal substances or illegally obtained substances.

If you think this may apply to you, you have the choice of (a) declining to participate (b) being aware that during the interview it is important that you do not reveal any information that may oblige the researcher to inform the authorities. This is not to say that you should not talk about your coping strategies during the interview, as information about these will be most welcome, but be aware that you should not provide details of potentially indictable offences. If this inadvertently occurs during the interview, the interview will be stopped and the tape turned off, while the researcher discusses with you the consequences of proceeding with this part of the interview.

Potential for concern about “impairment”
The researcher is not a clinician and is therefore under no legal obligation to notify AHPRA if she becomes aware that you as a participant may be using alcohol or drugs to the extent that your wellbeing and that of your patients may be at risk. Nevertheless, she may feel a moral obligation to exercise her duty of care towards you and your patients. Accordingly, she will use her judgement as to whether to proceed with the interview. She will at all times discuss this with you and speak with you about obtaining appropriate support. This discussion would not take place while the tape is running, and the interview will only continue by mutual agreement.

(8) Are there any benefits associated with being in the study?
While there are no tangible benefits of participating in this study, you will have the knowledge that you are making a substantial contribution to the profession’s understanding of the impact of complaints.

Much is known about complainants: who they are, their motivations for complaining, and their expectations of the complaints process. But little is known about doctors’ real experience and perceptions. Your contribution will be invaluable in adding to this knowledge, which will be used to help mitigate any adverse effects in others.

(9) What will happen to information about me that is collected during the study?
Material that includes personal information about you (name, address, contact details, type of practice), records of conversations with you, emails and correspondence will be
kept in a file that only the research team can have access to. This information will be used to communicate with you as necessary, and some de-identified demographic data may be referred to in the analysis. The latter may refer to your specialty or type of practice but will not in any way identify you.

Actual data collected will be in the form of written notes taken by the researcher, and an audio-recording and transcript of the interview. The transcript of the interview will only be known by a unique participant number. The transcript will be prepared by the researcher, so no third party will be able to associate you with the data collected in the interview.

Following analysis of the data, storage will be in the Medical Faculty storage facility. Materials collected will be kept for seven years, and will be de-identified, except for the consent form that you will have signed prior to your participation. The materials will then be shredded and recordings will be destroyed. The data will not be used in future research projects, nor will it be submitted to any data sharing resource.

The findings from the study will be published in the medical literature and as a doctoral thesis. The researcher has also undertaken to provide a report of the finding to relevant organisations including the medical defence organisations, AHPRA, the State Medical Councils, BeyondBlue, the Australasian Doctors Health Network and the Medical Benevolent Association. The medical press will be informed of the study outcomes and the researcher will be available for interviews, forums and conference presentations to discuss the implications of the findings. At no time will information that could reveal your identity be disclosed.

By providing your consent, you are agreeing to us collecting personal information about you for the purposes of this research study. Your information will only be used for the purposes outlined in this Participant Information Statement, unless you consent otherwise.

Your information will be stored securely and your identity and information will be kept strictly confidential, except as required by law. Study findings may be published, but you will not be individually identifiable in these publications.

(10) Can I tell other people about the study?
Yes, you are welcome to tell other people about the study.

(11) What if I would like further information about the study?
When you have read this information, Elizabeth van Ekert will be available to discuss it with you further and answer any questions you may have. If you would like to know more at any stage during the study, please feel free to contact her on 0401997537 or elizabth.vanekert@sydney.edu.au.

(12) Will I be told the results of the study?
You have a right to receive feedback about the overall results of this study. You can tell us that you wish to receive feedback in the form of a summary of findings by ticking the box on the consent form, and providing your mailing address. You will receive this feedback after the study is finished.

(13) What if I have a complaint or any concerns about the study?
Research involving humans in Australia is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this study (Protocol Number 2014/611) have been approved by the HREC of The University of Sydney, Approval Number 1139150. As part of this process, we have agreed to carry out the study according to the National Statement on Ethical Conduct in Human Research
This statement has been developed to protect people who agree to take part in research studies.

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the university using the details outlined below. Please quote the study title and protocol number.

