

# BMJ Open Doctors' experiences and their perception of the most stressful aspects of complaints processes in the UK: an analysis of qualitative survey data

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## ABSTRACT

**Objectives:** To examine doctors' experiences of complaints, including which aspects are most stressful. We also investigated how doctors felt complaints processes could be improved.

**Design and methods:** A qualitative study based on a cross-sectional survey of members of the British Medical Association (BMA). We asked the following: (1) Try to summarise as best as you can your experience of the complaints process and how it made you feel. (2) What were the most stressful aspects of the complaint? (3) What would you improve in the complaints system?

**Participants:** We sent the survey to 95 636 doctors, and received 10 930 (11.4%) responses. Of these, 6146 had a previous, recent or current complaint and 3417 (31.3%) of these respondents answered questions 1 and 2. We randomly selected 1000 answers for analysis, and included 100 using the saturation principle. Of this cohort, 93 responses for question 3 were available.

**Main results:** Doctors frequently reported feeling powerless, emotionally distressed, and experiencing negative feelings towards both those managing complaints and the complainants themselves. Many felt unsupported, fearful of the consequences and that the complaint was unfair. The most stressful aspects were the prolonged duration and unpredictability of procedures, managerial incompetence, poor communication and perceiving that processes are biased in favour of complainants. Many reported practising defensively or considering changing career after a complaint, and few found any positive outcomes from complaints investigations. Physicians suggested procedures should be more transparent, competently managed, time limited, and that there should be an open dialogue with complainants and policies for dealing with vexatious complaints. Some felt more support for doctors was needed.

**Conclusions:** Complaints seriously impact on doctors' psychological wellbeing, and are associated with defensive practise. This is not beneficial to patient care. To improve procedures, doctors propose they are simplified, time limited and more transparent.

## Strengths and limitations of this study

- The qualitative data in this paper adds further insights into how complaints procedures impact on the feelings, experiences and professional behaviour of doctors and adds to the quantitative data we have previously published from the same data set.
- This report is based on responses from over 6000 doctors who have experienced a complaint with the analysis performed until saturation on a randomly selected representative cohort of 1000.
- It is possible that only doctors with strong feelings about complaints procedures completed the open questions, furthermore the overall response rate was 11.4%, so ascertainment bias should be considered when interpreting these results. Conversely doctors most distressed by a complaint may have avoided engaging with the survey, and those struck off the register would not have been contacted through the British Medical Association (BMA).
- As we asked about past complaints, the possibility of recall bias must be considered.
- These results are based on the answers to open ended questions at the end of the survey. By the time participants arrived at these final questions, they may have been less likely to discuss issues that had already been touched on by the earlier closed questions. On the other hand, thoughts and feelings may have become apparent when answering earlier closed questions leading to respondents elaborating on issues they might otherwise not have reported.

## INTRODUCTION

Recent years have seen the number of patients who make a complaint about their doctor increase significantly;<sup>1 2</sup> For example in the UK, patients' complaints against general practitioners (GPs) more than doubled between 2007 and 2012, to a record level of 8109 in 2012.<sup>1-3</sup> In most cases

complaints relate to issues about clinical competence.<sup>1</sup> Overall in the UK there were 52 123 written complaints made against doctors working in hospital and community health services in the year 2013–2014.<sup>4</sup> Social media has been cited as one of the main drivers for this growth.<sup>5</sup>

In the UK the General Medical Council (GMC) sets clinical and behavioural standards for doctors and has the power to impose sanctions when these are not met. Although it is important that patients have the facility to complain, several reports have shown complaints have a negative impact on doctors' psychological and personal wellbeing.<sup>6–7</sup> Doctors have been shown to experience burnout, anger, shock, disappointment, depression and suicidal ideation associated with complaints procedures.<sup>8–11</sup> If doctors are unable to cope with these feelings, they can become 'second victims', and may exhibit symptoms of post-traumatic stress disorder.<sup>11</sup> In some cases these problems may lead to suicide.<sup>11</sup> Recently the GMC published an internal report on 28 cases of doctor's suicide while under fitness to practice procedures between 2005 and 2013 in the UK.<sup>12</sup> A report discussing these findings concluded these deaths were preventable and that the GMC has a legal duty to take positive actions to ensure fitness to practice proceedings do not damage the physical or mental health of doctors.<sup>13</sup> Exclusion from work, poor support networks, court cases and inquests are all risk factors for suicide among doctors.<sup>14</sup> Moreover, research indicates that complaints procedures themselves affect doctors' psychological wellbeing with high levels of stress being reported.<sup>15–17</sup>

In 2012 McGivern and Fischer<sup>18</sup> described how values associated with 'transparency' such as openness, independent review and accountability, though generally assumed to be beneficial, may have unintended consequences. This effect is perhaps exacerbated by the tendency for regulation to focus on relatively rare events that receive a high media profile, something that McGivern and Fischer<sup>19</sup> have described as 'spectacular regulation'. The result is that complaints are associated with clinicians practising medicine more defensively,<sup>6–7–9–10–15–20</sup> This pattern of behaviour includes hedging (over prescribing, over referral, over investigation) and avoidance (changing specialty or profession, avoiding high risk patients or procedures, abandoning procedures early).<sup>21</sup> Complaints procedures exist to protect patients. However, if they lead to emotionally distressed doctors who practice defensive medicine, the net result may be detrimental to the quality of care and patient safety. It is therefore important to understand how complaints procedures impact on clinicians and how these effects can be ameliorated.

