Complaints, hindsight bias, and the short-circuit of grief into grievance

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ABSTRACT

Assessing a doctor's clinical competence after a complaint from a patient is potentially difficult. However, despite concerns in New Zealand about a 'litigious' medical climate, the current assessment system is based on principles of natural justice and fairness. As an example, this article explores the review process by the Health and Disability Commissioner (HDC) in response to an enquiry from a relative of a patient; the Commissioner thoughtfully recommended an educative article rather than an investigation and potential disciplinary action against one of the doctors involved. Despite this overall outcome, the case still raises a number of important issues about how complaints are generated in medical practice and how they are subsequently reviewed in New Zealand. These issues include hindsight bias, links between grief and making a complaint, and the doctor–patient relationship.

Key words

Complaints, grief, hindsight bias, doctor–patient relationship.

Introduction

A recent article in this journal outlined the story of a woman in her mid-fifties who presented with a new illness to a locum practitioner while the principal doctor (referred to as Dr Y) was on leave. On his return, Dr Y also consulted with this patient a number of times over the next three months. Sadly, however, this patient died suddenly the day after seeing two other health professionals (an after-hours GP and a triage nurse at ED). The patient's son initiated a 'lengthy' correspondence with Dr Y and eventually laid a complaint, including in his correspondence a journal article on how the underlying condition can present in atypical ways. After assessing the case, the clinical advisor to the Commissioner recommended that the GP 'should have considered' this correct diagnosis in his clinical assessment of the patient.[1] I contend that this recommendation was influenced by hindsight bias, and that the advisor's assessment of this case should have been conducted, if at all possible, without prior knowledge of post-mortem findings; in other words, on clinical process and current clinical knowledge rather than on pathological findings and the benefit of hindsight.

I will firstly outline the clinical story (without initially revealing the final diagnosis) and then discuss the issues that are involved. In doing so, I acknowledge that this version of the story is taken from the journal article and there may be some inaccuracies in retelling. I also appreciate the risk of 'opening old wounds' and apologise in advance if this occurs. The intention of this article instead is to promote what could be called a more 'robust professionalism' with respect to complaints. Rather than seeing complaints as an isolated event or an 'affront' to the health professional concerned, there are a number of areas that the profession could be addressing. These include:

- more open acknowledgement of the inherent uncertainties in clinical practice;[2]
- more open disclosure of adverse outcomes;[3]
- greater expression of personal concern and apology[4] where needed;
- more use of reflective skills for difficult situations[5] and critical incidents;[6]
- incorporating personal and professional support as part of normal practice;[7]
- supporting a fair and transparent complaints system;[8]

- encouraging rigorous debate about standards of care;[9] and
- appropriately commenting on findings from bodies such as the Health Practitioners Disciplinary Tribunal and HDC.

The clinical story

From the doctor's point of view (i.e. in the present tense), Dr Y returns from holiday and is visited by Mrs X three weeks after her initial illness. The notes of the previous consultation described the patient as 'unwell with fever, back pain…nauseated'; these symptoms in a woman who made frequent business trips to tropical areas. Bloods taken at that time were described as being 'compatible with a viral infection'. On this first consultation with Dr Y, the patient complains of fatigue and is given Vitamin B12.

Some three months later, Dr Y sees her again with pain in the 'shoulder blade' along with other non specific symptoms, including 'fever and chills'. Bloods show a raised CRP to 76; it is also noted that this illness and the 'ache pain' across the back of the chest is similar to the previous presentation 15 weeks ago and that the CRP had also been raised on that occasion to 38. The presence of a fever seems to confirm another unusual viral illness.

Taking these notes at face value, it seems to me that Dr Y is doing a very thorough clinical assessment, including arranging bloods and follow-up. A CRP of 76, although significantly raised, is non-specific; it does not incline one towards any particular diagnosis. It seems highly reasonable that investigations at a follow-up consultation (by another doctor) were directed towards tropical illnesses (malaria etc.).

Dr Y sees the patient again over the next couple of weeks with ongoing fatigue; he offers a specialist referral, but this is declined by the patient. On the day before her death, she is seen by an out-of-hours doctor and is once again diagnosed with a viral illness. Later that night she presents to ED, is triaged as non urgent, and leaves before being assessed. At home, she tragically collapses and dies. A train of events later ensues; a relative's request for a Commissioner's review, a finding, an educational article.

Hindsight bias

It would be interesting to see how many readers of this article so far had made the 'correct' diagnosis, as I am sure many doctors would be 'thinking viral', given a story of relapsing illness with fever and fatigue. For example, when I presented this scenario to my peer group, none of them considered the underlying cause for this patient's symptoms. Similarly, this patient presented to three GPs and two nurses in the course of her illness, but none of them made the diagnosis either.

