Managing patients' complaints in China: what went wrong?

Journal:	*BMJ Open*
Manuscript ID:	bmjopen-2014-005131
Article Type:	Research
Date Submitted by the Author:	25-Feb-2014
Complete List of Authors:	Jiang, Yishi; Fudan University, School of Public Health; Shanghai Maternal and Child Health Center, YING, Xiaohua; Fudan University, School of Public Health ZHANG, Qian; Fudan University, School of Public Health Tang, Sirui; Fudan University, School of Public Health KANE, Sumit; Royal Tropical Institute, KIT Development Policy & Practice MUKHOPADHYAY, Maitrayee; Royal Tropical Institute, KIT Development Policy & Practice QIAN, Xu; Fudan University, School of Public Health
Primary Subject Heading:	Qualitative research
Secondary Subject Heading:	Health policy
Keywords:	QUALITATIVE RESEARCH, HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

Title page

1. Title of the article.

Managing patients' complaints in China: what went wrong?

2. Full name, postal address, e-mail, telephone and fax numbers of the corresponding author.

The corresponding author: Xu QIAN

Postal address: Mailbox 175, 138 Yi Xue Yuan Road, Shanghai, 200032, P. R. China

Tel: 86-21-54237267 Fax: 86-21-64174172

Email: xqian@fudan.edu.cn

3. Full names, departments, institutions, city and country of all co-authors.

1) Yishi JIANG: School of Public Health, Fudan University, Shanghai, China; Shanghai Maternal and Child Health Center, China

2) Xiaohua YING: School of Public Health, Fudan University, Shanghai, China

3) Qian ZHANG: School of Public Health, Fudan University, Shanghai, China

4) Sirui Rae TANG: School of Public Health, Fudan University, Shanghai, China

5) Sumit KANE: KIT Development Policy & Practice, Royal Tropical Institute, Amsterdam, Netherlands

6) Maitrayee MUKHOPADHYAY: KIT Development Policy & Practice, Royal Tropical Institute, Amsterdam, Netherlands

7) Xu QIAN: School of Public Health, Fudan University, Shanghai, China

8) HESVIC team authorship

4. Up to five keywords or phrases suitable for use in an index (it is recommended to use MeSH terms).

Patient Complaints; Complaint Handling Systems; Quality Improvement; Government Regulation; China

5. Word count - excluding title page, abstract, references, figures and tables.

6566

Abstract

Background: Effective management of patients' complaints is to improve the quality of healthcare. In China, the number of patients' complaints and disputes has been rising recently and become a social issue.

Objectives: To examine the handling system for patients' complaints and identify and analyse barriers to effective management in China.

Methods: A literature review was firstly conducted to understand the current handling system for patient complains. Then to explore the hampering factors, thirty-five semi-structured interviews were performed with key informants including policy-makers, hospital managers, health providers, users and other stakeholders in Shanghai. The snowball sampling method was used to reach information saturation.

Findings: The Chinese handling system for patients' complaints has been established in the past decade. Hospitals undertake the most responsibility of patients' complaint handling. Barriers to effective management of patient complaints are divided into four stages. The barriers to initiating the complaint process include low awareness of users about the systems. Barriers in the handling process include poor capacity and skills of healthcare providers, incompetence and powerlessness of complaints handlers and non-transparent exchange of information. Barriers to complaint solution stage include conflicts between relevant actors and regulations and unjustifiable complaints by patients. Barriers to post-complaint institutional changes include weak enforcement of the regulation, deficient information for managing patients' complaints and unwillingness of the hospitals to effectively handle complaints.

Conclusions: Barriers to the effective management of patients' complaint vary at the different stages of complaint handling, from the user and provider side, as well as system issues. Information, procedure design, human resources, system arrangement, unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management.

Article summary

Strengths and limitations of this study

This study explores the structure of managing patients' complaints in China and the views of key stakeholders on the barriers to effective complaint management. These findings are essential to plan strategy to improve the complaints system. Our study provides a new dimension of understanding to the complaints management system in China, a developing country. We explore the barriers through in-depth interviews with almost all stakeholders, not only health professionals. What we found will help develop procedures for more effective complaint management and to further improve the quality of care in China and other developing countries.

The selection of participants might bring some bias to our studies. Our focus was on the hospital, so some types of respondents may have been under-represented. For example, there are many other relevant actors, whereas we could only select important ones and we did not interview as many as respondents directly related. Moreover, we planned to recruit the same number of participants in multiple settings, but the number of participants from each was imbalanced because of information saturation.

Bullet points

1. Our study was to examine the handling system for patients' complaints and identify and analyse barriers to effective management in China.
2. We carried out a literature review and semi-structured interviews

with all categories of key informants.

3. Hospitals undertake the most responsibility of patients' complaint handling.
4. Barriers to the effective management of patients' complaint vary at the different stages of complaint handling, from the user and provider side, as well as system issues.
5. Information, procedure design, human resources, system arrangement, unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management.

Background

In recent years, patients' complaints across the world have garnered mounting concern among policymakers, academics and the general public.[1-3] As China prospers, making great advances in medicine and social welfare, people's expectations of better quality of care continue to grow. People's consciousness of the law and their rights has increased as a result of education and better understanding of the law. Patients are able to express their discontent by lodging complaints such that the number of complaints occurring internationally is on the rise.[4, 5] The growth in dollars paid on malpractice claims is also evident.[6] The current situation reveals much concern surrounding hospital accountability and clinical governance; in particular, the efficacy of the system for redress. There are likely to be grave consequences pertaining to both social and political stability if the health care system fails to meet expectations and achieve patient satisfaction. Indeed, the issue at hand is one of paramount importance- requiring urgent attention and immediate action at the highest level.

With no official statistics of patients' complaints available in Chinese records, we estimate that the number of complaints and disputes rose, based on the number of first trials for medical malpractice cases between 2002 and 2008, from 10,249 to 13,875.[7] Mounting dissatisfaction has been felt across the country, manifest in increasingly hostile and violent behaviour towards providers by patients and their families.[8] An investigation carried out by the Chinese Hospital Management Association in 2005 suggests that of 270 hospitals surveyed, 73 per cent experienced abuse in the form of

threats and assaults targeting doctors and management.[9] These incidents are only indicative of rising expectations, burgeoning patient discontent with services and dissatisfaction towards the manner in which matters are resolved.[10] Public outcry only exacerbates the need for more effective handling of individual cases under the overarching agenda for public hospital reform in China.[11]

In countries such as Australia and Britain, the state has sought to monitor complaints and complaint handling to improve and regulate the practice of health professionals.[12] A feedback system of this sort has proven instrumental in improving the quality of care. In Britain, the National Health Service (NHS) not only provides clear and transparent guidelines for both health providers and patients but also publicizes information regarding the routine reporting of patients' complaints.[13] In Australia, a large study was conducted before *Guide to Complaint Handling in Health Care Services* was formulated and subsequently updated.[14] Annually, statistics are compiled and published, detailing complaint trends, complaint management and reasons for complaints. Effective handling of complaints has been known to reduce friction between providers and consumers, with the even greater benefit of improving quality of care. As a supplement to peer review and administration, patients' complaints can provide important feedback concerning the delivery of health care services and can be a useful tool in the improvement of health care quality.[1-3, 15, 16]

Amidst soaring angst, the Chinese government have put in place a system for redress where grievances arise. A "complaint" is defined as *the behaviour of a patient or his/her representative(s) which signifies dissatisfaction towards medical services, nursing services, as well as treatment conditions through letters, calls or visits to the hospital where the purpose of these actions is to criticise the hospital and/or claim compensation".*[17]

Notwithstanding the alarming extent of these issues, few attempts have been made to formally examine how hospital complaints are addressed in developing countries. It is only recently that a handful of studies in China have sought to provide some understanding of the issue, by trying to ascertain the number of complaints and garnering patient feedback via questionnaires and interviews. A fuller understanding of the complaints system- the available channels for seeking redress, how the system operates and the barriers to conflict resolution- will be crucial to ameliorating the often fraught relationship between health care providers and consumers. The purpose of this study has been to examine the handling system for patients' complaints in China; to subsequently identify and analyse the various hospital-specific factors preventing grievances from being effectively addressed. The authors of this paper hope that such an undertaking- in strengthening clinical governance and enhancing doctors' performance- will reduce malpractice and above all, improve health service outcomes.

Methods

Study design

The "Health System Stewardship and Regulation in Vietnam, India and China" (HESVIC) research project was conducted by a consortium of six partners in Asia and Europe from 2009-2012, with the aim of supporting policy decisions in the application and extension of accessibility, affordability, equity and quality coverage of maternal health care in the three countries.

The project uses a multidisciplinary approach, drawing on multiple case studies to examine the impact of regulation in improving equitable access to quality health care in Vietnam, India and China. In each country, three cases were selected and studied. This paper shows the findings from the case study examining the regulation on Grievance Redressal (GR) in Shanghai, China. Here, regulation encompasses the formation of rules and practices, as well as their interpretation and implementing, such as the health policy processes covered in the HEPVIC project (HEPVIC).[18]

Phase One: Literature Review

Firstly we conducted a literature review drawing on relevant sources such as regulation documents, reports and studies from international and Chinese journals, using “grievance redressal," "patient complaint," "health care complaint" and "hospital complaint" as keywords in our search. We also collected key information and data relating to the handling of patients’ complaints at both the national and

Shanghai municipal levels. Special focus was put on patients' complaint management in hospitals, as we found that the vast majority of complaints are handled and resolved within the hospitals.[19]

Phase Two and Three: semi-structured interviews

Based on our understanding of the current patient complaint handling system, we then performed semi-structured interviews with key stakeholders- policy makers from the national level, administrators from the Shanghai municipal level, hospital managers, health providers, users and other related parties. We used the snowball sampling method to identify key stakeholders and collect important feedback from key informants from various disciplines.[20, 21]

In Phase Two (October-December 2010), a key actor from each of the three administrative levels were selected and interviewed: a policy-maker at the national level, a municipal administrator and a hospital manager. A pilot study was conducted to test the topic guidelines developed. These would allow us to gain a preliminary understanding of the process of complaint management in the hospital setting of China, and refine the data collection tools. These interviews served as the basis for the design of Phase Three interviews where some of those being interviewed in the third phase were respondents recommended by Phase Two interviewees.

Interviews in Phase Three were conducted from August-December of 2011. Key

stakeholders were interviewed in select hospitals based on location, level and type. Our sample was representative of both urban and suburban areas in Shanghai. General hospitals and specialist hospitals were selected. Phase Three began with interviews of hospital managers and health providers proposed in Phase Two. We asked interviewees from Phase Two to invite patients and other relevant stakeholders to contribute their views. Those invited patients had used different channels for lodging their complaints. However, they all shared one thing in common: all patients had first complained to the hospital. We then proceeded to interview the administrators and finally a high-level policy-maker. We continued to interview respondents, collecting and analysing their comments and feedback until no new themes emerged i.e. saturation had been reached. The number of participants involved in the different types of interviewees is depicted in Table 1.

Semi-structured interviews were conducted with 35 respondents face-to-face except one, via telephone. The interviews took place at private locations, for example at the institution where the interviewee or interviewer worked and were conducted by two of the authors of this paper. Each interview lasted 1-2 hours and was audio-taped with permission, apart from two which were not recorded but typewritten upon the respondents' request.

Table 1 The number of participants from different types of interviewees

Types of interviewees	Level	Number of Participants

Policy-makers	National	
Ministry of Health		1
A university		1
Administrators	Shanghai municipal	4
Hospital managers		
General hospital	Tertiary	3
General hospital	Secondary	3
Specialized hospital	Tertiary	1
Specialized hospital	Secondary	1
Private hospital	Secondary	2
Health providers		6
Users		6
Other actors		
Municipal Health Inspection Institute		2
Lawyers for medical disputes		2
The centre that processes medical liability insurance		1
The People's Mediation Committee for Medical Disputes		1
The Complaint Letters and Visits System		1
Total		**35**

Data collection and analysis

The topic guidelines for carrying out the interviews included questions on the participant's experience on complaint management in the hospital. Using probes and follow-up questions, attention was directed to factors that the interviewees perceived as barriers to effective complaint management. They were asked why they believed this to be the case. From existing literature, we identified a list of factors required for effective complaint management and successful resolution of disputes. Participants were asked to provide suggestions and feedback regarding how complaints could be more effectively dealt with given the barriers they had identified.

Audio-tapes recorded during the interviews were transcribed for word, which was used to compare with the field notes taken for accuracy checking. We analysed data through a process of rigorous and structured analysis.[22] The analysis was executed in several stages to 1) become familiar with the data; 2) identify emerging topics; 3) develop a topic index; 4) use the index to code the data; 5) consolidate the topics into themes; 6) further consolidate these themes into analytical categories/clusters; and 7) translate the analysis obtained into a narrative. Written consent was obtained from each interviewee before undertaking the interviews.

We performed the above tasks using the qualitative research software NVivo 9.0. The raw data was coded by 2 independent reviewers (YSJ, QZ). If some discrepancies emerged, a third reviewer (XHY) would participate in the group discussion until the

group arrived at a consensus. Our study was approved by Institutional Review Board (IRB), School of Public Health, Fudan University.

Findings

This section first presents a number of approaches developed and implemented in Shanghai to handle patients' complaints. It then focuses on the approach of Negotiation between Hospitals and Complainants, identifies its barriers, and proceeds to examine and analyse these barriers.

1. Approaches and mechanisms used in managing patients' complaints

The study identifies both formal and informal approaches and mechanisms used in handling patients' complaints.

- Negotiation between Hospitals and Complainants

The complaint handling department within the hospital is responsible for dealing with patients' complaints, first established on February 20, 2002, in accordance with the *Regulation on the Handling of Medical Malpractices.*[23] Since November 2009, these departments have been regulated by *Measures for the Handling of Patient Complaints in Hospitals (for Trial Implementation)*.[17] These acts require that a medical institution establishes a department specifically for the purpose of handling and resolving medical disputes. The department is primarily responsible for receiving patients' complaints- via calls, letters, visits, and/or cases referred from other

departments and institutions. Their role also includes counselling and communicating with patients, verifying and documenting disputes as well as resolving disputes.

- Administrative Mediation and Civil Lawsuits

If the hospital is unable to resolve certain conflicts through negotiation, these cases may be referred to an external body such as the health administrative department. Or they may be settled in the court by means of litigation. The *Tort Law of the People's Republic of China*, adopted at the twelfth session of the Standing Committee of the Eleventh National People's Congress on December 26 2009, provided a new legal definition of liability for medical malpractice, liability presumption and exemption.[24]

- Complaint Letters and Visits System

In February 2007, *Measures for the Complaint Letters and Visits System for Healthcare* came into force.[25] Its purpose is to protect the legal rights and interests of citizens, legal entities and other organizations, regulate behaviour and maintain order within the Complaint Letters and Visits System. It requires health administrative departments to set up the Complaint Letters and Visits office at different levels. These offices are responsible for receiving, assigning and transferring matters as appropriate, as well as supervise in the handling of various issues and complaints.

- People's Mediation- a form of Third-Party Facilitated Mediation

In July 2008, the Shanghai Justice Bureau and Health Bureau issued *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*, to establish the People's Mediation Committees for Medical Disputes.[26] Committee members mainly consist of retired judges and doctors. They serve to mediate disputes through reporting, explaining and analysing cases under the supervision of local judiciary. In January 2010, the Ministry of Justice, the Ministry of Health and the China Insurance Regulatory Commission jointly issued *Opinions on Strengthening People's Mediation for Medical Disputes* to strengthen the role of mediation in resolving medical disputes.[27] Its intent is to settle medical disputes in an effective way and maintain order within hospitals, all with a view for ensuring harmony and social stability. In July 2011, the Shanghai Justice Bureau and Health Bureau introduced *Measures on People's Mediation for Medical Disputes in Shanghai* to replace *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*.[26, 28]

Further to the aforementioned channels of complaint, patients have been found to express their discontent by exhibiting disruptive behaviour within the hospital- targeting doctors and nurses or hospital managers- by way of abuse, assault and other forms of violence. Much of this has garnered media attention, resulting in bad publicity for the hospital and damaging the reputation of doctors and staff.

2. The application of different complaint approaches

There shows the complex relationships between different approaches can be seen where many actors are involved. From the aspect of solution, approaches which can resolve medical disputes are mainly negotiation and civil lawsuits, while other approaches play a part in forwarding cases, such as Complaint Letters and Visits System or easing conflicts, such as mediation. Not any of the approaches is considered the most authoritative approach. Patients can continue to lodge complaints through the Complaint Letters and Visits System even if a decision has been finalised after a second trial in court.

In the above-mentioned approaches, the hospital is the main handler for patients' complaints. First of all, it can handle patients' complaints completely independently, from reception to solution, while the other approaches have to engage hospitals in complaint handling. Secondly, since the hospital is principally responsible for compensation, the complainant is more inclined to directly negotiate with hospital. From the literature it is found that the majority of medical disputes are resolved by negotiation between hospitals and complainants.[19] Thirdly, if hospitals handle complaints improperly, conflicts will become more volatile, resulting in serious incidents.[29] Therefore, hospitals have become the most common receiver, handler and resolver of disputes. (Figure 1)

3. Barriers to the effective management of patient complaints and their underlying causes at different stages of the complaint process

Our interviews revealed that different hospitals often use different complaint systems. For example, some hospitals operate a centralized complaints office, which may or may not be independent of the Medical Affairs (Administration) Department. Other hospitals have several complaints offices, each of which is responsive to different kinds of complaints. Complaint departments are generally managed by a hospital's deputy director, who also heads hospital complaint management. Barriers to effective complaints management varies at different stages of the complaint process- both from the sides of the user and provider.

.

- **Barriers to initiating the complaint process**

Low awareness of users about the handling system for patients' complaints

Although hospital staff claimed that the complaints office was accessible to those with grievances, patients did not always feel this was the case. One user looked up the hospital telephone number on the Internet and she said the complaint handling process was "very easy" while others did not concur. Almost all patients being interviewed found that signs and directions (to the complaints office) failed to catch the eye. In some cases none could be seen at all:

I wanted to lodge a complaint, but did not know how to find the place [the complaints office]… Because the hospital was so big, I did not know which department [was responsible for handling complaints]. …I simply did not know who to turn to. You see, the complaints department was in another building [rather than in the one in which I was treated i.e. the clinical department] (Female, Users-1,

01-09-2011)

- **Barriers in the handling process**

Poor capacity and skills of health care providers

The capacity and skills of healthcare providers in managing patients' complaints is critically important in problem solving. Our study found that the reasons patients complain lie mainly in poor communication and factors such as the provider's attitude, use of language, unprofessional behaviour, as well as dissatisfaction towards service procedures.

The Medical Doctors Association carried out a survey of the nature of medical disputes. 50 per cent of cases were a result of inappropriate attitudes in health care delivery, 25 per cent were caused by technology misuse and the rest were related to management. (Female, Policy makers-1, 16-12-2010)

The majority of complaints can be resolved by explanation issued by the hospital and/or verbal apology by the offending party.[5, 30, 31] However, practitioners are often too preoccupied with their clinical duties to be able to respond to patients' complaints.

Hospitals have not completely adhered to regulation, which is clearly outlined in the guidelines; not because they do not have the capacity, but because doctors and related staff are simply too busy. (Male, Administrators-1, 21-12-2010)

Doctors are not able to devote much time to handling disputes, because clinical work is highly demanding. [They need to attend to] many patients every day. If they

spend more time communicating with patients, they would lose time needed to carry out [clinical work]. That is to say, [doctors should be given] less [clinical] work, and more time to explain their work to patients. Our workload is very heavy, like a battle. (Female, Health providers-1, 01-09-2011)

Incompetence and powerlessness of complaints handlers

Complaint handlers played a more important role in cooperation and coordination. Although the complaint department was specifically set up in hospitals for receiving and handling complaints, the responsible persons in the department were mainly part-time medical staff. In some cases, those handling staff had been found to be inadequate- sometimes due to lack of training. Many of them had studied handling techniques on their own and had not acquired sufficient professional skills to appropriately analyse, assess and solve complaints.

Complaint handlers in the hospitals cannot solve everything. Because the disciplines involved in complaints are highly specialised. I am only familiar with general surgery and issues that require common sense, but [I am not familiar] with professional problems in other disciplines. (Male, Hospital managers-5, 08-09-2011)

It is difficult to recruit staff for our Medical Dispute Handling Office. No one wants to come. A boy recruited in 2007 could not stand the demands of the job [complicated disputes and violence] and so resigned. (Female, Hospital managers-3, 31-08-2011)

We have little time to do things other than receiving complaints. We lack staff. We are responsible for receiving and processing complaints, and expected- on top of this- to deal with other things. Hence why we are exhausted. (Male, Health providers-2, 16-09-2011)

Given that most complaints are handled and resolved in the hospital, it appeared that every complaint handler interviewed felt the same way: tired and stressful. Complaint handlers were insufficiently empowered to handle complaints. It was hard for them to coordinate between different departments, investigate cases, organize mediation, find solutions and then draw on patients' feedback to improve quality of care.

Recently, a fierce medical dispute occurred because of a possible misunderstanding between administrative departments. [Abusive] words erupted. As a consequence, staff involved in this incident were distraught- to the extent that they wanted to resign. Hence we need understanding and support among colleagues. ...Sometimes the clinical department concerned refuse to cooperate when investigated. He [the clinical department] is not very serious to cooperate with the investigation. (Female, Hospital managers-3, 31-08-2011)

Communication between administrative departments and clinical departments is not very effective sometimes. I am not satisfied with this. (Female, Hospital managers-2, 25-08-2011)

Non-transparent exchange of information

In addition, the complaint handling process was not truly open to the complainant and

information exchange was largely limited to hospital staff. In fact, it was found that staff at the complaints office were generally evasive towards patients who arrived wishing to be updated with the specifics of their complaint. The complainant had no opportunity to directly engage in the handling of the complaint or to meaningfully participate in the process. In addition, hospitals tended to oversimplify cases, assuming that the complainant's only desire was to report their complaint and ask for compensation. All this implies that the entire handling process is disclosed only among hospital staff. Therefore, the process becomes a "black box" to patients. It is easy for the hospital to manipulate a complainant by providing limited information to gain advantage in negotiations i.e. reduce loss from compensating patients.

Sometimes you have to circumvent something and use negotiating skills. Mistakes in medical services do not necessarily harm patients' health, but they can be very serious for the provider [...] for example, someone may not be very careful when writing a medical record and alter it by accident. But you are likely to lose a lawsuit on the grounds of having tampered with records. Incidents such as these clouds matter, making transparency difficult. (Female, Hospital managers-2, 25-08-2011)

If the incident is urgent or presents itself as a recurring problem, this incident might be shared to educate healthcare providers. But disclosure to complainants themselves remains limited. Only outcomes deemed to be of direct interest to patients including compensation amounts and medical service privileges were provided. Other results, however, including penalties imposed upon physicians and departments or

improvements made to hospital services were largely withheld from patients if they did not ask.

In individual cases, what are the outcomes of their complaints? How might a physician be punished/penalised/disciplined? Such information is requested by patients only occasionally. (Male, Health providers-2, 16-09-2011)

I want to know how to better educate the concerned health care providers. But I have not been told. (Female, Users-3, 20-09-2011)

- **Barriers to resolving conflict and reaching agreement**

Conflicts between relevant actors and regulations

Within the complaints system, conflicts or inconsistencies can arise between the legal system for handling complaints and the solutions determined by the hospital. As the structure of managing patients' complaints is shown in Figure 1, different regulations stipulate different approaches. There does not exist a unified law or guidelines to clearly illustrate the relationships between different approaches. It results in problems such as lack of authority or ultimate approach, uncertainty about how to apply different regulations to one case and no clear definitions or classifications as regards patients' complaints.

The current state of complaint management is disorderly. There are too many channels. For example, many departments are involved, including but not limited to Complaint Letters and Visits, online complaints etc. The Health Bureau has two departments [for complaint management], each district has a mediation office, a

district government website or a mayor-mail [to receive complaints], and a Complaint Letters and Visits office… Far too many heads of department within the health sector; it's chaos. (Male, Health providers-2, 16-09-2011)

Hospitals are required to report complaints to a lot of sectors, all of which wish to understand the issue from different angles. There are not necessarily conflicts between regulations, but different elements are emphasised. Hospitals are tired of these kinds of bureaucracy. ...Each sector carries out their designated duties where resources are not shared. The information possessed by each sector is fragmented. You know yours, I know mine. (Male, Administrators-2, 18-08-2011)

Medical malpractice is defined clearly in the Regulation on Handling Medical Malpractice. There are several benchmarks determining the amount of compensation issued. After the Tort Liability Law of the People's Republic of China was promulgated, [medical damage] was compensated for more in accordance with the Tort Liability Law, because it stipulates compensation for personal injury. (Female, Hospital managers-2, 25-08-2011)

Unjustifiable complaints by patients

In some cases, the patient experiences inconvenience when receiving medical services not because of poor conduct in attitude or behaviour on the part of health providers. It may be the case of long waiting times, too little time spent with the doctor and/or imperfect resources allocation. These are health system issues rather than problems caused by hospitals or individual physicians. And so to a certain extent, physicians

and hospitals have become scapegoats of the entire health system.

At times it is not us physicians who have made a patient angry. Certain factors are rooted in the fabric of health care systems, but we physicians [end up] taking the blame. (Male, Health providers-3, 16-09-2011)

For example, should a doctor need to see sixty patients in half a day, or indeed one hundred, you cannot demand that he puts on a smile for each one. A lot of patients complain about doctors with a straight face, but I think it is understandable. I have a very good relationship with our young doctors. They operate on a tight schedule. This week someone works at outpatient's. He is friendly with patients in the first month but struggles to sustain this sort of demeanour. He is not in the mood to smile at patients or engage in long conversations when he only has time to attend to their illnesses. (Male, Hospital managers-1, 15-12-2010)

For example, dissatisfaction voiced in the hospital may be related to health insurance policy rather than staff behaviour. Hospitals need to follow the policies made by Health Insurance Department. The purpose of those policies was to improve rational use of medicines and control healthcare cost, while the patients covered by health insurance may demand more medicines.

Chinese doctors have many rules to obey [this is to curb poor conduct]. The pressures for them to perform are relatively large. For example, doctors cannot prescribe too much medicine for a patient who has only [basic state-financed] medical insurance, but patients always want more. A while ago, the Medical

Insurance Bureau issued the following statement in a newspaper: The Medical Insurance Bureau never limits the volume of drugs prescribed, rather it is the doing of hospitals who wish to increase workload [in order to produce more statistics]. I think this is really unreasonable. The Bureau does not control the quantity of drugs prescribed in any given week, but there is a total quantity limit over a year. Doctors try their best not to prescribe drugs which must be self-financed i.e. not covered by basic medical insurance. They must also explain very clearly before prescribing self-financed drugs, otherwise, patients will lodge complaints once they find out. (Male, Hospital managers-1, 15-12-2010)

Complaints occur where the patient wants more drugs but the doctor has refuse to satisfy his or her demands. Why? The health insurance institution sets a limit for drug expenditure for each hospital; in turn, the hospital sets a limit for each doctor. So if a doctor has too many patients drawing from their health insurance scheme in any one month, he or she may very possibly have exceeded his/her limit. (Male, Health providers-3, 16-09-2011)

[A patient who has] basic state-financed medical coverage is entitled to blood and other auxiliary examinations. If the number of health checks prescribed exceeds a certain threshold, the doctor is viewed as exploiting basic medical insurance. The doctor is consequently punished. I was deducted more than seven hundred yuan (RMB) because of a case like this. I feel this is simply absurd- it is [unexpectedly] doctors who are to blame. Nothing seems to be wrong with the patient. ...The hospital can't do anything about medical insurance. I think this kind of thing is not

the problem at the hospital level. The complaints about medical insurance define without doubt problems underlying state and society. (Male, Health providers-4, 16-09-2011)

In addition, the safety of health providers is under threat in China today. Chinese medical workers are often victims of terrible violence. As a consequence, some health providers have decided not to treat patients deemed likely to assault staff, exhibit disruptive behaviour or prove difficult to deal with. Prescribing redundant check-ups and drugs are alternatives to properly seeing to patients.

In our interviews, fifteen interviewees mentioned "Chao" fifty-five times. "Chao" in Chinese means to argue with hospitals for patients' own rights and interests, while the other meaning is wrangle fiercely in hospitals or with senior management. Most of the hospital staff being interviewed suggest that some complainants are indeed unreasonable and impulsive, whose sole purpose is to ask for money.

If the case goes to court, the patient gathers a lot of people to go to the court, insulting and threatening concerned health care providers and their lawyers. That is not what we want to see. We want to talk about the truth, by thoroughly publicizing the truth. We cannot always be too specific with terminology [for fear of revealing too much]. When completely refuted, patients lose their temper. (Male, Other actors-2, 15-09-2011)

I feel that the widespread situation in China today is that you can do nothing if you run into the unreasonable. The legitimate way of going about this is once I receive your complaint, a fair decision is proposed. If complainants are not willing to settle

for this, we then transfer their case to other departments. However, complainants may not even agree to that, causing trouble and even threatening the safety of health care providers. (Female, Hospital managers-2, 25-08-2011)

The claim a complainant demands goes beyond the actual problem [but for the money] and he does not wish to resolve it in the legal way. ...Nowadays "Yi Nao" has brought about serious social effects, and escalated the tension between service users and providers. Complainants are unwilling to resolve things the legal way, rather, just pestering and hassling you [health care providers or complaint handlers] all day. (Male, Hospital managers-6, 01-11-2011)

- **Barriers to post-complaint institutional changes for quality improvement**

Weak enforcement of the regulation

The regulation for managing patients' complaints is merely a guideline, which contains no mandatory requirements such as assessment mechanisms. Because it takes into account the difference in local conditions throughout China, specific contents were not stipulated. The regulation is to be interpreted according to local circumstances and conditions. In the absence of strong public scrutiny, therefore, there is little accountability for how best to manage patients' complaints.

There are no penalties attached to (failure to follow) regulation. For example, there is no administrative aspect to the regulatory guidelines. We wanted to write a penalty provision, but it was not based on the top legislation. The purpose of the regulation is to emphasise self-discipline and serve as guidance for the hospital.

[The penalty was not enforceable,] so we decided to remove the penalty. It is indeed difficult and contradictory. (Female, Administrators-4, 30-11-2011)

Besides the legal system, the reporting system also has its problems. Some statistics about patients' complaints and medical malpractice were utilized as a part of assessments of hospital performance, health care quality, and so on. This meant that the more cases that were reported, the worse the evaluations received by hospitals, so that hospitals were inclined to report selectively or report fewer cases.

There are certainly no statistics for the number of patients' complaints. There is only the data on the number of cases of medical malpractice per year from the Bureau of Health, and an approximate amount of compensation issued by insurance companies. In some cases, if complaints were solved just between the hospital and the complainant, we have no data. (Male, Administrators-2, 18-08-2011)

These days, the information regarding the management of patients' complaints in hospitals is difficult to access. Hospitals are unwilling to provide that sort of information- considered confidential. We only have some profiles or the information from select hospitals. (Female, Policy makers-1, 16-12-2010)

Thus, the adoption of the incentive and sanction mechanism was contradictory for managing patients' complaints. From one side, the administrative department wanted hospitals to report patients' complaints because it is important for informing and improving the quality of care. From the other side, the more complaints that are registered, the worse it would appear a hospital is doing. In addition to this, managing patients' complaints remains low on the health reform agenda. The force for

inspecting complaint management in hospitals from senior management and administrative departments remains weak.

[Having a statistic for patients' complaints] is definitely necessary, from the aspect of effective management. If this statistic is disposable, I think no problem. If the statistic is routine, in fact, it will cost. (Male, Policy makers-2, 22-12-2011)

Hospitals doubt that the purpose of administration is for information management- to help them better handle and solve disputes. However, if you want me to report incidents but meanwhile punish me for that, then I have no incentive to report anything. This contradiction stands [in the way of effective reporting]. (Female, Administrators-4, 30-11-2011)

Deficient information system for managing patients' complaints

Although the regulations in place require collecting and analysing information, there exists no clear classification, definitions or unified coding system. Most hospitals have established their own systems for recording complaints and analysing cases, but no accurate or comparable data are available.

In fact a lot of cases should be recorded and analysed, [but] we do not even take into account so-called major cases of medical malpractice, mass disturbance or medical malpractice. We cannot distinguish between these concepts…. Relatively speaking, it is more feasible to publicize the data on public security e.g. the number of police records and people arrested, the number of crimes committed. Those definitions are more explicit, whereas those concerning complaints management are

not. Because all statistics are calculated in the hospital, we find that where standards are slack, the resulting statistic is large whereas with a strict standard, it will be small. There is hence great variability in our results. (Male, Policy makers-2, 22-12-2011)

Identical forms are sent to two hospitals at a similar level and the reported data can be quite different. ...Some hospitals only reported cases resulting in compensation and some hospitals record all persons who voice a concern, while others only report cases identified as medical malpractice. But it is impossible for me to verify [the reported data] in each hospital. (Male, Administrators-2, 18-08-2011)

Hospitals have not publicized complaints; neither have health administration departments. The Shanghai Bureau of Health launched a pilot project in 2005 to publicize the complaints reported by all hospitals in Shanghai. The project was welcomed by the public but discontinued soon after its launch due to mounting pressure from hospitals.

We already publicize complaints [medical malpractice] on our intranet for hospital staff. It is unnecessary to share this information on external sites. (Female, Hospital managers-4, 06-09-2011)

To my knowledge, such information was published once on the Xinmin Evening News in 2005. The newspaper named hospitals that had won awards and gave details of the number of medical malpractice cases inherent in each, as well as feedback regarding patient satisfaction. [We felt] the pressure was very, very high. It [publishing those] resulted in public outrage [from hospitals]. (Female,

Administrators-4, 30-11-2011)

Unwillingness on the part of hospitals to effectively handle complaints

Most hospitals did not devote much effort into managing complaints. There was no clear mechanism to utilize patients' complaints to improve quality of care unless serious medical malpractice had occurred or complaints are found to recur.

Hospitals just handle complaints when complaints happen. ...We are basically perfunctory, including hospitals, department directors and doctors. The best case scenario for me: do not approach me for these things [complaints]. Deal with complaints quickly and efficiently; in other words, spend money to buy peace. The impact of managing and addressing complaints is negligible, with very little effect on improving medical procedures and quality. (Male, Administrators-2, 18-08-2011)

Hospital directors were the key actors of complaint management in hospitals. The incentive and sanction mechanisms in hospital depended on how much they pay attention to complaint management. In the 1980s the government reduced subsidies for public hospitals under the context of transforming the planned economy to a so-called socialist market one in order to reduce inefficiencies in health care provision. Hospitals had to increase service charges to generate more revenue to recoup the operational costs and increase the income level of health workers. Complaint management occupied nothing but a small part of quality health care, so in most hospitals it failed to draw attention from senior management. Most complaints were

solved on a case-by-case basis, without sufficient concern for the overall improvement of health care services.

In practice, the head of department influences implementation. If he/she regards this as important, then subordinates work harder of course. Now the problem is that some heads of department do not pay attention to it [complaint management]. (Male, Health providers-2, 16-09-2011)

It is of course medical services that are the core of hospital work. Things such as [complaint management] are boring for the hospital. To a hospital, the fewer the complaints, the better. (Male, Administrators-2, 18-08-2011)

Conclusions

This study examined the structure of managing patients' complaints in China and the views of key stakeholders on the barriers to effective complaint management. It is shown that there are no standardized systems and procedures dealing with patients' complaints in China, due to conflicts between relevant actors and regulations. Having experienced rapid economic growth in the last 30 years, China is undergoing a socioeconomic transition. Like other developing countries, policies lag behind the country's economic transition. The Ministry of Health has tried to guide health providers by issuing special regulation, but health administrations do not apply strict regulation to complaint management. There lacks of clear relationships between patients' complaints and clinical outcomes or the quality of care.

The hospital leader is the key determinant for complaint handling inside the hospital. However, no apparent incentives exist to push hospital leaders to put complaint handling at a priority. The power of complaint handling department depends on how much attention the hospital leaders pay to. Under the current situation, the hospital leaders lack political will to manage complaint effectively. This led to inadequate human resource put in place at the appropriate department to handle complaints. The department also lack power to coordinate with clinical departments.

The patients' complaints in many Chinese hospitals are not well managed and handled. Most hospitals manage patient complaints on only a case-by-case basis. They lack clear mechanisms linking patients' complaint with improving the quality of care. Complaints are underutilised for organizational strategic planning or changing individual behavioural and attitudes.

Policy recommendations

The Chinese Ministry of Health and health authorities at provincial and municipal level should oversee the development of national guideline on handling patients' complaints which can be practically implemented in China. Legislation stipulates not only the principles and regulations of patients' complaint management, but also the responsibilities of sectors at different levels.

To alleviate patient complaints related violence, the guideline should be approved by

civil groups including service users and the hospital sector. In developed countries, patient's complaint management provides guidelines not only for health care providers, but also clear guidelines for patients. This not only makes it more convenient for patients, but also plays a positive role in helping patients' initiate the complaint process via legitimate means. This is crucial for society to view patients' complaint in a rational way.

If patients' complaints can be better managed and rectified, the instances of failure would be reduced and quality would be improved. Greater emphasis should be placed on quality improvement after patients' complaints. Strategies to improve quality following patients' complaints should be developed through a learning process. To promote the learning process, appropriate mechanisms should be developed and implemented to assess not only the number of patients' complaints occurring in hospitals, but also how these hospitals have handled these complaints. For example, reporting more patients' complaints should not be necessarily punished, while effectively handling of the patients' complaints should be appreciated.

ACKNOWLEDGEMENT

The HESVIC project received funding from the European Commission Framework 7. The views represented in this document are not necessary representative of the European Commission's views and belong solely to the authors. The consortium would like to thank all the study respondents and participants for their willingness to take part in the research, as well as the members of the Country Research Advisory Groups for their support at every stage of the HESVIC project. The authors of the paper very much appreciate constructive comments and suggestions on earlier version of the paper from Shenglan Tang from Duke Global Health Institute, USA.

CONTTRIBUTORSHIP STATEMENT

YJ, XY, QZ collected and analyzed the data primarily. All authors were involved in analyzing the data and editing the paper.

FUNDING

This study was supported by the European Commission Seventh Framework Programme (HEALTH-F2-2009-222970).

COMPETING INTERESTS

None.

DATA SHARING STATEMENT

No additional data

References:

1. Sage WM. Putting the patient in patient safety: linking patient complaints and malpractice risk. *JAMA* 2002;**287**:3003-5.

2. Hsieh SY. A system for using patient complaints as a trigger to improve quality. *Qual Manag Health Care* 2011;**20**:343-55.

3. Wofford MM, Wofford JL, Bothra J, et al. Patient complaints about physician behaviors: a qualitative study. *Acad Med* 2004;**79**:134-8.

4. Beecham L. Patients' complaints: GMC could do better. *BMJ* 1999;**319**:1022.

5. Anderson K, Allan D, Finucane P. A 30-month study of patient complaints at a major Australian hospital. *J Qual Clin Pract* 2001;**21**:109-11.

6. The Henry J. Kaiser Family Foundation. Medical Malpractice Law in the United States. http://www.kff.org/insurance/upload/Medical-Malpractice-Law-in-the-United-States-Report.pdf Accessed [08-31-2012].

7. Xi X. *Understanding and application of provisions in the Tort Liability Law*. Beijing: Press of the People's Court; 2010.

8. Chinese doctors are under threat. *Lancet* 2010;**376**:657.

9. Zheng XQ, Wei LY, Zhang BZ, et al. Domestic Survey of Medical Disputes and Foreign Medical Dispute Handling. *Chinese Hospitals* 2007; **7**:2-4.

10. Stafford C. Moral ambivalence in modern China. *Lancet* 2012;**9818**:793.

11. Communicating concern: complaints against doctors. *Lancet* 2013;**382**:1382.

12. Hsieh SY. Healthcare complaints handling systems: a comparison between Britain, Australia and Taiwan. *Health Serv Manage Res* 2011;**24**:91-5.

13. Department of Health, United Kingdom. Complaints procedure. http://www.dh.gov.uk/health/contact-dh/complaints/ Accessed [08-31-2012].

14. Cornwall A, Romios P. Turning Wrongs Into Rights. *Health Issues* 2004;**79**:13-8.

15. Hickson GB, Federspiel CF, Pichert JW, et al. Patient complaints and malpractice risk. *JAMA* 2002;**287**:2951-7.

16. Pichert JW, Hickson G, Moore I. Using Patient Complaints to Promote Patient Safety. *Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 2: Culture and Redesign)*. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008.

17. Ministry of Health. *Measures for the Handling of Patient Complaints in Hospitals (for Trial Implementation)*. Beijing: Ministry of Health; 2009.

18. Green A, Gerein N, Mirzoev T, et al. Health policy processes in maternal health: a comparison of Vietnam, India and China. *Health Policy* 2011;**100**:167-73.

19. Gao J, Cao W, Xu Y, et al. Survey analysis of consultation settlement for medical disputes in 30 medical institutions of Shanghai. *Journal of Shanghai Jiaotong University (Medical Science)* 2010;**30**:960-3.

20. Charmaz K. *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. Thousand Oaks, CA: Sage Publications, 2006.

21. Sadler GR, Lee HC, Lim RS, et al. Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nurs Health Sci*

2010;**12**:369-74.

22. Lacey A, Luff D. *Qualitative Research Analysis*. The NIHR RDS for the East Midlands / Yorkshire & the Humber, 2007.

23. State Council. *Regulation on the Handling of Medical Malpractices*. Beijing: Decree of the State Council; 2002.

24. Standing Committee of the Eleventh National People's Congress. *Tort Law of the People's Republic of China*. Beijing: Presidential Decree; 2009.

25. Ministry of Health. *Measures for the Complaint Letters and Visits System for Healthcare*. Beijing: Ministry of Health; 2007.

26. Shanghai Justice Bureau and Health Bureau. *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*. Shanghai: Shanghai Justice Bureau and Health Bureau; 2008.

27. Ministry of Justice, Ministry of Health, and China Insurance Regulatory Commission. *Opinions on Strengthening People's Mediation for Medical Disputes*. Beijing: Ministry of Justice, Ministry of Health, and China Insurance Regulatory Commission; 2010.

28. Shanghai Justice Bureau and Health Bureau. *Measures on People's Mediation for Medical Disputes in Shanghai*. Shanghai: Shanghai Justice Bureau and Health Bureau; 2011.

29. Yan X. Correctly Receive Medical Complaints and Establish Harmonious Doctor-patient Relationship. *Modern Hospital Management* 2008;**6**:24-5.

30. Manouchehri MJ, Ibrahimipour H, Sari AA, et al. Study of patient complaints

reported over 30 months at a large heart centre in Tehran. *Qual Saf Health Care* 2010;**19**:e28.

31. Siyambalapitiya S, Caunt J, Harrison N, et al. A 22 month study of patient complaints at a National Health Service hospital. *Int J Nurs Pract* 2007;**13**:107-10.

