Singapore Med J 1998; Vol 39(9):390-395

Why Do Patients Complain? A Primary Health Care Study

H C Lim, C B Tan, L G Goh, S L Ling

ABSTRACT

Background/Aim of Study: Patient complaints are indications of their dissatisfaction with the service received. With increasing patient expectations, we need to address this issue for a more satisfying relationship between healthcare provider and user. The objective of this study was to analyse the basis of patients' complaints and to make recommendations to reduce its incidence.

Method: This is a retrospective descriptive study of all complaints to the Family Health Service between January 1994 and December 1995. All complaints, investigations and replies to complainants were examined and analysed by the authors to determine the reasons for complaints and their justification.

Results: There were 226 complaint cases out of 5 620 834 attendances in two years, giving the complaint rate of 4 per 100,000 attendances per year. The complaint rate was highest for the 20 – 59-year age group and lowest in the 10 – 19-year age group (3.7 and 2.0 per 100,000 attendances respectively). Sixty-four percent of complaints were verbal and the rest were written. Forty-seven percent of the complaints were made by relatives and 46% were self-complaints. The main reasons for complaints were related to attitude/conduct (28.8%), professional skills (17.8%), patient expectations (16.2%), waiting time (10.0%) and communication (7.8%). Forty-three percent of complaints were evaluated as justifiable, 38% not justifiable and 19% inconclusive. There were no particular sex or ethnic group differences.

Conclusion: The rate of complaints in Family Health Service was low. Healthcare personnel need to pay attention to areas related to attitude/conduct, professional skills, patient expectations, waiting time and communication.

Keywords: complaints, primary health care, family health service, dissatisfaction

Geylang Polyclinic
21 Geylang East Central
Singapore 389707

H C Lim, MBBS, M Med (PH)
Registrar, Family Health Service

C B Tan, MBBS, M Med (FM)
Registrar, Family Health Service

Elderly & Continuing Care Division
Ministry of Health
16 College Road
College of Medicine Building
Singapore 169854

S L Ling, MBBS, MSc (PH)
Deputy Director of Medical Services

Department of Community, Occupational and Family Medicine
National University of Singapore
Lower Kent Ridge Road
Singapore 119074

L G Goh, MBBS, M Med (Int Med), FCGP
Associate Professor

Correspondence to:
Dr H C Lim

INTRODUCTION

The Family Health Service is a government department that provides primary health care to the population of Singapore through its network of clinics distributed throughout the island. It is currently responsible for about 20% of primary health care in Singapore, with the private practitioners being responsible for the other 80%. There had been no previous formal local studies on patient complaints in the primary health care clinics. This study was carried out to analyse the basis of patients' complaints of Family Health Services and to make recommendations to reduce its incidence where possible.

Patients' complaints are indications of their dissatisfaction with the service received. The doctor-patient relationship has changed with time. The yesteryears when the doctor was revered as a superior figure whose decisions were not questioned are long past. Rather, complaints by patients against doctors and medical services are no longer uncommon. The responses to the complaints of patients will include knowing agreement of its real existence, remarks that patient demands are high these days and sighs from those involved in the voluminous work that it generates.

The public being more educated and more well informed than before, will continue to expect more from doctors and other healthcare professionals. The issue of patient satisfaction and dissatisfaction, whilst it was underemphasized previously, should no longer be ignored. It is important for healthcare providers and users to understand and meet each others' expectations. This will result in a more satisfying relationship for both parties.

METHODS

This is a retrospective descriptive review of all complaints lodged against the Family Health Service clinics between January 1994 and December 1995.

The Family Health Service has 15 polyclinics, 6 outpatient dispensaries, 6 maternal and child health clinics and 1 government officials' clinic. The total clinic attendances were 2 799 248 for 1994 and 2 821 586 for 1995. All complaints against the Family Health Service clinics were brought to the attention of the Family Health Service HQ and investigated by the deputy director. Based on the results of the investigation, action was taken to resolve the complaint either by verbal or written communication. Complaints lodged against the Family Health Service were in the form of complaint letters, telephone calls and press write-ups. The complaints came through various sources: from the clinic themselves, the Family Health Service, the Public Affairs Department or from other departments in the Ministry.

