Published in final edited form as:

J Patient Saf. 2013 December ; 9(4): 224–231. doi:10.1097/PTS.0b013e3182913837.

Patients Do Not Always Complain When They Are Dissatisfied: Implications for Service Quality and Patient Safety

Matylda Howard, HlthScD, MBA (Quality Mgt), BNg, GradCert HEd[*], **Mary Louise Fleming, PhD, MA, BEd, Dip Teach**[†], and **Elizabeth Parker, EdD, MSW, BA**[†]

[*]Faculty of Health, School of Nursing, Griffith University, Queensland, Australia.

[†]Faculty of Health, School of Public Health and Social Work, Queensland University of Technology, Queensland, Australia.

Abstract

Objective: This study aimed to explore the actions taken by patients who had been admitted to an acute care Queensland hospital and experienced dissatisfaction with service delivery. It is proposed that before complaints can be used as part of a strategy to inform health service improvement and ultimately ensure patient safety, an understanding of the effectiveness of the complaints handling process from the patient's perspective must be gained.

Methods: In-depth qualitative interviews using a phenomenological exploration were undertaken. The theoretical framework supporting the thematic analysis of the interview data was drawn from Lazarus's cognitive emotive model of coping. Analysis of the research data, aided by Leximancer software, revealed a series of relational themes that supported the interpretative data analysis process undertaken.

Findings: In 16 interviews, the study outcomes identified that 15 of the participants did not voice their complaint at the time of the event, but after the event, they stated they wished that they had reacted differently and complained at the actual point in time that they were dissatisfied. The themes that emerged that reflected potential lost opportunities included issues with ineffective communication, being treated with disrespect, inconsistent standards of care, perceptions of negligence, and lack of information about how to make a complaint.

Conclusions: Our findings suggest that health-care professionals should take a more active role in identifying and responding to patients who are experiencing dissatisfaction but are not actively complaining. This level of vigilance and responsiveness will ensure opportunities to improve health service delivery, and patient safety are not lost.

Keywords

communication; complaints; emotions; qualitative

Correspondence: Matylda Howard, HlthScD, MBA (Quality Mgt), BNg, GradCert \HEd, Griffith University, Nathan Campus, School of Nursing, 170 Kessels Road, Nathan QLD 4111, Australia, (Matylda.howard@griffith.edu.au).

The authors disclose no conflict of interest.

There is no disputing the relevance that an effective complaints handling system can have to revealing both actual or potential incidents of concern[1–5] and the information that can be ascertained from complaints data cannot be underestimated. It would be reasonable to propose that most health-care organizations would be able to confirm the relevance of collecting complaints data. The same, however, cannot necessarily be said of the commitment toward giving patients the opportunity to voice their concerns before the issue develops into a complaint.

Over the last 20 years, a series of significant events have undergone public scrutiny, highlighting the inadequacies in complaints handling by health services in Australia. A major study commissioned by the Commonwealth Government in 1991 was the *Review of Professional Indemnity Arrangements for Health Care Professionals*, which examined the "adequacy of compensation and funding arrangements for health care misadventures in Australia."[6 p10] Several recommendations emerged from this report, but of particular interest was the recommendation for "establishing effective and accessible complaints and disciplinary processes."[6 p43]

Twenty years on, the measurement of patient satisfaction with health-care services is a well-accepted strategy to evaluate the quality of care being delivered. However, the majority of research into complaints handling has focused predominately on the complaining consumer and the analysis of findings from satisfaction surveys.[7–9] Findings from marketing and quality management research over the last 3 decades indicate that two-thirds of consumers do not complain when they are dissatisfied.[10–14] However, there is little evidence to suggest what this number could be when attributed to patients and the effect this has had in terms of lost opportunities to improve service and ensure patient safety.

The evidence that is available has clearly identified that a significant number of reported incidents of concern have resulted from communication failures.[15,16] This fact must raise alarm bells for all health-care providers and highlight the importance of having robust systems in place to enable all patients to complain effectively and to do so at the time of experiencing dissatisfaction.

METHODS

Design and Setting

A phenomenological perspective representing an interpretative approach from a Heideggerian standpoint guided this study. This experience means "being there," and it is a way to understand the experience of individuals who have become conscious of something that has occurred in their lifeworld.[16–18] As part of the interpretative endeavor of this study, Lazarus' cognitive-emotive model of coping with situational challenge (Fig. 1) was drawn on to provide a contextual understanding of the emotions discussed by the study participants.