We have previously shown that doctors with any type of recent or ongoing complaint are at risk of moderate to severe depression (16.9%), anxiety (15%) as well as suicidal ideation (9.7%). When a complaint involved the GMC the risk rose to 26.3%, 22.3% and 15.3%,

respectively. Moreover 80% of doctors in this study reported practising medicine more defensively. In general, doctors reported they felt neglected and betrayed by complaints procedures. They suggested greater transparency, managerial competence and speeding up processes (in particular GMC fitness-to-practice procedures) would improve how complaints investigations are carried out.<sup>21</sup> As a further part of this large study on UK doctors, this current paper is a qualitative study focusing on an in-depth analysis of the psychological processes and experiences of doctors who have received either a past, recent (resolved within the previous 6 months) or a current complaint.

## METHODS

### Design and participants

The participants were recruited from the 'IMPACT study'. Full details of the sampling and recruitment methods have been previously published.<sup>1</sup> Briefly, IMPACT is a cross-sectional anonymous survey study that aims to identify the impact of complaints procedures on the welfare, health and clinical practice of doctors in the UK. To assess doctors' experiences of a past (more than 6 months ago), recent (within the past 6 months), or current complaint a questionnaire was developed comprising of two parts: the first was concerned with demographic information, medical history and specific details about doctors' experiences of a complaint. The second consisted of three open questions inquiring about doctors' experiences of complaints procedures:

1. 'Try to summarize as best you can your experience of the complaints process and how it made you feel'
2. 'What were the most stressful aspects of the complaint?'
3. 'What would you improve in the complaints system?'

Doctors were guaranteed that responses were anonymous and untraceable. The survey including these open questions is included as an online supplementary material file. The survey was sent to 95 636 members of the British Medical Association who had previously consented to take part in research, the survey remained open for 2 weeks and three reminders were sent during this time. A total of 10 390 (11.4%) responded. As the initial intention of this qualitative study was to focus on the first two questions, we first selected all respondents who had answered the open questions 1 and 2 of the survey (n=3417). Participants were divided in two groups: past complaints (n=2088) and recent or current complaints (n=1329). As we planned to undertake a qualitative content analysis on a subset of these cases until content saturation was reached, we then randomly selected 500 doctors from each group and proceeded with the answers of 1000 doctors. Investigators were blind to which group the participants belonged.

The answers to each question were thoroughly read through several times by RV to immerse herself in the data. Data were then coded until saturation was reached.

Having read 80 answers, no new codes emerged. We decided to analyse the answers of a further 20 doctors to ensure saturation. In total, the answers from 100 doctors were read and coded, without a predefined coding frame.<sup>22</sup>

After critical evaluation and discussion of the coding with JV, a coding frame was developed. If new codes emerged the coding frame was changed and the answers were reread according to the new structure. This process was used to develop categories, which after discussion were then conceptualised into broad themes. If a theme was common, it was further analysed in detail to identify new and more in depth codes.

During the coding of the first and second open questions in the survey, it became clear that not only the complaint itself, but also the nature of the complaints procedure was experienced negatively and reported as being stressful by many doctors. We then decided to assess the third open question in the survey: What would you improve in the complaints system? We anticipated that the answers to this question could provide us with valuable proposals for improving complaints procedures. From the 100 doctors that were included for analysis of questions 1 and 2, 93 also answered question 3 and these answers were considered for further analysis following the coding procedure described above.

To avoid misinterpretation a third researcher (MJ) also coded the answers from the 100 respondents. The coding carried out by both teams was compared. All queries and conflicts over the meaning of the content and possible interpretations were discussed through a process of triangulation until consensus was reached between researchers. Issues that were of particular interest, or those in need of greater consideration were discussed between the researchers until a consensus was reached as to how data should be interpreted and reported.

Brief summaries and representative quotes for each theme were abstracted for reporting purposes. The quotes were selected, as being illustrative of the responses given.

Using the saturation principle, the responses from 100 doctors were included for this qualitative analysis. The average age was 49 years (25–70), and the majority were male (64/100). The mean time since qualification was 27 years (5–48). Thirteen had experienced an informal complaint, 59 a formal complaint, 9 a serious untoward incident (SUI) and 19 a GMC referral. These different types of complaint procedure are briefly explained below:

**Informal:** Usually involves the complainant discussing the issue directly with those responsible for their care. They are generally resolved locally but can be escalated.  
**Formal:** Usually written to the chief executive of an organization. These lead to an investigation requiring a written response within a fixed time period. The outcome can recommend disciplinary action or referral to the GMC.

**SUI:** An SUI investigation may be prompted by an unexpected death, poor clinical outcome, a hazard to public

health, a trend leading to reduced standards of care, or damage to the reputation or confidence in a service.

**GMC:** A complaint to the GMC can be made for issues ranging from their personal behaviour to clinical concerns about a doctor's practise. The GMC has the power to impose working under supervision, suspension from the medical register or removal of a doctor from the register permanently. The GMC may also issue warnings and undertakings to change behaviour or practise.

Of 100 doctors, information on the status of the outcome of the complaint was available for 80, of whom 67 were exonerated, two were subject to disciplinary action, one was suspended from practice and 10 were subject to an ongoing investigation with a pending outcome. The mean time since the investigation was five (1–8) months. Of the 100 doctors, 53 had a past complaint and 47 had a current complaint.