In this study, all complaint letters, investigation

reports and the replies to the complainants were examined. Complaints were evaluated as justifiable or otherwise based on the overall assessment of all these documents. Justifiable complaints were complaints assessed to be due to shortfalls in the services provided. Unjustifiable complaints were those not due to shortfalls in the system. Non-Family Health Service complaints and complaints which contained inadequate information for analysis were excluded from the study.

The information for the study was entered into a structured data entry form, one for each complaint case. The data was entered into a database software programme using the Dbase IV 1.1. Data analysis was done using a program written in Dbase IV 1.1.

RESULTS

Over the 2-year study period, there was a total of 238 complaints. Twelve of these were excluded from the study as the data was incomplete for analysis. The remaining 226 cases were analysed. There were 107 cases out of 2 799 248 attendances in 1994 and 119 cases out of 2 821 586 attendances in 1995. The rate of complaints was 3.82 per 100 000 patient attendance in 1994 and 4.21 in 1995.

Sixty-four percent of the complaints were verbal and 36%, written. Only 10.2% of the complaints were lodged at the clinic level, majority of the complaints were made to various sections of the Ministry of Health (Table I). The interval between the date of the incident and the date of the complaint ranged from less than a day to 137 days. Seventy percent of complaints were received within one week of the incident. In 4.8% of cases, this interval exceeded 4 weeks. This information was not available in 16.8% of cases. Complaints were lodged against all categories of staff in the polyclinics, ranging from doctors, nurses, registration clerks to pharmacy staff.

The proportion of self-complainants (46%) and complaints made by relatives (47%) were similar. 1.3% of complaints were lodged by friends (Table II).

Table I – Addressee

Addressee	Number	Percentage
Clinic	23	10.2
Family Health Service	64	28.3
Ministry of Health	126	55.8
Others	13	5.7
Total	226	100

Table II – Complainants

Addressee	Number	Percentage
Self	105	46.5
Relatives	106	46.9
Friends/colleagues	3	1.3
Others	12	5.3
Total	226	100

Table III shows the frequency distribution of complaints by age group. The complaint frequency was highest in the 20 – 59-year age group and lowest in the 10 – 19-year age group (3.7 and 2.0 per 100 000 attendances respectively). The proportion of males (104) and females (100) were equal. The ethnic distribution of the patients followed that of patients attending the clinics.

Fig 1 shows the distribution of complainants. Self-complainants were mainly adults in the age range of 20 to 59 years. There were two peaks for the non-self-complainants, at 0 – 9 years and 60 – 69 years. The ethnic distribution of self and non-self complainants were similar.

There were 371 complaints in the 226 complaint cases. In 125 of the complaint cases, there were dissatisfaction with more than one aspect of the service provided.

Table IV shows the categorisation of these complaints. The top 5 categories for complaints were related to attitude/conduct (28.8%), professional skills (17.8%), unmet patient expectations/requests (16.2%), waiting time (10.0%) and communication (7.8%). Under the category of attitude/conduct – rude, impolite, discourteous and uncaring behaviour accounted for 76% of complaints. The main criticism of professional skills were inadequate examination, incompetence and inadequate explanation. Most of the unmet patient/expectations/requests were related to medical leave and medicine prescribed. Waiting to see a doctor and registration accounted for 84% of complaints related to waiting time. Unnecessary comments and inadequate explanation attracted 90% of all complaints under communication. It was found that 43% of the complaint cases lodged were justifiable, 38% not justifiable and 19 % inconclusive.

Fig 2a shows the complaints that were evaluated as justifiable. The 4 main justifiable complaints were found to be related to staff attitude/conduct (31.5%), professional skills (31.5%), communication (18.5 %), and waiting time (6.5%). Fig 2b shows the complaints that were evaluated as not justifiable. Of these, 44.9% were unmet patient expectations/requests, 19.6% misperception of inadequate professional skills, 17.8% due to misperception of staff attitude/conduct and 6.5% were due to miscommunication. In 47 of the complaint cases, it was difficult to conclude on their justification.