Essentially, Lazarus' cognitive appraisal theory reflects the way human beings cope with life challenges and stresses.[19–21] Cognitive appraisal is a key part of the emotional experience, and studies to date show that anger is a main driver of complaining behavior, whereas the experience of resignation is the main driver of noncomplaining behavior.[22–24] An understanding of the emotions that drive patient complaint behavior may provide invaluable insights into early predicators of feelings of dissatisfaction, before resignation sets in.

Sampling and Recruitment

A purposive sampling strategy was used to enlist participants with direct knowledge of the experience of complaining. This study was approved by Queensland University of Technology research ethics committee. All participants were assigned a unique identifier number and a pseudonym.

A 3-stage approach was used to guide the recruitment strategy,[25,26] with the average duration of the interviews being 45 minutes. A total of 62,000 words represented the participants' narratives, and the transcription process was undertaken as soon after the interview as possible.

Stage 1—Preparation, Sampling Criteria

The primary criteria for the sampling strategy was to include people who

- had been an in-patient in a Queensland hospital or an advocate of a person who had been an in-patient in a Queensland hospital.
- had made a complaint, either written or verbal, to any agency during 1997–2007 about some aspect of their hospital stay.
- were older than 18 years.
- would be willing to participate in a face-to-face interview unless a significant reason could be established to warrant an alternative format.
- understood the length of time to undertake the interview was not prescriptive. All data would be analyzed, as long as the participant was able to relay their experience within the timeframe that suited them to tell their story.
- agreed to sign a consent form, indicating that they understood the information sent to them about the study and to confirm their willingness to be part of this study.
- No incentives were provided to participants.

Stage 2—Making Contact, Establishing Confirmation

A newspaper recruitment advertisement "seeking volunteers" was placed in 10 local newspapers throughout Queensland. The advertisement ran over a 4-month period. A Website was developed to provide potential participants and other interested parties with more information about the study. Potential participants who wanted to request an information package were able to create an automatic request via the Website's email link. A total of 47 information packages were distributed to interested parties. Twenty-two participants requested to proceed with the screening process for inclusion in the study. Exclusion criteria concluded that 4 of the 22 participants were unsuitable because their inpatient stay and complaint concerned another state in Australia or because the issue had occurred outside the acute health-care sector. Although 18 participants were selected for inclusion, 2 were unable to continue participating in the study.

The final 16 participants were all provided with information packages about the study, the consent process, an interview guide to the types of questions that could be explored in the interview, and a request for demographic information.

Stage 3—Providing Follow-Up, Feedback

The primary feedback and information update process was facilitated by a Web page. This Web page was updated as new information became available. All participants were provided with the Web page URL and contact details if they required any further information about the study. After the interviews, no further contact was made by any of the participants. Details of all research activities involving dissemination of the study via the conferences attended were also uploaded to the Web page (Table 1).

Introduction to the Analysis

The analysis process involved 3 levels, the first level known as the naive reading involved reading the interview transcripts several times over. The rationale for this was to try to grasp the overall meaning of the text. The understanding that was gained at this level guided level 2 of the structural analysis. At this level, the themes were determined in context with the first level of understanding, and then, they were further condensed to confirm or negate any assumptions that were made during the naive reading.[25] Finally, at level 3, a table of subthemes was developed, and the interviews were examined in relation to the emerging common themes to reveal the superordinate themes that were either shared or not.

Establishing Rigor

Attention to methodological rigor for this study has been guided by the direction provided by Sandelowski, who proposed that "qualitative inquiry may be viewed as blending scientific rules and artistic imagination."[26] Although it is important to maintain the artistic foundation that qualitative research offers, one must also be prepared to be transparent and credible in the methodological approach taken. While undertaking this study, there have been many occasions where conflicts have occurred concerning wanting to adhere to "known" or "expected" criteria of rigor, yet acknowledging that these were sometimes at odds with the interpretive nature of the methodology used.[27]