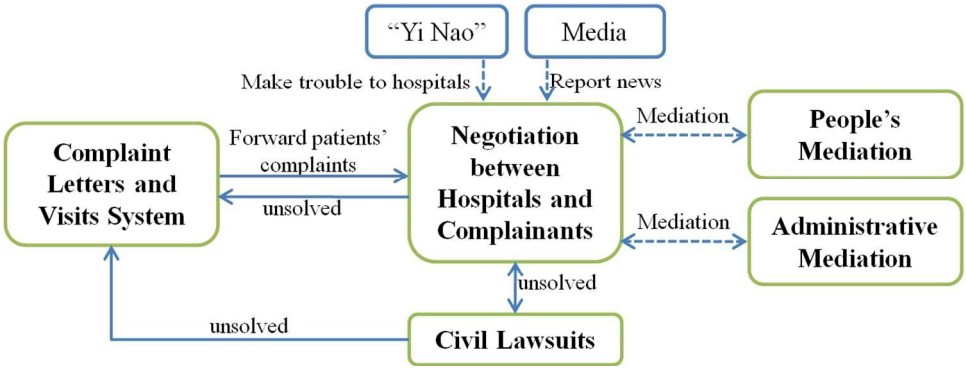

Figure 1 The structure of managing patients' complaints in China

374x174mm (96 x 96 DPI)

Qualitative research review guidelines – RATS

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
R Relevance of study question	
Is the research question interesting?	YES. Research question was explicitly stated.
Is the research question relevant to clinical practice, public health, or policy?	YES. Research question is justified and linked to the existing knowledge base (empirical research, policy).
A Appropriateness of qualitative method	
Is qualitative methodology the best approach for the study aims? • *Interviews:* experience, perceptions, behaviour, practice, process • *Focus groups:* group dynamics, convenience, non-sensitive topics • *Ethnography:* culture, organizational behaviour, interaction • *Textual analysis:* documents, art, representations, conversations	YES It is difficult to measure the regulation process quantitatively.
T Transparency of procedures	
Sampling	
Are the participants selected the most appropriate to provide access to the type of knowledge sought by the study?	YES.
Is the sampling strategy appropriate?	The respondents were sampled by the whole research framework: the regulation

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
	process. Different types of respondents were helpful for holistic understanding for transparency deficits. Key informants were interviewed by snowball sampling and saturation.
Recruitment	
Was recruitment conducted using appropriate methods?	In the methods part, it shows details of how recruitment was conducted and by whom.
Is the sampling strategy appropriate?	YES
Could there be selection bias?	The selection of participants might bring some bias to our studies. Our focus was on the hospital, so some types of respondents may have been under-represented. Moreover, we planned to recruit the same number of participants in multiple settings, but the number of participants from each was imbalanced because of information saturation.
Data collection	
Was collection of data systematic and comprehensive?	YES, the interview questions were introduced.
Are characteristics of the study group	YES. We just focused on their

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
and setting clear?	role/group on the regulation process.
Why and when was data collection stopped, and is this reasonable?	YES. The principle of saturation was used.
Role of researchers	
Is the researcher(s) appropriate? How might they bias (good and bad) the conduct of the study and results?	YES. Our research group is multidisciplinary, including social science, clinical medicine and public health.
Ethics	
Was informed consent sought and granted?	YES. Informed consent process was explicitly and clearly detailed.
Were participants' anonymity and confidentiality ensured?	YES.
Was approval from an appropriate ethics committee received?	YES. Ethics approval was cited.
S Soundness of interpretive approach *Analysis*	
Is the type of analysis appropriate for the type of study? • *thematic:* exploratory, descriptive, hypothesis generating • *framework:* e.g., policy • *constant comparison/grounded*	YES. Analytic approach was justified.

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
theory: theory generating, analytical	
• Are the interpretations clearly presented and adequately supported by the evidence?	YES.
Are quotes used and are these appropriate and effective?	YES.
Was trustworthiness/reliability of the data and interpretations checked?	YES, but it wasn't shown in the paper. We triangulated between interviews from various types of respondents, and different disciplines. We also trail the findings with observation.
Discussion and presentation	
Are findings sufficiently grounded in a theoretical or conceptual framework?	YES.
Is adequate account taken of previous knowledge and how the findings add?	YES.
Are the limitations thoughtfully considered?	NO
Is the manuscript well written and accessible?	YES
Are red flags present? These are common features of ill-conceived or poorly executed qualitative studies, are a cause for concern, and must be	NO

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
viewed critically. They might be fatal flaws, or they may result from lack of detail or clarity.	

BMJ Open

Managing patient complaints in China: what went wrong?

Journal:	*BMJ Open*
Manuscript ID:	bmjopen-2014-005131.R1
Article Type:	Research
Date Submitted by the Author:	27-May-2014
Complete List of Authors:	Jiang, Yishi; Fudan University, School of Public Health; Shanghai Maternal and Child Health Center, YING, Xiaohua; Fudan University, School of Public Health ZHANG, Qian; Fudan University, School of Public Health Tang, Sirui; Fudan University, School of Public Health KANE, Sumit; Royal Tropical Institute, KIT Development Policy & Practice MUKHOPADHYAY, Maitrayee; Royal Tropical Institute, KIT Development Policy & Practice QIAN, Xu; Fudan University, School of Public Health
Primary Subject Heading:	Qualitative research
Secondary Subject Heading:	Health policy
Keywords:	QUALITATIVE RESEARCH, HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

Title page

1. Title of the article.

Managing patient complaints in China: what went wrong?

2. Full name, postal address, e-mail, telephone and fax numbers of the corresponding author.

The corresponding author: Xu QIAN

Postal address: Mailbox 175, 138 Yi Xue Yuan Road, Shanghai, 200032, P. R. China

Tel: 86-21-54237267 Fax: 86-21-64174172

Email: xqian@fudan.edu.cn

3. Full names, departments, institutions, city and country of all co-authors.

1) Yishi JIANG: School of Public Health, Fudan University, Shanghai, China; Shanghai Maternal and Child Health Center, China

2) Xiaohua YING: School of Public Health, Fudan University, Shanghai, China

3) Qian ZHANG: School of Public Health, Fudan University, Shanghai, China

4) Sirui Rae TANG: School of Public Health, Fudan University, Shanghai, China

5) Sumit KANE: KIT Development Policy & Practice, Royal Tropical Institute, Amsterdam, Netherlands

6) Maitrayee MUKHOPADHYAY: KIT Development Policy & Practice, Royal Tropical Institute, Amsterdam, Netherlands

7) Xu QIAN: School of Public Health, Fudan University, Shanghai, China

8) HESVIC team authorship

4. Up to five keywords or phrases suitable for use in an index (it is recommended to use MeSH terms).

Qualitative Research; Patient Complaints; Complaint Handling Systems; Quality Improvement; Government Regulation

5. Word count - excluding title page, abstract, references, figures and tables.

6887

Abstract

Objectives: To examine the handling system for patient complaints and to identify existing barriers that are associated with effective management of patient complaints in China.

Setting: key stakeholders of the handling system for patient complaints, at the national, Shanghai municipal and hospital levels in China.

Participants: thirty-five key informants including policymakers, hospital managers, health providers, users and other stakeholders in Shanghai.

Primary and secondary outcome measures: semi-structured interviews were used to understand the process of handling patient complaints and factors affecting the process and outcomes of patient complaint management.

Results: The Chinese handling system for patient complaints has been established in the past decade. Hospitals undertake the most responsibility of patient complaint handling. Barriers to effective management of patient complaints included service users' low awareness about the systems in the initial stage of the process; poor capacity and skills of healthcare providers, incompetence and powerlessness of complaints handlers and non-transparent exchange of information during the process of complaint handling; conflicts between relevant actors and regulations and

unjustifiable complaints by patients during the stage of solution settlements; and weak enforcement of the regulation, deficient information for managing patient complaints and unwillingness of the hospitals to effectively handle complaints in the post-complaint stage.

Conclusions: Barriers to the effective management of patient complaint vary at the different stages of complaint handling and from the service user and provider perspectives. Information, procedure design, human resources, system arrangement, unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management.

Article summary

Strengths and limitations of this study

This study explores the handling system for patient complaints in China and the views of key stakeholders on the barriers to effective complaint management. These findings are essential to improve the complaints system. Our study provides a new dimension of understanding the complaints management system in China, a developing country. We explore the barriers through in-depth interviews with almost all stakeholders, not only health professionals. What we found will help develop procedures for more effective complaint management and to further improve the quality of care in China and other developing countries. The selection of participants may introduce some bias to our studies. Due to our focus on the hospital, there may be an underrepresentation of certain types of respondents.

Bullet points

1. Our study examined the handling system for patient complaints and identified and analysed barriers to effective management in China.
2. We carried out a literature review and semi-structured interviews with all categories of key informants.
3. Hospitals undertake the most responsibility of patient complaint handling.
4. Barriers to effective management of patient complaint vary at different stages of complaint handling, from the user and provider

side, as well as system issues.

5. Information, procedure design, human resources, system arrangement, unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management.

Background

In recent years, patient complaints around the world have garnered mounting concern among policymakers, academics and the general public.[1-3] As China prospers, making advances in medicine and social welfare, people's expectations of better quality of care continue to grow. People's knowledge of the law and their rights has increased as a result of education and better understanding of the law. Patients are able to express their discontent by lodging complaints such that the number of complaints occurring internationally is on the rise.[4, 5] The growth in dollars paid on malpractice claims is also evident.[6] The current situation reveals much concern surrounding hospital accountability and clinical governance; in particular, the efficacy of the system for redress. Grave consequences pertaining to both social and political stability are likely if the health care system fails to meet expectations and achieve patient satisfaction. Indeed, the issue at hand is one of paramount importance, requiring urgent attention and immediate action at the highest level.

With no official statistics of patient complaints available in Chinese records, we estimate that the number of complaints and disputes rose based on the number of first trials for medical malpractice cases between 2002 and 2008, from 10,249 to 13,875.[7] Mounting dissatisfaction has been felt across the country, manifesting in increasingly hostile and violent behaviour towards providers by patients and their families.[8] An investigation carried out by the Chinese Hospital Management Association in 2005 suggests that of 270 hospitals surveyed, 73 per cent experienced abuse in the form of

threats and assaults targeting doctors and management.[9] These incidents are only indicative of rising expectations, burgeoning patient discontent with services and dissatisfaction towards the manner in which matters are resolved.[10] Public outcry only exacerbates the need for more effective handling of individual cases under the overarching agenda for public hospital reform in China.[11]

In countries such as Australia and Britain, the state has sought to monitor complaints and complaint handling to improve and regulate the practice of health professionals.[12] A feedback system of this sort has proven instrumental in improving the quality of care. In Britain, the National Health Service (NHS) not only provides clear and transparent guidelines for both health providers and patients but also publicizes information regarding the routine reporting of patient complaints.[13] In Australia, a large study was conducted before *Guide to Complaint Handling in Health Care Services* was formulated and subsequently updated.[14] Annually, statistics are compiled and published, detailing complaint trends, complaint management and reasons for complaints. Effective handling of complaints has been known to reduce friction between providers and consumers, with the even greater benefit of improving quality of care. As a supplement to peer review and administration, patient complaints can provide important feedback concerning the delivery of health care services and can be a useful tool in the improvement of health care quality.[1-3, 15-18]

Amidst soaring angst, the Chinese government has put in place a system for redress where grievances arise. A "complaint" is defined as *the behaviour of a patient or his/her representative(s) which signifies dissatisfaction towards medical services, nursing services, as well as treatment conditions through letters, calls or visits to the hospital where the purpose of these actions is to criticise the hospital and/or claim compensation".*[19]

Notwithstanding the alarming extent of these issues, few attempts have been made to formally examine how hospital complaints are addressed in developing countries. It is only recently that a handful of studies in China have sought to provide some understanding of the issue, by trying to ascertain the number of complaints and garnering patient feedback via questionnaires and interviews. A fuller understanding of the complaints system- the available channels for seeking redress, how the system operates and the barriers to conflict resolution- will be crucial to ameliorating the often fraught relationship between health care providers and consumers. The purpose of this study has been to examine the handling system for patient complaints in China; to subsequently identify and analyse the various hospital-specific factors preventing grievances from being effectively addressed. The authors of this paper hope that such an undertaking will reduce malpractice and above all, improve health service outcomes.

This study is one of the tracing cases from the "Health System Stewardship and

Regulation in Vietnam, India and China" (HESVIC) research project. It was conducted by a consortium of six partners in Asia and Europe from 2009-2012, with the aim of supporting policy decisions in the application and extension of accessibility, affordability, equity and quality coverage of maternal health care in the three countries.

Methods

Study design

The project uses a multidisciplinary approach, drawing on multiple case studies to examine the impact of regulation on improving equitable access to quality health care in Vietnam, India and China. In each country, three cases were selected and studied. This paper shows the findings from the case study examining the regulation on Grievance Redressal (GR) in Shanghai, China. Here, regulation encompasses the formation of rules and practices, as well as their interpretation and implementation, such as the health policy processes covered in the HEPVIC project (HEPVIC).[20]

Phase One: Literature Review

Firstly, we conducted a literature review. The relevant sources, which included regulation documents relating to the handling of patient complaints at both the national and Shanghai municipal levels, were used to collect legal approaches and mechanisms used in managing patient complaints. These regulations were mainly stipulated from 2002 to 2011. To understand the application of different complaint

approaches, a search of scientific literature published between 2000 and 2011 was conducted. Databases MEDLINE-PubMed and WANFANG Data were consulted. A search strategy was established based on the following keywords: *grievance redressal, patient complaint, health care complaint and hospital complaint, and China*. Special focus was put on patient complaint management in hospitals, as we found that the vast majority of complaints are handled and resolved within the hospitals.[21]

Phase Two: pilot study - interviews

Based on our understanding of the current patient complaint handling system, we then performed semi-structured interviews with key stakeholders- policymakers from the national level, administrators from the Shanghai municipal level, hospital managers, health providers, users and other related parties. We used the snowball sampling method to identify key stakeholders and to collect important feedback from key informants from various disciplines.[22, 23]

In Phase Two (October-December 2010), one key actor from each of the three administrative levels were selected and interviewed: a policymaker at the national level, a municipal administrator and a hospital manager. A pilot study was conducted to test the topic guidelines developed. These would allow us to gain a preliminary understanding of the process of complaint management in the hospital setting of China, and refine the data collection tools. These interviews served as the basis for the design of Phase Three interviews where some of those being interviewed in the third

phase were respondents recommended by Phase Two interviewees.

Phase Three: main data collection

Interviews in Phase Three were conducted from August-December of 2011. Key stakeholders were interviewed in the selected hospitals based on location, level and type. Our sample was the representative of both urban and suburban areas in Shanghai. General hospitals and specialist hospitals were selected. Phase Three began with interviews of hospital managers and health providers proposed in Phase Two. We asked interviewees from Phase Two to invite patients and other relevant stakeholders to contribute their views. Those invited patients had used different channels for lodging their complaints. However, they all shared one thing in common: all patients had first complained to the hospital. We then proceeded to interview the administrators and finally a high-level policymaker. We continued to interview respondents, collecting and analysing their comments and feedback until no new themes emerged, i.e. saturation had been reached. The number of participants involved in the different types of interviewees is depicted in Table 1.

Semi-structured interviews were conducted with 35 respondents face-to-face, except one via telephone. The interviews took place at private locations, for example at the institution where the interviewee or interviewer worked, and were conducted by two of the authors of this paper. Each interview lasted 1-2 hours and was audiotaped with permission, apart from two which were not recorded but typewritten upon the

respondents' request.

Table 1 Number of interviewees by administrative level and facility

Types of interviewees	Level	Number of Participants
Policymakers	National	
Ministry of Health		1
A university		1
Administrators	Shanghai municipal	4
Hospital managers		
General hospital	Tertiary	3
General hospital	Secondary	3
Specialized hospital	Tertiary	1
Specialized hospital	Secondary	1
Private hospital	Secondary	2
Health providers		6
Users		6
Other actors		
Municipal Health Inspection Institute		2
Lawyers for medical disputes		2
The centre that processes medical liability insurance		1
The People's Mediation Committee for		1

Medical Disputes	
The Complaint Letters and Visits System	1
Total	**35**

The topic guidelines for carrying out the interviews included questions on the participant's experience on complaint management in the hospitals. Using probes and follow-up questions, attention was directed to factors that the interviewees perceived as barriers to effective complaint management. They were asked why they believed this to be the case. From existing literature, we identified a list of factors required for effective complaint management and successful resolution of disputes. Participants were asked to provide suggestions and feedback regarding how complaints could be more effectively dealt with given the barriers they had identified.

Data analysis

Audiotapes recorded during the interviews were transcribed and were compared with the field notes to check for accuracy. We analysed data through a process of rigorous and structured analysis.[24] The analysis was executed in several stages to 1) become familiar with the data; 2) identify emerging topics; 3) develop a topic index; 4) use the index to code the data; 5) consolidate the topics into themes; 6) further consolidate these themes into analytical categories/clusters; and 7) translate the analysis obtained into a narrative. Written consent was obtained from each interviewee before undertaking the interviews.

We performed the above tasks using the qualitative research software NVivo 9.0. The raw data was coded by two independent reviewers (YSJ, QZ). If some discrepancies emerged, a third reviewer (XHY) would participate in the group discussion until the group arrived at a consensus. There were some models for analysing complaint management, for example, a Managerial-Operational-Technical (MOT) model was developed to explore complaint management in hospitals.[2] In our study, we collected data according to the complaint management process. To analyse the data most efficiently and directly, we used the stages of the process. The stages included receive, handle and resolve complaints.[25] As the quality improvement following complaints is very important, we added the stage of "institutional changes for quality improvement using complaints data".[2, 16]

Our study was approved by Institutional Review Board (IRB), School of Public Health, Fudan University. Access to data was restricted to approved members of the research team who signed a confidential agreement with the principal investigator. Data were stored in secure electronic locations. Data processing was kept anonymously so as to protect the identity of interviewees. The names of the respondents have been deleted from quotations.

Findings

This section first presents a number of approaches developed and implemented in

Shanghai to handle patient complaints and their relationships. It then focuses on the approach of negotiation between hospitals and complainants, identifies its barriers, and proceeds to examine and analyse these barriers.

1. Approaches and mechanisms used in managing patient complaints

The study identifies both formal and informal approaches and mechanisms used in handling patient complaints.

- Negotiation between Hospitals and Complainants

The complaint handling department within the hospital is responsible for dealing with patient complaints, first established on February 20, 2002, in accordance with the *Regulation on the Handling of Medical Malpractices.*[26] Since November 2009, these departments have been regulated by *Measures for the Handling of Patient Complaints in Hospitals (for Trial Implementation).*[19] These acts require that a medical institution establish a department specifically for the purpose of handling and resolving medical disputes. The department is primarily responsible for receiving patient complaints- via calls, letters, visits, and/or cases referred from other departments and institutions. Their role also includes counselling and communicating with patients, verifying and documenting disputes as well as resolving disputes.

- Administrative Mediation and Civil Lawsuits

If the hospital is unable to resolve certain conflicts through negotiation, these cases

may be referred to an external body such as the health administrative department or they may be settled in the court by means of litigation. The *Tort Law of the People's Republic of China*, adopted at the twelfth session of the Standing Committee of the Eleventh National People's Congress on December 26 2009, provided a new legal definition of liability for medical malpractice, liability presumption and exemption.[27]

- Complaint Letters and Visits System

In February 2007, *Measures for the Complaint Letters and Visits System for Healthcare* came into force.[28] Its purpose is to protect the legal rights and interests of citizens, legal entities and other organizations, regulate behaviour and maintain order within the Complaint Letters and Visits System. It requires health administrative departments to set up the Complaint Letters and Visits office at different levels. These offices are responsible for receiving, assigning and transferring matters as appropriate, as well as supervise in the handling of various issues and complaints.

- People's Mediation- a form of Third-Party Facilitated Mediation

In July 2008, the Shanghai Justice Bureau and Health Bureau issued *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*, to establish the People's Mediation Committees for Medical Disputes.[29] Committee members, mainly retired judges and doctors, served to mediate disputes through reporting, explaining and analysing cases under the supervision of local

judiciary. In January 2010, the Ministry of Justice, the Ministry of Health and the China Insurance Regulatory Commission jointly issued *Opinions on Strengthening People's Mediation for Medical Disputes* to strengthen the role of mediation in resolving medical disputes.[30] Its intent is to settle medical disputes in an effective way and maintain order within hospitals, all with a view for ensuring harmony and social stability. In July 2011, the Shanghai Justice Bureau and Health Bureau introduced *Measures on People's Mediation for Medical Disputes in Shanghai* to replace *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*.[29, 31]

Further to the aforementioned channels of complaint, patients have been found to express their discontent by "Yi Nao"- exhibiting disruptive behaviour within the hospital, targeting doctors and nurses or hospital managers by way of abuse, assault and other forms of violence. Much of this has garnered media attention, resulting in bad publicity for the hospital and damaging the reputation of doctors and staff.

2. The application of different complaint approaches

Table 2 the characteristics of the approaches

	Negotiation between Hospitals and Complainants	**Administrative Mediation**	**Civil Lawsuits**	**Complaint Letters and Visits System**	**People's Mediation**
Responsible institution	Complaint Reception Office in hospitals	Health Inspection Institute	People's Court	Complaint Letters and Visits Office in health administrative departments	People's Mediation Committee for Medical Disputes
Responsibility	Receive and handle patients' complaints; compensate some complainants	Receive and mediate medical malpractices	Receive and settle medical litigations	Receive, transfer and supervise patients' complaints	Receive and mediate patients' complaints
Handling method	Negotiation	Mediation	Mediation; Trial	Supervise matters	Mediation
Processing duration	Indefinite	Only once	Six months	Two months	One month
Legal level of resolution	Low	Low	High	Low	Low
Administrative level of resolution	Low	High	High	High	Low

The complex relationships between different approaches can be seen where many actors are involved. From the aspect of solution, approaches that can resolve medical disputes are mainly negotiation and civil lawsuits, while other approaches play a part in forwarding cases, such as Complaint Letters and Visits System, or easing conflicts, such as mediation. None of the approaches are considered the most authoritative approach. Patients can continue to lodge complaints through the Complaint Letters and Visits System even if a decision has been finalised after a second trial in court.

In the above-mentioned approaches, the hospital is the main handler for patient complaints. First of all, it can handle patient complaints completely independently, from reception to solution, while the other approaches have to engage hospitals in complaint handling. Secondly, since the hospital is principally responsible for compensation, the complainant is more inclined to directly negotiate with the hospital. Findings from the literature show that the majority of medical disputes are resolved by negotiation between hospitals and complainants.[21] Thirdly, if hospitals handle complaints improperly, conflicts will become more volatile, resulting in serious incidents.[32] Therefore, hospitals have become the most common receiver, handler and resolver of disputes. (Figure 1)

3. Barriers to the effective management of patient complaints and their underlying causes at different stages

Our interviews revealed that different hospitals often use different complaint systems.

For example, some hospitals operate a centralized complaints office, which may or may not be independent of the Medical Affairs (Administration) Department. Other hospitals have several complaints offices, each of which is responsive to different kinds of complaints. A hospital's deputy director, who also heads hospital complaint management, generally manages complaint departments. Barriers to effective complaints management vary at different stages of the complaint process- both from the sides of the user and provider.

.

- **Barriers to receiving the complaints**

Low awareness of users about the handling system for patient complaints

Although hospital staff claimed that the complaints office was accessible to those with grievances, patients did not always feel this was the case. One user looked up the hospital telephone number on the Internet and said the complaint handling process was "very easy" while others did not concur. Almost all patients being interviewed found that signs and directions (to the complaints office) failed to catch the eye. In some cases none could be seen at all:

I wanted to lodge a complaint, but did not know how to find the place [the complaints office]… Because the hospital was so big, I did not know which department [was responsible for handling complaints]. …I simply did not know who to turn to. You see, the complaints department was in another building [rather than in the one in which I was treated i.e. the clinical department] (Female, Users-1, 01-09-2011)

- **Barriers to handling the complaints**

Poor capacity and skills of health care providers

The capacity and skills of healthcare providers in managing patient complaints is critically important in problem solving. Our study found that the reasons patients complain lie mainly in poor communication and factors such as the provider's attitude, use of language, unprofessional behaviour, as well as dissatisfaction towards service procedures.

The Medical Doctors Association carried out a survey of the nature of medical disputes. 50 per cent of cases were a result of inappropriate attitudes in health care delivery, 25 per cent were caused by technology misuse and the rest were related to management. (Female, Policy makers-1, 16-12-2010)

The majority of complaints can be resolved by an explanation issued by the hospital and/or a verbal apology by the offending party.[5, 33, 34] However, practitioners are often too preoccupied with their clinical duties to be able to respond to patient complaints.

Hospitals have not completely adhered to regulation, which is clearly outlined in the guidelines; not because they do not have the capacity, but because doctors and related staff are simply too busy. (Male, Administrators-1, 21-12-2010)

Doctors are not able to devote much time to handling disputes, because clinical work is highly demanding. [They need to attend to] many patients every day. If they spend more time communicating with patients, they would lose time needed to carry

out [clinical work]. That is to say, [doctors should be given] less [clinical] work, and more time to explain their work to patients. Our workload is very heavy, like a battle. (Female, Health providers-1, 01-09-2011)

Incompetence and powerlessness of complaints handlers

Complaint handlers played a more important role in cooperation and coordination. Although the complaint department was specifically set up in hospitals for receiving and handling complaints, the responsible persons in the department were mainly part-time medical staff. In some cases, those handling staff were found to be inadequate- sometimes due to lack of training. Many of them had studied handling techniques on their own and had not acquired sufficient professional skills to appropriately analyse, assess and solve complaints.

Complaint handlers in the hospitals cannot solve everything because the disciplines involved in complaints are highly specialised. I am only familiar with general surgery and issues that require common sense, but [I am not familiar] with professional problems in other disciplines. (Male, Hospital managers-5, 08-09-2011)

It is difficult to recruit staff for our Medical Dispute Handling Office. No one wants to come. A boy recruited in 2007 could not stand the demands of the job [complicated disputes and violence] and so resigned. (Female, Hospital managers-3, 31-08-2011)

We have little time to do things other than receiving complaints. We lack staff

members. We are responsible for receiving and processing complaints, and expected- on top of this- to deal with other things, hence why we are exhausted. (Male, Health providers-2, 16-09-2011)

Given that most complaints are handled and resolved in the hospital, it appeared that every complaint handler interviewed felt the same way: tired and stressed. Complaint handlers were insufficiently empowered to handle complaints. It was hard for them to coordinate between different departments, investigate cases, organize mediation, find solutions and then draw on patients' feedback to improve quality of care.

Recently, a fierce medical dispute occurred because of a possible misunderstanding between administrative departments. [Abusive] words erupted. As a consequence, staff members involved in this incident were distraught- to the extent that they wanted to resign. Hence we need understanding and support among colleagues. ...Sometimes the clinical department concerned refused to cooperate when investigated. He [the clinical department] is not very serious about cooperating with the investigation. (Female, Hospital managers-3, 31-08-2011)

Communication between administrative departments and clinical departments is not very effective sometimes. I am not satisfied with this. (Female, Hospital managers-2, 25-08-2011)

Non-transparent exchange of information

In addition, the complaint handling process was not truly open to the complainant and information exchange was largely limited to hospital staff. In fact, it was found that

the staff at the complaints office was generally evasive towards patients who arrived wishing to be updated with the specifics of their complaint. The complainant had no opportunity to directly engage in the handling of the complaint or to meaningfully participate in the process. In addition, hospitals tended to oversimplify cases, assuming that the complainant's only desire was to report their complaint and ask for compensation. This implies that the entire handling process is disclosed only among hospital staff. Therefore, the process becomes a "black box" to patients. It is easy for the hospital to manipulate a complainant by providing limited information to gain advantage in negotiations, i.e. reduce loss from compensating patients.

Sometimes you have to circumvent something and use negotiating skills. Mistakes in medical services do not necessarily harm patients' health, but they can be very serious for the provider [...] for example, someone may not be very careful when writing a medical record and alter it by accident. But you are likely to lose a lawsuit on the grounds of having tampered with records. Incidents such as these cloud the matter, making transparency difficult. (Female, Hospital managers-2, 25-08-2011)

If the incident is urgent or presents itself as a recurring problem, it might be shared to educate healthcare providers but disclosure to complainants themselves remains limited. Only outcomes deemed to be of direct interest to patients, including compensation amounts and medical service privileges, were provided. However, other results, including penalties imposed upon physicians and departments or improvements made to hospital services, were largely withheld from patients if they did not ask.

In individual cases, what are the outcomes of their complaints? How might a physician be punished/penalised/disciplined? Such information is requested by patients only occasionally. (Male, Health providers-2, 16-09-2011)

I want to know how to better educate the concerned health care providers. But I have not been told. (Female, Users-3, 20-09-2011)

- **Barriers to resolving the complaints**

Conflicts between relevant actors and regulations

Within the complaints system, conflicts or inconsistencies can arise between the legal system for handling complaints and the solutions determined by the hospital. As the structure of managing patient complaints is shown in Figure 1, different regulations stipulate different approaches. There does not exist a unified law or guidelines to clearly illustrate the relationships between different approaches, which results in problems such as lack of authority or ultimate approach, uncertainty about how to apply different regulations to one case and no clear definitions or classifications in regards to patient complaints.

The current state of complaint management is disorderly. There are too many channels. For example, many departments are involved, including but not limited to Complaint Letters and Visits, online complaints etc. The Health Bureau has two departments [for complaint management], each district has a mediation office, a district government website or a mayor-mail [to receive complaints], and a Complaint Letters and Visits office… Far too many heads of department within the

health sector; it's chaos. (Male, Health providers-2, 16-09-2011)

Hospitals are required to report complaints to a lot of sectors, all of which wish to understand the issue from different angles. There are not necessarily conflicts between regulations, but different elements are emphasised. Hospitals are tired of these kinds of bureaucracy. ...Each sector carries out their designated duties where resources are not shared. The information possessed by each sector is fragmented. You know yours, I know mine. (Male, Administrators-2, 18-08-2011)

Medical malpractice is defined clearly in the Regulation on Handling Medical Malpractice. There are several benchmarks determining the amount of compensation issued. After the Tort Liability Law of the People's Republic of China was promulgated, [medical damage] was compensated for more in accordance with the Tort Liability Law, because it stipulates compensation for personal injury. (Female, Hospital managers-2, 25-08-2011)

Unjustifiable complaints by patients

In some cases, the patient experiences inconvenience when receiving medical services not because of poor conduct in attitude or behaviour on the part of health providers. Instead, inconvenience may be due to long waiting times, too little time spent with the doctor and/or imperfect resource allocation. These are health system issues rather than problems caused by hospitals or individual physicians. And so to a certain extent, physicians and hospitals have become scapegoats of the entire health system.

At times it is not us physicians who have made a patient angry. Certain factors are

rooted in the fabric of health care systems, but we physicians [end up] taking the blame. (Male, Health providers-3, 16-09-2011)

For example, should a doctor need to see sixty patients in half a day, or indeed one hundred, you cannot demand that he puts on a smile for each one. A lot of patients complain about doctors with a straight face, but I think it is understandable. I have a very good relationship with our young doctors. They operate on a tight schedule. This week someone works at the outpatient facility. He is friendly with patients in the first month but struggles to sustain this sort of demeanour. He is not in the mood to smile at patients or engage in long conversations when he only has time to attend to their illnesses. (Male, Hospital managers-1, 15-12-2010)

For example, dissatisfaction voiced in the hospital may be related to health insurance policy rather than staff behaviour. Hospitals need to follow the policies made by the Health Insurance Department. The purpose of those policies was to improve rational use of medicines and control healthcare cost, while the patients covered by health insurance may demand more medicines.

Chinese doctors have many rules to obey [this is to curb poor conduct]. The pressures for them to perform are relatively large. For example, doctors cannot prescribe too much medicine for a patient who has only [basic state-financed] medical insurance, but patients always want more. A while ago, the Medical Insurance Bureau issued the following statement in a newspaper: The Medical Insurance Bureau never limits the volume of drugs prescribed, rather it is the doing

of hospitals who wish to increase workload [in order to produce more statistics]. I think this is really unreasonable. The Bureau does not control the quantity of drugs prescribed in any given week, but there is a total quantity limit over a year. Doctors try their best not to prescribe drugs which must be self-financed, i.e. not covered by basic medical insurance. They must also explain very clearly before prescribing self-financed drugs, otherwise, patients will lodge complaints once they find out. (Male, Hospital managers-1, 15-12-2010)

Complaints occur when the patient wants more drugs but the doctor refuses to satisfy his or her demands. Why? The health insurance institution sets a limit for drug expenditure for each hospital; in turn, the hospital sets a limit for each doctor. So if a doctor has too many patients drawing from their health insurance scheme in any one month, he or she may very possibly have exceeded his/her limit. (Male, Health providers-3, 16-09-2011)

[A patient who has] basic state-financed medical coverage is entitled to blood and other auxiliary examinations. If the number of health checks prescribed exceeds a certain threshold, the doctor is viewed as exploiting basic medical insurance. The doctor is consequently punished. I was deducted more than seven hundred yuan (RMB) because of a case like this. I feel this is simply absurd- it is [unexpectedly] doctors who are to blame. Nothing seems to be wrong with the patient. ...The hospital can't do anything about medical insurance. I think this kind of thing is not the problem at the hospital level. The complaints about medical insurance define without a doubt problems underlying state and society. (Male, Health providers-4,

16-09-2011)

In addition, the safety of health providers is under threat in China today. Chinese medical workers are often victims of terrible violence. As a consequence, some health providers have decided not to treat patients deemed likely to assault staff, exhibit disruptive behaviour or prove difficult to deal with. Prescribing redundant check-ups and drugs are alternatives to properly seeing to patients.

In our interviews, fifteen interviewees mentioned "Chao" fifty-five times. "Chao" in Chinese means to argue with hospitals for patients' own rights and interests, while the other meaning is wrangle fiercely in hospitals or with senior management. Most of the hospital staff being interviewed suggest that some complainants be indeed unreasonable and impulsive, whose sole purpose is to ask for money.

If the case goes to court, the patient gathers a lot of people to go to the court, insulting and threatening concerned health care providers and their lawyers. That is not what we want to see. We want to talk about the truth, by thoroughly publicizing the truth. We cannot always be too specific with terminology [for fear of revealing too much]. When completely refuted, patients lose their temper. (Male, Other actors-2, 15-09-2011)

I feel that the widespread situation in China today is that you can do nothing if you run into the unreasonable. The legitimate way of going about this is once I receive your complaint, a fair decision is proposed. If complainants are not willing to settle for this, we then transfer their case to other departments. However, complainants may not even agree to that, causing trouble and even threatening the safety of

health care providers. (Female, Hospital managers-2, 25-08-2011)

The claim a complainant demands goes beyond the actual problem [but for the money] and he does not wish to resolve it the legal way. ...Nowadays "Yi Nao" has brought about serious social effects, and escalated the tension between service users and providers. Complainants are unwilling to resolve things the legal way, rather, just pestering and hassling you [health care providers or complaint handlers] all day. (Male, Hospital managers-6, 01-11-2011)

- **Barriers to institutional changes for quality improvement using complaints data**

Weak enforcement of the regulation

The regulation for managing patient complaints is merely a guideline, which contains no mandatory requirements such as assessment mechanisms. Because it takes into account the difference in local conditions throughout China, specific contents were not stipulated. The regulation is to be interpreted according to local circumstances and conditions. Therefore, in the absence of strong public scrutiny, there is little accountability for how best to manage patient complaints.

There are no penalties attached to (failure to follow) regulation. For example, there is no administrative aspect to the regulatory guidelines. We wanted to write a penalty provision, but it was not based on the top legislation. The purpose of the regulation is to emphasise self-discipline and serve as guidance for the hospital. [The penalty was not enforceable,] so we decided to remove the penalty. It is indeed

difficult and contradictory. (Female, Administrators-4, 30-11-2011)

Besides the legal system, the reporting system also has its problems. Some statistics about patient complaints and medical malpractice were utilized as a part of assessments of hospital performance, health care quality, and so on. This meant that the more cases that were reported, the worse the evaluations received by the hospitals, so that hospitals were inclined to report selectively or report fewer cases.

There are certainly no statistics for the number of patient complaints. There is only the data on the number of cases of medical malpractice per year from the Bureau of Health, and an approximate amount of compensation issued by insurance companies. In some cases, if complaints were solved just between the hospital and the complainant, we have no data. (Male, Administrators-2, 18-08-2011)

These days, the information regarding the management of patient complaints in hospitals is difficult to access. Hospitals are unwilling to provide that sort of information- considered confidential. We only have some profiles or the information from select hospitals. (Female, Policy makers-1, 16-12-2010)

Thus, the adoption of the incentive and sanction mechanism was contradictory for managing patient complaints. From one side, the administrative department wanted hospitals to report patient complaints because it is important for informing and improving the quality of care. From the other side, the more complaints that are registered, the worse it would appear a hospital is doing. In addition to this, managing patient complaints remains low on the health reform agenda. The force for inspecting

complaint management in hospitals from senior management and administrative departments remains weak.

[Having a statistic for patient complaints] is definitely necessary, from the aspect of effective management. If this statistic is disposable, I think no problem. If the statistic is routine, in fact, it will cost [of all sorts of resources]. (Male, Policy makers-2, 22-12-2011)

Hospitals doubt that the purpose of administration is for information management- to help them better handle and solve disputes. However, if you want me to report incidents but meanwhile punish me for that, then I have no incentive to report anything. This contradiction stands [in the way of effective reporting]. (Female, Administrators-4, 30-11-2011)

Deficient information system for managing patient complaints

Although the regulations in place require collecting and analysing information, there exists no clear classification, definitions or unified coding system. Most hospitals have established their own systems for recording complaints and analysing cases, but no accurate or comparable data are available.

In fact a lot of cases should be recorded and analysed, [but] we do not even take into account so-called major cases of medical malpractice, mass disturbance or medical malpractice. We cannot distinguish between these concepts…. Relatively speaking, it is more feasible to publicize the data on public security, e.g. the number of police records and people arrested, the number of crimes committed. Those

definitions are more explicit, whereas those concerning complaints management are not. Because all statistics are calculated in the hospital, we find that where standards are slack, the resulting statistic is large whereas with a strict standard, it will be small. Hence, there is great variability in our results. (Male, Policy makers-2, 22-12-2011)

Identical forms are sent to two hospitals at a similar level and the reported data can be quite different. ...Some hospitals only reported cases resulting in compensation and some hospitals record all persons who voice a concern, while others only report cases identified as medical malpractice. But it is impossible for me to verify [the reported data] in each hospital. (Male, Administrators-2, 18-08-2011)

Hospitals have not publicized complaints; neither have health administration departments. The Shanghai Bureau of Health launched a pilot project in 2005 to publicize the complaints reported by all hospitals in Shanghai. The project was welcomed by the public but discontinued soon after its launch due to mounting pressure from the hospitals.

We already publicize complaints [medical malpractice] on our intranet for hospital staff. It is unnecessary to share this information on external sites. (Female, Hospital managers-4, 06-09-2011)

To my knowledge, such information was published once on the Xinmin Evening News in 2005. The newspaper named hospitals that had won awards and gave details of the number of medical malpractice cases inherent in each, as well as feedback regarding patient satisfaction. [We felt] the pressure was very, very high.

It [publishing those] resulted in public outrage [from hospitals]. (Female, Administrators-4, 30-11-2011)

Unwillingness of hospitals to effectively handle complaints

Most hospitals did not devote much effort into managing complaints. There was no clear mechanism to utilize patient complaints to improve quality of care unless serious medical malpractice had occurred or complaints were found to recur.

Hospitals just handle complaints when complaints happen. ...We are basically perfunctory, including hospitals, department directors and doctors. The best-case scenario for me: do not approach me for these things [complaints]. Deal with complaints quickly and efficiently; in other words, spend money to buy peace. The impact of managing and addressing complaints is negligible, with very little effect on improving medical procedures and quality. (Male, Administrators-2, 18-08-2011)

Hospital directors were the key actors of complaint management in hospitals. The incentive and sanction mechanisms in hospital depended on how much they pay attention to complaint management. In the 1980s the government reduced subsidies for public hospitals under the context of transforming the planned economy to a so-called socialist market in order to reduce inefficiencies in health care provision. Hospitals had to increase service charges to generate more revenue to recoup the operational costs and increase the income level of health workers. Complaint management occupied nothing but a small part of quality health care, so in most

hospitals it failed to draw attention from senior management. Most complaints were solved on a case-by-case basis, without sufficient concern for the overall improvement of health care services.

In practice, the head of department influences implementation. If he/she regards this as important, then subordinates work harder of course. Now the problem is that some heads of department do not pay attention to it [complaint management]. (Male, Health providers-2, 16-09-2011)

It is of course medical services that are the core of hospital work. Things such as [complaint management] are boring for the hospital. To a hospital, the fewer the complaints, the better. (Male, Administrators-2, 18-08-2011)

Discussion and Conclusions

This study examined the handling system for patient complaints in China and the views of key stakeholders on the barriers to effective complaint management. Our study provided a new dimension of understanding the complaints management system in China, a developing country. Hospitals are the most important handler and manager of patient complaints in China and similarly for other developing countries such as India and Vietnam. We explored the barriers through in-depth interviews with almost all stakeholders, not only health professionals. What we found would help develop procedures for more effective complaint management and to further improve the quality of care in China and other developing countries. The selection of participants may introduce some bias to our studies. Due to our focus on the hospital, there may be

an underrepresentation of certain types of respondents.

Our Findings showed that there are no standardized systems and procedures dealing with patient complaints in China, due to conflicts between relevant actors and regulations. Having experienced rapid economic growth in the last 30 years, China is undergoing a socioeconomic transition. Like other developing countries, policies lag behind the country's economic transition. The Ministry of Health has tried to guide health providers by issuing special regulation, but health administrations do not apply strict regulation to complaint management. There lacks clear relationships between patient complaints and clinical outcomes or the quality of care.

The hospital leader is the key determinant for complaint handling inside the hospital. However, no apparent incentives exist to push hospital leaders to place priority on complaint handling. The power of complaint handling departments depends on how much the hospital leaders pay attention to it. Under the current situation, hospital leaders lack political will to manage complaints effectively, leading to inadequate human resources in complaint handling departments. The departments also lack the power to coordinate with clinical departments.

The patient complaints in many Chinese hospitals are not well managed and handled. Most hospitals manage patient complaints on only a case-by-case basis. They lack clear mechanisms linking patient complaint with improving the quality of care.

Complaints are underutilised for organizational strategic planning or changing individual behavioural and attitudes. This implies that legislation should not only stipulate the principles and regulations of patient complaint management, but also the responsibilities of sectors at different levels.

To alleviate patient complaints related violence, civil groups, including service users and the hospital sector, should approve the guideline. In developed countries, patient complaint management provides guidelines not only for health care providers, but also clear guidelines for patients. This not only makes it more convenient for patients, but also plays a positive role in helping patients initiate the complaint process via legitimate means. This is crucial for society to view patient complaint in a rational way.

If patient complaints can be better managed and rectified, the instances of failure would be reduced and quality would be improved. Greater emphasis should be placed on quality improvement after patient complaints. Strategies to improve quality following patient complaints should be developed through a learning process. To promote the learning process, appropriate mechanisms should be developed and implemented to assess not only the number of patient complaints occurring in hospitals, but also how these hospitals have handled these complaints. For example, reporting more patient complaints should not be necessarily punished, while effective handling of the patient complaints should be appreciated.

Our final conclusion is that barriers to the effective management of patient complaint vary at the different stages of complaint handling, from the user and provider side, as well as systemic issues. Information, procedure design, human resources, system arrangement, unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management. Appropriate mechanisms should be developed to link patient complaint with improving the quality of care.

ACKNOWLEDGEMENT

The HESVIC project received funding from the European Commission Framework 7. The views represented in this document are not necessary representative of the European Commission's views and belong solely to the authors. The consortium would like to thank all the study respondents and participants for their willingness to take part in the research, as well as the members of the Country Research Advisory Groups for their support at every stage of the HESVIC project. The authors of the paper very much appreciate constructive comments and suggestions on earlier version of the paper from Shenglan Tang from Duke Global Health Institute, USA. The authors are also grateful to Ms. Kaori Sato for language editing.

COMPETING INTERESTS

None.

FUNDING

This study was supported by the European Commission Seventh Framework Programme (HEALTH-F2-2009-222970).

CONTRIBUTORSHIP STATEMENT

YJ, XY, QZ collected and analyzed the data primarily. All authors were involved in analyzing the data and editing the paper.

DATA SHARING

No additional data available.

