

# Prevalence and characteristics of complaint-prone doctors in private practice in Victoria

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Medicolegal matters are not uniformly distributed across the medical workforce. Previous research has shown that malpractice lawsuits,<sup>1-8</sup> complaints,<sup>8-11</sup> no-fault compensation claims,<sup>12</sup> disciplinary proceedings,<sup>8,13-15</sup> and other referrals to oversight bodies<sup>8,16</sup> tend to cluster among relatively small groups of doctors, who have identifiable characteristics. However, only three of these studies have centred on complaints: two were reviews of internal complaints within United States medical groups;<sup>9,10</sup> the other was a survey of New Zealand doctors.<sup>11</sup>

Patient complaints can provide useful insights into quality of care and patient dissatisfaction.<sup>17,18</sup> This is particularly true in Australia, where complaints to health service commissions — regulatory agencies that operate in all eight states and territories, resolving thousands of complaints each year — have become the primary avenue for medicolegal redress. Unlike lawsuits or disciplinary actions, complaints to commissions are almost entirely patient-driven, legal representation is not required, and matters are usually resolved within months.<sup>19</sup>

We analysed complaints against doctors in private practice in Victoria. We describe the distribution of these complaints and profile the subgroup of doctors involved in a disproportionately large number of them. Our goal was to inform strategies for identifying and intervening early with complaint-prone doctors.<sup>19</sup>

## METHODS

### Complaints data

We queried the database of the Health Services Commissioner of Victoria (“the Commissioner”) to identify all doctors in Victoria who were the subject of one or more complaints in the decade 1 January 2000 to 31 December 2009. We focused on doctors in private practice because the Commissioner’s complaint resolution processes for public hospital services do not identify individual doctors. In 2004, the midpoint of our study period, 14 581 doctors were registered to practice in Victoria: 72% (10 434) were in private practice, either fully (7052) or par-

## ABSTRACT

**Objective:** To identify characteristics of doctors who are repeated subjects of complaints by patients.

**Design and setting:** Case-control study of doctors about whom patients had complained to the Victorian Health Services Commissioner between 1 January 2000 and 31 December 2009.

**Participants:** 384 doctors in private practice; cases comprised 96 doctors who were the subject of four or more separate complaints; and the control group comprised 288 doctors who were the subject of a single complaint over the study period.

**Results:** Among doctors in private practice in Victoria, 20.5% (95% CI, 19.7%–21.3%) experienced at least one complaint over the decade. Among doctors who were the subject of a complaint, 4.5% (95% CI, 3.6%–5.4%) had four or more complaints, and this group accounted for 17.6% (95% CI, 16.3%–19.0%) of all complaints to the Victorian Health Services Commissioner. Multivariate analyses showed that surgeons (odds ratio [OR], 8.90; 95% CI, 3.69–21.50) and psychiatrists (OR, 4.59; 95% CI, 1.46–14.43) had higher odds of being in the complaint-prone group than general practitioners. Doctors trained overseas had lower odds of being complaint-prone than those trained in Australia (OR, 0.31; 95% CI, 0.13–0.72).

**Conclusions:** A small group of doctors in private practice in Victoria account for nearly 18% of complaints. Interventions to improve patient satisfaction and public confidence in health services should target complaint-prone subgroups of practitioners.

MJA 2011; 195: 25–28

tially (3382), and 28% (4147) were in public practice only.<sup>20</sup>

We excluded contacts with the Commissioner that did not proceed beyond the enquiry stage, but did not otherwise attempt to grade complaint severity because no principled criteria exist to allow such grading.

We used the number of complaints per doctor to identify complaint-prone doctors. We defined complaint-prone doctors as those with four or more complaints over the study period. For each complaint-prone doctor, three doctors were randomly selected from among those who were the subject of a single complaint to act as controls.

### Demographic data and variables

Using the name and practice address of each complaint-prone and control doctor, we searched the Medical Practitioners Board of Victoria’s register and the Medical Directory of Australia database. From these sources, we obtained information on the doctors’ sex, specialty, training location, practice location, date of graduation, and fellowship status.