A strong need to keep the interpretative nature of the narratives closely connected between the participants and the primary researcher naturally occurred. It was felt that other influences, such as other reviewers, might diminish or alter the thematic interpretations that emerged. Although this was the approach taken, recognition of this deviation from a traditional approach to undertaking the hermeneutic circle as part of the interpretative approach to this study was identified as a potential limitation. Alternative options were examined to identify whether there were any other processes that could assist in validating the data being examined. The use of a text analysis software tool in combination with the interpretative approach was considered to be an appropriate alternative to using multiple reviewers. The software, called Leximancer, is a tool that can be used to analyze the content of collections of textual documents and to display the extracted information visually. The information is displayed by means of a conceptual map that provides a bird's-eye view of the material, representing the main concepts contained within the text and information about how they are related. The map also allows one to view the conceptual structure of the information and to perform a directed search of the documents to explore instances of the concepts or their interrelationships.

FINDINGS

The narratives of the 16 participants were the focal points of the study; however, important information was also ascertained by understanding how the individuals concerned were represented and lived in the "world." The mean age of the participants was 49.4 years, with a standard deviation of 17.3. Although the demographic findings revealed a representation of participants who made a complaint emanating from a variety of admission needs, the participants were only representative of English-speaking participants from Australia, England, and New Zealand. The participants of this study made more complaints about public hospitals than private hospitals by a ratio of 3:1. Whereas all the participants made a verbal or written complaint to the hospital where the complaint occurred after the hospitalization, 7 also lodged a written complaint with other agencies.

The events described by the participants ranged from catastrophic events, which in some cases, led to death and, at the other end of the spectrum, to events where the participants were treated rudely. The connection between the participants was that the experience that precipitated the complaint was the significant event for them and that the actual trigger of the complaint did not diminish its significance to that individual.

> …Well, the reason I made a complaint in the first place is because I did not actually like the way that I was treated. I was treated, I felt like a piece of meat…"
>
> …I swear her death was preventable and the doctor and nurse involved in her care should have been subject to disciplinary action…"

Relational Statements and Emergence of Superordinate Themes

The focus of the analysis was the identification of relational themes. Although all of the narratives were unique in their representation of their experiences, they were also connected by common relational themes. Most of the narratives featured repetitions of the same subtheme, with only slight variations in the wording; the principle representation of that subtheme is what was extracted to represent the relational theme. The identification of these relational themes supported the emergence of the following 5 superordinate themes (Table 2): ineffective communication, being treated with disrespect, inconsistent standards of care, perceptions of negligence, and lack of information about how to make a complaint.

Learning From Patients to Inform Service Improvement

Although these 5 superordinate themes were identified from the collective narratives, one of the most positive points that emerged on an individual basis was that participant's wanted to influence change.

> …I think if people take my comments in a constructive way then it will be okay, I think there is nothing worse than getting into a situation where you get really upset about something where you have a valid reason for making a complaint and then you don't make a complaint for whatever reason then you whinge about it later to somebody else…"

This recognition that patients do want to play an active role in improving health-care service needs to be championed. The participants indicated that they have clear insights into what they perceive as being good or bad representations of care.

> …Iam a trained nurse be it a long time ago and maybe the nurse in me knows too much, but I felt that many of things could have been easily remedied with a little bit of thought …"

> …What you need is some sort of concrete link between the patient and the process and there isn't that link now, the process exists in its own little world and the patient exists in their own little world and the two worlds don't touch…"

Of interest was that none of the participants expressed during the interviews that they went into the hospital expecting to have a bad experience. With this understanding, it would be reasonable to assume that patients are accurate barometers of the emergence of positive or negative issues once they become an inpatient.

Finding Their Voice

The findings revealed that 15 of the 16 participants did not voice their complaint at the time of the event, when they experienced dissatisfaction with service delivery. The one participant that did speak up, an elderly man provided some insights into why he did speak up, for example, he stated the following:

> …I don't suffer fools lightly…the management don't frighten me a bit, not this fella…"

Despite this gentleman's display of confidence and his self disclosed capacity to respond at the time of the issue, he still expressed a concern that based on his previous experiences, he was not confident that his issue would be dealt with appropriately.