DISCUSSION

The Family Health Service provides primary medical care to the general public through its polyclinics, outpatient dispensaries and maternal and child health clinics in Singapore. The rate of complaint was about 4 per 100 000 attendances in 1994 and in 1995. This is much lower than the Emergency Department complaints of the National University Hospital, at 26 per 100 000 attendances[1]; the complaints at King's College Hospital, London, of 20.2 per 100 000 attendances[2] and the regional health office at Petah-Tiqva, Israel, of 40 per 100 000 patients[3]. The reported complaint rates were clearly higher in the hospital

Table III – Complaint case frequency by age groups

Age	No. of complaint cases	Attendances 1994 to 1995	Rate of complaints per 100,000 attendances
0 – 9	36	1,436,411	2.5
10 – 19	9	452,298	2.0
20 – 59	100	2,673,238	3.7
> 60	23	1,058,887	2.2
Unknown	58		-
Total	226	5,620,834	4.0

Table IV – All complaints

Complaints		Number	Percentage
1. Attitude/Conduct		107	28.8
rude/impolite/discourteous	66		
uncaring	15		
other conduct problems	12		
insensitive	8		
irresponsible	4		
arrogant/hostile	2		
2. Professional skills		66	17.8
Inadequate examination	27		
poor professional skills/incompetent	17		
inadequate explanation	9		
dispensing error	5		
poor professional conduct/attitude/style	3		
wrong diagnosis	2		
unnecessary medical examination	2		
drug allergy missed	1		
3. Unmet patient expectations/requests		60	16.2
medical leave	28		
medicine	18		
investigations	5		
other requests not met	5		
referral	3		
excessively high expectations	1		
4. Waiting time		37	10.0
waiting time for doctor	18		
waiting time for registration	13		
waiting time for nurse	3		
waiting time at pharmacy	3		
5. Communication		29	7.8
unnecessary comments	18		
inadequate explanation	8		
other communication problems	3		
6. Registration/MRO		28	7.7
registration problems	15		
medical records problems	8		
queue problems	5		
7. Physical environment		6	1.6
8. Others		38	10.2
others	11		
other drug related problems	11		
social/racial discrimination	5		
inefficient phone answering system	4		
too young doctor	3		
inexperienced doctor	2		
move from place to place	2		
Grand total		371	100

emergency departments as compared to that reported by the Family Health Service. Cultural differences, differences in complaints procedures, service provision and organisation may explain some of these differing rates.

Complaint rates reflect only the tip of the dissatisfaction iceberg[4]. Filed complaints should not be relied upon as adequate feedback about patient satisfaction as most cases of dissatisfaction go unreported. Patient satisfaction questionnaires or surveys are needed to assess the latter. Patient complaints reflect their dissatisfaction with some aspects of the health care delivery system. Some of these complaints are forerunners of potential medico-legal suits. Are complaints the unfounded expression of overly demanding patients or are they indications of deficiencies in the health care delivery system? The truth can only be known with an actual evaluation of the complaints.

Demography of patients

In this study, it was found that the complaints received involved patients of all age groups, sex and ethnic groups. Overall, there was no particular sex or ethnic group differences. A majority of the adults from the 20 – 59-year ago group made the complaints themselves whereas children less than 9 years old and the elderly above 60 years old had their complaints lodged by their relatives. This is expected as the children are too young to complain themselves. It is usually the accompanying parents or relatives who are the ones to complain. Similarly, it is often the accompanying relatives of the elderly patients who lodge the complaints. It is also possible that elderly patients tend to make known their unhappiness to their younger relatives who would then complain on their behalf.

Adult patients from the 20 – 59-year age group had the highest rate of complaints. This is probably due to the more assertive nature of these patients. They are also more knowledgeable and perhaps more demanding. Interestingly, the 0 – 9-year age group showed the second highest rate of complaints. This probably reflects the dissatisfaction and anxiety of their accompanying parents and relatives.