For two doctors who had died and three who had ceased practising, some informa-

tion could not be retrieved. Wherever possible, we retained these doctors in descriptive and univariate analyses, but they were dropped from the multivariate analyses.

We collapsed specialties into five groups: general practitioner, physician, psychiatrist, surgeon, and other. Years in practice were calculated by subtracting the date of graduation from the date of the first complaint, and then coded into tertiles (<21 years, 22–29 years, 30+ years). Training location was classified as Australia or overseas, based on the doctor’s primary medical qualification.

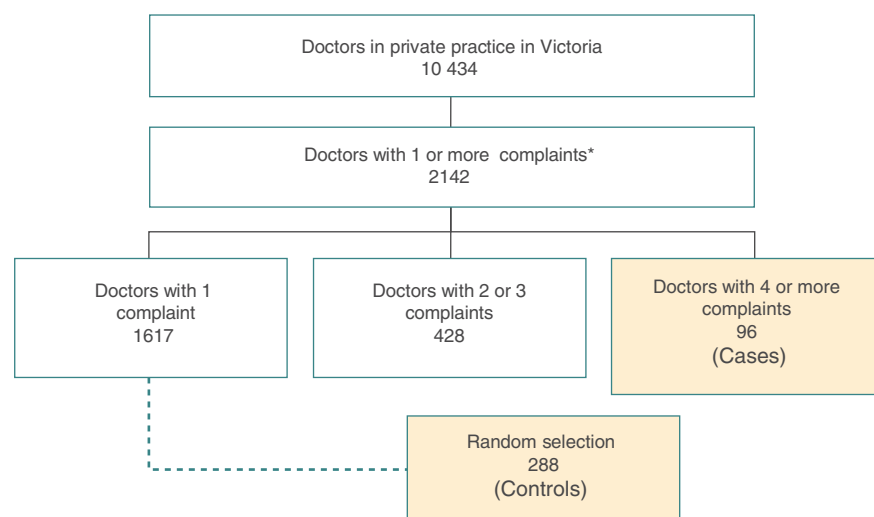
### Statistical analysis

Using logistic regression analyses at the doctor level, we regressed a binary variable distinguishing complaint-prone doctors from control doctors on six covariates: sex, practice location (urban or rural), years in practice, training location, specialty, and fellowship of an accredited college (yes or no). All analyses were conducted using Stata 11.1 (StataCorp, College Station, Tex, USA).

### Ethics approval

The study was approved by the ethics committee at the University of Melbourne.

## 1 Derivation of the study population



\* Complaints about them to the Health Services Commissioner of Victoria from 1 January 2000 to 31 December 2009.

## RESULTS

### Distribution of complaints among doctors

In the decade to 2010, the Commissioner received 3122 complaints against 2141 doctors in private practice in Victoria. A total of 20.5% of doctors in private practice were the subject of complaints (95% CI, 19.7%–21.3%), with an average of 1.5 complaints (SD, 1.3 complaints) per doctor who was complained against.

Three-quarters (1617/2141) of doctors complained against were the subject of a single complaint during the study period, and 20% (428/2141) were the subject of two or three complaints (Box 1). A total of 96 doctors had four or more complaints (median, 5; interquartile range, 4–6); this is the group we defined as complaint-prone and analysed further.

Box 2 shows the distribution of complaints among doctors. Complaint-prone doctors constituted 4.5% of doctors complained against (95% CI, 3.6%–5.4%) and accounted for 17.6% of all complaints (95% CI, 16.3%–19.0%).

### Distinctive characteristics of complaint-prone doctors

Univariate analyses showed that complaint-prone doctors were more likely than control doctors to be male, surgeons or psychiatrists, have trained in Australia, and have been in practice for at least 30 years (Box 3).