References:

1. Sage WM. Putting the patient in patient safety: linking patient complaints and malpractice risk. *JAMA* 2002;**287**:3003-5.
2. Hsieh SY. A system for using patient complaints as a trigger to improve quality. *Qual Manag Health Care* 2011;**20**:343-55.
3. Wofford MM, Wofford JL, Bothra J, et al. Patient complaints about physician behaviors: a qualitative study. *Acad Med* 2004;**79**:134-8.
4. Beecham L. Patients' complaints: GMC could do better. *BMJ* 1999;**319**:1022.
5. Anderson K, Allan D, Finucane P. A 30-month study of patient complaints at a major Australian hospital. *J Qual Clin Pract* 2001;**21**:109-11.
6. The Henry J. Kaiser Family Foundation. Medical Malpractice Law in the United States. http://www.kff.org/insurance/upload/Medical-Malpractice-Law-in-the-United-States-Report.pdf Accessed [08-31-2012].
7. Xi X. *Understanding and application of provisions in the Tort Liability Law*. Beijing: Press of the People's Court; 2010.
8. Chinese doctors are under threat. *Lancet* 2010;**376**:657.
9. Zheng XQ, Wei LY, Zhang BZ, et al. Domestic Survey of Medical Disputes and Foreign Medical Dispute Handling. *Chinese Hospitals* 2007; **7**:2-4.
10. Stafford C. Moral ambivalence in modern China. *The Lancet* 2012;**9818**:793.
11. Communicating concern: complaints against doctors. *Lancet* 2013;**382**:1382.

12. Hsieh SY. Healthcare complaints handling systems: a comparison between Britain, Australia and Taiwan. *Health Serv Manage Res* 2011;**24**:91-5.

13. Department of Health, United Kingdom. Complaints procedure. http://www.dh.gov.uk/health/contact-dh/complaints/ Accessed [08-31-2012].

14. Cornwall A, Romios P. Turning Wrongs Into Rights. *Health Issues* 2004;**79**:13-8.

15. Hickson GB, Federspiel CF, Pichert JW, et al. Patient complaints and malpractice risk. *JAMA* 2002;**287**:2951-7.

16. Pichert JW, Hickson G, Moore I. Using Patient Complaints to Promote Patient Safety. *Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 2: Culture and Redesign)*. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008.

17. Hickson GB, Moore IN, Pichert JW, et al. Balancing systems and individual accountability in a safety culture. *From Front Office to Front Line: Essential Issues for Health Care Leaders, 2nd ed*. Oakbrook Terrace, IL: Joint Commission Resources; 2012. p. 1-35.

18. Vincent C, Davis R. Patients and families as safety experts. *CMAJ* 2012;**184**:15-6.

19. Ministry of Health. *Measures for the Handling of Patient Complaints in Hospitals (for Trial Implementation)*. Beijing: Ministry of Health; 2009.

20. Green A, Gerein N, Mirzoev T, et al. Health policy processes in maternal health: a comparison of Vietnam, India and China. *Health Policy* 2011;**100**:167-73.

21. Gao J, Cao W, Xu Y, et al. Survey analysis of consultation settlement for medical

disputes in 30 medical institutions of Shanghai. *Journal of Shanghai Jiaotong University (Medical Science)* 2010;**30**:960-3.

22. Charmaz K. *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. Thousand Oaks, CA: Sage Publications, 2006.

23. Sadler GR, Lee HC, Lim RS, et al. Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nurs Health Sci* 2010;**12**:369-74.

24. Lacey A, Luff D. *Qualitative Research Analysis*. The NIHR RDS for the East Midlands / Yorkshire & the Humber, 2007.

25. Department of Health, NSW. *Complaint Management Guidelines*. North Sydney NSW: Guidelines; 2006.

26. State Council. *Regulation on the Handling of Medical Malpractices*. Beijing: Decree of the State Council; 2002.

27. Standing Committee of the Eleventh National People's Congress. *Tort Law of the People's Republic of China*. Beijing: Presidential Decree; 2009.

28. Ministry of Health. *Measures for the Complaint Letters and Visits System for Healthcare*. Beijing: Ministry of Health; 2007.

29. Shanghai Justice Bureau and Health Bureau. *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*. Shanghai: Shanghai Justice Bureau and Health Bureau; 2008.

30. Ministry of Justice, Ministry of Health, and China Insurance Regulatory Commission. *Opinions on Strengthening People's Mediation for Medical Disputes*.

Beijing: Ministry of Justice, Ministry of Health, and China Insurance Regulatory Commission; 2010.

31. Shanghai Justice Bureau and Health Bureau. *Measures on People's Mediation for Medical Disputes in Shanghai*. Shanghai: Shanghai Justice Bureau and Health Bureau; 2011.

32. Yan X. Correctly Receive Medical Complaints and Establish Harmonious Doctor-patient Relationship. *Modern Hospital Management* 2008;**6**:24-5.

33. Manouchehri MJ, Ibrahimipour H, Sari AA, et al. Study of patient complaints reported over 30 months at a large heart centre in Tehran. *Qual Saf Health Care* 2010;**19**:e28.

34. Siyambalapitiya S, Caunt J, Harrison N, et al. A 22 month study of patient complaints at a National Health Service hospital. *Int J Nurs Pract* 2007;**13**:107-10.

Title page

1. Title of the article.

Managing ~~patients'~~ patient complaints in China: what went wrong?

2. Full name, postal address, e-mail, telephone and fax numbers of the corresponding author.

The corresponding author: Xu QIAN

Postal address: Mailbox 175, 138 Yi Xue Yuan Road, Shanghai, 200032, P. R. China

Tel: 86-21-54237267 Fax: 86-21-64174172

Email: xqian@fudan.edu.cn

3. Full names, departments, institutions, city and country of all co-authors.

1) Yishi JIANG: School of Public Health, Fudan University, Shanghai, China; Shanghai Maternal and Child Health Center, China

2) Xiaohua YING: School of Public Health, Fudan University, Shanghai, China

3) Qian ZHANG: School of Public Health, Fudan University, Shanghai, China

4) Sirui Rae TANG: School of Public Health, Fudan University, Shanghai, China

5) Sumit KANE: KIT Development Policy & Practice, Royal Tropical Institute, Amsterdam, Netherlands

6) Maitrayee MUKHOPADHYAY: KIT Development Policy & Practice, Royal Tropical Institute, Amsterdam, Netherlands

7) Xu QIAN: School of Public Health, Fudan University, Shanghai, China

8) HESVIC team authorship

4. Up to five keywords or phrases suitable for use in an index (it is recommended to use MeSH terms).

Qualitative Research; Patient Complaints; Complaint Handling Systems; Quality Improvement; Government Regulation~~; China~~

5. Word count - excluding title page, abstract, references, figures and tables.

~~6566~~6887

Abstract

Background: Effective management of ~~patients'~~patient complaints is ~~to improve the~~an important part of quality ~~of~~ improvement and assurance for healthcare. In China, the number of ~~patients'~~patient complaints and disputes has ~~been rising recently and~~risen significantly in recent years and has become a social issue.

Objectives: To examine the handling system for ~~patients'~~patient complaints and to identify ~~and analyse~~existing barriers ~~to~~that are associated with effective management of patient complaints in China.

Methods: A literature review was firstly conducted to understand the current handling system for patient complains~~. Then to explore the hampering factors.~~, followed by thirty-five semi-structured interviews ~~were performed~~ with key informants including ~~policy makers~~policymakers, hospital managers, health providers, users and other stakeholders in Shanghai. ~~The snowball sampling method was~~ Interviews were used to ~~reach information saturation.~~understand the process of handling patient complaints and factors affecting the process and outcomes of patient complaint management.

Findings: The Chinese handling system for patient~~s'~~ complaints has been established in the past decade. Hospitals undertake the most responsibility of ~~patients'~~ patient complaint handling. Barriers to effective management of patient complaints ~~are divided into four stages. The barriers to initiating the complaint process include~~included service users' low awareness ~~of users~~ about the systems~~. Barriers~~ in the ~~handling~~initial stage of the process ~~include~~; poor capacity and skills of healthcare providers, incompetence and powerlessness of complaints handlers and

non-transparent exchange of information~~. Barriers to~~ during the process of complaint ~~solution stage include~~handling; conflicts between relevant actors and regulations and unjustifiable complaints by patients~~. Barriers to post-complaint institutional changes include~~ during the stage of solution settlements; and weak enforcement of the regulation, deficient information for managing ~~patients'~~patient complaints and unwillingness of the hospitals to effectively handle complaints in the post-complaint stage.

Conclusions: Barriers to the effective management of ~~patients'~~patient complaint vary at the different stages of complaint handling~~,~~ and from the service user and provider ~~side, as well as system issues.~~perspectives. Information, procedure design, human resources, system arrangement, unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management.

Article summary

Strengths and limitations of this study

This study explores the handling system for~~the structure of managing~~ ~~patients'~~patient complaints in China and the views of key stakeholders on the barriers to effective complaint management. These findings are essential to ~~plan strategy to~~ improve the complaints system. Our study provides a new dimension of understanding ~~to~~ the complaints management system in China, a developing country. We explore the barriers through in-depth interviews with almost all stakeholders, not only health professionals. What we found will help develop procedures for more effective complaint management and to further improve the quality of care in China and other developing countries. The selection of participants may introduce some bias to our studies. Due to our focus on the hospital, there may be an underrepresentation of certain types of respondents.

~~The selection of participants might bring some bias to our studies. Our focus was on the hospital, so some types of respondents may have been under represented. For example, there are many other relevant actors, whereas we could only select important ones and we did not interview as many as respondents directly related. Moreover, we planned to recruit the same number of participants in multiple settings, but the number of participants from each was imbalanced because of information saturation.~~

Bullet points

1. Our study ~~was to examine~~examined the handling system for

patients' complaints and identifyidentified and analyseanalysed barriers to effective management in China.

2. We carried out a literature review and semi-structured interviews with all categories of key informants.

3. Hospitals undertake the most responsibility of patients' complaint handling.

4. Barriers to the effective management of patients' complaint vary at the different stages of complaint handling, from the user and provider side, as well as system issues.

5. Information, procedure design, human resources, system arrangement, unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management.

Background

In recent years, ~~patients'~~patient complaints ~~across~~around the world have garnered mounting concern among policymakers, academics and the general public.[1-3] As China prospers, making ~~great~~ advances in medicine and social welfare, people's expectations of better quality of care continue to grow. People's ~~consciousness~~knowledge of the law and their rights has increased as a result of education and better understanding of the law. Patients are able to express their discontent by lodging complaints such that the number of complaints occurring internationally is on the rise.[4, 5] The growth in dollars paid on malpractice claims is also evident.[6] The current situation reveals much concern surrounding hospital accountability and clinical governance; in particular, the efficacy of the system for redress. ~~There are likely to be grave~~Grave consequences pertaining to both social and political stability are likely if the health care system fails to meet expectations and achieve patient satisfaction. Indeed, the issue at hand is one of paramount importance~~-~~, requiring urgent attention and immediate action at the highest level.

With no official statistics of patient~~s'~~ complaints available in Chinese records, we estimate that the number of complaints and disputes rose~~,~~ based on the number of first trials for medical malpractice cases between 2002 and 2008, from 10,249 to 13,875.[7] Mounting dissatisfaction has been felt across the country, ~~manifest~~manifesting in increasingly hostile and violent behaviour towards providers by patients and their families.[8] An investigation carried out by the Chinese Hospital Management

Association in 2005 suggests that of 270 hospitals surveyed, 73 per cent experienced abuse in the form of threats and assaults targeting doctors and management.[9] These incidents are only indicative of rising expectations, burgeoning patient discontent with services and dissatisfaction towards the manner in which matters are resolved.[10] Public outcry only exacerbates the need for more effective handling of individual cases under the overarching agenda for public hospital reform in China.[11]

In countries such as Australia and Britain, the state has sought to monitor complaints and complaint handling to improve and regulate the practice of health professionals.[12] A feedback system of this sort has proven instrumental in improving the quality of care. In Britain, the National Health Service (NHS) not only provides clear and transparent guidelines for both health providers and patients but also publicizes information regarding the routine reporting of patients' complaints.[13] In Australia, a large study was conducted before *Guide to Complaint Handling in Health Care Services* was formulated and subsequently updated.[14] Annually, statistics are compiled and published, detailing complaint trends, complaint management and reasons for complaints. Effective handling of complaints has been known to reduce friction between providers and consumers, with the even greater benefit of improving quality of care. As a supplement to peer review and administration, patients' complaints can provide important feedback concerning the delivery of health care services and can be a useful tool in the improvement of health care quality.[1-3, 15-18]

Amidst soaring angst, the Chinese government ~~have~~has put in place a system for redress where grievances arise. A "complaint" is defined as *the behaviour of a patient or his/her representative(s) which signifies dissatisfaction towards medical services, nursing services, as well as treatment conditions through letters, calls or visits to the hospital where the purpose of these actions is to criticise the hospital and/or claim compensation"*.[19]

Notwithstanding the alarming extent of these issues, few attempts have been made to formally examine how hospital complaints are addressed in developing countries. It is only recently that a handful of studies in China have sought to provide some understanding of the issue, by trying to ascertain the number of complaints and garnering patient feedback via questionnaires and interviews. A fuller understanding of the complaints system- the available channels for seeking redress, how the system operates and the barriers to conflict resolution- will be crucial to ameliorating the often fraught relationship between health care providers and consumers. The purpose of this study has been to examine the handling system for patient~~s'~~ complaints in China; to subsequently identify and analyse the various hospital-specific factors preventing grievances from being effectively addressed. The authors of this paper hope that such an undertaking ~~in strengthening clinical governance and enhancing doctors' performance~~ will reduce malpractice and above all, improve health service outcomes.

This study is one of the tracing cases from ~~The~~ the "Health System Stewardship and Regulation in Vietnam, India and China" (HESVIC) research project. It was conducted by a consortium of six partners in Asia and Europe from 2009-2012, with the aim of supporting policy decisions in the application and extension of accessibility, affordability, equity and quality coverage of maternal health care in the three countries.

Methods

Study design

The project uses a multidisciplinary approach, drawing on multiple case studies to examine the impact of regulation ~~in~~on improving equitable access to quality health care in Vietnam, India and China. In each country, three cases were selected and studied. This paper shows the findings from the case study examining the regulation on Grievance Redressal (GR) in Shanghai, China. Here, regulation encompasses the formation of rules and practices, as well as their interpretation and ~~implementing~~implementation, such as the health policy processes covered in the HEPVIC project (HEPVIC).[20]

Phase One: Literature Review

Firstly, we conducted a literature review. The relevant sources, which included regulation documents relating to the handling of patient complaints at both the

national and Shanghai municipal levels, were used to collect legal approaches and mechanisms used in managing patient complaints. These regulations were mainly stipulated from 2002 to 2011. To understand the application of different complaint approaches, a search of scientific literature published between 2000 and 2011 was conducted. Databases MEDLINE-PubMed and WANFANG Data were consulted. A search strategy was established based on the following keywords: *grievance redressal, patient complaint, health care complaint and hospital complaint, and China*. Special focus was put on patients~~'~~ complaint management in hospitals, as we found that the vast majority of complaints are handled and resolved within the hospitals.[21]

Phase Two: pilot study - interviews

Based on our understanding of the current patient complaint handling system, we then performed semi-structured interviews with key stakeholders- ~~policy makers~~policymakers from the national level, administrators from the Shanghai municipal level, hospital managers, health providers, users and other related parties. We used the snowball sampling method to identify key stakeholders and to collect important feedback from key informants from various disciplines.[22, 23]

In Phase Two (October-December 2010), ~~a~~one key actor from each of the three administrative levels were selected and interviewed: a ~~policy maker~~policymaker at the national level, a municipal administrator and a hospital manager. A pilot study was conducted to test the topic guidelines developed. These would allow us to gain a

preliminary understanding of the process of complaint management in the hospital setting of China, and refine the data collection tools. These interviews served as the basis for the design of Phase Three interviews where some of those being interviewed in the third phase were respondents recommended by Phase Two interviewees.

Phase Three: main data collection ~~by semi-structured interviews~~

Interviews in Phase Three were conducted from August-December of 2011. Key stakeholders were interviewed in ~~select~~the selected hospitals based on location, level and type. Our sample was the representative of both urban and suburban areas in Shanghai. General hospitals and specialist hospitals were selected. Phase Three began with interviews of hospital managers and health providers proposed in Phase Two. We asked interviewees from Phase Two to invite patients and other relevant stakeholders to contribute their views. Those invited patients had used different channels for lodging their complaints. However, they all shared one thing in common: all patients had first complained to the hospital. We then proceeded to interview the administrators and finally a high-level ~~policy maker.~~policymaker. We continued to interview respondents, collecting and analysing their comments and feedback until no new themes emerged, i.e. saturation had been reached. The number of participants involved in the different types of interviewees is depicted in Table 1.

Semi-structured interviews were conducted with 35 respondents face-to-face, except one~~,~~ via telephone. The interviews took place at private locations, for example at the

institution where the interviewee or interviewer worked, and were conducted by two of the authors of this paper. Each interview lasted 1-2 hours and was ~~audio taped~~audiotaped with permission, apart from two which were not recorded but typewritten upon the respondents' request.

Table 1 ~~The number of participants from different types~~Number of interviewees by administrative level and facility

Types of interviewees	**Level**	**Number of Participants**
~~Policy makers~~ Policymakers	National	
Ministry of Health		1
A university		1
Administrators	Shanghai municipal	4
Hospital managers		
General hospital	Tertiary	3
General hospital	Secondary	3
Specialized hospital	Tertiary	1
Specialized hospital	Secondary	1
Private hospital	Secondary	2
Health providers		6
Users		6
Other actors		
Municipal Health Inspection Institute		2

Lawyers for medical disputes	2
The centre that processes medical liability insurance	1
The People's Mediation Committee for Medical Disputes	1
The Complaint Letters and Visits System	1
Total	**35**

~~***Data analysis***~~

The topic guidelines for carrying out the interviews included questions on the participant's experience on complaint management in the ~~hospital.~~hospitals. Using probes and follow-up questions, attention was directed to factors that the interviewees perceived as barriers to effective complaint management. They were asked why they believed this to be the case. From existing literature, we identified a list of factors required for effective complaint management and successful resolution of disputes. Participants were asked to provide suggestions and feedback regarding how complaints could be more effectively dealt with given the barriers they had identified.

Data analysis~~Audio tapes~~

Audiotapes recorded during the interviews were transcribed ~~for word, which was used to compare~~and were compared with the field notes ~~taken~~to check for accuracy ~~checking~~. We analysed data through a process of rigorous and structured analysis.[24]

The analysis was executed in several stages to 1) become familiar with the data; 2) identify emerging topics; 3) develop a topic index; 4) use the index to code the data; 5) consolidate the topics into themes; 6) further consolidate these themes into analytical categories/clusters; and 7) translate the analysis obtained into a narrative. Written consent was obtained from each interviewee before undertaking the interviews.

We performed the above tasks using the qualitative research software NVivo 9.0. The raw data was coded by ~~2~~two independent reviewers (YSJ, QZ). If some discrepancies emerged, a third reviewer (XHY) would participate in the group discussion until the group arrived at a consensus. There were some models for analysing complaint management, for example, a Managerial-Operational-Technical (MOT) model was developed to explore complaint management in hospitals.[2] In our study, we collected data according to the complaint management process. To analyse the data most efficiently and directly, we used the stages of the process. The stages included receive, handle and resolve complaints.[25] As the quality improvement following complaints is very important, we added the stage of "institutional changes for quality improvement using complaints data".[2, 16]

Our study was approved by Institutional Review Board (IRB), School of Public Health, Fudan University. Access to data was restricted to approved members of the research team who signed a confidential agreement with the principal investigator. Data were stored in secure electronic locations. Data processing was kept

anonymously so as to protect the identity of interviewees. The names of the respondents have been deleted from quotations.

Findings

This section first presents a number of approaches developed and implemented in Shanghai to handle patients' complaints and their relationships. It then focuses on the approach of Negotiationnegotiation between Hospitalshospitals and Complainantscomplainants, identifies its barriers, and proceeds to examine and analyse these barriers.

1. Approaches and mechanisms used in managing patients' complaints

The study identifies both formal and informal approaches and mechanisms used in handling patients' complaints.

- Negotiation between Hospitals and Complainants

The complaint handling department within the hospital is responsible for dealing with patients'patient complaints, first established on February 20, 2002, in accordance with the *Regulation on the Handling of Medical Malpractices.*[26] Since November 2009, these departments have been regulated by *Measures for the Handling of Patient Complaints in Hospitals (for Trial Implementation).*[19] These acts require that a medical institution establishesestablish a department specifically for the purpose of handling and resolving medical disputes. The department is primarily responsible for

receiving patients' complaints- via calls, letters, visits, and/or cases referred from other departments and institutions. Their role also includes counselling and communicating with patients, verifying and documenting disputes as well as resolving disputes.

- Administrative Mediation and Civil Lawsuits

If the hospital is unable to resolve certain conflicts through negotiation, these cases may be referred to an external body such as the health administrative department. Or or they may be settled in the court by means of litigation. The *Tort Law of the People's Republic of China*, adopted at the twelfth session of the Standing Committee of the Eleventh National People's Congress on December 26 2009, provided a new legal definition of liability for medical malpractice, liability presumption and exemption.[27]

- Complaint Letters and Visits System

In February 2007, *Measures for the Complaint Letters and Visits System for Healthcare* came into force.[28] Its purpose is to protect the legal rights and interests of citizens, legal entities and other organizations, regulate behaviour and maintain order within the Complaint Letters and Visits System. It requires health administrative departments to set up the Complaint Letters and Visits office at different levels. These offices are responsible for receiving, assigning and transferring matters as appropriate, as well as supervise in the handling of various issues and complaints.

- People's Mediation- a form of Third-Party Facilitated Mediation

In July 2008, the Shanghai Justice Bureau and Health Bureau issued *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*, to establish the People's Mediation Committees for Medical Disputes.[29] Committee members, mainly ~~consist of~~ retired judges and doctors~~. They serve~~, served to mediate disputes through reporting, explaining and analysing cases under the supervision of local judiciary. In January 2010, the Ministry of Justice, the Ministry of Health and the China Insurance Regulatory Commission jointly issued *Opinions on Strengthening People's Mediation for Medical Disputes* to strengthen the role of mediation in resolving medical disputes.[30] Its intent is to settle medical disputes in an effective way and maintain order within hospitals, all with a view for ensuring harmony and social stability. In July 2011, the Shanghai Justice Bureau and Health Bureau introduced *Measures on People's Mediation for Medical Disputes in Shanghai* to replace *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*.[29, 31]

Further to the aforementioned channels of complaint, patients have been found to express their discontent by "Yi Nao"- exhibiting disruptive behaviour within the hospital, targeting doctors and nurses or hospital managers by way of abuse, assault and other forms of violence. Much of this has garnered media attention, resulting in bad publicity for the hospital and damaging the reputation of doctors and staff.

2. The application of different complaint approaches

Table 2 the characteristics of the approaches

	Negotiation between Hospitals and Complainants	**Administrative Mediation**	**Civil Lawsuits**	**Complaint Letters and Visits System**	**People's Mediation**
Responsible institution	Complaint Reception Office in hospitals	Health Inspection Institute	People's Court	Complaint Letters and Visits Office in health administrative departments	People's Mediation Committee for Medical Disputes
Responsibility	Receive and handle patients' complaints; compensate some complainants	Receive and mediate medical malpractices	Receive and settle medical litigations	Receive, transfer and supervise patients' complaints	Receive and mediate patients' complaints
Handling method	Negotiation	Mediation	Mediation; Trial	Supervise matters	Mediation
Processing duration	Indefinite	Only once	Six months	Two months	One month
Legal level of resolution	Low	Low	High	Low	Low
Administrative level of resolution	Low	High	High	High	Low

~~There shows the~~The complex relationships between different approaches can be seen where many actors are involved. From the aspect of solution, approaches ~~which~~that can resolve medical disputes are mainly negotiation and civil lawsuits, while other approaches play a part in forwarding cases, such as Complaint Letters and Visits System, or easing conflicts, such as mediation. ~~Not any~~None of the approaches ~~is~~are considered the most authoritative approach. Patients can continue to lodge complaints through the Complaint Letters and Visits System even if a decision has been finalised after a second trial in court.

In the above-mentioned approaches, the hospital is the main handler for ~~patients'~~patient complaints. First of all, it can handle ~~patients'~~patient complaints completely independently, from reception to solution, while the other approaches have to engage hospitals in complaint handling. Secondly, since the hospital is principally responsible for compensation, the complainant is more inclined to directly negotiate with the hospital. ~~From~~Findings from the literature ~~it is found~~show that the majority of medical disputes are resolved by negotiation between hospitals and complainants.[21] Thirdly, if hospitals handle complaints improperly, conflicts will become more volatile, resulting in serious incidents.[32] Therefore, hospitals have become the most common receiver, handler and resolver of disputes. (Figure 1)

3. Barriers to the effective management of patient complaints and their underlying causes at different stages ~~of the complaint process~~

Our interviews revealed that different hospitals often use different complaint systems. For example, some hospitals operate a centralized complaints office, which may or may not be independent of the Medical Affairs (Administration) Department. Other hospitals have several complaints offices, each of which is responsive to different kinds of complaints. ~~Complaint departments are generally managed by a~~A hospital's deputy director, who also heads hospital complaint management~~.~~, generally manages complaint departments. Barriers to effective complaints management ~~varies~~vary at different stages of the complaint process- both from the sides of the user and provider.

.

- **Barriers to receiving the complaints**

Low awareness of users about the handling system for patient~~s~~' complaints

Although hospital staff claimed that the complaints office was accessible to those with grievances, patients did not always feel this was the case. One user looked up the hospital telephone number on the Internet and ~~she~~ said the complaint handling process was "very easy" while others did not concur. Almost all patients being interviewed found that signs and directions (to the complaints office) failed to catch the eye. In some cases none could be seen at all:

I wanted to lodge a complaint, but did not know how to find the place [the complaints office]… Because the hospital was so big, I did not know which department [was responsible for handling complaints]. …I simply did not know who to turn to. You see, the complaints department was in another building [rather than in the one in which I was treated i.e. the clinical department] (Female, Users-1,

01-09-2011)

- **Barriers to handling the complaints**

Poor capacity and skills of health care providers

The capacity and skills of healthcare providers in managing patients' complaints is critically important in problem solving. Our study found that the reasons patients complain lie mainly in poor communication and factors such as the provider's attitude, use of language, unprofessional behaviour, as well as dissatisfaction towards service procedures.

The Medical Doctors Association carried out a survey of the nature of medical disputes. 50 per cent of cases were a result of inappropriate attitudes in health care delivery, 25 per cent were caused by technology misuse and the rest were related to management. (Female, Policy makers-1, 16-12-2010)

The majority of complaints can be resolved by an explanation issued by the hospital and/or a verbal apology by the offending party.[5, 33, 34] However, practitioners are often too preoccupied with their clinical duties to be able to respond to patients' complaints.

Hospitals have not completely adhered to regulation, which is clearly outlined in the guidelines; not because they do not have the capacity, but because doctors and related staff are simply too busy. (Male, Administrators-1, 21-12-2010)

Doctors are not able to devote much time to handling disputes, because clinical work is highly demanding. [They need to attend to] many patients every day. If they

spend more time communicating with patients, they would lose time needed to carry out [clinical work]. That is to say, [doctors should be given] less [clinical] work, and more time to explain their work to patients. Our workload is very heavy, like a battle. (Female, Health providers-1, 01-09-2011)

Incompetence and powerlessness of complaints handlers

Complaint handlers played a more important role in cooperation and coordination. Although the complaint department was specifically set up in hospitals for receiving and handling complaints, the responsible persons in the department were mainly part-time medical staff. In some cases, those handling staff ~~had been~~were found to be inadequate- sometimes due to lack of training. Many of them had studied handling techniques on their own and had not acquired sufficient professional skills to appropriately analyse, assess and solve complaints.

Complaint handlers in the hospitals cannot solve everything~~. Because~~ because the disciplines involved in complaints are highly specialised. I am only familiar with general surgery and issues that require common sense, but [I am not familiar] with professional problems in other disciplines. (Male, Hospital managers-5, 08-09-2011)

It is difficult to recruit staff for our Medical Dispute Handling Office. No one wants to come. A boy recruited in 2007 could not stand the demands of the job [complicated disputes and violence] and so resigned. (Female, Hospital managers-3, 31-08-2011)

We have little time to do things other than receiving complaints. We lack staff members. We are responsible for receiving and processing complaints, and expected- on top of this- to deal with other things~~. Hence~~, hence why we are exhausted. (Male, Health providers-2, 16-09-2011)

Given that most complaints are handled and resolved in the hospital, it appeared that every complaint handler interviewed felt the same way: tired and ~~stressful.~~stressed. Complaint handlers were insufficiently empowered to handle complaints. It was hard for them to coordinate between different departments, investigate cases, organize mediation, find solutions and then draw on patients' feedback to improve quality of care.

Recently, a fierce medical dispute occurred because of a possible misunderstanding between administrative departments. [Abusive] words erupted. As a consequence, staff members involved in this incident were distraught- to the extent that they wanted to resign. Hence we need understanding and support among colleagues. …Sometimes the clinical department concerned ~~refuse~~refused to cooperate when investigated. He [the clinical department] is not very serious ~~to cooperate~~about cooperating with the investigation. (Female, Hospital managers-3, 31-08-2011)

Communication between administrative departments and clinical departments is not very effective sometimes. I am not satisfied with this. (Female, Hospital managers-2, 25-08-2011)

Non-transparent exchange of information

In addition, the complaint handling process was not truly open to the complainant and information exchange was largely limited to hospital staff. In fact, it was found that the staff at the complaints office ~~were~~was generally evasive towards patients who arrived wishing to be updated with the specifics of their complaint. The complainant had no opportunity to directly engage in the handling of the complaint or to meaningfully participate in the process. In addition, hospitals tended to oversimplify cases, assuming that the complainant's only desire was to report their complaint and ask for compensation. ~~All this~~This implies that the entire handling process is disclosed only among hospital staff. Therefore, the process becomes a "black box" to patients. It is easy for the hospital to manipulate a complainant by providing limited information to gain advantage in negotiations, i.e. reduce loss from compensating patients.

Sometimes you have to circumvent something and use negotiating skills. Mistakes in medical services do not necessarily harm patients' health, but they can be very serious for the provider [...] for example, someone may not be very careful when writing a medical record and alter it by accident. But you are likely to lose a lawsuit on the grounds of having tampered with records. Incidents such as these cloud the matter, making transparency difficult. (Female, Hospital managers-2, 25-08-2011)

If the incident is urgent or presents itself as a recurring problem, ~~this incident~~it might be shared to educate healthcare providers~~. But~~ but disclosure to complainants themselves remains limited. Only outcomes deemed to be of direct interest to patients, including compensation amounts and medical service privileges, were provided.

~~Other~~However, other results~~, however~~, including penalties imposed upon physicians and departments or improvements made to hospital services, were largely withheld from patients if they did not ask.

In individual cases, what are the outcomes of their complaints? How might a physician be punished/penalised/disciplined? Such information is requested by patients only occasionally. (Male, Health providers-2, 16-09-2011)

I want to know how to better educate the concerned health care providers. But I have not been told. (Female, Users-3, 20-09-2011)

- **Barriers to resolving the complaints**

Conflicts between relevant actors and regulations

Within the complaints system, conflicts or inconsistencies can arise between the legal system for handling complaints and the solutions determined by the hospital. As the structure of managing ~~patients'~~patient complaints is shown in Figure 1, different regulations stipulate different approaches. There does not exist a unified law or guidelines to clearly illustrate the relationships between different approaches~~. It,~~ which results in problems such as lack of authority or ultimate approach, uncertainty about how to apply different regulations to one case and no clear definitions or classifications ~~as~~in regards ~~patients'~~to patient complaints.

The current state of complaint management is disorderly. There are too many channels. For example, many departments are involved, including but not limited to Complaint Letters and Visits, online complaints etc. The Health Bureau has two

departments [for complaint management], each district has a mediation office, a district government website or a mayor-mail [to receive complaints], and a Complaint Letters and Visits office… Far too many heads of department within the health sector; it's chaos. (Male, Health providers-2, 16-09-2011)

Hospitals are required to report complaints to a lot of sectors, all of which wish to understand the issue from different angles. There are not necessarily conflicts between regulations, but different elements are emphasised. Hospitals are tired of these kinds of bureaucracy. ...Each sector carries out their designated duties where resources are not shared. The information possessed by each sector is fragmented. You know yours, I know mine. (Male, Administrators-2, 18-08-2011)

Medical malpractice is defined clearly in the Regulation on Handling Medical Malpractice. There are several benchmarks determining the amount of compensation issued. After the Tort Liability Law of the People's Republic of China was promulgated, [medical damage] was compensated for more in accordance with the Tort Liability Law, because it stipulates compensation for personal injury. (Female, Hospital managers-2, 25-08-2011)

Unjustifiable complaints by patients

In some cases, the patient experiences inconvenience when receiving medical services not because of poor conduct in attitude or behaviour on the part of health providers. ~~It~~Instead, inconvenience may be ~~the case of~~due to long waiting times, too little time spent with the doctor and/or imperfect ~~resources~~resource allocation. These are health

system issues rather than problems caused by hospitals or individual physicians. And so to a certain extent, physicians and hospitals have become scapegoats of the entire health system.

At times it is not us physicians who have made a patient angry. Certain factors are rooted in the fabric of health care systems, but we physicians [end up] taking the blame. (Male, Health providers-3, 16-09-2011)

For example, should a doctor need to see sixty patients in half a day, or indeed one hundred, you cannot demand that he puts on a smile for each one. A lot of patients complain about doctors with a straight face, but I think it is understandable. I have a very good relationship with our young doctors. They operate on a tight schedule. This week someone works at the outpatient~~'s.~~ facility. He is friendly with patients in the first month but struggles to sustain this sort of demeanour. He is not in the mood to smile at patients or engage in long conversations when he only has time to attend to their illnesses. (Male, Hospital managers-1, 15-12-2010)

For example, dissatisfaction voiced in the hospital may be related to health insurance policy rather than staff behaviour. Hospitals need to follow the policies made by the Health Insurance Department. The purpose of those policies was to improve rational use of medicines and control healthcare cost, while the patients covered by health insurance may demand more medicines.

Chinese doctors have many rules to obey [this is to curb poor conduct]. The pressures for them to perform are relatively large. For example, doctors cannot

prescribe too much medicine for a patient who has only [basic state-financed] medical insurance, but patients always want more. A while ago, the Medical Insurance Bureau issued the following statement in a newspaper: The Medical Insurance Bureau never limits the volume of drugs prescribed, rather it is the doing of hospitals who wish to increase workload [in order to produce more statistics]. I think this is really unreasonable. The Bureau does not control the quantity of drugs prescribed in any given week, but there is a total quantity limit over a year. Doctors try their best not to prescribe drugs which must be self-financed, i.e. not covered by basic medical insurance. They must also explain very clearly before prescribing self-financed drugs, otherwise, patients will lodge complaints once they find out. (Male, Hospital managers-1, 15-12-2010)

Complaints occur ~~where~~when the patient wants more drugs but the doctor ~~has refuse~~refuses to satisfy his or her demands. Why? The health insurance institution sets a limit for drug expenditure for each hospital; in turn, the hospital sets a limit for each doctor. So if a doctor has too many patients drawing from their health insurance scheme in any one month, he or she may very possibly have exceeded his/her limit. (Male, Health providers-3, 16-09-2011)

[A patient who has] basic state-financed medical coverage is entitled to blood and other auxiliary examinations. If the number of health checks prescribed exceeds a certain threshold, the doctor is viewed as exploiting basic medical insurance. The doctor is consequently punished. I was deducted more than seven hundred yuan (RMB) because of a case like this. I feel this is simply absurd- it is [unexpectedly]

doctors who are to blame. Nothing seems to be wrong with the patient. …The hospital can't do anything about medical insurance. I think this kind of thing is not the problem at the hospital level. The complaints about medical insurance define without a doubt problems underlying state and society. (Male, Health providers-4, 16-09-2011)

In addition, the safety of health providers is under threat in China today. Chinese medical workers are often victims of terrible violence. As a consequence, some health providers have decided not to treat patients deemed likely to assault staff, exhibit disruptive behaviour or prove difficult to deal with. Prescribing redundant check-ups and drugs are alternatives to properly seeing to patients.

In our interviews, fifteen interviewees mentioned "Chao" fifty-five times. "Chao" in Chinese means to argue with hospitals for patients' own rights and interests, while the other meaning is wrangle fiercely in hospitals or with senior management. Most of the hospital staff being interviewed suggest that some complainants ~~are~~be indeed unreasonable and impulsive, whose sole purpose is to ask for money.

If the case goes to court, the patient gathers a lot of people to go to the court, insulting and threatening concerned health care providers and their lawyers. That is not what we want to see. We want to talk about the truth, by thoroughly publicizing the truth. We cannot always be too specific with terminology [for fear of revealing too much]. When completely refuted, patients lose their temper. (Male, Other actors-2, 15-09-2011)

I feel that the widespread situation in China today is that you can do nothing if you

run into the unreasonable. The legitimate way of going about this is once I receive your complaint, a fair decision is proposed. If complainants are not willing to settle for this, we then transfer their case to other departments. However, complainants may not even agree to that, causing trouble and even threatening the safety of health care providers. (Female, Hospital managers-2, 25-08-2011)

The claim a complainant demands goes beyond the actual problem [but for the money] and he does not wish to resolve it ~~in~~ the legal way. …Nowadays "Yi Nao" has brought about serious social effects, and escalated the tension between service users and providers. Complainants are unwilling to resolve things the legal way, rather, just pestering and hassling you [health care providers or complaint handlers] all day. (Male, Hospital managers-6, 01-11-2011)

- **Barriers to institutional changes for quality improvement using complaints data**

Weak enforcement of the regulation

The regulation for managing ~~patients'~~patient complaints is merely a guideline, which contains no mandatory requirements such as assessment mechanisms. Because it takes into account the difference in local conditions throughout China, specific contents were not stipulated. The regulation is to be interpreted according to local circumstances and conditions. ~~In~~Therefore, in the absence of strong public scrutiny~~,~~ ~~therefore~~, there is little accountability for how best to manage patient~~s'~~ complaints.

There are no penalties attached to (failure to follow) regulation. For example, there

is no administrative aspect to the regulatory guidelines. We wanted to write a penalty provision, but it was not based on the top legislation. The purpose of the regulation is to emphasise self-discipline and serve as guidance for the hospital. [The penalty was not enforceable,] so we decided to remove the penalty. It is indeed difficult and contradictory. (Female, Administrators-4, 30-11-2011)

Besides the legal system, the reporting system also has its problems. Some statistics about ~~patients'~~ patient complaints and medical malpractice were utilized as a part of assessments of hospital performance, health care quality, and so on. This meant that the more cases that were reported, the worse the evaluations received by the hospitals, so that hospitals were inclined to report selectively or report fewer cases.

There are certainly no statistics for the number of patient~~s'~~ complaints. There is only the data on the number of cases of medical malpractice per year from the Bureau of Health, and an approximate amount of compensation issued by insurance companies. In some cases, if complaints were solved just between the hospital and the complainant, we have no data. (Male, Administrators-2, 18-08-2011)

These days, the information regarding the management of patient~~s'~~ complaints in hospitals is difficult to access. Hospitals are unwilling to provide that sort of information- considered confidential. We only have some profiles or the information from select hospitals. (Female, Policy makers-1, 16-12-2010)

Thus, the adoption of the incentive and sanction mechanism was contradictory for managing ~~patients'~~ patient complaints. From one side, the administrative department

wanted hospitals to report ~~patients'~~patient complaints because it is important for informing and improving the quality of care. From the other side, the more complaints that are registered, the worse it would appear a hospital is doing. In addition to this, managing ~~patients'~~patient complaints remains low on the health reform agenda. The force for inspecting complaint management in hospitals from senior management and administrative departments remains weak.

[Having a statistic for ~~patients'~~patient complaints] is definitely necessary, from the aspect of effective management. If this statistic is disposable, I think no problem. If the statistic is routine, in fact, it will cost~~.~~ [of all sorts of resources]. (Male, Policy makers-2, 22-12-2011)

Hospitals doubt that the purpose of administration is for information management- to help them better handle and solve disputes. However, if you want me to report incidents but meanwhile punish me for that, then I have no incentive to report anything. This contradiction stands [in the way of effective reporting]. (Female, Administrators-4, 30-11-2011)

Deficient information system for managing ~~patients'~~patient complaints

Although the regulations in place require collecting and analysing information, there exists no clear classification, definitions or unified coding system. Most hospitals have established their own systems for recording complaints and analysing cases, but no accurate or comparable data are available.

In fact a lot of cases should be recorded and analysed, [but] we do not even take

into account so-called major cases of medical malpractice, mass disturbance or medical malpractice. We cannot distinguish between these concepts.… Relatively speaking, it is more feasible to publicize the data on public security, e.g. the number of police records and people arrested, the number of crimes committed. Those definitions are more explicit, whereas those concerning complaints management are not. Because all statistics are calculated in the hospital, we find that where standards are slack, the resulting statistic is large whereas with a strict standard, it will be small. ~~There~~Hence, there is ~~hence~~ great variability in our results. (Male, Policy makers-2, 22-12-2011)

Identical forms are sent to two hospitals at a similar level and the reported data can be quite different. …Some hospitals only reported cases resulting in compensation and some hospitals record all persons who voice a concern, while others only report cases identified as medical malpractice. But it is impossible for me to verify [the reported data] in each hospital. (Male, Administrators-2, 18-08-2011)

Hospitals have not publicized complaints; neither have health administration departments. The Shanghai Bureau of Health launched a pilot project in 2005 to publicize the complaints reported by all hospitals in Shanghai. The project was welcomed by the public but discontinued soon after its launch due to mounting pressure from the hospitals.

We already publicize complaints [medical malpractice] on our intranet for hospital staff. It is unnecessary to share this information on external sites. (Female, Hospital managers-4, 06-09-2011)

To my knowledge, such information was published once on the Xinmin Evening News in 2005. The newspaper named hospitals that had won awards and gave details of the number of medical malpractice cases inherent in each, as well as feedback regarding patient satisfaction. [We felt] the pressure was very, very high. It [publishing those] resulted in public outrage [from hospitals]. (Female, Administrators-4, 30-11-2011)

Unwillingness ~~on the part~~ of hospitals to effectively handle complaints

Most hospitals did not devote much effort into managing complaints. There was no clear mechanism to utilize ~~patients'~~patient complaints to improve quality of care unless serious medical malpractice had occurred or complaints ~~are~~were found to recur.

Hospitals just handle complaints when complaints happen. …We are basically perfunctory, including hospitals, department directors and doctors. The best~~--~~case scenario for me: do not approach me for these things [complaints]. Deal with complaints quickly and efficiently; in other words, spend money to buy peace. The impact of managing and addressing complaints is negligible, with very little effect on improving medical procedures and quality. (Male, Administrators-2, 18-08-2011)

Hospital directors were the key actors of complaint management in hospitals. The incentive and sanction mechanisms in hospital depended on how much they pay attention to complaint management. In the 1980s the government reduced subsidies for public hospitals under the context of transforming the planned economy to a

so-called socialist market ~~one~~ in order to reduce inefficiencies in health care provision. Hospitals had to increase service charges to generate more revenue to recoup the operational costs and increase the income level of health workers. Complaint management occupied nothing but a small part of quality health care, so in most hospitals it failed to draw attention from senior management. Most complaints were solved on a case-by-case basis, without sufficient concern for the overall improvement of health care services.