It would be interesting to know the socio-economic and educational status of patients as it is generally accepted that patients belonging to higher social economic groups are more likely to complain[4]. However, these data were not available in this study.

Reasons for complaints

Compared to other studies, the main reasons why patients in this study complained, were strikingly similar. Poor attitude/conduct, unprofessional conduct, mismanagement, poor communication and long waiting time were common causes of patients' unhappiness[2-8]. The Medical Defence Union reported that breakdown in communication between doctor and patient constitutes a major component in complaints and claims[7]. In this study, the main reasons for complaints were found to be related to

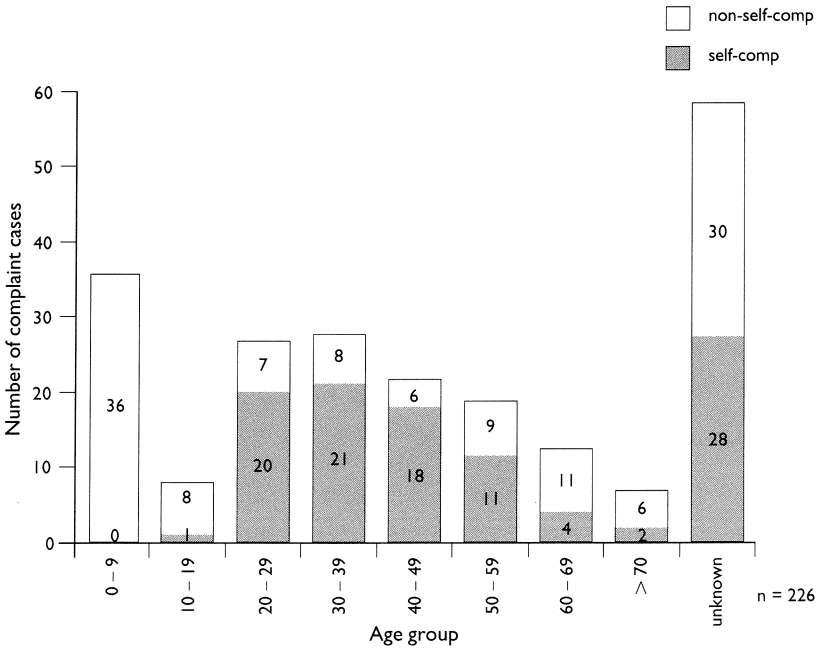

Fig 1 – Age distribution of self-complainants and non-self-complainants

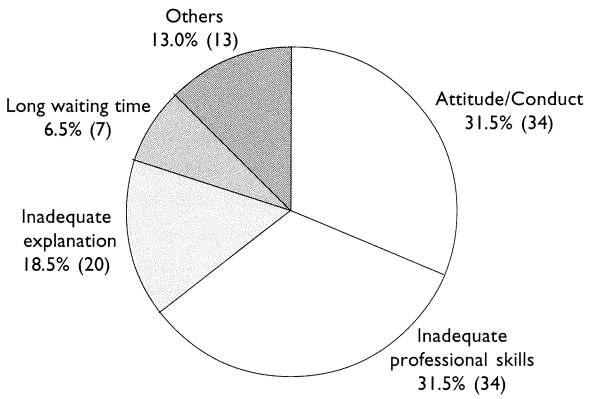

Fig 2a – Justifiable complaints

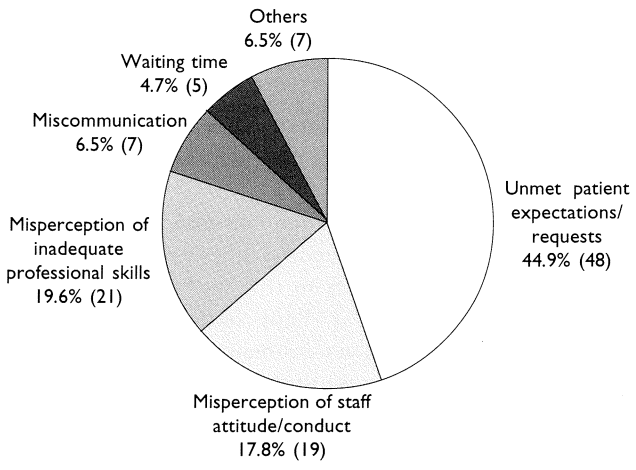

Fig 2b – Non-justifiable complaints

attitude/conduct (28.8%), professional skills (17.8%), unmet patient expectations/requests (16.2%), waiting time (10.0%) and communication (7.8%). Awareness of these reasons for patient dissatisfaction is necessary as a first step in the prevention and management of complaints.

In this study, the top patient complaint was related to attitude/conduct. Patients seeking medical care expect to be treated by doctors and other healthcare personnel with kindness, concern and empathy. With increasing consumerism and the evolving medical scene into a more customer-orientated service, patients not only expect good medical care but also good service from the medical profession. Real or perceived poor attitudinal behaviour would cause dissatisfaction. Real conduct problems should be reduced to a minimum. It is also important for healthcare personnel to portray a professional and caring image so that patients do not misperceive them as being rude and uncaring. Healthcare personnel also need to match their professional styles according to different patients. A doctor's personal style is not always appropriate for all his patients and may sometimes be misinterpreted as hostile even when it is not[3].

The second main reason for complaints was related to professional skills. The complaints were mainly of cursory examination, incompetence and inadequate explanation. Patients expect doctors to be competent and skillful, thorough in their clinical examination and to provide adequate explanation regarding patients' illnesses. Competency and good professional skills are basic requirements expected of any healthcare professional. With rapid advances in medical science and technology and with an increasingly well-informed public, healthcare personnel need to involve themselves