The Manager, Ethics Administration, The University of Sydney:

- **Telephone:** +61 2 8627 8176
- **Email:** ro.humanethics@sydney.edu.au
- **Fax:** +61 2 8627 8177 (Facsimile)

This information sheet is for you to keep.
SUPPORT SERVICES

1. Australasian Doctors Health Network www.adhn.org.au has contact details for specific services in each state, as well as links to useful resources. These services can provide advice about dealing with anxiety, depression or distress, and also about drug and alcohol problems, family or workplace difficulties. For urgent assistance from a **doctors’ health advisory service** in your state:

   (1) **Australian Capital Territory**: 02 6270 5410
   (2) **New South Wales**: 02 9437 6552
   (3) **Northern Territory**: 02 9437 6552
   (4) **Queensland**: 07 3833 4352
   (5) **South Australia**: 08 8366 0250
   (6) **Tasmania**: 1300 853 338
   (7) **Victoria**: 1300 853 338
   (8) **Western Australia**: 08 9321 3098

2. BeyondBlue: phone 1300 22 4636 for 24/7 crisis support

3. Lifeline: phone 13 11 44 for 24/7 crisis support

4. If you are an employee and your organisation has contracted an employment assistance program www.employeeassistanceprogramme.com.au, you are entitled to free and counselling confidential services

5. The AMA in your state
Appendix Two

Doctors' experience of complaints against them

PARTICIPANT INFORMATION STATEMENT

(14) What is this study about?
You are invited to take part in a research study about understanding doctors' experience of complaints against them, and about the effectiveness of any support obtained during the complaints process. The results will be used to inform complaints-handling bodies and AHPRA, providers of support services, the Colleges and the medical defence organisations about the impact of complaints from the doctors' perspective. The knowledge will also contribute to a greater understanding of the nature and impact of the regulatory environment on the profession, so that medical educators and curriculum developers may better prepare student and junior doctors for what may lie ahead.

You have been invited to participate in this study because your experience in supporting doctors will provide a valuable contribution to understanding why doctors respond as they do. This Participant Information Statement tells you about the research study. Knowing what is involved will help you decide if you want to take part in the research. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary. So it is up to you whether you wish to take part or not.

By giving your consent to take part in this study, you are telling us that you:
✔ Understand what you have read
✔ Agree to take part in the research study as outlined below
✔ Agree to the use of your personal information as described.

You may keep this Participant Information Statement.

(15) Who is running the study?
The study is being conducted by Elizabeth van Ekert as the basis for the degree of Doctor of Philosophy at the Centre for Values, Ethics and Law in Medicine, Faculty of Medicine, The University of Sydney. This will take place under the supervision of Dr Claire Hooker, senior lecturer, Centre for Values, Ethics and Law in Medicine, Faculty of Medicine, The University of Sydney.

Auxiliary supervision is being provided by:
• A/Professor Ian Kerridge, Associate Professor in Bioethics, Centre for Values, Ethics and Law in Medicine, Faculty of Medicine, The University of Sydney
• Professor Garry Walter, Professor Child and Adolescent Psychiatry, The University of Sydney
• Professor Cameron Stewart, Professor of Health, Law and Ethics, Sydney Law School, The University of Sydney
• Dr Jennifer Fleming, Postdoctoral Research Associate, Centre for Values, Ethics and Law in Medicine, Faculty of Medicine, The University of Sydney.

(16) What will the study involve for me?
The study will build on previous studies concerning the adverse impact of medico-legal matters on many doctors’ health and wellbeing and aims to understand the reasons why this may be. Previous studies have also found that many doctors are reticent to seek support during or after the complaints process. As a doctor who has provided professional support or advice to doctors who have undergone this experience, we are
interested in your perceptions of what doctors experience, the impact of the complaints process and how the experience may have changed doctors’ practice and identity.

You will participate in a face-to-face interview with the researcher that will be conducted at a venue, time and date to suit your convenience. The interview will be semi-structured, asking questions that draw on your experience and observations.

The interview will be audio-taped and professionally transcribed. If any identifying details are inadvertently included in the tape, they will be removed from the data before it is analysed.

(17) How much of my time will the study take?
The interview will take from 60 to 90 minutes of your time.

(18) Who can take part in the study?
The study will be conducted in phases:
   i. Doctors such as yourself who have provided professional support or advice to doctors who have been complained about
   ii. Doctors with experience of at least one complaint
   iii. The final phase invites participants from Phase One to a second interview to review the preliminary findings from Phase Two.

As a participant in Phase One, you will be one of 4-5 doctors with relevant experience of assisting doctors who have been the subject of complaints.