In practice, the head of department influences implementation. If he/she regards this as important, then subordinates work harder of course. Now the problem is that some heads of department do not pay attention to it [complaint management]. (Male, Health providers-2, 16-09-2011)

It is of course medical services that are the core of hospital work. Things such as [complaint management] are boring for the hospital. To a hospital, the fewer the complaints, the better. (Male, Administrators-2, 18-08-2011)

Discussion and Conclusions

This study examined the handling system for patient complaints in China and the views of key stakeholders on the barriers to effective complaint management. Our study provided a new dimension of understanding the complaints management system in China, a developing country. Hospitals are the most important handler and manager of patient complaints in China and similarly for other developing countries such as India and Vietnam. We explored the barriers through in-depth interviews with almost

all stakeholders, not only health professionals. What we found would help develop procedures for more effective complaint management and to further improve the quality of care in China and other developing countries. The selection of participants may introduce some bias to our studies. Due to our focus on the hospital, there may be an underrepresentation of certain types of respondents.

~~This study examined the structure of managing patients' complaints in China and the views of key stakeholders on the barriers to effective complaint management. It is shown that there are no standardized systems and procedures dealing with patients'~~Our Findings showed that there are no standardized systems and procedures dealing with patient complaints in China, due to conflicts between relevant actors and regulations. Having experienced rapid economic growth in the last 30 years, China is undergoing a socioeconomic transition. Like other developing countries, policies lag behind the country's economic transition. The Ministry of Health has tried to guide health providers by issuing special regulation, but health administrations do not apply strict regulation to complaint management. There lacks ~~of~~ clear relationships between ~~patients'~~patient complaints and clinical outcomes or the quality of care.

The hospital leader is the key determinant for complaint handling inside the hospital. However, no apparent incentives exist to push hospital leaders to ~~put~~ place priority on complaint handling ~~at a priority.~~. The power of complaint handling ~~department~~departments depends on how much ~~attention~~ the hospital leaders pay

attention to it. Under the current situation, ~~the~~ hospital leaders lack political will to manage ~~complaint~~ complaints effectively~~. This led~~, leading to inadequate human ~~resource put~~resources in ~~place at the appropriate department to handle complaints.~~complaint handling departments. The ~~department~~departments also lack the power to coordinate with clinical departments.

The ~~patients'~~patient complaints in many Chinese hospitals are not well managed and handled. Most hospitals manage patient complaints on only a case-by-case basis. They lack clear mechanisms linking ~~patients'~~patient complaint with improving the quality of care. Complaints are underutilised for organizational strategic planning or changing individual behavioural and attitudes.

~~**Policy recommendations**~~

~~The Chinese Ministry of Health and health authorities at provincial and municipal level should oversee the development of national guideline on handling patients' complaints which can be practically implemented in China. Legislation stipulates not only~~This implies that legislation should not only stipulate the principles and regulations of patient~~s'~~ complaint management, but also the responsibilities of sectors at different levels.

To alleviate patient complaints related violence, ~~the guideline should be approved by~~ civil groups, including service users and the hospital sector~~.~~, should approve the

guideline. In developed countries, patient~~'s~~ complaint management provides guidelines not only for health care providers, but also clear guidelines for patients. This not only makes it more convenient for patients, but also plays a positive role in helping patients initiate the complaint process via legitimate means. This is crucial for society to view patient~~s'~~ complaint in a rational way.

If ~~patients'~~patient complaints can be better managed and rectified, the instances of failure would be reduced and quality would be improved. Greater emphasis should be placed on quality improvement after ~~patients'~~patient complaints. Strategies to improve quality following ~~patients'~~patient complaints should be developed through a learning process. To promote the learning process, appropriate mechanisms should be developed and implemented to assess not only the number of ~~patients'~~patient complaints occurring in hospitals, but also how these hospitals have handled these complaints. For example, reporting more ~~patients'~~patient complaints should not be necessarily punished, while ~~effectively~~effective handling of the ~~patients'~~patient complaints should be appreciated.

Our final conclusion is that barriers to the effective management of patient complaint vary at the different stages of complaint handling, from the user and provider side, as well as systemic issues. Information, procedure design, human resources, system arrangement, unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management.

Appropriate mechanisms should be developed to link patient complaint with improving the quality of care.

ACKNOWLEDGEMENT

The HESVIC project received funding from the European Commission Framework 7. The views represented in this document are not necessary representative of the European Commission's views and belong solely to the authors. The consortium would like to thank all the study respondents and participants for their willingness to take part in the research, as well as the members of the Country Research Advisory Groups for their support at every stage of the HESVIC project. The authors of the paper very much appreciate constructive comments and suggestions on earlier version of the paper from Shenglan Tang from Duke Global Health Institute, USA. The authors are also grateful to Ms. Kaori Sato for language editing.

COMPETING INTERESTS

None.

FUNDING

This study was supported by the European Commission Seventh Framework Programme (HEALTH-F2-2009-222970).

CONTRIBUTORSHIP STATEMENT

YJ, XY, QZ collected and analyzed the data primarily. All authors were involved in analyzing the data and editing the paper.

DATA SHARING

No additional data available.

References:

1. Sage WM. Putting the patient in patient safety: linking patient complaints and malpractice risk. *JAMA* 2002;**287**:3003-5.
2. Hsieh SY. A system for using patient complaints as a trigger to improve quality. *Qual Manag Health Care* 2011;**20**:343-55.
3. Wofford MM, Wofford JL, Bothra J, et al. Patient complaints about physician behaviors: a qualitative study. *Acad Med* 2004;**79**:134-8.
4. Beecham L. Patients' complaints: GMC could do better. *BMJ* 1999;**319**:1022.
5. Anderson K, Allan D, Finucane P. A 30-month study of patient complaints at a major Australian hospital. *J Qual Clin Pract* 2001;**21**:109-11.
6. The Henry J. Kaiser Family Foundation. Medical Malpractice Law in the United States. http://www.kff.org/insurance/upload/Medical-Malpractice-Law-in-the-United-States-Report.pdf Accessed [08-31-2012].
7. Xi X. *Understanding and application of provisions in the Tort Liability Law*. Beijing: Press of the People's Court; 2010.
8. Chinese doctors are under threat. *Lancet* 2010;**376**:657.
9. Zheng XQ, Wei LY, Zhang BZ, et al. Domestic Survey of Medical Disputes and Foreign Medical Dispute Handling. *Chinese Hospitals* 2007; **7**:2-4.
10. Stafford C. Moral ambivalence in modern China. *The Lancet* 2012;**9818**:793.
11. Communicating concern: complaints against doctors. *Lancet* 2013;**382**:1382.

12. Hsieh SY. Healthcare complaints handling systems: a comparison between Britain, Australia and Taiwan. *Health Serv Manage Res* 2011;**24**:91-5.

13. Department of Health, United Kingdom. Complaints procedure. http://www.dh.gov.uk/health/contact-dh/complaints/ Accessed [08-31-2012].

14. Cornwall A, Romios P. Turning Wrongs Into Rights. *Health Issues* 2004;**79**:13-8.

15. Hickson GB, Federspiel CF, Pichert JW, et al. Patient complaints and malpractice risk. *JAMA* 2002;**287**:2951-7.

16. Pichert JW, Hickson G, Moore I. Using Patient Complaints to Promote Patient Safety. *Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 2: Culture and Redesign)*. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008.

17. Hickson GB, Moore IN, Pichert JW, et al. Balancing systems and individual accountability in a safety culture. *From Front Office to Front Line: Essential Issues for Health Care Leaders, 2nd ed.* Oakbrook Terrace, IL: Joint Commission Resources; 2012. p. 1-35.

18. Vincent C, Davis R. Patients and families as safety experts. *CMAJ* 2012;**184**:15-6.

19. Ministry of Health. *Measures for the Handling of Patient Complaints in Hospitals (for Trial Implementation)*. Beijing: Ministry of Health; 2009.

20. Green A, Gerein N, Mirzoev T, et al. Health policy processes in maternal health: a comparison of Vietnam, India and China. *Health Policy* 2011;**100**:167-73.

21. Gao J, Cao W, Xu Y, et al. Survey analysis of consultation settlement for medical

disputes in 30 medical institutions of Shanghai. *Journal of Shanghai Jiaotong University (Medical Science)* 2010;**30**:960-3.

22. Charmaz K. *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. Thousand Oaks, CA: Sage Publications, 2006.

23. Sadler GR, Lee HC, Lim RS, et al. Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nurs Health Sci* 2010;**12**:369-74.

24. Lacey A, Luff D. *Qualitative Research Analysis*. The NIHR RDS for the East Midlands / Yorkshire & the Humber, 2007.

25. Department of Health, NSW. *Complaint Management Guidelines*. North Sydney NSW: Guidelines; 2006.

26. State Council. *Regulation on the Handling of Medical Malpractices*. Beijing: Decree of the State Council; 2002.

27. Standing Committee of the Eleventh National People's Congress. *Tort Law of the People's Republic of China*. Beijing: Presidential Decree; 2009.

28. Ministry of Health. *Measures for the Complaint Letters and Visits System for Healthcare*. Beijing: Ministry of Health; 2007.

29. Shanghai Justice Bureau and Health Bureau. *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*. Shanghai: Shanghai Justice Bureau and Health Bureau; 2008.

30. Ministry of Justice, Ministry of Health, and China Insurance Regulatory Commission. *Opinions on Strengthening People's Mediation for Medical Disputes*.

Beijing: Ministry of Justice, Ministry of Health, and China Insurance Regulatory Commission; 2010.

31. Shanghai Justice Bureau and Health Bureau. *Measures on People's Mediation for Medical Disputes in Shanghai*. Shanghai: Shanghai Justice Bureau and Health Bureau; 2011.

32. Yan X. Correctly Receive Medical Complaints and Establish Harmonious Doctor-patient Relationship. *Modern Hospital Management* 2008;**6**:24-5.

33. Manouchehri MJ, Ibrahimipour H, Sari AA, et al. Study of patient complaints reported over 30 months at a large heart centre in Tehran. *Qual Saf Health Care* 2010;**19**:e28.

34. Siyambalapitiya S, Caunt J, Harrison N, et al. A 22 month study of patient complaints at a National Health Service hospital. *Int J Nurs Pract* 2007;**13**:107-10.

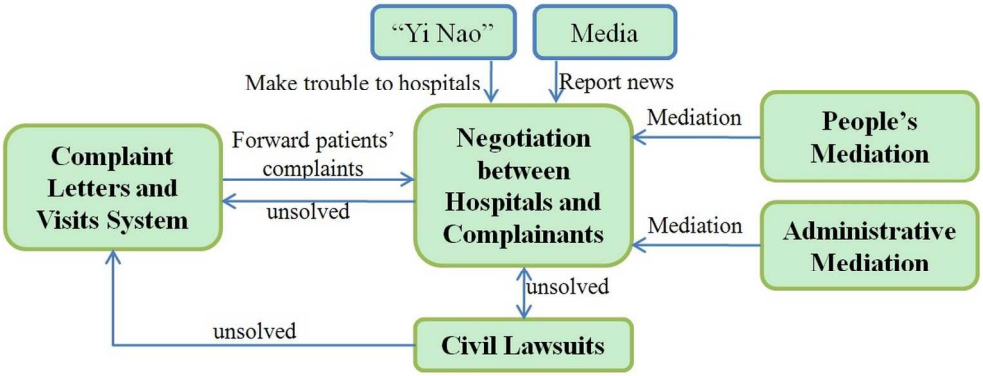

Figure 1 The structure of managing patients' complaints in China

199x90mm (300 x 300 DPI)

Qualitative research review guidelines – RATS

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
R Relevance of study question	
Is the research question interesting?	YES. Research question was explicitly stated.
Is the research question relevant to clinical practice, public health, or policy?	YES. Research question is justified and linked to the existing knowledge base (empirical research, policy).
A Appropriateness of qualitative method	
Is qualitative methodology the best approach for the study aims? • *Interviews:* experience, perceptions, behaviour, practice, process • *Focus groups:* group dynamics, convenience, non-sensitive topics • *Ethnography:* culture, organizational behaviour, interaction • *Textual analysis:* documents, art, representations, conversations	YES It is difficult to measure the regulation process quantitatively.
T Transparency of procedures	
Sampling	
Are the participants selected the most appropriate to provide access to the type of knowledge sought by the study?	YES.
Is the sampling strategy appropriate?	The respondents were sampled by the whole research framework: the regulation

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
	process. Different types of respondents were helpful for holistic understanding for transparency deficits. Key informants were interviewed by snowball sampling and saturation.
Recruitment	
Was recruitment conducted using appropriate methods?	In the methods part, it shows details of how recruitment was conducted and by whom.
Is the sampling strategy appropriate?	YES
Could there be selection bias?	The selection of participants might bring some bias to our studies. Our focus was on the hospital, so some types of respondents may have been under-represented. Moreover, we planned to recruit the same number of participants in multiple settings, but the number of participants from each was imbalanced because of information saturation.
Data collection	
Was collection of data systematic and comprehensive?	YES, the interview questions were introduced.
Are characteristics of the study group	YES. We just focused on their

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
and setting clear?	role/group on the regulation process.
Why and when was data collection stopped, and is this reasonable?	YES. The principle of saturation was used.
Role of researchers	
Is the researcher(s) appropriate? How might they bias (good and bad) the conduct of the study and results?	YES. Our research group is multidisciplinary, including social science, clinical medicine and public health.
Ethics	
Was informed consent sought and granted?	YES. Informed consent process was explicitly and clearly detailed.
Were participants' anonymity and confidentiality ensured?	YES.
Was approval from an appropriate ethics committee received?	YES. Ethics approval was cited.
S Soundness of interpretive approach *Analysis*	
Is the type of analysis appropriate for the type of study? • *thematic:* exploratory, descriptive, hypothesis generating • *framework:* e.g., policy • *constant comparison/grounded*	YES. Analytic approach was justified.

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
theory: theory generating, analytical	
Are the interpretations clearly presented and adequately supported by the evidence?	YES.
Are quotes used and are these appropriate and effective?	YES.
Was trustworthiness/reliability of the data and interpretations checked?	YES, but it wasn't shown in the paper. We triangulated between interviews from various types of respondents, and different disciplines. We also trail the findings with observation.
Discussion and presentation	
Are findings sufficiently grounded in a theoretical or conceptual framework?	YES.
Is adequate account taken of previous knowledge and how the findings add?	YES.
Are the limitations thoughtfully considered?	YES
Is the manuscript well written and accessible?	YES
Are red flags present? These are common features of ill-conceived or poorly executed qualitative studies, are a cause for concern, and must be	NO

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
viewed critically. They might be fatal flaws, or they may result from lack of detail or clarity.	

BMJ Open

Managing patient complaints in China – a qualitative study in Shanghai

Journal:	*BMJ Open*
Manuscript ID:	bmjopen-2014-005131.R2
Article Type:	Research
Date Submitted by the Author:	17-Jul-2014
Complete List of Authors:	Jiang, Yishi; Fudan University, School of Public Health; Shanghai Maternal and Child Health Center, YING, Xiaohua; Fudan University, School of Public Health ZHANG, Qian; Fudan University, School of Public Health Tang, Sirui; Fudan University, School of Public Health KANE, Sumit; Royal Tropical Institute, KIT Development Policy & Practice MUKHOPADHYAY, Maitrayee; Royal Tropical Institute, KIT Development Policy & Practice QIAN, Xu; Fudan University, School of Public Health
Primary Subject Heading:	Qualitative research
Secondary Subject Heading:	Health policy
Keywords:	QUALITATIVE RESEARCH, HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

Title page

1. Title of the article.

Managing patient complaints in China – a qualitative study in Shanghai

2. Full name, postal address, e-mail, telephone and fax numbers of the corresponding author.

The corresponding author: Xu QIAN

Postal address: Mailbox 175, 138 Yi Xue Yuan Road, Shanghai, 200032, P. R. China

Tel: 86-21-54237267 Fax: 86-21-64174172

Email: xqian@fudan.edu.cn

3. Full names, departments, institutions, city and country of all co-authors.

1) Yishi JIANG: School of Public Health, Fudan University, Shanghai, China; Shanghai Maternal and Child Health Center, China

2) Xiaohua YING: School of Public Health, Fudan University, Shanghai, China

3) Qian ZHANG: School of Public Health, Fudan University, Shanghai, China

4) Sirui Rae TANG: School of Public Health, Fudan University, Shanghai, China

5) Sumit KANE: KIT Development Policy & Practice, Royal Tropical Institute, Amsterdam, Netherlands

6) Maitrayee MUKHOPADHYAY: KIT Development Policy & Practice, Royal Tropical Institute, Amsterdam, Netherlands

7) Xu QIAN: School of Public Health, Fudan University, Shanghai, China

8) HESVIC team authorship

4. Up to five keywords or phrases suitable for use in an index (it is recommended to use MeSH terms).

Qualitative Research; Patient Complaints; Complaint Handling Systems; Quality Improvement; Government Regulation

5. Word count - excluding title page, abstract, references, figures and tables.

6902

Abstract

Objectives: To examine the handling system for patient complaints and to identify existing barriers that are associated with effective management of patient complaints in China.

Setting: Key stakeholders of the handling system for patient complaints at the national, Shanghai municipal, and hospital levels in China.

Participants: Thirty-five key informants including policymakers, hospital managers, health care providers, users and other stakeholders in Shanghai.

Primary and secondary outcome measures: Semi-structured interviews were conducted to understand the process of handling patient complaints and factors affecting the process and outcomes of patient complaint management.

Results: The Chinese handling system for patient complaints was established in the past decade. Hospitals shoulder the most responsibility of patient complaint handling. Barriers to effective management of patient complaints included service users' low awareness of the systems in the initial stage of the process; poor capacity and skills of healthcare providers, incompetence and powerlessness of complaints handlers and non-transparent exchange of information during the process of complaint handling; conflicts between relevant actors and regulations, and unjustifiable complaints by

patients during solution settlements; and weak enforcement of regulations, deficient information for managing patient complaints and unwillingness of the hospitals to effectively handle complaints in the post-complaint stage.

Conclusions: Barriers to the effective management of patient complaints vary at the different stages of complaint handling and perspectives on these barriers differ between the service users and providers. Information, procedure design, human resources, system arrangement, unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management.

Article summary

Strengths and limitations of this study

This study explores the handling system for patient complaints in China and the views of key stakeholders on the barriers to effective complaint management. These findings are essential to improve the complaints system. Our study provides a new dimension of understanding the complaints management system in China, an emerging market country. We explore the barriers through in-depth interviews with almost all stakeholders, not only health professionals. What we found will help develop procedures for more effective complaint management and to further improve the quality of care in China and other developing countries. The selection of participants may introduce some bias to our studies. Due to our focus on the hospital, there may be an underrepresentation of certain types of respondents.

Bullet points

1. Our study examined the handling system for patient complaints and identified and analysed barriers to effective management in China.
2. We carried out a literature review and semi-structured interviews with all categories of key informants.
3. Hospitals undertake the most responsibility for patient complaint handling.
4. Barriers to effective management of patient complaint vary at different stages of complaint handling, from the user and provider

side, as well as system issues.

5. Information, procedure design, human resources, system arrangement, unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management.

Background

In recent years, patient complaints around the world have garnered mounting concern among policymakers, academics and the general public.[1-3] As China prospers, making advances in medicine and social welfare, expectations of better quality of care continue to grow. People's knowledge of the law and their rights has increased as a result of better education and understanding of the law. Patients are able to express their discontent by lodging complaints such that the number of complaints occurring internationally is on the rise.[4, 5] A "complaint" is defined as *the behaviour of a patient or his/her representative(s) which signifies dissatisfaction towards medical services, nursing services, as well as treatment conditions through letters, calls or visits to the hospital where the purpose of these actions is to criticise the hospital and/or claim compensation"*.[6] In addition, the growth in dollars paid on malpractice claims is evident.[7] China's current situation reveals growing concerns surrounding hospital accountability and clinical governance; in particular, the efficacy of the redress system. Grave consequences affecting both social and political stability are likely if the health care system fails to meet expectations and to achieve patient satisfaction. Indeed, the issue at hand is one of paramount importance, requiring urgent attention and immediate action at the highest level.

In countries such as Australia and Britain, the states have sought to monitor complaints and complaint handling to improve and regulate the practice of health professionals.[8] A feedback system of this sort has proven instrumental in improving

the quality of care. In Britain, the National Health Service (NHS) not only provides clear and transparent guidelines for both health care providers and patients but also publicizes information regarding the routine reporting of patient complaints.[9] In Australia, a large study was conducted before *Guide to Complaint Handling in Health Care Services* was formulated and subsequently updated.[10] Annually, statistics are compiled and published, detailing complaint trends, complaint management and reasons for complaints. Effective handling of complaints has been known to reduce friction between providers and consumers, with the even greater benefit of improving quality of care. As a supplement to peer reviews and administration, patient complaints can provide important feedback concerning the delivery of health care services and can be a useful tool in the improvement of health care quality.[1-3, 11-14]

With no official statistics of patient complaints available in Chinese records, we estimated that the number of complaints and disputes rose, from 10,249 to 13,875 claims, based on the number of first trials for medical malpractice cases between 2002 and 2008.[15] Mounting dissatisfaction has been felt across the country, manifesting in increasingly hostile and violent behaviour towards providers from patients and their families.[16] An investigation carried out by the Chinese Hospital Management Association in 2005 suggested that of 270 hospitals surveyed, 73 per cent experienced abuse in the form of threats and assaults targeting doctors and management.[17] These incidents are only indicative of rising expectations, burgeoning patient discontent with

services and dissatisfaction towards the way in which matters are resolved.[18] Public outcry only exacerbates the need for more effective handling of individual cases under the overarching agenda of public hospital reform in China.[19]

Notwithstanding the alarming extent of these issues, few attempts have been made to formally examine how hospital complaints are addressed in developing countries. It is only recently that a handful of studies in China have sought to provide some understanding of the issue by trying to ascertain the number of complaints in the studied hospitals or garnering patient feedback via questionnaires and interviews.[20-22] A fuller understanding of the complaints system – the available channels for seeking redress, how the system operates and the barriers to conflict resolution – will be crucial to ameliorating the often fraught relationships between health care providers and consumers. The purpose of this study has been to examine the handling system for patient complaints in China, and to subsequently identify and analyse the various hospital-specific factors preventing grievances from being effectively addressed. The authors of this paper hope that such an undertaking will reduce malpractice and above all, improve health service outcomes.

This study is one of the cases from the "Health System Stewardship and Regulation in Vietnam, India and China" (HESVIC) research project. It was conducted by a consortium of six partners in Asia and Europe from 2009-2012, with the aim of supporting policy decisions in the application and extension of accessibility,

affordability, equity and quality of coverage of maternal health care in the three countries.

Methods

Study design

The project uses a multidisciplinary approach, drawing on multiple case studies to examine the impact of regulation on improving equitable access to quality health care in Vietnam, India and China. In each country, three cases were selected and studied. This paper shows the findings from the case study, examining the regulation on Grievance Redressal (GR) in Shanghai, China. Here, regulation encompasses the formation of rules and practices, as well as their interpretation and implementation, such as the health policy processes covered in the HEPVIC project (HEPVIC).[23]

Phase One: Literature Review

Firstly, we conducted a literature review. The relevant sources, which included regulation documents related to the handling of patient complaints at both the national and Shanghai municipal levels, were used to collect legal approaches and mechanisms used in managing patient complaints. These regulations were mainly stipulated from 2002 to 2011. To understand the application of different complaint approaches, a search of scientific literature published between 2000 and 2011 was conducted. Databases MEDLINE-PubMed and WANFANG Data were consulted. A search strategy was established based on the following keywords: *grievance redressal,*

patient complaint, health care complaint and hospital complaint, and China. Special focus was placed on patient complaint management in hospitals, as we found that the vast majority of complaints were handled and resolved within the hospitals.[22]

Phase Two: Pilot Study – Interviews

Based on our understanding of the current patient complaint handling system, we performed semi-structured interviews with key stakeholders – policymakers from the national level, administrators from the Shanghai municipal level, hospital managers, health care providers, users and other related parties. We used the snowball sampling method to identify key stakeholders and to collect important feedback from key informants from various disciplines.[24, 25]

In Phase Two (October-December 2010), one key actor from each of the three administrative levels was selected and interviewed: a policymaker at the national level, a municipal administrator and a hospital manager. A pilot study was conducted to test the topic guidelines developed. These allowed us to gain a preliminary understanding of the complaint management process in the hospital setting, and to refine the data collection tools. These interviews served as the basis for the design of Phase Three interviews, where some of those being interviewed in the third phase were respondents recommended by Phase Two interviewees.

Phase Three: Main Data Collection

Interviews in Phase Three were conducted from August-December of 2011. Key stakeholders were interviewed in the selected hospitals based on location, level and type. Our sample represented both urban and suburban areas in Shanghai. General and specialist hospitals were selected. Phase Three began with interviews of hospital managers and health care providers proposed in Phase Two. We asked interviewees from Phase Two to invite patients and other relevant stakeholders to contribute their views. Those invited patients used different channels for lodging their complaints; however, they all shared one thing in common: all patients had first complained to the hospital. We then proceeded to interview the administrators and finally a high-level policymaker. We continued to interview respondents, collecting and analysing their comments and feedback until no new themes emerged, i.e. saturation had been reached. The number of participants involved in the different types of interviewees is depicted in Table 1.

Semi-structured interviews were conducted with 35 respondents face-to-face, except one via telephone. The interviews took place at private locations, for example at the institution where the interviewee or interviewer worked, and were conducted by two of the authors of this paper. Each interview lasted 1-2 hours and was audiotaped with permission, apart from two which were not recorded but typewritten upon the respondents' request.

Table 1 Number of interviewees by administrative level and facility

Types of interviewees	Level	Number of Participants
Policymakers	National	
Ministry of Health		1
A university		1
Administrators	Shanghai municipal	4
Hospital managers		
General hospital	Tertiary	3
General hospital	Secondary	3
Specialized hospital	Tertiary	1
Specialized hospital	Secondary	1
Private hospital	Secondary	2
Health care providers		6
Users		6
Other actors		
Municipal Health Inspection Institute		2
Lawyers for medical disputes		2
The centre that processes medical liability insurance		1
The People's Mediation Committee for		1

Medical Disputes	
The Complaint Letters and Visits System	1
Total	**35**

The topic guidelines for carrying out the interviews included questions on the participant's experience in complaint management in the hospitals. Using probes and follow-up questions, attention was directed to factors that the interviewees perceived as barriers to effective complaint management, and interviewees were asked to explain their reasoning. From existing literature, we identified a list of factors required for effective complaint management and successful resolution of disputes. Participants were asked to provide suggestions and feedback regarding how complaints could be more effectively dealt with given the barriers they had identified.

Data analysis

Audiotapes recorded during the interviews were transcribed and were compared with the field notes to check for accuracy. We analysed data through a process of rigorous and structured analysis.[26] The analysis was executed in several stages to 1) become familiar with the data; 2) identify emerging topics; 3) develop a topic index; 4) use the index to code the data; 5) consolidate the topics into themes; 6) further consolidate these themes into analytical categories/clusters; and 7) translate the analysis obtained into a narrative. Written consent was obtained from each interviewee before undertaking the interviews.

We performed the above tasks using the qualitative research software NVivo 9.0. The raw data was coded by two independent reviewers (YSJ, QZ). If discrepancies emerged, a third reviewer (XHY) participated in the group discussion until the group arrived at a consensus. There were some models for analysing complaint management;[2, 13] for example, the Managerial-Operational-Technical (MOT) model was developed by Hsieh SY to explore complaint management in hospitals.[2] In our study, we collected data according to the complaint management process. To analyse the data most efficiently and directly, we used the stages of the process, which included receiving, handling and resolving complaints.[27] As quality improvement following complaints is crucial, we added the stage of "institutional changes for quality improvement using complaints data".[2, 12]

Our study was approved by Institutional Review Board (IRB), School of Public Health, Fudan University. Access to data was restricted to approved members of the research team who signed a confidential agreement with the principal investigator. Data were stored in secure electronic locations. Data processing was kept anonymous so as to protect the identity of interviewees. The names of the respondents have been deleted from the quotations.

Findings

This section first presents a number of approaches developed and implemented in

Shanghai to handle patient complaints and their relationships. It then focuses on the approach of negotiation between hospitals and complainants, identifies its barriers, and proceeds to examine and analyse these barriers.

1. Approaches and mechanisms used in managing patient complaints

The study identifies both formal and informal approaches and mechanisms used in handling patient complaints.

a. Negotiation between Hospitals and Complainants

The complaint handling department within the hospital is responsible for dealing with patient complaints, first established on February 20, 2002, in accordance with the *Regulation on the Handling of Medical Malpractices.*[28] Since November 2009, these departments have been regulated by *Measures for the Handling of Patient Complaints in Hospitals (for Trial Implementation).*[6] These acts require that a medical institution establish a department specifically for the purpose of handling and resolving medical disputes. The department is primarily responsible for receiving patient complaints via calls, letters, visits, and/or cases referred from other departments and institutions. Their role also includes counselling and communicating with patients, verifying and documenting disputes as well as resolving disputes.

b. Administrative Mediation and Civil Lawsuits

If the hospital is unable to resolve certain conflicts through negotiation, the cases may

be referred to an external body such as the health administrative department or they may be settled in court by means of litigation. The *Tort Law of the People's Republic of China*, adopted at the twelfth session of the Standing Committee of the Eleventh National People's Congress on December 26, 2009, provided a new legal definition of liability for medical malpractice, liability presumption and exemption.[29]

c. Complaint Letters and Visits System

In February 2007, *Measures for the Complaint Letters and Visits System for Healthcare* was established.[30] Its purpose is to protect the legal rights and interests of citizens, legal entities, and other organizations, and to regulate behaviour and maintain order within the Complaint Letters and Visits System. It requires health administrative departments to set up Complaint Letters and Visits offices at different levels. These offices are responsible for receiving, assigning and transferring matters as appropriate, as well as supervising the handling of various issues and complaints.

d. People's Mediation – a form of Third-Party Facilitated Mediation

In July 2008, the Shanghai Justice Bureau and Health Bureau issued *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*, to establish the People's Mediation Committees for Medical Disputes.[31] Committee members, mainly retired judges and doctors, served to mediate disputes through reporting, explaining and analysing cases under the supervision of the local judiciary. In January 2010, the Ministry of Justice, the Ministry of Health and the

China Insurance Regulatory Commission jointly issued *Opinions on Strengthening People's Mediation for Medical Disputes* to bolster the role of mediation in resolving medical disputes.[32] Its intent is to settle medical disputes in an effective way and to maintain order within hospitals, all with a view for ensuring harmony and social stability. In July 2011, the Shanghai Justice Bureau and Health Bureau introduced *Measures on People's Mediation for Medical Disputes in Shanghai* to replace *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*.[31, 33]

In addition to the aforementioned channels of complaint, patients have also been found to express their discontent by "Yi Nao" – exhibiting disruptive behaviour within the hospital by targeting doctors and nurses or hospital managers by way of abuse, assault and other forms of violence. Much of this has garnered media attention, resulting in bad publicity for the hospital and damaging the reputation of doctors and staff.

Table 2 the characteristics of the approaches

	Negotiation between Hospitals and Complainants	**Administrative Mediation**	**Civil Lawsuits**	**Complaint Letters and Visits System**	**People's Mediation**
Responsible institution	Complaint Reception Office in hospitals	Health Inspection Institute	People's Court	Complaint Letters and Visits Office in health administrative departments	People's Mediation Committee for Medical Disputes
Responsibility	Receive and handle patients' complaints; compensate some complainants	Receive and mediate medical malpractices	Receive and settle medical litigations	Receive, transfer and supervise patients' complaints	Receive and mediate patients' complaints
Handling method	Negotiation	Mediation	Mediation; Trial	Supervise matters	Mediation
Processing duration	Indefinite	Only once	Six months	Two months	One month
Legal level of resolution	Low	Low	High	Low	Low
Administrative level of resolution	Low	High	High	High	Low

2. The application of different complaint approaches

The complexity of relationships between different approaches can be seen where many actors are involved. Approaches that can resolve medical disputes are mainly negotiations and civil lawsuits, while other approaches play a part in forwarding cases, such as Complaint Letters and Visits System, or easing conflicts, such as mediation. None of the approaches are considered the ultimate arbiter. Patients can continue to lodge complaints through the Complaint Letters and Visits System even if a decision has been finalised after a second trial in court.

In the above-mentioned approaches, the hospital is the main handler for patient complaints. First of all, it can handle patient complaints completely independently, from reception to solution, while the other approaches, such as Civil Lawsuits and mediation, must engage hospitals in complaint handling. Secondly, since the hospital is principally responsible for compensation, the complainant is more inclined to directly negotiate with the hospital. Findings from the literature show that the majority of medical disputes are resolved by negotiation between hospitals and complainants.[22] Thirdly, if hospitals handle complaints improperly, conflicts will become more volatile, resulting in serious incidents.[34] Therefore, hospitals have become the most common receiver, handler and resolver of disputes. (Figure 1)

3. Barriers to the effective management of patient complaints and their underlying causes at different stages

Our interviews revealed that different hospitals often use different complaint systems. For example, some hospitals operate a centralized complaints office, which may or may not be independent of the Medical Affairs (Administration) Department. Other hospitals have several complaints offices, each of which is responsive to different kinds of complaints. A hospital's deputy director, who also heads hospital complaint management, generally manages complaint departments. Barriers to effective complaints management vary at different stages of the complaint process, both from the sides of the user and provider.

.

a. Barriers to receiving the complaints

Low awareness of users about the handling system for patient complaints

Although hospital staff claimed that the complaints office was accessible to those with grievances, patients did not always feel this was the case. One user looked up the hospital telephone number on the Internet and said the complaint handling process was "very easy" while others did not concur. Almost all the patients interviewed found that signs and directions (to the complaints office) failed to catch the eye. In some cases none could be seen at all:

I wanted to lodge a complaint, but did not know how to find [the complaints office]… Because the hospital was so big, I did not know which department [was responsible for handling complaints]. …I simply did not know who to turn to. You see, the complaints department was in another building [rather than in the one in which I was treated i.e. the clinical department] (Female, Users-1, 01-09-2011)

b. Barriers to handling the complaints

Poor capacity and skills of health care providers

The capacity and skills of health care providers in managing patient complaints is critically important in problem solving. Our study found that the reasons patients complained lay mainly in poor communication and factors such as the provider's attitude, use of language, unprofessional behaviour, as well as dissatisfaction towards service procedures.

The Medical Doctors Association carried out a survey on the nature of medical disputes. 50 per cent of cases were results of inappropriate attitudes about health care delivery, 25 per cent were caused by technology misuse and the rest were related to management. (Female, Policy makers-1, 16-12-2010)

The majority of complaints can be resolved by an explanation issued by the hospital and/or a verbal apology by the offending party.[5, 35, 36] However, practitioners are often too preoccupied with their clinical duties to be able to respond to patient complaints.

Doctors are not able to devote much time to handling disputes, because clinical work is highly demanding. [They need to attend to] many patients every day. If they spend more time communicating with patients, they would lose time needed to carry out [clinical work]. That is to say, [doctors should be given] less [clinical] work, and more time to explain their work to patients. Our workload is very heavy, like a battle. (Female, Health care providers-1, 01-09-2011)

Incompetence and powerlessness of complaints handlers

In comparison to health care providers, complaint handlers played a more important role in cooperation and coordination. Although complaint departments were specifically set up in hospitals for receiving and handling complaints, the responsible persons in the department were mainly part-time medical staff. In some cases those handling staff were found to be inadequate due to lack of training. Many of them had studied handling techniques on their own and had not acquired sufficient professional skills to appropriately analyse, assess and solve complaints.

Complaint handlers in the hospitals cannot solve everything because the disciplines involved in complaints are highly specialised. I am only familiar with general surgery and issues that require common sense, but [I am not familiar] with professional problems in other disciplines. (Male, Hospital managers-5, 08-09-2011)

It is difficult to recruit staff for our Medical Dispute Handling Office. No one wants to come. A boy recruited in 2007 could not stand the demands of the job [complicated disputes and violence] and so resigned. (Female, Hospital managers-3, 31-08-2011)

We have little time to do things other than receiving complaints. We lack staff members. We are responsible for receiving and processing complaints, and expected – on top of this – to deal with other things, hence why we are exhausted. (Male, Health care providers-2, 16-09-2011)

Given that most complaints are handled and resolved in the hospital, it appeared that every complaint handler interviewed felt the same way: tired and stressed. Complaint handlers were insufficiently empowered to handle complaints. It was hard for them to coordinate between different departments, investigate cases, organize mediation, find solutions and then draw on patients' feedback to improve quality of care.

Recently, a fierce medical dispute occurred because of a possible misunderstanding between administrative departments. [Abusive] words erupted. As a consequence, staff members involved in this incident were distraught – to the extent that they wanted to resign. Hence, we need understanding and support among colleagues. ...Sometimes the clinical department at hand refused to cooperate when investigated. He [the clinical department] is not very serious about cooperating with the investigation. (Female, Hospital managers-3, 31-08-2011)

Communication between administrative departments and clinical departments is not very effective sometimes. I am not satisfied with this. (Female, Hospital managers-2, 25-08-2011)

Non-transparent exchange of information

In addition, the complaint handling process was not truly open to the complainant, and information exchange was largely limited to hospital staff. In fact, it was found that the staff at the complaints office was generally evasive towards patients who arrived wishing to be updated with the specifics of their complaint. Complainants had no opportunity to directly engage in the handling of their complaints or to meaningfully

participate in the process. In addition, hospitals tended to oversimplify cases, assuming that the complainant's only desire was to report their complaint and ask for compensation. This implies that the entire handling process is disclosed only among hospital staff. Therefore, the process becomes a "black box" to patients. It is easy for the hospital to manipulate a complainant by providing limited information to gain advantage in negotiations, i.e. reduce loss from compensating patients.

Sometimes you have to circumvent something and use negotiating skills. Mistakes in medical services do not necessarily harm patients' health, but they can be very serious for the provider [...] for example, someone may not be very careful when writing a medical record and alter it by accident. But you are likely to lose a lawsuit on the grounds of having tampered with records. Incidents such as these cloud the matter, making transparency difficult. (Female, Hospital managers-2, 25-08-2011)

If the incident is urgent or presents itself as a recurring problem, it might be shared to educate healthcare providers but disclosure to complainants themselves remains limited. Only outcomes deemed to be of direct interest to patients, including compensation amounts and medical service privileges, were provided. However, other results, including penalties imposed upon physicians and departments or improvements made to hospital services, were largely withheld from patients if they did not ask.

In individual cases, what are the outcomes of their complaints? How might a physician be punished/penalised/disciplined? Such information is requested by patients only occasionally. (Male, Health care providers-2, 16-09-2011)

I want to know how to better educate the concerned health care providers. But I have not been told. (Female, Users-3, 20-09-2011)

c. Barriers to resolving the complaints

Conflicts between relevant actors and regulations

Within the complaints system, conflicts or inconsistencies can arise between the legal system for handling complaints and the solutions determined by the hospital. As the structure of managing patient complaints is shown in Figure 1, different regulations stipulate different approaches. Unified laws or guidelines do not exist to clearly illustrate the relationships between different approaches, which results in problems such as a lack of authority or ultimate approach, uncertainty about how to apply different regulations to one case, and no clear definitions or classifications in regards to patient complaints.

The current state of complaint management is disorderly. There are too many channels. For example, many departments are involved, including but not limited to Complaint Letters and Visits, online complaints, etc. The Health Bureau has two departments [for complaint management], and each district has a mediation office, a district government website or a mayor-mail [to receive complaints], and a Complaint Letters and Visits office… Far too many heads of departments within the health sector; it is chaos. (Male, Health care providers-2, 16-09-2011)

Hospitals are required to report complaints to a lot of sectors, all of which wish to understand the issue from different angles. Conflicts between regulations do not

necessarily exist, but different elements are emphasised. Hospitals are tired of these kinds of bureaucracy. ...Each sector carries out their designated duties where resources are not shared. The information possessed by each sector is fragmented. You know yours, I know mine. (Male, Administrators-2, 18-08-2011)

Medical malpractice is defined clearly in the Regulation on Handling Medical Malpractice. There are several benchmarks determining the amount of compensation issued. After the Tort Liability Law of the People's Republic of China was promulgated, [medical damage] was compensated for more in accordance with the Tort Liability Law because it stipulates compensation for personal injury. (Female, Hospital managers-2, 25-08-2011)

Unjustifiable complaints by patients

In some cases, the patient experiences inconvenience when receiving medical services not because of poor conduct in attitude or behaviour on the part of health care providers, but possibly because of long wait times, too little time spent with the doctor, and/or imperfect resource allocation. These are health system issues rather than problems caused by hospitals or individual physicians. And so, to a certain extent, physicians and hospitals have become scapegoats of the entire health system.

At times it is not us physicians who make patients angry. Certain factors are rooted in the fabric of health care systems, but we physicians [end up] taking the blame. (Male, Health care providers-3, 16-09-2011)

For example, should a doctor need to see sixty patients in half a day, or indeed one

hundred, you cannot demand that he puts on a smile for each one. A lot of patients complain about doctors with a straight face, but I think it is understandable. I have a very good relationship with our young doctors. They operate on a tight schedule. This week someone worked at the outpatient facility. He was friendly with patients in the first month but struggled to sustain that sort of demeanour. He is not in the mood to smile at patients or engage in long conversations when he only has time to attend to their illnesses. (Male, Hospital managers-1, 15-12-2010)

For example, dissatisfaction voiced in the hospital may be related to health insurance policy rather than staff behaviour. Hospitals need to follow the policies made by the Health Insurance Department. The purpose of those policies was to improve rational use of medicines and control healthcare costs, while the patients covered by health insurance may demand more medicines.

Chinese doctors have many rules to obey [this is to curb poor conduct]. The pressures for them to perform are relatively large. For example, doctors cannot prescribe too much medicine for a patient who has only [basic state-financed] medical insurance, but patients always want more. A while ago, the Medical Insurance Bureau issued the following statement in a newspaper: "The Medical Insurance Bureau never limits the volume of drugs prescribed, rather it is the doing of hospitals who wish to increase workload [in order to produce more statistics]." I think this is really unreasonable. The Bureau does not control the quantity of drugs prescribed in any given week, but there is a total quantity limit over a year. Doctors

try their best not to prescribe drugs which must be self-financed, i.e. not covered by basic medical insurance. They must also explain very clearly before prescribing self-financed drugs, otherwise, patients will lodge complaints once they find out. (Male, Hospital managers-1, 15-12-2010)

Complaints occur when the patient wants more drugs but the doctor refuses to satisfy his or her demands. Why? The health insurance institution sets a limit on drug expenditure for each hospital; in turn, the hospital sets a limit for each doctor. So if a doctor has too many patients drawing from their health insurance scheme in any one month, he or she may very possibly have exceeded his/her limit. (Male, Health care providers-3, 16-09-2011)

[A patient who has] basic state-financed medical coverage is entitled to blood and other auxiliary examinations. If the number of health checks prescribed exceeds a certain threshold, the doctor is viewed as exploiting basic medical insurance. The doctor is consequently punished. I was deducted more than seven hundred yuan (RMB) because of a case like this. I feel this is simply absurd – it is [unexpectedly] doctors who are to blame. Nothing seems to be wrong with the patient. ...The hospital can not do anything about medical insurance. I think this kind of thing is not the problem at the hospital level. The complaints about medical insurance define, without a doubt, problems underlying the state and society. (Male, Health care providers-4, 16-09-2011)

In addition, the safety of health care providers is under threat in China today. Chinese medical workers are often victims of violence. As a consequence, some health care

providers have decided to not treat patients deemed likely to assault staff, exhibit disruptive behaviour, or otherwise prove to be difficult. Prescribing redundant check-ups and drugs are alternatives to properly seeing to patients.

In our interviews, fifteen interviewees mentioned "Chao" fifty-five times. "Chao" in Chinese means to argue with hospitals for patients' rights and interests, while the other meaning is to wrangle fiercely in hospitals or with senior management. Most of the hospital staff interviewed suggested that some complainants were indeed unreasonable and impulsive with the sole purpose of claiming.

