ANALYSIS OF PATIENT COMPLAINTS IN AN OUTPATIENT SETTING

by

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CHAPTER I

INTRODUCTION

Statement of the Problem

In recent years, consumers have been increasingly involved in planning and evaluating health care. Public concern has been expressed about the availability, adequacy, cost and convenience of health care (Hulka, Zyzanski, Cassel & Thompson, 1971). Factors which are related to increased consumerism in health care include the growing emphasis health has received as a factor in the quality of life, and the increased availability of government monies for research and health services.

As consumers have become more informed about health care, their power to influence the health care system has expanded. This power is evident in legislative mandates regarding consumer input in health care evaluation and planning, such as the Health Systems Agencies established by the National Health Planning and Resources Development Act of 1974 (P.L. 93-641). The imminence of National Health Insurance is also likely to give impetus to additional consumer participation in the health care delivery system.

As the consumer movement in health care has taken hold, providers have become more conscious of the need to insure quality in health care delivery. Yet the involvement of consumers in health care quality evaluation has been restricted

(Kelman, 1976; Novello, 1978). Consequently, the power and control held by health providers has maintained professional standards and norms regarding the quality and availability of health care (Drucker, 1974; Marram, 1973). The validity and even objectivity of these standards of care and health care procedures are being challenged by active and vocal consumer groups (Drucker, 1974). Consumers want to be active participants in shaping health care services which are beneficial to them. Health care providers who treat their patients as consumers see their customers as having legitimate requests and as being partners with them in health care negotiations (Lazare, Cohen, Jacobson, Williams, Mignone & Zissok, 1972). If one defines health care quality to include such aspects of care as accessibility, acceptability, compliance, communication and patient satisfaction, then consumer evaluation of health care is an important part of quality assessment. There is the need to structure the participation of consumers and providers in ways that contribute to <u>both</u> in the evolution of modern health care. However, one of the difficulties with consumer involvement in quality assessment is that there are limitations in our current knowledge about how consumers define health care quality.

The literature is replete with attempts to document the satisfaction of consumers toward their health care. Generally,

consumers have consistently rated health care very highly (Alpert, Kosa, Haggerty, Robertson & Heagarty, 1970; Berkanovic & Marcus, 1976; Deisher, Engel, Spielholz & Standfast, 1965; Lebow, 1974; Noyes, Levy, Chase & Udry, 1974). However, there are many difficulties in research which attempts to document patient attitudes and opinions. Patients tend to respond in stereotypical, socially acceptable ways, and may be reluctant to make negative or critical comments regarding the health care they receive (Berkanovic & Marcus, 1976; Nehring & Geach, 1973; Noyes et al., 1974). In spite of the high ratings that consumers tend to give to their own health care, there may be a tendency for them to forget some of their negative feelings, or to decline from mentioning their complaints (Berkanovic & Marcus, 1976; Deisher et al., 1965; Nehring & Geach, 1973). Many patients would share their feelings candidly, but are never asked to do so. Health professionals cannot assume that they know or understand patient complaints, because professionals, patients, administrators and families all have different perspectives on the nature of health care (Lebow, 1974; Reeves, Bergwall & Woodside, 1979; Wessler, 1968). It is not likely that every consumer in a single health care facility will be completely satisfied. Nevertheless, it is essential for any health service facility to consider

in detail each complaint and grievance (Bellin & Geiger, 1972). In addition, efforts need to be made in applying consumers' evaluation of health care to issues of change and health care policy. Problems of health care quality have become not only issues of personal and professional competence, but also issues of structure and organization (Clancy, 1973).

One source of information regarding patient opinions and attitudes which is seldom mentioned in the literature but which is available in many health care organizations is patient complaints. Wessler (1968) suggests that patient complaints are an important aspect of the planning, implementation and feedback cycle in health care organizations. The present use of patient complaints in this cycle may occur through the work of an employed patient advocate or ombudsman. Such a person often deals with each individual complaint separately, and may be able to discuss trends in patient expectations and dissatisfactions. However, a more systematic, objective analysis of patient complaints would be useful to health care providers in several ways. An analysis of patient complaints would describe trends in complaints as they relate to a specific health care setting so that appropriate changes in health care delivery could be planned and implemented. An analysis of complaints

would add further documentation of patient expectations, attitudes and needs, and patient complaints would provide one aspect of evaluation and feedback regarding recent organizational changes which have occurred in a specific health care setting. Undoubtedly, patient dissatisfaction is only one aspect of the feedback needed to evaluate the effectiveness of any health care program.

Berkanovic and Marcus (1976) suggest that the policy implications of consumer satisfaction and dissatisfaction are often unclear in efforts to improve the organization of health services. They suggest that if consumer assessments of health care are to be policy relevant, two conditions must be met; 1) satisfaction should be manipulable through organizational means; and 2) satisfaction should also be shown to affect the behavior of consumers with respect to their use of health care services. Previous studies have demonstrated that providing a change in health care delivery can lead to changes by consumers in health service utilization, and health attitudes and behavior (Alpert et al., 1970; Bellin & Geiger, 1972). The purpose of the present research was to demonstrate that patient complaints can be used as a part of the feedback process by which a health care organization evaluates and plans its health care services. Thus, satisfaction and dissatisfaction

will be shown to be manipulable through organizational means. Another purpose of this descriptive study was to generate hypotheses and to suggest areas for future research regarding patient complaints.

Review of the Literature

Theoretical Implications Regarding Consumer Dissatisfaction

The literature regarding patient opinions and attitudes is generally oriented towards patient satisfaction. Few authors discuss dissatisfaction specifically other than as it relates to satisfaction. The concepts regarding consumer complaints and dissatisfaction are not yet mature. Thus, further definition of consumer dissatisfaction is necessary.

There are indications in the literature that patient complaints and perceptions are specific in nature. Wessler (1968) did a scalogram analysis of patient complaints to determine whether patterns of responses from patients could be reproduced with a minimum of error. No pattern of dissatisfaction emerged from the investigator's data, revealing that these reports of unpleasant events are made independently of each other. Wessler concluded that patient complaints were related to specific events, not to general conditions.

The specific nature of patient perceptions regarding health care is also indicated in a study conducted by Ware,

Wright, Snyder and Chu in 1975. The investigators hypothesized that patients would perceive quality of care as one concept. However, seven quality of care factors were derived from their data, including thoroughness, preventive measures, surgical prudence (discretion), female health care, use of medication, information giving, and use of the health care system. The data from this study also suggested that these aspects of health care are important correlates of patient outcomes.

An important aspect of consumer satisfaction and/or dissatisfaction is whether or not expectations related to health care services are met during the process of health care delivery. Freidson (1961) found that patients generally had a practical satisfaction with the present, but were dissatisfied enough to have an unrealized ideal in mind. Freidson conducted intensive interviews with 36 families as a part of his investigation, and in every interview, consumers mentioned two major criteria regarding their expectations and desires in medical care; 1) to feel that providers had a personal interest in them; and 2) to feel certain that they were receiving health care of high technical quality.

Korsch, Gozzi and Francis (1968) used tape recordings of patient visits, reviewed medical charts, and conducted

two interviews with parents of children visiting an outpatient emergency clinic. One interview was completed immediately after health care was given, and the other interview was conducted a substantial time later. Seventy-six percent of the respondents were satisfied generally with their health care. However, their satisfaction decreased if the physician did not meet their expectations. Some of the factors related to consumers' expectations not being met which substantially decreased their satisfaction included: failure to learn the cause of a disorder, failure to receive an X-ray, injection, or some medication, failure to be hospitalized. Only 35% of the patients' expectations and 24% of their main worries were even mentioned to the health care providers.

Another research project relating consumer satisfaction and dissatisfaction to the degree of fulfillment of their expectations as they participated in the health care process was conducted by Noyes, Levy, Chase and Udry (1974). These investigators used a pretest to find out patient expectations in a gynecology clinic, followed by a posttest to measure the degree to which patient expectations were fulfilled. Patient expectations were explored regarding the time they expected to spend on their clinic visit, the cost of the visit, the amount of pain or embarrassment they would

experience, and how they expected to be treated by the clinic staff. Questionnaires were presented orally and in writing. The findings indicated that patients spent more time during the visit, found higher health care costs, and experienced more pain than expected, resulting in net dissatisfaction with these factors. However, the patients experienced less embarrassment, felt they were treated better, and were more satisfied with the care they received than they expected. Assumptions were made regarding unmet expectations which would result in dissatisfaction.

More recently, Segall and Burnett (1980) hypothesized that the degree to which consumers perceive that a physician is conforming to their overall expectations will be related to their general level of satisfaction with the physician. Patients were randomly selected from a Family Medical Center in Winnipeg, Canada, to receive a mailed questionnaire which contained a Physician Conformity Index, measures of patient satisfaction and perception of physician technical competence. A correlational analysis of data confirmed this hypothesis.

Dissatisfaction as it Affects Consumers' Health Attitudes and Behaviors

One of the conditions that must be met if consumer assessments of health care are to be policy relevant is that consumer satisfaction should be shown to affect the

behavior of consumers with respect to their use of health care services (Berkanovic & Marcus, 1976). A number of studies relate health care utilization and compliance by consumers to their satisfaction with the health care they receive. In an investigation conducted by Francis, Korsch and Morris (1969), patients who were highly satisfied with their care were more likely to comply with prescribed treatments and return for follow-up visits than patients who were dissatisfied. Of the noncompliant patients, 56% had none of their stated expectations fulfilled at the time of their first visit. Berkanovic and Marcus (1976) found that consumer satisfaction with health care was moderately associated with a tendency to delay seeking care, or to fail to seek care.

Bellin and Geiger (1970) described their efforts to relate structural changes in the provision of health services to the attitudes and behaviors of consumers in Dorchester, Massachusetts. A community health center was created which provided comprehensive, multi-disciplinary health care, and was oriented toward maximum participation by consumers. Interviews were conducted with 357 household heads before the advent of the community health center, and 434 household heads were interviewed two years following the provision of the health center. Respondents indicated behavior and

attitude changes regarding health service utilization following their use of the community health center. They also indicated significantly greater satisfaction with the health services they received. Two years after the community health center opened, 59% of the respondents had received an asymptomatic general health examination, compared to only 17% who had received such an examination 12 months earlier. Polio immunizations among children increased from 78% to 92% during the time between the two interviews. The proportion of families who reported a delay in seeking health care decreased from 23% to 10% between the two interviews. An investigation conducted by Schlesinger, Davis and Milliken (1962) further documents the relationship between satisfaction and compliance and utilization.

In summary, consumer perceptions and satisfaction with health care are important correlates of their behavior regarding health care utilization and compliance with suggested treatments. For the purposes of this investigation, patient complaints will be assumed to be related to specific events experienced by consumers in which their expectations and desires regarding health care services are not met. It will also be assumed that these experiences directly affect health care utilization and behaviors and attitudes of consumers regarding their health.

Specific Factors Related To Consumer Dissatisfaction

Numerous researchers have investigated various aspects of patient satisfaction and dissatisfaction (Bellin & Geiger, 1972; Berkanovic & Marcus, 1976; Deisher et al., 1965; Fisher, 1971; Hulka et al., 1975; Korsch et al., 1968). While many common themes appear in these reports, there are numerous operational definitions of these themes. This investigator has categorized the dissatisfaction themes into four major areas: 1) consumer-provider relationship; 2) accessibility and convenience of health care; 3) monetary costs of health care; and 4) technical aspects of the quality of health care. Research relating to each category will be examined separately.

Consumer-provider relationship. The consumer-provider relationship is considered important to consumer satisfaction. Freidson (1961) suggests that the interest health care providers display to consumers relates to the identities of consumers as persons. Patients need to understand their illnesses and treatments, and they need to have providers understand the emotions which are invested in their personal difficulties.

In an investigation conducted by Koos (1955), clients felt that providers lacked personal interest in them, and gave them insufficient information regarding their condition.

Korsch, Gozzi and Francis (1968) found that a high proportion of pediatric clinic parents expect the physician to be friendly, concerned, sympathetic, and to take time to answer questions or to offer explanations. Bellin and Geiger (1972) asked their subjects what their general dissatisfactions were. Among other dissatisfaction factors mentioned, 8% of the respondents felt that there were unsatisfactory interpersonal relations between themselves and their health care providers. Eleven percent of the respondents felt that the providers really did not give them a chance to explain their problem adequately, and 12% felt that the providers did not take a personal interest in them.

Zeev (1976) described an investigation which was carried out in Israel regarding patient satisfaction as it related to the affective behavior of the health professional. It was found that patient satisfaction correlated highly with the amount of time the physician spent with the patient, the amount of interest the physician showed in the patient, and the devotion the physician demonstrated to the management of the patients' problems. Zeev asked his subjects how often they sought health care from other sources when they were dissatisfied with the care received initially from a general practitioner. Subjects were given two choices to answer this question -- another general practitioner or an

outpatient clinic. Zeev assumed that if subjects chose another general practitioner, they were indicating a preference for "affective" behavior. By the same token, consumers indicating a preference for more technical proficiency would choose an outpatient clinic, due to their more ready access to sophisticated treatment and diagnostic facilities and to high ranking medical consultation. The investigator's data supported his hypothesis that subjects who were dissatisfied with their initial health care encounters would express their solution more frequently by turning to a provider more likely to give high affective support (a general practitioner) than to an agent of high professional competence (an outpatient clinic).

A more recent investigation conducted by Segall and Burnett (1980) confirmed Zeev's findings. Two hundred and thirty-one patients responded to a mailed questionnaire which contained a Physician Conformity Index and measures of patient satisfaction and their assessment of the physician's technical competence. The analysis of data utilizing correlational techniques demonstrated that the strongest factor affecting general consumer satisfaction was the degree to which physicians conformed to the patients' expectations related to the affective dimension, e.g., showing personal interest, showning concern, explaining, being frank,

listening, giving sufficient time, encouraging the patient to ask questions. The level of general satisfaction among these patients was measured by two four-choice items dealing with their feelings of reassurance after being treated by the physician and their willingness to return to the same physician with another health problem.

In one investigation conducted by DiMatteo, Prince and Taranta (1979), it was hypothesized that patients decide to remain with a physician or leave them and "doctorshop" based upon the "socioemotional" aspects of physicians' behavior, e.g., physicians' demonstrations of caring for patients as people and their openness to communication. Interviews were conducted with 342 inpatients and ambulatory patients in a large urban community teaching hospital after a visit with one of 38 house physicians. The patients' decisions to continue the physician-patient relationship weighed heavily on the physicians' socioemotional behavior as well as their accessibility. In subsequent studies conducted by the same investigators (DiMatteo, Taranta, Friedman & Prince, 1980), measures of nonverbal communication skills of 71 physicians were correlated with the ratings of 462 of their ambulatory and hospitalized patients regarding their satisfactions and perceptions of the technical quality of the care they received. Although the physicians' nonverbal communication skills did not show much relationship

to the patients' ratings of the technical quality of their care, it did predict patient satisfaction with the socio-emotional aspects of their care.

Berkanovic and Marcus (1976) conducted interviews with 598 recipients of Medicaid in two counties adjacent to Portland, Oregon with the purpose of examining consumers' satisfaction with health services and their tendency to seek care. Two of the factors which related significantly to consumer satisfaction were the amount of information consumers received regarding their health care, and negative perceptions of local physicians' behavior.

In a research project conducted to evaluate comprehensive pediatric care for low-income families in Boston (Alpert et al., 1970), specific questions were asked of the respondents relating satisfaction to waiting time and to whether the providers gave enough time and were easy to talk to, and whether the providers told the consumers what the trouble was. The experimental group received comprehensive pediatric care, and two control groups did not. Patients in the control groups were significantly more dissatisfied with the time given to them by the providers, and the ease with which they were able to talk to the doctor or nurse.

A common thread in these expressions of dissatisfaction with health care include the aspect of information giving

and receiving. Berkatis (1977) correlated patient satisfaction with the amount of information given to patients by the physician regarding their conditions, and found that patients' satisfaction with their health care increased as information from the physician increased, and as the consumer retention of that information increased.

Brown (1980) was asked by the Ad Hoc Malpractice Insurance Crisis Committee of the Arizona Medical Association to conduct a study to examine the attitudes, opinions and behaviors of consumers toward health care, especially as they impact on malpractice. A random sample of 997 adult residents of Arizona participated in the consumer survey through telephone interviews. Just over half of the respondents felt that doctors in general do a poor job of explaining medical problems to their patients. In a pilot study conducted by Ater (1978) at the University of Oregon Health Sciences Center in Neurology Clinics, "13% of the patients thought that their doctor didn't explain his or her instructions in a comprehensible fashion".

The literature is consistent in indicating that consumers want to know about their illnesses and the recommended treatments, even though they do not ask questions about them.

Additional investigations which have documented the relationship between consumer satisfaction and consumer

perceptions of provider behavior include: Gray, 1980; Mechanic, Greenley, Cleary, Hooper and Wenzel, 1980; Ross, 1978; and Woodward, Santa-Barbara, Levin and Epstein, 1978.

Accessibility and convenience of health care. Weinerman (1964), in his review and analysis of studies regarding the choice and utilization of prepaid group practice plans, concluded that

> a show of personal interest by the doctor is not, apparently, the only criterion by which patients judge the adequacy of medical care. Accessibility and convenience from the patient's vantage point are also stressed in every survey. (p. 886)

Bellin and Geiger (1972) questioned subjects regarding their general dissatisfactions with health care. Eight percent of the respondents mentioned inconvenience.

In contrast to Zeev's (1976) study, citing the importance of the consumer-provider relationship, results of other studies have found greater consumer dissatisfaction with other aspects of health care. For example, Hulka, et al. (1975) investigated consumer attitudes toward three components of health care, including: 1) the professional and technical competence of the physician, 2) the personal qualities of the physician, 3) the consumers' accessibility to health care, including the aspects of the cost and convenience of care. Although the findings suggest that their subjects tended to be more satisfied than dissatisfied,

the most frequent area of dissatisfaction was in the area of the cost and convenience of their health care. The investigators speculated whether, in their population, subjects may have been more willing to criticize the system (accessibility-cost-convenience) than the physician (competence-personal qualities). The fact that the subjects in Zeev's study were the private patients of general practitioners may account for their greater dissatisfaction with their provider's behavior than with the accessibility aspects of health care cited as most important in the Hulka study, where patients had a less regular source of care.

Factors thought to explain consumer satisfaction with physician provided care were analyzed by Gray (1980) in causally ordered models using cross-sectional and longitudinal data. Variables which were used to account for variances in consumer satisfaction included prior satisfaction, assessment of the availability of services, health status of the consumer, utilization of services, the context of health service delivery and selected demographic characteristics. Telephone interviews were conducted with 821 employees enrolled in two health plans of the Federal Employees Health Benefit Program. The most striking result of the study was the relationship between consumers' satisfaction with physician provided care and the availability of health services.

Mechanic et al., (1980) interviewed 1,026 adults in Wisconsin in the geographical area served by the Marshfield Clinic to compare satisfaction among prepaid, Medicaid and fee-for-service patients using the Marshfield Clinic and affiliated non-clinic physicians. Between one-tenth and one quarter of the persons interviewed reported difficulty in getting a doctor's appointment, and almost half of the respondents reported that the office waiting time was too long.

