

# *Unfit to be a doctor - for the time being*

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Physicians should provide adequate medical care (1). Nevertheless health authorities accept that care is given that differs from good practice without it immediately being labelled as irresponsible. There is a grey area between good and unjustifiable that most physicians have probably established familiarity with. As a manager in an outlying municipality with many short-term locum staff, I have gained valuable insight into these grey areas. I also began to interest myself in what is definitely not good enough practice and how we in GP practices can relate to it.

This is both a legal and medical field, and use of the concepts varies. There is reason to avoid the concept of "medical error" that focuses on personal failings, while "deviation" points to the actions that led to any damage [2]. Here I will use the term adverse events.

**Adverse events.** Adverse events are part of practical medical work which cannot be eliminated. The aim is to learn from them to the greatest extent possible to reduce the incidence and adverse consequences. Hjort has referred to studies which show that adverse events occur in approximately ten percent of hospital admissions, and that approximately five percent are fatal (3, 4). We have fewer data on the extent of adverse events in primary health care. Comprehensive English studies indicate that there may be significant errors in approximately seven percent of consultations and these can be classified under the headings diagnostics, prescribing, communication and organization (5, 6). One can divide adverse events into system failure, human error and accident, but the boundaries are not always clear. Malfunction caused by the organization and planning of the work it is believed to be the most frequent cause of unfortunate events. Human error due to insufficient expertise or personal conditions that prevent proper practice, and they account for around one third of adverse events [3]. Random misfortune reflects the calculated risks inherent in any medical procedure.

**Good enough - Less good - Currently unfit.** Conducting practice to generally-accepted professional standards presupposes basic knowledge and basic skills. Core basic skills should offer the patient confidence about being taken seriously, but should also allow the doctor to challenge the patient. This can result in the patient being disappointed and feeling the doctor did not "take me seriously." Some patients will also complain after such an experience. Complaints do not necessarily reflect bad practice or an adverse event. On the contrary, I would almost say "If you never experience a complaint – are you giving a reasonable degree

## *Key Messages*

- Adverse medical events are common in general practice
- All practising doctors must consider themselves responsible for adverse events
- Adverse events can be the basis for learning and improving work
- Ensuring this learning takes place is a leadership responsibility
- In the event of seriously deviant behaviour the health authority must assess whether the doctor is fit, for the time being, to practice

of challenge?

There is more reason to look at ourselves in the mirror when we have repeated complaints. Is there anything about our knowledge or my practice which does not measure up? Is it a random accumulation of incidents? Many are their own strongest judges and barely need a complaint to know about the failure of quality. But: we will unfortunately all experience making mistakes that have consequences for a patient.

Some of us will experience tougher times. Personal difficulties, private lives in disarray, the accumulation of problems in our jobs may all put us out so that our mental reserve is less than what we need to work as a practicing physician. We are currently incapable of being a physician. Tables 1 and 2 give give an impression of the scope of responses from the health inspectorate and the kind of issues underlying referrals. Substance abuse and behaviour control are commonest.

Table 1. *Number of supervision cases concluded by National Board of Health and the number of actions taken 2002-8. (16)*

Year	Completed cases	Action taken	No action taken
2002	173	103	71
2003	172	125	55
2004	237	148	101
2005	242	168	87
2006	252	184	76
2007	271	181	95
2008	224	155	65

Table 2. *Reasons for revocation of licence by healthcare professional group 2002-8. (16)*

	<b>Nurse</b>	<b>Nursing assistant</b>	<b>Doctor</b>	<b>Others</b>	<b>total</b>
<b>Intoxication</b>	15	7	10	5	37
<b>Sickness</b>			1		1
<b>Sexual exploitation of patients</b>	1		1	2	4
<b>Behaviour</b>	2	3		3	8
<b>Irresponsibility</b>	1		2		3
<b>Not complying after warning</b>			3		3
<b>Disappeared</b>	2		2	2	6

<b>abroad</b>					
<b>Other</b>			1		1
<b>Total</b>	21	10	20	12	63

We must assume that behind every doctor who is ‘caught’ and gets such a reaction, there are many others currently unfit to practice. Increasing immigration of doctors with different cultural backgrounds and language has highlighted a type of unfitness based on communication failure, lack of cultural competence, expertise and at times lack of basic skills. The number of referrals of trainees has increased, not least because of language problems and assessment of suitability. Trainers have previously been in the habit of letting trainees slip through the cracks almost regardless of performance, but this is changing (Table 3). Some examples may clarify what I'm talking about.