## RESULTS

### Doctors' experiences of the complaint

Doctors' experiences of a complaint and how it made them feel could be categorised into five themes (table 1): (1) negative feelings towards the complainant or those managing the complaint (48/100), (2) feeling impotent, powerless or helpless (45/100), (3) emotional distress (42/100), (4) positive feelings about some aspects of the complaint (eg, the level of support received during the complaint or learning from the complaint) (24/100) and (5) negative feelings towards self (22/100). We have in general limited giving example quotes to when at least five or more respondents gave answers that fitted a specific theme, we have also included quotes for themes in the tables.

(1) *Negative feelings towards the complainant or those managing the complaint (48/100).* Most commonly this meant feeling that *the complaint was unfair* (31/100): "I felt like a criminal when referred to the GMC when the complaint was clearly vexatious..." *Feeling unsupported during the process* (23/100) was a frequent concern: "The managers do not care about finding out the truth or supporting their staff. They only wish to avoid escalation of the complaint [...]. They do not support staff at all." Further examples of feelings towards others were *anger* (7/100): "I feel angry at [the] process and "pain" [I was] put through. Then [the] issue becomes nothing. I had to fight very hard to contain my desire for "revenge", and *feeling attacked* (5/100): "I still find it very hard that a patient's family could be so vindictive and unpleasant."

(2) *Feeling impotent, powerless or helpless (45/100):* "The patient is at liberty to make unpleasant inaccurate and very personal accusations (I was unfairly accused of being racist) and the doctor has no means of redress." These feelings were often due to the *protracted timeframe associated with the process* (23/100): "Nevertheless the GMC took an inordinate amount of time to deal with the complaint and provided no feedback whatsoever



**Table 1** Doctors' experiences of the complaint: themes

Main themes	Doctors n/100	Example quote
1. Negative feelings toward the complainant or those managing the complaint	48	"I felt like a criminal when referred to the GMC when the complaint was clearly vexatious, altering MRI scans in 3 venues is physically impossible."
2. Feelings of impotence, powerlessness, or helplessness	45	"The patient is at liberty to make unpleasant inaccurate and very personal accusations (I was unfairly accused of being racist) and the doctor has no means of redress."
3. Emotional distress	42	"It was a stressful situation to be in, which significantly affected my work performance and the rest of my life."
4. Positive feelings	23	"I had full support of colleagues, clear understanding of procedure, support and advice from Defence Union throughout the process."
5. Negative feelings towards self	22	
Being stigmatised or victimised	13	"Even if the complaint is found to have no foundation there is an ongoing stigma attached to it."
Feelings of having failed or being incompetent	11	"Makes you feel worthless even when you know you've done the best you can"

GMC, General Medical Council; MRI, magnetic resonance imaging.

while their internal processes were continuing," or due to *feeling powerless towards the system* (24/100): "Because the advice from Medical Defence Union (MDU)/BMA even when the complaints are clearly vexatious is so passive this made me feel helpless so I took independent legal advice."

(3) *Emotional distress* (42/100). Diverse feelings of emotional distress were reported such as *stress* (14/100): "It was a stressful situation to be in, which significantly affected my work performance and the rest of my life", *feelings of failure or incompetence* (11/100): "I felt low, anxious, incompetent and thought about leaving medicine for the few months while waiting for the interview", *anxiety* (11/100): "The most frustrating thing was that [the] other consultants in the department were reassuring me that the complaint was the results of "professional jealousy" and nothing else, but that did nothing to ease the stress or anxiety brought on by the complaint", *being upset* (11/100): "It is very distressing and upsetting to get complaint.", *feeling sad or distressed* (5/100): "Sad and spent a lot of time worrying about it and indeed still do as I feel the patient is going to escalate the complaint", and *outrage* (5/100): "How is that fair and just?".

(4) *Positive feelings towards some aspects of the experience* (23/100), such as *being supported* (17/100): "I had full support of colleagues, clear understanding of procedure, support and advice from Defence Union throughout the process." Although not reflecting positive feelings in relation to the overall process, some reported they felt *relief over the type and outcome of the complaint* (6/100): "Although I am very grateful that my career was not affected I still feel responsible to an extent." or "My complaint was relatively informal and I am lucky to have only one." Some doctors *felt confident about how things were managed* or that the complaint was a *wake-up call or learning experience* (6/100): "I have been fortunate (or perhaps good at preventing) in having only minor

matters complained about formally about which I felt I could learn things but did not feel really threatened."

(5) A few doctors expressed *negative feelings towards self* (22/100), with mostly feelings of being stigmatised or victimised (13/100): "Even if the complaint is found to have no foundation there is an ongoing stigma attached to it", and *feelings of having failed or being incompetent* (11/100): "Makes you feel worthless even when you know you've done the best you can".

### Doctors' perception of the most stressful aspects of the complaint

Doctors' perceptions of the most stressful aspects of the complaint could be categorised into seven main themes (table 2): (1) procedural issues (60/100), (2) fear of the consequences (20/100), (3) negative self-image and lack of professional confidence (14/100), (4) fear of the reaction of colleagues and managers (13/100), (5) aware that the complaint was justified (9/100), (6) feeling the complaint was unfair (8/100), (7) dealing with the complainant (5/100).