In multivariate analysis, surgeons had ninefold greater odds of being complaint-prone than GPs (odds ratio [OR], 8.90; 95% CI, 3.69–21.50) and psychiatrists had more than fourfold greater odds of being complaint-prone (OR, 4.59; 95% CI, 1.46–14.43). Doctors trained overseas had lower

odds of being complaint-prone than Australian-trained doctors (OR, 0.31; 95% CI, 0.13–0.72). There were no significant differences among the other characteristics examined.

## DISCUSSION

This study found that, in the decade to 2010, one in five of Victoria's approximately 10 000 doctors in private practice had at least one complaint from a patient to the state Health Services Commissioner. There was a heavy concentration of these complaints among a small group of doctors. Specialty was an important marker, with surgeons and psychiatrists significantly overrepresented in the complaint-prone group. Overseas trained doctors, on the other hand, were significantly underrepresented in this group.

More generally, our findings reinforce the conclusion of previous research that it is incorrect at the population level to construe doctors' experiences with medicolegal matters as merely the "luck of the draw".<sup>7</sup> Complaints clearly cluster around certain doctors — in Victoria, extrapolations from our findings indicate that less than 100 practitioners, or 1% of the medical workforce in private practice, account for nearly 20% of complaints.

It would be a feasible proposition to mount interventions in a group of this size, and this may help improve patient satisfaction, quality of care, and public confidence in the health care system. Such interventions should be tailored to the concerns identified in complaints and the degree of recidivism. At the low end of the spectrum, they may involve simple guidance (eg, information and feedback), graduating to moderately intrusive measures (eg, specific professional development modules). At the upper end of the spectrum, stronger interventions may be warranted (eg, referral for competence or health assessment), rising to practice restrictions by the appropriate agency where required. In most cases, remediation, re-skilling, or rehabilitation should be enough to help doctors return to safe practice.<sup>16</sup>

Why surgeons and psychiatrists are disproportionately at risk is not well understood. Previous complaints studies have identified the same phenomenon,<sup>9,10,18</sup> as have studies of other medicolegal matters.<sup>1,2,5,7-10,12,13,15,16</sup> In surgery, the inherent risks of surgical procedures and the relative visibility of poor outcomes of care are likely to play a role.<sup>21</sup> In psychiatry, certain patients may have an increased pro-

## 2 Distribution among doctors in private practice in Victoria of complaints about them to the Victorian Health Services Commissioner, 2000–2009

No. of complaints	Doctors		Complaints	
	Number	% (95% CI)	Number	% (95% CI)
≥ 1	2141	—	3122	—
≥ 2	524	24.5 (22.7–26.4)	1505	48.2 (46.4–50.0)
≥ 3	196	9.2 (8.0–10.5)	849	27.2 (25.6–28.8)
≥ 4	96	4.5 (3.6–5.4)	549	17.6 (16.3–19.0)
≥ 5	50	2.3 (1.7–3.0)	365	11.7 (10.6–12.9)
≥ 6	32	1.5 (1.0–2.1)	275	8.8 (7.8–9.9)
≥ 7	20	0.9 (0.6–1.4)	203	6.5 (5.7–7.4)