Table 3. Trends in medical licence withdrawals [17]

2008	18
2007	17
2006	15
2005	10

- The increase is slight from year to year, but the trend is increasing
- The threshold is dropping for preparing a case
- In recent years there is an increasing tendency towards striking off. All of it is in hospital practice.

*"Currently out for the count"* For Johan, it took going through a divorce. He chose nevertheless to remain at work on the ‘outpost’ when his wife and children moved away. Alcohol use increased without being dangerous, but the reserve was gone. That was when disaster hit. He misinterpreted a meningitis, and sent a 17 year old girl home. She died there the next day in the morning hours. Formally little was done wrong. The records were clear, examination and assessment documented. But the clinical evaluation was wrong. The County Physician gave no formal reaction. His colleagues were fine, but a little flickering in his eyes? Worse was wondering whether it was his own distraction that was the cause of misjudgment. Three weeks after the funeral, he requested sick leave and contacted a colleague he knew from the support group in the local Medical Association.

Six months later Johan was back at work.

*"Medical nomad" - The popular charlatan* A central fringe municipality had struggled with physician recruitment for a long time. A reputable Norwegian locum agency provided doctor Seb, with a foreign cultural background and extensive work experience in Denmark. He appeared to be a reliable, hardworking and cheerful colleague. After a few months a pattern began to emerge. Seb kept his cards close to his chest and said little in professional discussions. Every week he received flowers and gifts from delighted patients. Clever and kind doctor. Meanwhile many patients were referred from the same doctor to get a second opinion on treatment. There was discussion in the workplace when many patients with various ailments all got the same diagnosis and the same broad-spectrum antibiotics. The municipality discontinued his locum contract. Last season there was a total of nine well-founded complaints to the county medical office about the doctor. Then he got a job on a different continent and did not answer any further correspondence.

Seb actually had a good deal of medical knowledge, but he was not willing either to recognize or discuss the fact that his knowledge also had holes.

*"Medical driftwood"* A peripheral municipality got a new locum who was educated at a military academy, but with later additional education which gave him Norwegian authorization to practice. The local culture in his educational setting was highly gender segregated and the medical education he had received proved to have hardly included women. After a short time the office manager received a verbal complaint from a woman who thought she had been forced to undress more than would have been expected for her complaint of back pain. Soon after came one from someone who had had to take off everything to be examined for a sore throat. The office manager confronted the locum with this. The doctor believed that a thorough investigation involved a full physical examination. It was made clear that he had to change his practice. Constantly new women were asked to strip naked on the basis of banal ailments. The office manager followed a similar procedure recommended in this article. The locum doctor was reported to the county doctor, but was relocated and given another chance in in another county. He continued as before and was again referred both to the county doctor and this time also to the police. He lost his licence to practice and received a legal verdict which was enforceable.

**Scripture's unrelenting message.** There is an unpleasant regional profile of systematic medical unfitness. I've got access to several different medical offices in rural Norway. Most are managed properly. But reviewing the records yesterday shows me that changing locums at times offer dangerous and unsatisfactory medical care. Quality failure is such that you would never have got away with it if you practiced in a context where there was greater transparency in the activity. "In the shade of" a proven nomadic strategy is scope for charlatans earning well over a million [£100k] in annual salary. Matthew 25.29 has a familiar message: "For he that hath shall be given, and in abundance. But for he who has not shall be taken away even that which he hath." Those affected are a fringe population that some places have little: expensive and bad doctoring.

**What do I do when I'm having a problem?** Johans situation can affect everyone. Think about the experiences you have with making medical near-errors or errors. How did you deal with it then?

Are there aspects of your particular background that can help you or make it difficult when/if you get in this situation? Knowledge of yourself and your own reaction patterns can be a help in cognitive preparation. Who do you think can help?

When the situation has occurred many people have means of talking to a colleague they trust or a friend from college. The Medical Association supports colleagues in all provinces.

**What do I do when a colleague has problem?** It starts with you receiving verbal complaints from patients or observing a practice you question. In most cases the task will be to provide support to the colleague in order to work better, by conversation, by informing about support schemes, other resources or support agencies (7).

So far everything is fine. But sometimes the gravity and the deviation in the professional or human actions is so pronounced that you think this is not enough. You suspect serious deviations without at this time have the opportunity to get an overall view. what do you do? (Box 2)

As important as guiding the doctor is protecting the population against a potentially harmful colleague.

It is reasonable to start by informing the doctor about the complaint you have received in a confidential conversation. The threshold for doing this may be felt as significant, but it must be done. There is a seriousness about such cases indicating that you should note the date of the conversation and make a short synopsis from each such conversation.