If the case goes to court, the patient gathers a lot of people to go to the court, insulting and threatening concerned health care providers and their lawyers. That is not what we want to see. We want to talk about the truth, by thoroughly publicizing the truth. We cannot always be too specific with terminology [for fear of revealing too much]. When completely refuted, patients lose their temper. (Male, Other actors-2, 15-09-2011)

I feel that the widespread situation in China today is that you can do nothing if you run into the unreasonable. The legitimate way of going about this is to propose a fair decision once I receive your complaint. If complainants are not willing to settle for this, we then transfer their case to other departments. However, complainants may not even agree to that, causing trouble and even threatening the safety of health care providers. (Female, Hospital managers-2, 25-08-2011)

The claim a complainant demands goes beyond the actual problem [but for the money] and he does not wish to resolve it the legal way. ...Nowadays "Yi Nao" has

brought about serious social effects, and has escalated the tension between service users and providers. Complainants are unwilling to resolve things the legal way, rather, just pestering and hassling you [health care providers or complaint handlers] all day. (Male, Hospital managers-6, 01-11-2011)

d. Barriers to institutional changes for quality improvement using complaints data

Weak enforcement of the regulation

The regulation for managing patient complaints is merely a guideline, which contains no mandatory requirements such as assessment mechanisms. Because it takes into account the difference in local conditions throughout China, specific contents were not stipulated. The regulation is to be interpreted according to local circumstances and conditions. Therefore, in the absence of strong public scrutiny, there is little accountability for how best to manage patient complaints.

There are no penalties attached to (failure to follow) regulation. For example, there is no administrative aspect to the regulatory guidelines. We wanted to write a penalty provision, but it was not based on the top legislation. The purpose of the regulation is to emphasise self-discipline and to serve as guidance for the hospital. [The penalty was not enforceable,] so we decided to remove the penalty. It is indeed difficult and contradictory. (Female, Administrators-4, 30-11-2011)

Besides the legal system, the reporting system also has its problems. Some statistics about patient complaints and medical malpractice were utilized as a part of

assessments of hospital performance, health care quality, and so on. This meant that the more cases that were reported, the worse the evaluations received by the hospitals so that hospitals were inclined to report selectively or report fewer cases.

There are certainly no statistics for the number of patient complaints. There is only the data on the number of medical malpractice cases per year from the Bureau of Health, and an approximate amount of compensation issued by insurance companies. In some cases, if complaints were solved just between the hospital and the complainant, we have no data. (Male, Administrators-2, 18-08-2011)

These days, the information regarding the management of patient complaints in hospitals is difficult to access. Hospitals are unwilling to provide that sort of information – it is considered confidential. We only have some profiles or the information from select hospitals. (Female, Policy makers-1, 16-12-2010)

Thus, the adoption of the incentive and sanction mechanism was contradictory for managing patient complaints. From one side, the administrative department wanted hospitals to report patient complaints because it is important for informing and improving the quality of care. From the other side, the more complaints that are registered, the worse it would appear a hospital is doing. In addition to this, managing patient complaints remains low on the health reform agenda. The force for inspecting complaint management in hospitals from senior management and administrative departments remains weak.

[Having a statistic for patient complaints] is definitely necessary from the aspect of

effective management. If this statistic is disposable, I think nothing of it. If the statistic is routine, in fact, it will cost [all sorts of resources]. (Male, Policy makers-2, 22-12-2011)

Hospitals doubt that the purpose of administration is for information management – to help them better handle and solve disputes. However, if you want me to report incidents but meanwhile punish me for that, then I have no incentive to report anything. This contradiction stands [in the way of effective reporting]. (Female, Administrators-4, 30-11-2011)

Deficient information system for managing patient complaints

Although the regulations in place require collecting and analysing information, there exists no clear classification, definitions or unified coding system. Most hospitals have established their own systems for recording complaints and analysing cases, but no accurate or comparable data are available.

In fact a lot of cases should be recorded and analysed, [but] we do not even take into account so-called major cases of medical malpractice, mass disturbance or medical malpractice. We cannot distinguish between these concepts.... Relatively speaking, it is more feasible to publicize the data on public security, e.g. the number of police records and people arrested, and the number of crimes committed. Those definitions are more explicit, whereas those concerning complaints management are not. Because all statistics are calculated in the hospital, we find that where standards are slack, the resulting statistic is large and where standards are strict,

the statistic is small. Hence, there is great variability in our results. (Male, Policy makers-2, 22-12-2011)

Identical forms are sent to two hospitals at a similar level and the reported data can be quite different. ...Some hospitals only reported cases resulting in compensation and some hospitals record all persons who voice a concern, while others only report cases identified as medical malpractice. But it is impossible for me to verify [the reported data] in each hospital. (Male, Administrators-2, 18-08-2011)

Hospitals have not publicized complaints; neither have health administration departments. The Shanghai Bureau of Health launched a pilot project in 2005 to publicize the complaints reported by all hospitals in Shanghai. The project was welcomed by the public but discontinued soon after its launch due to mounting pressure from the hospitals.

We already publicize complaints [medical malpractice] on our intranet for hospital staff. It is unnecessary to share this information on external sites. (Female, Hospital managers-4, 06-09-2011)

To my knowledge, such information was published once on the Xinmin Evening News in 2005. The newspaper named hospitals that had won awards and gave details of the number of medical malpractice cases happening in each, as well as feedback regarding patient satisfaction. [We felt] the pressure was very, very high. It [publishing those] resulted in public outrage [from hospitals]. (Female, Administrators-4, 30-11-2011)

Unwillingness of hospitals to effectively handle complaints

Most hospitals did not devote much effort into managing complaints. There was no clear mechanism to utilize patient complaints to improve quality of care unless serious medical malpractice had occurred or complaints were found to recur.

Hospitals just handle complaints when complaints happen. ...We are basically perfunctory, including hospitals, department directors and doctors. The best-case scenario for me: do not approach me for these things [complaints]. Deal with complaints quickly and efficiently; in other words, spend money to buy peace. The impact of managing and addressing complaints is negligible, with very little effect on improving medical procedures and quality. (Male, Administrators-2, 18-08-2011)

Hospital directors were the key actors of complaint management in hospitals. The incentive and sanction mechanisms in hospitals depended on how much attention directors pay to complaint management. In the 1980s the government reduced subsidies for public hospitals under the context of transforming the planned economy to a so-called socialist market in order to reduce inefficiencies in health care provision. Hospitals had to increase service charges to recoup the operational costs and to increase the income level of health workers. Complaint management occupied nothing but a small part of quality health care, so in most hospitals it failed to draw attention from senior management. Most complaints were solved on a case-by-case basis, without sufficient concern for the overall improvement of health care services.

In practice, the head of department influences implementation. If he/she regards

this as important, then subordinates work harder of course. Now the problem is that some heads of department do not pay attention to it [complaint management]. (Male, Health care providers-2, 16-09-2011)

It is of course medical services that are the core of hospital work. Things such as [complaint management] are boring for the hospital. To a hospital, the fewer the complaints, the better. (Male, Administrators-2, 18-08-2011)

Discussion and Conclusions

This study examined the handling system for patient complaints in China and the views of key stakeholders on the barriers to effective complaint management. Our study provided a new dimension for understanding the complaints management system in China, an emerging market country. Hospitals are the most important handler and manager of patient complaints in China and similarly for other developing countries, such as India and Vietnam.[22] We explored the barriers through in-depth interviews with almost all stakeholders, not only health professionals. We hope that our findings will help develop procedures for more effective complaint management and further improve the quality of care in China and other developing countries. The selection of participants may introduce some bias to our studies. Due to our focus on the hospital, there may be an underrepresentation of certain types of respondents. Since there are no unified classifications for complaints, we did not include patients with different types of complaints.

We found that the three main project elements adopted from Hickson GB et al. were relevant and useful for the discussion of our results: (A) organizational supports, (B) commitment from key people, and (C) learning systems.[13]

A. Organizational Supports

Our findings showed that there are no standardized systems and procedures dealing with patient complaints in China due to conflicts between relevant actors and regulations. Having experienced rapid economic growth in the last 30 years, China is undergoing a socioeconomic transition. Like other developing countries, policies lag behind the country's economic transition.[37, 38] The Ministry of Health has tried to guide health care providers by issuing special regulations, but health administrations do not apply strict regulations to complaint management. There lacks clear relationships between patient complaints and clinical outcomes or the quality of care.

The patient complaints in many Chinese hospitals are not well-managed and handled. Most hospitals manage patient complaints on only a case-by-case basis. They lack clear mechanisms linking patient complaints with improving the quality of care. Complaints are underutilised for organizational strategic planning or for changing an individual's behaviour and attitude. This implies that legislation should not only stipulate the principles and regulations of patient complaint management, but also the responsibilities of sectors at different levels.[39]

B. Commitment from People

The hospital leader is the key determinant for complaint handling inside the hospital. However, no apparent incentives exist to push hospital leaders to prioritize complaint handling. The power of complaint handling departments depends on how much the hospital leaders pay attention to it. Under current conditions, hospital leaders lack political will to manage complaints effectively, leading to inadequate human resources in complaint handling departments. The departments also lack the power to coordinate with clinical departments.

To alleviate patient complaints-related violence, civil groups, including service users and the hospital sector, should approve the guideline. In developed countries, patient complaint management provides guidelines not only for health care providers, but also clear guidelines for patients. This not only makes it more convenient for patients, but also plays a positive role in helping patients initiate the complaint process via legitimate means. This is crucial for society to view patient complaint in a rational way.

C. Learning Systems

If patient complaints can be better managed and rectified, the instances of failure would be reduced and quality would be improved.[40, 41] Greater emphasis should be placed on quality improvement after patients complain. Strategies to improve quality following patient complaints should be developed through a learning process.[42] To

promote the learning process, appropriate mechanisms should be developed and implemented to assess not only the number of patient complaints occurring in hospitals, but also how these hospitals have handled these complaints. For example, reporting more patient complaints should not be necessarily punished, while effective handling of the patient complaints should be appreciated.

Our final conclusion is that barriers to the effective management of patient complaints vary at the different stages of complaint handling, from the user and provider side, as well as systemic issues. Information, procedure design, human resources, system arrangement, a unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management. Appropriate mechanisms should be developed to link patient complaints with improving the quality of care.

ACKNOWLEDGEMENT

The HESVIC project received funding from the European Commission Framework 7. The views represented in this document are not necessary representative of the European Commission's views and belong solely to the authors. The consortium would like to thank all the study respondents and participants for their willingness to take part in the research, as well as the members of the Country Research Advisory Groups for their support at every stage of the HESVIC project. The authors of the paper very much appreciate constructive comments and suggestions on earlier version of the paper from Shenglan Tang from Duke Global Health Institute, USA. The authors are also grateful to Ms. Kaori Sato for language editing.

COMPETING INTERESTS

None.

FUNDING

This study was supported by the European Commission Seventh Framework Programme (HEALTH-F2-2009-222970).

CONTRIBUTORSHIP STATEMENT

1) Yishi JIANG: substantial contributions to conception and design, acquisition of data, and analysis and interpretation of data; drafting the article and revising it; and final approval of the version to be published.

2) Xiaohua YING: substantial contributions to conception and design, acquisition of data, and analysis and interpretation of data; drafting the article; and final approval of the version to be published.

3) Qian ZHANG: substantial contributions to acquisition of data, and analysis and interpretation of data; drafting the article; and final approval of the version to be published.

4) Sirui Rae TANG: substantial contributions to analysis and interpretation of data; drafting the article; and final approval of the version to be published.

5) Sumit KANE: substantial contributions to conception and design, and analysis and interpretation of data; revising the article critically for important intellectual content; and final approval of the version to be published.

6) Maitrayee MUKHOPADHYAY: substantial contributions to conception and design, and analysis and interpretation of data; revising the article critically for important intellectual content; and final approval of the version to be published.

7) Xu QIAN: substantial contributions to conception and design, and analysis and interpretation of data; drafting the article and revising it critically for important intellectual content; and final approval of the version to be published.

8) HESVIC team authorship

DATA SHARING

No additional data available.

References:

1. Sage WM. Putting the patient in patient safety: linking patient complaints and malpractice risk. *JAMA* 2002;**287**:3003-5.
2. Hsieh SY. A system for using patient complaints as a trigger to improve quality. *Qual Manag Health Care* 2011;**20**:343-55.
3. Wofford MM, Wofford JL, Bothra J, et al. Patient complaints about physician behaviors: a qualitative study. *Acad Med* 2004;**79**:134-8.
4. Beecham L. Patients' complaints: GMC could do better. *BMJ* 1999;**319**:1022.
5. Anderson K, Allan D, Finucane P. A 30-month study of patient complaints at a major Australian hospital. *J Qual Clin Pract* 2001;**21**:109-11.
6. Ministry of Health. *Measures for the Handling of Patient Complaints in Hospitals (for Trial Implementation)*. Beijing: Ministry of Health; 2009.
7. The Henry J. Kaiser Family Foundation. Medical Malpractice Law in the United States. http://www.kff.org/insurance/upload/Medical-Malpractice-Law-in-the-United-States-Report.pdf Accessed [08-31-2012].
8. Hsieh SY. Healthcare complaints handling systems: a comparison between Britain, Australia and Taiwan. *Health Serv Manage Res* 2011;**24**:91-5.
9. Department of Health, United Kingdom. Complaints procedure. http://www.dh.gov.uk/health/contact-dh/complaints/ Accessed [08-31-2012].
10. Cornwall A, Romios P. Turning Wrongs Into Rights. *Health Issues* 2004;**79**:13-8.

11. Hickson GB, Federspiel CF, Pichert JW, et al. Patient complaints and malpractice risk. *JAMA* 2002;**287**:2951-7.

12. Pichert JW, Hickson G, Moore I. Using Patient Complaints to Promote Patient Safety. *Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 2: Culture and Redesign)*. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008.

13. Hickson GB, Moore IN, Pichert JW, et al. Balancing systems and individual accountability in a safety culture. *From Front Office to Front Line: Essential Issues for Health Care Leaders, 2nd ed*. Oakbrook Terrace, IL: Joint Commission Resources; 2012. p. 1-35.

14. Vincent C, Davis R. Patients and families as safety experts. *CMAJ* 2012;**184**:15-6.

15. Xi X. *Understanding and application of provisions in the Tort Liability Law*. Beijing: Press of the People's Court; 2010.

16. Chinese doctors are under threat. *Lancet* 2010;**376**:657.

17. Zheng XQ, Wei LY, Zhang BZ, et al. Domestic Survey of Medical Disputes and Foreign Medical Dispute Handling. *Chinese Hospitals* 2007; **7**:2-4.

18. Stafford C. Moral ambivalence in modern China. *The Lancet* 2012;**9818**:793.

19. Communicating concern: complaints against doctors. *Lancet* 2013;**382**:1382.

20. Zhuang Y, Zhong C, Liu J, et al. A survey and analysis of complaint management in five tertiary hospitals. *Chinese Journal of Hospital Administration* 2006;**22**:45-8.

21. Gan N, Yu T, Chen W, et al. Analysis of differences in cognition between doctors

and patients and causes of medical disputes. *Journal of Shanghai Jiaotong University (Medical Science)* 2008;**28**:1035-7.

22. Gao J, Cao W, Xu Y, et al. Survey analysis of consultation settlement for medical disputes in 30 medical institutions of Shanghai. *Journal of Shanghai Jiaotong University (Medical Science)* 2010;**30**:960-3.

23. Green A, Gerein N, Mirzoev T, et al. Health policy processes in maternal health: a comparison of Vietnam, India and China. *Health Policy* 2011;**100**:167-73.

24. Charmaz K. *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. Thousand Oaks, CA: Sage Publications, 2006.

25. Sadler GR, Lee HC, Lim RS, et al. Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nurs Health Sci* 2010;**12**:369-74.

26. Lacey A, Luff D. *Qualitative Research Analysis*. The NIHR RDS for the East Midlands / Yorkshire & the Humber, 2007.

27. Department of Health, NSW. *Complaint Management Guidelines*. North Sydney NSW: Guidelines; 2006.

28. State Council. *Regulation on the Handling of Medical Malpractices*. Beijing: Decree of the State Council; 2002.

29. Standing Committee of the Eleventh National People's Congress. *Tort Law of the People's Republic of China*. Beijing: Presidential Decree; 2009.

30. Ministry of Health. *Measures for the Complaint Letters and Visits System for Healthcare*. Beijing: Ministry of Health; 2007.

31. Shanghai Justice Bureau and Health Bureau. *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*. Shanghai: Shanghai Justice Bureau and Health Bureau; 2008.

32. Ministry of Justice, Ministry of Health, and China Insurance Regulatory Commission. *Opinions on Strengthening People's Mediation for Medical Disputes*. Beijing: Ministry of Justice, Ministry of Health, and China Insurance Regulatory Commission; 2010.

33. Shanghai Justice Bureau and Health Bureau. *Measures on People's Mediation for Medical Disputes in Shanghai*. Shanghai: Shanghai Justice Bureau and Health Bureau; 2011.

34. Yan X. Correctly Receive Medical Complaints and Establish Harmonious Doctor-patient Relationship. *Modern Hospital Management* 2008;**6**:24-5.

35. Manouchehri MJ, Ibrahimipour H, Sari AA, et al. Study of patient complaints reported over 30 months at a large heart centre in Tehran. *Qual Saf Health Care* 2010;**19**:e28.

36. Siyambalapitiya S, Caunt J, Harrison N, et al. A 22 month study of patient complaints at a National Health Service hospital. *Int J Nurs Pract* 2007;**13**:107-10.

37. Grundy J, Khut QY, Oum S, et al. Health system strengthening in Cambodia-a case study of health policy response to social transition. *Health Policy* 2009;**92**:107-15.

38. Luong DH, Tang S, Zhang T, et al. Vietnam during economic transition: a tracer study of health service access and affordability. *Int J Health Serv* 2007;**37**:573-88.

39. Shaw K, Cassel CK, Black C, et al. Shared medical regulation in a time of increasing calls for accountability and transparency: comparison of recertification in the United States, Canada, and the United Kingdom. *JAMA* 2009;**302**:2008-14.

40. Winkler F. Complaints by patients. *BMJ* 1993;**306**:472-3.

41. Baker R. Learning from complaints about general practitioners. *BMJ* 1999;**318**:1567-8.

42. Mintzberg H. The Fall and Rise of Strategic Planning. *Harvard Business Review* 1994:107-14.

Title page

1. Title of the article.

Managing patient complaints in China – a qualitative study in Shanghai~~Managing patient complaints in China: what went wrong?~~

2. Full name, postal address, e-mail, telephone and fax numbers of the corresponding author.

The corresponding author: Xu QIAN

Postal address: Mailbox 175, 138 Yi Xue Yuan Road, Shanghai, 200032, P. R. China

Tel: 86-21-54237267 Fax: 86-21-64174172

Email: xqian@fudan.edu.cn

3. Full names, departments, institutions, city and country of all co-authors.

1) Yishi JIANG: School of Public Health, Fudan University, Shanghai, China; Shanghai Maternal and Child Health Center, China

2) Xiaohua YING: School of Public Health, Fudan University, Shanghai, China

3) Qian ZHANG: School of Public Health, Fudan University, Shanghai, China

4) Sirui Rae TANG: School of Public Health, Fudan University, Shanghai, China

5) Sumit KANE: KIT Development Policy & Practice, Royal Tropical Institute, Amsterdam, Netherlands

6) Maitrayee MUKHOPADHYAY: KIT Development Policy & Practice, Royal Tropical Institute, Amsterdam, Netherlands

7) Xu QIAN: School of Public Health, Fudan University, Shanghai, China

8) HESVIC team authorship

4. Up to five keywords or phrases suitable for use in an index (it is recommended to use MeSH terms).

Qualitative Research; Patient Complaints; Complaint Handling Systems; Quality Improvement; Government Regulation

5. Word count - excluding title page, abstract, references, figures and tables.

~~6887~~6902

Abstract

Objectives: To examine the handling system for patient complaints and to identify existing barriers that are associated with effective management of patient complaints in China.

Setting: Key stakeholders of the handling system for patient complaints at the national, Shanghai municipal, and hospital levels in China.

Participants: Thirty-five key informants including policymakers, hospital managers, ~~health provider~~health care providers, users and other stakeholders in Shanghai.

Primary and secondary outcome measures: Semi-structured interviews were ~~used~~ conducted to understand the process of handling patient complaints and factors affecting the process and outcomes of patient complaint management.

Results: The Chinese handling system for patient complaints ~~has been~~was established in the past decade. Hospitals ~~undertake~~ shoulder the most responsibility of patient complaint handling. Barriers to effective management of patient complaints included service users' low awareness ~~about~~ of the systems in the initial stage of the process; poor capacity and skills of healthcare providers, incompetence and powerlessness of complaints handlers and non-transparent exchange of information during the process of complaint handling; conflicts between relevant actors and regulations, and

unjustifiable complaints by patients during ~~the stage of~~ solution settlements; and weak enforcement of ~~the~~ regulations, deficient information for managing patient complaints and unwillingness of the hospitals to effectively handle complaints in the post-complaint stage.

Conclusions: Barriers to the effective management of patient complaints vary at the different stages of complaint handling and perspectives on these barriers differ between~~from~~ the service users and providers ~~perspectives~~. Information, procedure design, human resources, system arrangement, unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management.

Article summary

Strengths and limitations of this study

This study explores the handling system for patient complaints in China and the views of key stakeholders on the barriers to effective complaint management. These findings are essential to improve the complaints system. Our study provides a new dimension of understanding the complaints management system in China, an ~~developing country~~emerging market country. We explore the barriers through in-depth interviews with almost all stakeholders, not only health professionals. What we found will help develop procedures for more effective complaint management and to further improve the quality of care in China and other developing countries. The selection of participants may introduce some bias to our studies. Due to our focus on the hospital, there may be an underrepresentation of certain types of respondents.

Bullet points

1. Our study examined the handling system for patient complaints and identified and analysed barriers to effective management in China.
2. We carried out a literature review and semi-structured interviews with all categories of key informants.
3. Hospitals undertake the most responsibility for patient complaint handling.
4. Barriers to effective management of patient complaint vary at different stages of complaint handling, from the user and provider

side, as well as system issues.

5. Information, procedure design, human resources, system arrangement, unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management.

Background

In recent years, patient complaints around the world have garnered mounting concern among policymakers, academics and the general public.[1-3] As China prospers, making advances in medicine and social welfare, ~~people's~~ expectations of better quality of care continue to grow. People's knowledge of the law and their rights has increased as a result of better education and ~~better~~ understanding of the law. Patients are able to express their discontent by lodging complaints such that the number of complaints occurring internationally is on the rise.[4, 5] A "complaint" is defined as *the behaviour of a patient or his/her representative(s) which signifies dissatisfaction towards medical services, nursing services, as well as treatment conditions through letters, calls or visits to the hospital where the purpose of these actions is to criticise the hospital and/or claim compensation".*[6] In addition, ~~T~~the growth in dollars paid on malpractice claims is ~~also~~ evident.[7] ~~The~~ China's current situation reveals ~~much~~ growing concerns surrounding hospital accountability and clinical governance; in particular, the efficacy of the ~~system for~~ redress system. Grave consequences ~~pertaining to~~affecting both social and political stability are likely if the health care system fails to meet expectations and to achieve patient satisfaction. Indeed, the issue at hand is one of paramount importance, requiring urgent attention and immediate action at the highest level.

In countries such as Australia and Britain, the states have sought to monitor complaints and complaint handling to improve and regulate the practice of health

professionals.[8] A feedback system of this sort has proven instrumental in improving the quality of care. In Britain, the National Health Service (NHS) not only provides clear and transparent guidelines for both ~~health provider~~health care providers and patients but also publicizes information regarding the routine reporting of patient complaints.[9] In Australia, a large study was conducted before *Guide to Complaint Handling in Health Care Services* was formulated and subsequently updated.[10] Annually, statistics are compiled and published, detailing complaint trends, complaint management and reasons for complaints. Effective handling of complaints has been known to reduce friction between providers and consumers, with the even greater benefit of improving quality of care. As a supplement to peer reviews and administration, patient complaints can provide important feedback concerning the delivery of health care services and can be a useful tool in the improvement of health care quality.[1-3, 11-14]

With no official statistics of patient complaints available in Chinese records, we estimated that the number of complaints and disputes rose, from 10,249 to 13,875 claims~~ceases~~, based on the number of first trials for medical malpractice cases between 2002 and 2008~~, from 10,249 to 13,875~~.[15] Mounting dissatisfaction has been felt across the country, manifesting in increasingly hostile and violent behaviour towards providers ~~by~~ from patients and their families.[16] An investigation carried out by the Chinese Hospital Management Association in 2005 suggested~~s~~ that of 270 hospitals surveyed, 73 per cent experienced abuse in the form of threats and assaults targeting

doctors and management.[17] These incidents are only indicative of rising expectations, burgeoning patient discontent with services and dissatisfaction towards the ~~manner~~ way in which matters are resolved.[18] Public outcry only exacerbates the need for more effective handling of individual cases under the overarching agenda ~~for~~ of public hospital reform in China.[19]

~~In countries such as Australia and Britain, the states have has sought to monitor complaints and complaint handling to improve and regulate the practice of health professionals.~~[8] ~~A feedback system of this sort has proven instrumental in improving the quality of care. In Britain, the National Health Service (NHS) not only provides clear and transparent guidelines for both health providers and patients but also publicizes information regarding the routine reporting of patient complaints.~~[9] ~~In Australia, a large study was conducted before *Guide to Complaint Handling in Health Care Services* was formulated and subsequently updated.~~[10] ~~Annually, statistics are compiled and published, detailing complaint trends, complaint management and reasons for complaints. Effective handling of complaints has been known to reduce friction between providers and consumers, with the even greater benefit of improving quality of care. As a supplement to peer reviews and administration, patient complaints can provide important feedback concerning the delivery of health care services and can be a useful tool in the improvement of health care quality.~~[1-3, 11-14]

~~Amidst soaring angst, the Chinese government has put in place a system for redress where when grievances arise. A "complaint" is defined as *the behaviour of a patient or his/her representative(s) which signifies dissatisfaction towards medical services, nursing services, as well as treatment conditions through letters, calls or visits to the hospital where the purpose of these actions is to criticise the hospital and/or claim compensation".*~~[6]

Notwithstanding the alarming extent of these issues, few attempts have been made to formally examine how hospital complaints are addressed in developing countries. It is only recently that a handful of studies in China have sought to provide some understanding of the issue~~,~~ by trying to ascertain the number of complaints in the studied hospitals or ~~and~~ garnering patient feedback via questionnaires and interviews.[20-22] A fuller understanding of the complaints system – the available channels for seeking redress, how the system operates and the barriers to conflict resolution – ~~–~~ will be crucial to ameliorating the often fraught relationships between health care providers and consumers. The purpose of this study has been to examine the handling system for patient complaints in China, and~~;~~ to subsequently identify and analyse the various hospital-specific factors preventing grievances from being effectively addressed. The authors of this paper hope that such an undertaking will reduce malpractice and above all, improve health service outcomes.

This study is one of the ~~tracing~~ cases from the "Health System Stewardship and

Regulation in Vietnam, India and China" (HESVIC) research project. It was conducted by a consortium of six partners in Asia and Europe from 2009-2012, with the aim of supporting policy decisions in the application and extension of accessibility, affordability, equity and quality of coverage of maternal health care in the three countries.

Methods

Study design

The project uses a multidisciplinary approach, drawing on multiple case studies to examine the impact of regulation on improving equitable access to quality health care in Vietnam, India and China. In each country, three cases were selected and studied. This paper shows the findings from the case study, examining the regulation on Grievance Redressal (GR) in Shanghai, China. Here, regulation encompasses the formation of rules and practices, as well as their interpretation and implementation, such as the health policy processes covered in the HEPVIC project (HEPVIC).[23]

Phase One: Literature Review

Firstly, we conducted a literature review. The relevant sources, which included regulation documents related~~ing~~ to the handling of patient complaints at both the national and Shanghai municipal levels, were used to collect legal approaches and mechanisms used in managing patient complaints. These regulations were mainly stipulated from 2002 to 2011. To understand the application of different complaint

approaches, a search of scientific literature published between 2000 and 2011 was conducted. Databases MEDLINE-PubMed and WANFANG Data were consulted. A search strategy was established based on the following keywords: *grievance redressal, patient complaint, health care complaint and hospital complaint, and China*. Special focus was ~~put~~ placed on patient complaint management in hospitals, as we found that the vast majority of complaints ~~are~~ were handled and resolved within the hospitals.[22]

Phase Two: Pilot Study – Interviews

Based on our understanding of the current patient complaint handling system, we ~~then~~ performed semi-structured interviews with key stakeholders – policymakers from the national level, administrators from the Shanghai municipal level, hospital managers, ~~health provider~~health care providers, users and other related parties. We used the snowball sampling method to identify key stakeholders and to collect important feedback from key informants from various disciplines.[24, 25]

In Phase Two (October-December 2010), one key actor from each of the three administrative levels ~~were~~ was selected and interviewed: a policymaker at the national level, a municipal administrator and a hospital manager. A pilot study was conducted to test the topic guidelines developed. These ~~would~~ allowed us to gain a preliminary understanding of the ~~process of~~ complaint management process in the hospital setting ~~of China~~, and to refine the data collection tools. These interviews served as the basis

for the design of Phase Three interviews, where some of those being interviewed in the third phase were respondents recommended by Phase Two interviewees.

Phase Three: Main Data Collection

Interviews in Phase Three were conducted from August-December of 2011. Key stakeholders were interviewed in the selected hospitals based on location, level and type. Our sample ~~was the representative of~~represented both urban and suburban areas in Shanghai. General ~~hospitals~~ and specialist hospitals were selected. Phase Three began with interviews of hospital managers and ~~health provider~~health care providers proposed in Phase Two. We asked interviewees from Phase Two to invite patients and other relevant stakeholders to contribute their views. Those invited patients ~~had~~ used different channels for lodging their complaints; h~~. H~~owever, they all shared one thing in common: all patients had first complained to the hospital. We then proceeded to interview the administrators and finally a high-level policymaker. We continued to interview respondents, collecting and analysing their comments and feedback until no new themes emerged, i.e. saturation had been reached. The number of participants involved in the different types of interviewees is depicted in Table 1.

Semi-structured interviews were conducted with 35 respondents face-to-face, except one via telephone. The interviews took place at private locations, for example at the institution where the interviewee or interviewer worked, and were conducted by two of the authors of this paper. Each interview lasted 1-2 hours and was audiotaped with

permission, apart from two which were not recorded but typewritten upon the respondents' request.

Table 1 Number of interviewees by administrative level and facility

Types of interviewees	**Level**	**Number of Participants**
Policymakers	National	
Ministry of Health		1
A university		1
Administrators	Shanghai municipal	4
Hospital managers		
General hospital	Tertiary	3
General hospital	Secondary	3
Specialized hospital	Tertiary	1
Specialized hospital	Secondary	1
Private hospital	Secondary	2
~~Health provider~~Health care providers		6
Users		6
Other actors		
Municipal Health Inspection Institute		2
Lawyers for medical disputes		2
The centre that processes medical liability insurance		1

The People's Mediation Committee for Medical Disputes	1
The Complaint Letters and Visits System	1
Total	**35**

The topic guidelines for carrying out the interviews included questions on the participant's experience ~~on~~in complaint management in the hospitals. Using probes and follow-up questions, attention was directed to factors that the interviewees perceived as barriers to effective complaint management~~. They were~~, and interviewees were asked to explain their reasoning~~why they believed this to be the case~~. From existing literature, we identified a list of factors required for effective complaint management and successful resolution of disputes. Participants were asked to provide suggestions and feedback regarding how complaints could be more effectively dealt with given the barriers they had identified.

Data analysis

Audiotapes recorded during the interviews were transcribed and were compared with the field notes to check for accuracy. We analysed data through a process of rigorous and structured analysis.[26] The analysis was executed in several stages to 1) become familiar with the data; 2) identify emerging topics; 3) develop a topic index; 4) use the index to code the data; 5) consolidate the topics into themes; 6) further consolidate these themes into analytical categories/clusters; and 7) translate the analysis obtained

into a narrative. Written consent was obtained from each interviewee before undertaking the interviews.

We performed the above tasks using the qualitative research software NVivo 9.0. The raw data was coded by two independent reviewers (YSJ, QZ). If ~~some~~ discrepancies emerged, a third reviewer (XHY) ~~would~~ participated in the group discussion until the group arrived at a consensus. There were some models for analysing complaint management~~,~~;[2, 13] for example, ~~a~~ the Managerial-Operational-Technical (MOT) model was developed by Hsieh SY to explore complaint management in hospitals.[2] In our study, we collected data according to the complaint management process. To analyse the data most efficiently and directly, we used the stages of the process, which~~.~~ ~~The stages~~ included receiving~~e~~, handling~~e~~ and resolving~~e~~ complaints.[27] As ~~the~~ quality improvement following complaints is ~~very important~~crucial, we added the stage of "institutional changes for quality improvement using complaints data".[2, 12]

Our study was approved by Institutional Review Board (IRB), School of Public Health, Fudan University. Access to data was restricted to approved members of the research team who signed a confidential agreement with the principal investigator. Data were stored in secure electronic locations. Data processing was kept anonymous~~ly~~ so as to protect the identity of interviewees. The names of the respondents have been deleted from the quotations.

Findings

This section first presents a number of approaches developed and implemented in Shanghai to handle patient complaints and their relationships. It then focuses on the approach of negotiation between hospitals and complainants, identifies its barriers, and proceeds to examine and analyse these barriers.

1. Approaches and mechanisms used in managing patient complaints

The study identifies both formal and informal approaches and mechanisms used in handling patient complaints.

a. Negotiation between Hospitals and Complainants

The complaint handling department within the hospital is responsible for dealing with patient complaints, first established on February 20, 2002, in accordance with the *Regulation on the Handling of Medical Malpractices*.[28] Since November 2009, these departments have been regulated by *Measures for the Handling of Patient Complaints in Hospitals (for Trial Implementation)*.[6] These acts require that a medical institution establish a department specifically for the purpose of handling and resolving medical disputes. The department is primarily responsible for receiving patient complaints via calls, letters, visits, and/or cases referred from other departments and institutions. Their role also includes counselling and communicating with patients, verifying and documenting disputes as well as resolving disputes.

b. Administrative Mediation and Civil Lawsuits

If the hospital is unable to resolve certain conflicts through negotiation, these cases may be referred to an external body such as the health administrative department or they may be settled in the court by means of litigation. The *Tort Law of the People's Republic of China*, adopted at the twelfth session of the Standing Committee of the Eleventh National People's Congress on December 26, 2009, provided a new legal definition of liability for medical malpractice, liability presumption and exemption.[29]

c. Complaint Letters and Visits System

In February 2007, *Measures for the Complaint Letters and Visits System for Healthcare* was established came into force.[30] Its purpose is to protect the legal rights and interests of citizens, legal entities, and other organizations, and to regulate behaviour and maintain order within the Complaint Letters and Visits System. It requires health administrative departments to set up the Complaint Letters and Visits offices at different levels. These offices are responsible for receiving, assigning and transferring matters as appropriate, as well as supervising in the handling of various issues and complaints.

d. People's Mediation – a form of Third-Party Facilitated Mediation

In July 2008, the Shanghai Justice Bureau and Health Bureau issued *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute*

Mediation, to establish the People's Mediation Committees for Medical Disputes.[31] Committee members, mainly retired judges and doctors, served to mediate disputes through reporting, explaining and analysing cases under the supervision of the local judiciary. In January 2010, the Ministry of Justice, the Ministry of Health and the China Insurance Regulatory Commission jointly issued *Opinions on Strengthening People's Mediation for Medical Disputes* to ~~strengthen~~ bolster the role of mediation in resolving medical disputes.[32] Its intent is to settle medical disputes in an effective way and to maintain order within hospitals, all with a view for ensuring harmony and social stability. In July 2011, the Shanghai Justice Bureau and Health Bureau introduced *Measures on People's Mediation for Medical Disputes in Shanghai* to replace *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*.[31, 33]

~~Further~~ In addition to the aforementioned channels of complaint, patients have also been found to express their discontent by "Yi Nao" – exhibiting disruptive behaviour within the hospital by~~,~~ targeting doctors and nurses or hospital managers by way of abuse, assault and other forms of violence. Much of this has garnered media attention, resulting in bad publicity for the hospital and damaging the reputation of doctors and staff.

2. The application of different complaint approaches

Table 2 the characteristics of the approaches

	Negotiation between Hospitals and Complainants	**Administrative Mediation**	**Civil Lawsuits**	**Complaint Letters and Visits System**	**People's Mediation**
Responsible institution	Complaint Reception Office in hospitals	Health Inspection Institute	People's Court	Complaint Letters and Visits Office in health administrative departments	People's Mediation Committee for Medical Disputes
Responsibility	Receive and handle patients' complaints; compensate some complainants	Receive and mediate medical malpractices	Receive and settle medical litigations	Receive, transfer and supervise patients' complaints	Receive and mediate patients' complaints
Handling method	Negotiation	Mediation	Mediation; Trial	Supervise matters	Mediation
Processing duration	Indefinite	Only once	Six months	Two months	One month
Legal level of resolution	Low	Low	High	Low	Low
Administrative level of resolution	Low	High	High	High	Low

2. The application of different complaint approaches

The complexity of relationships between different approaches can be seen where many actors are involved. ~~From the aspect of solution, a~~Approaches that can resolve medical disputes are mainly negotiations and civil lawsuits, while other approaches play a part in forwarding cases, such as Complaint Letters and Visits System, or easing conflicts, such as mediation. None of the approaches are considered the ~~most authoritative~~ultimate arbiter ~~approach~~. Patients can continue to lodge complaints through the Complaint Letters and Visits System even if a decision has been finalised after a second trial in court.

In the above-mentioned approaches, the hospital is the main handler for patient complaints. First of all, it can handle patient complaints completely independently, from reception to solution, while the other approaches, such as Civil Lawsuits and mediation, ~~have to~~must engage hospitals in complaint handling. Secondly, since the hospital is principally responsible for compensation, the complainant is more inclined to directly negotiate with the hospital. Findings from the literature show that the majority of medical disputes are resolved by negotiation between hospitals and complainants.[22] Thirdly, if hospitals handle complaints improperly, conflicts will become more volatile, resulting in serious incidents.[34] Therefore, hospitals have become the most common receiver, handler and resolver of disputes. (Figure 1)

3. Barriers to the effective management of patient complaints and their

underlying causes at different stages

Our interviews revealed that different hospitals often use different complaint systems. For example, some hospitals operate a centralized complaints office, which may or may not be independent of the Medical Affairs (Administration) Department. Other hospitals have several complaints offices, each of which is responsive to different kinds of complaints. A hospital's deputy director, who also heads hospital complaint management, generally manages complaint departments. Barriers to effective complaints management vary at different stages of the complaint process, both from the sides of the user and provider.

.

~~c.~~a. Barriers to receiving the complaints

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0" + Indent at: 0.29"

Low awareness of users about the handling system for patient complaints

Although hospital staff claimed that the complaints office was accessible to those with grievances, patients did not always feel this was the case. One user looked up the hospital telephone number on the Internet and said the complaint handling process was "very easy" while others did not concur. Almost all the patients ~~being~~ interviewed found that signs and directions (to the complaints office) failed to catch the eye. In some cases none could be seen at all:

I wanted to lodge a complaint, but did not know how to find ~~the place~~ [the complaints office]… Because the hospital was so big, I did not know which department [was responsible for handling complaints]. …I simply did not know who to turn to. You see, the complaints department was in another building [rather than

in the one in which I was treated i.e. the clinical department] (Female, Users-1, 01-09-2011)

~~f.~~b. Barriers to handling the complaints

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0" + Indent at: 0.29"

Poor capacity and skills of health care providers

The capacity and skills of health care providers in managing patient complaints is critically important in problem solving. Our study found that the reasons patients complained lay~~ie~~ mainly in poor communication and factors such as the provider's attitude, use of language, unprofessional behaviour, as well as dissatisfaction towards service procedures.

The Medical Doctors Association carried out a survey ~~of~~ on the nature of medical disputes. 50 per cent of cases were ~~a~~ results of inappropriate attitudes ~~in~~about health care delivery, 25 per cent were caused by technology misuse and the rest were related to management. (Female, Policy makers-1, 16-12-2010)

The majority of complaints can be resolved by an explanation issued by the hospital and/or a verbal apology by the offending party.[5, 35, 36] However, practitioners are often too preoccupied with their clinical duties to be able to respond to patient complaints.

~~*Hospitals have not completely adhered to regulation, which is clearly outlined in the guidelines; not because they do not have the capacity, but because doctors and related staff are simply too busy. (Male, Administrators-1, 21-12-2010)*~~

Doctors are not able to devote much time to handling disputes, because clinical

work is highly demanding. [They need to attend to] many patients every day. If they spend more time communicating with patients, they would lose time needed to carry out [clinical work]. That is to say, [doctors should be given] less [clinical] work, and more time to explain their work to patients. Our workload is very heavy, like a battle. (Female, ~~Health provider~~Health care providers-1, 01-09-2011)

Incompetence and powerlessness of complaints handlers

In comparison to health care providers, ~~C~~complaint handlers played a more important role in cooperation and coordination. Although ~~the~~ complaint departments ~~was~~ were specifically set up in hospitals for receiving and handling complaints, the responsible persons in the department were mainly part-time medical staff. In some cases~~,~~ those handling staff were found to be inadequate ~~sometimes~~ due to lack of training. Many of them had studied handling techniques on their own and had not acquired sufficient professional skills to appropriately analyse, assess and solve complaints.

Complaint handlers in the hospitals cannot solve everything because the disciplines involved in complaints are highly specialised. I am only familiar with general surgery and issues that require common sense, but [I am not familiar] with professional problems in other disciplines. (Male, Hospital managers-5, 08-09-2011)

It is difficult to recruit staff for our Medical Dispute Handling Office. No one wants to come. A boy recruited in 2007 could not stand the demands of the job [complicated disputes and violence] and so resigned. (Female, Hospital

managers-3, 31-08-2011)

We have little time to do things other than receiving complaints. We lack staff members. We are responsible for receiving and processing complaints, and expected – on top of this – to deal with other things, hence why we are exhausted. (Male, ~~Health provider~~Health care providers-2, 16-09-2011)

Given that most complaints are handled and resolved in the hospital, it appeared that every complaint handler interviewed felt the same way: tired and stressed. Complaint handlers were insufficiently empowered to handle complaints. It was hard for them to coordinate between different departments, investigate cases, organize mediation, find solutions and then draw on patients' feedback to improve quality of care.

Recently, a fierce medical dispute occurred because of a possible misunderstanding between administrative departments. [Abusive] words erupted. As a consequence, staff members involved in this incident were distraught – to the extent that they wanted to resign. Hence, we need understanding and support among colleagues. ...Sometimes the clinical department at hand ~~concerned~~ refused to cooperate when investigated. He [the clinical department] is not very serious about cooperating with the investigation. (Female, Hospital managers-3, 31-08-2011)

Communication between administrative departments and clinical departments is not very effective sometimes. I am not satisfied with this. (Female, Hospital managers-2, 25-08-2011)

Non-transparent exchange of information

In addition, the complaint handling process was not truly open to the complainant, and information exchange was largely limited to hospital staff. In fact, it was found that the staff at the complaints office was generally evasive towards patients who arrived wishing to be updated with the specifics of their complaint. ~~The e~~Complainants had no opportunity to directly engage in the handling of their complaints or to meaningfully participate in the process. In addition, hospitals tended to oversimplify cases, assuming that the complainant's only desire was to report their complaint and ask for compensation. This implies that the entire handling process is disclosed only among hospital staff. Therefore, the process becomes a "black box" to patients. It is easy for the hospital to manipulate a complainant by providing limited information to gain advantage in negotiations, i.e. reduce loss from compensating patients.