Fisher (1971) conducted interviews using a structured questionnaire with 150 patients in an outpatient clinic at the University of Oklahoma Hospital, with the purpose of exploring factors which influence patient satisfaction. Patients rated their care at the outpatient clinic as better than, as good as, or worse than their private care. Generally, patients who rated the outpatient clinic care as worse than their private care expressed more dissatisfaction overall with clinic care, convenience and accessibility, and toward physicians in general. However, the majority of the patients (95%) were dissatisfied with parking. Many patients expressed dissatisfaction with not seeing the same doctor on repeated visits, with waiting times, and the seating comfort. Other areas of dissatisfaction included length of stay, convenience of food facilities, rest rooms, and

pain during the week previous to their visit, and treatment by student-physicians.

In the research conducted by Berkanovic and Marcus (1976) cited above, patients' satisfaction with health care was strongly related to obtaining an appointment, among other factors. In Ater's pilot study (1978), a number of respondents believed that they had to wait too long in the reception area and in the examination room (19% and 16% respectively). In a study conducted to assess the out-patient health care quality of pregnant women (Jolly, Held, Caraway & Prythowsky, 1971), more than one third of the respondents indicated that they had transportation difficulties. Consumer dissatisfactions with the convenience and accessibility of health care have been cited by numerous other authors (Deisher et al., 1965; Foster & Louria, 1979; Friedson, 1961; Koos, 1955; Ross, 1978; Weinerman, 1964; Woodward et al., 1978).

In summary, consumers' dissatisfactions regarding the convenience and accessibility of health care have included factors such as availability, parking difficulties, transportation problems, waiting times, convenience of food facilities and rest rooms, inconvenient location of health care facilities, difficulties getting an appointment, and lack of house calls. It is likely that most patients no longer expect house calls by health providers, in that it

is no longer customary. Previous studies indicating consumer dissatisfaction in this area were conducted in a time period when house calls were more customary.

Monetary costs of health care. The financial charges for health services has also surfaced repeatedly in the literature as a source of dissatisfaction among consumers. In Brown's (1980) random sample of 997 adults who were interviewed by telephone in Arizona regarding their attitudes and opinions toward physicians and health care, 62.9% of the respondents either strongly or somewhat agreed with the statement, "Doctors charge too much for the services they provide". The interviews conducted by Fisher (1971) with 150 patients in an outpatient clinic at the University of Oklahoma Hospital revealed that the majority of the respondents thought that the fees for health care were too high.

The utilization of medical services and satisfaction with ambulatory care among a rural Minnesota population was studied by Chaska, Krishan, Smoldt, Ilstrup, Weidman & Nobuga (1980). A questionnaire including 40 items pertaining to patient satisfaction was utilized in 1,332 interviews conducted by these investigators, which formed 18 health care opinion indices. Three of the opinion indices related to costs; fees, insurance and payment mechanisms. In the

population studied, fees, insurance and the availability of physicians scored lowest in satisfaction as compared with the remaining 15 health care opinion indices.

Hulka et al., (1970) developed a Thurstone "Equal Appearing Interval" Scale to assist in gathering quantitative information regarding consumers' attitudes toward physicians and primary medical care. Over 300 statements in three content areas of professional competence, personal qualities and cost/convenience were devised and edited. Of these, 149 statements were given to three different judging groups; physicians, social workers, and members of a women's club. The investigators compared the scale values for each statement from the three judging groups by using the Pearson-product moment method to calculate correlation coefficients. The results (0.98, 0.98 and 0.99) verified that people with different values and attitudes can perform as reliable judges. Subsequently, a pilot test was conducted with a low income group of White and Negro mothers in a clinic setting. The resulting correlation coefficients were 0.75 for personal qualities, 0.63 for professional competence and 0.43 for cost/convenience. The investigators suggested that the low correlation value for the cost/convenience area could have been caused by the diverse content of the category.

The four categories presented by this investigator

which separates the cost factors from the convenience/ accessibility factors are in part based upon the findings of Hulka et al., (1970).

Technical aspects of the quality of health care. Kelman (1976) suggests that

> recipients of care are more concerned or dissatisfied with the manner and means of the process of health care delivery, the way in which they are regarded and dealt with by health care personnel, and by certain structural characteristics of these programs, both physical and administrative, than with the outcome of care or the competencies of the health care personnel providing care (p. 436).

Nevertheless, patients do express dissatisfaction regarding the technical aspects of their health care. In the previously cited study conducted by Bellin and Geiger (1972), 10% of the respondents indicated dissatisfaction with the poor quality of care they received, and 11% felt that "doctors don't give you a really good exam".

In a structured questionnaire used to explore patient satisfaction in an outpatient clinic, Fisher (1971) had patients rate a list of 15 factors according to whether they thought they were most important, important, or nice for any good clinic. Those factors rated as most important included: "good" doctors, well-trained staff, and information from doctors. Those factors rated as important included personal interest in patient, pleasant staff, and privacy in discussing illness.

In another study conducted to determine mothers' satisfaction with the health care their children received (Deisher, 1965), respondents were asked specifically what they liked least about their child's medical care. In spite of the fact that only about two-thirds of the 136 subjects responded to this question, 23% of those who responded indicated dissatisfaction with the medical advice or treatment they received, or with the doctor's ability or personality. According to the investigators, such dissatisfactions were considered insignificant in relation to the mother's overall satisfactions. In Pope's survey of Kaiser Permanente Program members and former members (1975), former members indicated one of their dissatisfactions as being the technical knowledge, ability, and competence of the doctors.

In a study conducted to evaluate brief family therapy (Woodward et al., 1978), 279 families were administered a Family Satisfaction Questionnaire in their own homes six months after treatment. Although many dissatisfied families experienced successful treatment outcomes, 45% of the families did not feel that the services provided were comprehensive and adequate. In Brown's (1980) investigation cited previously, almost half of the 997 respondents took a neutral position in relation to the statement "In most malpractice suits, the doctor (physician) is <u>not</u> at fault", and 25.3%

of the respondents disagreed with this statement. Of the 1,026 persons interviewed by Mechanic et al., (1980), between 19% and 27% of the respondents were not very satisfied with the training and technical competence of the physicians; 8%-22% of the respondents were not very satisfied with the quality of care; and 14%-19% of the respondents were not very satisfied with the completeness of health service.

Another factor which relates to the perceptions of consumers regarding the technical quality of their health care includes the diagnostic services provided by health care organizations. In the investigations Friedson conducted in the Bronx (1961), patients generally agreed that the greater the quantity of "objective" tests used, such as X-ray, blood pressure determinations, and electrical measurements, thee higher the quality of health care they received. Consumers in Friedson's interviews also indicated great satisfaction with the technical quality of their health care if their physician was able to avoid surgery, or especially frightening and noxious treatments. Patients generally believed that providers should actively intervene in their illness, and consumers also had some notion about what was a "reasonable time" required for cure.

These consumer perceptions about health care quality

have been documented elsewhere in the literature. Fisher (1971) noted that consumers' experience of pain during the week prior to their clinic visit may be one of the factors influencing their general satisfaction with their health care. In another investigation (Korsch et al., 1968), patient expectations which were not met and which decreased consumer satisfaction included the failure to receive an X-ray, injection, medication or to be hospitalized. Segall and Burnett (1980) determined that the consumers' perception of the level of physician competence is strongly related to their general satisfaction with the physician and with whether or not the physician conforms to the consumers' affective expectations of physician performance.

Ater (1978) used a quality-control in a pilot study regarding the satisfaction of Neurology Clinic patients, which involved setting a goal of an "acceptable range" of dissatisfaction responses per 100 patients. One of the patient dissatisfactions which surpassed the "acceptable range" established by the Clinic Director was that 9% of the patients did not feel better after seeing their doctor. Thus, the provider group also expected to actively intervene in the illness of consumers, and expected that their clients would feel better following their health visit.

Other Aspects of Consumer Dissatisfaction

One additional factor which has been identified as a source of consumer dissatisfaction is the lack of privacy. One investigation which was conducted to evaluate consumer satisfaction with the health care provided by medical studentd (Swee & Warburton, 1980) found that 11% of the patients indicated feeling a lack of privacy, even though 97% of the consumers were satisfied overall with the care they received from the students. Twelve percent of the patients interviewed in Ross's investigation (1978) to seek opinions regarding antenatal and obstetric care indicated that they were dissatisfied with lack of privacy during labor. Privacy in discussing illnesses was rated as important in outpatient health care according to the patients interviewed by Fisher (1971).

Relation of Patient Complaints to the Organization of Health Care

Eliot Freidson (1961) suggests that not only is health care affected by different perspectives of providers and consumers, but also by the organization of health care.

> The way a task is organized affects the way it can be performed independently of the intent or skill of the performer; the way medical practice is organized affects the way medicine is likely to be applied (Friedson, 1961, p. 10).

In addition, the organization of consumers' communities is

likely to mold patients' responses to the provider group. In Freidson's investigations, comparsons were made regarding consumers' perceptions and views of different health care structures. Generally, patients expected that individual, solo practitioners would take more personal interest in them, but they expected that medical group practices would provide greater technical health care quality because of the availability of specialist and diagnostic services.

One factor which has repeatedly surfaced as important to consumers in their health care relates to the continuity of the care they receive. One of the findings of Hulka et al., (1975) was that consumer satisfaction was affected by whether or not consumers had a regular source of health care, with more dissatisfaction expressed when there was no regular source of care. Gray (1980) found that consumer satisfaction was strongly influenced by having or not having a personal physician.

Linn (1975) conducted a survey of 1,739 patient-provider encounters in 11 different ambulatory care settings in Southern California. Patients generally evaluated their care in a highly positive way, and those factors which correlated most with patient satisfaction were the age of client, degree of which the patient was satisfied with the community in which they lived, and the continuity of health care they received. The settings that had lower levels of patient

satisfaction included areas that had more young adult patients, who were scheduled for few return visits, and did not emphasize seeing the same provider each visit.

The lack of continuity in health care was also identified as a trouble spot in a study conducted in an outpatient clinic which was designed to relate patient, staff and organizational needs (Schlesinger, Davis & Milliken, 1962). These investigators found that patients from the higher social classes tended to be more upset about the lack of continuity in their health care.

> Those patients who were unhappy about not seeing the same physician appeared to lose, or never to obtain, a sense of personal relationship (Schlesinger, et al., 1962, p. 1848).

The investigators speculated whether the patients who were less concerned about continuity in health care might have rationalized that all physicians were equally competent or that it was helpful to have more than one opinion. They also questioned whether patients could really evaluate the technical quality of health care, and suggested that some patients may be trying to live up to the expectations of the provider group.

One factor which is important to consider with regard to continuity in health care is the fact that it is directly associated with organizational needs. Schlesinger et al., (1962) noted that previous evaluations of outpatient health

care had often focused on patients' needs and less often considered the needs of the staff or the organization. The needs of all three aspects of organized health care influence the quality and efficiency of services. For example, an outpatient clinic often has more purposes than simply to supply health services to consumers. A major function of clinic services may be to teach health professionals. A staff member who is focusing on developing technical competence may require more of the patient's time than someone who has already acquired the necessary skills. Student health professionals rotate through a variety of health care situations, and seldom are able to see the same patients for extended lengths of time. In addition, a teaching clinic must often serve all eligible consumers who apply for services, regardless of available space, time or personnel. As the teaching loads and patient loads increase, the patient's needs may be sacrificed. Schlesinger et al., (1962) suggested that research regarding consumer evaluations and complaints would be greatly strengthened by recognition of the inter-relationships between provider, consumer and organizational needs.

The issue of control is critical in terms of problem solving outcomes if these inter-relationships between needs are considered important in evaluation processes. Organizational policies and procedures influence the way providers

can do their work and limit the ways that providers can accomodate themselves to the clients' desires.

> The very cooperative organization that stimulates the development of professional control of the quality of technical care also stimulates the development of unprecedented professional control of the client (Freidson, 1961, p. 225).

It is not likely that consumer utilization of health services will be maximized, or consumer cooperation enhanced if the consumer feels helpless and unable to influence the management of his or her problems.

The issue of health care control is particularly important in health care evaluation and research. Evaluation is a tool of social control and social change. So far, consumers have had a very minor role in planning and research, and thus have had very little input into policy formulation. An assumption of the premise that consumers need to be an integral part of the process of health care evaluation is that solutions to problems will emerge as the political control over the evaluation process is shared.

Relation of Patient Complaints to Issues of Change and Health Care Policy

Frequently, an analysis of policy issues in health care organizations begins with consideration of matters such as trends in population, different forms of health care delivery, total budgetary expenditures, the availability and distribution of health care givers, educational issues, and the role

of state and federal governments in health care issues. Such analyses of health care issues thus begin at the "macro" level, and are in danger of remaining general issues. Stimson and Stimson (1976) suggest that there is also the need for "micro" events in an approach to policy issue analysis. Such micro events would include the personal experiences of consumers as they seek and receive health care. In this way, translating policy issues into effective health care delivery programs can become explicit, and one can examine the outcomes and effectiveness or organizational decisions in relation to consumers' experiences. Patient complaints are related to specific events (Wessler, 1968) and can provide a part of the micro analysis in the evaluation of health care.

Alvin Gouldner (1956), identifies two major models of applied science regarding the formulation of policies and plans. The first model, the Engineering model of applied science is based upon the interpretation of experts as to what the needs are as well as the relevant technical and objective and economic requirements. The plans made to meet the needs of the people are made by the experts, and after the plan is made, the consent of those affected by the plan is engineered by effective monologic persuasion. Those persons who follow this model would believe that

consumers lack sufficient knowledge and technical expertise to make good judgements about their own health care, and that such evaluations need to be made by professional and organizational experts.

In contrast, the Clinical model of applied science involves the collaboration between experts and those affected by policy -- to make, evaluate and remake plans. Thus, experts may inform clients appropriately, but clients are participants in the evaluation and planning processes. It is not assumed that more technical information will necessarily produce the most desirable problem solutions. As the clients of the system are involved in working out programs of change and improvement for themselves, the power and control between groups is shared.

Previously cited studies have demonstrated the correlation between changes in health care delivery systems and patient satisfaction. Berkanovic and Marcus (1976) suggest that consumer satisfaction can be altered by making changes in organizational behavior, but that such changes must be perceived as changes by the patient in order for satisfaction to be altered, even though those perceived aspects of the health care system may not be totally objective. Thus, consumers must be an integral part of the change process.

Summary and Purpose

A review of the literature has shown that patient complaints are related to specific events in the health care process. Consumer dissatisfaction is affected by whether or not patients' expectations regarding their health care are met during the health care process. Consumers have expressed dissatisfaction about the consumer-provider relationships, the accessibility and convenience of their health care, the technical quality of their health care, and health care costs.

The organization of health care is also important to consider while evaluating health care. For example, continuity of health care has been identified by consumers as an important factor which affects their satisfaction with health care. The needs of organizations, staff members and consumers are interrelated, and need to be considered in health care evaluations. As patients share in the planning, implementation and feedback cycle of health care organizations, they will share in the control of our future health care delivery systems, and viable solutions will emerge to identified problems.

The purpose of this investigation was to provide one answer to the question, "How can patient complaints be made useful to an organization in evaluating and

planning health care?" Based upon previous research regarding patient satisfaction and dissatisfaction, and by demonstration of a systematic and objective analysis of patient complaints in a specific health care facility, it was proposed that:

1. Consumers will express more dissatisfaction regarding the accessibility, convenience, and the cost elements of their health care than with the provider-consumer relationship.
2. More consumer dissatisfaction will be expressed regarding the consumer-provider relationship than the technical aspects of the quality of care.
3. Consumers who are scheduled for return visits to the same provider(s) will express less dissatisfaction in all four categories of patient complaints than consumers who do not see the same provider(s) on subsequent visits.

Thus, an analysis of patient complaint themes can provide important data in health services evaluation and planning, leading toward consideration of organizational policy changes.

CHAPTER II

METHODOLOGY

Setting

An analysis of patient complaints was conducted at the University of Oregon Health Sciences Center Outpatient Clinics. Such an analysis of patient complaints was requested by the outpatient clinic administration, making the organizational usefulness of this evaluative research feasible. A Patient Relations Coordinator has served consumers regarding their complaints at the outpatient clinics since March 1, 1976. This employee has kept written anecdotal records of most patient complaints which she has serviced, as well as the action taken on the patients' behalf.

This outpatient facility is a part of a greater health care facility, including hospitals and schools. Medical and nursing students are members of the health provider group in the clinics. The daily average of outpatient visits to this facility from 1975 to 1976 was 527 patient visits. Approximately 60 separate specialty clinics are included in this outpatient facility. In some of the clinics, patients are assigned to the same team of providers on repeated visits. In other clinics, patients are likely to see different providers on each repeated visit.

The patients who attend the University of Oregon Outpatient Clinics are from every age group, and they come from

all areas in the State of Oregon, as well as from other states. Many of these patients are from the lower income groups, although a few patients who attend the clinics are also in the higher income groups. The majority of the clinic patients use the outpatient care facilities as their primary source of health care. The patients also represent the various minority groups that live in Oregon or in nearby states.

Data Collection Methods

A retrospective study of records was conducted of the patient complaint records kept by the Patient Relations Coordinator between August 1, 1977 and March 31, 1979.

Research Design and Procedure

The written documents of patient complaints which were kept by the Patient Relations Coordinator in the University of Oregon Health Sciences Center Outpatient Clinics were categorized regarding complaint themes. The consumer complaints were categorized according to four major variables: consumer-provider relationship, convenience and accessibility, costs, technical aspects of health care quality. In addition, more specific information regarding the nature of consumer complaints was tallied by the use of sub-categories

under each of the four major variables, using themes that were suggested in the review of literature. An outline of the four major categories and their respective sub-categories is given below.

Consumer Complaint Categories

1.0 Consumer-provider relationship

- 1.1 Consumer given insufficient information
- 1.2 Providers failed to show interest and devotion, including negative perceptions of the provider's behavior
- 1.3 Consumer unable to explain his or her problems and worries

2.0 Convenience and accessibility

- 2.1 Difficulty with the appointment process
- 2.2 Transportation problems
- 2.3 Waiting times too long
- 2.4 Parking problems
- 2.5 Lack of convenient and comfortable waiting areas, rest rooms, food facilities
- 2.6 Difficulty getting care without an appointment
- 2.7 Difficulty getting information over the telephone
- 2.8 Child care difficulties

3.0 Costs

- 3.1 Fees too high (including charge unwarranted for service given)
- 3.2 Loss of wages
- 3.4 Unable to pay
- 3.5 Erroneous charge

4.0 Technical aspects of health care quality

- 4.1 Lack of thoroughness, incomplete exam, insufficient use of diagnostic tests and services -- also includes providers in a hurry or spent insufficient time
- 4.2 Defects in provider competence, abilities, knowledge

4.3 Prudence in treatments, surgery
4.4 Treatment didn't help, or patient didn't feel better following care, patient experienced pain following care
4.5 Dissatisfied with advice and/or treatment given
4.6 Lack of follow-up or preventive measures
4.7 Conclusive diagnosis not reached

5.0 Other

5.1 Lack of privacy
5.2 Miscellaneous

Examples of complaints which were assigned to selected sub-categories are given below:

1.1 Consumer given insufficient information

"I didn't find out what the trouble was", or

"I don't understand why I have to take this medicine."

