What's New in the Patient Safety World

April 2017

Relation of Complaints about Physicians to Outcomes

And speaking about the culture of safety…

While true learning organizations value non-punitive environments that promote transparency and the ability to report concerns without fear of retribution, there remains a role for recognizing that certain issues are red flags that merit review and often intervention. Complaints about physicians are a good example.

It's long been known that a small number of physicians experience a disproportionate share of malpractice claims and expenses and that patient complaints are associated with a higher risk of malpractice actions. Hickson and colleagues (Hickson 2002) demonstrated that risk management file openings, file openings with expenditures, and lawsuits were significantly related to total numbers of patient complaints, even when data were adjusted for clinical activity.

We've discussed patient complaints about physicians in a few columns (see below). But a new study demonstrates, apparently for the first time, that outcomes for surgeons are also clearly linked to such complaints (Cooper 2017). Prior unsolicited patient observations for surgeons were significantly associated with the risk of a patient having any complication, any surgical complication, any medical complication, and being readmitted. The adjusted rate of complications was 13.9% higher for patients whose surgeon was in the highest quartile of unsolicited patient observations compared with patients whose surgeon was in the lowest quartile.

The editorial (Kachalia 2017) accompanying the Cooper study points out that the relationship between a surgeon's proneness to patient complaints and outcomes is likely complex. For example, they note that surgeons with poor interpersonal skills may end up with lower quality surgical teams, perhaps leading to poor overall performance even if the surgeon's individual performance was adequate.

Our July 7, 2015 Patient Safety Tip of the Week "Medical Staff Risk Issues" noted a study which developed an algorithm to predict physician risk of formal patient complaints using routinely collected administrative data (Spittal 2015). The **PRONE** (**P**redicted **R**isk **O**f **N**ew **E**vent) **score** is based upon 4 variables: (1) physician specialty (2) physician gender (3) number of previous complaints (4) time since last complaint. While most patient complaints (60%) were related to clinical issues, about a fifth were

related to communication issues (13% related to physician attitude or manner). The algorithm led to a possible total score of 22. Those with scores of 0-2 had a 14% risk of a complaint in the next 2 years, whereas those with scores of 15-17 had an 88% risk of a complaint in the next 2 years. The authors suggest the PRONE score could be used to flag physicians needing deeper review. They also suggest one might "tier" interventions based upon the PRONE score. This is interesting and likely to be especially of interest to risk managers. But review of patient complaint patterns should be part of the credentialing process for all healthcare providers.

In our July 2013 What's New in the Patient Safety World column "'Bad Apples" Back In?" we noted a study by Bismark et al. (Bismark 2013) which found that 3% of Australia's medical workforce accounted for 49% of all complaints by patients and 1% accounted for 25% of the complaints. Moreover, there was a striking dose-response relationship, i.e. the more complaints about a physician the higher the likelihood that there would be yet further complaints. A doctor with a third complaint had a 38% chance of a further complaint within a year and 57% chance of another complaint within 2 years. For one with a fifth complaint, the chance of another complaint within 1 and 2 years, respectively, was 59% and 79%. The authors point out that we are often too late to respond to physicians who have attracted multiple complaints and that we should really look at complaints as sentinel events. The hope is that early response may result in changes in physician behaviors. An accompanying editorial (Paterson 2013) noted that patient complaints are the "canaries in the coal mine" that should alert us to deeper problems and should not be ignored. Another accompanying editorial (Gallagher 2013) focuses on the need to end our silence and speak up and tell our colleagues about ways they can improve their care and communicate better. They argue we need to do a much better job acting locally (at the departmental, medical staff, academic unit, and clinical unit levels) to address these behaviors before they need to go to higher levels. They also note the need to develop better metrics for incorporating measures of patient satisfaction. And yet a third accompanying editorial (Shojania 2013) argues there is a systems problem and that we need to focus our resources on identifying such individuals and dealing with them. They also note that, in some cases, there may be multiple system problems that lead to a physician attracting multiple complaints (eg. understaffing in a clinical area).

We, of course, would remind you that **staff complaints about physicians** are just as important as patient complaints. Sometimes the patient complaints go elsewhere (eg. to state health departments, professional disciplinary bodies, medical societies, etc.) and you may not be aware of these for some time. Staff complaints are more often available to you immediately. It would be interesting to see how the PRONE score algorithm would work using staff complaints rather than patient complaints.

Some of our prior columns on the impact of "bad behavior" of healthcare workers:

January 2011 "No Improvement in Patient Safety: Why Not?"

March 29, 2011 "The Silent Treatment: A Dose of Reality"
July 2012 "A Culture of Disrespect"
July 2013 ""Bad Apples" Back In?"
July 7, 2015 "Medical Staff Risk Issues"
September 22, 2015 "The Cost of Being Rude"

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