Sometimes you have to circumvent something and use negotiating skills. Mistakes in medical services do not necessarily harm patients' health, but they can be very serious for the provider [...] for example, someone may not be very careful when writing a medical record and alter it by accident. But you are likely to lose a lawsuit on the grounds of having tampered with records. Incidents such as these cloud the matter, making transparency difficult. (Female, Hospital managers-2, 25-08-2011)

If the incident is urgent or presents itself as a recurring problem, it might be shared to educate healthcare providers but disclosure to complainants themselves remains limited. Only outcomes deemed to be of direct interest to patients, including compensation amounts and medical service privileges, were provided. However, other results, including penalties imposed upon physicians and departments or

improvements made to hospital services, were largely withheld from patients if they did not ask.

In individual cases, what are the outcomes of their complaints? How might a physician be punished/penalised/disciplined? Such information is requested by patients only occasionally. (Male, ~~Health provider~~Health care providers-2, 16-09-2011)

I want to know how to better educate the concerned health care providers. But I have not been told. (Female, Users-3, 20-09-2011)

~~g.~~c. Barriers to resolving the complaints

Conflicts between relevant actors and regulations

Within the complaints system, conflicts or inconsistencies can arise between the legal system for handling complaints and the solutions determined by the hospital. As the structure of managing patient complaints is shown in Figure 1, different regulations stipulate different approaches. ~~There does not exist a u~~Unified laws or guidelines do not exist to clearly illustrate the relationships between different approaches, which results in problems such as a lack of authority or ultimate approach, uncertainty about how to apply different regulations to one case, and no clear definitions or classifications in regards to patient complaints.

The current state of complaint management is disorderly. There are too many channels. For example, many departments are involved, including but not limited to Complaint Letters and Visits, online complaints, etc. The Health Bureau has two

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0" + Indent at: 0.29"

departments [for complaint management], and each district has a mediation office, a district government website or a mayor-mail [to receive complaints], and a Complaint Letters and Visits office… Far too many heads of departments within the health sector; it' is chaos. (Male, ~~Health provider~~Health care providers-2, 16-09-2011)

Hospitals are required to report complaints to a lot of sectors, all of which wish to understand the issue from different angles. Conflicts between regulations do not necessarily exist.~~There are not necessarily conflicts between regulations,~~ but different elements are emphasised. Hospitals are tired of these kinds of bureaucracy. ...Each sector carries out their designated duties where resources are not shared. The information possessed by each sector is fragmented. You know yours, I know mine. (Male, Administrators-2, 18-08-2011)

Medical malpractice is defined clearly in the Regulation on Handling Medical Malpractice. There are several benchmarks determining the amount of compensation issued. After the Tort Liability Law of the People's Republic of China was promulgated, [medical damage] was compensated for more in accordance with the Tort Liability Law~~,~~ because it stipulates compensation for personal injury. (Female, Hospital managers-2, 25-08-2011)

Unjustifiable complaints by patients

In some cases, the patient experiences inconvenience when receiving medical services not because of poor conduct in attitude or behaviour on the part of ~~health~~

~~provider~~health care providers, but possibly~~. Instead,~~ because ~~inconvenience may be due to~~ of long wait~~ing~~ times, too little time spent with the doctor, and/or imperfect resource allocation. These are health system issues rather than problems caused by hospitals or individual physicians. And so, to a certain extent, physicians and hospitals have become scapegoats of the entire health system.

At times it is not us physicians who ~~have made a~~make patients angry. Certain factors are rooted in the fabric of health care systems, but we physicians [end up] taking the blame. (Male, ~~Health provider~~Health care providers-3, 16-09-2011)

For example, should a doctor need to see sixty patients in half a day, or indeed one hundred, you cannot demand that he puts on a smile for each one. A lot of patients complain about doctors with a straight face, but I think it is understandable. I have a very good relationship with our young doctors. They operate on a tight schedule. This week someone worked~~s~~ at the outpatient facility. He ~~i~~was friendly with patients in the first month but struggle~~s~~ to sustain that~~is~~ sort of demeanour. He is not in the mood to smile at patients or engage in long conversations when he only has time to attend to their illnesses. (Male, Hospital managers-1, 15-12-2010)

For example, dissatisfaction voiced in the hospital may be related to health insurance policy rather than staff behaviour. Hospitals need to follow the policies made by the Health Insurance Department. The purpose of those policies was to improve rational use of medicines and control healthcare costs, while the patients covered by health insurance may demand more medicines.

Chinese doctors have many rules to obey [this is to curb poor conduct]. The pressures for them to perform are relatively large. For example, doctors cannot prescribe too much medicine for a patient who has only [basic state-financed] medical insurance, but patients always want more. A while ago, the Medical Insurance Bureau issued the following statement in a newspaper: "The Medical Insurance Bureau never limits the volume of drugs prescribed, rather it is the doing of hospitals who wish to increase workload [in order to produce more statistics]." I think this is really unreasonable. The Bureau does not control the quantity of drugs prescribed in any given week, but there is a total quantity limit over a year. Doctors try their best not to prescribe drugs which must be self-financed, i.e. not covered by basic medical insurance. They must also explain very clearly before prescribing self-financed drugs, otherwise, patients will lodge complaints once they find out. (Male, Hospital managers-1, 15-12-2010)

Complaints occur when the patient wants more drugs but the doctor refuses to satisfy his or her demands. Why? The health insurance institution sets a limit ~~for~~ on drug expenditure for each hospital; in turn, the hospital sets a limit for each doctor. So if a doctor has too many patients drawing from their health insurance scheme in any one month, he or she may very possibly have exceeded his/her limit. (Male, ~~Health provider~~Health care providers-3, 16-09-2011)

[A patient who has] basic state-financed medical coverage is entitled to blood and other auxiliary examinations. If the number of health checks prescribed exceeds a certain threshold, the doctor is viewed as exploiting basic medical insurance. The

doctor is consequently punished. I was deducted more than seven hundred yuan (RMB) because of a case like this. I feel this is simply absurd – it is [unexpectedly] doctors who are to blame. Nothing seems to be wrong with the patient. …The hospital can~~'~~ not do anything about medical insurance. I think this kind of thing is not the problem at the hospital level. The complaints about medical insurance define, without a doubt, problems underlying the state and society. (Male, ~~Health provider~~Health care providers-4, 16-09-2011)

In addition, the safety of ~~health provider~~health care providers is under threat in China today. Chinese medical workers are often victims of ~~terrible~~ violence. As a consequence, some ~~health provider~~health care providers have decided ~~not~~ to not treat patients deemed likely to assault staff, exhibit disruptive behaviour, or otherwise prove to be difficult ~~to deal with~~. Prescribing redundant check-ups and drugs are alternatives to properly seeing to patients.

In our interviews, fifteen interviewees mentioned "Chao" fifty-five times. "Chao" in Chinese means to argue with hospitals for patients' ~~own~~ rights and interests, while the other meaning is to wrangle fiercely in hospitals or with senior management. Most of the hospital staff ~~being~~ interviewed suggested that some complainants ~~be~~ were indeed unreasonable and impulsive~~, whose~~ with the sole purpose ~~is to~~of ~~asking for~~claiming ~~money~~.

If the case goes to court, the patient gathers a lot of people to go to the court, insulting and threatening concerned health care providers and their lawyers. That is not what we want to see. We want to talk about the truth, by thoroughly publicizing

the truth. We cannot always be too specific with terminology [for fear of revealing too much]. When completely refuted, patients lose their temper. (Male, Other actors-2, 15-09-2011)

I feel that the widespread situation in China today is that you can do nothing if you run into the unreasonable. The legitimate way of going about this is to propose a fair decision once I receive your complaint~~, a fair decision is proposed~~. If complainants are not willing to settle for this, we then transfer their case to other departments. However, complainants may not even agree to that, causing trouble and even threatening the safety of health care providers. (Female, Hospital managers-2, 25-08-2011)

The claim a complainant demands goes beyond the actual problem [but for the money] and he does not wish to resolve it the legal way. …Nowadays "Yi Nao" has brought about serious social effects, and has escalated the tension between service users and providers. Complainants are unwilling to resolve things the legal way, rather, just pestering and hassling you [health care providers or complaint handlers] all day. (Male, Hospital managers-6, 01-11-2011)

~~h.~~d. Barriers to institutional changes for quality improvement using complaints data

Weak enforcement of the regulation

The regulation for managing patient complaints is merely a guideline, which contains no mandatory requirements such as assessment mechanisms. Because it takes into

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0" + Indent at: 0.29"

account the difference in local conditions throughout China, specific contents were not stipulated. The regulation is to be interpreted according to local circumstances and conditions. Therefore, in the absence of strong public scrutiny, there is little accountability for how best to manage patient complaints.

There are no penalties attached to (failure to follow) regulation. For example, there is no administrative aspect to the regulatory guidelines. We wanted to write a penalty provision, but it was not based on the top legislation. The purpose of the regulation is to emphasise self-discipline and to serve as guidance for the hospital. [The penalty was not enforceable,] so we decided to remove the penalty. It is indeed difficult and contradictory. (Female, Administrators-4, 30-11-2011)

Besides the legal system, the reporting system also has its problems. Some statistics about patient complaints and medical malpractice were utilized as a part of assessments of hospital performance, health care quality, and so on. This meant that the more cases that were reported, the worse the evaluations received by the hospitals, so that hospitals were inclined to report selectively or report fewer cases.

There are certainly no statistics for the number of patient complaints. There is only the data on the number of ~~cases of~~ medical malpractice cases per year from the Bureau of Health, and an approximate amount of compensation issued by insurance companies. In some cases, if complaints were solved just between the hospital and the complainant, we have no data. (Male, Administrators-2, 18-08-2011)

These days, the information regarding the management of patient complaints in hospitals is difficult to access. Hospitals are unwilling to provide that sort of

information – it is considered confidential. We only have some profiles or the information from select hospitals. (Female, Policy makers-1, 16-12-2010)

Thus, the adoption of the incentive and sanction mechanism was contradictory for managing patient complaints. From one side, the administrative department wanted hospitals to report patient complaints because it is important for informing and improving the quality of care. From the other side, the more complaints that are registered, the worse it would appear a hospital is doing. In addition to this, managing patient complaints remains low on the health reform agenda. The force for inspecting complaint management in hospitals from senior management and administrative departments remains weak.

[Having a statistic for patient complaints] is definitely necessary~~,~~ from the aspect of effective management. If this statistic is disposable, I think nothing of it~~I think no problem~~. If the statistic is routine, in fact, it will cost [~~of~~ all sorts of resources]. (Male, Policy makers-2, 22-12-2011)

Hospitals doubt that the purpose of administration is for information management – to help them better handle and solve disputes. However, if you want me to report incidents but meanwhile punish me for that, then I have no incentive to report anything. This contradiction stands [in the way of effective reporting]. (Female, Administrators-4, 30-11-2011)

Deficient information system for managing patient complaints

Although the regulations in place require collecting and analysing information, there exists no clear classification, definitions or unified coding system. Most hospitals have established their own systems for recording complaints and analysing cases, but no accurate or comparable data are available.

In fact a lot of cases should be recorded and analysed, [but] we do not even take into account so-called major cases of medical malpractice, mass disturbance or medical malpractice. We cannot distinguish between these concepts.… Relatively speaking, it is more feasible to publicize the data on public security, e.g. the number of police records and people arrested, and the number of crimes committed. Those definitions are more explicit, whereas those concerning complaints management are not. Because all statistics are calculated in the hospital, we find that where standards are slack, the resulting statistic is large ~~whereas~~ and where standards are~~with a~~ strict~~ standard~~, ~~it will be~~the statistic is small. Hence, there is great variability in our results. (Male, Policy makers-2, 22-12-2011)

Identical forms are sent to two hospitals at a similar level and the reported data can be quite different. …Some hospitals only reported cases resulting in compensation and some hospitals record all persons who voice a concern, while others only report cases identified as medical malpractice. But it is impossible for me to verify [the reported data] in each hospital. (Male, Administrators-2, 18-08-2011)

Hospitals have not publicized complaints; neither have health administration departments. The Shanghai Bureau of Health launched a pilot project in 2005 to publicize the complaints reported by all hospitals in Shanghai. The project was

welcomed by the public but discontinued soon after its launch due to mounting pressure from the hospitals.

We already publicize complaints [medical malpractice] on our intranet for hospital staff. It is unnecessary to share this information on external sites. (Female, Hospital managers-4, 06-09-2011)

To my knowledge, such information was published once on the Xinmin Evening News in 2005. The newspaper named hospitals that had won awards and gave details of the number of medical malpractice cases ~~inherent~~ happening in each, as well as feedback regarding patient satisfaction. [We felt] the pressure was very, very high. It [publishing those] resulted in public outrage [from hospitals]. (Female, Administrators-4, 30-11-2011)

Unwillingness of hospitals to effectively handle complaints

Most hospitals did not devote much effort into managing complaints. There was no clear mechanism to utilize patient complaints to improve quality of care unless serious medical malpractice had occurred or complaints were found to recur.

Hospitals just handle complaints when complaints happen. …We are basically perfunctory, including hospitals, department directors and doctors. The best-case scenario for me: do not approach me for these things [complaints]. Deal with complaints quickly and efficiently; in other words, spend money to buy peace. The impact of managing and addressing complaints is negligible, with very little effect on improving medical procedures and quality. (Male, Administrators-2,

18-08-2011)

Hospital directors were the key actors of complaint management in hospitals. The incentive and sanction mechanisms in hospitals depended on how much attention ~~they~~ directors pay ~~attention~~ to complaint management. In the 1980s the government reduced subsidies for public hospitals under the context of transforming the planned economy to a so-called socialist market in order to reduce inefficiencies in health care provision. Hospitals had to increase service charges ~~to generate more revenue~~ to recoup the operational costs and to increase the income level of health workers. Complaint management occupied nothing but a small part of quality health care, so in most hospitals it failed to draw attention from senior management. Most complaints were solved on a case-by-case basis, without sufficient concern for the overall improvement of health care services.

In practice, the head of department influences implementation. If he/she regards this as important, then subordinates work harder of course. Now the problem is that some heads of department do not pay attention to it [complaint management]. (Male, ~~Health provider~~Health care providers-2, 16-09-2011)

It is of course medical services that are the core of hospital work. Things such as [complaint management] are boring for the hospital. To a hospital, the fewer the complaints, the better. (Male, Administrators-2, 18-08-2011)

Discussion and Conclusions

This study examined the handling system for patient complaints in China and the

views of key stakeholders on the barriers to effective complaint management. Our study provided a new dimension for ~~of~~ understanding the complaints management system in China, an ~~developing country~~emerging market country. Hospitals are the most important handler and manager of patient complaints in China and similarly for other developing countries, such as India and Vietnam.[22] We explored the barriers through in-depth interviews with almost all stakeholders, not only health professionals. We hope that our findings will~~What we found would~~ help develop procedures for more effective complaint management and ~~to~~ further improve the quality of care in China and other developing countries. The selection of participants may introduce some bias to our studies. Due to our focus on the hospital, there may be an underrepresentation of certain types of respondents. Since there are no~~t~~ unified classifications for complaints, we did not~~n't~~ include patients with different types of complaints.

We found that the three main project elements adopted from Hickson GB et al. were relevant and useful for the discussion of our results: (A) organizational supports, (B) commitment from key people, and (C) learning systems.[13]

A. Organizational Supports

Our ~~F~~findings showed that there are no standardized systems and procedures dealing with patient complaints in China~~,~~ due to conflicts between relevant actors and regulations. Having experienced rapid economic growth in the last 30 years, China is

undergoing a socioeconomic transition. Like other developing countries, policies lag behind the country's economic transition.[37, 38] The Ministry of Health has tried to guide ~~health provider~~health care providers by issuing special regulations, but health administrations do not apply strict regulations to complaint management. There lacks clear relationships between patient complaints and clinical outcomes or the quality of care.

~~The hospital leader is the key determinant for complaint handling inside the hospital. However, no apparent incentives exist to push hospital leaders to place priority on complaint handling. The power of complaint handling departments depends on how much the hospital leaders pay attention to it. Under the current situation, hospital leaders lack political will to manage complaints effectively, leading to inadequate human resources in complaint handling departments. The departments also lack the power to coordinate with clinical departments.~~

The patient complaints in many Chinese hospitals are not well--managed and handled. Most hospitals manage patient complaints on only a case-by-case basis. They lack clear mechanisms linking patient complaints with improving the quality of care. Complaints are underutilised for organizational strategic planning or for changing an individual's behaviour~~al~~ and attitude~~s~~. This implies that legislation should not only stipulate the principles and regulations of patient complaint management, but also the responsibilities of sectors at different levels.[39]

B. Commitment from People

The hospital leader is the key determinant for complaint handling inside the hospital. However, no apparent incentives exist to push hospital leaders to prioritize complaint handling. The power of complaint handling departments depends on how much the hospital leaders pay attention to it. Under current conditions, hospital leaders lack political will to manage complaints effectively, leading to inadequate human resources in complaint handling departments. The departments also lack the power to coordinate with clinical departments.

To alleviate patient complaints--related violence, civil groups, including service users and the hospital sector, should approve the guideline. In developed countries, patient complaint management provides guidelines not only for health care providers, but also clear guidelines for patients. This not only makes it more convenient for patients, but also plays a positive role in helping patients initiate the complaint process via legitimate means. This is crucial for society to view patient complaint in a rational way.

C. Learning Systems

If patient complaints can be better managed and rectified, the instances of failure would be reduced and quality would be improved.[40, 41] Greater emphasis should be placed on quality improvement after patients complaints. Strategies to improve quality

following patient complaints should be developed through a learning process.[42] To promote the learning process, appropriate mechanisms should be developed and implemented to assess not only the number of patient complaints occurring in hospitals, but also how these hospitals have handled these complaints. For example, reporting more patient complaints should not be necessarily punished, while effective handling of the patient complaints should be appreciated.

Our final conclusion is that barriers to the effective management of patient complaints vary at the different stages of complaint handling, from the user and provider side, as well as systemic issues. Information, procedure design, human resources, system arrangement, a unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management. Appropriate mechanisms should be developed to link patient complaints with improving the quality of care.

ACKNOWLEDGEMENT

The HESVIC project received funding from the European Commission Framework 7. The views represented in this document are not necessary representative of the European Commission's views and belong solely to the authors. The consortium would like to thank all the study respondents and participants for their willingness to take part in the research, as well as the members of the Country Research Advisory Groups for their support at every stage of the HESVIC project. The authors of the paper very much appreciate constructive comments and suggestions on earlier version of the paper from Shenglan Tang from Duke Global Health Institute, USA. The authors are also grateful to Ms. Kaori Sato for language editing.

COMPETING INTERESTS

None.

FUNDING

This study was supported by the European Commission Seventh Framework Programme (HEALTH-F2-2009-222970).

CONTRIBUTORSHIP STATEMENT

1) Yishi JIANG: substantial contributions to conception and design, acquisition of data, and analysis and interpretation of data; drafting the article and revising it; and final approval of the version to be published.

2) Xiaohua YING: substantial contributions to conception and design, acquisition of data, and analysis and interpretation of data; drafting the article; and final approval of the version to be published.

3) Qian ZHANG: substantial contributions to acquisition of data, and analysis and interpretation of data; drafting the article; and final approval of the version to be published.

4) Sirui Rae TANG: substantial contributions to analysis and interpretation of data; drafting the article; and final approval of the version to be published.

5) Sumit KANE: substantial contributions to conception and design, and analysis and interpretation of data; revising the article critically for important intellectual content; and final approval of the version to be published.

6) Maitrayee MUKHOPADHYAY: substantial contributions to conception and design, and analysis and interpretation of data; revising the article critically for important intellectual content; and final approval of the version to be published.

7) Xu QIAN: substantial contributions to conception and design, and analysis and interpretation of data; drafting the article and revising it critically for important intellectual content; and final approval of the version to be published.

8) HESVIC team authorship

~~YJ, XY, QZ collected and analyzed the data primarily. All authors were involved in analyzing the data and editing the paper.~~

DATA SHARING

No additional data available.

References:

1. Sage WM. Putting the patient in patient safety: linking patient complaints and malpractice risk. *JAMA* 2002;**287**:3003-5.
2. Hsieh SY. A system for using patient complaints as a trigger to improve quality. *Qual Manag Health Care* 2011;**20**:343-55.
3. Wofford MM, Wofford JL, Bothra J, et al. Patient complaints about physician behaviors: a qualitative study. *Acad Med* 2004;**79**:134-8.
4. Beecham L. Patients' complaints: GMC could do better. *BMJ* 1999;**319**:1022.
5. Anderson K, Allan D, Finucane P. A 30-month study of patient complaints at a major Australian hospital. *J Qual Clin Pract* 2001;**21**:109-11.
6. Ministry of Health. *Measures for the Handling of Patient Complaints in Hospitals (for Trial Implementation)*. Beijing: Ministry of Health; 2009.
7. The Henry J. Kaiser Family Foundation. Medical Malpractice Law in the United States. http://www.kff.org/insurance/upload/Medical-Malpractice-Law-in-the-United-States-Report.pdf Accessed [08-31-2012].
8. Hsieh SY. Healthcare complaints handling systems: a comparison between Britain, Australia and Taiwan. *Health Serv Manage Res* 2011;**24**:91-5.
9. Department of Health, United Kingdom. Complaints procedure. http://www.dh.gov.uk/health/contact-dh/complaints/ Accessed [08-31-2012].
10. Cornwall A, Romios P. Turning Wrongs Into Rights. *Health Issues* 2004;**79**:13-8.

11. Hickson GB, Federspiel CF, Pichert JW, et al. Patient complaints and malpractice risk. *JAMA* 2002;**287**:2951-7.

12. Pichert JW, Hickson G, Moore I. Using Patient Complaints to Promote Patient Safety. *Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 2: Culture and Redesign)*. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008.

13. Hickson GB, Moore IN, Pichert JW, et al. Balancing systems and individual accountability in a safety culture. *From Front Office to Front Line: Essential Issues for Health Care Leaders, 2nd ed*. Oakbrook Terrace, IL: Joint Commission Resources; 2012. p. 1-35.

14. Vincent C, Davis R. Patients and families as safety experts. *CMAJ* 2012;**184**:15-6.

15. Xi X. *Understanding and application of provisions in the Tort Liability Law*. Beijing: Press of the People's Court; 2010.

16. Chinese doctors are under threat. *Lancet* 2010;**376**:657.

17. Zheng XQ, Wei LY, Zhang BZ, et al. Domestic Survey of Medical Disputes and Foreign Medical Dispute Handling. *Chinese Hospitals* 2007; **7**:2-4.

18. Stafford C. Moral ambivalence in modern China. *The Lancet* 2012;**9818**:793.

19. Communicating concern: complaints against doctors. *Lancet* 2013;**382**:1382.

20. Zhuang Y, Zhong C, Liu J, et al. A survey and analysis of complaint management in five tertiary hospitals. *Chinese Journal of Hospital Administration* 2006;**22**:45-8.

21. Gan N, Yu T, Chen W, et al. Analysis of differences in cognition between doctors

and patients and causes of medical disputes. *Journal of Shanghai Jiaotong University (Medical Science)* 2008;**28**:1035-7.

22. Gao J, Cao W, Xu Y, et al. Survey analysis of consultation settlement for medical disputes in 30 medical institutions of Shanghai. *Journal of Shanghai Jiaotong University (Medical Science)* 2010;**30**:960-3.

23. Green A, Gerein N, Mirzoev T, et al. Health policy processes in maternal health: a comparison of Vietnam, India and China. *Health Policy* 2011;**100**:167-73.

24. Charmaz K. *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. Thousand Oaks, CA: Sage Publications, 2006.

25. Sadler GR, Lee HC, Lim RS, et al. Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nurs Health Sci* 2010;**12**:369-74.

26. Lacey A, Luff D. *Qualitative Research Analysis*. The NIHR RDS for the East Midlands / Yorkshire & the Humber, 2007.

27. Department of Health, NSW. *Complaint Management Guidelines*. North Sydney NSW: Guidelines; 2006.

28. State Council. *Regulation on the Handling of Medical Malpractices*. Beijing: Decree of the State Council; 2002.

29. Standing Committee of the Eleventh National People's Congress. *Tort Law of the People's Republic of China*. Beijing: Presidential Decree; 2009.

30. Ministry of Health. *Measures for the Complaint Letters and Visits System for Healthcare*. Beijing: Ministry of Health; 2007.

31. Shanghai Justice Bureau and Health Bureau. *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*. Shanghai: Shanghai Justice Bureau and Health Bureau; 2008.

32. Ministry of Justice, Ministry of Health, and China Insurance Regulatory Commission. *Opinions on Strengthening People's Mediation for Medical Disputes*. Beijing: Ministry of Justice, Ministry of Health, and China Insurance Regulatory Commission; 2010.

33. Shanghai Justice Bureau and Health Bureau. *Measures on People's Mediation for Medical Disputes in Shanghai*. Shanghai: Shanghai Justice Bureau and Health Bureau; 2011.

34. Yan X. Correctly Receive Medical Complaints and Establish Harmonious Doctor-patient Relationship. *Modern Hospital Management* 2008;**6**:24-5.

35. Manouchehri MJ, Ibrahimipour H, Sari AA, et al. Study of patient complaints reported over 30 months at a large heart centre in Tehran. *Qual Saf Health Care* 2010;**19**:e28.

36. Siyambalapitiya S, Caunt J, Harrison N, et al. A 22 month study of patient complaints at a National Health Service hospital. *Int J Nurs Pract* 2007;**13**:107-10.

37. Grundy J, Khut QY, Oum S, et al. Health system strengthening in Cambodia-a case study of health policy response to social transition. *Health Policy* 2009;**92**:107-15.

38. Luong DH, Tang S, Zhang T, et al. Vietnam during economic transition: a tracer study of health service access and affordability. *Int J Health Serv* 2007;**37**:573-88.

39. Shaw K, Cassel CK, Black C, et al. Shared medical regulation in a time of increasing calls for accountability and transparency: comparison of recertification in the United States, Canada, and the United Kingdom. *JAMA* 2009;**302**:2008-14.

40. Winkler F. Complaints by patients. *BMJ* 1993;**306**:472-3.

41. Baker R. Learning from complaints about general practitioners. *BMJ* 1999;**318**:1567-8.

42. Mintzberg H. The Fall and Rise of Strategic Planning. *Harvard Business Review* 1994:107-14.

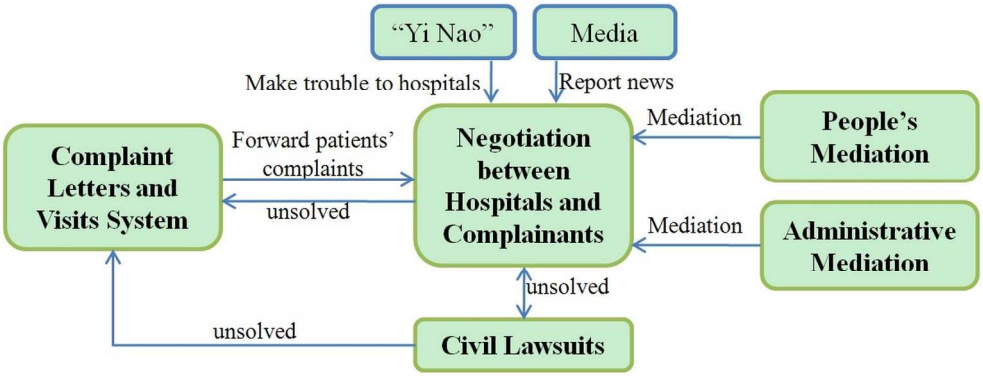

Figure 1 The structure of managing patients' complaints in China

199x90mm (300 x 300 DPI)

Qualitative research review guidelines – RATS

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
R Relevance of study question	
Is the research question interesting?	YES. Research question was explicitly stated.
Is the research question relevant to clinical practice, public health, or policy?	YES. Research question is justified and linked to the existing knowledge base (empirical research, policy).
A Appropriateness of qualitative method	
Is qualitative methodology the best approach for the study aims? • *Interviews:* experience, perceptions, behaviour, practice, process • *Focus groups:* group dynamics, convenience, non-sensitive topics • *Ethnography:* culture, organizational behaviour, interaction • *Textual analysis:* documents, art, representations, conversations	YES It is difficult to measure the regulation process quantitatively.
T Transparency of procedures	
Sampling	
Are the participants selected the most appropriate to provide access to the type of knowledge sought by the study?	YES.
Is the sampling strategy appropriate?	The respondents were sampled by the whole research framework: the regulation

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
	process. Different types of respondents were helpful for holistic understanding for transparency deficits. Key informants were interviewed by snowball sampling and saturation.
Recruitment	
Was recruitment conducted using appropriate methods?	In the methods part, it shows details of how recruitment was conducted and by whom.
Is the sampling strategy appropriate?	YES
Could there be selection bias?	The selection of participants might bring some bias to our studies. Our focus was on the hospital, so some types of respondents may have been under-represented. Moreover, we planned to recruit the same number of participants in multiple settings, but the number of participants from each was imbalanced because of information saturation.
Data collection	
Was collection of data systematic and comprehensive?	YES, the interview questions were introduced.
Are characteristics of the study group	YES. We just focused on their

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
and setting clear?	role/group on the regulation process.
Why and when was data collection stopped, and is this reasonable?	YES. The principle of saturation was used.
Role of researchers	
Is the researcher(s) appropriate? How might they bias (good and bad) the conduct of the study and results?	YES. Our research group is multidisciplinary, including social science, clinical medicine and public health.
Ethics	
Was informed consent sought and granted?	YES. Informed consent process was explicitly and clearly detailed.
Were participants' anonymity and confidentiality ensured?	YES.
Was approval from an appropriate ethics committee received?	YES. Ethics approval was cited.
S Soundness of interpretive approach *Analysis*	
Is the type of analysis appropriate for the type of study? • *thematic:* exploratory, descriptive, hypothesis generating • *framework:* e.g., policy • *constant comparison/grounded*	YES. Analytic approach was justified.

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
theory: theory generating, analytical	
Are the interpretations clearly presented and adequately supported by the evidence?	YES.
Are quotes used and are these appropriate and effective?	YES.
Was trustworthiness/reliability of the data and interpretations checked?	YES, but it wasn't shown in the paper. We triangulated between interviews from various types of respondents, and different disciplines. We also trail the findings with observation.
Discussion and presentation	
Are findings sufficiently grounded in a theoretical or conceptual framework?	YES.
Is adequate account taken of previous knowledge and how the findings add?	YES.
Are the limitations thoughtfully considered?	YES
Is the manuscript well written and accessible?	YES
Are red flags present? These are common features of ill-conceived or poorly executed qualitative studies, are a cause for concern, and must be	NO

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
viewed critically. They might be fatal flaws, or they may result from lack of detail or clarity.	

BMJ Open

Managing patient complaints in China – a qualitative study in Shanghai

Journal:	*BMJ Open*
Manuscript ID:	bmjopen-2014-005131.R3
Article Type:	Research
Date Submitted by the Author:	31-Jul-2014
Complete List of Authors:	Jiang, Yishi; Fudan University, School of Public Health; Shanghai Maternal and Child Health Center, YING, Xiaohua; Fudan University, School of Public Health ZHANG, Qian; Fudan University, School of Public Health Tang, Sirui; Fudan University, School of Public Health KANE, Sumit; Royal Tropical Institute, KIT Development Policy & Practice MUKHOPADHYAY, Maitrayee; Royal Tropical Institute, KIT Development Policy & Practice QIAN, Xu; Fudan University, School of Public Health
Primary Subject Heading:	Qualitative research
Secondary Subject Heading:	Health policy
Keywords:	QUALITATIVE RESEARCH, HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

Title page

1. Title of the article.

Managing patient complaints in China – a qualitative study in Shanghai

2. Full name, postal address, e-mail, telephone and fax numbers of the corresponding author.

The corresponding author: Xu QIAN

Postal address: Mailbox 175, 138 Yi Xue Yuan Road, Shanghai, 200032, P. R. China

Tel: 86-21-54237267 Fax: 86-21-64174172

Email: xqian@fudan.edu.cn

3. Full names, departments, institutions, city and country of all co-authors.

1) Yishi JIANG: School of Public Health, Fudan University, Shanghai, China; Shanghai Maternal and Child Health Center, China

2) Xiaohua YING: School of Public Health, Fudan University, Shanghai, China

3) Qian ZHANG: School of Public Health, Fudan University, Shanghai, China

4) Sirui Rae TANG: School of Public Health, Fudan University, Shanghai, China

5) Sumit KANE: KIT Development Policy & Practice, Royal Tropical Institute, Amsterdam, Netherlands

6) Maitrayee MUKHOPADHYAY: KIT Development Policy & Practice, Royal Tropical Institute, Amsterdam, Netherlands

7) Xu QIAN: School of Public Health, Fudan University, Shanghai, China

8) HESVIC team authorship

4. Up to five keywords or phrases suitable for use in an index (it is recommended to use MeSH terms).

Qualitative Research; Patient Complaints; Complaint Handling Systems; Quality Improvement; Government Regulation

5. Word count - excluding title page, abstract, references, figures and tables.

7030

Abstract

Objectives: To examine the handling system for patient complaints and to identify existing barriers that are associated with effective management of patient complaints in China.

Setting: Key stakeholders of the handling system for patient complaints at the national, Shanghai municipal, and hospital levels in China.

Participants: Thirty-five key informants including policymakers, hospital managers, health care providers, users and other stakeholders in Shanghai.

Primary and secondary outcome measures: Semi-structured interviews were conducted to understand the process of handling patient complaints and factors affecting the process and outcomes of patient complaint management.

Results: The Chinese handling system for patient complaints was established in the past decade. Hospitals shoulder the most responsibility of patient complaint handling. Barriers to effective management of patient complaints included service users' low awareness of the systems in the initial stage of the process; poor capacity and skills of healthcare providers, incompetence and powerlessness of complaints handlers and non-transparent exchange of information during the process of complaint handling; conflicts between relevant actors and regulations, and unjustifiable complaints by

patients during solution settlements; and weak enforcement of regulations, deficient information for managing patient complaints and unwillingness of the hospitals to effectively handle complaints in the post-complaint stage.

Conclusions: Barriers to the effective management of patient complaints vary at the different stages of complaint handling and perspectives on these barriers differ between the service users and providers. Information, procedure design, human resources, system arrangement, unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management.

Article summary

Strengths and limitations of this study

This study explores the handling system for patient complaints in China and the views of key stakeholders on the barriers to effective complaint management. These findings are essential to improve the complaints system. Our study provides a new dimension of understanding the complaints management system in China, an emerging market country. We explore the barriers through in-depth interviews with almost all stakeholders, not only health professionals. What we found will help develop procedures for more effective complaint management and to further improve the quality of care in China and other developing countries. The selection of participants may introduce some bias to our studies. Due to our focus on the hospital, there may be an underrepresentation of certain types of respondents.

Background

In recent years, patient complaints around the world have garnered mounting concern among policymakers, academics and the general public.[1-3] As China prospers, making advances in medicine and social welfare, expectations of better quality of care continue to grow. People's knowledge of the law and their rights has increased as a result of better education and understanding of the law. Patients are able to express their discontent by lodging complaints such that the number of complaints occurring internationally is on the rise.[4, 5] A "complaint" is defined as *the behaviour of a patient or his/her representative(s) which signifies dissatisfaction towards medical services, nursing services, as well as treatment conditions through letters, calls or visits to the hospital where the purpose of these actions is to criticise the hospital and/or claim compensation"*.[6] In addition, the growth in dollars paid on malpractice claims is evident.[7] China's current situation reveals growing concerns surrounding hospital accountability and clinical governance; in particular, the efficacy of the redress system. Grave consequences affecting both social and political stability are likely if the health care system fails to meet expectations and to achieve patient satisfaction. Indeed, the issue at hand is one of paramount importance, requiring urgent attention and immediate action at the highest level.

In countries such as Australia and Britain, the states have sought to monitor complaints and complaint handling to improve and regulate the practice of health professionals.[8] A feedback system of this sort has proven instrumental in improving

the quality of care. In Britain, the National Health Service (NHS) has not only provided clear and transparent guidelines for both health care providers and patients but has also publicized information regarding the routine reporting of patient complaints.[9] In Australia, a large study was conducted before *Guide to Complaint Handling in Health Care Services* was formulated and subsequently updated.[10] Annually, statistics are compiled and published, detailing complaint trends, complaint management and reasons for complaints. Effective handling of complaints has been known to reduce friction between providers and consumers, with the even greater benefit of improving quality of care. As a supplement to peer reviews and administration, patient complaints can provide important feedback concerning the delivery of health care services and can be a useful tool in the improvement of health care quality.[1-3, 11-14]

With no official statistics of patient complaints available in Chinese records, we estimated that the number of complaints and disputes rose, from 10,249 to 13,875 claims, based on the number of first trials for medical malpractice cases between 2002 and 2008.[15] Mounting dissatisfaction has been felt across the country, manifesting in increasingly hostile and violent behaviour towards providers from patients and their families.[16] An investigation carried out by the Chinese Hospital Management Association in 2005 suggested that of 270 hospitals surveyed, 73 per cent experienced abuse in the form of threats and assaults targeting doctors and management.[17] These incidents are only indicative of rising expectations, burgeoning patient discontent with

services and dissatisfaction towards the way in which matters are resolved.[18] Public outcry only exacerbates the need for more effective handling of individual cases under the overarching agenda of public hospital reform in China.[19]

Notwithstanding the alarming extent of these issues, few attempts have been made to formally examine how hospital complaints are addressed in developing countries. It is only recently that a handful of studies in China have sought to provide some understanding of the issue by trying to ascertain the number of complaints in the studied hospitals or garnering patient feedback via questionnaires and interviews.[20-22] A fuller understanding of the complaints system – the available channels for seeking redress, how the system operates and the barriers to conflict resolution – will be crucial to ameliorating the often fraught relationships between health care providers and consumers. The purpose of this study has been to examine the handling system for patient complaints in China, and to subsequently identify and analyse the various hospital-specific factors preventing grievances from being effectively addressed. The authors of this paper hope that such an undertaking will reduce malpractice and above all, improve health service outcomes.

This study is one of the cases from the "Health System Stewardship and Regulation in Vietnam, India and China" (HESVIC) research project. It was conducted by a consortium of six partners in Asia and Europe from 2009-2012, with the aim of supporting policy decisions in the application and extension of accessibility,

affordability, equity and quality of coverage of maternal health care in the three countries.

Methods

Study design

The project uses a multidisciplinary approach, drawing on multiple case studies to examine the impact of regulation on improving equitable access to quality health care in Vietnam, India and China. In each country, three cases were selected and studied. This paper shows the findings from the case study, examining the regulation on Grievance Redressal (GR) in Shanghai, China. Here, regulation encompasses the formation of rules and practices, as well as their interpretation and implementation, such as the health policy processes covered in the HEPVIC project (HEPVIC).[23]

Phase One: Literature Review

Firstly, we conducted a literature review. The relevant sources, which included regulation documents related to the handling of patient complaints at both the national and Shanghai municipal levels, were used to collect legal approaches and mechanisms used in managing patient complaints. These regulations were mainly stipulated from 2002 to 2011. To understand the application of different complaint approaches, a search of scientific literature published between 2000 and 2011 was conducted. Databases MEDLINE-PubMed and WANFANG Data were consulted. A search strategy was established based on the following keywords: *grievance redressal,*

patient complaint, health care complaint and hospital complaint, and China. Special focus was placed on patient complaint management in hospitals, as we found that the vast majority of complaints were handled and resolved within the hospitals.[22]

Phase Two: Pilot Study – Interviews

Based on our understanding of the current patient complaint handling system, we performed semi-structured interviews with key stakeholders – policymakers from the national level, administrators from the Shanghai municipal level, hospital managers, health care providers, users and other related parties. We used the snowball sampling method to identify key stakeholders and to collect important feedback from key informants from various disciplines.[24, 25]

In Phase Two (October-December 2010), one key actor from each of the three administrative levels was selected and interviewed: a policymaker at the national level, a municipal administrator and a hospital manager. A pilot study was conducted to test the topic guidelines developed. These allowed us to gain a preliminary understanding of the complaint management process in the hospital setting, and to refine the data collection tools. These interviews served as the basis for the design of Phase Three interviews, where some of those being interviewed in the third phase were respondents recommended by Phase Two interviewees.

Phase Three: Main Data Collection

Interviews in Phase Three were conducted from August-December of 2011. Key stakeholders were interviewed in the selected hospitals based on location, level and type. Our sample represented both urban and suburban areas in Shanghai. General and specialist hospitals were selected. Phase Three began with interviews of hospital managers and health care providers proposed in Phase Two. We asked interviewees from Phase Two to invite patients and other relevant stakeholders to contribute their views. Those invited patients used different channels for lodging their complaints; however, they all shared one thing in common: all patients had first complained to the hospital. We then proceeded to interview the administrators and finally a high-level policymaker. We continued to interview respondents, collecting and analysing their comments and feedback until no new themes emerged, i.e. saturation had been reached. The number of participants involved in the different types of interviewees is depicted in Table 1.

Semi-structured interviews were conducted with 35 respondents face-to-face, except one via telephone. The interviews took place at private locations, for example at the institution where the interviewee or interviewer worked, and were conducted by two of the authors of this paper. Each interview lasted 1-2 hours and was audiotaped with permission, apart from two which were not recorded but typewritten upon the respondents' request.

Table 1 Number of interviewees by administrative level and facility

Types of interviewees	Level	Number of

		Participants
Policymakers	National	
Ministry of Health		1
A university		1
Administrators	Shanghai municipal	4
Hospital managers		
General hospital	Tertiary	3
General hospital	Secondary	3
Specialized hospital	Tertiary	1
Specialized hospital	Secondary	1
Private hospital	Secondary	2
Health care providers		6
Users		6
Other actors		
Municipal Health Inspection Institute		2
Lawyers for medical disputes		2
The centre that processes medical liability insurance		1
The People's Mediation Committee for Medical Disputes		1
The Complaint Letters and Visits System		1
Total		**35**

The topic guidelines for carrying out the interviews included questions on the participant's experience in complaint management in the hospitals. Using probes and follow-up questions, attention was directed to factors that the interviewees perceived as barriers to effective complaint management, and interviewees were asked to explain their reasoning. From existing literature, we identified a list of factors required for effective complaint management and successful resolution of disputes. Participants were asked to provide suggestions and feedback regarding how complaints could be more effectively dealt with given the barriers they had identified.

Data analysis

Audiotapes recorded during the interviews were transcribed and were compared with the field notes to check for accuracy. We analysed data through a process of rigorous and structured analysis.[26] The analysis was executed in several stages to 1) become familiar with the data; 2) identify emerging topics; 3) develop a topic index; 4) use the index to code the data; 5) consolidate the topics into themes; 6) further consolidate these themes into analytical categories/clusters; and 7) translate the analysis obtained into a narrative. Written consent was obtained from each interviewee before undertaking the interviews.

We performed the above tasks using the qualitative research software NVivo 9.0. The raw data was coded by two independent reviewers (YSJ, QZ). If discrepancies

emerged, a third reviewer (XHY) participated in the group discussion until the group arrived at a consensus. There were some models for analysing complaint management;[2, 13] for example, the Managerial-Operational-Technical (MOT) model was developed by Hsieh SY to explore complaint management in hospitals.[2] In our study, we collected data according to the complaint management process. To analyse the data most efficiently and directly, we used the stages of the process, which included receiving, handling and resolving complaints.[27] As quality improvement following complaints is crucial, we added the stage of "institutional changes for quality improvement using complaints data".[2, 12]

Our study was approved by Institutional Review Board (IRB), School of Public Health, Fudan University. Access to data was restricted to approved members of the research team who signed a confidential agreement with the principal investigator. Data were stored in secure electronic locations. Data processing was kept anonymous so as to protect the identity of interviewees. The names of the respondents have been deleted from the quotations.