1.2 Providers failed to show interest and devotion including negative perceptions of the provider's behavior

"The doctor was very abrupt and didn't introduce himself."

"The doctor was rude."

"I was waiting to speak to the doctor, but she ignored me."

1.3 Consumer unable to explain his or her problems and worries

"I didn't even get treated for what I came for."

2.1 Difficulty getting an appointment

"I can't come early in the morning, and that was the only time they could give me an appointment."

2.3 Waiting times too long

"I waited for three hours, just to be given a place to sit in the exam room."

"The patient was dissatisfied about the inconvenience of losing work, driving from Amity, and waiting for an hour -- just to have the doctor ask if the treatment was satisfactory."

2.2 Transportation problems

"I don't want to make another appointment next week because I have to ask someone to drive me here."

2.5 Lack of convenient and comfortable waiting areas, rest rooms, food facilities, etc.

"There should be a place for a person to sit in the waiting areas without having to breathe all of the smoke."

2.7 Difficulty getting information over the telephone

"The woman was unable to get lab results over the telephone."

2.8 Child care difficulties

"I can't keep coming in so often to find out what is the matter -- I can't afford to keep paying a babysitter."

3.1 Fees too high

"The patient was charged $80 for a tetanus shot and a bandaid."

3.2 Loss of wages

"I lost three days wages and paid the expenses of being at the medical center for 15 minutes of the doctor's time."

4.1 Lack of thoroughness, etc.

"He was not given any tests -- only an examination."

"She claims that the doctor didn't examine her, and that he said he couldn't find anything. Later her problem was discovered at another hospital."

4.2 Defects in provider competence, abilities, knowledge

"A student doctor talked to me, but I don't think she knew what she was doing."

"They had to stick my baby four times before they finally got a blood sample."

4.4 Treatment didn't help, etc.

"The patient claims that the doctor didn't do much for the problem -- a medication was prescribed which didn't work."

4.5 Dissatisfied with advice given

"The patient doesn't feel that he should pay because

his problem was not resolved, and he went elsewhere for proper treatment."

4.6 Lack of follow-up or preventive measures

"The patient is dissatisfied because she feels that follow-through is lacking."

In tabulating complaints in the outpatient clinics, any complaint regarding any person who relates directly with patients were tallied, including receptionists, secretaries, technicians, administrative staff. This approach was based upon the assumption that each member of the health care team shares in the responsibility of providing acceptable care to consumers.

Patient complaints included any statements which indicated that patients' expectations or desires regarding health care services were not met. It was not expected that complaints would always include expressions of grief or pain, discomfort or anger since there are individual differences in the amount of feeling a specific experience generates, or in individuals' ways of expressing complaints. Therefore, only records which clearly indicated relief or joy over the consumer's expectations not being met were deleted from the tabulation.

Any written documents that included more than one category of complaints were tabulated more than once, based

upon the assumption that consumers could have more than one complaint regarding a single health care experience. Thus, every occurrence of the categories outlined were tallied. For example, consider a patient who complained that the physician was rude, that his advice was not helpful, and that the bill was at least two or three times what would be reasonable. This complaint would have been tallied three times: 1.2 for rudeness, 4.5 for unsatisfactory advice, and 3.1 for unreasonable fees. In conducting the consumer complaint tally, it was assumed that the frequency of occurrence of complaints in a given category was a valid indicator of those categories which consumers were most dissatisfied about.

All patient complaints which were included in this analysis were specific to outpatient care. The Patient Relations Coordinator also handles complaints related to hospital and inpatient care. The documents for outpatient complaints and inpatient complaints were kept together. Therefore, any complaints which were included in the tally specified the specific outpatient experience and mention was made of which clinic was involved. A listing of the outpatient clinics is included in Appendix C.

In order to insure that single complaints were not tallied more than once, each complaint record was assigned

a number. The patient number was included on the tally sheet in addition to the month during which the complaint was expressed. Any patient numbers which appeared more than once were re-examined to insure that the complaints were specific to different health care experiences. To provide a check in case a complaint did not fit easily into the categories outlined, the tally sheet included an "other" category column. The tally sheet which was used to collect the data is included in Appendix D.

Thus, comparisons included differences in complaint themes and quantities between clinics and differences in complaint themes and quantities according to months of the year. An additional comparison was made also, involving organizational changes which occurred during the time period analyzed, and which related to the concept of health care continuity.

In July, 1978, changes were made in two of the largest clinics so that they would more closely resemble private care. In the General Medicine Clinics, providers were divided into East and West teams. Physicians, nurses, medical students and nurse aides were assigned to a team. Each professional provider was then assigned to specific patients. When patients were rescheduled for return visits to this clinic, they were assigned to the same team, and if

possible to the same provider. This change occurred on July 1, 1978.

In the Ob/Gyn Clinics, similar changes were made beginning July 17, 1978. Here, professionals were divided into the Green, Red and Brown teams. Again, patients were rescheduled to return to the clinic on the day that their particular team was scheduled to cover the clinics. Effort was made to assign the patient to the same provider.

The permanent staff members assigned to the teams in these two clinics included the nurse midwives, nurse practitioners, registered nurses, aides, and staff physicians. Other members of the provider teams which were not permanently assigned to the clinics included medical students, nursing students, visiting professionals and faculty members.

Since the continuity of care concept has been mentioned in the literature as a factor affecting patient satisfaction, comparisons will be made regarding the number of themes of complaints in these two clinics before and after the described changes were made.

This researcher recognizes that the units chosen for the analysis of patient complaints affects the results, and that other units of analysis would provide additional insight into consumers' dissatisfactions regarding their health care.

Reliability of the tabulation of consumer dissatisfactions was established by computing intercoder agreement between the investigator and one research assistant, using a random sampling of 30 complaints.

Limitations

Several limitations regarding this research design and procedure have been identified:

1. It is not known to what extent the complaints analyzed accurately reflect the general views and opinions of patients at the University of Oregon Health Sciences Center Outpatient Clinics.
2. The extent of consumer concern and dissatisfaction cannot be established by the analysis of complaints, and priorities cannot be gauged.
3. Patient complaints do not provide empirical data which speaks directly to what consumers regard as the quality characteristics of health care.
4. It is not known to what extent patient complaints accurately reflect the health care given.
5. Because different assessment methods are not being used to determine consumer attitudes and opinions, the research design does not provide concurrent validity.

Data Analysis

Comparisons were made regarding the predominance of patient dissatisfaction in the four categories by quantification.

CHAPTER III

RESULTS AND DISCUSSION

Respondents Eliminated

Complaints were tallied by month, using the first date recorded on the complaint record. Seven complaints were deleted from the tabulation because no date was recorded.

Thirty-one complaints were tallied which did not include unit numbers. Of these, the researcher was able to track down 12 unit numbers. The remaining 19 complaints were deleted from the tabulation of results.

The investigator compared unit numbers to determine whether the same consumers complained more than once, and to provide a check against coding a single complaint more than once. Fourteen consumers complained about more than one health encounter. Twelve of these complained about two different health care experiences, one consumer complained about three separate experiences, and one consumer complained about four different health care experiences. This process did not reveal any single complaints that had been tallied more than once.

Twenty-seven complaiots were deleted from the tabulation because the specific clinic involved in the health care encounter was not identified. (Two of these included a complaint that had been initiated by a consumer that had complained about two separate health care experiences).

In summary, 53 complaints were deleted from the sample.

A total of 245 complaints were included in the results reported.

Intercoder Reliability

Reliability scores were computed by comparing the complaint theme tabulations between the primary investigator and one research assistant, using a random sampling of 30 complaints. Reliability scores were first computed for the four major categories of complaints by using the sum of all major category tabulations recorded by both individuals as the denominator, and the sum of all major categories tallied simultaneously by both coders as the numerator. The reliability score for the sample using the major complaint themes was 76%.

Secondly, reliability scores were computed for the subcatories under each separate major complaint theme, using the method described above. Results are given below:

Complaint Theme	Intercoder Reliability Score
Consumer-provider relationship	56%
Convenience-accessibility	100%
Monetary costs	41%
Technical aspects of health care	36%

Since reliability scores were very low for the subcategories under three of the major complaint themes, the investigator did not report comparisons between the subcategories under the consumer-provider relationship theme, the monetary costs of health care, and the technical aspects of health care quality theme.

Closer scrutiny of the subcategory tabulations between the investigator and the research assistant revealed several areas of confusion which may explain in part, the lower reliability scores for the subcategories under three of the major complaint themes.

Under the theme of the monetary costs of health care, there were several instances in which one tabulator used the category of "fees too high - including charge unwarranted for service given" at the same time the second tabulator used the category of "erroneous charge." Another time, one tabulator used the "fees too high" category at the same time the "unable to pay" category was used by the second tabulator. It is very likely that these subcategories are not mutually exclusive.

Under the consumer-provider relationship theme of consumer dissatisfaction, there were four disagreements between the investigator and the research assistant as to whether or not "providers failed to show interest and devotion,

including negative perceptions of the providers behavior." In each case, no other subcategory was tallied as an alternate by the other tabulator. Each tabulator used this subcategory twice when the other coder did not use it. It is possible that this dimension of consumer dissatisfaction is not stated by the consumer initiating the complaint, but rather is interpreted as a dissatisfaction theme by the evaluators.

Under the consumer-provider relationship theme, there were also three disagreements between the tabulators regarding whether or not consumers were given insufficient information. In one instance, the category of "dissatisfied with advice and/or treatment given" was used by the second tabulator as an alternate. Again, these subcategories which appear under two separate major complaint themes may not be mutually exclusive.

The technical aspects of health care quality theme also revealed considerable confusion between the subcategories given, particularly between the "treatment didn't help" category and the "dissatisfied with advice and/or treatment given" theme. In four instances when one of these two subcategories was tallied by one of the coders, the other tabulator did not use a single subcategory under the technical aspects theme. In several other instances, the alternate

subcategories utilized included; "lack of thorouthness," "lack of follow-up or preventive measures," and "defects in provider competence, abilities, knowledge."

Possible explanations for these inconsistencies include the lack of mutually exclusive subcategories and the blending of subcategory themes even across the major complaint themes.

Since the intercoder agreement was high under the subcategories of the convenience-accessibility aspects of health care theme (100%) and between the four major themes of consumer dissatisfaction (76%), the results and discussion which follow were completed as planned.

Consumer Profile

Of the 245 complaints which were included in the sample, only 12 consumers complained about more than once health care experience. Of these 12 consumers, 10 complained about two separate health care experiences, one consumer complained about three separate health care experiences, and one consumer complained about four different health care experiences.

Therefore, it would appear that very few consumer complaints are initiated by the "chronic complainers" who are perpetually critical of the health care they receive.

The majority of all consumer complaints were tallied under one complaint theme. However, 42.9% of the consumer complaints were tallied under two or more themes. There were a total of 376 category tabulations for the 245 individual complaints included in the sample. A summary of the number of consumers complaining about one or more aspects of health care in a single complaint record is given in Table 1.

Table 1

Comparison of the Number of Consumers Who Were Dissatisfied About One or More Themes Within the Single Complaint Recorded

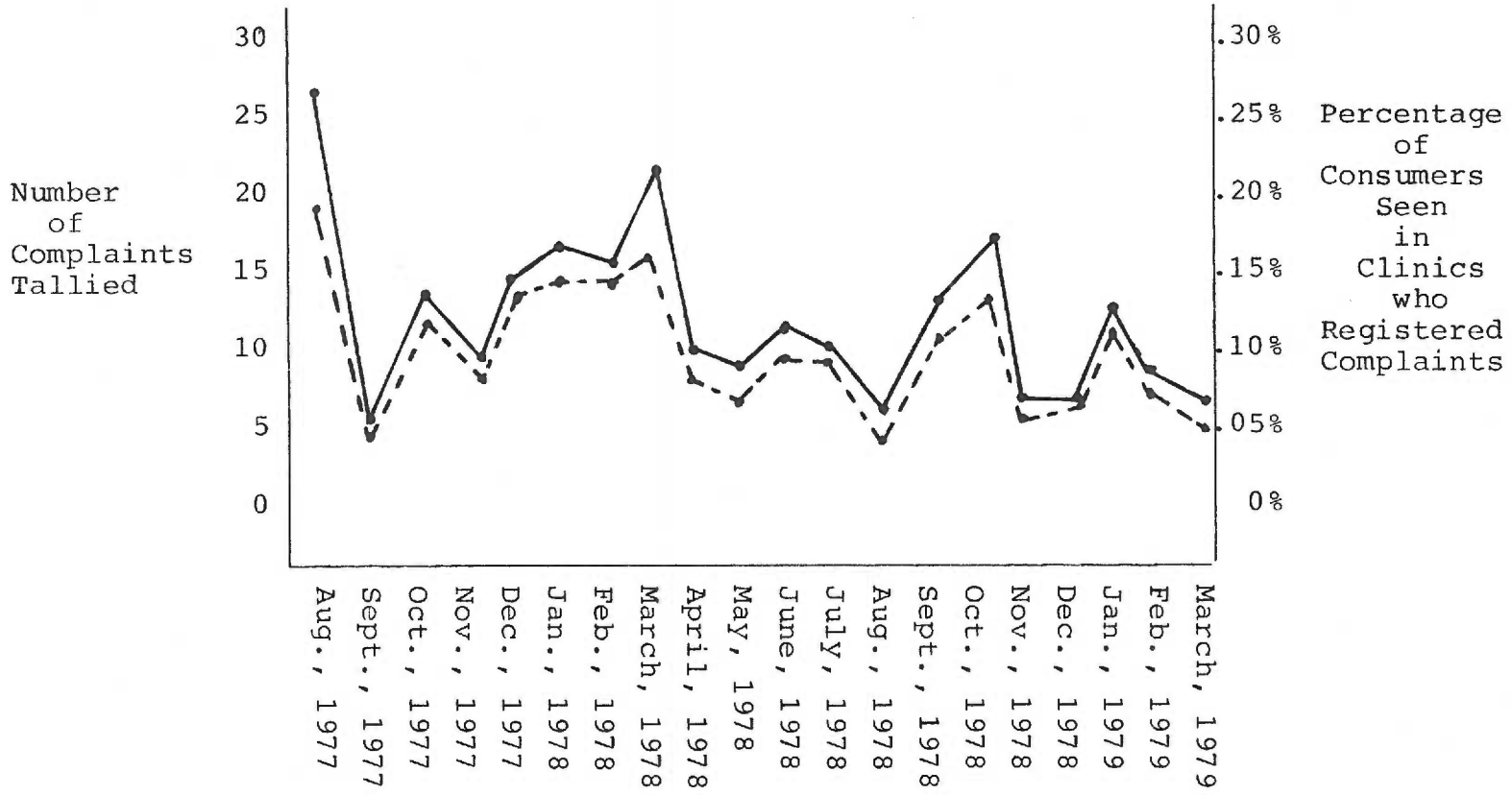
Number of Individual Complaints	Number of Themes Tabulated	Percentage of Complaints Tabulated into One or More Themes
140	1	57.1%
81	2	33.1%
22	3	9.0%
2	4	0.8%

This result supports the theory that consumer complaints are related to specific events that occur during the health care process. However, there may be a close relationship between two or more of the consumer dissatisfaction themes, since a substantial number of the complaints initiated included mention about more than one aspect of health care. Future correlational analysis of these themes may provide additional insight into the relationships between the consumer dissatisfaction themes utilized in this descriptive study.

Comparison of Consumer Complaints Initiated According to Month and Year

Comparisons were made according to the date recorded on the complaints to see whether more complaints would be initiated during specific months of the year. Several peaks in the complaints initiated by consumers occurred during the 20 months included in the study (August, 1977; March, 1978; October, 1978). The lowest number of complaints recorded occurred during September, 1977, as shown in Figure 1.

Since it was conceivable that the total number of complaints tabulated might be different than the percentages of consumers who complained during the months tallied, the total tabulations by month were compared to the total patient visits, as presented in Table 2. The overall percentage of consumers who received health care services and also registered complaints with the Patient Relations Coordinator were less than one quarter of 1% in all cases. When the percentage of consumers registering a complaint were compared with the total number of complaints tallied in Figure 1, no appreciable differences were noted. The fluctuations in the complaint tallies were indicative of fluctuations also in the percentages of consumers who decide to express dissatisfaction with health care to the clinic representative.



KEY: ——— Total Number of Complaints
---- Percentage of consumers seen in clinics who registered complaints

Figure 1. Comparison of the total number of complaints tallied by month and year from August, 1977 through March, 1979 and the percentage of the total number of consumers seen in the outpatient clinics who registered complaints.

Table 2

Comparison of the Total Outpatient Clinic Visits by Month and Year With the Number of Complaints Tallied

Month/Year	Total Patient Visits	Total Complaints Tallied	Percentage of Patients Registering a Complaint
August, 1977	13,395	26	0.19
September, 1977	12,852	6	0.05
October, 1977	12,058	14	0.12
November, 1977	11,259	9	0.08
December, 1977	11,291	15	0.13
January, 1978	12,371	17	0.14
February, 1978	11,680	16	0.14
March, 1978	14,039	21	0.15
April, 1978	12,379	10	0.08
May, 1978	13,339	9	0.07
June, 1978	12,621	12	0.10
July, 1978	11,307	11	0.10
August, 1978	13,266	7	0.05
September, 1978	11,942	13	0.11
October, 1978	12,919	17	0.13
November, 1978	11,425	7	0.06
December, 1978	10,399	7	0.07
January, 1979	11,388	12	0.11
February, 1979	11,794	9	0.08
March, 1979	13,602	7	0.05

No identifiable trends were noted in the complaint tabulations according to the month in which they were initiated by the consumers.

Since previous investigators have compared consumer dissatisfaction with socio-economic characteristics and have found positive correlations, it would be useful to compare the patient complaints initiated with "macro" events such as unemployment rates, inflation factors, public elections, or other events which would potentially increase stress levels among the consumer or provider groups. It is also possible that major events occurring at the University of Oregon Health Sciences Center might affect the number of consumer complaints initiated, such as major confrontations between management and employees, major construction or repair projects, or changes in organizational leadership and policies.

Comparison of Individual Clinics According to the Percentages of Consumers Registering Complaints

The individual clinics were compared according to the percentage of patients who complained about their health care experiences. The total number of patient visits were gathered only for the months during which complaints were tallied in each of the individual clinics. These total

patient visits were then averaged per month, and multiplied by the 20 months included in the study to compute the total approximate number of patients visits for each individual clinic for the time period analyzed. The percentages of consumers registering complaints in the clinics where only one complaint was tallied for the entire 20 months were not figured. Table 3 summarizes the total complaints tallied according to the individual clinics providing health care, including the percentage of consumers registering complaints. In nine of the consumer complaints tabulated, more than one clinic was recorded on the complaint record. In each case, every clinic mentioned was tallied. (Eight complaints tallied mentioned two cinics; one complaint mentioned four separate clinics).