As it turned out, post-mortem demonstrated severe coronary atherosclerosis with 'recent and aged' myocardial infarctions. In retrospect, it is probable that her clinical story is explained by repeated infarctions, but without typical chest pain, important cardiac signs, or complications such as failure. In my view, and in contrast to the view of the clinical advisor for this case, common medical knowledge at the present time does not support the earlier diagnosis of a cardiac cause for her illness, given her symptoms and reported clinical signs.

Notwithstanding that statement, a very recent research report describes 'prodromal and infarction symptoms' in women.[10] This report suggests that women may experience unusual fatigue, sleep disturbance, and shortness of breath prior to their actual infarction. On a number of grounds, however, it seems inappropriate to use this particular research as the basis for a clinical recommendation with this case. Firstly, this report could be labelled as 'emerging knowledge'; found within research reports, yet to be ratified by further studies and yet to become rules of thumb in clinical practice. Secondly, it is not clear when the patient's symptoms changed from being 'prodromal' to actual cardiac damage (with probable post-infarction fatigue). Without clearer correlation of symptoms to pathological changes, it seems problematic to base a clinical recommendation on this particular article.†

The difficulty for the Commissioner, however, is apparent: how can he pass on the facts of this or any other case to a clinical advisor without also passing on the reasons for the complaint (death) or the post-mortem findings? Even just giving the consultation notes would not necessarily 'blind' the advisors, as one would presume there had been a poor outcome of some kind, which had initiated the complaint.

In this case, the family's complaint was made on the basis of the final outcome (death) and it was accompanied by the above article on atypical presentation of cardiac disease in women patients. It is difficult to see how these factors would not influence the advisor's assessment of the doctor's clinical skills. The educational review then starts with an overview of the article supplied by the relative, and later presents the case as it unfolded. Despite the caveat that Dr Y's consultation process was of a 'high standard', it is hard not to conclude that the advisor had been compromised by hindsight bias in his assessment of the case and in his recommendation to the Commissioner. Fortunately, the Commissioner took a wider view and recommended an educational article. This is a good overall outcome, as clinical practice should necessarily be

† While the intent of an educational article is a good one (drawing attention to atypical presentation of cardiac disease in this group of patients), a clinical update should also include a wider review of the latest research findings including, but only if appropriate, the article supplied by the relative.

guided by up-to-date research. Drawing attention to atypical cardiac presentation should help lower the current threshold of awareness.

However, the issue of hindsight bias is clearly difficult. A recent Australian review concluded: *'There is evidence that hindsight bias, which may cause the expert to simplify, trivialise and criticise retrospectively the decisions of the treating doctor, is inevitable when the expert knows there has been an adverse outcome.'*[11] Similarly, a 2004/5 summer studentship research project in Wellington[12] revealed that local expert advisors to the Commissioner and other agencies would like more training, support and feedback on their work. These wider issues, including bias, are currently being reviewed by the Commissioner.

This clinical case and the review process also raise a number of other theoretical issues that will now be considered below.

The short circuit of grief into grievance

Faced with loss (expected or unexpected) persons undergo a grieving process which can include anger, sadness, withdrawal, depression, and so on. 'Scapegoating' is when the anger of grief is directed externally towards other members of the family, any of the many health professionals involved, or even innocent bystanders.

It is possible that complex emotions within grief such as guilt, anger and shame can be driving forces behind many complaints. I am not suggesting this applies to the case described above, but there have been a number of salient examples in New Zealand where complainants seem quite unmollifiable, despite any number of official inquires into the same adverse outcome. This may be because the underlying grief has not been acknowledged or addressed.

According to research in the UK, reasons why patients make a formal complaint are:

- standards of care;
- need for an explanation;
- compensation; and accountability.[13]

Similar research in the US[14] produced comparable findings despite the differences in medico-legal systems. However, both research methods were based on questionnaires rather than interviews; this prevented the researchers being able to explore deeper underlying emotions and motives.

At the moment then, the hypothesis that unresolved or diverted grief can be a driving force for a complaint has not been disproved by available evidence. The theory has some intuitive merit (reflected in current descriptive phrases such as 'culture of blame') but more specific research is needed.

It is difficult to distinguish between helpful feedback to the doctor on clinical processes that will improve patient care and diverted grief and anger by the complainant that is projected onto the health professional. Box 1 outlines a personal example that illustrates this difficulty.