### 3 Unadjusted and adjusted odds of being a complaint-prone doctor

Variable	Cases* (n = 96)	Controls* (n = 288)	Unadjusted odds ratio (95% CI)	P	Adjusted odds ratio <sup>‡</sup> (95% CI)	P
Sex <sup>†</sup>				0.006		0.148
Female	8%	22%	1.00		1.00	
Male	92%	78%	2.98 (1.37–6.48)		1.90 (0.81–4.44)	
Trained in Australia <sup>†</sup>				0.004		0.006
Yes	90%	76%	1.00		1.00	
No	10%	24%	0.34 (0.16–0.71)		0.31 (0.13–0.72)	
Specialty				< 0.001		< 0.001
General practitioner	23%	43%	1.00		1.00	
Physician	9%	13%	1.40 (0.59–3.30)		1.39 (0.48–4.03)	
Psychiatrist	9%	6%	3.14 (1.24–8.00)		4.59 (1.46–14.43)	
Surgeon	45%	10%	8.59 (4.44–16.57)		8.90 (3.69–21.50)	
Other	14%	30%	0.86 (0.41–1.79)		0.98 (0.41–2.34)	
Location				0.080		0.084
Rural	7%	14%	1.00		1.00	
Urban	93%	86%	2.11 (0.91–4.88)		2.51 (0.88–7.12)	
Years in practice <sup>†</sup>				0.023		0.356
≤ 21 years	23%	36%	1.00		1.00	
22–29 years	30%	31%	1.59 (0.85–3.00)		1.60 (0.79–3.24)	
30 + years	47%	33%	2.29 (1.27–4.13)		1.52 (0.78–2.97)	
Fellow of an accredited college				0.043		0.5
No	23%	34%	1.00		1.00	
Yes	77%	66%	1.73 (1.02–2.96)		0.78 (0.35–1.74)	

\* Percentages may not sum to 100 because of rounding error. † Missing data on sex (1 doctor), trained in Australia (4 doctors), and years in practice (5 doctors).

‡ The multivariate logistic regression model adjusted for all variables shown.

pensity to initiate medicolegal action, although, despite speculation about this phenomenon, there is little hard evidence of it.<sup>22</sup> Additionally, the potential for power imbalances between doctor and patient is high in both specialties.

Previous studies have found that overseas training is not a risk factor for complaints,<sup>8,11</sup> our findings go a step further and find a “protective effect” associated with training outside of Australia. The extent to which this effect can be generalised is questionable. For example, a recent report from the United Kingdom indicated a higher rate of referral to the National Clinical Assessment Service for non-white doctors and doctors who qualified outside Europe.<sup>23</sup>

Our study has some limitations. First, we used head counts of practitioners in each descriptive category, rather than more sophisticated measures of doctors’ exposure to complaint risk, such as full-time equivalents, or volumes of patients seen and procedures conducted. Second, we selected our control group from among doctors who had experienced one isolated complaint

over a decade, rather than doctors who had experienced none. A comparison of the doctors in our control group to summary statistics for all doctors in Victoria suggests that our controls closely resemble the wider pool in terms of specialty and location,<sup>20</sup> but slightly larger proportions were male and had been in practice for more than 21 years. These differences, although minor, open up the possibility of biases toward the null in our analyses of sex and years in practice. Third, the characteristics we examined were doctor-focused. Patient characteristics,<sup>24,25</sup> treatment outcomes,<sup>24</sup> and the nature of the patient–doctor relationship<sup>26–29</sup> are also likely to be important predictors. Finally, our findings are from an analysis of complaints against doctors in private practice in Victoria; the extent to which they can be generalised to practitioners in public hospital settings and in other states is unknown.

The insight that large numbers of complaints are concentrated among a small group of doctors, and that those doctors exhibit distinctive characteristics, has

important policy implications. Case-by-case complaint resolution processes overlook the importance of past complaints as a predictor of future complaints, and spread regulators’ scarce resources thinly across a wide group of practitioners, most of whom are at minimal risk of future complaints. Aiming interventions at high-risk doctors has the potential to steer outliers back towards safer practice, thereby reducing risks of future harm and patient dissatisfaction. Realising that potential requires two advances: better tools for flagging complaint-prone doctors early in their complaints trajectory; and effective interventions to address problems in a timely fashion.<sup>30</sup> Future research should address both challenges.

#### ACKNOWLEDGEMENTS

This study was funded through an Australian Research Council Federation Fellowship (to David Studdert). We thank Beth Wilson, Health Services Commissioner of Victoria, and Grant Davies, Deputy Commissioner. Without their support and the assistance of their team in preparing the data, this study would not have been possible.

## COMPETING INTERESTS

None identified.

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**Provenance:** Not commissioned; externally peer reviewed.

(Received 24 Jan 2011, accepted 18 May 2011) □