

Risk of Malpractice Claims and Changes in Professional Autonomy: A Qualitative Study of Obstetrician-Gynaecologists in Switzerland

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Abstract: Based on interviews, this article explores how obstetrician-gynaecologists in Switzerland deal with and respond to the risk of malpractice claims. It describes the factors associated with the interviewees' perceived increasing risk of litigation, as well as three attitudes towards the use of consent forms as a means of managing such a risk. This article suggests that the perceived risk of claims is closely linked to the physicians' perception of how external regulation shapes their professional autonomy.

Keywords: malpractice claim, defensive medicine, professional autonomy, obstetrician-gynaecologist, Switzerland

Das Klagerisiko wegen Behandlungsfehlern und Veränderungen der professionellen Autonomie: eine qualitative Befragung von Gynäkologen in der Schweiz

Zusammenfassung: Dieser Artikel zeigt auf, wie Gynäkologen in der Schweiz mit dem Risiko einer Anklageerhebung umgehen und wie sie darauf reagieren. Er beschreibt die Faktoren, die mit dem von den Befragten wahrgenommenen zunehmenden Risiko von Rechtsstreitigkeiten zusammenhängen, sowie drei Einstellungen zur Verwendung von Einwilligungserklärungen, um allfällige Klagen zu umgehen. Das wahrgenommene Risiko steht in einem engen Zusammenhang mit der Wahrnehmung, wie externe Regelungen die professionelle Autonomie beeinflussen.

Schlüsselwörter: Klage wegen Behandlungsfehlern, defensive Medizin, professionelle Autonomie, Gynäkologie, Schweiz

Risque de plainte et transformations de l'autonomie professionnelle : une étude qualitative auprès de gynécologues-obstétriciens en Suisse

Résumé: Basé sur des entretiens, cet article explore de quelle manière des gynécologues-obstétriciens en Suisse définissent le risque de plainte des patients et y répondent dans leur pratique. Il décrit les facteurs liés à la perception d'une judiciarisation des soins et trois postures à l'égard des formulaires de consentement comme moyen de gérer le risque de plainte. L'article suggère que la perception du risque de plainte par les médecins est étroitement liée à l'influence perçue de la régulation externe sur leur autonomie professionnelle.

Mots-clés: plainte pour faute professionnelle, médecine défensive, autonomie professionnelle, gynécologue-obstétricien, Suisse

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1 Introduction

The issue of defensive medicine has become a significant issue of contemporary changes affecting health care systems and health care delivery. It is generally defined as poor medical practice, in which a physician performs in order to avoid or reduce the risk of malpractice claims rather than to meet the patients' medical needs (Studdert et al. 2005). Main clinical outcomes resulting from the practice of defensive medicine are ordering additional and unnecessary tests and diagnostic procedures (Vincent et al. 1994). Physicians are reluctant to perform high-risk procedures, or even refuse to accept certain types of cases that are known to be associated with a high incidence of malpractice claims (Studdert et al. 2005). Although various segments of health care professions are concerned about the fear of litigation, obstetrician-gynaecologists are particularly exposed to the risk of a malpractice claims (Jena et al. 2011) and are most likely to change their practices accordingly (Tussing and Wojtowycz 1997). Beyond debates about healthcare costs (Thomas et al. 2010), effects on quality and access to healthcare (Dalton et al. 2008), the issue of defensive medicine is of major sociological interest as it is closely linked to current transformations of the medical profession. Within this framework, this paper aims to contribute to current sociological debates surrounding physicians' professional autonomy by examining how obstetrician-gynaecologists in Switzerland perceive and respond to the risk of malpractice claims.

2 Malpractice claims as a challenge to professional dominance

Professional autonomy has been one of the key sociological issues on the status of medical profession in contemporary societies, and at the core of debates on transformations of medical dominance (Bergeron and Castel 2014). Much of this research argued that the medical profession's autonomy has been eroded from the 1960s–1970s, while it was characterised until then by a high level of self-regulation (Freidson 1970).

Proletarianisation and corporatisation theories suggested that the expansion of capitalism involved a process of deskilling and routinisation of medical work, resulting from an increasing physicians' dependency on corporate organisations and administrative bureaucracy (McKinlay and Stoeckle 1988). Although such perspectives have been deemed exaggerated (Hafferty and Light 1995), they pointed out some of the significant changes that have transformed organisation of health care systems and the nature of medical work over the past decades. Such changes refer particularly to the administrative (Freidson 1994), financial and organisational (Exworthy et al. 2003) control levied over medical practices, but also to the development of standardisation of medical practices under the influence of evidence-based

medicine and epidemiology (Timmermans and Kolker 2004; Cambrosio et al. 2006). In particular, the introduction of new managerialism in health care, especially in hospitals, has been described as challenging doctors' authority insofar as medical work has become subordinated to economic and policy constraints implemented through various control systems, such as performance indicators (Harrison and Ahmad 2000; Numerato et al. 2012).