> …The time before this last time I had an issue I went and found the complaints lady and I told her all about my concerns with the staff…she sat there and listened to me but that was it…"

This gentleman did comment that his previous occupation prepared him to be… not scared of anyone…. and he did recognize that, even with this type of approach, he does not always get a resolution …they fight you all the way…

Another finding showed that many of the participants had wished, in hindsight, they had had reacted differently. Another participant stated:

> …I'm not a person that suffers in silence if someone does something to upset me I make it, make it known as soon as I can and in most cases immediately. I have a tendency to speak possibly before I think a bit, but I'm a firm believer in if you

> don't tell someone they are doing something wrong they don't know they are doing it wrong and they will carry on doing it because they think what they are doing is right and it isn't …"

Despite such a strong reflection about how he perceived himself, at the time of the issue that he shared for this study, the participant did not react in the way that he expected he would.

Although the remainder of the participants all eventually made a complaint, it was after the fact; and in some cases, it was days, weeks, months, or years after the initial event had occurred.

This outcome regarding how many of the study participants did not voice their complaint at the time of experiencing the issue provides some insight into how patients view themselves in terms of their consumer role within health care. The findings revealed that many of the participants viewed themselves as being assertive, but this was not reflected by their behavior. This could indicate that being a patient in a hospital does not have the same "customer/consumer" implications as someone having a bad dining experience, for example. So, while a diner who is unhappy with his meal could become angry and then make a conscious decision to send his meal back to demonstrate that he is unhappy with the service, it would appear that the participants in this study did not believe that they had that same type of recourse. Perhaps …"patients must learn to become their best advocates for good health care,"[28 para 3] and not just accept what they receive.

Ineffective Communication

Overall, the most significant theme that emerged from the narratives was the issue of the participants feeling that they were not being listened to nor supported to voice their concerns or complaints, as the following extracts reflect:

> …I just wanted someone to tell me what was going on and how were they going to help me…"
>
> …I had to find my voice and stand up and get people to listen to me…"
>
> …I kept saying to the midwife I don't want this, this is not what I want to happen and so on…"
>
> No-one really cared enough to listen…"
>
> …I needed someone to talk to…"
>
> …who is in charge, who do you talk to?"

The study patients articulated the need for health-care system reform; they primarily wanted to be listened to, to be acknowledged, to be believed, for people to take ownership if they had made a mistake, for mistakes not to occur again, and to receive an apology.

DISCUSSION

In the period from 1989 to 2009 in Australia, a number of studies were undertaken from a range of health-care sectors investigating a variety of patient outcomes and their satisfaction with different aspects of their service. An analysis of these studies indicated that a retrospective approach, using questionnaires, surveys, and case studies, was identified in 68% of the studies (n = 41) reviewed. The remainder of the studies used a mixed methodological approach. Overall, 5 distinct categories were recognized across the 41 studies. The majority of the studies (62%) sought to confirm satisfaction with their particular service area. Fourteen percent focused on evaluating quality or change management initiatives. The remainder of the studies included investigating the identification of organizational impacts (10%), understanding the influences of satisfaction (7%), and the actual experience of the complainant making a complaint (7%). Despite this relative abundance of health services evaluating and reporting on patient satisfaction or effectiveness of service delivery, there are identifiable research gaps. For example, an understanding of the cognitive decisions made by patients that influence whether they are satisfied or dissatisfied with the care that they are receiving has had limited research attention thus far.

The emotion of anger has previously been firmly linked to complaining behavior[29] yet in this study, the emotion of anxiety not anger was the dominant emotion identified. This finding is valuable as it suggests that patients react differently from consumers in other service areas. This insight has the potential to inform and assist the relationship that develops between the patient and their service provider. An understanding that patients do not instinctively express anger when they are dissatisfied should alert the service provider that vigilance must be directed toward identifying other predicators of dissatisfaction, such as expressions of anxiety.

This approach has the potential to identify those patients who show signs of anxiety or distress and yet do not turn those feelings into formal complaints. If these signs can be identified at the time the patient is experiencing dissatisfaction and they can be shown to be linked to a specific issue, then they could be used as the basis for influencing an improvement in service in "real time."

A concerning factor from an analysis of the literature on complaint handling is that the issue of ineffective communication has been identified repeatedly over the last 2 decades as a major contributing factor to patients making complaints and being "the cause of systems failures and human errors."[13 p.148] For example, a retrospective study conducted in 2001 representing a 30-month period of patients at a major Australian hospital revealed that 57% of the 1308 complaints investigated were related to poor communication or to the treatment provided.[29] The findings from the study being presented in this paper also identified both of these themes but as separate issues. So, although there is insufficient evidence to confirm how much of the (57%) 2001 study concerned communication and how much was related to treatment issues, the significant factor here is that, a decade later, these issues are still the most prominent factors being reported related to complaints.