Findings

This section first presents a number of approaches developed and implemented in Shanghai to handle patient complaints and their relationships. It then focuses on the approach of negotiation between hospitals and complainants, identifies its barriers, and proceeds to examine and analyse these barriers.

1. Approaches and mechanisms used in managing patient complaints

The study identifies both formal and informal approaches and mechanisms used in handling patient complaints.

a. Negotiation between Hospitals and Complainants

The complaint handling department within the hospital is responsible for dealing with patient complaints, first established on February 20, 2002, in accordance with the *Regulation on the Handling of Medical Malpractices.*[28] Since November 2009, these departments have been regulated by *Measures for the Handling of Patient Complaints in Hospitals (for Trial Implementation).*[6] These acts require that a medical institution establish a department specifically for the purpose of handling and resolving medical disputes. The department is primarily responsible for receiving patient complaints via calls, letters, visits, and/or cases referred from other departments and institutions. Their role also includes counselling and communicating with patients, verifying and documenting disputes as well as resolving disputes.

b. Administrative Mediation and Civil Lawsuits

If the hospital is unable to resolve certain conflicts through negotiation, the cases may be referred to an external body such as the health administrative department or they may be settled in court by means of litigation. The *Tort Law of the People's Republic of China*, adopted at the twelfth session of the Standing Committee of the Eleventh

National People's Congress on December 26, 2009, provided a new legal definition of liability for medical malpractice, liability presumption and exemption.[29]

c. Complaint Letters and Visits System

In February 2007, *Measures for the Complaint Letters and Visits System for Healthcare* was established.[30] Its purpose is to protect the legal rights and interests of citizens, legal entities, and other organizations, and to regulate behaviour and maintain order within the Complaint Letters and Visits System. It requires health administrative departments to set up Complaint Letters and Visits offices at different levels. These offices are responsible for receiving, assigning and transferring matters as appropriate, as well as supervising the handling of various issues and complaints.

d. People's Mediation – a form of Third-Party Facilitated Mediation

In July 2008, the Shanghai Justice Bureau and Health Bureau issued *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*, to establish the People's Mediation Committees for Medical Disputes.[31] Committee members, mainly retired judges and doctors, served to mediate disputes through reporting, explaining and analysing cases under the supervision of the local judiciary. In January 2010, the Ministry of Justice, the Ministry of Health and the China Insurance Regulatory Commission jointly issued *Opinions on Strengthening People's Mediation for Medical Disputes* to bolster the role of mediation in resolving medical disputes.[32] Its intent is to settle medical disputes in an effective way and to

maintain order within hospitals, all with a view for ensuring harmony and social stability. In July 2011, the Shanghai Justice Bureau and Health Bureau introduced *Measures on People's Mediation for Medical Disputes in Shanghai* to replace *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*.[31, 33]

In addition to the aforementioned channels of complaint, patients have also been found to express their discontent by "Yi Nao" – exhibiting disruptive behaviour within the hospital by targeting doctors and nurses or hospital managers by way of abuse, assault and other forms of violence. Much of this has garnered media attention, resulting in bad publicity for the hospital and damaging the reputation of doctors and staff.

Table 2 the characteristics of the approaches

	Negotiation between Hospitals and Complainants	**Administrative Mediation**	**Civil Lawsuits**	**Complaint Letters and Visits System**	**People's Mediation**
Responsible institution	Complaint Reception Office in hospitals	Health Inspection Institute	People's Court	Complaint Letters and Visits Office in health administrative departments	People's Mediation Committee for Medical Disputes
Responsibility	Receive and handle patients' complaints; compensate some complainants	Receive and mediate medical malpractices	Receive and settle medical litigations	Receive, transfer and supervise patients' complaints	Receive and mediate patients' complaints
Handling method	Negotiation	Mediation	Mediation; Trial	Supervise matters	Mediation
Processing duration	Indefinite	Only once	Six months	Two months	One month
Legal level of resolution	Low	Low	High	Low	Low
Administrative level of resolution	Low	High	High	High	Low

2. The application of different complaint approaches

The complexity of relationships between different approaches can be seen where many actors are involved. The responsible institutions of all approaches can receive complaints. Generally speaking, patients first lodge complaints to hospitals. If complainants or hospitals are unwilling or fail to negotiate, they may file applications to other approaches. Approaches that can resolve medical disputes are mainly negotiations and civil lawsuits, while other approaches play a part in forwarding cases, such as Complaint Letters and Visits System, or easing conflicts, such as mediation. None of the approaches are considered the ultimate arbiter. For example, patients can continue to lodge complaints through the Complaint Letters and Visits System even if a decision has been finalised after a second trial in court or after negotiations with hospitals.

In the above-mentioned approaches, the hospital is the main handler for patient complaints. First of all, it can handle patient complaints completely independently, from reception to solution, while the other approaches, such as the Complaint Letters and Visits System and mediation, must engage hospitals in complaint handling. Secondly, since the hospital is principally responsible for compensation, the complainant is more inclined to directly negotiate with the hospital. Findings from the literature show that the majority of medical disputes are resolved by negotiation between hospitals and complainants.[22] Thirdly, if hospitals handle complaints improperly, conflicts will become more volatile, resulting in serious incidents, such as "Yi Nao".[34] Therefore, hospitals have become the most common receiver, handler

and resolver of disputes. (Figure 1)

3. Barriers to the effective management of patient complaints and their underlying causes at different stages

Our interviews revealed that different hospitals often use different complaint systems. For example, some hospitals operate a centralized complaints office, which may or may not be independent of the Medical Affairs (Administration) Department. Other hospitals have several complaints offices, each of which is responsive to different kinds of complaints. A hospital's deputy director, who also heads hospital complaint management, generally manages complaint departments. Barriers to effective complaints management vary at different stages of the complaint process, both from the sides of the user and provider.

.

a. Barriers to receiving the complaints

Low awareness of users about the handling system for patient complaints

Although hospital staff claimed that the complaints office was accessible to those with grievances, patients did not always feel this was the case. One user looked up the hospital telephone number on the Internet and said the complaint handling process was "very easy" while others did not concur. Almost all the patients interviewed found that signs and directions (to the complaints office) failed to catch the eye. In some cases none could be seen at all:

I wanted to lodge a complaint, but did not know how to find [the complaints

office]… Because the hospital was so big, I did not know which department [was responsible for handling complaints]. …I simply did not know who to turn to. You see, the complaints department was in another building [rather than in the one in which I was treated i.e. the clinical department] (Female, Users-1, 01-09-2011)

b. Barriers to handling the complaints

Poor capacity and skills of health care providers

The capacity and skills of health care providers in managing patient complaints is critically important in problem solving. Our study found that the reasons patients complained lay mainly in poor communication and factors such as the provider's attitude, use of language, unprofessional behaviour, as well as dissatisfaction towards service procedures.

The Medical Doctors Association carried out a survey on the nature of medical disputes. 50 per cent of cases were results of inappropriate attitudes about health care delivery, 25 per cent were caused by technology misuse and the rest were related to management. (Female, Policy makers-1, 16-12-2010)

The majority of complaints can be resolved by an explanation issued by the hospital and/or a verbal apology by the offending party.[5, 35, 36] However, practitioners are often too preoccupied with their clinical duties to be able to respond to patient complaints.

Doctors are not able to devote much time to handling disputes, because clinical work is highly demanding. [They need to attend to] many patients every day. If they

spend more time communicating with patients, they would lose time needed to carry out [clinical work]. That is to say, [doctors should be given] less [clinical] work, and more time to explain their work to patients. Our workload is very heavy, like a battle. (Female, Health care providers-1, 01-09-2011)

Incompetence and powerlessness of complaints handlers

In comparison to health care providers, complaint handlers played a more important role in cooperation and coordination. Although complaint departments were specifically set up in hospitals for receiving and handling complaints, the responsible persons in the department were mainly part-time medical staff. In some cases those handling staff were found to be inadequate due to lack of training. Many of them had studied handling techniques on their own and had not acquired sufficient professional skills to appropriately analyse, assess and solve complaints.

Complaint handlers in the hospitals cannot solve everything because the disciplines involved in complaints are highly specialised. I am only familiar with general surgery and issues that require common sense, but [I am not familiar] with professional problems in other disciplines. (Male, Hospital managers-5, 08-09-2011)

It is difficult to recruit staff for our Medical Dispute Handling Office. No one wants to come. A boy recruited in 2007 could not stand the demands of the job [complicated disputes and violence] and so resigned. (Female, Hospital managers-3, 31-08-2011)

We have little time to do things other than receiving complaints. We lack staff members. We are responsible for receiving and processing complaints, and expected – on top of this – to deal with other things, hence why we are exhausted. (Male, Health care providers-2, 16-09-2011)

Given that most complaints are handled and resolved in the hospital, it appeared that every complaint handler interviewed felt the same way: tired and stressed. Complaint handlers were insufficiently empowered to handle complaints. It was hard for them to coordinate between different departments, investigate cases, organize mediation, find solutions and then draw on patients' feedback to improve quality of care.

Recently, a fierce medical dispute occurred because of a possible misunderstanding between administrative departments. [Abusive] words erupted. As a consequence, staff members involved in this incident were distraught – to the extent that they wanted to resign. Hence, we need understanding and support among colleagues. ...Sometimes the clinical department at hand refused to cooperate when investigated. He [the clinical department] is not very serious about cooperating with the investigation. (Female, Hospital managers-3, 31-08-2011)

Communication between administrative departments and clinical departments is not very effective sometimes. I am not satisfied with this. (Female, Hospital managers-2, 25-08-2011)

Non-transparent exchange of information

In addition, the complaint handling process was not truly open to the complainant, and

information exchange was largely limited to hospital staff. In fact, it was found that the staff at the complaints office was generally evasive towards patients who arrived wishing to be updated with the specifics of their complaint. Complainants had no opportunity to directly engage in the handling of their complaints or to meaningfully participate in the process. In addition, hospitals tended to oversimplify cases, assuming that the complainant's only desire was to report their complaint and ask for compensation. This implies that the entire handling process is disclosed only among hospital staff. Therefore, the process becomes a "black box" to patients. It is easy for the hospital to manipulate a complainant by providing limited information to gain advantage in negotiations, i.e. reduce loss from compensating patients.

Sometimes you have to circumvent something and use negotiating skills. Mistakes in medical services do not necessarily harm patients' health, but they can be very serious for the provider [...] for example, someone may not be very careful when writing a medical record and alter it by accident. But you are likely to lose a lawsuit on the grounds of having tampered with records. Incidents such as these cloud the matter, making transparency difficult. (Female, Hospital managers-2, 25-08-2011)

If the incident is urgent or presents itself as a recurring problem, it might be shared to educate healthcare providers but disclosure to complainants themselves remains limited. Only outcomes deemed to be of direct interest to patients, including compensation amounts and medical service privileges, were provided. However, other results, including penalties imposed upon physicians and departments or improvements made to hospital services, were largely withheld from patients if they

did not ask.

In individual cases, what are the outcomes of their complaints? How might a physician be punished/penalised/disciplined? Such information is requested by patients only occasionally. (Male, Health care providers-2, 16-09-2011)

I want to know how to better educate the concerned health care providers. But I have not been told. (Female, Users-3, 20-09-2011)

c. Barriers to resolving the complaints

Conflicts between relevant actors and regulations

Within the complaints system, conflicts or inconsistencies can arise between the legal system for handling complaints and the solutions determined by the hospital. As the structure of managing patient complaints is shown in Figure 1, different regulations stipulate different approaches. Unified laws or guidelines do not exist to clearly illustrate the relationships between different approaches, which results in problems such as a lack of authority or ultimate approach, uncertainty about how to apply different regulations to one case, and no clear definitions or classifications in regards to patient complaints.

The current state of complaint management is disorderly. There are too many channels. For example, many departments are involved, including but not limited to Complaint Letters and Visits, online complaints, etc. The Health Bureau has two departments [for complaint management], and each district has a mediation office, a district government website or a mayor-mail [to receive complaints], and a

Complaint Letters and Visits office… Far too many heads of departments within the health sector; it is chaos. (Male, Health care providers-2, 16-09-2011)

Hospitals are required to report complaints to a lot of sectors, all of which wish to understand the issue from different angles. Conflicts between regulations do not necessarily exist, but different elements are emphasised. Hospitals are tired of these kinds of bureaucracy. ...Each sector carries out their designated duties where resources are not shared. The information possessed by each sector is fragmented. You know yours, I know mine. (Male, Administrators-2, 18-08-2011)

Medical malpractice is defined clearly in the Regulation on Handling Medical Malpractice. There are several benchmarks determining the amount of compensation issued. After the Tort Liability Law of the People's Republic of China was promulgated, [medical damage] was compensated for more in accordance with the Tort Liability Law because it stipulates compensation for personal injury. (Female, Hospital managers-2, 25-08-2011)

Unjustifiable complaints by patients

In some cases, the patient experiences inconvenience when receiving medical services not because of poor conduct in attitude or behaviour on the part of health care providers, but possibly because of long wait times, too little time spent with the doctor, and/or imperfect resource allocation. These are health system issues rather than problems caused by hospitals or individual physicians. And so, to a certain extent, physicians and hospitals have become scapegoats of the entire health system.

At times it is not us physicians who make patients angry. Certain factors are rooted in the fabric of health care systems, but we physicians [end up] taking the blame. (Male, Health care providers-3, 16-09-2011)

For example, should a doctor need to see sixty patients in half a day, or indeed one hundred, you cannot demand that he puts on a smile for each one. A lot of patients complain about doctors with a straight face, but I think it is understandable. I have a very good relationship with our young doctors. They operate on a tight schedule. This week someone worked at the outpatient facility. He was friendly with patients in the first month but struggled to sustain that sort of demeanour. He is not in the mood to smile at patients or engage in long conversations when he only has time to attend to their illnesses. (Male, Hospital managers-1, 15-12-2010)

For example, dissatisfaction voiced in the hospital may be related to health insurance policy rather than staff behaviour. Hospitals need to follow the policies made by the Health Insurance Department. The purpose of those policies was to improve rational use of medicines and control healthcare costs, while the patients covered by health insurance may demand more medicines.

Chinese doctors have many rules to obey [this is to curb poor conduct]. The pressures for them to perform are relatively large. For example, doctors cannot prescribe too much medicine for a patient who has only [basic state-financed] medical insurance, but patients always want more. A while ago, the Medical Insurance Bureau issued the following statement in a newspaper: "The Medical

Insurance Bureau never limits the volume of drugs prescribed, rather it is the doing of hospitals who wish to increase workload [in order to produce more statistics].” I think this is really unreasonable. The Bureau does not control the quantity of drugs prescribed in any given week, but there is a total quantity limit over a year. Doctors try their best not to prescribe drugs which must be self-financed, i.e. not covered by basic medical insurance. They must also explain very clearly before prescribing self-financed drugs, otherwise, patients will lodge complaints once they find out. (Male, Hospital managers-1, 15-12-2010)

Complaints occur when the patient wants more drugs but the doctor refuses to satisfy his or her demands. Why? The health insurance institution sets a limit on drug expenditure for each hospital; in turn, the hospital sets a limit for each doctor. So if a doctor has too many patients drawing from their health insurance scheme in any one month, he or she may very possibly have exceeded his/her limit. (Male, Health care providers-3, 16-09-2011)

[A patient who has] basic state-financed medical coverage is entitled to blood and other auxiliary examinations. If the number of health checks prescribed exceeds a certain threshold, the doctor is viewed as exploiting basic medical insurance. The doctor is consequently punished. I was deducted more than seven hundred yuan (RMB) because of a case like this. I feel this is simply absurd – it is [unexpectedly] doctors who are to blame. Nothing seems to be wrong with the patient. ...The hospital can not do anything about medical insurance. I think this kind of thing is not the problem at the hospital level. The complaints about medical insurance

define, without a doubt, problems underlying the state and society. (Male, Health care providers-4, 16-09-2011)

In addition, the safety of health care providers is under threat in China today. Chinese medical workers are often victims of violence. As a consequence, some health care providers have decided to not treat patients deemed likely to assault staff, exhibit disruptive behaviour, or otherwise prove to be difficult. Prescribing redundant check-ups and drugs are alternatives to properly seeing to patients.

In our interviews, fifteen interviewees mentioned "Chao" fifty-five times. "Chao" in Chinese means to argue with hospitals for patients' rights and interests, while the other meaning is to wrangle fiercely in hospitals or with senior management. Most of the hospital staff interviewed suggested that some complainants were indeed unreasonable and impulsive with the sole purpose of claiming.

If the case goes to court, the patient gathers a lot of people to go to the court, insulting and threatening concerned health care providers and their lawyers. That is not what we want to see. We want to talk about the truth, by thoroughly publicizing the truth. We cannot always be too specific with terminology [for fear of revealing too much]. When completely refuted, patients lose their temper. (Male, Other actors-2, 15-09-2011)

I feel that the widespread situation in China today is that you can do nothing if you run into the unreasonable. The legitimate way of going about this is to propose a fair decision once I receive your complaint. If complainants are not willing to settle for this, we then transfer their case to other departments. However, complainants

may not even agree to that, causing trouble and even threatening the safety of health care providers. (Female, Hospital managers-2, 25-08-2011)

The claim a complainant demands goes beyond the actual problem [but for the money] and he does not wish to resolve it the legal way. ...Nowadays "Yi Nao" has brought about serious social effects, and has escalated the tension between service users and providers. Complainants are unwilling to resolve things the legal way, rather, just pestering and hassling you [health care providers or complaint handlers] all day. (Male, Hospital managers-6, 01-11-2011)

d. Barriers to institutional changes for quality improvement using complaints data

Weak enforcement of the regulation

The regulation for managing patient complaints is merely a guideline, which contains no mandatory requirements such as assessment mechanisms. Because it takes into account the difference in local conditions throughout China, specific contents were not stipulated. The regulation is to be interpreted according to local circumstances and conditions. Therefore, in the absence of strong public scrutiny, there is little accountability for how best to manage patient complaints.

There are no penalties attached to (failure to follow) regulation. For example, there is no administrative aspect to the regulatory guidelines. We wanted to write a penalty provision, but it was not based on the top legislation. The purpose of the regulation is to emphasise self-discipline and to serve as guidance for the hospital.

[The penalty was not enforceable,] so we decided to remove the penalty. It is indeed difficult and contradictory. (Female, Administrators-4, 30-11-2011)

Besides the legal system, the reporting system also has its problems. Some statistics about patient complaints and medical malpractice were utilized as a part of assessments of hospital performance, health care quality, and so on. This meant that the more cases that were reported, the worse the evaluations received by the hospitals so that hospitals were inclined to report selectively or report fewer cases.

There are certainly no statistics for the number of patient complaints. There is only the data on the number of medical malpractice cases per year from the Bureau of Health, and an approximate amount of compensation issued by insurance companies. In some cases, if complaints were solved just between the hospital and the complainant, we have no data. (Male, Administrators-2, 18-08-2011)

These days, the information regarding the management of patient complaints in hospitals is difficult to access. Hospitals are unwilling to provide that sort of information – it is considered confidential. We only have some profiles or the information from select hospitals. (Female, Policy makers-1, 16-12-2010)

Thus, the adoption of the incentive and sanction mechanism was contradictory for managing patient complaints. From one side, the administrative department wanted hospitals to report patient complaints because it is important for informing and improving the quality of care. From the other side, the more complaints that are registered, the worse it would appear a hospital is doing. In addition to this, managing

patient complaints remains low on the health reform agenda. The force for inspecting complaint management in hospitals from senior management and administrative departments remains weak.

[Having a statistic for patient complaints] is definitely necessary from the aspect of effective management. If this statistic is disposable, I think nothing of it. If the statistic is routine, in fact, it will cost [all sorts of resources]. (Male, Policy makers-2, 22-12-2011)

Hospitals doubt that the purpose of administration is for information management – to help them better handle and solve disputes. However, if you want me to report incidents but meanwhile punish me for that, then I have no incentive to report anything. This contradiction stands [in the way of effective reporting]. (Female, Administrators-4, 30-11-2011)

Deficient information system for managing patient complaints

Although the regulations in place require collecting and analysing information, there exists no clear classification, definitions or unified coding system. Most hospitals have established their own systems for recording complaints and analysing cases, but no accurate or comparable data are available.

In fact a lot of cases should be recorded and analysed, [but] we do not even take into account so-called major cases of medical malpractice, mass disturbance or medical malpractice. We cannot distinguish between these concepts…. Relatively speaking, it is more feasible to publicize the data on public security, e.g. the number

of police records and people arrested, and the number of crimes committed. Those definitions are more explicit, whereas those concerning complaints management are not. Because all statistics are calculated in the hospital, we find that where standards are slack, the resulting statistic is large and where standards are strict, the statistic is small. Hence, there is great variability in our results. (Male, Policy makers-2, 22-12-2011)

Identical forms are sent to two hospitals at a similar level and the reported data can be quite different. ...Some hospitals only reported cases resulting in compensation and some hospitals record all persons who voice a concern, while others only report cases identified as medical malpractice. But it is impossible for me to verify [the reported data] in each hospital. (Male, Administrators-2, 18-08-2011)

Hospitals have not publicized complaints; neither have health administration departments. The Shanghai Bureau of Health launched a pilot project in 2005 to publicize the complaints reported by all hospitals in Shanghai. The project was welcomed by the public but discontinued soon after its launch due to mounting pressure from the hospitals.

We already publicize complaints [medical malpractice] on our intranet for hospital staff. It is unnecessary to share this information on external sites. (Female, Hospital managers-4, 06-09-2011)

To my knowledge, such information was published once on the Xinmin Evening News in 2005. The newspaper named hospitals that had won awards and gave details of the number of medical malpractice cases happening in each, as well as

feedback regarding patient satisfaction. [We felt] the pressure was very, very high. It [publishing those] resulted in public outrage [from hospitals]. (Female, Administrators-4, 30-11-2011)

Unwillingness of hospitals to effectively handle complaints

Most hospitals did not devote much effort into managing complaints. There was no clear mechanism to utilize patient complaints to improve quality of care unless serious medical malpractice had occurred or complaints were found to recur.

Hospitals just handle complaints when complaints happen. …We are basically perfunctory, including hospitals, department directors and doctors. The best-case scenario for me: do not approach me for these things [complaints]. Deal with complaints quickly and efficiently; in other words, spend money to buy peace. The impact of managing and addressing complaints is negligible, with very little effect on improving medical procedures and quality. (Male, Administrators-2, 18-08-2011)

Hospital directors were the key actors of complaint management in hospitals. The incentive and sanction mechanisms in hospitals depended on how much attention directors pay to complaint management. In the 1980s the government reduced subsidies for public hospitals under the context of transforming the planned economy to a so-called socialist market in order to reduce inefficiencies in health care provision. Hospitals had to increase service charges to recoup the operational costs and to increase the income level of health workers. Complaint management occupied nothing

but a small part of quality health care, so in most hospitals it failed to draw attention from senior management. Most complaints were solved on a case-by-case basis, without sufficient concern for the overall improvement of health care services.

In practice, the head of department influences implementation. If he/she regards this as important, then subordinates work harder of course. Now the problem is that some heads of department do not pay attention to it [complaint management]. (Male, Health care providers-2, 16-09-2011)

It is of course medical services that are the core of hospital work. Things such as [complaint management] are boring for the hospital. To a hospital, the fewer the complaints, the better. (Male, Administrators-2, 18-08-2011)

Discussion and Conclusions

This study examined the handling system for patient complaints in China and the views of key stakeholders on the barriers to effective complaint management. Our study provided a new dimension for understanding the complaints management system in China, an emerging market country. Hospitals are the most important handler and manager of patient complaints in China and similarly for other developing countries, such as India and Vietnam.[22] We explored the barriers through in-depth interviews with almost all stakeholders, not only health professionals. We hope that our findings will help develop procedures for more effective complaint management and further improve the quality of care in China and other developing countries.

To reduce the heavy burden placed on hospitals, the government has tried to seek help from other approaches aside from negotiation with hospitals. Initially, those other approaches were frequently welcomed and praised, but they seemed to be ineffective and inefficient. The effectiveness and efficiency of those other approaches needs further research. The selection of participants may introduce some bias to our studies. Due to our focus on the hospital, there may be an underrepresentation of certain types of respondents. Since there are no unified classifications for complaints, we did not include patients with different types of complaints. Moreover, we planned to recruit the same number of participants in multiple settings, but the number of participants from each was imbalanced because of information saturation.

We found that the three main project elements adopted from Hickson GB et al. were relevant and useful for the discussion of our results: (A) organizational supports, (B) commitment from key people, and (C) learning systems.[13]

A. Organizational Supports

Our findings showed that there are no standardized systems and procedures dealing with patient complaints in China due to conflicts between relevant actors and regulations. Having experienced rapid economic growth in the last 30 years, China is undergoing a socioeconomic transition. Like other developing countries, policies lag behind the country's economic transition.[37, 38] The Ministry of Health has tried to

guide health care providers by issuing special regulations, but health administrations do not apply strict regulations to complaint management. There lacks clear relationships between patient complaints and clinical outcomes or the quality of care.

The patient complaints in many Chinese hospitals are not well-managed and handled. Most hospitals manage patient complaints on only a case-by-case basis. They lack clear mechanisms linking patient complaints with improving the quality of care. Complaints are underutilised for organizational strategic planning or for changing an individual's behaviour and attitude. This implies that legislation should not only stipulate the principles and regulations of patient complaint management, but also the responsibilities of sectors at different levels.[39]

B. Commitment from People

The hospital leader is the key determinant for complaint handling inside the hospital. However, no apparent incentives exist to push hospital leaders to prioritize complaint handling. The power of complaint handling departments depends on how much the hospital leaders pay attention to it. Under current conditions, hospital leaders lack political will to manage complaints effectively, leading to inadequate human resources in complaint handling departments. The departments also lack the power to coordinate with clinical departments.

To alleviate patient complaints-related violence, civil groups, including service users

and the hospital sector, should approve the guideline. In developed countries, patient complaint management provides guidelines not only for health care providers, but also clear guidelines for patients. This not only makes it more convenient for patients, but also plays a positive role in helping patients initiate the complaint process via legitimate means. This is crucial for society to view patient complaint in a rational way.

C. Learning Systems

If patient complaints can be better managed and rectified, the instances of failure would be reduced and quality would be improved.[40, 41] Greater emphasis should be placed on quality improvement after patients complain. Strategies to improve quality following patient complaints should be developed through a learning process.[42] To promote the learning process, appropriate mechanisms should be developed and implemented to assess not only the number of patient complaints occurring in hospitals, but also how these hospitals have handled these complaints. For example, reporting more patient complaints should not be necessarily punished, while effective handling of the patient complaints should be appreciated.

Our final conclusion is that barriers to the effective management of patient complaints vary at the different stages of complaint handling, from the user and provider side, as well as systemic issues. Information, procedure design, human resources, system arrangement, a unified legal system and regulations and factors shaping the social

context all play important roles in effective patient complaint management. Appropriate mechanisms should be developed to link patient complaints with improving the quality of care.

ACKNOWLEDGEMENT

The HESVIC project received funding from the European Commission Framework 7. The views represented in this document are not necessary representative of the European Commission's views and belong solely to the authors. The consortium would like to thank all the study respondents and participants for their willingness to take part in the research, as well as the members of the Country Research Advisory Groups for their support at every stage of the HESVIC project. The authors of the paper very much appreciate constructive comments and suggestions on earlier version of the paper from Shenglan Tang from Duke Global Health Institute, USA. The authors are also grateful to Ms. Kaori Sato for language editing.

COMPETING INTERESTS

None.

FUNDING

This study was supported by the European Commission Seventh Framework Programme (HEALTH-F2-2009-222970).

CONTRIBUTORSHIP STATEMENT

1) Yishi JIANG: substantial contributions to conception and design, acquisition of data, and analysis and interpretation of data; drafting the article and revising it; and final approval of the version to be published.
2) Xiaohua YING: substantial contributions to conception and design, acquisition of data, and analysis and interpretation of data; drafting the article; and final approval of the version to be published.

3) Qian ZHANG: substantial contributions to acquisition of data, and analysis and interpretation of data; drafting the article; and final approval of the version to be published.

4) Sirui Rae TANG: substantial contributions to analysis and interpretation of data; drafting the article; and final approval of the version to be published.

5) Sumit KANE: substantial contributions to conception and design, and analysis and interpretation of data; revising the article critically for important intellectual content; and final approval of the version to be published.

6) Maitrayee MUKHOPADHYAY: substantial contributions to conception and design, and analysis and interpretation of data; revising the article critically for important intellectual content; and final approval of the version to be published.

7) Xu QIAN: substantial contributions to conception and design, and analysis and interpretation of data; drafting the article and revising it critically for important intellectual content; and final approval of the version to be published.

8) HESVIC team authorship

DATA SHARING

No additional data available.

References:

1. Sage WM. Putting the patient in patient safety: linking patient complaints and malpractice risk. *JAMA* 2002;**287**:3003-5.
2. Hsieh SY. A system for using patient complaints as a trigger to improve quality. *Qual Manag Health Care* 2011;**20**:343-55.
3. Wofford MM, Wofford JL, Bothra J, et al. Patient complaints about physician behaviors: a qualitative study. *Acad Med* 2004;**79**:134-8.
4. Beecham L. Patients' complaints: GMC could do better. *BMJ* 1999;**319**:1022.
5. Anderson K, Allan D, Finucane P. A 30-month study of patient complaints at a major Australian hospital. *J Qual Clin Pract* 2001;**21**:109-11.
6. Ministry of Health. *Measures for the Handling of Patient Complaints in Hospitals (for Trial Implementation)*. Beijing: Ministry of Health; 2009.
7. The Henry J. Kaiser Family Foundation. Medical Malpractice Law in the United States. http://www.kff.org/insurance/upload/Medical-Malpractice-Law-in-the-United-States-Report.pdf Accessed [08-31-2012].
8. Hsieh SY. Healthcare complaints handling systems: a comparison between Britain, Australia and Taiwan. *Health Serv Manage Res* 2011;**24**:91-5.
9. Department of Health, United Kingdom. Complaints procedure. http://www.dh.gov.uk/health/contact-dh/complaints/ Accessed [08-31-2012].
10. Cornwall A, Romios P. Turning Wrongs Into Rights. *Health Issues* 2004;**79**:13-8.

11. Hickson GB, Federspiel CF, Pichert JW, et al. Patient complaints and malpractice risk. *JAMA* 2002;**287**:2951-7.

12. Pichert JW, Hickson G, Moore I. Using Patient Complaints to Promote Patient Safety. *Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 2: Culture and Redesign)*. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008.

13. Hickson GB, Moore IN, Pichert JW, et al. Balancing systems and individual accountability in a safety culture. *From Front Office to Front Line: Essential Issues for Health Care Leaders, 2nd ed*. Oakbrook Terrace, IL: Joint Commission Resources; 2012. p. 1-35.

14. Vincent C, Davis R. Patients and families as safety experts. *CMAJ* 2012;**184**:15-6.

15. Xi X. *Understanding and application of provisions in the Tort Liability Law*. Beijing: Press of the People's Court; 2010.

16. Chinese doctors are under threat. *Lancet* 2010;**376**:657.

17. Zheng XQ, Wei LY, Zhang BZ, et al. Domestic Survey of Medical Disputes and Foreign Medical Dispute Handling. *Chinese Hospitals* 2007; **7**:2-4.

18. Stafford C. Moral ambivalence in modern China. *The Lancet* 2012;**9818**:793.

19. Communicating concern: complaints against doctors. *Lancet* 2013;**382**:1382.

20. Zhuang Y, Zhong C, Liu J, et al. A survey and analysis of complaint management in five tertiary hospitals. *Chinese Journal of Hospital Administration* 2006;**22**:45-8.

21. Gan N, Yu T, Chen W, et al. Analysis of differences in cognition between doctors

and patients and causes of medical disputes. *Journal of Shanghai Jiaotong University (Medical Science)* 2008;**28**:1035-7.

22. Gao J, Cao W, Xu Y, et al. Survey analysis of consultation settlement for medical disputes in 30 medical institutions of Shanghai. *Journal of Shanghai Jiaotong University (Medical Science)* 2010;**30**:960-3.

23. Green A, Gerein N, Mirzoev T, et al. Health policy processes in maternal health: a comparison of Vietnam, India and China. *Health Policy* 2011;**100**:167-73.

24. Charmaz K. *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. Thousand Oaks, CA: Sage Publications, 2006.

25. Sadler GR, Lee HC, Lim RS, et al. Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nurs Health Sci* 2010;**12**:369-74.

26. Lacey A, Luff D. *Qualitative Research Analysis*. The NIHR RDS for the East Midlands / Yorkshire & the Humber, 2007.

27. Department of Health, NSW. *Complaint Management Guidelines*. North Sydney NSW: Guidelines; 2006.

28. State Council. *Regulation on the Handling of Medical Malpractices*. Beijing: Decree of the State Council; 2002.

29. Standing Committee of the Eleventh National People's Congress. *Tort Law of the People's Republic of China*. Beijing: Presidential Decree; 2009.

30. Ministry of Health. *Measures for the Complaint Letters and Visits System for Healthcare*. Beijing: Ministry of Health; 2007.

31. Shanghai Justice Bureau and Health Bureau. *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*. Shanghai: Shanghai Justice Bureau and Health Bureau; 2008.

32. Ministry of Justice, Ministry of Health, and China Insurance Regulatory Commission. *Opinions on Strengthening People's Mediation for Medical Disputes*. Beijing: Ministry of Justice, Ministry of Health, and China Insurance Regulatory Commission; 2010.

33. Shanghai Justice Bureau and Health Bureau. *Measures on People's Mediation for Medical Disputes in Shanghai*. Shanghai: Shanghai Justice Bureau and Health Bureau; 2011.

34. Yan X. Correctly Receive Medical Complaints and Establish Harmonious Doctor-patient Relationship. *Modern Hospital Management* 2008;**6**:24-5.

35. Manouchehri MJ, Ibrahimipour H, Sari AA, et al. Study of patient complaints reported over 30 months at a large heart centre in Tehran. *Qual Saf Health Care* 2010;**19**:e28.

36. Siyambalapitiya S, Caunt J, Harrison N, et al. A 22 month study of patient complaints at a National Health Service hospital. *Int J Nurs Pract* 2007;**13**:107-10.

37. Grundy J, Khut QY, Oum S, et al. Health system strengthening in Cambodia-a case study of health policy response to social transition. *Health Policy* 2009;**92**:107-15.

38. Luong DH, Tang S, Zhang T, et al. Vietnam during economic transition: a tracer study of health service access and affordability. *Int J Health Serv* 2007;**37**:573-88.

39. Shaw K, Cassel CK, Black C, et al. Shared medical regulation in a time of increasing calls for accountability and transparency: comparison of recertification in the United States, Canada, and the United Kingdom. *JAMA* 2009;**302**:2008-14.

40. Winkler F. Complaints by patients. *BMJ* 1993;**306**:472-3.

41. Baker R. Learning from complaints about general practitioners. *BMJ* 1999;**318**:1567-8.

42. Mintzberg H. The Fall and Rise of Strategic Planning. *Harvard Business Review* 1994:107-14.

Title page

1. Title of the article.

Managing patient complaints in China – a qualitative study in Shanghai

2. Full name, postal address, e-mail, telephone and fax numbers of the corresponding author.

The corresponding author: Xu QIAN

Postal address: Mailbox 175, 138 Yi Xue Yuan Road, Shanghai, 200032, P. R. China

Tel: 86-21-54237267 Fax: 86-21-64174172

Email: xqian@fudan.edu.cn

3. Full names, departments, institutions, city and country of all co-authors.

1) Yishi JIANG: School of Public Health, Fudan University, Shanghai, China; Shanghai Maternal and Child Health Center, China

2) Xiaohua YING: School of Public Health, Fudan University, Shanghai, China

3) Qian ZHANG: School of Public Health, Fudan University, Shanghai, China

4) Sirui Rae TANG: School of Public Health, Fudan University, Shanghai, China

5) Sumit KANE: KIT Development Policy & Practice, Royal Tropical Institute, Amsterdam, Netherlands

6) Maitrayee MUKHOPADHYAY: KIT Development Policy & Practice, Royal Tropical Institute, Amsterdam, Netherlands

7) Xu QIAN: School of Public Health, Fudan University, Shanghai, China

8) HESVIC team authorship

4. Up to five keywords or phrases suitable for use in an index (it is recommended to use MeSH terms).

Qualitative Research; Patient Complaints; Complaint Handling Systems; Quality Improvement; Government Regulation

5. Word count - excluding title page, abstract, references, figures and tables.

~~6902~~7030

Abstract

Objectives: To examine the handling system for patient complaints and to identify existing barriers that are associated with effective management of patient complaints in China.

Setting: Key stakeholders of the handling system for patient complaints at the national, Shanghai municipal, and hospital levels in China.

Participants: Thirty-five key informants including policymakers, hospital managers, health care providers, users and other stakeholders in Shanghai.

Primary and secondary outcome measures: Semi-structured interviews were conducted to understand the process of handling patient complaints and factors affecting the process and outcomes of patient complaint management.

Results: The Chinese handling system for patient complaints was established in the past decade. Hospitals shoulder the most responsibility of patient complaint handling. Barriers to effective management of patient complaints included service users' low awareness of the systems in the initial stage of the process; poor capacity and skills of healthcare providers, incompetence and powerlessness of complaints handlers and non-transparent exchange of information during the process of complaint handling; conflicts between relevant actors and regulations, and unjustifiable complaints by

patients during solution settlements; and weak enforcement of regulations, deficient information for managing patient complaints and unwillingness of the hospitals to effectively handle complaints in the post-complaint stage.

Conclusions: Barriers to the effective management of patient complaints vary at the different stages of complaint handling and perspectives on these barriers differ between the service users and providers. Information, procedure design, human resources, system arrangement, unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management.

Article summary

Strengths and limitations of this study

This study explores the handling system for patient complaints in China and the views of key stakeholders on the barriers to effective complaint management. These findings are essential to improve the complaints system. Our study provides a new dimension of understanding the complaints management system in China, an emerging market country. We explore the barriers through in-depth interviews with almost all stakeholders, not only health professionals. What we found will help develop procedures for more effective complaint management and to further improve the quality of care in China and other developing countries. The selection of participants may introduce some bias to our studies. Due to our focus on the hospital, there may be an underrepresentation of certain types of respondents.

~~**Bullet points**~~

~~1. Our study examined the handling system for patient complaints and identified and analysed barriers to effective management in China.~~

~~2. We carried out a literature review and semi-structured interviews with all categories of key informants.~~

~~3. Hospitals undertake the most responsibility for patient complaint handling.~~

~~4. Barriers to effective management of patient complaint vary at different stages of complaint handling, from the user and provider~~

side, as well as system issues.

5. Information, procedure design, human resources, system arrangement, unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management.

Background

In recent years, patient complaints around the world have garnered mounting concern among policymakers, academics and the general public.[1-3] As China prospers, making advances in medicine and social welfare, expectations of better quality of care continue to grow. People's knowledge of the law and their rights has increased as a result of better education and understanding of the law. Patients are able to express their discontent by lodging complaints such that the number of complaints occurring internationally is on the rise.[4, 5] A "complaint" is defined as *the behaviour of a patient or his/her representative(s) which signifies dissatisfaction towards medical services, nursing services, as well as treatment conditions through letters, calls or visits to the hospital where the purpose of these actions is to criticise the hospital and/or claim compensation"*.[6] In addition, the growth in dollars paid on malpractice claims is evident.[7] China's current situation reveals growing concerns surrounding hospital accountability and clinical governance; in particular, the efficacy of the redress system. Grave consequences affecting both social and political stability are likely if the health care system fails to meet expectations and to achieve patient satisfaction. Indeed, the issue at hand is one of paramount importance, requiring urgent attention and immediate action at the highest level.

In countries such as Australia and Britain, the states have sought to monitor complaints and complaint handling to improve and regulate the practice of health professionals.[8] A feedback system of this sort has proven instrumental in improving

the quality of care. In Britain, the National Health Service (NHS) has not only provideds clear and transparent guidelines for both health care providers and patients but has also publicizeds information regarding the routine reporting of patient complaints.[9] In Australia, a large study was conducted before *Guide to Complaint Handling in Health Care Services* was formulated and subsequently updated.[10] Annually, statistics are compiled and published, detailing complaint trends, complaint management and reasons for complaints. Effective handling of complaints has been known to reduce friction between providers and consumers, with the even greater benefit of improving quality of care. As a supplement to peer reviews and administration, patient complaints can provide important feedback concerning the delivery of health care services and can be a useful tool in the improvement of health care quality.[1-3, 11-14]

With no official statistics of patient complaints available in Chinese records, we estimated that the number of complaints and disputes rose, from 10,249 to 13,875 claims, based on the number of first trials for medical malpractice cases between 2002 and 2008.[15] Mounting dissatisfaction has been felt across the country, manifesting in increasingly hostile and violent behaviour towards providers from patients and their families.[16] An investigation carried out by the Chinese Hospital Management Association in 2005 suggested that of 270 hospitals surveyed, 73 per cent experienced abuse in the form of threats and assaults targeting doctors and management.[17] These incidents are only indicative of rising expectations, burgeoning patient discontent with

services and dissatisfaction towards the way in which matters are resolved.[18] Public outcry only exacerbates the need for more effective handling of individual cases under the overarching agenda of public hospital reform in China.[19]

Notwithstanding the alarming extent of these issues, few attempts have been made to formally examine how hospital complaints are addressed in developing countries. It is only recently that a handful of studies in China have sought to provide some understanding of the issue by trying to ascertain the number of complaints in the studied hospitals or garnering patient feedback via questionnaires and interviews.[20-22] A fuller understanding of the complaints system – the available channels for seeking redress, how the system operates and the barriers to conflict resolution – will be crucial to ameliorating the often fraught relationships between health care providers and consumers. The purpose of this study has been to examine the handling system for patient complaints in China, and to subsequently identify and analyse the various hospital-specific factors preventing grievances from being effectively addressed. The authors of this paper hope that such an undertaking will reduce malpractice and above all, improve health service outcomes.

This study is one of the cases from the "Health System Stewardship and Regulation in Vietnam, India and China" (HESVIC) research project. It was conducted by a consortium of six partners in Asia and Europe from 2009-2012, with the aim of supporting policy decisions in the application and extension of accessibility,

affordability, equity and quality of coverage of maternal health care in the three countries.

Methods

Study design

The project uses a multidisciplinary approach, drawing on multiple case studies to examine the impact of regulation on improving equitable access to quality health care in Vietnam, India and China. In each country, three cases were selected and studied. This paper shows the findings from the case study, examining the regulation on Grievance Redressal (GR) in Shanghai, China. Here, regulation encompasses the formation of rules and practices, as well as their interpretation and implementation, such as the health policy processes covered in the HEPVIC project (HEPVIC).[23]

Phase One: Literature Review

Firstly, we conducted a literature review. The relevant sources, which included regulation documents related to the handling of patient complaints at both the national and Shanghai municipal levels, were used to collect legal approaches and mechanisms used in managing patient complaints. These regulations were mainly stipulated from 2002 to 2011. To understand the application of different complaint approaches, a search of scientific literature published between 2000 and 2011 was conducted. Databases MEDLINE-PubMed and WANFANG Data were consulted. A search strategy was established based on the following keywords: *grievance redressal,*

patient complaint, health care complaint and hospital complaint, and China. Special focus was placed on patient complaint management in hospitals, as we found that the vast majority of complaints were handled and resolved within the hospitals.[22]

Phase Two: Pilot Study – Interviews

Based on our understanding of the current patient complaint handling system, we performed semi-structured interviews with key stakeholders – policymakers from the national level, administrators from the Shanghai municipal level, hospital managers, health care providers, users and other related parties. We used the snowball sampling method to identify key stakeholders and to collect important feedback from key informants from various disciplines.[24, 25]

In Phase Two (October-December 2010), one key actor from each of the three administrative levels was selected and interviewed: a policymaker at the national level, a municipal administrator and a hospital manager. A pilot study was conducted to test the topic guidelines developed. These allowed us to gain a preliminary understanding of the complaint management process in the hospital setting, and to refine the data collection tools. These interviews served as the basis for the design of Phase Three interviews, where some of those being interviewed in the third phase were respondents recommended by Phase Two interviewees.