These various pressures from stakeholders outside of the medical profession have reduced physicians' clinical autonomy, defined as the "ability of individual physicians to determine their own clinical practices and to evaluate their own performances, in both cases without normally having to account to others" (Harrison and Dowswell 2002, 209). According to Harrison and Ahmad (2000), physicians' clinical autonomy in the United Kingdom is being undermined as they are subjected to more stringent regulations in daily practice. In Switzerland, significant transformations of medical work have occurred in the early-2000s, resulting in a greater accountability process. Such changes can be related to a growing dissatisfaction of doctors with loss of clinical autonomy which "echoes the negative perceptions that doctors have of many managed care tools" (Perneger et al. 2012, 482).

Debates about changes in professional dominance have given rise to pluralist frameworks taking into account the multiplicity of stakeholders involved in the organisation and definition of contemporary health care. For example, Light (2010) proposes a "countervailing powers" perspective where medical dominance must be understood within a broad constellation of various stakeholders, such as the other health occupations, the state, the pharmaceutical industry, patients' organizations, which compete for power and resources. Similarly, Abbott (1988) emphasizes that professions are engaged in a constant competition to achieve or maintain jurisdictional power. Freidson (1985) contributed to conceptualising transformations of autonomy also occurring from within the medical profession by pointing out the emergence of professional elites who retain a high-level of control over the content of medical work, whereas rank-and-file doctors' clinical autonomy is eroded. As a result, some of the constraints on medical work, such as clinical guidelines, are produced by a fraction of the medical profession itself (Freidson 1994).

2.1 Legal challenge and patients' complaints

In this context of external regulation of medical practice, physicians' exposure to legal liability can be seen as part of a general professional accountability process (Bury 2010). In particular, the issue of malpractice claims points out the growing influence of legal rules on medical work. Overall, empirical research shows that physicians are likely to perceive increased legal accountability negatively and as a constraining force (Dingwall and Hobson-West 2006). Moreover, physicians are said to be suspicious of the legal process as an appropriate and legitimate regulatory body of medical work (Hupert et al. 1996; Marjoribanks et al. 1996; Liang 2003).

The growing importance of law and justice in medical matters is perceived as having a distorting effect on healthcare providers and medical practice, resulting in defensive attitudes and feelings of professional vulnerability (Jain and Ogden 1999). Thus, law and medicine tend to be seen as conflicting institutions, since legal rules are perceived as a means of enframing medical practices and of making doctors more subject to liability through malpractice claims (Dingwall and Hobson-West 2006).

Sociologists have underlined that challenges to medical autonomy come from the state and formal regulatory bodies, but also from patients (Light 2010). In particular, the deprofessionalisation thesis claimed that professional dominance has been eroded by consumerism movements in health care (Haug and Lavin 1983). The trend towards more demanding patients, complaints and the application of regulatory law can be seen as a new form of lay criticism against doctors' professional and moral authority (Nettleton 1995). Patients' complaints are experienced by doctors as a challenge to their expertise and as a potential threat to their professional identity (Marjoribanks et al. 1996; Allsop and Mulcahy 1998). Several studies suggested that medical encounters have been deeply altered by a growing litigious environment, since the trusting patient was replaced by a threatening or confrontational patient (Mello et al. 2004; Jacques 2007), resulting in strained doctor-patient relationships (Cook and Neff 1994). For example, it has been said that increased physicians' liability degraded the traditional trust-based doctor-patient relationship (Vanderminden and Potter 2010).

Risk of malpractice claims therefore appears to be at the centre of significant sociological changes of medical work, and tends to be seen as the apex of the erosion of professional dominance and physicians' authority (Annandale 1989). This risk highlights the role played both by external regulation bodies and the consumer-oriented nature of the doctor-patient relationship on professional autonomy. Most studies on the meaning of litigation provide an overall quite negative if not alarmist picture of how physicians see changes in their working environment and their relationships with patients. However, two arguments suggest that physicians' perception of risk of malpractice claims is more complex than merely in terms of challenging clinical autonomy, breakdown of trust with patients and strained attitudes towards legal regulation.

2.2 The influence of national and professional contexts

First, literature on defensive medicine and perceived risk of malpractice claims was focused on the United States (Studdert et al. 2005), thereby overlooking the structural context in which healthcare professionals evolve. Indeed, differences in legal and healthcare systems matter when studying and comparing professional perceptions of litigation from one country to another (Hassenteufel 1997; Cartwright and Thomas 2001; Laude 2010). Moreover, the degree to which the law impacts medical practices as well as physicians' exposure to litigation risk is not the same

from country to country (Barbot and Fillion 2006). In this respect, unlike France (Moyse and Diederich 2006) and the United Kingdom (Bury 2010, 417), Switzerland has been spared from high-profile medical malpractice cases or scandals in the healthcare field, causing distrust towards the medical profession. In addition, despite the lack of data on the extent to which the healthcare system has been affected by a malpractice crisis or on the number of patients' malpractice claims in Switzerland (Rothhardt 2015), malpractice claims are considered to be markedly lower than in the United States (Steurer et al. 2009).

