

## The bogeyman of defensive medicine

Few stories are guaranteed to attract media attention like the claim that defensive medicine is rife. Why is it newsworthy? Perhaps because the practice of defensive medicine is so starkly at odds with the heart of professionalism, which has been described as “using a doctor’s knowledge, clinical skills, and judgement in the service of protecting and restoring human well-being”.<sup>1</sup> Defensive doctors focus on themselves, rather than their patients. Defensive medicine is alarming because it implies unethical behaviour (avoiding “risky” patients) and wasteful practices (ordering unnecessary tests and investigations).

Typically, claims of defensive medicine abound in overseas jurisdictions that retain the right to sue for medical negligence, leading to headlines like “More tests for sick as GPs fear being sued”.<sup>2</sup> As noted recently by Justice Potter in striking out a claim for negligent failure to ensure the compulsory detention of a mental health patient who later killed his father, “Health professionals could become unduly defensive if continually faced with the spectre of exposure to common law claims in negligence”.<sup>1</sup> As the *Ellis* judgment attests, such fears are groundless in New Zealand.

The recent RNZCGP conference included two conference papers by GP researchers raising the bogeyman of defensive medicine in New Zealand general practice, in the context of complaints. The papers were entitled “Defensive medicine: how doctors change their practice in response to complaints” (by Wayne Cunningham) and “Complaints as a quality measure” (by Rob Henderson). Both papers present the findings of interesting, though somewhat dated research. It is worth evaluating the research and the claims that the authors make.

### *Cunningham’s research*

This research dates from a 2001 survey of a sample of 1200 doctors on the New Zealand medical register, including 400 vocationally registered GPs. Of the 971 respondents, 330 (34%) had *ever* received a complaint, and 641 (66%) had *never* received a complaint. Complaint was not defined (thus it included complaints made directly to the provider, and not just complaints to an external agency, as well as compensation claims filed with ACC) and there was no time limit – so the complaint experience reported on could have been recent or decades old. Clearly, all of the complaints pre-dated the radical reforms of the HDC complaints system since 2001, the dramatic decline in medical discipline in recent years, and the major changes to ACC treatment injury coverage, in 2005. Thus the research presents a historic picture of medical complaints in New Zealand, and doctors’ response to them.

Cunningham’s analysis is based on the written responses from the surveyed doctors. There are some methodological problems with this approach, since the 330 doctors who had *ever* received a complaint provided 527 comments (an average of 1.6 per doctor), compared with the 111 comments from the 641 doctors who had not been complained about (0.2 per doctor). Cunningham also conducted in-depth interviews with 12 of 25 hospital-based specialists who responded to an invitation extended to 40 hospital-based specialists by the Medical Protection Society. The 40 doctors were

selected by MPS, being doctors for whom they had provided medico-legal advice in the previous five years. This is not a random sample.

The research is described as “thematic analysis”. Cunningham’s new (as yet unpublished) findings claim that a culture of defensive medicine has taken hold in New Zealand, in which doctors act to reduce the possibility of complaints, rather than in the best interests of patients. This finding is based on free-text responses from doctors, in contrast to the leading US study, in which 824 (of 1268 surveyed) physicians in Pennsylvania responded whether they had been sued (within the past three years, or before then) and provided specific details of defensive practices.<sup>3</sup>

#### *Impact on quality of care*

Cunningham asks “Do complaints improve the quality of care?” and answers: “As a society, we believe that by making complaints we’re going to improve the delivery of health care. In fact, there is an increasing wealth of evidence to show doctors practice worse.”<sup>4</sup> He suggests that the purpose of the complaints system is to improve the quality of patient care; it is “therapy” applied by society to doctors, and so the efficacy of the therapy should be tested.

A number of points can be made in response. First, quality improvement is not the sole purpose of a complaints system. A primary goal is to give “voice” to patients,<sup>5</sup> and 95% of Cunningham’s respondents agreed it is important that society can complain about doctors.<sup>6</sup> Secondly, although it is true that the focus of the HDC complaints system over the past five years has been “resolution, not retribution” and “learning, not lynching”, it seems rather perverse to claim that because the link to improved quality has not yet been proven, the system is thereby somehow called into question. Almost without exception, other service industries welcome complaints as an opportunity to improve quality, make fewer mistakes, and better understand their customers’ needs.

It is not at all surprising that some doctors react to complaints by changing the way they deliver care. This is *a* goal of the complaints system. To assess accurately whether those changes *actually* improve the quality of care would require the use of objective measures of quality (outcomes data, utilisation patterns, etc). Anecdotes from the targets of complaints will not suffice. I would welcome a sound and independent evaluation of the link between complaints and improved quality of care in the New Zealand system. In the meantime, researchers who suggest that complaints may improve quality of care are more circumspect in their claims. Marie Bismark and colleagues<sup>7</sup> compared 398 HDC complaints relating to public hospital admission in 1998, with a nationally representative sample of non-complainants who suffered adverse events in the same year. The probability of complaint was found to increase steeply with severity of injury, and preventable injuries were much more likely to lead to a complaint than unpreventable ones. Bismark concluded that “complaints offer a valuable portal for observing serious threats to patient safety and may facilitate efforts to improve quality”.<sup>8</sup>