Phase Three: Main Data Collection

Interviews in Phase Three were conducted from August-December of 2011. Key stakeholders were interviewed in the selected hospitals based on location, level and type. Our sample represented both urban and suburban areas in Shanghai. General and specialist hospitals were selected. Phase Three began with interviews of hospital managers and health care providers proposed in Phase Two. We asked interviewees from Phase Two to invite patients and other relevant stakeholders to contribute their views. Those invited patients used different channels for lodging their complaints; however, they all shared one thing in common: all patients had first complained to the hospital. We then proceeded to interview the administrators and finally a high-level policymaker. We continued to interview respondents, collecting and analysing their comments and feedback until no new themes emerged, i.e. saturation had been reached. The number of participants involved in the different types of interviewees is depicted in Table 1.

Semi-structured interviews were conducted with 35 respondents face-to-face, except one via telephone. The interviews took place at private locations, for example at the institution where the interviewee or interviewer worked, and were conducted by two of the authors of this paper. Each interview lasted 1-2 hours and was audiotaped with permission, apart from two which were not recorded but typewritten upon the respondents' request.

Table 1 Number of interviewees by administrative level and facility

Types of interviewees	Level	Number of

		Participants
Policymakers	National	
Ministry of Health		1
A university		1
Administrators	Shanghai municipal	4
Hospital managers		
General hospital	Tertiary	3
General hospital	Secondary	3
Specialized hospital	Tertiary	1
Specialized hospital	Secondary	1
Private hospital	Secondary	2
Health care providers		6
Users		6
Other actors		
Municipal Health Inspection Institute		2
Lawyers for medical disputes		2
The centre that processes medical liability insurance		1
The People's Mediation Committee for Medical Disputes		1
The Complaint Letters and Visits System		1
Total		**35**

The topic guidelines for carrying out the interviews included questions on the participant's experience in complaint management in the hospitals. Using probes and follow-up questions, attention was directed to factors that the interviewees perceived as barriers to effective complaint management, and interviewees were asked to explain their reasoning. From existing literature, we identified a list of factors required for effective complaint management and successful resolution of disputes. Participants were asked to provide suggestions and feedback regarding how complaints could be more effectively dealt with given the barriers they had identified.

Data analysis

Audiotapes recorded during the interviews were transcribed and were compared with the field notes to check for accuracy. We analysed data through a process of rigorous and structured analysis.[26] The analysis was executed in several stages to 1) become familiar with the data; 2) identify emerging topics; 3) develop a topic index; 4) use the index to code the data; 5) consolidate the topics into themes; 6) further consolidate these themes into analytical categories/clusters; and 7) translate the analysis obtained into a narrative. Written consent was obtained from each interviewee before undertaking the interviews.

We performed the above tasks using the qualitative research software NVivo 9.0. The raw data was coded by two independent reviewers (YSJ, QZ). If discrepancies

emerged, a third reviewer (XHY) participated in the group discussion until the group arrived at a consensus. There were some models for analysing complaint management;[2, 13] for example, the Managerial-Operational-Technical (MOT) model was developed by Hsieh SY to explore complaint management in hospitals.[2] In our study, we collected data according to the complaint management process. To analyse the data most efficiently and directly, we used the stages of the process, which included receiving, handling and resolving complaints.[27] As quality improvement following complaints is crucial, we added the stage of "institutional changes for quality improvement using complaints data".[2, 12]

Our study was approved by Institutional Review Board (IRB), School of Public Health, Fudan University. Access to data was restricted to approved members of the research team who signed a confidential agreement with the principal investigator. Data were stored in secure electronic locations. Data processing was kept anonymous so as to protect the identity of interviewees. The names of the respondents have been deleted from the quotations.

Findings

This section first presents a number of approaches developed and implemented in Shanghai to handle patient complaints and their relationships. It then focuses on the approach of negotiation between hospitals and complainants, identifies its barriers, and proceeds to examine and analyse these barriers.

1. Approaches and mechanisms used in managing patient complaints

The study identifies both formal and informal approaches and mechanisms used in handling patient complaints.

a. Negotiation between Hospitals and Complainants

The complaint handling department within the hospital is responsible for dealing with patient complaints, first established on February 20, 2002, in accordance with the *Regulation on the Handling of Medical Malpractices.*[28] Since November 2009, these departments have been regulated by *Measures for the Handling of Patient Complaints in Hospitals (for Trial Implementation).*[6] These acts require that a medical institution establish a department specifically for the purpose of handling and resolving medical disputes. The department is primarily responsible for receiving patient complaints via calls, letters, visits, and/or cases referred from other departments and institutions. Their role also includes counselling and communicating with patients, verifying and documenting disputes as well as resolving disputes.

b. Administrative Mediation and Civil Lawsuits

If the hospital is unable to resolve certain conflicts through negotiation, the cases may be referred to an external body such as the health administrative department or they may be settled in court by means of litigation. The *Tort Law of the People's Republic of China*, adopted at the twelfth session of the Standing Committee of the Eleventh

National People's Congress on December 26, 2009, provided a new legal definition of liability for medical malpractice, liability presumption and exemption.[29]

c. Complaint Letters and Visits System

In February 2007, *Measures for the Complaint Letters and Visits System for Healthcare* was established.[30] Its purpose is to protect the legal rights and interests of citizens, legal entities, and other organizations, and to regulate behaviour and maintain order within the Complaint Letters and Visits System. It requires health administrative departments to set up Complaint Letters and Visits offices at different levels. These offices are responsible for receiving, assigning and transferring matters as appropriate, as well as supervising the handling of various issues and complaints.

d. People's Mediation – a form of Third-Party Facilitated Mediation

In July 2008, the Shanghai Justice Bureau and Health Bureau issued *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*, to establish the People's Mediation Committees for Medical Disputes.[31] Committee members, mainly retired judges and doctors, served to mediate disputes through reporting, explaining and analysing cases under the supervision of the local judiciary. In January 2010, the Ministry of Justice, the Ministry of Health and the China Insurance Regulatory Commission jointly issued *Opinions on Strengthening People's Mediation for Medical Disputes* to bolster the role of mediation in resolving medical disputes.[32] Its intent is to settle medical disputes in an effective way and to

maintain order within hospitals, all with a view for ensuring harmony and social stability. In July 2011, the Shanghai Justice Bureau and Health Bureau introduced *Measures on People's Mediation for Medical Disputes in Shanghai* to replace *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*.[31, 33]

In addition to the aforementioned channels of complaint, patients have also been found to express their discontent by "Yi Nao" – exhibiting disruptive behaviour within the hospital by targeting doctors and nurses or hospital managers by way of abuse, assault and other forms of violence. Much of this has garnered media attention, resulting in bad publicity for the hospital and damaging the reputation of doctors and staff.

Table 2 the characteristics of the approaches

	Negotiation between Hospitals and Complainants	**Administrative Mediation**	**Civil Lawsuits**	**Complaint Letters and Visits System**	**People's Mediation**
Responsible institution	Complaint Reception Office in hospitals	Health Inspection Institute	People's Court	Complaint Letters and Visits Office in health administrative departments	People's Mediation Committee for Medical Disputes
Responsibility	Receive and handle patients' complaints; compensate some complainants	Receive and mediate medical malpractices	Receive and settle medical litigations	Receive, transfer and supervise patients' complaints	Receive and mediate patients' complaints
Handling method	Negotiation	Mediation	Mediation; Trial	Supervise matters	Mediation
Processing duration	Indefinite	Only once	Six months	Two months	One month
Legal level of resolution	Low	Low	High	Low	Low
Administrative level of resolution	Low	High	High	High	Low

2. The application of different complaint approaches

The complexity of relationships between different approaches can be seen where many actors are involved. The responsible institutions of all approaches can receive complaints. Generally speaking, patients firstly lodge complaints to hospitals. If complainants or hospitals are unwilling or fail to ~~succeed at negotiation~~negotiate, they may file applications to other approaches. Approaches that can resolve medical disputes are mainly negotiations and civil lawsuits, while other approaches play a part in forwarding cases, such as Complaint Letters and Visits System, or easing conflicts, such as mediation. None of the approaches are considered the ultimate arbiter. For example, p~~P~~atients can continue to lodge complaints through the Complaint Letters and Visits System even if a decision has been finalised after a second trial in court or after ~~the~~ negotiations with hospitals.

In the above-mentioned approaches, the hospital is the main handler for patient complaints. First of all, it can handle patient complaints completely independently, from reception to solution, while the other approaches, such as the Complaint Letters and Visits System~~Civil Lawsuits~~ and mediation, must engage hospitals in complaint handling. Secondly, since the hospital is principally responsible for compensation, the complainant is more inclined to directly negotiate with the hospital. Findings from the literature show that the majority of medical disputes are resolved by negotiation between hospitals and complainants.[22] Thirdly, if hospitals handle complaints improperly, conflicts will become more volatile, resulting in serious incidents, such as

"Yi Nao".[34] Therefore, hospitals have become the most common receiver, handler and resolver of disputes. (Figure 1)

3. Barriers to the effective management of patient complaints and their underlying causes at different stages

Our interviews revealed that different hospitals often use different complaint systems. For example, some hospitals operate a centralized complaints office, which may or may not be independent of the Medical Affairs (Administration) Department. Other hospitals have several complaints offices, each of which is responsive to different kinds of complaints. A hospital's deputy director, who also heads hospital complaint management, generally manages complaint departments. Barriers to effective complaints management vary at different stages of the complaint process, both from the sides of the user and provider.

.

a. Barriers to receiving the complaints

Low awareness of users about the handling system for patient complaints

Although hospital staff claimed that the complaints office was accessible to those with grievances, patients did not always feel this was the case. One user looked up the hospital telephone number on the Internet and said the complaint handling process was "very easy" while others did not concur. Almost all the patients interviewed found that signs and directions (to the complaints office) failed to catch the eye. In some cases none could be seen at all:

I wanted to lodge a complaint, but did not know how to find [the complaints office]… Because the hospital was so big, I did not know which department [was responsible for handling complaints]. …I simply did not know who to turn to. You see, the complaints department was in another building [rather than in the one in which I was treated i.e. the clinical department] (Female, Users-1, 01-09-2011)

b. Barriers to handling the complaints

Poor capacity and skills of health care providers

The capacity and skills of health care providers in managing patient complaints is critically important in problem solving. Our study found that the reasons patients complained lay mainly in poor communication and factors such as the provider's attitude, use of language, unprofessional behaviour, as well as dissatisfaction towards service procedures.

The Medical Doctors Association carried out a survey on the nature of medical disputes. 50 per cent of cases were results of inappropriate attitudes about health care delivery, 25 per cent were caused by technology misuse and the rest were related to management. (Female, Policy makers-1, 16-12-2010)

The majority of complaints can be resolved by an explanation issued by the hospital and/or a verbal apology by the offending party.[5, 35, 36] However, practitioners are often too preoccupied with their clinical duties to be able to respond to patient complaints.

Doctors are not able to devote much time to handling disputes, because clinical

work is highly demanding. [They need to attend to] many patients every day. If they spend more time communicating with patients, they would lose time needed to carry out [clinical work]. That is to say, [doctors should be given] less [clinical] work, and more time to explain their work to patients. Our workload is very heavy, like a battle. (Female, Health care providers-1, 01-09-2011)

Incompetence and powerlessness of complaints handlers

In comparison to health care providers, complaint handlers played a more important role in cooperation and coordination. Although complaint departments were specifically set up in hospitals for receiving and handling complaints, the responsible persons in the department were mainly part-time medical staff. In some cases those handling staff were found to be inadequate due to lack of training. Many of them had studied handling techniques on their own and had not acquired sufficient professional skills to appropriately analyse, assess and solve complaints.

Complaint handlers in the hospitals cannot solve everything because the disciplines involved in complaints are highly specialised. I am only familiar with general surgery and issues that require common sense, but [I am not familiar] with professional problems in other disciplines. (Male, Hospital managers-5, 08-09-2011)

It is difficult to recruit staff for our Medical Dispute Handling Office. No one wants to come. A boy recruited in 2007 could not stand the demands of the job [complicated disputes and violence] and so resigned. (Female, Hospital

managers-3, 31-08-2011)

We have little time to do things other than receiving complaints. We lack staff members. We are responsible for receiving and processing complaints, and expected – on top of this – to deal with other things, hence why we are exhausted. (Male, Health care providers-2, 16-09-2011)

Given that most complaints are handled and resolved in the hospital, it appeared that every complaint handler interviewed felt the same way: tired and stressed. Complaint handlers were insufficiently empowered to handle complaints. It was hard for them to coordinate between different departments, investigate cases, organize mediation, find solutions and then draw on patients' feedback to improve quality of care.

Recently, a fierce medical dispute occurred because of a possible misunderstanding between administrative departments. [Abusive] words erupted. As a consequence, staff members involved in this incident were distraught – to the extent that they wanted to resign. Hence, we need understanding and support among colleagues. ...Sometimes the clinical department at hand refused to cooperate when investigated. He [the clinical department] is not very serious about cooperating with the investigation. (Female, Hospital managers-3, 31-08-2011)

Communication between administrative departments and clinical departments is not very effective sometimes. I am not satisfied with this. (Female, Hospital managers-2, 25-08-2011)

Non-transparent exchange of information

In addition, the complaint handling process was not truly open to the complainant, and information exchange was largely limited to hospital staff. In fact, it was found that the staff at the complaints office was generally evasive towards patients who arrived wishing to be updated with the specifics of their complaint. Complainants had no opportunity to directly engage in the handling of their complaints or to meaningfully participate in the process. In addition, hospitals tended to oversimplify cases, assuming that the complainant's only desire was to report their complaint and ask for compensation. This implies that the entire handling process is disclosed only among hospital staff. Therefore, the process becomes a "black box" to patients. It is easy for the hospital to manipulate a complainant by providing limited information to gain advantage in negotiations, i.e. reduce loss from compensating patients.

Sometimes you have to circumvent something and use negotiating skills. Mistakes in medical services do not necessarily harm patients' health, but they can be very serious for the provider [...] for example, someone may not be very careful when writing a medical record and alter it by accident. But you are likely to lose a lawsuit on the grounds of having tampered with records. Incidents such as these cloud the matter, making transparency difficult. (Female, Hospital managers-2, 25-08-2011)

If the incident is urgent or presents itself as a recurring problem, it might be shared to educate healthcare providers but disclosure to complainants themselves remains limited. Only outcomes deemed to be of direct interest to patients, including compensation amounts and medical service privileges, were provided. However, other results, including penalties imposed upon physicians and departments or

improvements made to hospital services, were largely withheld from patients if they did not ask.

In individual cases, what are the outcomes of their complaints? How might a physician be punished/penalised/disciplined? Such information is requested by patients only occasionally. (Male, Health care providers-2, 16-09-2011)

I want to know how to better educate the concerned health care providers. But I have not been told. (Female, Users-3, 20-09-2011)

c. Barriers to resolving the complaints

Conflicts between relevant actors and regulations

Within the complaints system, conflicts or inconsistencies can arise between the legal system for handling complaints and the solutions determined by the hospital. As the structure of managing patient complaints is shown in Figure 1, different regulations stipulate different approaches. Unified laws or guidelines do not exist to clearly illustrate the relationships between different approaches, which results in problems such as a lack of authority or ultimate approach, uncertainty about how to apply different regulations to one case, and no clear definitions or classifications in regards to patient complaints.

The current state of complaint management is disorderly. There are too many channels. For example, many departments are involved, including but not limited to Complaint Letters and Visits, online complaints, etc. The Health Bureau has two departments [for complaint management], and each district has a mediation office,

a district government website or a mayor-mail [to receive complaints], and a Complaint Letters and Visits office… Far too many heads of departments within the health sector; it is chaos. (Male, Health care providers-2, 16-09-2011)

Hospitals are required to report complaints to a lot of sectors, all of which wish to understand the issue from different angles. Conflicts between regulations do not necessarily exist, but different elements are emphasised. Hospitals are tired of these kinds of bureaucracy. ...Each sector carries out their designated duties where resources are not shared. The information possessed by each sector is fragmented. You know yours, I know mine. (Male, Administrators-2, 18-08-2011)

Medical malpractice is defined clearly in the Regulation on Handling Medical Malpractice. There are several benchmarks determining the amount of compensation issued. After the Tort Liability Law of the People's Republic of China was promulgated, [medical damage] was compensated for more in accordance with the Tort Liability Law because it stipulates compensation for personal injury. (Female, Hospital managers-2, 25-08-2011)

Unjustifiable complaints by patients

In some cases, the patient experiences inconvenience when receiving medical services not because of poor conduct in attitude or behaviour on the part of health care providers, but possibly because of long wait times, too little time spent with the doctor, and/or imperfect resource allocation. These are health system issues rather than problems caused by hospitals or individual physicians. And so, to a certain extent,

physicians and hospitals have become scapegoats of the entire health system.

At times it is not us physicians who make patients angry. Certain factors are rooted in the fabric of health care systems, but we physicians [end up] taking the blame. (Male, Health care providers-3, 16-09-2011)

For example, should a doctor need to see sixty patients in half a day, or indeed one hundred, you cannot demand that he puts on a smile for each one. A lot of patients complain about doctors with a straight face, but I think it is understandable. I have a very good relationship with our young doctors. They operate on a tight schedule. This week someone worked at the outpatient facility. He was friendly with patients in the first month but struggled to sustain that sort of demeanour. He is not in the mood to smile at patients or engage in long conversations when he only has time to attend to their illnesses. (Male, Hospital managers-1, 15-12-2010)

For example, dissatisfaction voiced in the hospital may be related to health insurance policy rather than staff behaviour. Hospitals need to follow the policies made by the Health Insurance Department. The purpose of those policies was to improve rational use of medicines and control healthcare costs, while the patients covered by health insurance may demand more medicines.

Chinese doctors have many rules to obey [this is to curb poor conduct]. The pressures for them to perform are relatively large. For example, doctors cannot prescribe too much medicine for a patient who has only [basic state-financed] medical insurance, but patients always want more. A while ago, the Medical

Insurance Bureau issued the following statement in a newspaper: "The Medical Insurance Bureau never limits the volume of drugs prescribed, rather it is the doing of hospitals who wish to increase workload [in order to produce more statistics]." I think this is really unreasonable. The Bureau does not control the quantity of drugs prescribed in any given week, but there is a total quantity limit over a year. Doctors try their best not to prescribe drugs which must be self-financed, i.e. not covered by basic medical insurance. They must also explain very clearly before prescribing self-financed drugs, otherwise, patients will lodge complaints once they find out. (Male, Hospital managers-1, 15-12-2010)

Complaints occur when the patient wants more drugs but the doctor refuses to satisfy his or her demands. Why? The health insurance institution sets a limit on drug expenditure for each hospital; in turn, the hospital sets a limit for each doctor. So if a doctor has too many patients drawing from their health insurance scheme in any one month, he or she may very possibly have exceeded his/her limit. (Male, Health care providers-3, 16-09-2011)

[A patient who has] basic state-financed medical coverage is entitled to blood and other auxiliary examinations. If the number of health checks prescribed exceeds a certain threshold, the doctor is viewed as exploiting basic medical insurance. The doctor is consequently punished. I was deducted more than seven hundred yuan (RMB) because of a case like this. I feel this is simply absurd – it is [unexpectedly] doctors who are to blame. Nothing seems to be wrong with the patient. ...The hospital can not do anything about medical insurance. I think this kind of thing is

not the problem at the hospital level. The complaints about medical insurance define, without a doubt, problems underlying the state and society. (Male, Health care providers-4, 16-09-2011)

In addition, the safety of health care providers is under threat in China today. Chinese medical workers are often victims of violence. As a consequence, some health care providers have decided to not treat patients deemed likely to assault staff, exhibit disruptive behaviour, or otherwise prove to be difficult. Prescribing redundant check-ups and drugs are alternatives to properly seeing to patients.

In our interviews, fifteen interviewees mentioned "Chao" fifty-five times. "Chao" in Chinese means to argue with hospitals for patients' rights and interests, while the other meaning is to wrangle fiercely in hospitals or with senior management. Most of the hospital staff interviewed suggested that some complainants were indeed unreasonable and impulsive with the sole purpose of claiming.

If the case goes to court, the patient gathers a lot of people to go to the court, insulting and threatening concerned health care providers and their lawyers. That is not what we want to see. We want to talk about the truth, by thoroughly publicizing the truth. We cannot always be too specific with terminology [for fear of revealing too much]. When completely refuted, patients lose their temper. (Male, Other actors-2, 15-09-2011)

I feel that the widespread situation in China today is that you can do nothing if you run into the unreasonable. The legitimate way of going about this is to propose a fair decision once I receive your complaint. If complainants are not willing to settle

for this, we then transfer their case to other departments. However, complainants may not even agree to that, causing trouble and even threatening the safety of health care providers. (Female, Hospital managers-2, 25-08-2011)

The claim a complainant demands goes beyond the actual problem [but for the money] and he does not wish to resolve it the legal way. ...Nowadays "Yi Nao" has brought about serious social effects, and has escalated the tension between service users and providers. Complainants are unwilling to resolve things the legal way, rather, just pestering and hassling you [health care providers or complaint handlers] all day. (Male, Hospital managers-6, 01-11-2011)

d. Barriers to institutional changes for quality improvement using complaints data

Weak enforcement of the regulation

The regulation for managing patient complaints is merely a guideline, which contains no mandatory requirements such as assessment mechanisms. Because it takes into account the difference in local conditions throughout China, specific contents were not stipulated. The regulation is to be interpreted according to local circumstances and conditions. Therefore, in the absence of strong public scrutiny, there is little accountability for how best to manage patient complaints.

There are no penalties attached to (failure to follow) regulation. For example, there is no administrative aspect to the regulatory guidelines. We wanted to write a penalty provision, but it was not based on the top legislation. The purpose of the

regulation is to emphasise self-discipline and to serve as guidance for the hospital. [The penalty was not enforceable,] so we decided to remove the penalty. It is indeed difficult and contradictory. (Female, Administrators-4, 30-11-2011)

Besides the legal system, the reporting system also has its problems. Some statistics about patient complaints and medical malpractice were utilized as a part of assessments of hospital performance, health care quality, and so on. This meant that the more cases that were reported, the worse the evaluations received by the hospitals so that hospitals were inclined to report selectively or report fewer cases.

There are certainly no statistics for the number of patient complaints. There is only the data on the number of medical malpractice cases per year from the Bureau of Health, and an approximate amount of compensation issued by insurance companies. In some cases, if complaints were solved just between the hospital and the complainant, we have no data. (Male, Administrators-2, 18-08-2011)

These days, the information regarding the management of patient complaints in hospitals is difficult to access. Hospitals are unwilling to provide that sort of information – it is considered confidential. We only have some profiles or the information from select hospitals. (Female, Policy makers-1, 16-12-2010)

Thus, the adoption of the incentive and sanction mechanism was contradictory for managing patient complaints. From one side, the administrative department wanted hospitals to report patient complaints because it is important for informing and improving the quality of care. From the other side, the more complaints that are

registered, the worse it would appear a hospital is doing. In addition to this, managing patient complaints remains low on the health reform agenda. The force for inspecting complaint management in hospitals from senior management and administrative departments remains weak.

[Having a statistic for patient complaints] is definitely necessary from the aspect of effective management. If this statistic is disposable, I think nothing of it. If the statistic is routine, in fact, it will cost [all sorts of resources]. (Male, Policy makers-2, 22-12-2011)

Hospitals doubt that the purpose of administration is for information management – to help them better handle and solve disputes. However, if you want me to report incidents but meanwhile punish me for that, then I have no incentive to report anything. This contradiction stands [in the way of effective reporting]. (Female, Administrators-4, 30-11-2011)

Deficient information system for managing patient complaints

Although the regulations in place require collecting and analysing information, there exists no clear classification, definitions or unified coding system. Most hospitals have established their own systems for recording complaints and analysing cases, but no accurate or comparable data are available.

In fact a lot of cases should be recorded and analysed, [but] we do not even take into account so-called major cases of medical malpractice, mass disturbance or medical malpractice. We cannot distinguish between these concepts…. Relatively

speaking, it is more feasible to publicize the data on public security, e.g. the number of police records and people arrested, and the number of crimes committed. Those definitions are more explicit, whereas those concerning complaints management are not. Because all statistics are calculated in the hospital, we find that where standards are slack, the resulting statistic is large and where standards are strict, the statistic is small. Hence, there is great variability in our results. (Male, Policy makers-2, 22-12-2011)

Identical forms are sent to two hospitals at a similar level and the reported data can be quite different. ...Some hospitals only reported cases resulting in compensation and some hospitals record all persons who voice a concern, while others only report cases identified as medical malpractice. But it is impossible for me to verify [the reported data] in each hospital. (Male, Administrators-2, 18-08-2011)

Hospitals have not publicized complaints; neither have health administration departments. The Shanghai Bureau of Health launched a pilot project in 2005 to publicize the complaints reported by all hospitals in Shanghai. The project was welcomed by the public but discontinued soon after its launch due to mounting pressure from the hospitals.

We already publicize complaints [medical malpractice] on our intranet for hospital staff. It is unnecessary to share this information on external sites. (Female, Hospital managers-4, 06-09-2011)

To my knowledge, such information was published once on the Xinmin Evening News in 2005. The newspaper named hospitals that had won awards and gave

details of the number of medical malpractice cases happening in each, as well as feedback regarding patient satisfaction. [We felt] the pressure was very, very high. It [publishing those] resulted in public outrage [from hospitals]. (Female, Administrators-4, 30-11-2011)

Unwillingness of hospitals to effectively handle complaints

Most hospitals did not devote much effort into managing complaints. There was no clear mechanism to utilize patient complaints to improve quality of care unless serious medical malpractice had occurred or complaints were found to recur.

Hospitals just handle complaints when complaints happen. …We are basically perfunctory, including hospitals, department directors and doctors. The best-case scenario for me: do not approach me for these things [complaints]. Deal with complaints quickly and efficiently; in other words, spend money to buy peace. The impact of managing and addressing complaints is negligible, with very little effect on improving medical procedures and quality. (Male, Administrators-2, 18-08-2011)

Hospital directors were the key actors of complaint management in hospitals. The incentive and sanction mechanisms in hospitals depended on how much attention directors pay to complaint management. In the 1980s the government reduced subsidies for public hospitals under the context of transforming the planned economy to a so-called socialist market in order to reduce inefficiencies in health care provision. Hospitals had to increase service charges to recoup the operational costs and to

increase the income level of health workers. Complaint management occupied nothing but a small part of quality health care, so in most hospitals it failed to draw attention from senior management. Most complaints were solved on a case-by-case basis, without sufficient concern for the overall improvement of health care services.

In practice, the head of department influences implementation. If he/she regards this as important, then subordinates work harder of course. Now the problem is that some heads of department do not pay attention to it [complaint management]. (Male, Health care providers-2, 16-09-2011)

It is of course medical services that are the core of hospital work. Things such as [complaint management] are boring for the hospital. To a hospital, the fewer the complaints, the better. (Male, Administrators-2, 18-08-2011)

Discussion and Conclusions

This study examined the handling system for patient complaints in China and the views of key stakeholders on the barriers to effective complaint management. Our study provided a new dimension for understanding the complaints management system in China, an emerging market country. Hospitals are the most important handler and manager of patient complaints in China and similarly for other developing countries, such as India and Vietnam.[22] We explored the barriers through in-depth interviews with almost all stakeholders, not only health professionals. We hope that our findings will help develop procedures for more effective complaint management and further improve the quality of care in China and other developing

countries.

To reduce the heavy burden placed on hospitals, t~~T~~he government has tried to seek help from other approaches aside from negotiation with hospitals~~, to reduce the heavy burden placed on hospitals~~. Initially, those other approaches were frequently welcomed and praised ~~at the beginning~~, but they seemed to ~~not to~~ be ineffective ~~or~~and inefficient. The effectiveness and efficiency of those other approaches needs further research. The selection of participants may introduce some bias to our studies. Due to our focus on the hospital, there may be an underrepresentation of certain types of respondents. Since there are no unified classifications for complaints, we did not include patients with different types of complaints. Moreover, we planned to recruit the same number of participants in multiple settings, but the number of participants from each was imbalanced because of information saturation.

We found that the three main project elements adopted from Hickson GB et al. were relevant and useful for the discussion of our results: (A) organizational supports, (B) commitment from key people, and (C) learning systems.[13]

A. Organizational Supports

Our findings showed that there are no standardized systems and procedures dealing with patient complaints in China due to conflicts between relevant actors and regulations. Having experienced rapid economic growth in the last 30 years, China is

undergoing a socioeconomic transition. Like other developing countries, policies lag behind the country's economic transition.[37, 38] The Ministry of Health has tried to guide health care providers by issuing special regulations, but health administrations do not apply strict regulations to complaint management. There lacks clear relationships between patient complaints and clinical outcomes or the quality of care.

The patient complaints in many Chinese hospitals are not well-managed and handled. Most hospitals manage patient complaints on only a case-by-case basis. They lack clear mechanisms linking patient complaints with improving the quality of care. Complaints are underutilised for organizational strategic planning or for changing an individual's behaviour and attitude. This implies that legislation should not only stipulate the principles and regulations of patient complaint management, but also the responsibilities of sectors at different levels.[39]

B. Commitment from People

The hospital leader is the key determinant for complaint handling inside the hospital. However, no apparent incentives exist to push hospital leaders to prioritize complaint handling. The power of complaint handling departments depends on how much the hospital leaders pay attention to it. Under current conditions, hospital leaders lack political will to manage complaints effectively, leading to inadequate human resources in complaint handling departments. The departments also lack the power to coordinate with clinical departments.

To alleviate patient complaints-related violence, civil groups, including service users and the hospital sector, should approve the guideline. In developed countries, patient complaint management provides guidelines not only for health care providers, but also clear guidelines for patients. This not only makes it more convenient for patients, but also plays a positive role in helping patients initiate the complaint process via legitimate means. This is crucial for society to view patient complaint in a rational way.

C. Learning Systems

If patient complaints can be better managed and rectified, the instances of failure would be reduced and quality would be improved.[40, 41] Greater emphasis should be placed on quality improvement after patients complain. Strategies to improve quality following patient complaints should be developed through a learning process.[42] To promote the learning process, appropriate mechanisms should be developed and implemented to assess not only the number of patient complaints occurring in hospitals, but also how these hospitals have handled these complaints. For example, reporting more patient complaints should not be necessarily punished, while effective handling of the patient complaints should be appreciated.

Our final conclusion is that barriers to the effective management of patient complaints vary at the different stages of complaint handling, from the user and provider side, as

well as systemic issues. Information, procedure design, human resources, system arrangement, a unified legal system and regulations and factors shaping the social context all play important roles in effective patient complaint management. Appropriate mechanisms should be developed to link patient complaints with improving the quality of care.

ACKNOWLEDGEMENT

The HESVIC project received funding from the European Commission Framework 7. The views represented in this document are not necessary representative of the European Commission's views and belong solely to the authors. The consortium would like to thank all the study respondents and participants for their willingness to take part in the research, as well as the members of the Country Research Advisory Groups for their support at every stage of the HESVIC project. The authors of the paper very much appreciate constructive comments and suggestions on earlier version of the paper from Shenglan Tang from Duke Global Health Institute, USA. The authors are also grateful to Ms. Kaori Sato for language editing.

COMPETING INTERESTS

None.

FUNDING

This study was supported by the European Commission Seventh Framework Programme (HEALTH-F2-2009-222970).

CONTRIBUTORSHIP STATEMENT

1) Yishi JIANG: substantial contributions to conception and design, acquisition of data, and analysis and interpretation of data; drafting the article and revising it; and final approval of the version to be published.

2) Xiaohua YING: substantial contributions to conception and design, acquisition of data, and analysis and interpretation of data; drafting the article; and final approval of the version to be published.

3) Qian ZHANG: substantial contributions to acquisition of data, and analysis and interpretation of data; drafting the article; and final approval of the version to be published.

4) Sirui Rae TANG: substantial contributions to analysis and interpretation of data; drafting the article; and final approval of the version to be published.

5) Sumit KANE: substantial contributions to conception and design, and analysis and interpretation of data; revising the article critically for important intellectual content; and final approval of the version to be published.

6) Maitrayee MUKHOPADHYAY: substantial contributions to conception and design, and analysis and interpretation of data; revising the article critically for important intellectual content; and final approval of the version to be published.

7) Xu QIAN: substantial contributions to conception and design, and analysis and interpretation of data; drafting the article and revising it critically for important intellectual content; and final approval of the version to be published.

8) HESVIC team authorship

DATA SHARING

No additional data available.

References:

1. Sage WM. Putting the patient in patient safety: linking patient complaints and malpractice risk. *JAMA* 2002;**287**:3003-5.
2. Hsieh SY. A system for using patient complaints as a trigger to improve quality. *Qual Manag Health Care* 2011;**20**:343-55.
3. Wofford MM, Wofford JL, Bothra J, et al. Patient complaints about physician behaviors: a qualitative study. *Acad Med* 2004;**79**:134-8.
4. Beecham L. Patients' complaints: GMC could do better. *BMJ* 1999;**319**:1022.
5. Anderson K, Allan D, Finucane P. A 30-month study of patient complaints at a major Australian hospital. *J Qual Clin Pract* 2001;**21**:109-11.
6. Ministry of Health. *Measures for the Handling of Patient Complaints in Hospitals (for Trial Implementation)*. Beijing: Ministry of Health; 2009.
7. The Henry J. Kaiser Family Foundation. Medical Malpractice Law in the United States. http://www.kff.org/insurance/upload/Medical-Malpractice-Law-in-the-United-States-Report.pdf Accessed [08-31-2012].
8. Hsieh SY. Healthcare complaints handling systems: a comparison between Britain, Australia and Taiwan. *Health Serv Manage Res* 2011;**24**:91-5.
9. Department of Health, United Kingdom. Complaints procedure. http://www.dh.gov.uk/health/contact-dh/complaints/ Accessed [08-31-2012].
10. Cornwall A, Romios P. Turning Wrongs Into Rights. *Health Issues* 2004;**79**:13-8.

11. Hickson GB, Federspiel CF, Pichert JW, et al. Patient complaints and malpractice risk. *JAMA* 2002;**287**:2951-7.

12. Pichert JW, Hickson G, Moore I. Using Patient Complaints to Promote Patient Safety. *Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 2: Culture and Redesign)*. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008.

13. Hickson GB, Moore IN, Pichert JW, et al. Balancing systems and individual accountability in a safety culture. *From Front Office to Front Line: Essential Issues for Health Care Leaders, 2nd ed*. Oakbrook Terrace, IL: Joint Commission Resources; 2012. p. 1-35.

14. Vincent C, Davis R. Patients and families as safety experts. *CMAJ* 2012;**184**:15-6.

15. Xi X. *Understanding and application of provisions in the Tort Liability Law*. Beijing: Press of the People's Court; 2010.

16. Chinese doctors are under threat. *Lancet* 2010;**376**:657.

17. Zheng XQ, Wei LY, Zhang BZ, et al. Domestic Survey of Medical Disputes and Foreign Medical Dispute Handling. *Chinese Hospitals* 2007; **7**:2-4.

18. Stafford C. Moral ambivalence in modern China. *The Lancet* 2012;**9818**:793.

19. Communicating concern: complaints against doctors. *Lancet* 2013;**382**:1382.

20. Zhuang Y, Zhong C, Liu J, et al. A survey and analysis of complaint management in five tertiary hospitals. *Chinese Journal of Hospital Administration* 2006;**22**:45-8.

21. Gan N, Yu T, Chen W, et al. Analysis of differences in cognition between doctors

and patients and causes of medical disputes. *Journal of Shanghai Jiaotong University (Medical Science)* 2008;**28**:1035-7.

22. Gao J, Cao W, Xu Y, et al. Survey analysis of consultation settlement for medical disputes in 30 medical institutions of Shanghai. *Journal of Shanghai Jiaotong University (Medical Science)* 2010;**30**:960-3.

23. Green A, Gerein N, Mirzoev T, et al. Health policy processes in maternal health: a comparison of Vietnam, India and China. *Health Policy* 2011;**100**:167-73.

24. Charmaz K. *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. Thousand Oaks, CA: Sage Publications, 2006.

25. Sadler GR, Lee HC, Lim RS, et al. Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nurs Health Sci* 2010;**12**:369-74.

26. Lacey A, Luff D. *Qualitative Research Analysis*. The NIHR RDS for the East Midlands / Yorkshire & the Humber, 2007.

27. Department of Health, NSW. *Complaint Management Guidelines*. North Sydney NSW: Guidelines; 2006.

28. State Council. *Regulation on the Handling of Medical Malpractices*. Beijing: Decree of the State Council; 2002.

29. Standing Committee of the Eleventh National People's Congress. *Tort Law of the People's Republic of China*. Beijing: Presidential Decree; 2009.

30. Ministry of Health. *Measures for the Complaint Letters and Visits System for Healthcare*. Beijing: Ministry of Health; 2007.

31. Shanghai Justice Bureau and Health Bureau. *Opinions on Regulating People's Mediation Organizations to Participate in Medical Dispute Mediation*. Shanghai: Shanghai Justice Bureau and Health Bureau; 2008.

32. Ministry of Justice, Ministry of Health, and China Insurance Regulatory Commission. *Opinions on Strengthening People's Mediation for Medical Disputes*. Beijing: Ministry of Justice, Ministry of Health, and China Insurance Regulatory Commission; 2010.

33. Shanghai Justice Bureau and Health Bureau. *Measures on People's Mediation for Medical Disputes in Shanghai*. Shanghai: Shanghai Justice Bureau and Health Bureau; 2011.

34. Yan X. Correctly Receive Medical Complaints and Establish Harmonious Doctor-patient Relationship. *Modern Hospital Management* 2008;**6**:24-5.

35. Manouchehri MJ, Ibrahimipour H, Sari AA, et al. Study of patient complaints reported over 30 months at a large heart centre in Tehran. *Qual Saf Health Care* 2010;**19**:e28.

36. Siyambalapitiya S, Caunt J, Harrison N, et al. A 22 month study of patient complaints at a National Health Service hospital. *Int J Nurs Pract* 2007;**13**:107-10.

37. Grundy J, Khut QY, Oum S, et al. Health system strengthening in Cambodia-a case study of health policy response to social transition. *Health Policy* 2009;**92**:107-15.

38. Luong DH, Tang S, Zhang T, et al. Vietnam during economic transition: a tracer study of health service access and affordability. *Int J Health Serv* 2007;**37**:573-88.

39. Shaw K, Cassel CK, Black C, et al. Shared medical regulation in a time of increasing calls for accountability and transparency: comparison of recertification in the United States, Canada, and the United Kingdom. *JAMA* 2009;**302**:2008-14.

40. Winkler F. Complaints by patients. *BMJ* 1993;**306**:472-3.

41. Baker R. Learning from complaints about general practitioners. *BMJ* 1999;**318**:1567-8.

42. Mintzberg H. The Fall and Rise of Strategic Planning. *Harvard Business Review* 1994:107-14.

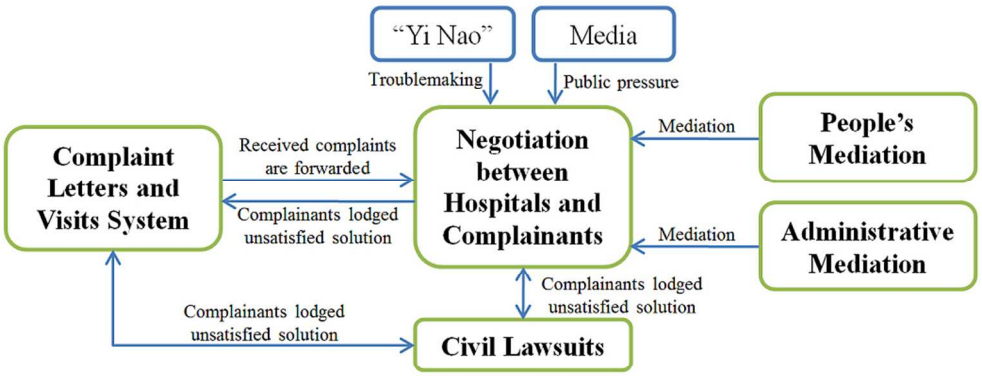

Figure 1 The structure of managing patient complaints in China

90x41mm (300 x 300 DPI)

Qualitative research review guidelines – RATS

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
R Relevance of study question	
Is the research question interesting?	YES. Research question was explicitly stated.
Is the research question relevant to clinical practice, public health, or policy?	YES. Research question is justified and linked to the existing knowledge base (empirical research, policy).
A Appropriateness of qualitative method	
Is qualitative methodology the best approach for the study aims? • *Interviews:* experience, perceptions, behaviour, practice, process • *Focus groups:* group dynamics, convenience, non-sensitive topics • *Ethnography:* culture, organizational behaviour, interaction • *Textual analysis:* documents, art, representations, conversations	YES It is difficult to measure the regulation process quantitatively.
T Transparency of procedures	
Sampling	
Are the participants selected the most appropriate to provide access to the type of knowledge sought by the study?	YES. The respondents were sampled by the whole research framework: the regulation
Is the sampling strategy appropriate?	

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
	process. Different types of respondents were helpful for holistic understanding for transparency deficits. Key informants were interviewed by snowball sampling and saturation.
Recruitment	
Was recruitment conducted using appropriate methods?	In the methods part, it shows details of how recruitment was conducted and by whom.
Is the sampling strategy appropriate?	YES
Could there be selection bias?	The selection of participants might bring some bias to our studies. Our focus was on the hospital, so some types of respondents may have been under-represented. Moreover, we planned to recruit the same number of participants in multiple settings, but the number of participants from each was imbalanced because of information saturation.
Data collection	
Was collection of data systematic and comprehensive?	YES, the interview questions were introduced.
Are characteristics of the study group	YES. We just focused on their

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
and setting clear?	role/group on the regulation process.
Why and when was data collection stopped, and is this reasonable?	YES. The principle of saturation was used.
Role of researchers	
Is the researcher(s) appropriate? How might they bias (good and bad) the conduct of the study and results?	YES. Our research group is multidisciplinary, including social science, clinical medicine and public health.
Ethics	
Was informed consent sought and granted?	YES. Informed consent process was explicitly and clearly detailed.
Were participants' anonymity and confidentiality ensured?	YES.
Was approval from an appropriate ethics committee received?	YES. Ethics approval was cited.
S Soundness of interpretive approach *Analysis*	
Is the type of analysis appropriate for the type of study? • *thematic:* exploratory, descriptive, hypothesis generating • *framework:* e.g., policy • *constant comparison/grounded*	YES. Analytic approach was justified.

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
theory: theory generating, analytical	
Are the interpretations clearly presented and adequately supported by the evidence?	YES.
Are quotes used and are these appropriate and effective?	YES.
Was trustworthiness/reliability of the data and interpretations checked?	YES, but it wasn't shown in the paper. We triangulated between interviews from various types of respondents, and different disciplines. We also trail the findings with observation.
Discussion and presentation	
Are findings sufficiently grounded in a theoretical or conceptual framework?	YES.
Is adequate account taken of previous knowledge and how the findings add?	YES.
Are the limitations thoughtfully considered?	YES
Is the manuscript well written and accessible?	YES
Are red flags present? These are common features of ill-conceived or poorly executed qualitative studies, are a cause for concern, and must be	NO

ASK THIS OF THE MANUSCRIPT	THIS SHOULD BE INCLUDED IN THE MANUSCRIPT
viewed critically. They might be fatal flaws, or they may result from lack of detail or clarity.	