Second, debates on professional autonomy have failed to take into account how physicians make sense of changes within their working environment, and how they respond to such changes in daily practice. Bergeron and Castel (2014, 251) have underlined that the range of physicians' reactions to the rationalisation of medical work (such as practice guidelines and assessment tools) is "very wide and largely undetermined," therefore having variable effects on their clinical autonomy and professional identity. Fillion (2009) has shown that physicians' perception of constraints affecting medical work is more complex than just fear, suspicion or outright rejection, and Harrison and Dowswell (2002) have reported that general practitioners integrated accountability obligations with little resistance. Moreover, health professionals' reactions to management culture and control measures take on various forms, such as internalisation, negotiation or strategic adaptation (Numerato et al. 2012).

Comparative studies have shown that how doctors perceive and cope with risk of litigation is partly influenced by the specialty (Barbot and Fillion 2006; Biancucci 2011). However, little work, especially in Switzerland, has been conducted from a comprehensive perspective on how doctors within the same specialty view the issues of threat of litigation and legal regulation more broadly. This article examines how obstetrician-gynaecologists in Switzerland perceive and interpret the risk of malpractice claims. Bucher and Strauss (1961) have emphasised the heterogeneity within a profession, not only in terms of practices, but also in terms of values, interests, or conception of professional activity. Following an interactionist approach (Dubar et al. 2011), we make the assumption that ways of understanding and responding to risk of malpractice claims vary within the segment of obstetrician-gynaecologists. We will argue that their attitudes towards risk of malpractice claims are shaped by sociological changes that have affected their medical autonomy and their social status more broadly (Lupton 1997; Allsop and Mulcahy 1998; Barbot and Fillion 2006; Dingwall and Hobson-West 2006).

3 Data and methods

This article is based on face-to-face semi-structured interviews carried out in 2009 with 26 obstetrician-gynaecologists practicing in a big town in the French-speaking part of Switzerland.¹ This study was part of a larger research project dedicated to understanding how pregnant women and health care providers managed information and risks during pregnancy (Manai et al. 2010; Hammer and Burton-Jeangros 2013).² Obstetrician-gynaecologists were recruited from two different professional settings: 18 worked in private practice (9 women and 9 men) and 8 in a maternity hospital (5 women and 3 men). Those working in private practice were selected using a simple random selection from the official directory of private obstetrician-gynaecologists. Six of them were recruited thanks to personal contacts. Obstetricians-gynaecologists working in the maternity hospital were recruited thanks to the support of the head physician of the department of obstetrics who encouraged his team physicians to participate to the study. The participants ranged in age from 35 to 65 (mean age = 48), those working in the hospital were younger on average (mean age = 41.1) than those working in private practice (mean age = 51.1). The participants had obtained certification as specialists in gynaecology and obstetrics and had practiced in the field for 13.6 years on average, with a standard deviation of 5.7 years.

The mean duration of the interviews was 75 minutes with the private practitioners and 68 minutes with the hospital practitioners.³ The interview schedule focused on three main issues: participants' views and experiences on the evolution of their professional activity and working conditions over the past few years, including changes in patients' attitudes; information disclosure strategies concerning risks associated with pregnancy; and perception of the current medico-legal context in Switzerland. In this respect, we particularly explored interviewees' attitudes towards the Federal Act on Human Genetic Testing. This new law on genetic analysis has entered into force in 2007 and details the scope and content of information to be provided to the patient (Büchler and Gächter 2011). It specifies that written consent must be obtained in the case of genetic diagnosis procedures, and that oral consent is sufficient in cases of prenatal tests for risks, but must be recorded by the doctor in the patient's file. This significant change in legal framework has resulted in strengthening the doctors' duty to inform and in an increased formalisation of medical work (Manai 2010).

All interviews were recorded and transcribed verbatim. We used the Atlas.ti software program to manage data and to attach codes to segments of transcripts. Data analysis combined theoretical coding and thematic coding (Flick 2009). We first established a list of descriptive categories from interviews (such as "evolution

1 Interviews have been conducted by the author and Samuele Cavalli.

2 This research was funded by the Swiss National Science Foundation.

3 Long interviews with healthcare professionals in Switzerland have been reported in other studies, such as Cavalli (2014) and Courvoisier et al. (2011).

of litigation,” “use of consent forms” or “fear of litigation”), and then explored how these categories were interrelated and developed common thematic domains across interviews in order to organize our results. The study was approved by the Research Ethics Committee of the local medical association.

4 Results

In this section, we first examine to what extent interviewees felt concerned by the issue of malpractice claims and what factors were related to their perception of an increased risk of litigation (4.1). We then describe three contrasting attitudes expressed by the interviewees regarding the use of consent forms as a means of managing risk of malpractice claims in daily practice (4.2).