(19) Do I have to be in the study? Can I withdraw from the study once I've started?
Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect your current or future relationship with the researchers or anyone else at The University of Sydney.

If you decide to take part in the study and then change your mind later, you are free to withdraw at any time. You can do this by informing the researcher, Ms Elizabeth van Ekert, on 0401997537 or elizabeth.vanekert@sydney.edu.au

You will be free to stop the interview at any time. Unless you say that you want us to keep them, any recordings will be erased and the information you have provided will not be included in the study results. You may also refuse to answer any questions that you do not wish to answer during the interview.

If you decide to withdraw from the study, we will not collect any more information from you. Please let us know at the time when you withdraw what you would like us to do with the information we have collected about you up to that point. If you wish, your information will be removed from our study records and will not be included in the study results, up to the point that we have analysed and published the results.

(20) Are there any risks or costs associated with being in the study?
Aside from giving up your time, we do not expect that there will be any risks or costs associated with taking part in this study.

(21) Are there any benefits associated with being in the study?
While there are no tangible benefits of participating in this study, you will have the knowledge that you are making a substantial contribution to the profession’s understanding of the impact of complaints.

Much is known about complainants: who they are, their motivations for complaining, and their expectations of the complaints process. But little is known about doctors’ real
experience and perceptions. Your contribution will be invaluable in adding to this knowledge, which will be used to help mitigate any adverse effects in others.

(22) **What will happen to information about me that is collected during the study?**

Material that includes personal information about you (name, address, contact details, type of practice), records of conversations with you, emails and correspondence will be kept in a file that only the research team can have access to. This information will be used to communicate with you as necessary, and some demographic data may be referred to in the analysis. The latter may refer to your specialty or type of practice but will not in any way identify you.

Actual data collected will be in the form of written notes taken by the researcher, and an audio-recording and transcript of the interview. The transcript of the interview will only be known by a unique participant number. The transcript will be prepared by the researcher, so no third party will be able to associate you with the data collected in the interview.

Following analysis of the data, storage will be in the Medical Faculty storage facility. Materials collected will be kept for seven years, and will be de-identified, except for the consent form that you will have signed prior to your participation. The materials will then be shredded and recordings will be destroyed. The data will not be used in future research projects, nor will it be submitted to any data sharing resource.

The findings from the study will be published in the medical literature and as a doctoral thesis. The researcher has also undertaken to provide a report of the finding to relevant organisations including the medical defence organisations, AHPRA, the State Medical Councils, BeyondBlue, the Australasian Doctors Health Network and the Medical Benevolent Association. The medical press will be informed of the study outcomes and the researcher will be available for interviews, forums and conference presentations to discuss the implications of the findings. At no time will information that could reveal your identity be disclosed.

By providing your consent, you are agreeing to us collecting personal information about you for the purposes of this research study. Your information will only be used for the purposes outlined in this Participant Information Statement, unless you consent otherwise.

Your information will be stored securely and your identity/information will be kept strictly confidential, except as required by law. Study findings may be published, but you will not be individually identifiable in these publications.

(23) **Can I tell other people about the study?**

Yes, you are welcome to tell other people about the study.

(24) **What if I would like further information about the study?**

When you have read this information, Elizabeth van Ekert will be available to discuss it with you further and answer any questions you may have. If you would like to know more at any stage during the study, please feel free to contact her on 0401997537 or elizabeth.vanekert@sydney.edu.au

(25) **Will I be told the results of the study?**

You have a right to receive feedback about the overall results of this study. You can tell us that you wish to receive feedback in the form of a summary of findings by ticking the box on the consent form, and providing your mailing address. You will receive this feedback after the study is finished.
(26) What if I have a complaint or any concerns about the study?

Research involving humans in Australia is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this study have been approved by the HREC of The University of Sydney, Approval Number 1139150. As part of this process, we have agreed to carry out the study according to the National Statement on Ethical Conduct in Human Research (2007). This statement has been developed to protect people who agree to take part in research studies.

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the university using the details outlined below. Please quote the study title and protocol number.

The Manager, Ethics Administration, The University of Sydney:

- **Telephone:** +61 2 8627 8176
- **Email:** ro.humanethics@sydney.edu.au
- **Fax:** +61 2 8627 8177 (Facsimile)

This information sheet is for you to keep
Appendix Three

PARTICIPANT CONSENT FORM

I, ................................................................................... [PRINT NAME], agree to take part in this research study. In giving my consent I state that:

✓ I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.