(1) Doctors reported that the most stressful aspect of the complaint related to *procedural issues involved in complaints procedures* (60/100). Most commonly the reason was the *perception that the process was biased in favour of the complainant* (28/100): "It seemed as if the patient is presumed to be right, and the doctor is presumed to be wrong, unless you can prove otherwise." as well as *the duration and unpredictable nature of the procedure and outcome* (28/100): "Not knowing what was happening and when." Furthermore *the incompetent management of complaints* (21/100) was considered a stressor: "The GMC are borderline competent at best and the Interim Orders Panel (IOP) hearing I went through was a "kangaroo court" beyond any doubt", and also *the poor communication and inadequate information provided throughout the procedure* (12/100): "Waiting for something to

**Table 2** Doctors' perceived most stressful aspects of the complaint: themes

Main themes	N doctors	Example quote
1. Procedural issues	60	"It seemed as if the patient is presumed to be right, and the doctor is presumed to be wrong, unless you can prove otherwise."
2. Fear of the consequences of the complaint	20	"I was catastrophizing about what 'may' happen (however unlikely)."
3. Impairment of doctors' self-image and confidence	14	"We do take it very personally if someone calls into question our professional competence. It leaves you very shaken and lacking in confidence."
4. Feeling intimidated or embarrassed by having to justify the complaint to seniors	13	"Most stressful to me was the pressure from managers as above or explaining to senior colleagues the background to a personal complaint."
5. Awareness that a complaint was justified	9	"Feeling that the complaint was completely right and our way of working needed scrutiny."
6. Feeling that a complaint was unfair	8	"Being accused of serious misdemeanors when nothing like that took place."
7. Dealing with the complainant	5	"Most stressful to me was dealing with the relatives who seemed hell bent on going for compensation."

happen/not being informed what is happening" "Not being able to see responses to patients before they are sent."

(2) Besides the complaint procedure itself, other aspects of the complaint were also considered very stressful, such as *the fear of the consequences* (20/100): "I was catastrophizing about what 'may' happen (however unlikely)".

(3) *Doctors' negative self-image and lack of professional confidence* was a further stressor (14/100): "We do take it very personally if someone calls into question our professional competence. It leaves you very shaken and lacking in confidence."

(4) Several doctors *felt intimidated or embarrassed by having to explain their response to the complaint to management or senior colleagues* (13/100): "Most stressful to me was the pressure from managers as above or explaining to senior colleagues the background to a personal complaint".

(5) For some doctors an *awareness that the complaint was justified* and of what might have gone wrong made the whole complaint procedure very stressful (9/100): "Feeling that the complaint was completely right and our way of working needed scrutiny."

(6) For others, a sense that *the complaint was unfair* (8/100) was the most stressful aspect of the complaint: "Being accused of serious misdemeanors when nothing like that took place".

(7) In some cases doctors found it most stressful *to deal with the complainant or their family* (5/100): "Most stressful to me was dealing with the relatives who seemed hell bent on going for compensation."

### Changes in Doctor's professional (eg, changing career, practising more defensively) and personal life in relation to complaints

As a result of a complaint, 26/100 doctors reported that it led to changes in their professional (23/26) and/or

personal life (4/26). Professionally this included *changing how they practised medicine*. These changes were analysed in more detail by further in-depth coding leading to them being categorised into five themes (table 3), the most common of these were: (1) changes in career (10/26), (2) practising more defensively (7/26), and (3) practising poorer medicine (6/26).

(1) In a number of cases, doctors (*considered*) a *career change* following a complaint (10/26). Some reduced their working hours and level of responsibility after the complaint, whilst others changed profession: "The only positive decision that came from the complaint was it helped me take the decision, to change careers.....this was after 20 years of medicine", or planned for an early retirement: "This has been an unpleasant experience. [...], I intend to retire as soon as possible."

(2) Doctors also described starting to *practise more defensively* (7/26), leading to hedging or avoidance (7/26). 'Hedging' can be described as being overcautious, leading for example, to overprescribing, over-investigating or over-referring: "I was always cautious and careful, but I am even more so now." 'Avoidance' includes not taking on complicated patients and avoiding certain procedures or more difficult cases. "I have limited my practice to try and avoid all but essential child protection work as that has generated the most complaints."

### Doctor's suggestions to improve the complaints system

Of the 100 doctors included in the analysis of the first two open questions, 93 gave suggestions to improve the complaints system, which could be categorised into five main themes (table 4): (1) transparency, neutrality and time-efficiency (41/93), (2) the need for a policy for vexatious, baseless or unnecessary complaints (27/93), (3) an open dialogue between doctors and

**Table 3** Doctors' changes in their professional and personal life: themes

Main themes	N doctors (/26)	Example quote
1. Impact on career	10	"I felt hurt and victimized, as a result I stopped being a full time GP principal and became a part time salaried GP."
2. Practising defensively	7	"Everybody who knows about the complaint in a professional capacity become very risk averse which impacts on your entire professional life."
3. Practising poorer medicine	6	"I am fairly sure that this results in me practicing poorer medicine"
4. Negative impact on their personal lives	4	"My life was ruined."
5. Impacted on the doctor-patient relationship	2	"I felt that our doctor-patient relationship was adversely affected."

GP, general practitioners.

complainants (23/93), (4) physician support (14/93), and (5) a less formal approach (11/93).