4.1 Malpractice claim as a true cause for concern

The risk of malpractice claims appeared to be a true cause for concern. Almost all of the interviewees felt concerned about medico-legal issues and acknowledged that risk of litigation was now part and parcel of practicing obstetrics and gynaecology. They recurrently described such a risk as “worrying,” “palpable” or something “we must make do with,” and very few interviewees considered themselves safe from possible patient complaints. We now consider the three factors which made malpractice claims a significant concern in the obstetrician-gynaecologists’ discourses.

First, the subject of defensive medicine in the context of the United States strongly influenced the perception of malpractice claims. Almost all obstetrician-gynaecologists referred to the North American context in connection with the possible or effective growing importance of the medico-legal issue in Switzerland. The interviewees especially criticised unfounded malpractice claims, the adversarial nature of the legal system, and the decline of the quality of health care as a consequence of physicians engaging in defensive behaviours due to fear of litigation. They expressed a quite negative picture of how law and justice impact professional practices in the United States: “attempts of delivery from below after a C-section, forceps or vacuum extractions are almost banished also because the risk for complications that exists and the risk of litigation seems too high” (MH05, 52 years old).⁴

Although the interviewees viewed defensive medicine as a “scarecrow,” they stressed the institutional and legal features rendering the situation of medical profession in Switzerland substantially different from the North American context, such as the lower level of compensation to which plaintiffs are entitled in Switzerland, the fact that medical errors are not treated as a business opportunity for lawyers, or the fact that Swiss lawyers are not allowed to charge contingency fees. Others also stressed

4 “PP” stands for “private practice” and “MH” for “maternity hospital.”

that health insurance is compulsory for all persons residing in Switzerland.⁵ Another interviewee mentioned, among other factors, the role played by professional elites; “we’re not totally immune but I think it also depends on the recommendations on medical practices made by our medical societies” (PP09, 49 years old). As a result, no interviewee stated that practicing obstetrics and gynaecology in Switzerland was currently shifting toward an American-style of litigation, although defensive medicine in the United States was a frequent source of worry regarding the near future.

Besides the “scarecrow” of defensive medicine in the United States, cultural transformations of lay attitudes towards medicine were associated with the perception of risk of malpractice claims as a cause for concern in our sample. Many interviewees referred to a waning social acceptance of fate, misfortune, or risk as legitimate explanations for pregnancy failure, foetal malformations, or labour and delivery complications. Several interviewees pointed out a growing tendency of patients to control aspects of life previously understood as uncontrollable – such as a pregnancy and healthy birth on demand. Therefore, medical complications or any unintended event would have become less and less tolerated nowadays by patients. Many obstetrician-gynaecologists in our sample also pointed out that lay people were expecting more and more from applied sciences, as if doctors were able to ensure a “perfect” baby. For them, such high expectations of technology reflected a broader social evolution, including the tendency for people to look for someone to blame. The general social intolerance of unintended outcomes in medical matters was strongly linked with a tendency to go to court:

People can't stand when things don't go as expected, but it's not because of a medical error but because it does go wrong (...) generally people manage life frustrations less well (...) I still have a feeling that the general tendency is to go more easily to formal complaint, to courts. (PP11, 46 years old)

However, such shared views about changes in lay expectations towards medicine were rarely personally experienced by the interviewees in daily practice. Patients described by several interviewees as “quibbling,” unduly pressuring health care providers, or searching for fault were reported to make up only a very small fraction of their patients, defined in terms of psychological profile or particular occupations, such as nurses, legal experts or school teachers (see also Biancucci 2011). Most interviewees rejected the thesis that patients had, on the whole, become more litigious against doctors, and no one supported the idea of a general process of strained doctor-patient relationships.

5 The benefit package of the mandatory health insurance in the Swiss system offers a comprehensive and equal coverage, characterised by a high level of access to health services (OECD/WHO 2011). Moreover, it must be emphasized that punitive damages do not exist (Büchler and Gächter 2011). Such institutional and legal features are likely to limit malpractice claims in Switzerland, especially the financial motivation for suing doctors.

Referring to their own experiences, they stressed that most formal complaints hinged on the physician's attitude and quality of communication with patients before and following an adverse outcome. They underlined that providing clear explanations to patients was a crucial step that may prevent dissatisfaction from developing into a malpractice claim:

In the case of a C-section for example, or when a forceps is used or for vacuum extractions, if we inform the person a little bit better beforehand or if we take time right after the difficult situation to inform and explain, by resuming things with the patient, we could avoid quite a lot of complaints or disputes. (MH04, 35 years old)

Admitting one's mistakes, demonstrating honesty, or even showing empathy were seen as the best means of "neutralising" the risk of a complaint or "keeping it at a distance." As a result, the obstetrician-gynaecologists in our sample considered the risk of malpractice claims above all as a matter of bad interaction or of misunderstandings between health professionals and lay people, instead of the expression of patient's litigious ethos. Rather, they claimed that their encounters with patients were, overall, still based on trust.