✓ I have read the Participant Information Statement and have been able to discuss my involvement in the study with the researcher if I wished to do so.

✓ The researcher, Elizabeth van Ekert, has answered any questions that I had about the study and I am happy with the answers.

✓ I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at The University of Sydney, now or in the future.

✓ I understand that I can withdraw from the study at any time.

✓ I understand that I may stop the interview at any time if I do not wish to continue, and that unless I indicate otherwise, any recordings will then be erased and the information provided will not be included in the study. I also understand that I may refuse to answer any questions I don’t wish to answer.

✓ I understand that the results of this study may be published, and that publications will not contain my name or any identifiable information about me.

✓ I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information about me will only be told to others with my permission, except as required by law. The instances which may oblige the researcher to breach confidentiality include:

  o Where the researcher believes there is significant risk of harm to me or another person

  o When ordered by a court of law, although I understand that the University will do its upmost to protect my privacy

  o Where the researcher believes I may be guilty of a criminal offence.

I consent to:

- Audio-recording

  YES ☐ NO ☐

- Being contacted about future studies

  YES ☐ NO ☐

Would you like to receive feedback about the overall results of this study?

YES ☐ NO ☐
If you answered **YES**, please indicate your preferred form of feedback and address:

- [ ] Postal: ______________________________________________________
  ______________________________________________________

- [ ] Email: ______________________________________________________

Signature

PRINT name

Date
Appendix Four

Doctors’ experience of complaints against them

PARTICIPANT CONSENT FORM

I, ................................................................................... [PRINT NAME], agree to take part in this research study.

In giving my consent, I state that:

✓ I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.

✓ I have read the Participant Information Statement and have been able to discuss my involvement in the study with the researchers if I wished to do so.

✓ The researchers have answered any questions that I had about the study and I am happy with the answers.

✓ I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at the University of Sydney now or in the future.

✓ I understand that I can withdraw from the study at any time.

✓ I understand that I may stop the interview at any time if I do not wish to continue, and that unless I indicate otherwise any recordings will then be erased and the information provided will not be included in the study. I also understand that I may refuse to answer any questions I don’t wish to answer.

✓ I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information about me will only be told to others with my permission, except as required by law.

✓ I understand that the results of this study may be published, and that publications will not contain my name or any identifiable information about me.

I consent to:

- Audio-recording
  - YES □  NO □

- Being contacted about future studies
  - YES □  NO □

Would you like to receive feedback about the overall results of this study?

- YES □  NO □

If you answered YES, please indicate your preferred form of feedback and address:

□ Postal: _____________________________________________________________

_____________________________________________________________
Email: ____________________________________________________________

..............................................................................................................
Signature
..............................................................................................................
PRINT name
..............................................................................................................
Date
### Appendix Five

**INTERVIEW SCHEDULE**

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<td>DiT13</td>
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<td>Interstate, city, in public area</td>
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</tr>
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</tr>
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<td>19 April 2016</td>
<td>NSW city, at home</td>
</tr>
</tbody>
</table>

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<th>Location</th>
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<td>EI5</td>
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<td>Interstate, workplace</td>
</tr>
</tbody>
</table>
Appendix Six

Interview questions for Phase 2

Doctors’ experience of complaints against them

Introduction

1. Thank you for agreeing to participate in this study, which, as we have spoken about, aims at gathering your perceptions of the complaints process and of your own personal experience of having a complaint. We would like to know if you obtained any support, what that was and whether it made a difference.
2. We are not concerned about the complaint itself, what it was about, whom it was from or what the outcome was. However, if it helps in your account of your experience, you may certainly mention talk about it, though please do not use names or other details that may identify parties to the complaint. If such details are inadvertently mentioned, they will be erased from the record of this interview.
3. If you wish to pause at any time, you may. If you wish to discontinue, you are free to do so.
4. Do you agree to the interview being recorded? This will ensure we have an accurate record and will enable me to listen and engage with you freely.
5. I would also like to remind you of the advice provided in the Information Sheet and Consent form relating to disclosure of illegal activity. Do you recall reading this warning, and do you have any questions about it?
6. Do you have any other questions before we start?

The interview

Introductory questions
[This is to warm up the interviewee and to obtain a brief profile of the nature of their practice]

Can you tell me a little about yourself as a doctor?

How long have you been practising and in what speciality?