in continuing medical education and training to maintain their professional skills and knowledge. Continuing educational and service training for all categories of healthcare personnel should be emphasised and maintained. In a busy polyclinic with a heavy workload, consultation time is sometimes limited. Complaints about cursory examination and inadequate explanation are often the reflection of short consultation time. Measures taken to increase the consultation time would also increase patient satisfaction and decrease complaints arising from a rushed consultation.

Dissatisfaction also occurs when there is a mismatch between patients' expectations or demands and medical services received or offered. These unmet expectations were found to be mostly related to medical leave, medication or referral. It is crucial for healthcare personnel to provide clear and adequate explanation to address these unmet needs and expectations. In cases of unrealistically high expectations, a more tactful approach is necessary. The information provided by the mass media and the press may sometimes be misinterpreted by the public resulting in unrealistic expectations. Healthcare personnel and the mass media should work together to provide appropriate information to better inform and educate the public.

Waiting time was found to be an important cause of unhappiness. Waiting to consult a doctor and registration accounted for the majority of complaints on waiting time. Patient load, staff situation and flow of patients in the polyclinics are factors that would affect waiting time. Having an adequate staff complement appropriate for the patient load is important in reducing waiting time. Continuing efforts at workflow improvement in the polyclinics would also help increase efficiency.

Unnecessary comments and inadequate explanation accounted for the majority of complaints under the category of communications. Whilst it is necessary to provide patients with adequate information, healthcare providers should at the same time avoid making unnecessary remarks. Complaints often follow a conflict situation. Good listening, communication and negotiation skills are needed to resolve these unpleasant situations. These are skills that can be learnt and improved upon[9]. Role playing complaint situations can help healthcare personnel develop better strategies in the management of such problems.

Justifiable and not justifiable complaints

It is a common belief among healthcare personnel that most complaints are a result of high patient demands. It is never easy to evaluate whether patients' complaints are justifiable or not. There is no standard yardstick which can be used to measure the justification of a complaint. In this study, the authors made an attempt to determine the justification of the complaints.