While defensive medicine in the United States and the perception of more demanding patients played an important role, interviewees' experience of working conditions turned out to be an even more significant factor associated with concern about risk of malpractice claims. Worries about litigation were indeed most often associated with the feeling that their working environment had been changing over the last years towards a generally greater accountability process. The interviewees mentioned an increased administrative workload: "We spend more time with administrative things than really taking care of patients, just to justify and prove that we do our job properly" (MH07, 43 years old); "our job has become more difficult, we are more obliged to justify and to explain what we do" (PP10, 58 years old). Such complaints referred to greater control measures from health insurance companies and to the introduction of the new Swiss medical fee schedule, which implied "more onerous requirements for documenting and referencing each medical service provided" (Perneger et al. 2012, 482).

Referring partly to the effects of the new law on genetic analysis mentioned above, the interviewees particularly pointed out the patients' file keeping and the growing use of consent forms for many procedures as the most significant changes in medical work. They viewed such changes not only as an additional bureaucratic burden in daily practice but also as a reminder of the liability issue and the threat of a lawsuit: "That's how it works now, we have to write down correctly because if there's a problem, it's gonna backfire on us, therefore we have to use these forms" (PP26, 49 years old). The interviewees referred to an increased formalisation of medical work and communication with patients as part of daily practice:

Of course, we have a duty of information, it is permanent, even if it's not about forms to be signed, we must inform people and we must write it down that we have informed people, because if it is not included in the patient's record and you go to court, you're done for, so it's a little bit exasperating (...) even if we did inform the patient, we have to... [write it down], we must clear ourselves. (PP25, 65 years old)

For many interviewees, use of consent forms was identified as a meaningful change in patient information and epitomized the problem of the risk of malpractice claims.

It must be stressed that risk of malpractice claims as a true cause for concern in our sample was seldom referred to precise facts, concrete events or experiences. Few interviewees reported to have been personally involved in a patient's formal complaint, and only a small minority of them firmly claimed that there was actually a rise in legal actions in Switzerland, whereas many of them just could not agree it was realistic. Moreover, the interviewees seldom referred to specific judicial cases, court judgments or changes in the law. Finally, they rarely mentioned concrete professional practices or changes in clinical attitudes as a result of risk of litigation, with the exception of decreasing attempts at vaginal birth after a Caesarean delivery.

In summary, obstetrician-gynaecologists' worries about a possible growing litigious environment in Switzerland were rather grounded in a widespread perception of a greater accountability process than underpinned by clear-cut assertions or experiences directly related to litigation or defensive medicine. Perception of changes in work routines, such as increasing incitement or duty to use more and more consent forms and information documents, therefore played a large part in making the risk of malpractice claims a true cause for concern. In the next section, we focus on how the obstetrician-gynaecologists in our sample managed the use of consent forms and show that such a perceived change in working conditions was related to the issue of professional autonomy.

4.2 Use of consent forms: three ways of managing the risk of malpractice claims

All interviewees strongly rejected defensive behaviours in medical practice, arguing that it would mean practicing with fear and adopting dysfunctional clinical reasoning. In their views, properly managing the risk of malpractice claims required not paying excessive attention to it in day-to-day medical practice, in order to minimise its influence on reasoning and decisions. Beyond shared refusal of defensive medicine, interviewees held contrasting views on the issue of consent forms as a means to manage risk of a patient's complaint. On this basis, we identified three groups of obstetrician-gynaecologists which differed in age profile and, to a lesser extent, in professional setting.

The first group labelled "integration" was composed of twelve interviewees who were mostly in their forties, and included six of the eight hospital practitioners.

Most of the young and least experienced doctors were, therefore, part of this group. These interviewees assumed that any obstetrician-gynaecologist should take the risk of malpractice claims into account in daily practice. They reported frequently using consent forms, as well as information documents, when legally required or recommended, and considered consent forms a “normal” part of medical work:

There's a medico-legal dimension which is compulsory in my job, but I try to do my best. For an operation I'll inform, I'll have an informed consent form signed, that's sure, it's compulsory, it's important for the patient, there's also a medico-legal report to do, we know that there are things to be done. (PP22, 40 years old)

The acceptance of the medico-legal feature of medical work by hospital practitioners was also often related to the emphasis put by the head physician on the importance of carefully following guidelines and paying attention to medico-legal issues: “it's strongly expressed by my boss, all the same we've been conditioned all the time, so is it the fear of complaint? yes, of course, but it's also the desire to do well” (MH06, 44 years old).