Where do you practise? (in a hospital, solo, group, partnership, community-based, etc.)

The complaint and you

Can you tell me about your experience of the complaint process?

What will follow depends on the response of the interviewee to the flow of the conversation. The aim is to have the doctor give their own account of what it was like to receive a complaint, such as:

What happened when you first received a complaint? What did you think of the complaint itself: can you recall the patient and issues they were complaining about?

What did you do next? What were your feelings at that time?

Did you tell anyone about it? How did you feel about telling them? What did you think they may say? What do you think they may have thought about you?

What did you understand you had to do about the complaint: did the letter explain this? Did you feel you had to comply with the instructions set out in that letter?

Did you inform your MDO? Did they give you advice on what to do? Did this advice make sense to you?
Can you tell me about how you were feeling at this point of time, after it became “official”? How did this feeling change once the “process” took charge of what you had to do?

**Support**
Did you obtain any formal or informal support during the process?

Can you tell me more about the support you received?

Did you at any point seek out any professional support? Can you tell me about this? (e.g., professional psychological, GP, EAP, supervisor or senior colleague, medical adviser at MDO, doctors’ health advisory service, BeyondBlue, etc.) Did you find this helpful? What was helpful about it? What could have been better handled? Why do you say this?

If you did not have professional support, did you speak to anyone else about it? Did this make a difference?

Did you seek any other source of information that may help you? (e.g., online resource, literature). Can you tell me more about this? Did this encourage or help you in any way?

**Changes to you and your practice**
Did anything change about you or your practice during the course of the complaint-handling process? Can you tell me more about this? (e.g., behavioural change, changes in practice). What about after it was all over: did anything change then?

Did the complaint or the process itself make any difference to how you felt about your patients? (e.g., trust) Or about your colleagues?

**Impact on your perception of medicine**
Now I would like for us to take a step back in time: When you first went into medicine, what did you think it would be like? Has this attitude changed with experience?

Has having a complaint added to this change?

Has the experience changed your feelings about being a doctor in any way? Can you elaborate?

**Impact on others’ perceptions of you**
If others around you know of this complaint, such as your family, friends, colleagues, has their attitude towards you changed in any way that you are aware of? What do you attribute this to?

**Perceptions of the whole process**
Overall, looking back, can you describe how you feel about the whole process? How do you think you were treated by the system?

How could the process have been improved for you?

**Closing**
We are coming to the end of the interview now. Is there anything you would like to add or clarify?

Are you clear about what will happen next? [transcribing, de-identifying any personal details, analysis, write-up, publication; access to findings; how confidential information will be stored]

[Assurance that if anything has disturbed them as a result of their participation, they may call me or speak with their adviser at their MDO or other professional. There is also the list of support services tuned in to the special needs of doctors, provided in the Information sheet (if they do not still have it, I will have another list on hand to give them.)]
You may feel welcome to keep in touch if you wish about progress with the study.

Thank you again for your assistance with this study. Knowing how much this has affected you, your participation and candid opinions are very much appreciated. I wish you well in your practice.
Appendix Seven

Phase one Interview questions

Doctors’ experience of complaints against them

Introduction
1. Thank you for agreeing to participate in this study, which, as we have spoken about, aims at gathering your perceptions of the complaints process and how it impacts on doctors whom you have worked with to provide support.
2. Do you agree to the interview being recorded? This will ensure we have an accurate record and will enable me to listen and engage with you more freely.
3. I can assure you that your identity will not be revealed and any information obtained from you or about you will be held in a secure place.
4. Do you have any questions before we start?

The interview

Introductory questions
[This is to warm up the interviewee and to obtain a brief profile of the nature of their practice and the doctor-to-doctor/patient relationship]

Can you tell me a little about your role as a doctor providing support to doctors?

How do you usually undertake these encounters (e.g., by telephone, face-to-face or some other method)? How would you describe the relationship you have with these doctors? (e.g., is there a pattern; does the service involve one-off contact; is it a normal doctor-patient therapeutic relationship or is it more of a colleague-to-colleague relationship?)

Does this make a difference as to your expectations of their ‘treatment’? Do you think these doctors have different expectations of you than your usual patients? If so, what do you attribute this to?

How did you assume this role? What proportion of your current practice involves supporting doctors?

How do doctors generally come to you: through word of mouth, or by referral? Who refers them and how do they know about the service you provide?

Why are they referred to you?