As shown in Table 3, five of the clinics reflected a higher percentage of consumer complaints than the overall percentages of consumer complaints computed according to month and year, as presented in Table 2. Of these, the Tumor Clinic patients complained about their health care experiences twice as often as the next highest percentage of the consumer complaints initiated based upon health care experiences in the Emergency Room. The Gastroenterology Clinics, Neurosurgery Clinics and Nephrology Clinics also reflected higher percentages of consumer complaints than the

Table 3

Comparison of Total Outpatient Visits With the Total Number of Complaints Tallied in Individual Complaints

Clinics	Total Complaints Tabulated	Approximate Total Number of Patient Visits	Percentage of Consumers Registering Compalints
Chemotherapy	1		
Dermatology	11	16,900	0.07
Family Practice	2	22,860	0.01
Gynecology	23	34,870	0.07
Obstetrics	7	18,623	0.04
Medicine	38	36,120	0.10
Allergy	4	3,087	0.13
Gastroenterology	7	2,026	0.35*
Metabolic	1		
Nephrology	2	850	0.24*
Chest	1		
Rheumatology	1		
Neurology	10	5,578	0.18
Seizure	2		
Ophthalmology	16	19,020	0.08
Orthopedics	8	12,088	0.07
Otolaryngology	9	14,493	0.06
Pediatrics	16	30,716	0.05
Psychiatry/Psychology	10		
Surgery	20	12,993	0.15
Neurosurgery	5	1,580	0.32*
Minor Surgery	1		
Proctology	1		
Vein	1		
Urology	9	6,590	0.14
Tumor	9	1,165	0.77*
Emergency	59	15,612	0.38*
Pharmacy	3		
X-Ray	6		
Laboratory	2		
Clinic Admitting	1		
Physical Therapy	1		

*Percentages higher than the overall percentages of consumers registering complaints by month and year as presented in Table 2.

remaining outpatient clinics at the University of Oregon Health Sciences Center.

There are numerous variables which have been described in the literature as influencing consumer satisfaction with health care. Therefore, it would be reasonable to assume that multiple factors are responsible for the higher percentages of consumer initiated complaints in the five clinics named above.

Four of the five clinics which reflected higher percentages of consumer complaints were specialty clinics (Tumor, Gastroenterology, Neurosurgery and Nephrology). Consumers are referred to these clinics for diagnosis of a disease or condition, or to be treated and monitored over a period of time. The continuity of relationships between consumers and health care providers would be more constant in these specialty clinics than in the larger, more general clinics. However, it is conceivable that a greater proportion of the consumers seen in these specialty clinics were suffering from chronic and disabling diseases. In the literature, one factor which is described as important in consumer satisfaction with health care is whether or not the consumers felt pain, or felt better following their visit. Patients with chronic diseases would be less likely to feel better following health care. It is also

possible that personality defense mechanisms were being activated among these consumers due to their disease states, such as denial or projection.

On the other hand, the health care providers in these specialty clinics might feel less successful in helping their clients to feel better, resulting in fewer demonstrations of warmth or interest to their patients. Providers who felt helpless over their ability to influence the outcome of their client's condition might also tend to offer less information to their patients regarding the prognosis or recommended treatment of a disease.

In contrast, the health care provided in the Emergency Room would include immediate evaluation and treatment for acute conditions. Few consumers would be expected to return to the Emergency Room for follow-up care, and few providers would see the same client for continued supervision of their health status. The costs for emergency room visits are also higher for the consumers. These factors might explain in part, the higher numbers of consumer initiated complaints based upon health care experiences in the Emergency Room.

One question which might be raised is why greater numbers of consumers did not initiate complaints from the remaining specialty clinic, where the numbers of patients suffering from chronic disease or from disabling conditions would

also be greater than in the larger, general clinics. Examples of these clinics include the Allergy Clinics, Metabolic Clinics, Chest Clinics, Rheumatology Clinics, and Chemotherapy Clinics. Since the sample sizes in four of these clinics was one, the investigator did not compute the percentages of consumers registering complaints. Continued evaluations of the differences in these clinics over time in the numbers of consumer initiated complaints may reveal additional insight into this question.

Comparison of Consumer Dissatisfaction Themes

The comparison of complaint themes by major category revealed some unexpected results. More consumers complained about the technical aspects of their health care than they did about the three remaining categories. The total tabulations recorded according to the four major complaint themes are shown in Table 4. The second highest number of complaints were tallied under the convenience-accessibility aspects of health care, followed by the consumer-provider relationship and the monetary costs of health care.

However, the differences in the number of complaints tallied in the latter three categories varied by less than 5%. Thus, the first portion of Proposal 1 was supported, but the relationship demonstrated in the complaint tally was not very strong. Only seven more consumers complained

about the convenience-accessibility aspects of their health care than about the consumer-provider relationship.

The second portion of Proposal 1 was not supported. The relationship between consumer dissatisfactions regarding the monetary costs of health care and the consumer-provider relationship was opposite of that predicted. However, only three fewer consumers complained about the health care costs than about their relationships with the provider group, so again, the differences were very slight.

Table 4

Comparison of Consumer Dissatisfactions Tallied According to Major Complaint Themes

	Consumer-Provider Relationship	Convenience Accessibility	Monetary Costs	Technical Aspects	Other
Total Number of Tabulations	80	87	77	114	11
Percent of Consumers Expressing Dissatisfaction	32.7	35.5	31.4	46.5	4.0

The relationship shown in the data between the consumer-provider relationship and the technical aspects of the quality of care was also opposite from that predicted in Proposal 2. Thirty-four more consumers (13.8%) expressed dissatisfaction regarding the technical aspects of their health care than about their relationships with the provider group.

Perhaps the increased involvement of consumers in health care planning, the wider dissemination of information and the greater emphasis health has received as an important factor in the quality of life has given consumers more specific expectations regarding the health care process, diagnostic tools, and treatment modalities than before. Although consumers expressed the greatest amount of dissatisfaction with the technical aspects of health care quality, substantial numbers of consumers also initiated complaints regarding the convenience-accessibility aspects of health care, the monetary costs of health care, and the provider-consumer relationship.

The practical application of this finding might be to ask consumers what they know about their disease and/or condition and its treatment possibilities, as well as what they want to happen during their clinic visit. At the end of the visit, consumers could then be reminded about what they expected or wanted from their health care visit, and

asked whether these expectations and desires had been met.

Convenience-Accessibility Aspects of Health Care

A comparison of the subcategories tallied under the convenience-accessibility aspects of health care revealed that the most frequent areas for consumer dissatisfaction were the waiting times at the clinics, and difficulty with the appointment process as shown in Figure 2. Very few consumers expressed dissatisfaction regarding transportation, parking, comfort and convenience of waiting areas, getting information over the telephone, or getting care without an appointment. No one complained about child care difficulties. There were 13 complaints which did not fit easily into the subcategories given, but which clearly identified convenience-accessibility problems. These are summarized below.

Areas for Consumer Dissatisfaction	Number of Complaints
Difficulty getting prescription filled or refilled	4
Attended clinics unnecessarily	2
Medical Records lost or unavailable	2
Not eligible for care	1
Phone call not returned	1
Expected reports to be sent to family doctor	1
Waited a long time for a glasses prescription	1
Family member was taken to wrong department	1

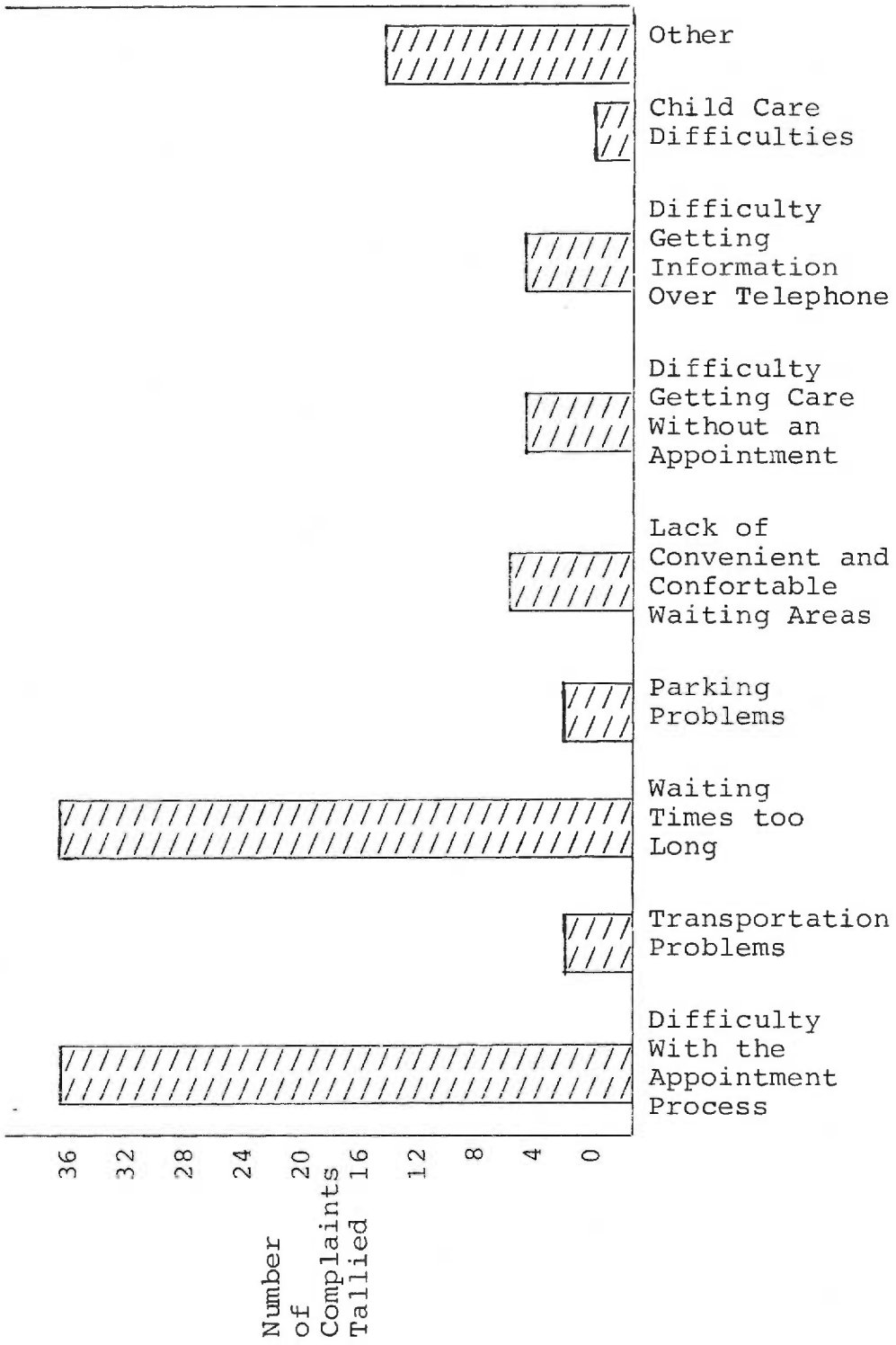


Figure 2. Comparison of consumer complaint themes under the convenience-accessibility aspects of health care.

The one complaint about waiting too long for a glasses perscription was not tallied under "waiting times too long" category because in every other case, consumers were dissatisfied with the waiting times at the clinics during the time they were expecting to be seen by a health care provider.

The most striking factor regarding the overwhelming dominance of consumer dissatisfactions with the clinic waiting times and difficulties with the appointment process is that both can be manipulated administratively.

Very few consumers complained about transportation problems or parking difficulties, even though public parking spaces at the Health Sciences Center were often filled up during the day. One explanation for the low number of complaints related to transportation and parking may be the convenience of the public bus system, which stops at the door of the Outpatient Clinics at regular intervals throughout the day. It is also possible that consumers recognize the limited possibilities available for expanding public parking facilities, and therefore perceive it as a problem which cannot be resolved.

It is also interesting to note that no one complained about child care difficulties. Consumers may consider child care arrangements a personal problem to resolve, rather than the responsibility of the provider institution.

Complaint Themes Compared
by Month and Year

Complaint themes were also examined according to the months in which they were initiated to see whether dissatisfaction in any one of the major categories might be more pronounced during specific times of the year. A summary of this comparison is given in Figure 3. Generally, it was difficulty to find consistent patterns in the data regarding complaint themes and time of year in which complaints were initiated. There were fewer tabulations overall from November, 1978 through March, 1979 as compared with the same five month period a year earlier. The complaint tabulations in August, 1977 were much lower than the tabulations recorded in August, 1978. In contrast, the tabulations of complaint themes were much higher in September, 1978 than in September, 1977.

In order to more completely examine the differences in complaints according to time, complaint themes were then examined individually by comparing the same months of different years since there was an eight month overlap during the complaint tabulation. Figure 4 compares the complaint tabulations in the consumer-provider relationship as they were recorded by month.

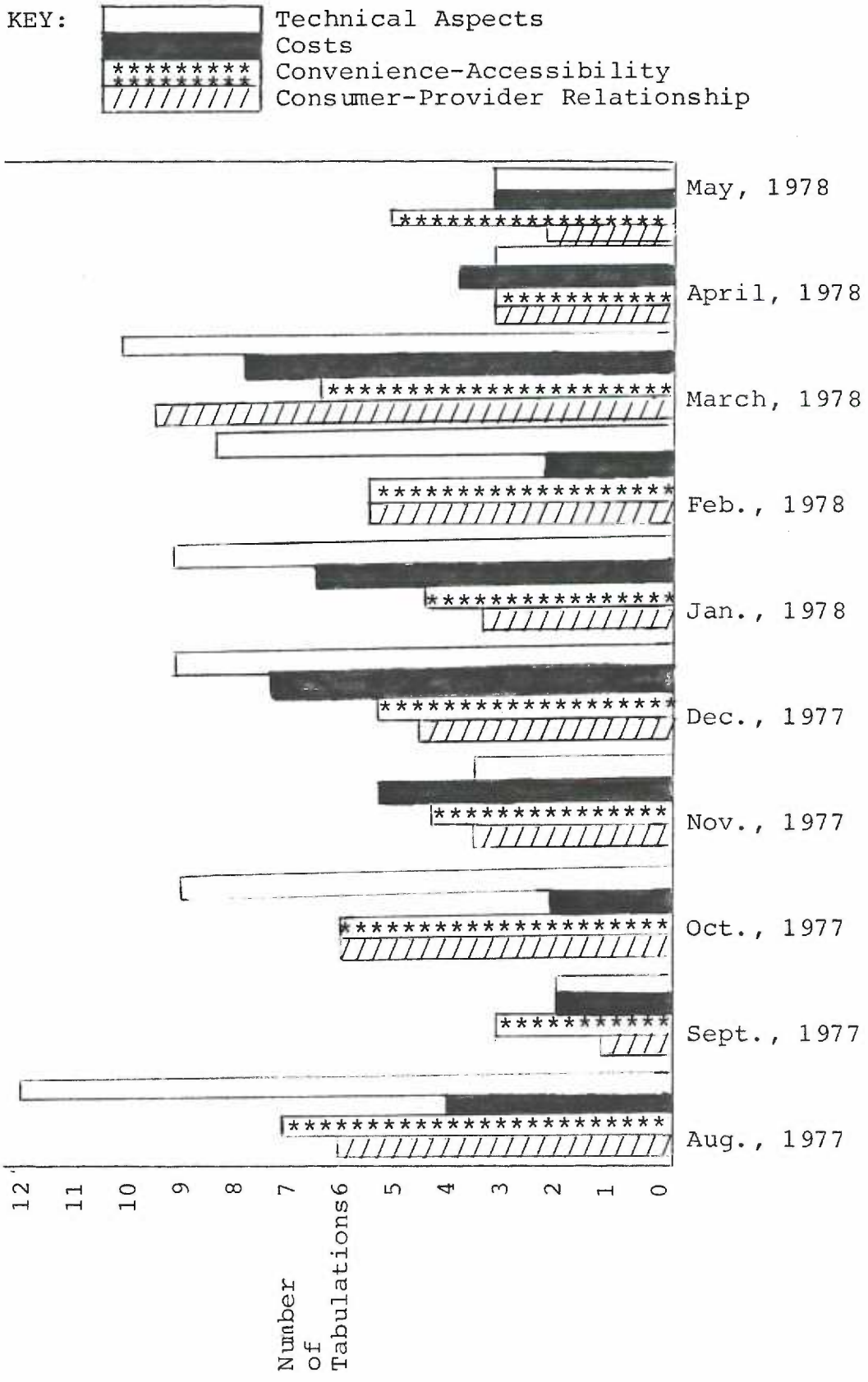


Figure 3. Comparison of complaint themes according to month and year complaints were initiated.

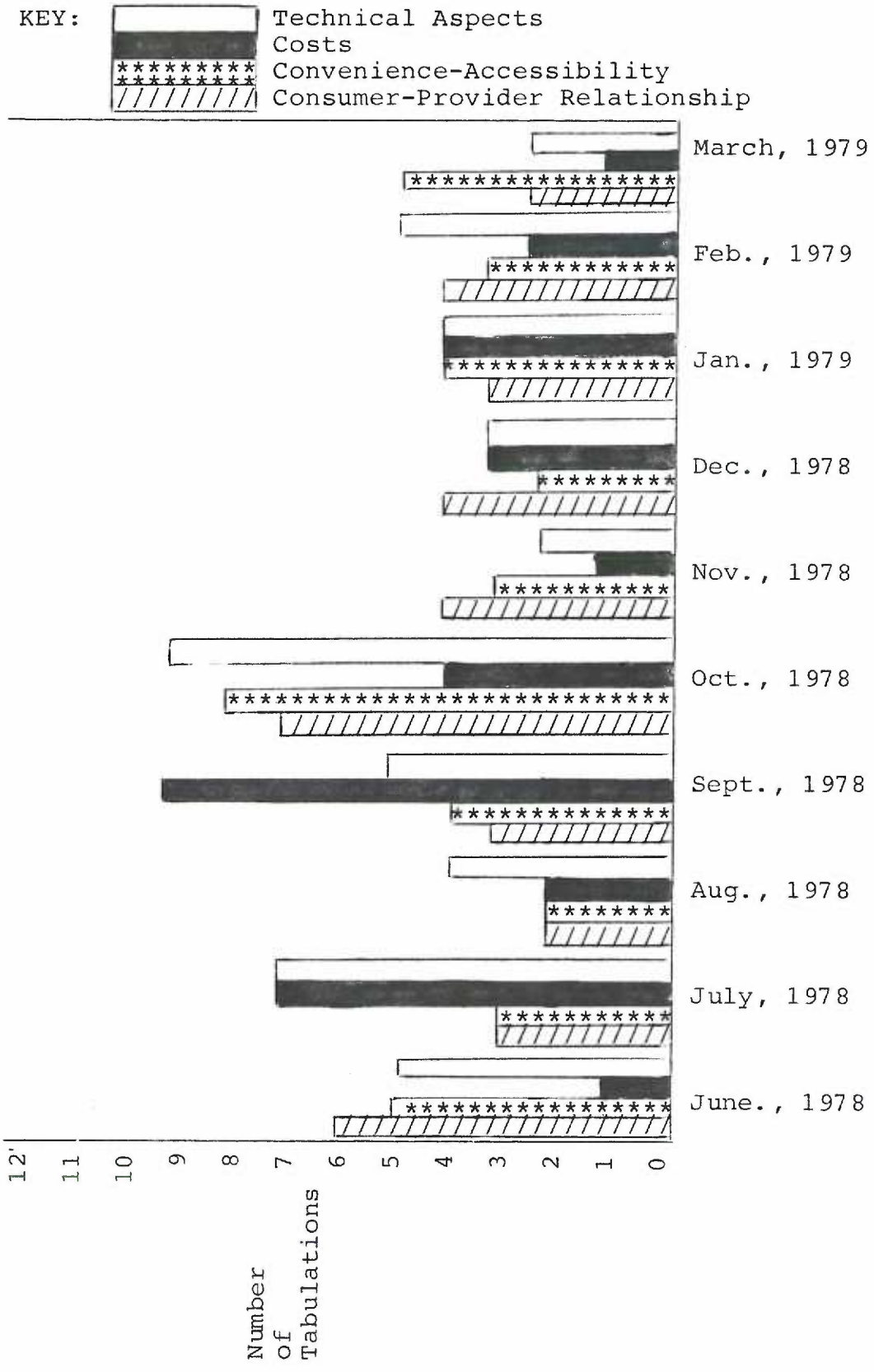


Figure 3 (continued).