For these interviewees, using consent forms and keeping careful patient files were useful and necessary protective behaviours from a liability perspective, that is, they served as a proof reflecting the information content provided to the patient in case of litigation. Although pointing out that their use was time-consuming, they perceived consent forms and standardised documents of information as likely to improve communication with patients:

We're made aware of dialogue with patients, of informing, of explaining all we do (...) we're a little bit forced by the increasingly litigious nature of our specialty but I think that on the whole it's rather beneficial. (MH04, 35 years old)

The interviewees also described such documents as complementary to specific explanations the doctor might provide in a second step. In addition, referring to the new law on genetic analysis, they valued the mandatory use of consent forms in the case of an amniocentesis for example, as it incites practitioners to provide clear information and to find the right balance between giving too much and too little details about risks.

At a general level, these interviewees saw greater legal accountability through the duty of information as an opportunity for integrating the risk of malpractice claims without having excessive influence on medical reasoning and behaviours. In particular, they stressed the improvement of professionals' communication skills as departing from “old obstetrician-gynaecologists” who used to have little regard for discussion with patients, and where “the doctor decided everything and the patient was subjected to him” (MH05, 52 years old). Another interviewee perceived the

widespread use of consent forms as a means of breaking with paternalistic attitudes in previous generations; “this general trend toward greater disclosure of information to patients is a good thing, this was not necessarily the case with older gynaecologists” (MH04, 35 years old).

In summary, this group’s interviewees adopted a position of “integration” of medico-legal matters in their daily work, placing more emphasis on positive outcomes than on negative aspects. Consent forms and information documents were thought to aid in managing the risk of malpractice claims within an acceptable legal and ethical framework, considering that both the patients’ interest and professional values could be satisfactorily maintained. These obstetrician-gynaecologists regarded the use of consent forms as a constitutive part of a new professionalism (Tousijn 2006). However, the question is still open of whether such integration resulted from an “indoctrination” of doctors (Numerato et al. 2012, 629) or reflected a strategic compliance with the imperatives of accountability and management culture in the hospital setting.

The second group labelled “critical adaptation” included five private practitioners and two hospital practitioners of all ages. For these interviewees, taking the risk of a malpractice claim into account in daily practice turned out to be a sensitive issue and resulted in criticism regarding contemporary changes in medical work. Contrary to the first group, they challenged the use of consent forms by focusing on the difficulty of implementation as well as its disruptive effects in real situations. Some of these interviewees referred to an anxiety-provoking approach since it was likely to cause professionals to talk too much about risks. They also criticized a time-consuming and unduly formalistic procedure, resulting in impoverishment of communication with patients:

Now we got to have signed consent forms for inserting an intrauterine device (laughter), that means that the patient comes, I explain to her, I draw her a picture, I give her [the consent form], she’s got three days of reflection, she comes back with the form read and signed, I mean, that represents more consultations, all that in order to avoid that she might claim: “but I didn’t know that it was possible to lose an intrauterine device, that one might get pregnant or that one might have bleeding,” all information that we used to tell them all the time but that was not written, these forms are really used only for that. (PP14, 52 years old)

This group’s interviewees challenged pressures to use consent forms for liability reasons, arguing that it ultimately offered little benefit for patients. For these obstetrician-gynaecologists, patients’ and professionals’ interests were difficult to reconcile adequately in daily practice. Striking the right balance between ignoring the medico-legal issue and being gripped by the fear of a patient’s complaint appeared to be quite a serious concern. These interviewees were thus fundamentally

torn between recognition and criticism of the necessity of protecting oneself against the risk of a malpractice claim. While reluctant, they reported using consent forms when legally required or recommended by their professional association.

Ambivalence towards the use of consent forms was part of a broader criticism of recent changes in medical work. These interviewees claimed that an erosion of their professional autonomy was occurring, resulting from the multiplication of administrative controls and legal constraints. These obstetrician-gynaecologists expressed as follows the feeling that medical practice was subject to an increased unjustified external regulation: "What is really disturbing is this feeling to be accountable, to be supervised by people who are not necessarily competent" (PP14, 52 years old); "we spend much more time doing administrative things than really taking care of our patients, just because we have to justify and prove that we do our job properly (...) we must write an enormous amount of letters and reports to explain all that we do in case of there is a complaint, even twenty years later, we must justify what we do at all levels" (MH07, 43 years old). These interviewees experienced the trend towards greater accountability and state control equal to suggesting that practitioners otherwise would not provide good information and request patients' consents. Conversely, they considered professional and ethical standards sufficient to ensure good practice. Along with the bureaucratic burden, a growing body of legal rules and recommendations bearing on medical work was felt to be a latent societal distrust towards professional skills and their ability to act in the patient's best interest: "Ultimately, this is what has changed, society does no longer trust doctor's common sense" (PP12, 46 years old). These interviewees therefore perceived the issue of consent forms as another sign indicating an increasing societal suspicion against professionalism in medicine.

In summary, a stance of "critical adaptation" towards development of medico-legal issues characterised this second group's interviewees. While recognising the use of consent forms to be a necessity from a liability perspective, they expressed serious criticism towards this practice taken as a necessary evil. They primarily perceived protective behaviours against the risk of malpractice claims as part of a growing body of external rules and accountability procedures affecting daily medical work. Unlike the first group, these obstetrician-gynaecologists experienced the formalisation of the communication with patients as eroding their clinical autonomy and challenging their professional identity.