#### *Henderson’s research*

This published research<sup>9</sup> is based on analysis (including in-depth interviews) of the impact of complaints against 33 doctors and nurses in 16 small rural communities in New Zealand. Many of the complaints dated from Medical Practitioners Disciplinary

Committee days (ie, pre-1996), which may explain Henderson’s finding that “fragile local health systems were damaged by the quasi-judicial investigations of the medical disciplinary body”. A consistent finding was that “after about two years, either the doctor or the complainant left the area ... both of them could not live together in the same community”. This is perhaps unsurprising given the reports that complainants were subject to “subtle but effective pressure” — one doctor quoted his supportive patients as saying, “We will go out and lynch them for you doc, you know ... we’ll go and sort them out and rough them up”!

Putting aside the small sample size and historic nature of his study, the following claim by Henderson seems intuitively correct: “There is no doubt that investigating complaints can improve the quality of services, as many effective organisations demonstrate, but whether they lead to improvements depends on the process.” The process *has* changed dramatically since the days when it was run by doctors themselves (ie, the MPDC as part of the Medical Council). It has evolved still further since the changes to the HDC Act in 2004.

#### *Latest HDC data*

The HDC complaints process is intended to be “fair, simple, speedy, and efficient”,<sup>10</sup> and this is now being achieved, with 83% of complaint files closed within six months. Early in my time as Commissioner, HDC adopted the mission of “fair processes, credible decisions, and just outcomes”. Credible decision-making means being alert to the risk that a finding will lead to unnecessary tests and investigations — not every lump needs to be biopsied. The task of adjudicating complaints is facilitated by the pragmatic advice I receive from credible peers nominated by their Colleges, on the appropriate standard of care in such circumstances.

In the year ended 30 June 2006, HDC received 390 complaints about doctors ([a drop of 21% on the previous year](#)). All were assessed, but there were only 98 formal investigations of medical complaints, resulting in 48 findings of breach of the Code of Patients’ Rights. And only 7 doctors faced disciplinary charges. So statistically, the “nervous doctors dodging complaints” appear unnecessarily defensive given the statistical odds (with over 10,000 practising doctors, many undertaking thousands of consultations annually).

Reviewing the 8 HDC cases in which a GP has been found in breach of the Code in 2006, 2 were for inadequate record-keeping; 1 for a sexual relationship with a patient; 1 for a botched vasectomy; 2 for failure to respond adequately to the deteriorating health of a patient in a rest home; 1 for poor history taking and examination of an elderly patient; and 1 for failure to investigate a patient’s recurrent abdominal symptoms. If these cases lead the individual doctors to keep better records, abstain from sex with a current patient, perform vasectomies more skilfully, monitor the health of rest-home patients more carefully, etc, is that “defensive medicine”, or simply better quality care? And if other doctors read the published decisions on the HDC website ([www.hdc.org.nz](http://www.hdc.org.nz)) and reflect on possible improvements to their own practice, is that a bad thing?

#### *Don’t overreact*

There is surely some responsibility on doctors not to over-react to complaints — and then cite their overreaction as self-fulfilling evidence of a harmful impact on quality

of care. Given the absence of malpractice litigation in New Zealand, there is something rather self-indulgent in the response of the small minority of doctors who cry: “Woe is me! I must practise defensive medicine.” What other industry would tolerate such a dismissive and defensive attitude to public concerns?

In my experience, most doctors find receiving a complaint an unpleasant experience, but they get over it — learn any lessons, and get on with life. For the minority who become fixated on the experience, and make disproportionate changes to their practice, the challenge is for the profession to find ways to educate and support its own members. As noted by Milton long ago, “When complaints are freely heard, deeply considered, and speedily reformed, then this is the utmost bound of civil liberty attained that wise men look for.”<sup>11</sup>

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<sup>1</sup> *Ellis v Counties Manukau DHB* (High Court, Auckland, 17 July 2006).

<sup>2</sup> *The West Australian*, 18 August 2006.

<sup>3</sup> Studdert et al, “Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment”, *JAMA* (2005) 293;21:2609-2617.

<sup>4</sup> “Nervous docs dodge the complainers”, *Sunday Star Times*, 30 April 2006, A8.

<sup>5</sup> Cunningham and Tilyard, “The Queenstown Report: proposals for change in the medical disciplinary process”, *NZMJ* (2003) 116:1170.

<sup>6</sup> Cunningham, “New Zealand doctors’ attitudes towards the complaints and disciplinary system”, *NZMJ* (2004) 117(1198).

<sup>7</sup> Co-authors included myself, Peter Davis, Troy Brennan, and David Studdert.

<sup>8</sup> Bismark et al, “Relationship between complaints and quality of care in New Zealand: a descriptive analysis of complainants and non-complainants following adverse events” *Qual Saf Health Care* (2006) 15:17-22.

<sup>9</sup> Henderson et al, “Investigations of complaints and quality of health care” (2005) 12 *Journal of Law & Medicine* 366-372.

<sup>10</sup> The HDC Act 1994, s 6.

<sup>11</sup> Milton, “Areopagitica: A speech for the liberty of unlicensed printing” (1644).