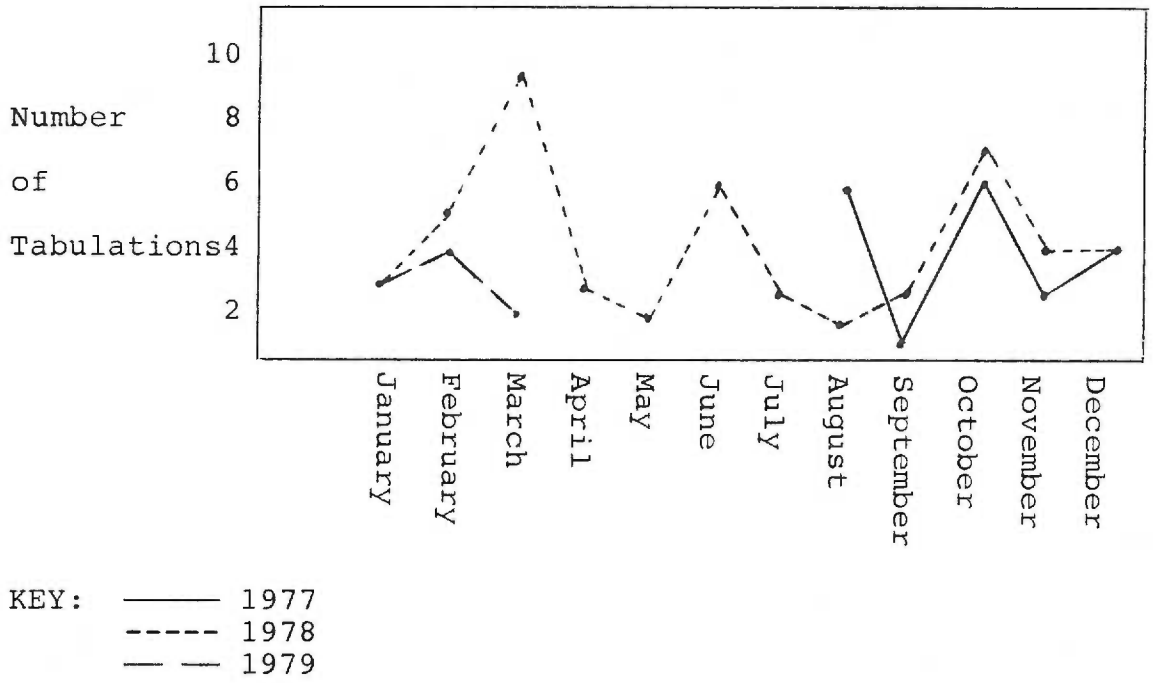


Figure 4. Comparison between months in which consumer complaints were tabulated under the consumer-provider relationship.

Figures 5, 6 and 7 compare the complaint tabulations in the convenience-accessibility category, the category of health care costs, and the technical aspects of health care quality as they were recorded by month and year respectively.

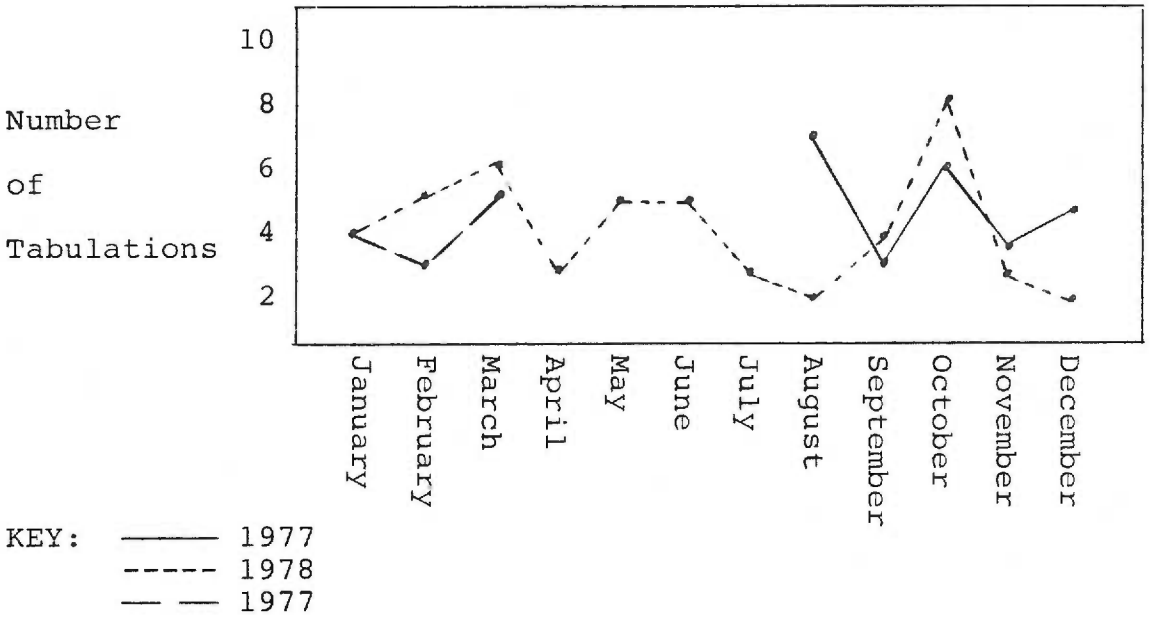


Figure 5. Comparison between months in which consumer complaints were tabulated under the convenience-accessibility aspects of health care.

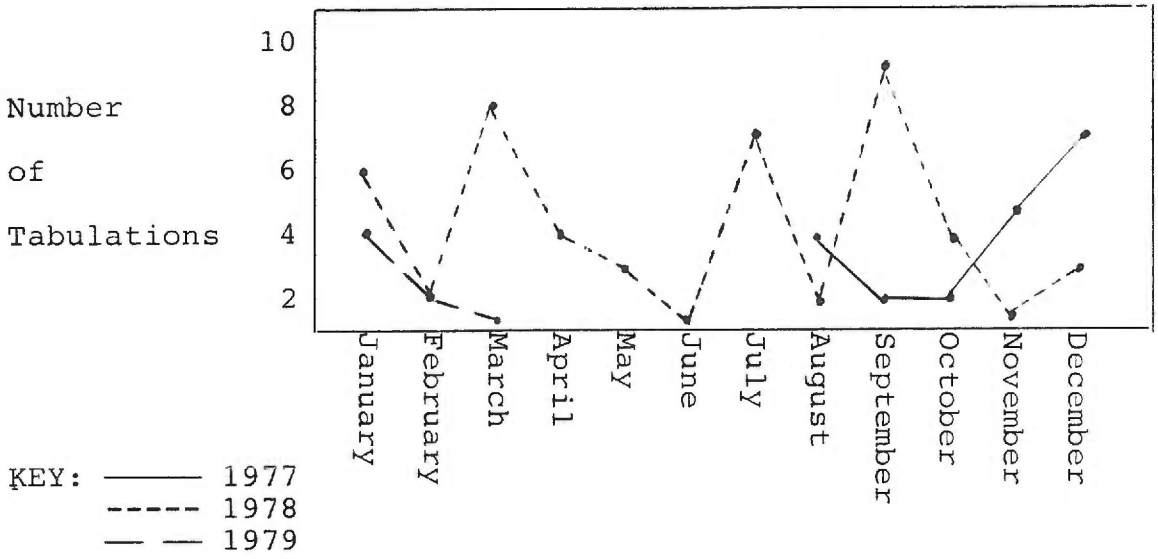


Figure 6. Comparison between months in which consumer complaints were tabulated under the category of health care costs.

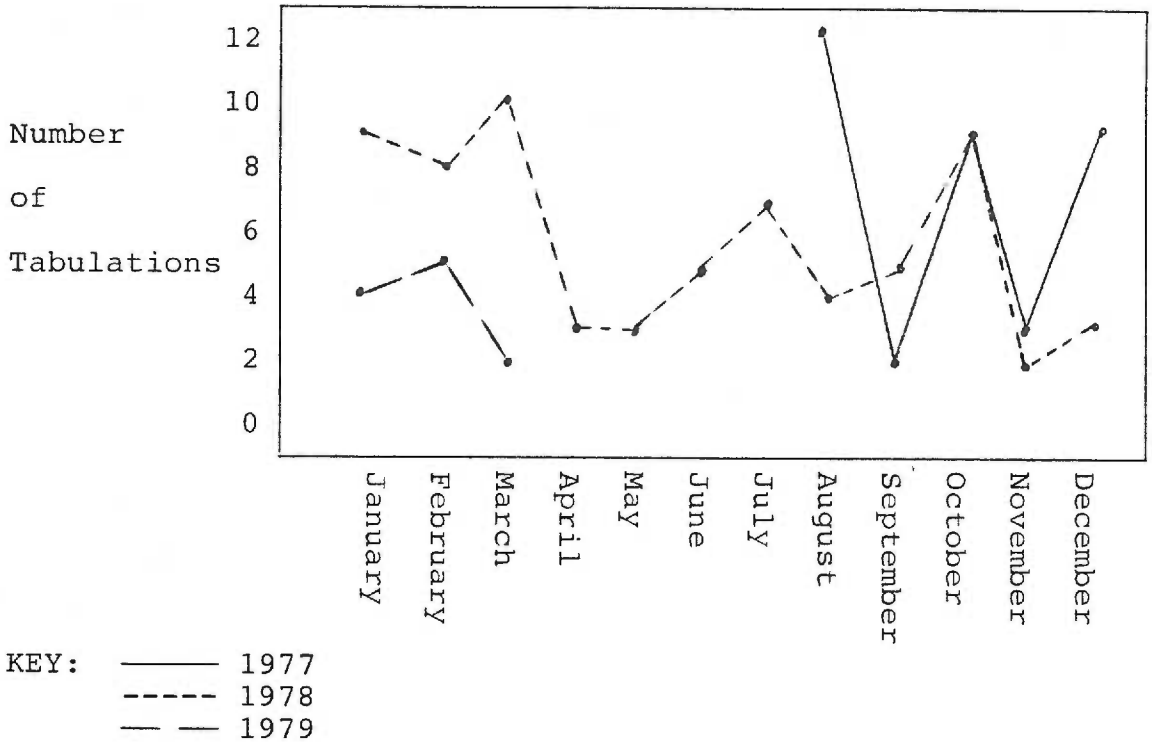


Figure 7. Comparison between months in which consumer complaints were tabulated under the technical aspects of health care quality.

There are similarities in the complaint themes tabulated during January and February in 1978 and 1979 except in the category of the technical aspects of health care quality. Similarities are also apparent in the tabulation of complaint themes during September, October and November, 1977 and 1978 with the exception of the category of health care costs. In contrast, the months of March 1978 and 1979, and August and December, 1977 and 1978 reveal marked differences in the tabulation of complaint themes. In most of the

examples mentioned above, the notable differences in the complaint theme tabulation by month were generally in the direction of fewer tabulations with the progression of time. The major exception to this trend was evident in the category of health care costs, where complaint tabulations in September, 1978 were much higher than in this same month a year earlier.

Since the comparison of complaint themes by month and year reveals similarities as well as marked differences, general statements cannot be made about trends in complaint themes according to time of year. Complaint themes would need to be tabulated over a longer period of time such as several years before general trends could be observed and reported. These themes would also need to be compared with organizational, social and political changes in order to effectively evaluate changes in complaint themes over time.

There might be multiple reasons also for the decrease in complaint tabulations over time except for the category of health care costs. It is possible that the priorities or responsibilities of the Patient Relations Coordinator might have changed during the time included in the complaint tabulation, resulting in fewer anecdotal records, or shared responsibilities in this area by other members of the health provider group. It isn't surprising that during a time

of accelerating health care costs, that more consumers would express dissatisfaction with monetary costs of health care.

Complaint Themes Compared by Clinics

A comparison of the specific clinics mentioned in the complaint tabulation according to dissatisfaction themes expressed by consumers was also conducted. A summary of the complaint themes in individual clinics is presented in Table 5. More graphic representations of the differences in complaint themes according to the specific clinics involved are given in the histograms that follow.

The complaint themes which were tabulated following consumers' health care experiences in the Emergency Room shown in Figure 8 reveal greater consumer dissatisfaction with the technical aspects of health care than the remaining dissatisfaction themes.

Similar trends in consumer dissatisfaction themes with slight variations are evident in the Surgery Clinics and the Obstetric-Gynecology Clinics as shown in Figures 9 and 10 respectively.

Table 5

Total Tabulations According to Complaint Themes in Individual Clinics

Clinics	Total Complaints Tallied	Consumer Provider Relationship	Convenience Accessibility	Costs	Technical Quality	Other
Emergency Room	59	24	21	24	30	3
Surgery (includes) Minor Surgery Neurosurgery Vein Proctology	20	7	8	7	11	1
X-Ray	6	0	5	1	2	0
Pediatrics	16	5	2	8	7	1
Medicine (includes) Allergy Gastroenterology Metabolic Nephrology Chest Rheumatology	37	12	16	10	13	1
Tumor	9	2	2	4	5	0
Urology	9	4	3	5	2	1

Table 5 (continued)

Clinics	Total Complaints Tallied	Consumer Provider Relationship	Convenience Accessibility	Costs	Technical Quality	Other
Otolaryngology	9	2	4	3	2	1
Neurology (includes) Seizure	11	0	2	3	7	0
Obstetrics-Gynecology	23	8	10	8	11	2
Psychiatry/Psychology	10	0	0	7	1	3
Ophthalmology	16	3	8	4	8	0
Dermatology	11	6	2	5	5	1
Orthopedic	8	3	4	0	7	1
Pharmacy	3	1	2	0	0	0
Laboratory	2	0	2	0	0	0
Family Practice	2	2	0	1	2	0
Physical Therapy	1	0	0	0	0	1
Chemotherapy	1	0	0	1	0	0
Clinic Admitting	1	0	0	1	0	0

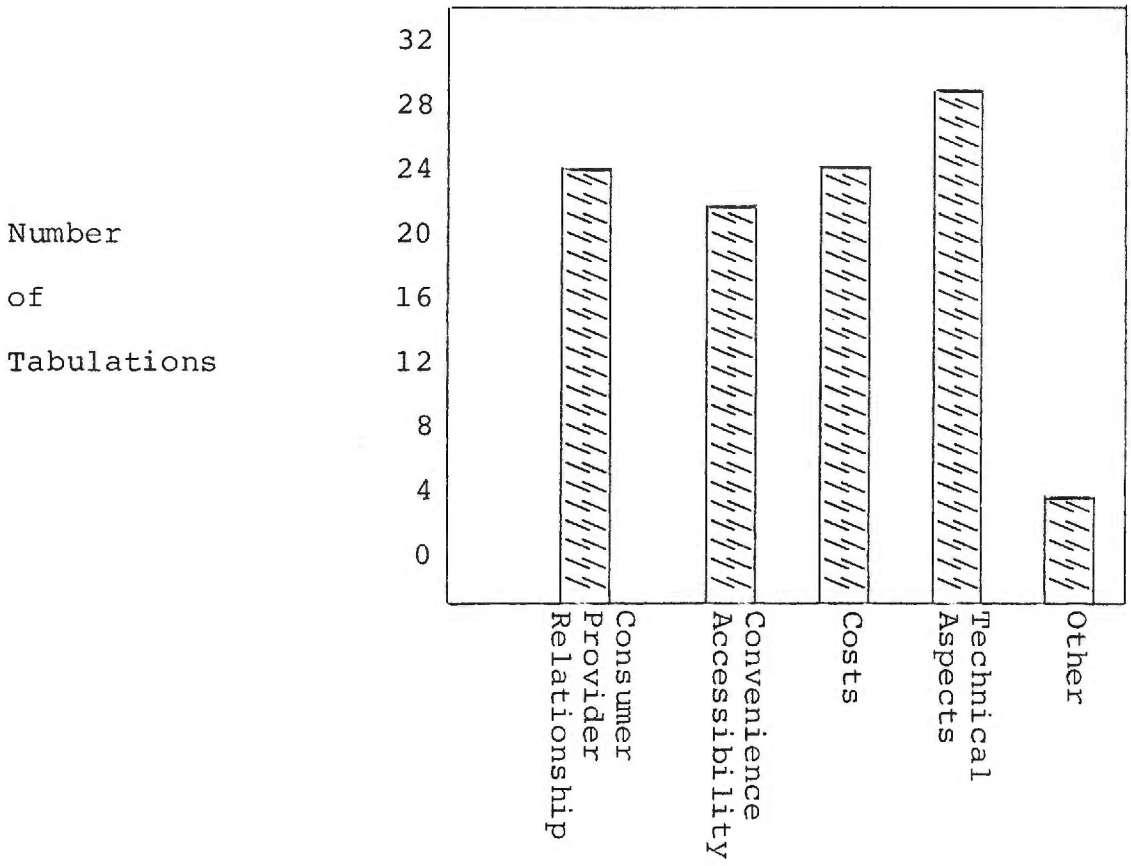


Figure 8. Histogram comparing consumer dissatisfaction themes in the Emergency Room based upon 59 individual complaints.