With this evidence as basis, health service providers need to identify and assess their listening capabilities to ensure they are not missing out on the valuable insights that their patients might be able to share with them. Essentially, listening is a key communication skill required to facilitate quality care.[30,31]

Implications for Future Research

The findings of this study have highlighted and extended important information about complaints handling from a Queensland patients perspective. However, limitations were also identified. The sample size was limited in terms of location and the fact that there was no culturally and linguistically diverse (CALD) or indigenous representation. A broader sample and greater diversity of participants that extends throughout Queensland would be valuable to test and compare the findings identified from this study. This proposed study aligns well with the Australian Commission on Safety and Quality in Health Care, where they acknowledge that

> …An understanding of the actual experiences of patients is essential for an accurate appreciation of the overall safety and quality of care. Patients have a unique perspective regarding the health care that they receive, and can provide information and insights that healthcare workers might not otherwise have known…[32 p3]”

Once the above findings have been identified from a broader Queensland sample, it would be appropriate to consider implementing this study in other states in Australia. This approach would provide valuable insight into whether systemic issues are occurring across Australia.

The opportunity to extend this study to other health-care settings, for example, residential aged care communities is significant. In line with the issues associated with our aging population and the impact of chronic disease in Australia, this target group are the most likely to be current and future consumers in the acute-care health sector. Understanding and exploring their experiences should provide valuable insight into this target group’s expectation when they are in hospital.

CONCLUSIONS

The primary purpose of this study was to understand the “lived experience” of individuals who had complained about some aspect of their inpatient stay in an acute care hospital in Queensland. This exploration has identified many relevant issues in terms of patient experiences and the issues they identified that are related to complaint handling in the current health-care system in Queensland, Australia.

For these identified issues in complaint management to be redressed, the paradigm shift must go beyond regurgitating complaint data metrics in percentages per patient contact, toward a concerted effort to evaluate what the complaint data are really saying. The voices of the taciturn dissatisfied patients need to be encouraged so that their complaints are heard at the time they are experiencing dissatisfaction. This opportunity to identify a more positive and proactive approach in encouraging our patients to complain when they are dissatisfied has the potential to influence real-time improvements and patient safety.

APPENDIX.: Participants' Details

Categories	n (%)
Sex	
Male	n = 5 (31)
Female	n = 11 (69)
Actual patient made the complaint	n = 13 (81)
Advocate of patient made the complaint	n = 3 (19)
Age group (yr)	
18–24	n = 1 (6)
25–34	n = 2 (13)
35–49	n = 5 (31)
50–64	n = 4 (25)
65–79	n = 4 (25)
80 and older	n = 0 (0)
Country of birth	
Australia	n = 12 (75)
UK	n = 3 (19)
New Zealand	n = 1 (6)
Greece	n = 0 (0)
Italy	n = 0 (0)
Others—please specify	n = 0 (0)
Agencies involved in complaint	
Original hospital where complaint originated	n = 16 (100)
Ombudsman	n = 2 (13)
Member of parliament	n = 3(19)
Crime and misconduct commission	n = 2 (13)
Quality and complaints commisssion	n = 5 (31)
Legal aid	n = 3(19)
Mental health services	n = 2 (13)
Department of child safety	n = 2 (13)

REFERENCES

1. Brouwer GE. Good practice guide to complaint handling for Victorian public sector agencies. 2007;57.
2. Hsieh SY, Thomas D, Rotem A. The organisational response to patient complaints: a case study in Taiwan. Int J Health Care QA. 2005;18:308–320.
3. Nisselle P Managing medical indemnity: must we choose between quality assurance and risk management? Med J Aust. 2004;181:64–65. [PubMed: 15257637]
4. Romios P, Newby L, Wohlers M, et al. Turning wrongs into rights: learning from consumer reported incidents: An annotated literature review. Department of Health and Ageing, Commonwealth of Australia; 2003.
5. Wilson L, Fulton M. Risk management: how doctors, hospitals and MDOs can limit the costs of malpractice litigation. Med J Aust. 2000;172:77–80. [PubMed: 10738478]