The third group labelled "disenchanted resistance" included seven private and seasoned obstetrician-gynaecologists, all aged 50 years and older. These interviewees expressed a strong criticism against the recent evolution of medical practice. They particularly challenged the excessive development of medico-legal issues and self-protective behaviours, resulting in creeping defensive medicine strategies and poorer health outcomes. Young physicians working in hospital were especially targeted:

Unfortunately today young [doctors] are first taught to keep patients' files, to make cast-iron files in case of an attack, and only then they think of their patients, that's the sad evolution I see today. In the end, they no longer have time to see patients, patients get information from nurses or nurse-assistants, it's a pity. (PP21, 60 years old)

These interviewees pointed out the many drawbacks of consent forms and firmly rejected adopting protective behaviours against the risk of malpractice claims. Although required by law, they reported refusing to use consent forms for an amniocentesis or an elective Caesarean section, for example. Instead, they claimed realizing informed consent by giving priority to oral explanations and dialogue with patients. Talking about the case of an amniocentesis, this interviewee challenged the use of consent forms: "It's very formalistic and counterproductive because we should be more concerned with trust" (PP10, 58 years old). Whereas in the second group criticism of self-protection strategies was directed at the growing external regulation of medical work, in the third group challenging attitudes towards consent forms referred to the defence of the traditional concept of the doctor-patient relationship. Indeed, these interviewees described the use of consent forms as distorting the essence of medical practice based on trust and close relationship: "It's a dehumanisation of the contact you have with your clients, with people who trust you" (PP15, 50 years old). Another interviewee, who referred to his own "attitude of trust in patients" as opposed to "colleagues who document everything," criticized "an evolution that doesn't move towards a better doctor-patient relationship (...) in this way, one doesn't necessarily do good medicine" (PP24, 52 years old).

Interpersonal trust and legal or administrative rules were therefore perceived as two mutually exclusive doctor-patient relationship regulatory modes. These interviewees regarded the increasing use of consent forms and of information documents as going against their own generation's professional ethos, characterized by "honesty," "generosity," and an unwavering dedication to the good of patients:

People of my generation, we don't take risk of malpractice claim into account because we take things to heart and spontaneously, without calculating, we give our best and I talk with my patients, I don't spend hours and hours filling forms to cover myself, my ambition is really to strive to help and save people. (PP21, 60 years old)

To some extent, these interviewees criticised colleagues submitting to the use of consent forms, rather than the process of accountability and its origins.

In this "disenchanted resistance" group, risk of malpractice claim was strongly associated with current transformations of medical work, perceived as undermining the traditional doctor-patient relationship. These obstetrician-gynaecologists can be described as "disenchanted" because they tended to see themselves as the last representatives of a genuine medical practice based on interpersonal trust, physician's

empathy and strong commitment to patients. For these interviewees, this image of the true doctor-patient relationship represented the general frame of their resistance to consent forms, seen as leading to depersonalised medicine and increased distrust in health care.

5 Conclusion

This study contributes to debates on the contemporary status of the medical profession by providing a better understanding of how and to what extent obstetrician-gynaecologists regarded the issue of malpractice claims as challenging professional autonomy in the Swiss context. We have suggested that overlooking features of legal and health care systems as well as diversity within a medical specialty could explain the rather bleak and simplistic picture produced by the literature dealing with the perception of risk of malpractice claims. In many respects, this article offers a different perspective from studies stating that physicians view increasing liability through legal rules and patients' complaints as challenging their authority and the control over their work (Dingwall and Hobson-West 2006). We conclude by summarizing and discussing the major findings of our study.

The first contribution provides a nuanced picture of attitudes among obstetrician-gynaecologists, which contradicts the deprofessionalisation thesis, linking doctors' loss of authority and autonomy with the evolution of patients in terms of growing consumerist ethos (Haug and Lavin 1983). Indeed, the true cause for concern expressed by the obstetrician-gynaecologists in our study about the issue of malpractice claims stands in sharp contrast with doctors' concern about liability in terms of consumers' rights ideology and development of a suit-prone ethos (Anandale 1996). Consistent with Lupton (1997), patients as such were not seen as the primary source of litigation and doctor-patient relationships were seen as still based on trust. Such a perception was also grounded in the conviction that formal complaints were often based on misunderstandings and could be thus avoided by establishing a transparent communication with patients. Our findings also emphasised the important role played by the professional and legal environment in shaping obstetrician-gynaecologists' attitudes, since the changing nature of medical work was the most significant factor associated with their concern about litigation. In particular, the increasing use of consent forms epitomized the perception of a greater accountability process and contributed to make "real" the issue of litigation in daily practice. Altogether, the risk of malpractice claims was rather perceived as a political and social issue than as a cultural or strictly judicial one.