If you suspect serious deviations you should simultaneously inform the office manager. What does she think? How will you progress through the grey area? It is time to log complaints when they were received, or what you have observed and when you have seen it.

If little changes, you must again engage the leader in the office and give her access to your

*Box 2. A procedure for the office when a colleague shows signs of unfitness*

- Tell the doctor about the complaint you received
- Discuss with office manager
- Create a log of complaints and observations that can illuminate the claim
- The office manager convenes a formal discussion in which the doctor is clearly confronted with which points the office is not happy with. Doctor receives a copy of the minutes of the meeting.
- Office manager informs the director of health in the municipality. Plan according to the seriousness. Advise the County Medical Officer at this point? Is withdrawal of licence to practice applicable?
- Office manager maintains a log of complaints and observations
- If the concern continues: office manager call the doctor again and inform him about what he / she has knowledge of
- the office manager contacts County Medical Officer to get advice on the matter
- Continue to maintain the record
- Report the matter in writing to the county medical officer. Assess the licencing of the doctor

material. Managers have responsibility to clean up such cases. If the case is serious enough the municipality or the practice must suspend the doctor before he does more damage. The County Doctor's response will take time and in specific cases one must act quickly.

### **Assessment and reporting - Simplicity is a good start**

The Health Authority is criticised by GPs for not contributing to a reasonable professional conversation about mistakes through the working methods they use in system audits and appeals. Supervision methods based on system revision have introduced an alienating power-language (system audits, supervision objects etc.) that focuses on deviations and thus understates the fact that an entity is mainly working well. Practitioners have called for a toning down of formal reactions towards minor deviations and a larger space for supervision and guidance in dialogue (8, 9).

Norwegian anaesthesiologists have experience with using simple reporting systems for deviations during anaesthesia as learning points to improve practice (10). It is possible to introduce routine registration of adverse events in an enterprise if the system is so simple that it can be integrated into daily operations. In anaesthesia discipline a trust-based reporting culture is shown to work better than systems based on inspection and control. Public notification systems have little support. This may indicate that they are not perceived as good starting points for discussions. A number of studies show that GPs are interested in participating in messaging systems that emphasize prevention and learning rather than disciplinary measures (4).

There are teaching materials based on review of other colleagues' unfortunate incidents that have led to complaints. Participants can discuss progress and procedure in order to understand how the medical assessments failed and how the communication about the complaint eventually resolved (7, 11). The County Doctor in Sogn og Fjordane has also demonstrated methods to run a learning network primary care based on registration of activity and tolerance (12).

A supportive collegial environment may be what helps one over the hump when it is one's turn to feel that one's practice should have been done better. If one manages to talk about the little mistakes (this week's mistake) one is on one's way to relax a little. If I experience being heard by my colleagues, I find it easier to listen to the patient (13).

**A management responsibility.** Younger physicians should expect of a good leader that she can talk about mistakes - their own and others. Internal conversations will lower the threshold for being able to talk with patients and their families when the worst happens. And it will make it less stressful for doctors to live with the risk of their own miscalculations.

In addition, managers must report serious adverse incidents to regulatory authorities according to established rules. Unsound medical practice must be captured so that the practitioner can get counselling, treatment or other measures. There is a collegial responsibility to see the doctor in this situation is safeguarded both personally and in the workplace. Practice shows, however, that management of some departments still responds to allegations of errors by picking out individuals.

**Transparency still lacking.** Most US doctors say they want to report adverse events that may cause patient injury, but only a small number have actually reported error (14). A Norwegian study found that doctors in Norway and Australia essentially agreed on what is the appropriate reaction for such events. Norwegian doctors were nevertheless less open than the Australians to share experiences of serious discrepancies (15). In the cold light of Hjord's article on undesirable incidents in the Journal of the Norwegian Medical Association, there followed a discussion with a sarcastic undertone about the impartiality and "objectivity" in his writing because he was both a doctor and a relative of a patient who suffered an adverse event. Are Norwegian doctors mature enough to read about, let alone discuss, their own adverse events?

**The discomfort.** Physicians must learn not to be defensive when they encounter patients who have been exposed to adverse events (13). Patients who have experienced a loss of health or of a relative, must have an opportunity to present their despair with no hint of resistance - in the first place. Only later the doctor should also be able to present their version of events. But there and then, in the moment the painful story is presented, the physician must be able to meet the patient with a bare: "I'm sorry".

There is a discomfort associated with doing this. Just as it is perceived burdensome to confront a colleague with complaints about his / her practice. But it must be done.

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