6. Taskforce on Quality in Australian Health Care. Final Report to the Hon Dr Michael Wooldridge MP, Minister for Health and Family Services. Commonwealth of Australia; 1996.
7. Marcinowicz l, Chlabicz S, Grebowski R. Patient satisfaction with healthcare provided by family doctors: primary dimensions and an attempt at typology. BMC Health Services Research. 2009;9:63–68. [PubMed: 19371417]
8. Otani K, Waterman B, Faulkner K M, et al. Patient satisfaction: focusing on “excellent”. J Healthcare Manage. 2009;54:93–103.
9. Bodey K, Grace D. Segmenting service “complainers” and “non-complainers” on the basis of consumer characteristics. J Services Market. 2006;20:178–187.
10. Chulmin K, Sounghie K, Subin I, et al. The effect of attitude and perception on consumer complaint intentions. J Consum Market. 2003;20:352–371.
11. Davidow M Organizational responses to customer complaints: what works and what doesn’t. J Serv Res. 2003;5:225–250.
12. Phau I, Baird M. Complainers versus non-complainers retaliatory responses towards service dissatisfactions. Market Intell Plann. 2008;26:587–604.
13. Thoegersen J, Juhl HJ, Poulsen CS. Complaining: a function of attitude, personality, and situation. Psychol Market. 2009;26:760–777.
14. Nyer PU. An investigation into whether complaining can cause increased consumer satisfaction. J Consum Market. 2000;17:9–19.
15. Stauss B The dimensions of complaint satisfaction: process and outcome complaint satisfaction versus cold fact and warm act complaint satisfaction. Manag Serv Qual. 2002;12:173–183.
16. Denham CR, Dingman J, Foley ME, et al. A. Are you listening…Are you really listening? J Patient Saf. 2008;4:148–161.
17. Van Manen M Phenomenology of practice. Phenomenology and Practice. 2007;1:11–30.
18. Wojnar DM, Swanson KM. Phenomenology: an exploration. J Holistic Nurs. 2007;25:172–180.
19. Lazarus RS. From psychological stress to the emotions: a history of changing outlooks. Annu Rev Psychol. 1993;44:1–22. [PubMed: 8434890]
20. Stephens N, Gwinner KP. Why don’t some people complain? A cognitive-emotive process model of consumer complaint behavior. J Acad Market Sci. 1998;26:172–189.
21. Watson L, Spence MT. Causes and consequences of emotions on consumer behaviour: a review and integrative cognitive appraisal theory. Eur J Market. 2007;41:487–511.
22. Bagozzi RP, Gopinath M, Nyer PU. The role of emotions in marketing. J Acad Market Sci. 1999;27:184–206.
23. Chebat JC, Davidow M, Codjovi I. Silent voices: why some dissatisfied consumers fail to complain. J Serv Res. 2005;7:328–342.
24. Lazarus RS. Emotion and Adaptation. New York, NY: Oxford University Press; 1991.
25. De Witt L, Ploeg J. Critical appraisal of rigour in interpretive phenomenological nursing research. J Adv Nurs. 2006;55:215–229. [PubMed: 16866813]
26. MacDougall C, Fudge E. Planning and recruiting the sample for focus groups and in-depth interviews. Qual Health Res. 2001;11:117–126. [PubMed: 11147158]
27. Sandelowski M Sample size in qualitative research. Res Nurs Health. 1995;18:179–183. [PubMed: 7899572]
28. Blumenberg L Patients as consumers and advocates. 3, 2003 Available at: http://thyroid.about.com/library/news/bladvocate.htm. Accessed April 2, 2012.
29. Anderson K, Allan D, Finucane P. A 30-month study of patients complaints at a major Australian hospital. J Qual Clin Pract. 2001;21:109–111. [PubMed: 11856405]
30. Stein-Parbury J. Patient and Person, Interpersonal Skills in Nursing. 4th ed. Australia: Elsevier; 2009.
31. Tamparo CC, Lindh WQ. Therapeutic Communication for Health Care. 3rd ed. Stanford, CT: Delmar Cengage Learning; 2008.
32. Windows into Safety and Quality in Health Care 2010 Australian commission on safety and quality in health care web site, Available at: http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/com-pubs_windows_sandq_2011. Accessed January 30, 2012.