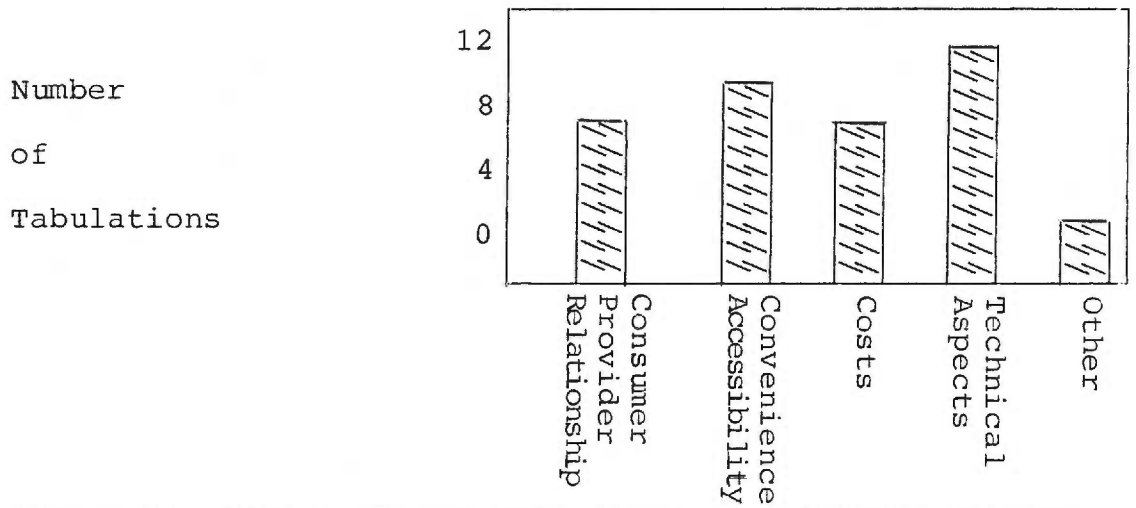


Figure 9. Histogram comparing consumer dissatisfaction themes in the Surgery Clinics based upon 20 individual complaints (Totals include the following clinics: Neurosurgery, Minor Surgery, Proctology, vein).

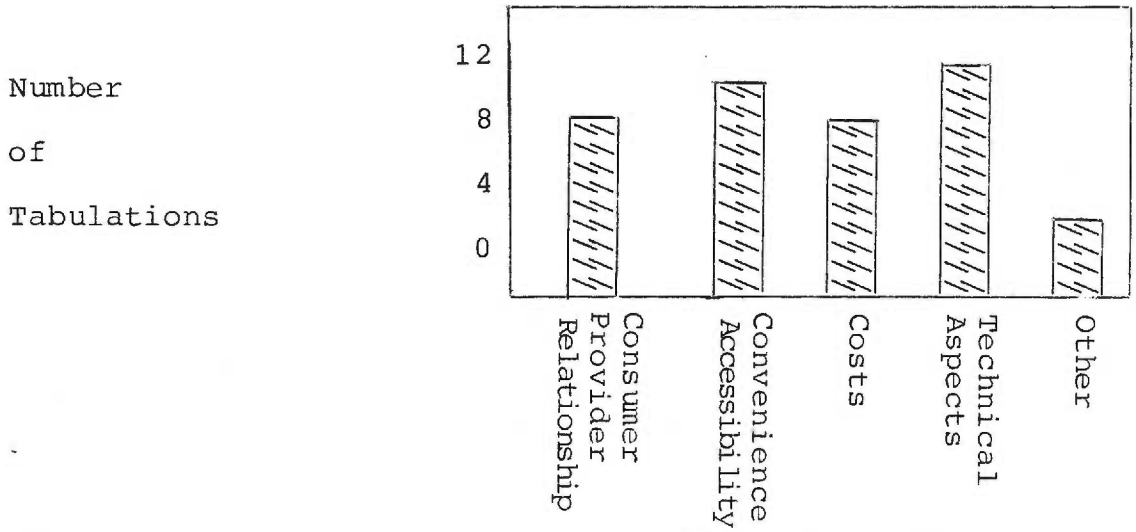


Figure 10. Comparison of consumer dissatisfaction themes in the Obstetric-Gynecology Clinics based upon 23 individual complaints.

One would expect that in the clinics where there are similarities in complaint themes, there would also be similar conditions with respect to the processes, structure, and outcomes of the health care provided. However, the nature of the health care processes, the consumer populations, and the clinic structures for the Emergency Room, Surgery Clinics, and the Obstetrics-Gynecology Clinics have some notable differences. For example, the Emergency Room is the only acute care center of the three clinics. Costs are higher, and consumers would not expect to see the same providers on subsequent visits. The patients seeking care in the Emergency Room would represent a cross section of the overall consumer population at the University of Oregon Health Sciences Center. In contrast, the patients in the Surgery Clinics are all adults seeking evaluation and/or treatment of very specific health problems of a less acute nature. The consumers in the Obstetrics-Gynecology Clinics are all women, some of whom would not be considered ill but rather would be receiving periodic health exams for early detection of health problems.

One factor which all three clinics have in common is their relatively larger size with respect to many of the other clinics mentioned in the complaint tabulations. Larger and busier clinics could be characterized by greater turnover

among staff members, medical students and nursing students, resulting in more fragmentation and lower levels of continuity with respect to the delivery of health care services. There might also be less time for providers to counsel and teach their clients about the processes, expected outcomes and preventive measures with regard to the health care provided. The major exception to the comparison of complaint themes according to the clinic size are the Medicine Clinics, where the majority of consumer complaint tabulations were in the category of the convenience-accessibility aspects of health care (See Figure 19).

Previous suggestions that the increased costs for Emergency Room care might explain in part the greater number of consumer initiated complaints from these clinics are not supported by greater number of complaint tabulations in the category of the monetary costs of health care.

Although greater consumer dissatisfaction with the technical aspects of health care were evident in other clinics also, variations in the other themes were more noticeable. In the Tumor Clinic, costs were a factor causing slightly more dissatisfaction among consumers than the consumer-provider relationship or the convenience-accessibility aspects of care, as shown in Figure 11.

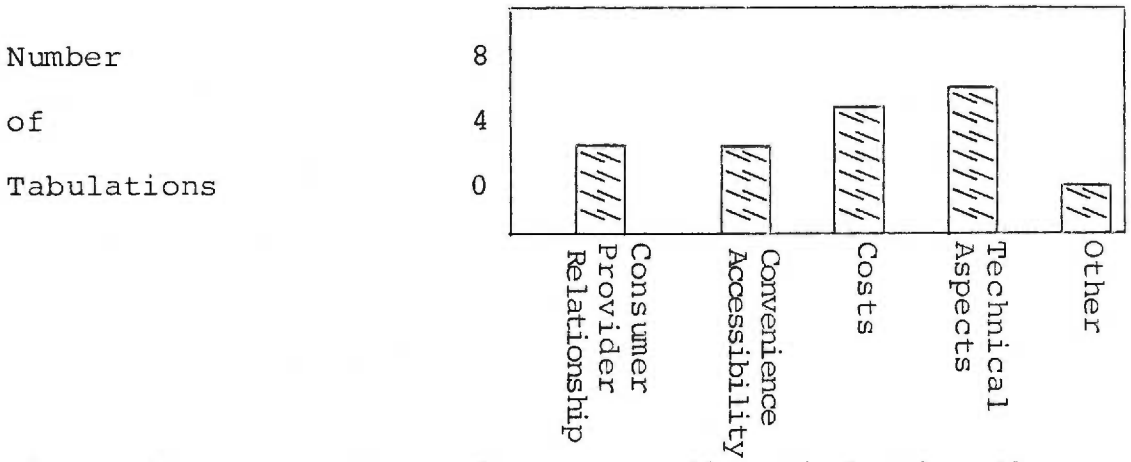


Figure 11. Comparison of consumer dissatisfaction themes in the Tumor Clinics based upon nine individual complaints.

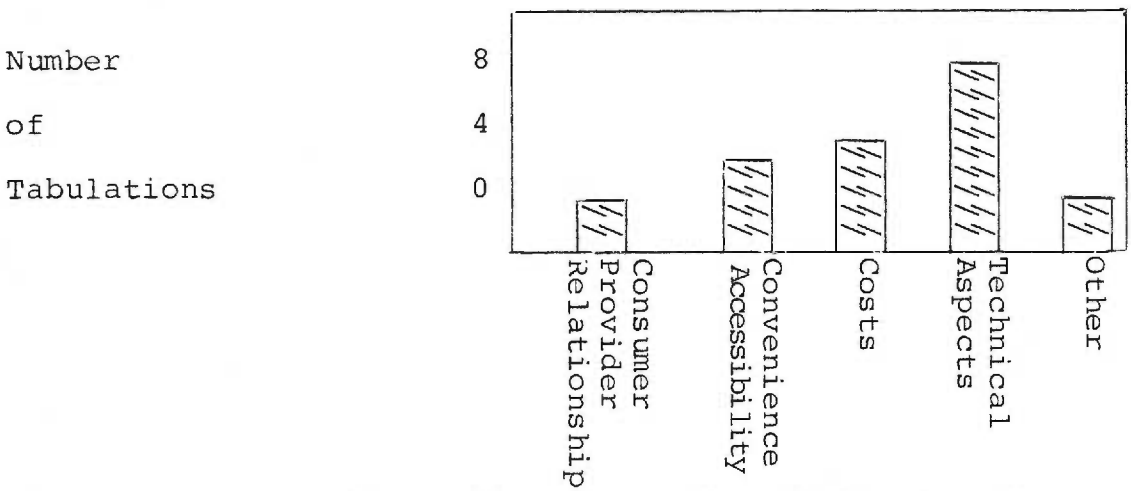


Figure 12. Comparison of consumer dissatisfaction themes in the Neurology Clinics based upon 11 individual complaints. (Totals include the Seizure Clinics).

In the Neurology Clinics, there wer no complaint tabulations in the consumer-provider relationship category, while seven of the 11 consumer complaints tallied came under the technical aspects of the health care quality catetory (See Figure 12).

Reference was made in the review of the literature to a patient satisfaction study which was conducted in the Neurology Clinics at the University of Oregon Health Sciences Center (Ater, 1978). The major consumer dissatisfaction areas which surfaced during the pilot study included waiting times in the reception areas and exam rooms, the fact that a numer of patients did not feel better following their clinic visit, and dissatisfaction with the explanations and instructions provided by the physician. Based upon Ater's study, one would have expected greater numbers of complaint tabulations in the consumer-provider relationship category and in the convenience-accessibility category. Ater suggested that the nature of neurological conditions might explain in part the patient dissatisfaction in these clinics as well as the population served. For example, the prognosis for neurological conditions might be less optimistic than in other clinics, patients may not have the cognitive capacity to understand explanations regarding their condition, and diagnosis may require more time due to the elusive nature of neurological conditions.

Since Ater's study was conducted between November 10, 1977 and January 22, 1978, one must consider the conduction of the patient satisfaction study and the reporting of results

as a variable which might have influenced the tabulation of consumer complaints by themes and months. The increased provider consciousness regarding the fact that their explanations to their clients are important in the patient's overall satisfaction with their health care might account for the resulting lack of complaint tabulations in the consumer-provider relationship. It is also possible that changes might have occurred in the Neurology Clinics in response to Ater's study to reduce the waiting times in the reception areas and exam rooms, accounting for the lower number of complaint tabulations in the convenience-accessibility category. On the other hand, it may not be possible for providers to help their clients feel better following their clinic visit.

One must also keep in mind that the nature of neurological conditions with respect to their elusive nature in diagnosis and the less optimistic prognosis likely influences the attitudes, behaviors and clinical practices of the provider groups. Any analysis of consumer dissatisfaction must view the responsibilities of consumers and providers equally with respect to the processes and outcomes of the health care experience.

In the Ophthamology Clinics, the convenience-accessibility factors of health care received as many complaints from

consumers as the technical aspects of care (See Figure 13), and the consumer-provider relationship theme received the fewest complaints.

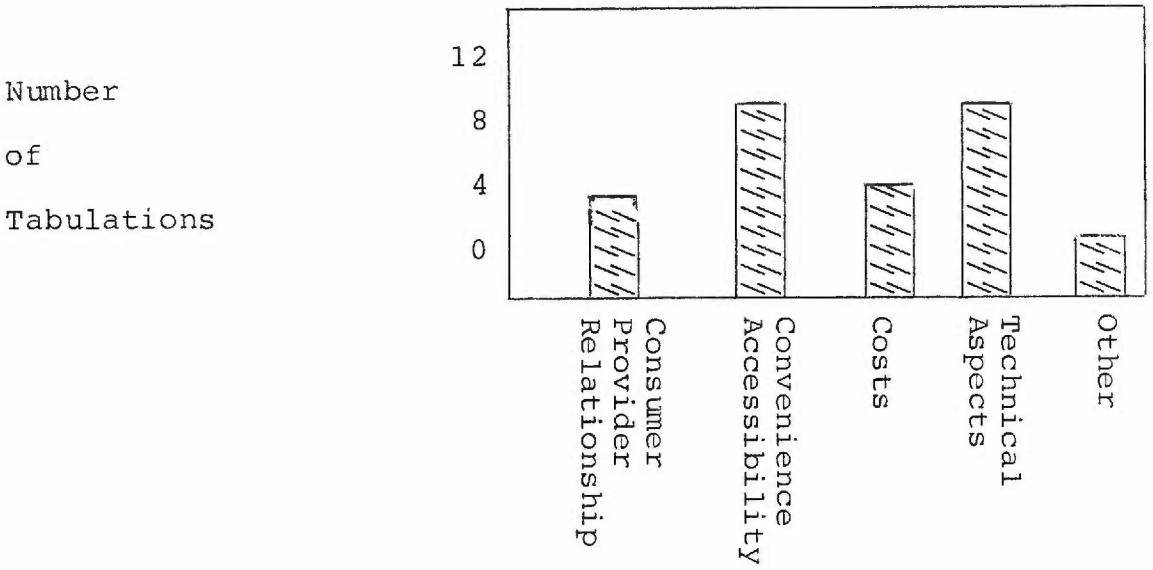


Figure 13. Comparison of consumer dissatisfaction themes in the Ophthalmology Clinic based upon 16 individual complaints.

Another interesting contrast is the absence of tabulations in the costs category in the Orthopedic Clinics (See Figure 14), but the dominance of consumer dissatisfaction with costs in the Psychiatry and Psychology Clinics (See Figure 15). The very opposite in the complaint themes tabulated in these clinics is also evident in the category of the technical aspects of health care quality, and in the categories of convenience-accessibility and the consumer-provider relationship.

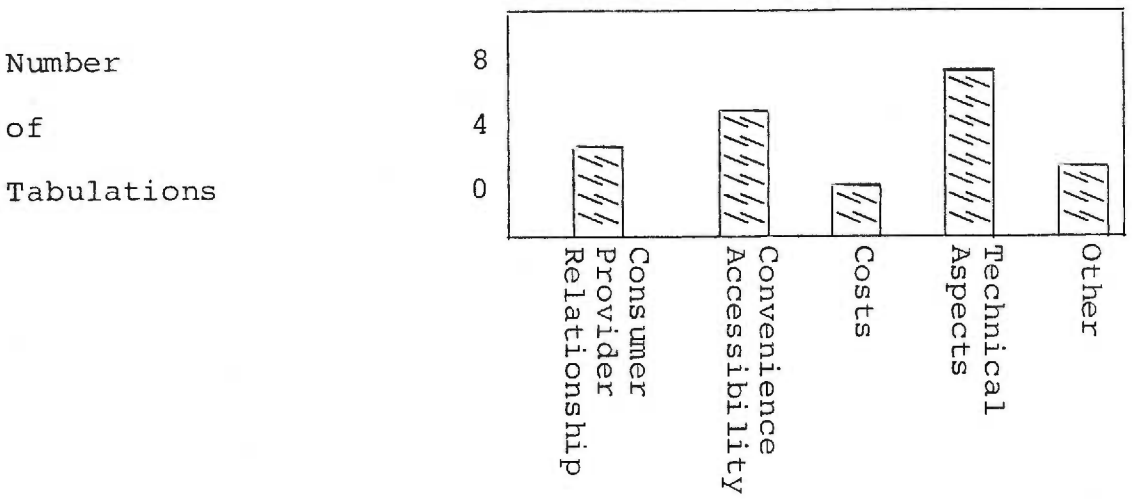


Figure 14. Comparison of consumer dissatisfaction themes in the Orthopedic Clinics based upon eight individual complaints.

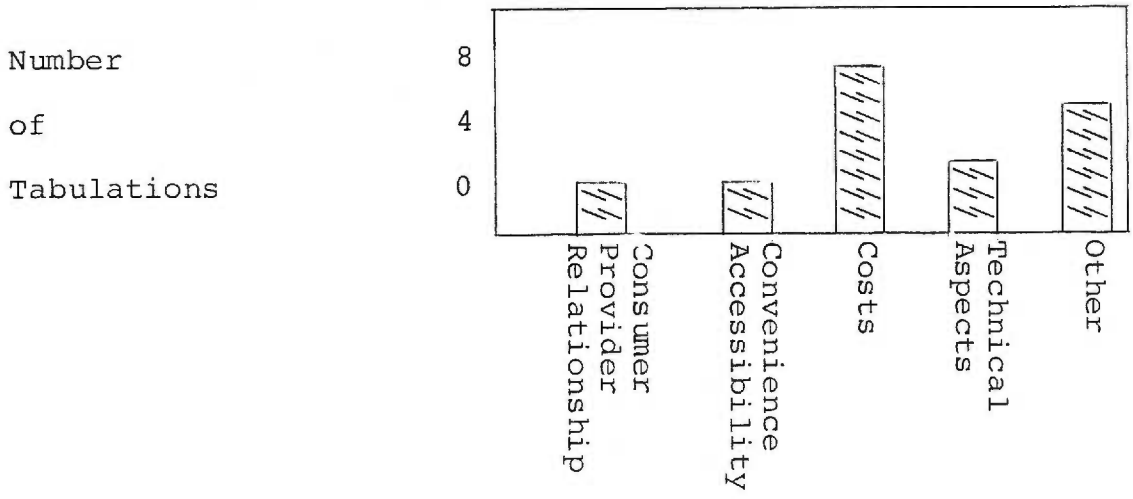


Figure 15. Comparison of consumer dissatisfaction themes in the Psychiatry and Psychology Clinics based upon 10 individual complaints.

The differences in the complaint theme tabulations between the Orthopedic and the Psychiatry and Psychology Clinics may be related to the differences in the treatment methods as well as to differences in consumer expectations regarding the health care process. For example, the treatment focus in the Orthopedic Clinics is on the mechanical problems of structure, movement and balance. These problems are more easily identified, are frequently visible even to an untrained observer, and may have even been caused by an accidental injury. Therefore, the patients in the Orthopedic Clinics may have clearer expectations regarding the diagnosis and treatment of their problems than the patients in the Psychiatry and Psychology Clinics, where the causes of the problems are less well understood, and the cures less defined.

The differences in the complaint tabulations in the category of health care costs may be related to whether or not consumers expected that their insurance would cover the costs of the clinic visits. Psychiatric and psychological care would be less likely to be included in health insurance contracts. The fewer number of consumer complaints in the category of the consumer-provider relationship in the Psychiatric and Psychology Clinics would be expected, since the treatment focuses on communication skills.

Greater consumer dissatisfaction with the monetary costs of health care than with the remaining three themes was also shown in the Pediatric Clinics (See Figure 16) and in the Urology Clinics (See Figure 17). The consumers who received care in the Pediatric Clinics were least likely to initiate complaints relating to the convenience-accessibility aspects of their care. The technical aspects of health care quality received the fewest number of consumer complaints tabulations in the Urology Clinics.