(1) The principal suggestion was that procedures should be made *more transparent, neutral and time-efficient* (41/93). In particular, they felt that more clarity about the content and any supporting evidence relating to a complaint would be positive. They also suggested that there should be fixed time limits imposed on the various elements of complaints processes to increase predictability and reduce the distress caused by protracted investigations: "The person making a complaint must provide some evidence when such is applicable. Witnesses should be cross-examined."

(2) A number of doctors (27/93) proposed that there should be a policy to deal with *vexatious, baseless or unnecessary complaints*: "Sanctions (or drag the patient through the courts)."

(3) One-third (23/93) felt there should be a more *open dialogue* between doctors and patients rather than information being passed via managers, as well as better communication with both NHS bodies and the GMC: "Give a right to reply".

(4) Doctors also suggested efforts should be made to provide *physician support* (14/93): "Proactive support for the doctor and a "complaint friend".

(5) Respondents described wanting an *open, less formal approach to complaints procedures* that allows a culture of improvement, acceptance and openness (11/93): "Remove some of the red tape and make it less formal." or "Some form of informal get together by both parties: where is there common ground; where is there an issue."

For less commonly reported themes, we have included quotes where fewer than five doctors gave answers for that specific feeling in table 5 so the reader can see the full spectrum of responses.

## DISCUSSION

We have shown that doctors experience a range of negative feelings towards those making and managing complaints as well as the processes they experience. Many felt their complaint was unfair (31%) and that they were unsupported (21%). They frequently reported feeling powerless and impotent when going through a complaints process (45%). Many doctors experienced emotional distress (42%) and a significant number reported a damaging impact on their clinical practice leading to them practising more defensively, reducing their responsibilities or even leaving the profession altogether (23%). Doctors felt frustrated by the complaints system itself and

**Table 4** Doctor's suggestions to improve the system: themes

Main themes	N doctors (/93)	Example quote
1. Greater transparency, neutrality and a more time-efficient procedure	41	"Investigators and experts should clearly justify their arguments and help the patients to understand to develop trust with the health care professionals."
2. A policy for vexatious, baseless or unnecessary complaints	27	"A screening tool so that complaints designed to waste time are thrown out early before the wheels are set-in-motion."
3. Improved open dialogue with patients and supervising bodies	23	"Encouraging direct face-to-face contact and an open dialogue."
4. More support for physicians during the process	14	"Have a confidential counsellor who was skilled in helping comes to terms with (and normalise) the feelings."
5. Open, less formal approach	11	"The opportunity to review the situation with parents/ patients in person through a 'mediation' type process."

**Table 5** Less commonly reported themes

Theme	Number of doctors/100	Example quote
Negative feelings towards complainant or those managing them	48	
Disappointment	3	"I felt disappointed that having spent over 1 hour face to face in a PALs facilitated meeting, and that the complainant had said all questions had been answered to his satisfaction that the exact same points were raised in a complaint to the PCT some months later."
Being bullied	3	"He then proceeded to look for errors in my work every day, double checking and questioning everything I did. He finally found some personal mail that I had delivered to my work address and used that as a basis of a complaint."
Unappreciated	2	"I felt fed up and unappreciated. Seems anyone can complain and about anything. Never really get much thanks when things go well."
Humiliated	2	"I felt a bit paranoid, and humiliated."
Emotional distress	42	
Exhaustion	4	"I became obsessional about my record keeping to the point my working days extended and I became exhausted."
Depression	3	"I became exhausted; had a year later to take 4 months off with an agitated depression."
Loneliness	2	"Despite support from my employer, the BMA, the MPS and others—I still felt very alone in dealing with this, and felt very unsure about the best way forward and the timescales involved."
Became ill	2	"I had a malicious complaint from someone I now know to be a serial complainer, it was the first time I've experienced a complaint and I've had physical and mental health symptoms since it occurred."
Suicidal	1	"I cry, can't sleep and contemplate suicide and certainly not being a doctor anymore."
Negative feelings towards self	22	
Feeling responsible	1	"I was devastated when one of our patients collapsed with an avoidable complication and later died. It could have been prevented."
Doctors suggestions to improve the complaints system	93	
Patients should lose their right of confidentiality in the event that a complaint was vexatious	2	"If patient charter better protected the doctor against unfounded allegations. Any patient going to the media should automatically give up their right of confidentiality for the issues they raise in the complaint."
No changes needed	3	"I don't feel there is a fundamental problem with the complaints system."

BMA, British Medical Association; MPS, Medical Protection Society; PALs, Patient Advice and Liaison Service; PCT, Primary Care Trust.

considered procedures to be heavily biased in favour of complainants (21%). They called for procedures to be more transparent and efficient (44%), policies for vexatious or unnecessary complaints (29%) and increased physician support (15%). It was rare for doctors to describe a complaint as a learning process (6%).

A strength of this study is that to our knowledge, this is the largest qualitative study on doctors' experiences of complaints in the UK. It is a complement to the quantitative data derived from the same study published by Bourne *et al* in 2015.<sup>21</sup> The high response rate to the open questions is an indicator of an urge to vent and

strengthens the quality of data. Moreover, because of the size of our study we were able to identify a wide range of psychological, emotional and attitudinal experiences felt by clinicians facing a complaint. The fact that we reached data saturation strengthens the likelihood that our results represent a realistic and complete overview of doctors' experiences. A weakness of our study is that ascertainment bias must be considered when interpreting the results. It is possible that more doctors with negative experiences of complaints procedures were motivated to fill out the questionnaire, and the data were derived from a survey with an overall response rate



of 11.4%. On the other hand doctors most traumatised by a complaint may be more likely to avoid engagement with a survey of this type and doctors who have left the profession as a result of a complaint would not have been contacted. Furthermore, we have asked doctors to comment on past complaints so recall bias may also be a factor in our results. Our results are limited to doctors practising in the UK, accordingly the findings may not be generalisable internationally.