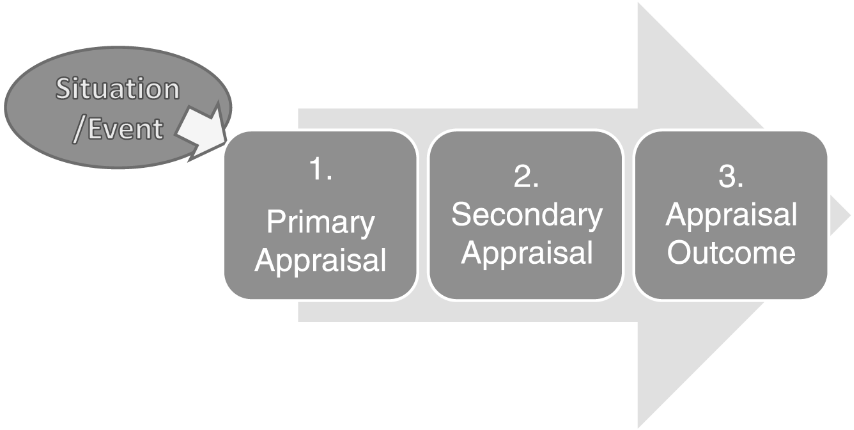


FIGURE 1.

How to understand the cognitive appraisal process (adapted from[19,22]:) A, We think about the situation/event and how it will affect us. B, We determine how we will cope or respond to the situation or the event. C, The emotion or coping strategy is expressed.

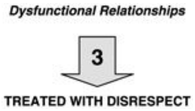
TABLE 1.

Interview Guide

1. Can you tell me about the reason/s why you made a complaint about your hospital stay?
2. Can you tell me about your knowledge of the hospital complaint system?
3. What type of encouragement did you receive from the staff to provide feedback regarding your care throughout your hospital stay?
4. What aspects of the complaints handling system were you especially satisfied, or dissatisfied, with?
5. Can you tell me how what happened to you has affected you—for example, inconvenience, personal trauma, physical or psychological issues?
6. Can you tell me what you hoped to achieve by making a complaint?
7. Can you tell me about any barriers you faced having your complaint heard or resolved?
8. Can you make any suggestions for better management of how your complaints or the process in general should have been handled?
9. Can you tell me about the emotions you experienced while you were engaging in the complaints process and after you lodged the complaint?
10. Can you tell me about what coping strategies you used while you were engaging in the complaints process and after you lodged the complaint?
11. If you were able to improve the complaints handling process what would you recommend?

TABLE 2.

Emergence of Superordinate Themes

Examples of Relational Statements	Subordinate and 5 Superordinate Themes
• They just did not listen. • Hard to get information about what was happening to me • Who is in charge, who do you talk to? • I just wanted someone to tell me what was going on and how were they going to help me. • Fired all these questions at me, not prepared to listen • I needed someone to talk to. • I had to find my voice and stand up and get people to listen to me. • Having to fight to be heard • It was hard to get information about what was happening to me.	
• Poor standard of care • No confidence in graduate nurses, where are all the staff with experience? • Nurses were too busy. • Not the same sort of care that you received by nurses years ago • I would have been better off in a public hospital. • There was no standard procedures carried out. • Standard of care provided was not right. • Different nurses every day • No consistency in care • I was not receiving the attention or care that I should.	
• Treated as a test subject not as an individual • I felt like I was a nuisance. • I was so fearful and scared I did not feel as if anyone cared. • I was left to my own devices. • No one cared enough to listen. • Very short and very rushed • Treated as a complainer • I cannot believe this happened to me I am not a bad person… • I found it extremely degrading.	
• No information about complaints system, had to work it out on my own • No one to tell you what to do • No one to identify as being in charge to tell that you are unhappy with care • No information on who to speak to • I worked through the system, and by trial and error, I got different people to listen to me. • I had to work it out; I spoke to everyone who would listen to me. • I was sent from pillar to post. • No one offered to listen to me.	
• Where is their duty of care? • I was treated very badly. • No one cares. • Poor standard of care • We were treated badly, and I did not have the opportunity to give informed consent. • How could they get it so wrong? • So many issues went wrong? • Her death was preventable. • You know there is a saying that says doctors bury their dead, no what is it, doctors bury their mistakes • I am really worried that I am going to take him out of here in a box.