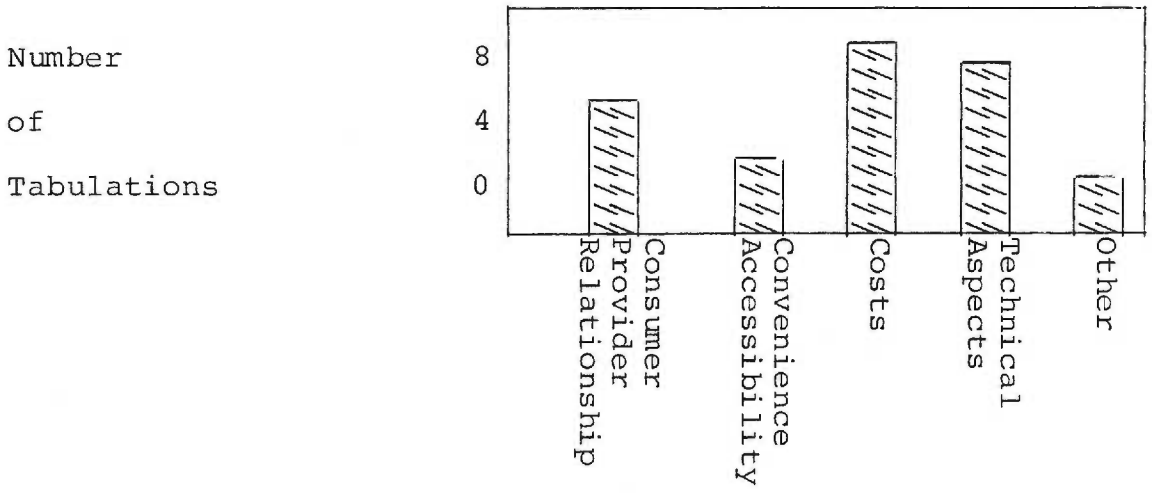


Figure 16. Comparison of consumer dissatisfaction themes in the Pediatric Clinics based upon 16 individual complaints.

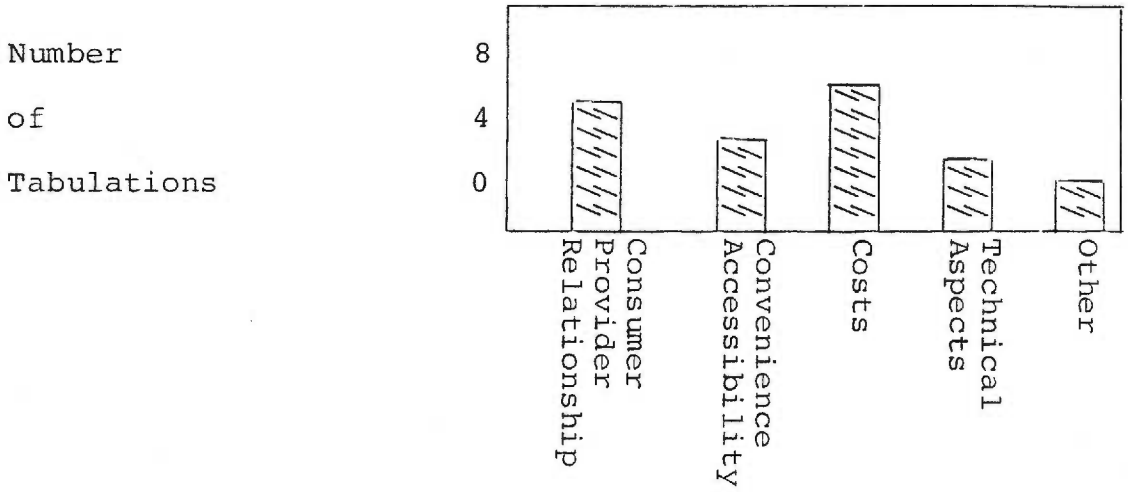


Figure 17. Comparison of consumer dissatisfaction themes in the Urology Clinics based upon nine individual complaints.

In several of the clinics, the convenience-accessibility aspects of health care received the greatest quantity of consumer initiated dissatisfaction. The most pronounced difference in tabulations between the convenience aspect and the remaining complaint themes was in the X-Ray Department (See Figure 18). The absence of tabulations under the consumer-provider relationship may be explained in part by the shortened nature of the consumer's visit to X-Ray, as well as reduced expectations by consumers for explanations and treatments. On the other hand, consumers likely expect that the x-rays will be completed in an efficient and timely manner, a possible explanation for the greater number of complaint tabulations in the convenience-accessibility category.

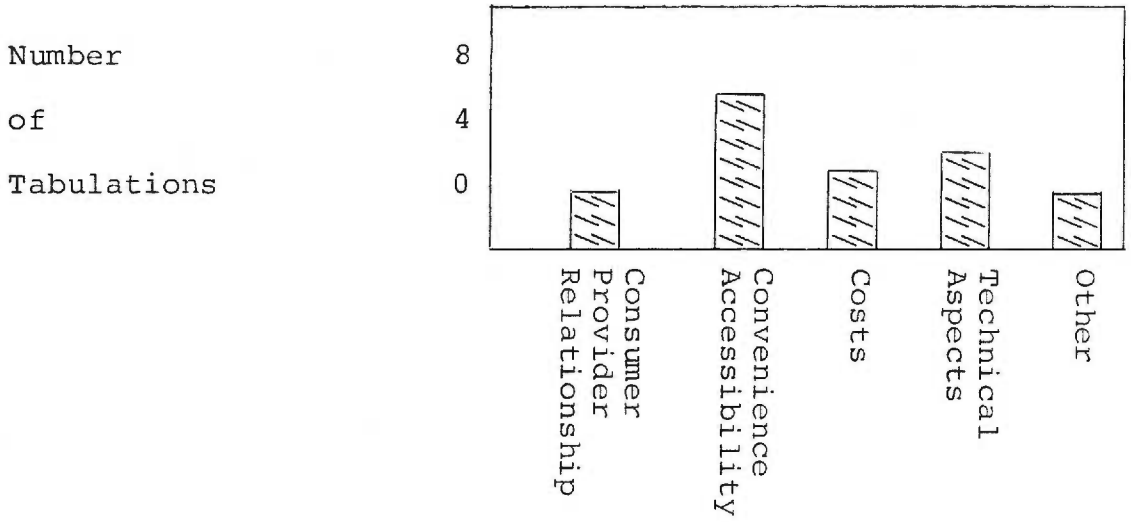


Figure 18. Comparison of consumer dissatisfaction themes in the X-Ray Department based upon six individual complaints.

Greater consumer dissatisfaction regarding the convenience-accessibility aspects of health care was also demonstrated in the Medicine Clinics and in the Otolaryngology Clinics (See Figures 19 and 20) respectively. The convenience-accessibility theme of consumer dissatisfaction also received equal emphasis with the technical aspects of health care quality in the Opthamology Clinics (See Figure 13).

The only clinics in which the consumer-provider relationship dominated the complaint theme tabulation were the Dermatology Clinics, as shown in Figure 21. However, there were no great differences in the complaint theme tabulation

in the Dermatology Clinics between the consumer-provider relationship, health care costs and technical aspects of health care.

The remaining health service areas included in the Outpatient Clinics received very few complaints. Table 3 summarizes the complaints tabulated in the Chemotherapy Clinics, Family Practice Clinics, Pharmacy, Laboratory, Physical Therapy, and Clinic Admitting.

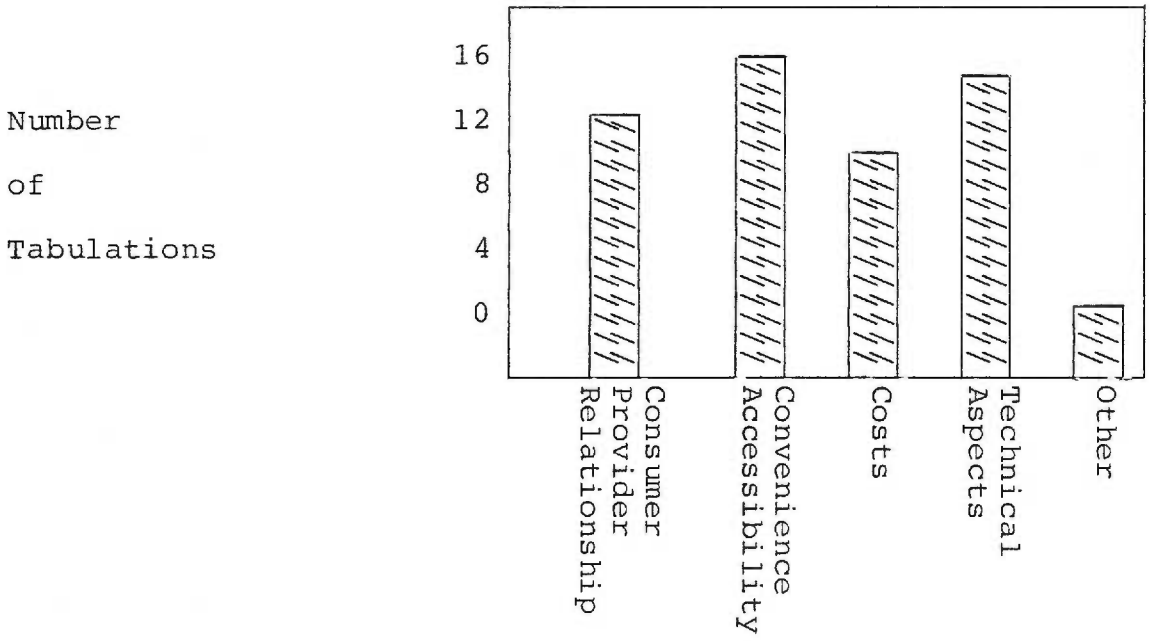


Figure 19. Comparison of consumer dissatisfaction themes in the Medicine Clinics based upon 38 individual complaints. (Totals include the following specialty clinics: Allergy, Gasterenterology, Metabolic, Nephrology, Chest, and Rheumatology).

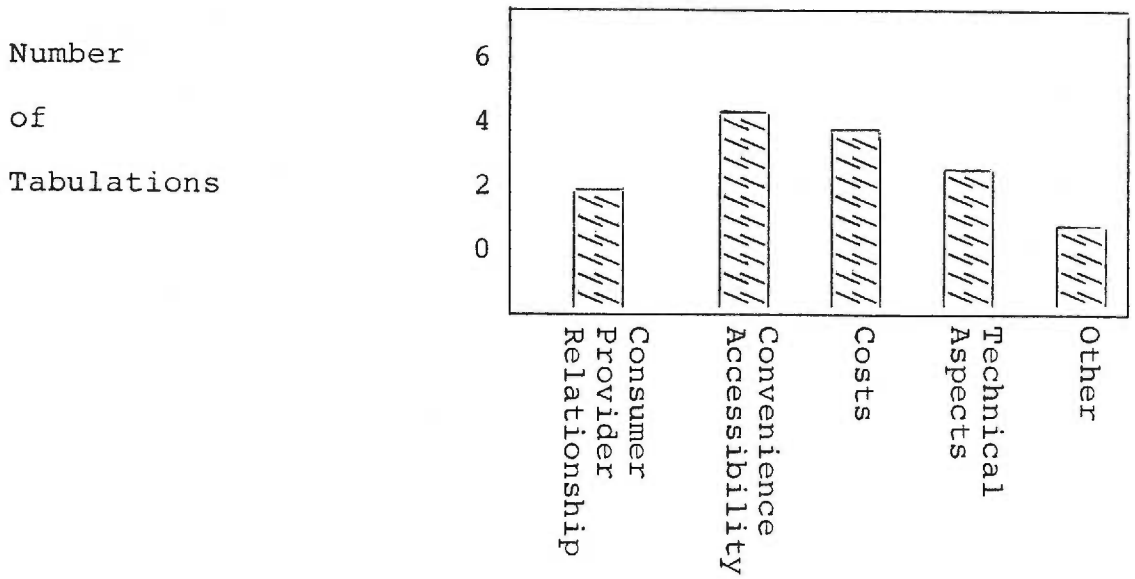


Figure 20. Comparison of consumer dissatisfaction themes in the Otolaryngology Clinics based on nine individual complaints.

One might question whether the population represented in the present tabulation of consumer dissatisfaction themes might be different than the sample populations studies in the literature. Patients who actually initiated complaints without solicitation might view their health care experiences differently than consumers who were approached by other people for their thoughts and feelings regarding their health care experiences.

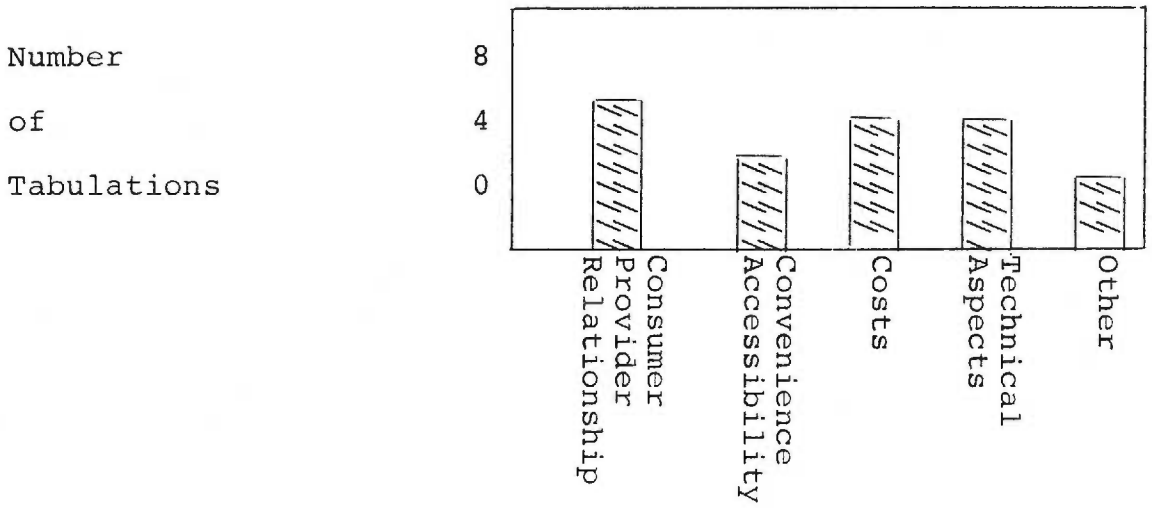


Figure 21. Comparison of consumer dissatisfaction themes in the Dermatology Clinic based upon 11 individual complaints.

Comparison of Consumer Complaints in the General Medicine Clinics and the Obstetric-Gynecology Clinics Before and After Organizational Changes

In the General Medicine Clinics, complaint comparisons were based upon a nine-month period before the clinics were changed to the team concept on July 1, 1978, (November, 1977 through June, 1978) and nine-months after the changes were instituted (July, 1978-March, 1979). Also, complaint tabulations reported did not include the following specialty clinics: Allergy, Gastroenterology, Metabolic, Nephrology, Chest, Rheumatology. These specialty clinics were not affected by the organizational changes which were instituted.

In the Ob/Gyn Clinics, the complaint tabulations reported were based upon an eight-month period before the changes occurred on July 17, 1978 (December, 1977 through July, 1978) and eight months following the organizational changes (August, 1978-March, 1979).

The comparisons of the number of complaints tallied in the General Medicine Clinics and the Ob/Gyn Clinics before and after their organizational structures were changed to a team approach revealed mixed results. Figure 22 shows the marked decrease of complaints in the Ob/Gyn clinics after the change occurred, and the marked increase in complaints following the organizational changes in the General Medicine Clinics.

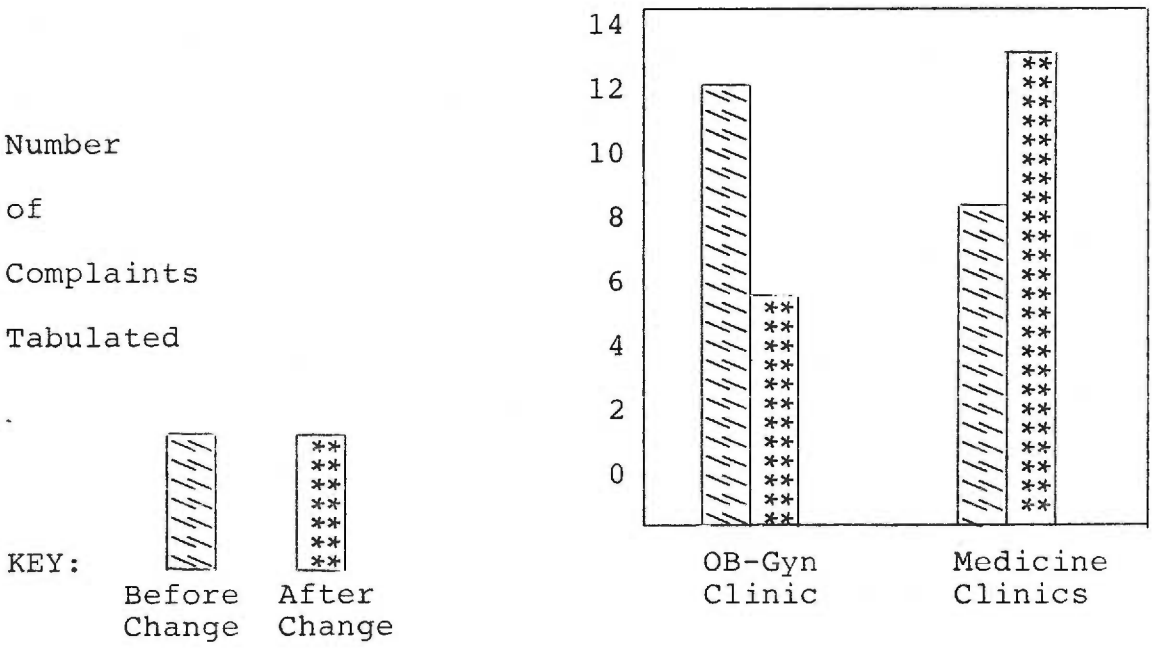


Figure 22. Comparison of the total number of consumer complaints tallied in the OB-Gyn Clinics and the General Medicine Clinics before and after organizational changes occurred.

The prediction in Proposal 3 that consumers who are scheduled for return visits to the same provider(s) will express less dissatisfaction in all four categories of patient dissatisfaction than consumers who do not see the same providers on subsequent visits was only partially supported. In the Obstetrics-Gynecology Clinics, there were fewer consumer complaints tallied under the convenience-accessibility aspects of health care and the technical aspects of health care quality following the organizational change to provider teams (See Figure 23).