What do you think motivates them to contact you?

The study and your perceptions
You have been describing this aspect of your practice and your involvement with doctors who need your support and advice.

What I am interested in is your perceptions of what, in general, these doctors go through when dealing with a complaint and the official process of managing the complaint by the authorities. If you wish to provide examples, please go ahead, though I would request that you do not use names or identify them in any way.

1. Experience of complaints

You have been doing this work for X years now. Do you have any comments on how complaints impact on doctors’ health and wellbeing?
There has been some research that indicates that doctors are affected by complaints against them more than other professionals of a similar level of status and complexity (e.g., engineers, lawyers: ref Clode, 2004). Do you have any views about why this may be so? What is it about doctors that they are affected more than others, as a generality?

From doctors’ accounts, have you found that doctors’ perceptions of themselves as people and as professionals have changed since being complained about? Can you elaborate?

Have any doctors talked to you about how they may have changed the way they practise? If so, in what way? Do you have any views as to why they may have done this?

2. Obtaining support

BeyondBlue conducted a large study of about 14 000 doctors in 2013 about the mental health of doctors in Australia. What was observed was that doctors are generally reticent about seeking support when they are in trouble over any aspect of their lives. The reasons include stigma, embarrassment, fear of losing their job or advancement, while junior doctors are worried about not being passed, being victimised, being ashamed. As a doctor who has provided professional support to doctors, what are the characteristics of these doctors that have motivated them to seek out your service?

(Shame, stigma, personality, being caught out)

3. The complaints process

Would you like to talk about your impressions of how the complaints process impacts on doctors?

Do you think complaints could be handled differently, being mindful of the fact that people will always complain, and have the right to do so, as well as there being statutory bodies established to protect the public and maintain standards of the profession? If you were in a position to do so, what recommendations would you have for those organisations that handle complaints or that assist doctors with their complaints (e.g., complaints commissions, Medical Board/AHPRA, other regulatory bodies, and the MDOs).

Reflections

Do you find that you identify with some doctors? Or some whom you have little sympathy for, or who may even annoy you? Can you elaborate?

Do you have any other observations you would like to share with me? Or have any questions or suggestions?

Closing

We are coming to the end of the interview now. Is there anything you would like to add or clarify?

Are you clear about what will happen next? [transcribing, de-identifying any personal details, analysis, write-up, publication; access to findings; how confidential information will be stored]

Would you like to participate in the final phase of this study? This would mean re-visiting some of these topics but also reflecting on the results we will have obtained after interviewing a number of doctors. It may be interesting to compare their responses to your impressions.

You may prefer to let me know at a later date. If you wish to do so, I will contact you again closer to the time to make arrangements. As it is another integral component of the study with a delay of
several months between phases, this will involve my sending you further information and asking for your consent again.

Please be assured that you are welcome to keep in touch if you wish about the progress with the study, or if you have any other thoughts you may wish to share.

Thank you again for your assistance with this study.

If you wish to contact me:

Phone: 0401997537 or 0290363432

Email: elizabeth.vanekert@sydney.edu.au
Appendix Eight

CIVIL LIABILITY ACT 2002 - Section 5O

Standard of care for professionals

(1) A person practising a profession ("a professional") does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.

(2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.

(3) The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.

(4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.
Appendix Nine

HEALTH PRACTITIONER REGULATION NATIONAL LAW (NSW) - SECT 144

Grounds for complaint about registered health practitioner [NSW]

144 Grounds for complaint about registered health practitioner [NSW]

The following complaints may be made about a registered health practitioner--

(a) A complaint the practitioner has, either in this jurisdiction or elsewhere, been convicted of or made the subject of a criminal finding for an offence.
(b) A complaint the practitioner has been guilty of unsatisfactory professional conduct or professional misconduct.
(c) A complaint the practitioner is not competent to practise the practitioner's profession.
(d) A complaint the practitioner has an impairment.
(e) A complaint the practitioner is otherwise not a suitable person to hold registration in the practitioner's profession.
Appendix Ten

PRESENTATIONS

1. The silent narrative: Doctors’ experience of complaints against them. Conversation, Centre for Values Ethics and Law in Medicine (VELiM): with A/Professor Louise Nash. 14 September 2014.

2. The silent narrative: Doctors’ experience of complaints against them. Conversation, Centre for Values Ethics and Law in Medicine (VELiM). 27 August 2015.