Although our results apply to a specific UK population of doctors, the findings can be related to similar situations;<sup>7 9 20 23</sup> or other stressful contexts/situations such as the experience of a psychiatrist when a patient commits suicide.<sup>24</sup> It is interesting that similar themes emerged in a recent report on the regulation and practice of osteopaths in the UK.<sup>25</sup> Osteopaths interviewed in this study expressed suspicion and fear of their regulator, however, it also highlighted that better communication with the profession by the regulator had recently led to improvements in their relationship with those being regulated.

Like other studies,<sup>7 23</sup> our results strongly suggest that complaints are associated with a negative impact on doctors' psychological and emotional wellbeing including feeling incompetent, anxious, depressed and suicidal. Our findings also suggest that complaints processes have a deleterious effect on patient care as 'damaged' physicians report practising more defensively with increased hedging and avoidance. Others have shown that emotional distress may cause medical errors.<sup>26 27</sup> The fear of a new complaint can make doctors more anxious and cautious, leading to a reduced ability to work confidently and decisively, to adverse doctor-patient relationships, practising more defensively or even changing their career.<sup>7 9 17 20 26</sup> In the first, quantitative part of this study, 82–89% of doctors reported hedging and 46–50% avoidance.<sup>21</sup> In our cohort, based on qualitative data from the same study, fewer doctors (23%) stated that they had changed their clinical practise following a complaint. This discrepancy could be explained by study bias, as in the quantitative part of the questionnaire there were specific questions that focused on changes in clinical practise whereas the three open questions did not.

Other studies have suggested complaints may lead to positive outcomes such as better patient communication.<sup>26</sup> In this way a complaint could also be a learning process, giving feedback that could improve a clinician's performance. While this would be the desired outcome, the doctors in our study with few exceptions considered the process a stressful and negative experience. Only a small number (6%) described the experience of receiving and dealing with a complaint as a learning process. If respondents in our cohort had any positive feelings, these related to receiving support, being grateful that events did not turn out any worse, and that they still had a career afterwards. These feelings should perhaps be more correctly classified as a negative reflection on complaints processes.

In our cohort one doctor stated that they contemplated suicide. However, we should be aware that the negative feelings following complaints described by many doctors might in some cases be precursors of suicidal ideation and behaviour.<sup>14</sup> We know doctors have higher rates of psychological problems compared to other occupational groups;<sup>28 29</sup> About 10–20% become depressed at some time during their career;<sup>30 31</sup> Unfortunately doctors are generally less prone to seek help as they consider this a sign of weakness,<sup>28</sup> and may inherently be a more vulnerable group.

When asked how procedures might be improved, key themes were greater transparency and a reduction in the time required to deal with complaints (44%), an open dialogue with complainants (24%), and strong penalties in the event of a complaint being found to be vexatious (29%). Doctors frequently reported a perceived bias in the system (21%), whereby patients are always presumed right, while doctors are presumed guilty until proven otherwise.<sup>8</sup> While our survey related to the views of doctors, it would seem likely that delays and lack of transparency in complaints systems are also distressing for complainants, and that a shift to a more timely and supportive process would benefit both parties.

Previous studies have suggested that some of the emotions described above represent a failure by doctors to take responsibility in the event of a complaint, tending to describe complainants as vindictive or unrealistic, while citing external factors such as a lack of resources or the natural history of a disease to refute any allegations.<sup>32 33</sup> In this context it is interesting to note in our study, of the 70 cases where the outcome of the complaint investigation was known, in 67 (96%) the doctor was exonerated. This perhaps explains why doctors often 'deny' the substance of complaints, as according to our data it is likely that they do not have a significant case to answer. A similar pattern is seen with the GMC in the UK, where of 2696 fitness-to-practise investigations that were closed in 2014, in 2217 (82%) no sanctions or warnings were imposed.<sup>34</sup>

It is also worth noting that there were very few comments that expressed empathy or compassion for patients. Reasons for this may be that we did not specifically ask doctors to comment on this issue, that clinicians perceived the complainants to be vexacious, or a number of the complaints originated from colleagues rather than patients. In any event it has been previously reported that physician burnout is associated with a lack of empathy and compassion,<sup>35</sup> and we would hypothesise that experiencing a complaint investigation may have similar negative impacts on doctors' facility to relate to patients emotionally.

Both this and our previous study<sup>21</sup> show complaints are associated with very significant psychological morbidity among doctors, while leading to them changing their practice in ways that are likely damage to patient care and incur unnecessary costs to health services. It is important to note this study relates to all complaints procedures with only a minority involving the GMC.



