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Public Complaints And The Emergency Department

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It is not uncommon to hear that an Emergency Department is the source of the largest number of complaints received by any hospital. This is often true and many reasons may be attributed to it. There is a need to understand why these complaints originate and some of the options available to Emergency Department and hospital managers.

The Emergency Department (ED) is the first point of hospital contact for the majority of patients and relatives (P&R). An understanding of the state of mind of P&Rs at this first point of contact is pertinent.

Early presentations of illness are often laced with an area of uncertainty and anxiety on the part of patients and relatives. Whether the presentation is a manifestation of a more serious illness, or whether an injury sustained has resulted in fracture or soft tissue damage is a common cause for concern. It is this concern that has brought them to the ED, and often in a hurry with resulting physical tiredness. Is it any wonder that at this phase they are often short on "patience"? Time is crucial for outcomes in illness or injury. The P&R is often someone believing they have a potentially major problem that, if not addressed in good time, may have dire consequences. Then again, it must have been worth their effort to have rushed all the way from home or their work place to the ED.

All these contribute to a heightened state of anxiety that is directly related to a level of expectation of service delivery that has to be met, the consequences of failure of which manifest in a variety of responses ranging from mild disappointment to an adverse feedback form, a complaint letter or a verbal confrontation and rarely a legal suit. However, if the expectations are met, the result is often relief, sometimes a verbal compliment and very occasionally a letter of appreciation.

Is the P&R always right? The targets of complaints often disagree. As service providers, they feel wronged to have been criticised despite all their efforts to provide what they consider to be a reasonable level of service. Yet, if they were to switch sides and place themselves in the shoes of the complainant, then perceptions begin to change and one begins to wonder why the numbers of complaints are not anymore than what they are being faced with. Are complaints, therefore, just the tip of the iceberg and are they reflective of major underlying problems in the Emergency Services? Four studies[1-4] indicate a rate of complaints ranging from 0.20% to 3.8% of all ED attendances. Yet, all four institutions have tried to address the problems with major undertakings that indicate a more rampant existence of problems with potential for complaints. Therefore, it may not be too far wrong to conclude that there is a large factor of validity in the majority of complaints. Often the reasons given for unhappiness may not be the sole factors that led to the complaint. A combination of factors contributed and then something went wrong and triggered off the complaint.

The first contact is frequently the registration clerk who has registered so many patients earlier and even perhaps been admonished by one or two for something she is not sure of, that she has forgotten that important smile, the look of friendliness, eye contact, correct tone of voice, body language and all that is necessary for the registrant to feel welcome. The triage officer who followed may not have improved the situation very much. Other than recording the vital signs and asking for the initial complaint, how often does this contact result in a speeding up of the queue? Only sometimes. For the P&R, this is the first time the chief complaints of the illness or injury are related. Often, the P&R have felt that they did not get the priority they truly deserve.

Then comes the "long-wait". The length of wait is dependent on the following :

- The number of patients ahead in the queue.
- The consultation time spent on each patient by the attending doctor. Again the complaints given in triage need to be repeated.
- The number of doctors and nurses available to attend to the queue.
- The acuity of the patient's illness or injury.

The wait has been known to vary from just a few minutes to a few hours. Many factors affect the quality of this waiting period. Some EDs have introduced activities to occupy the P&R during this "wait". Such activities include performance of blood tests, X-rays and filling out questionnaires that would assist the attending doctor later in arriving at a better diagnosis. Others make available video clips and reading material so that the P&R do not feel bored. Boredom is dangerous. It leads to impatience, frustration and a greater tendency to seek out minor shortcomings and raise them as complaints.

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Practically all patients who turn up at EDs regard themselves as some form of "Emergency". To be told otherwise upsets them. To be further lectured at that they should have gone to their own private practitioner and admonished for coming so late, sows the seeds for complaints. A combination of long waiting, a doctor or nurse who seems just a little impersonal, not getting VVIP treatment, a tired doctor, a less-than-preferred patient disposition and an early presentation of illness leading to a missed diagnosis usually combine to result in unhappiness and the generation of a complaint. When such complaints do occur, complainants spice up the story with all the little less-than-perfect encounters so that often the true reason for a complaint becomes less apparent. However, careful analysis of such complaints, as has been done in this issue of the SMJ by the staff of the National University Hospital[2], will usually bring out a list of imperfections that could have contributed to the complaint. Such an understanding helps the process of planning for a more complaint-free emergency department.

What do patients want when they visit an Emergency Department?

1) Patients and relatives want the personal touch.
2) They want themselves or their relatives to be cared for by professionals.
3) Patients and their relatives want to be managed as expeditiously as possible.

While it is true that there is no single answer, as the problem is multifactorial, the following need to be addressed :

a) Inappropriate attendances at Emergency Departments. With lesser inappropriate attendances, emergency patients have less non-emergencies to compete with, resulting in shorter waiting times.

b) Interpersonal communication within the Emergency Department needs to be adequately addressed. Most complaints can be nipped in the bud and most patients and relatives are willing to overlook departmental shortcomings if there is present, an excellent level of staff-patient communication.

c) The level of staffing required in an Emergency Department is highly dependent on the workload that can be expected per unit staff. A lot of effort to address various other issues may come to nought if the department is not provided with adequate staff to handle the heavy patient load and to provide an acceptable level of professional medical care within a reasonable time frame.

d) An adequate quality of staff, skills and expertise is required. In an era of high patient expectations and of rapid changes and advances in the discipline of emergency care, the traditional practice of having only minimal senior medical staff means that complaints such as "missed diagnosis", "inadequate care" and related professional issues will keep recurring. The Medical Staffing level for the Emergency Departments of the three largest public general hospitals in Singapore currently stands at between 1:15,000 to 1:30,000 for Senior Medical Staff and 1:6,000 for Medical Officers. While Emergency Departments in the West may be said to be arguably overstaffed, an optimal and reasonable level of staffing for our own Emergency Departments would be about 1:10,000 for Senior Medical Staff and 1:4,000 for Medical Officers, which is somewhere in between current levels here and the current figures in the West.

e) Designating staff to handle potential complaints is one area that has not been given due attention. An alternative is to have a public/patient relations officer (PRO) who moves around the Emergency Department shop floor frequently, keeping a bird's eye view of the general situation, identifying problem areas early and doing something about them. PROs would, in addition, be able to handle other tasks related to service quality and public relations, such as monitoring feedback from public, conducting telephone follow-up of selected patients, conducting or overseeing the conduct of service quality programs within the emergency department and also attending to the variety of complaints that are made. This frees medical and nursing staff to concentrate on providing professional care.

f) Sometimes it is useful to obtain the views of Emergency Department users. It is well-appreciated that studies on Emergency Departments are more difficult, costly and time-consuming than outpatient research[6]. However, these difficulties will all be overcome with time and care spent at the planning stage.

Most in the practice of Emergency Medicine would not have heard of Emergency Departments against which there are absolutely no complaints. Though all Emergency Department staff have an important role to play to provide a professional level of emergency care in a timely manner and with care, compassion, consideration and courtesy, hospitals and hospital authorities also have an equally important role to ensure that such emergency staff are able to function in a conducive environment and with the provision of resources that are adequate to meet the ever-rising expectations of an increasingly educated and sophisticated public. As partners in the provision of Emergency Care at the shop-window of the hospital, both hospital administration and departmental professionals can work together towards a relatively complaint-free Emergency Department.

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