To summarise this section, it is easy to justify a complaint when there is an 'obvious' identifiable medical error that contributed directly to the outcome. However, cause and effect within medical practice is extraordinarily difficult to define; it is all too easy to focus on, and/or scapegoat, one particular health professional, when in fact many are involved and when sometimes a poor outcome may be part of the disease process itself. In this particular case, it is curious that only one of the many health professionals involved was named by the complainant and that this doctor was the only one whose actions were subsequently reviewed by the Commissioner.

The doctor–patient relationship

Another interesting aspect to this case is the doctor's offer to refer the patient for a second opinion, an offer that was declined by the patient. One could speculate as to which specialist would have been appropriate had she accepted and, further, whether or not they would have identified the underlying disease (general physician, possibly; infectious diseases physician, unlikely). Furthermore, the patient later declined assessment at ED (in other words, exercised her right to autonomous decision-making).

Box 1

I became angry with the attending gynaecology registrar after my wife suffered a second miscarriage complicated by severe haemorrhage, eventually dropping the Hb to 70. While the doctor's interpersonal and clinical skills seemed inadequate, it was difficult at the time to distinguish between grief about the miscarriage and the urge to address medical competencies. Fortunately, this was resolved with the help of a good consultant who listened carefully and acknowledged our concerns; subsequent pregnancy was successful.

The underlying important issue here however, is the tension between two models of practice. On the one hand, 'patient-centred' medicine[15] has been widely promulgated in the last few decades; this model advises exploration of patient ideas and concerns, respect for autonomy, and negotiated decisions. It is widely taught in undergraduate medical education all around the world as well as in postgraduate training for general practice. To some extent, this model of professional care is gradually replacing the more traditional biomedical model[16] that includes elements of paternalism in which the doctor knows best and in which there is less consideration of the person of the patient (who is also expected to be 'compliant' with the doctor's instructions).

However, despite this apparent shift in responsibility towards shared decision-making, there has been little change in the model of practice used to assess adverse outcomes. In my view, the recommendations by the clinical advisor in this case were based on rather paternalistic bio-

medical principles, as if the patient was not involved in any of the clinical decisions along the way. A more appropriate assessment of the doctor's actions within prevalent culture should include acknowledgment of the responsibilities of both parties within this significant healthcare relationship. If the patient chooses not to follow what was presumably clear advice (in this instance, on two occasions), then it is difficult to see how the doctor is responsible for eventual failure of diagnosis.

Autonomy is clearly a double-edged sword; a doctor should not be held accountable if, by the patient's informed choice of action, there has been a poor outcome.

The review process

Is the investigation of complaints a fair process in New Zealand? I asked the Commissioner to comment on the current review process. On receipt of a complaint, the Commissioner asks the health professional to respond, and both the response and the complaint are sent to a clinical advisor for their opinion. There is usually only one advisor but he or she is encouraged to discuss the case anonymously with colleagues or other advisors. Their recommendations are contestable as they are sent to the health professional or DHB for their response. At the present time, advisors are not blinded to the outcome of the clinical case, but this option is being considered where possible. Advisors are named in reports and face external criticism from colleagues if their advice is unsound or (to use the Commissioner's phrase) too 'gold standard'.

At face value then, it sounds as though the system is orientated toward natural justice and fairness. The Commissioner has the final say and may or may not follow the clinical advisor's recommendations (as in this case). Clinical advisors take their role seriously and are generally performing an excellent service, although more training and support could be offered.

Summary

While the *Commissioner's Comment* article on 'missed' myocardial infarction has helpfully contributed to an increased awareness of atypical cardiac presentations in middle-aged female patients, this sentinel case raises a number of ongoing issues with respect to complaints. It seems that the current review process by the Commissioner following receipt of a complaint from a patient or their family has improved considerably in the last five years or so in New Zealand. While there are safeguards in the system to allow health professionals to contest the recommendations from clinical advisors, there are background societal issues that influence the generation of complaints (unrealistic expectations of health care and issues in grief). Similarly, there are also issues within current process (the difficulty of blinding advisors to outcome, recommendations based not on current practice but on emerging knowledge, and using 'gold standard' criteria) that continue to make clinical assessment problematic.

In a number of ways the medical profession is moving towards a more robust professionalism with respect to clinical uncertainty, adverse outcomes, and complaints; despite this, review of complaints will always be a difficult task. As this case illustrates, however, the best final outcome is one that avoids any tendency towards simplistic findings. Medical practice is an extraordinarily complex social activity with many players; the outcome of investigation into complaints should reflect this complexity.

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