Accordingly while the GMC has examined the high rates of suicide associated with their investigations,<sup>12 36</sup> and made proposals to try and reduce this number,<sup>37</sup> the problem appears to be much wider. In the event the GMC does reform its processes in the UK, it is important that the problem is not merely devolved elsewhere.<sup>38</sup>

Our qualitative data suggest doctors perceive complaints processes do not offer procedural fairness. It is therefore perhaps not surprising they express little confidence in the system. It is axiomatic given a doctors perception that his or her entire livelihood might be at stake, it is essential they believe that a complaint will be handled fairly, competently and without bias. The majority of suggestions to improve procedures given in the study are rational and deliverable. These relate to transparency, reasonable timeframes and fairness. Interestingly while there has been a focus on supporting doctors and increasing resilience,<sup>36 39</sup> this was not the most common reform proposed. Doctors in general wanted the processes to be reformed, not to be given support to deal with a system they do not appear to have confidence in. An important issue to consider in relation to support, is whether doctors who have experienced a complaint represent an at risk group for recurrent complaints or medicolegal problems. In a national study, Bismark *et al*<sup>40</sup> presented data to show that prior complaints are a significant risk factor for recurrent complaints or medico-legal problems. The key issue is why this might be the case. Doctors who experience recurrent complaints may be a recidivist group of 'problem doctors' who require careful supervision. However a plausible hypothesis may also be that the psychological sequelae of complaint investigations leads to doctors being at higher risk of similar problems in the future because they become disaffected. We also know complaints are associated with anger and irritability, lack of sleep, and relationship problems.<sup>1</sup> All of these would seem likely to make a doctor underperform. This adds further weight to the argument that complaints procedures need to be reformed and support given to doctors to prevent them being caught in a complaints spiral whereby one complaint may lead to another, with a subsequent deterioration in clinical performance.

We conclude that the culture and processes associated with how all complaints procedures are carried out need to be reviewed and not just those relating to the GMC. Currently it is not unreasonable to argue that there is a risk that rather than providing feedback and an opportunity to improve, complaints cause psychological damage to doctors and lead to worse patient care. Based on this study and our previous quantitative research we would suggest that significant changes must be made in a system that the evidence suggests is both unnecessarily confrontational and damaging to all parties.

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**Contributors** TB conceived of the original idea for the whole study quantitatively and qualitatively. JV cleaned, analysed and recoded the data and drafted the paper. RV coded the data. MJ designed the overall protocol and the questionnaire, obtained ethical approval and also contributed to the coding of data. CVA directed the qualitative research methodology and supervised the content analysis. LW, BDC and BVC cleaned and managed the database and extracted the samples for analysis. MP facilitated access to the database of doctors at the BMA and the distribution of questionnaires, contributed to the IMPACT study design, the interpretation of results and commented on drafts of the paper. DT contributed to the overall protocol design, the interpretation of results and commented on drafts of the paper. All authors contributed to interpretation of results and commented on drafts of the paper and approved the final version of the manuscript.

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#### REFERENCES

1. General Medical Council. The state of medical education and practice in the UK report: 2013. 2013. <http://www.gmc-uk.org/publications/23435.asp> (accessed 08 Jul 2015).
2. General Medical Council. The state of medical education and practice in the UK report: 2014. 2014. <http://www.gmc-uk.org/publications/25452.asp> (accessed 08 Jul 2015).
3. General Medical Council. The state of medical education and practice in the UK report: 2015. 2015. <http://www.gmc-uk.org/publications/somep2015.asp> (accessed 18 Jan 2015).
4. Workforce and Facilities Team HaSCIC. Data on Written Complaints in the NHS 2013–2014. 28 August 2014. <http://www.hscic.gov.uk/catalogue/PUB14705/data-writ-comp-nhs-2013-2014-rep.pdf> (accessed 7 Sep 2015).
5. Smith R. Social media driving rise in complaints to GMC: report. *Telegraph*. 21–7–2014 (accessed 23 Nov 2015).
6. Davis J. Complaints procedures traumatise doctors and could lead to patient harm, warn researchers. *Pulse Today*. 15–1–2015. <http://www.pulsetoday.co.uk/your-practice/regulation/complaints-procedures-traumatise-doctors-and-could-lead-to-patient-harm-warn-researchers/20008922.fullarticle> (accessed 15 Sep 2015).
7. Verhoef LM, Weenink JW, Winters S, *et al*. The disciplined healthcare professional: a qualitative interview study on the impact of