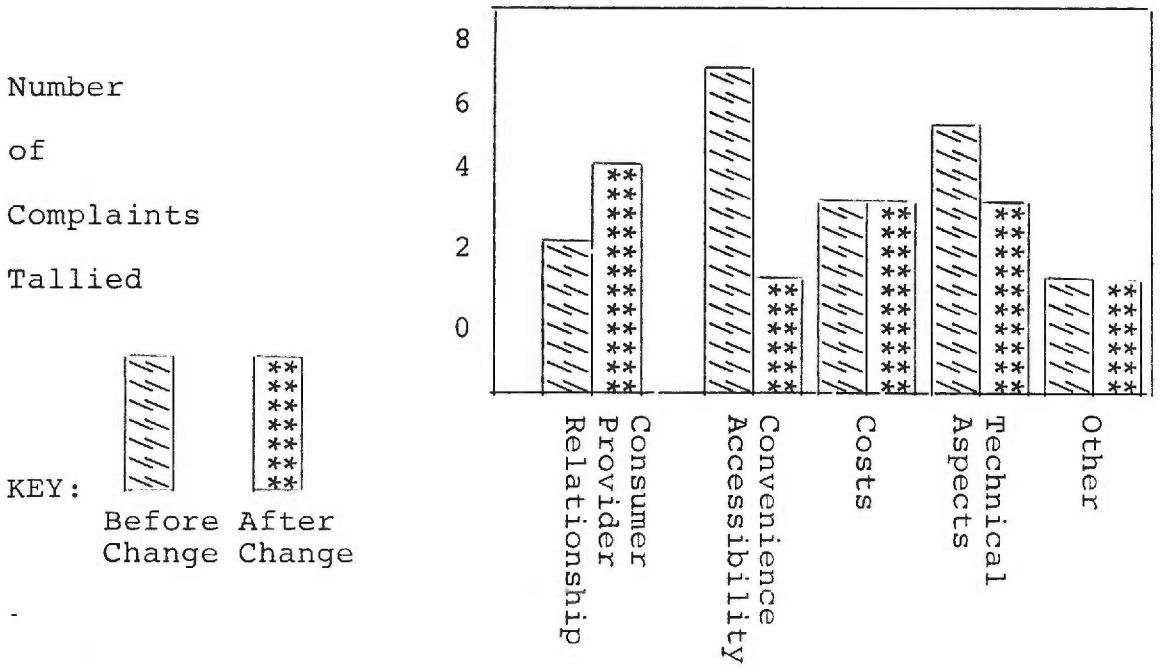


Figure 23. Comparison of total consumer complaint tabulations according to major complaint themes in the Ob/Gyn Clinics before and after organizational changes occurred.

In the General Medicine Clinics, fewer complaints were tallied under the category of the technical aspects of health care following the change to provider teams (See Figure 24). However, in the remaining comparisons of major

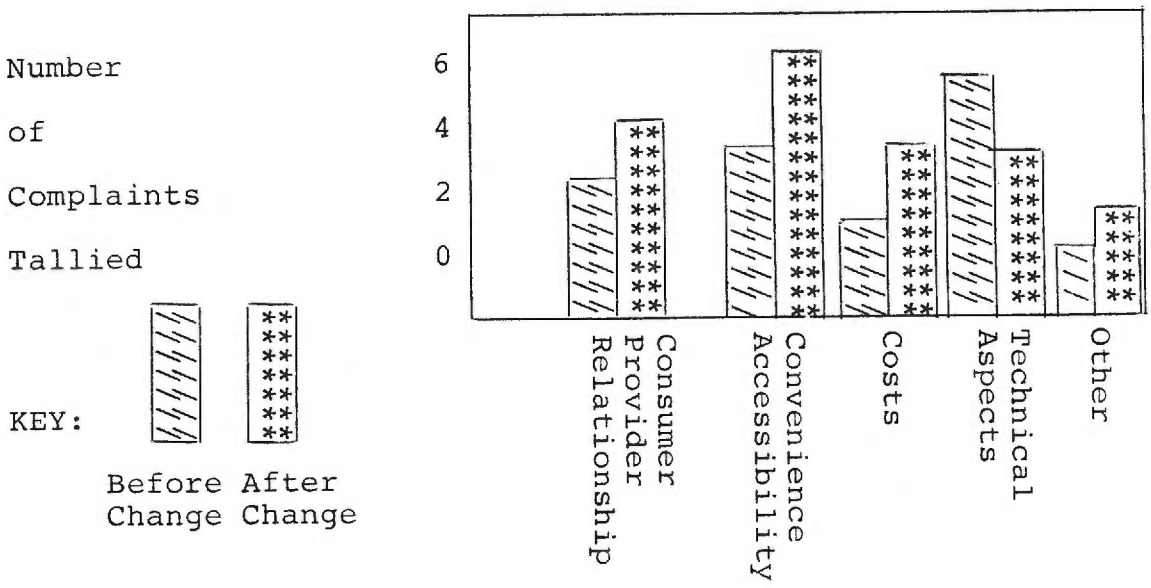


Figure 24. Comparison of total consumer complaint tabulations according to major complaint themes in the General Medicine Clinics before and after organizational changes occurred.

complaint themes themes tabulated in the Ob/Gyn Clinics and the General Medicine Clinics, consumer dissatisfactions expressed were at least equal to or greater following the changes than the dissatisfactions expressed before the changes occurred.

The following factors need to be considered in evaluating inconsistencies in the numbers of consumer complaints initiated before and after the organizational changes occurred in the Ob/Gyn Clinics and in the General Medicine Clinics.

A. The consumers' perceptions of the changes which occurred are important variables. Berkanovic and Marcus (1976) suggested that organizational changes must be perceived as changes by the patients in order for satisfaction to be altered, even though those perceived aspects of the health care system may not be totally objective. One method by which this consumer input might be implemented in the future to suggest and evaluate organizational changes would be the formation of a consumer advisory committee. An ongoing evaluation of patient complaint themes and quantities could assist such a committee in evaluating the health care delivery, but consumers also would need to be solicited for their evaluation of their health care on a regular basis. A part of this advisory committee's responsibilities might also be to find ways of notifying the consumer population of needed and pending changes, as well as planning

for ways in which feedback might be gathered from consumers to evaluate changes which have been implemented.

B. Equally as important as the consumers' perceptions of the changes are the perceptions of the provider groups. In both clinics, consumer complaint tabulations under the consumer-provider relationship increased following the changes which were implemented. Simultaneously, consumer complaint tabulations under the category of the technical aspects of health care quality decreased following the organizational changes. Internal resistance to the changes which were implemented by staff members might have had an impact on the actual delivery of health care to consumer groups. Again, the involvement of health care providers in planning, implementing and evaluating organizational changes would be essential in any organization.

C. A period of adjustment following the changes which were implemented was inevitable. Even the physical rearrangements of offices, furniture and supplies would have decreased work efficiency until regular patterns of work could again be established. Complaint themes would need to be tabulated for a longer length of time following the changes which

occurred in order to insure a minimum of influence of the adjustment period on the complaint tabulations.

D. The differences between clinics according to the number of complaints tabulated before and after the changes also need to be addressed. It is possible that the problems in each of the clinics were different prior to the changes instituted. Other variables which could have influenced the differences between clinics include variations in the levels of staff resistance to the changes, variations in the providers' and consumers' perceptions of the changes which occurred, as well as each group's perceptions of the need for the change to a new clinic structure.

E. One factor which may have reduced the overall impact of the "team concept" in each of the clinics was the continued rotation of students, faculty and consultants through the clinics.

CHAPTER IV

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Consumers are becoming increasingly involved in planning and evaluating health care, although health providers have generally maintained control over the planning and organization of the health care delivery system. Consumers' evaluation of health care need to be applied to issues of change and health care policy in organizations in order to insure viable solutions to identified problems.

One source of information regarding patient opinions and attitudes toward health care which is frequently available, but seldom used in the evaluation of health care is patient complaints. This study was conducted to demonstrate that patient complaints can be used as a part of the feedback process by which an organization evaluates and plans its health care services.

A retrospective analysis of patient complaints was conducted at the University of Oregon Health Sciences Center Outpatient Clinics using the written records of complaints which were kept by the Patient Relations Coordinator between November 1, 1977 and March 31, 1979. Complaints were categorized according to four major themes; the convenience and accessibility of health care, the consumer-provider relationship, the monetary costs of health care, and the technical aspects of health care quality. Comparisons were made

between the numbers of complaints tallied by month and year, the quantities of complaints tallied by theme, and the quantities of complaints tallied according to the clinics involved in providing care.

As reported in the results, the first portion of Proposal 1 was supported, i.e., consumers expressed more dissatisfaction regarding the convenience-accessibility aspects of health care (35.5%) than with the consumer-provider relationship (32.7%).

The second portion of Proposal 1 was not supported. This portion of the hypothesis stated that more consumers would express dissatisfaction with the monetary costs of health care than with the consumer-provider relationship. It was found that more consumers were dissatisfied with the consumer-provider relationahip (32.7%) than with the costs of care (31.4%). However, in both cases, the differences in numbers of complaints tallied under the themes compared were very slight.

Proposal 2 was not supported. This proposal stated that more consumer dissatisfaction would be expressed regarding the consumer-provider relationship than with the technical aspects of the quality of care. It was found that the greatest percentage of consumers (46.5%) expressed dissatisfaction with the technical aspects of health care

quality in comparison to the percentage of consumers who complained about the consumer-provider relationship (32.7%).

Proposal 3 was only partially supported. It was stated that consumers who are scheduled for return visits to the same providers will express less dissatisfaction in all four categories of patient complaints than consumers who do not see the same providers on subsequent visits. In the Obstetrics and Gynecology Clinics, the numbers of complaints tallied following the structural changes to provider teams which could offer increased health care continuity decreased in two categories only; the convenience-accessibility aspects of health care, and the technical aspects of health care. Consumer dissatisfaction in the category of the consumer-provider relationship increased following the organizational changes to provider teams.

In the General Medicine Clinics, the numbers of complaints tallied following the organizational changes decreased in only one category; the technical aspects of health care. It was found that the numbers of consumers initiating complaints increased under the three remaining themes following the changes to provider teams. The tabulation of consumer complaints according to month and year did not reveal any recognizable patterns. The percentages of patients initiating complaints based upon care in

specific clinics produced data which can be used by administrators, health professionals and staff members in evaluating consumer expectations regarding their health care, as well as in considering changes in the delivery of health care as it relates to specific clinics. In addition, the comparison of consumer dissatisfaction themes within the major category of the convenience-accessibility of care produced the greatest amount of patient dissatisfaction with the waiting times and with the appointment process, both of which can be manipulated administratively.

Therefore, the results of this complaint analysis have produced data which can be useful in evaluating and planning changes in the delivery of health care in the Outpatient Clinics at the University of Oregon Health Sciences Center.

On the basis of the present study, the following recommendations can be made:

1. Continued refinement of the data collection tool so that mutually exclusive sub-categories can be used to provide additional insight into consumer expectations and complaints.
2. Correlational analysis of complaint themes to provide insight into the relationship between the consumer dissatisfaction themes utilized in this descriptive study.

3. Comparison of complaint themes tabulated with "macro" events such as unemployment rates, inflation factors, political events, and major events occurring at the University of Oregon Health Sciences Center which might affect the number of consumer complaints initiated.
4. Incorporation of the data from this study into the feedback systems which are in use to evaluate and plan health care at the University of Oregon Health Sciences Center Outpatient Clinics.
5. Continued utilization of the complaint tabulation tool by the Outpatient Clinics to gather immediate information regarding patient complaints on a regular basis.
6. Active solicitation from patients regarding their expectations and desires for their health care at the beginning of each clinic visit.
7. Evaluation of the appointment making process in operation at the University of Oregon Health Sciences Center and with the appointment systems as they affect waiting times in order to make changes accordingly.
8. Formation of a consumer advisory committee, (if one does not already exist), to collect information

regarding patient expectations and their satisfaction or dissatisfaction with health care, evaluate policies and procedures, and recommend changes.

9. Replication of the complaint analysis in another setting to determine how data and methods of analysis can be applied to other locations.

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APPENDIX A

NUMBER OF CATEGORY TABULATIONS FOR EACH COMPLAINT BY MONTH AND YEAR

Month/Year	Number of Categories Tallied Per Complaint ----------Tabulations---------- 1	2	3	4	Categories Tallied: Total
Aug., 1977	16	8	2	0	38
Sept., 1977	4	1	1	0	9
Oct., 1977	8	3	3	0	23
Nov., 1977	3	4	1	0	14
Dec., 1977	8	4	3	0	25
Jan., 1978	11	6	0	0	23
Feb., 1978	12	3	1	0	21
March, 1978	10	11	1	0	35
April, 1978	7	2	1	0	14
May, 1978	5	4	0	0	13
June, 1978	8	2	2	0	18
July, 1978	5	4	1	1	20
Aug., 1978	3	4	0	0	11
Sept., 1978	6	6	1	0	21
Oct., 1978	7	8	2	0	29
Nov., 1978	4	3	0	0	10
Dec., 1978	4	2	0	1	12
Jan., 1979	9	3	0	0	15
Feb., 1979	5	2	2	0	15
March, 1979	5	1	1	0	10
TOTALS	140	81	22	2	376

APPENDIX B

TOTAL MAJOR CATEGORIES

Total Major Categories

Month/Year	Total Complaints Tabulated	Consumer Provider Relationship	Convenience Accessibility	Costs	Technical Aspects	Other
Aug., 1977	26	6	7	4	12	0
Sept., 1977	6	1	3	2	2	1
Oct., 1977	14	6	6	2	9	0
Nov., 1977	9	3	4	5	3	0
Dec., 1977	15	4	5	7	9	0
Jan., 1978	17	3	4	6	9	1
Feb., 1978	16	5	5	2	8	2
March, 1978	21	9	6	8	10	2
April, 1978	10	3	3	4	3	1
May, 1978	9	2	5	3	3	0
June, 1978	12	6	5	1	5	1
July, 1978	11	3	3	7	7	0
Aug., 1978	7	2	2	2	4	1
Sept., 1978	13	3	4	9	5	0
Oct., 1978	17	7	8	4	9	1
Nov., 1978	7	4	3	1	2	0
Dec., 1978	7	4	2	3	3	0
Jan., 1979	12	3	4	4	4	0
Feb., 1979	9	4	3	2	5	1
March, 1979	7	2	5	1	2	0
TOTALS	245	80	87	77	114	11
TOTAL PERCENTAGE OF TABULATIONS		32.7	35.5	31.4	46.5	4.0

APPENDIX C

UNIVERSITY OF OREGON HEALTH SCIENCES CENTER
OUTPATIENT CLINIC NURSING DEPARTMENT
CLINIC DAYS

Clinic Days

A.M.	Monday	A.M.	Tuesday
	Cast Room/Trauma		Anticoagulant
	Dermatology		Cast Room/Trauma
	Derm PUVA		Dermatology
	Eye Clinics		Derm PUVA
	ENT		Chemotherapy
	Medicine, General		MPG
	Rheumatology		ENT
	MPG		Medicine, General
	Anticoagulant		Obstetrics
	Obstetrics/H.R.		Pediatrics
	Pediatrics		Surgery
	Proctology		Rheumatology
	Surgery		
	Vascular		
	Minor Surgery		
P.M.	Cardiology, Area I	P.M.	Peds. Cystic Fib.
	Chest, Area II		ENT
	Peds. Cystic Fib.		MPG
	ENT		Gastroenterology
	Gynecology		Gynecology
	GYN-Tumor		Hematology
	MPG		Special Neuro.
	Orthopedics		Peds Allergy
	Peds Cardiology		Peds Ment Health
	Peds Metabolic		Peds Renal
	Urology		U.G.S.C.
	Derm Private Pts.		Urology
	U.G.S.C.		Derm Private Pts.
			Laminaria
			Neurosurgery

Psychiatry and Psychology any day from 8:00 to 5:00 p.m.

A.M. Wednesday

Cast Room/Trauma
Chemotherapy
Dermatology
Derm PUVA
MPG
ENT
Medicine, General
Lipid, Area III
Obstetrics, H.R.
Minor Surgery
Pediatrics
Peds Surgery Tumor
Surgery
Urology Tumor
Vein
Renal Transplant
Metabolic

P.M. Cardiology
Cardiac Surgery
Endocrinology
ENT
MPG
Gynecology
Orthopedics
Peds Neurology
Peds Surgery
Peds Urology
Renal Transplant
U.G.S.C.
Derm Peds
Urology Private Pts.

A.M. Thursday

Cast Room/Trauma
Chemotherapy
Dermatology
Derm PUVA
MPG
ENT
Medicine, General
Hypertension, Area III
Obstetrics
Orthopedics FU
Pediatrics
Peds Urology
Tumor (Proctology)
Tumor (Surgery)
U.G.S.C.
Private Pts. (Urology)

P.M. Allergy, Immuno.
ENT
MPG
Gynecology
Neurology
Plastic Surgery
Surgery Follow-up
U.G.S.C.
Urology
Well Baby
Derm/Surgery

Area I - flow over

A.M. Friday

Anticoagulant, Area I
Cast Room/Trauma
Dermatology
Derm PUVA
MPG
ENT
Medicine, General
Obstetrics
Minor Surgery
Pediatrics
Peds Endocrine
Surgery
Tumor Board (Surgery)
Area III - Lipid - PRN

P.M. Derm/Surgery
Derm Tumor Board (last Friday of month)
ENT
MPG
Gynecology
Orthopedics
Peds Hematology
Thoracic Surgery, (Pacemaker)
U.G.S.C.
Nephrology, Area I
Headache Screening, Area II
Private Pts. Urology
Peds Chemotherapy (every other week)

APPENDIX D

COMPLAINT TALLY CATEGORIES

Clinic Name	Complaint Number	Cons.-Prov. Relationship			Convenience-Accessibility								Costs				Technical Aspects								Other		Date	Patient Number
		1.1	1.2	1.3	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	3.1	3.2	3.3	3.4	4.1	4.2	4.3	4.4	4.5	4.6	4.7	4.8	5.1	5.2		

AN ABSTRACT OF THE THESIS OF

Rita J. Snyder

For the MASTER OF NURSING

Date of Receiving this Degree: June 12, 1981

Title: ANALYSIS OF PATIENT COMPLAINTS IN AN OUTPATIENT SETTING

APPROVED: [redacted]

Marie C. Berger, Ph.D., Thesis Advisor

The purpose of the present study was to demonstrate that patient complaints can be used as a part of the feedback process by which a health care organization evaluates and plans its health care services. Thus, consumer satisfaction and dissatisfaction was shown to be influenced by organizational policies and procedures. Another purpose of this study was to generate hypotheses and to suggest areas for future research.

A retrospective analysis of patient complaint records was conducted in the Outpatient Clinics of a University health care center between November 1, 1977 and March 31, 1979. Complaints were categorized according to four major themes; convenience and accessibility factors, monetary costs, technical aspects of health care quality, and the consumer-provider relationship. Comparisons were made between the numbers of complaints initiated by month and year, the quanitities of complaints tallied by theme, and the numbers of complaints tallied according to the specific clinics involved in providing care.

It was found that more consumers expressed dissatisfaction with the technical aspects of health care quality than with the three remaining themes of complaints. In addition, consumers expressed considerable dissatisfaction with the appointment process, and with the waiting times in the clinics, demonstrating that the data can be utilized by the clinics in making changes in policies and procedures.

Continued use of the complaint theme tabulation was recommended for continued use by health care providers in evaluating and planning health care.