The second contribution is that obstetrician-gynaecologists' responses to the growing external regulation of medical work were not uniform. Indeed, increased individual accountability through use of consent forms lead to different interpre-

tations of how to manage the risk of malpractice claims and revealed contrasting professional issues. In the “critical adaptation” group, use of consent forms was perceived as a threat to *clinical autonomy* in terms of external and unfair control over day-to-day work (Annandale 1989; Allsop and Mulcahy 1998). These obstetrician-gynaecologists saw such a procedure as questioning their competence to act voluntarily in the patient’s best interest. More broadly, they interpreted the greater accountability process as a breach of the contract between the medical profession and society. Therefore, only some obstetrician-gynaecologists in our sample interpreted changes affecting medical work primarily in terms of challenging both medical autonomy and professional dominance. Such attitudes are more broadly consistent with the perception of management in health care and medical professionalism as “two conflicting cultures” (Numerato et al. 2012, 632).

In the “disenchanted resistance” group, use of consent forms was framed as a challenge to the physician’s *professional ethos*, based on trust and dedication as core values structuring the doctor-patient relationship, with reference to an idealized and traditional view of doctoring. These discourses were partly grounded in a nostalgic view on a medical practice (Barbot and Fillion 2006), based on a “strong association between a doctor and patient, characterized by intimacy and trust” (Vanderminde and Potter 2010, 356). These obstetrician-gynaecologists regretted the emergence of a depersonalised medicine, primarily ruled by formalisation of exchanges and fear of the patients.

In the “integration” group, use of consent form was not perceived as a major challenge to professional practice, but as a necessary *adaptation* of medical work to its broader evolving context. These interviewees tended to view such changes as a significant improvement in the doctor-patient relationship, especially in terms of communication and transparency. They assumed that complying with medico-legal recommendations and the ethical standards was enough to protect a doctor from malpractice claims. This underlines that increased individual accountability is not necessarily primarily interpreted as a threat to professional autonomy, or as an unjustified constraint with negative consequences. It also confirms that physicians do not necessarily view the issue of malpractice claims as challenging their authority and limiting their control over the content of their work, consistently with other studies about external regulation (Bergeron and Castel 2014).

These findings indicate that a medical segment may be characterised by contrasting, if not conflictual, values and definitions of professional activity (Bucher and Strauss 1961), especially within a context of changes affecting the nature of medical work (Barbot and Fillion 2006; Perneger et al. 2012). The problem remains how to explain such different perceptions of rationalisation of medical work within the same professional segment. In this respect, age is a partial response, as it shaped how the obstetrician-gynaecologists responded to the risk of malpractice claims. Our findings revealed a contrast between young and older interviewees:

The former were much less likely to hold a strained stance towards increased legal regulation and strengthening duty to inform, whereas the latter held the most challenging attitudes. A similar generation gap was observed by Cavalli (2014), who found that older obstetrician-gynaecologists were more likely to criticise the new recommendations of the Federal Office of Public Health on toxoplasmosis. Regarding our data, we suggest that generational differences in professional socialisation can account, at least in part, for doctors' distinct attitudes towards medical work and its changes. Following Barbot and Fillion (2006, 27), it can be argued that the perception of changes of medical regulation in terms of "defensive medicine" is strongly related to a bygone form of practicing medicine: the "clinical tradition, based on the moral and cognitive authority of a completely autonomous clinician." Whereas the older obstetrician-gynaecologists in our sample have been trained within this context of "clinical tradition" and experienced its progressive erosion, the professional socialisation of younger participants is embedded in the contemporary "participative therapeutic modernity," where medical work is influenced by multiple bodies of regulation and the patient's consent is strongly defined by legal rules and accountability (Barbot 2008).

The present study should be viewed in the context of its limitations. The small number of maternity hospital practitioners prevents from examining in more detail how the organisational context influences physicians' perception and education. In this respect, further research is needed to better understand how medical students and young physicians in hospital settings are getting socialised to issues of litigation and of patients' complaints. Moreover, the hospital practitioners involved in this study are from the same maternity unit. Longitudinal research including several and various maternity hospitals is therefore needed to explore how organisational culture and professional socialisation are linked and to investigate to what extent physicians' attitudes toward the issue of litigation evolve in the course of their professional career. Finally, further research is necessary to examine whether the differences in attitudes we have observed among obstetrician-gynaecologists can be generalised to other medical profession segments.

Beyond these limitations, this study contributes to the debate on the contemporary status of the medical profession by providing a better understanding of how and to what extent obstetrician-gynaecologists in the Swiss context regarded the issue of malpractice claims as challenging professional autonomy. Doctors' worries about litigation are not (solely) a matter of perceived likelihood of being sued, but a more complex issue, where it is crucial to take into account the health system within which doctors practice, as well as how they make sense of their professional activity and its environment at large to understand their response to the risk of patients' complaints.

6 References

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