- the disciplinary process and imposed measures in the Netherlands. *BMJ Open* 2015;5:e009275.
8. Madden D, O'Donovan O. Qualitative Review of Complaints Received by the Medical Council 2008–2012 and Doctors' Responses. 30 June 2015. <https://www.medicalcouncil.ie/News-and-Publications/Publications/Listening-to-Complaints-Qualitative-Report.pdf> (accessed 15 Sep 2015).
  9. Jain A, Ogden J. General practitioners' experiences of patients' complaints: qualitative study. *BMJ* 1999;318:1596–9.
  10. Shanafelt TD, Balch CM, Dyrbye L, *et al.* Special report: suicidal ideation among American surgeons. *Arch Surg* 2011;146:54–62.
  11. Wu AW. Medical error: the second victim: the doctor who makes the mistake needs help too. *BMJ* 2000;320:726.
  12. GMC. 2014. [http://www.gmc-uk.org/Internal\\_review\\_into\\_suicide\\_in\\_FTP\\_processes.pdf\\_59088696.pdf](http://www.gmc-uk.org/Internal_review_into_suicide_in_FTP_processes.pdf_59088696.pdf) (accessed 30 Apr 2016).
  13. Casey D, Choong KA. Suicide whilst under GMC's fitness to practise investigation: were those deaths preventable? *J Forensic Leg Med* 2016;37:22–7.
  14. Department of Health. Mental health and ill health in doctors. 2008. [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_083090.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083090.pdf) (accessed 08 Jul 2015).
  15. Cooper CL, Rout U, Faragher B. Mental health, job satisfaction, and job stress among general practitioners. *BMJ* 1989;298:366–70.
  16. Montgomery LM, Cupit BE, Wimberley TK. Complaints, malpractice and risk management: professional issues and personal experiences. *Prof Psychol Res Pr* 1999;30:402–10.
  17. Brooks SK, Del Busso L, Chalder T, *et al.* You feel you've been bad, not ill. Sick doctors' experiences of interactions with the General Medical Council. *BMJ Open* 2014;4:e005537.
  18. McGivern G, Fischer MD. Reactivity and reactions to regulatory transparency in medicine, psychotherapy and counseling. *Soc Sci Med* 2012;74:289–96.
  19. McGivern G, Fischer M. Medical regulation, spectacular transparency and the blame business. *J Health Organ Manag* 2010;24:597–610.
  20. Cunningham W, Dovey S. The effect on medical practice of disciplinary complaints: potentially negative for patient care. *NZ Med J* 2000;113:464–7.
  21. Bourne T, Wynants L, Peters M, *et al.* The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey. *BMJ Open* 2015;5:e006687.
  22. Krippendorff K. *Content analysis: an introduction to its methodology*. 2nd edn. Thousand Oaks, CA: Sage, 2004:413. ISBN 9780761915454.
  23. Cunningham W. The immediate and long-term impact on New Zealand doctors who receive patient complaints. *NZ Med J* 2004;117:U972.
  24. Rothes Is A, Scheerder G, Audenhove C, *et al.* Patient suicide: the experience of Flemish psychiatrists. *Suicide Life Threat Behav* 2013;43:379–94.
  25. McGivern G, Fischer M, Palaima T, *et al.* Exploring and explaining the dynamics of osteopathic regulation, professionalism and compliance with standards in practice. 2015. <http://www.osteopathy.org.uk/news-and-resources/documentlibrary/research-and-surveys/dynamics-of-effective-regulation-final-report/> (accessed 30 Mar 2016).
  26. West CP, Huschka MM, Novotny PJ, *et al.* Association of perceived medical errors with resident distress and empathy: a prospective longitudinal study. *JAMA* 2006;296:1071–8.
  27. Gool SD, Lipkin M. The doctor-patient relationship. *J Gen Intern Med* 1999;14:26–33.
  28. Cunningham W, Dovey S. Defensive changes in medical practice and the complaints process: a qualitative study of New Zealand doctors. *N Z Med J* 2006;119:U2283.
  29. Brooks SK, Gerada C, Chalder T. Review of literature on the mental health of doctors: are specialist services needed? *J Ment Health* 2011;20:146–56.
  30. beyondblue. National Mental Health Survey of Doctors and Medical Students. 2013. [https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report—nmhdms-full-report\\_web.pdf?sfvrsn=4](https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report—nmhdms-full-report_web.pdf?sfvrsn=4) (accessed 08 Oct 2015).
  31. Firth-Cozens J. A perspective on stress and depression. In: Cox J, King J, Hutchinson P, *et al.*, eds. *Understanding doctors performance*. Abingdon: Radcliffe, 2006:22–5.
  32. Alsop J, Mulcahy L. Maintaining professional identity: doctors' responses to complaints. *Social Health Illn* 1998;20:802–24.
  33. Alsop J. Two sides to every story: complainants' and doctors' perspectives in disputes about medical care in a general practice setting. *Law Policy* 1994;16:149–83.
  34. State of Medical Education and Practice in the UK report: 2015. <http://www.gmc-uk.org/publications/somep2015.asp> (accessed 30 Apr 2016).
  35. Back AL, Deignan PF, Potter PA. Compassion, compassion fatigue, and burnout: key insights for oncology professionals. *Am Soc Clin Oncol Educ Book* 2014:e454–9.
  36. Davis J. GMC to introduce 'emotional resilience' training after finding 28 doctors under investigation committed suicide. *Pulse Today*. 19-12-2014. <http://www.pulsetoday.co.uk/your-practice/regulation/gmc-to-introduce-emotional-resilience-training-after-finding-28-doctors-under-investigation-committed-suicide/20008791.fullarticle> (accessed 23 Nov 2015).
  37. Draft proposals to reduce the impact of GMC fitness to practise processes. [http://www.gmc-uk.org/Suicide\\_review\\_Final\\_Draft\\_Proposals\\_for\\_Publication\\_FINAL\\_20160418.pdf\\_65748529.pdf](http://www.gmc-uk.org/Suicide_review_Final_Draft_Proposals_for_Publication_FINAL_20160418.pdf_65748529.pdf) (accessed 30 Apr 2016).
  38. Bourne T. Cutting GMC investigations must not simply devolve problems elsewhere. *BMJ* 2016;353:i2445.
  39. Rimmer A. GMC urges national support service for doctors' health concerns. *BMJ* 2014;22:349.
  40. Bismark MM, Spittal MJ, Gurrin LC, *et al.* Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia. *BMJ Qual Saf* 2013;22:532–40.