The authors evaluated all written reports of the complaints and investigations as an objective party. Interestingly, it was found that the majority of the complaints could be classified easily as justifiable or not. Only in 19% of the complaint cases, was it difficult to arrive at a conclusion. These were mainly due to contradictory accounts from the complainants and staff as well as unclear documentation of the investigations.

Nearly 43% of the complaint cases lodged in this study were found by the authors to be justifiable. In these complaints, the four main shortcomings were poor staff attitude/conduct, lack of professional skills, inadequate explanation and long waiting time. These closely correspond to the main reasons why patients complain. Rude behaviour, unnecessary comments and failure to greet patients were common attitudinal shortcomings. Problems with professional skills included wrong diagnoses, delayed diagnoses, errors in prescribing or dispensing medications, and poor surgical techniques or procedures. Inadequate explanation and clarification by staff were also found to be areas of deficiencies. Long waiting time in a busy polyclinic with a high patient load can happen and some were due to registration and records tracing problems while others were related to long waiting time to consult a doctor.

Thirty-eight percent of the complaint cases were evaluated to be not justifiable. These were related to unmet patients' expectations, and patients' misperception of poor staff attitude/conduct, information and professionalism. Although it is not possible to satisfy everyone all the time, positive steps could be taken to explore patients' ideas, concerns and expectations in an attempt to reduce misunderstandings and unhappiness.

Miscommunication is a key factor in patient complaints. A possible approach to better healthcare personnel-patient communication is to "L-I-S-T-E-N":

Listening to patients allows us to understand their fears, concerns and expectations and to take steps to address them.

Look out, be aware that conflicting situations can arise in a consultation.

Reduce interruptions during a potential conflicting situation to allow continuing communications eg. defer answering non-urgent phone calls.

Provide information to allay underlying fears and in answer to queries.

Develop interpersonal and professional skills continually. In a conflict, try not to lose one's cool, it is important to sustain the communication to the point of resolution.

Try to get out of the tug of war situation of "I am right and you are wrong" for either parties. Exercise tact in telling the truth and in talking to patients.

Show empathy and explain at the patients' level, avoid excessive use of medical terminology.

Control negative emotions and the urge to end the communication prematurely. In the majority of cases, it is neither the desire of the healthcare personnel nor the patient to be caught in a conflict. It is usually the wish of both parties for it to be settled amiably. Aim to negotiate for a win-win agreement which takes away the bitter aftertaste of an unsettled conflict.

CONCLUSION

This study has shown that the rate of complaints in the Family Health Service is low. Nevertheless, we should not be complacent. Healthcare personnel need to pay attention to attitude/conduct, professional skills, patients' expectations, waiting time and communication. Reduction of complaints starts from an awareness of the reasons why patients complain. A positive and proactive approach to the issue of why patients complain would result in a more satisfying relationship between the healthcare provider and user.

ACKNOWLEDGEMENT

The authors would like to thank Madam Cheong Lau Yuan for her help in retrieval of the files required in the study.

REFERENCES

1. Ooi SBS. Emergency department complaints: A ten-year review. Singapore Med J 1997; 38:102- 7.
2. Hunt MT, Glucksman ME. A review of 7 years of complaints in an inner city. Accident and Emergency. Arch Emerg Med 1991; 8:17-23.
3. Hart J, Weingarten MA. A procedure for handling complaints against general practitioners. Fam Pract 1986; 3:107-12.
4. Schwartz LR, Overton DT. The management of patient complaints dissatisfaction. Emerg Med Clin North Am 1992; 10:557-72.
5. Bellamy M. Why do patients complain? Australas J Medical Defence Union 1993; 3:45.
6. Owen CA. Formal complaints against general practitioners: a study of 1000 cases. Br J Gen Pract 1991: 41:113-5.
7. Owen CA. General Practice Complaints – A look at both sides. Medical Protection Society Annual Report & Accounts 1987; 95:36-41.
8. Hawkins C. Causes of complaints and their prevention. Mishaps or malpractice. Oxford: Blackwell, 1985:269-94.
9. Grace M. The importance of good communication. Medical Protection Society Annual Report & Accounts 1987; 95:49-52.