



Managing patients' complaints in China: what went wrong?

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| Journal: | <i>BMJ Open</i> |
| 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 |
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Title page

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4 8) HESVIC team authorship
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8
9 4. Up to five keywords or phrases suitable for use in an index (it is recommended to
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11 use MeSH terms).
12

13 Patient Complaints; Complaint Handling Systems; Quality Improvement;
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15 Government Regulation; China
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20
21 5. Word count - excluding title page, abstract, references, figures and tables.
22

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24 6566
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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.

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4 **Conclusions:** Barriers to the effective management of patients' complaint vary at the
5
6 different stages of complaint handling, from the user and provider side, as well as
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8 system issues. Information, procedure design, human resources, system arrangement,
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10 unified legal system and regulations and factors shaping the social context all play
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12 important roles in effective patient complaint management.
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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

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4 with all categories of key informants.
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6 3. Hospitals undertake the most responsibility of patients' complaint
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8 handling.
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11 4. Barriers to the effective management of patients' complaint vary at
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13 the different stages of complaint handling, from the user and
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15 provider side, as well as system issues.
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19 5. Information, procedure design, human resources, system
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21 arrangement, unified legal system and regulations and factors
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23 shaping the social context all play important roles in effective
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25 patient complaint management.
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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

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4 threats and assaults targeting doctors and management.[9] These incidents are only
5
6 indicative of rising expectations, burgeoning patient discontent with services and
7
8 dissatisfaction towards the manner in which matters are resolved.[10] Public outcry
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10 only exacerbates the need for more effective handling of individual cases under the
11
12 overarching agenda for public hospital reform in China.[11]
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18 In countries such as Australia and Britain, the state has sought to monitor complaints
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20 and complaint handling to improve and regulate the practice of health
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22 professionals.[12] A feedback system of this sort has proven instrumental in
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24 improving the quality of care. In Britain, the National Health Service (NHS) not only
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26 provides clear and transparent guidelines for both health providers and patients but
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28 also publicizes information regarding the routine reporting of patients' complaints.[13]
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33 In Australia, a large study was conducted before *Guide to Complaint Handling in*
34
35 *Health Care Services* was formulated and subsequently updated.[14] Annually,
36
37 statistics are compiled and published, detailing complaint trends, complaint
38
39 management and reasons for complaints. Effective handling of complaints has been
40
41 known to reduce friction between providers and consumers, with the even greater
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43 benefit of improving quality of care. As a supplement to peer review and
44
45 administration, patients' complaints can provide important feedback concerning the
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47 delivery of health care services and can be a useful tool in the improvement of health
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49 care quality.[1-3, 15, 16]
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4 Amidst soaring angst, the Chinese government have put in place a system for redress
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6 where grievances arise. A “complaint” is defined as *the behaviour of a patient or*
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8 *his/her representative(s) which signifies dissatisfaction towards medical services,*
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10 *nursing services, as well as treatment conditions through letters, calls or visits to the*
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12 *hospital where the purpose of these actions is to criticise the hospital and/or claim*
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14 *compensation”.*[17]
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21 Notwithstanding the alarming extent of these issues, few attempts have been made to
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23 formally examine how hospital complaints are addressed in developing countries. It is
24
25 only recently that a handful of studies in China have sought to provide some
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27 understanding of the issue, by trying to ascertain the number of complaints and
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29 garnering patient feedback via questionnaires and interviews. A fuller understanding
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31 of the complaints system- the available channels for seeking redress, how the system
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33 operates and the barriers to conflict resolution- will be crucial to ameliorating the
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35 often fraught relationship between health care providers and consumers. The purpose
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37 of this study has been to examine the handling system for patients’ complaints in
38
39 China; to subsequently identify and analyse the various hospital-specific factors
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41 preventing grievances from being effectively addressed. The authors of this paper
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43 hope that such an undertaking- in strengthening clinical governance and enhancing
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45 doctors’ performance- will reduce malpractice and above all, improve health service
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47 outcomes.
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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

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4 Shanghai municipal levels. Special focus was put on patients' complaint management
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6 in hospitals, as we found that the vast majority of complaints are handled and resolved
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8 within the hospitals.[19]
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10 11 12 13 **Phase Two and Three: semi-structured interviews** 14

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16 Based on our understanding of the current patient complaint handling system, we then
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18 performed semi-structured interviews with key stakeholders- policy makers from the
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20 national level, administrators from the Shanghai municipal level, hospital managers,
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22 health providers, users and other related parties. We used the snowball sampling
23
24 method to identify key stakeholders and collect important feedback from key
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26 informants from various disciplines.[20, 21]
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34 In Phase Two (October-December 2010), a key actor from each of the three
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36 administrative levels were selected and interviewed: a policy-maker at the national
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38 level, a municipal administrator and a hospital manager. A pilot study was conducted
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40 to test the topic guidelines developed. These would allow us to gain a preliminary
41
42 understanding of the process of complaint management in the hospital setting of
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44 China, and refine the data collection tools. These interviews served as the basis for the
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46 design of Phase Three interviews where some of those being interviewed in the third
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48 phase were respondents recommended by Phase Two interviewees.
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56 Interviews in Phase Three were conducted from August-December of 2011. Key
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4 stakeholders were interviewed in select hospitals based on location, level and type.
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6 Our sample was representative of both urban and suburban areas in Shanghai. General
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8 hospitals and specialist hospitals were selected. Phase Three began with interviews of
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10 hospital managers and health providers proposed in Phase Two. We asked
11
12 interviewees from Phase Two to invite patients and other relevant stakeholders to
13
14 contribute their views. Those invited patients had used different channels for lodging
15
16 their complaints. However, they all shared one thing in common: all patients had first
17
18 complained to the hospital. We then proceeded to interview the administrators and
19
20 finally a high-level policy-maker. We continued to interview respondents, collecting
21
22 and analysing their comments and feedback until no new themes emerged i.e.
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24 saturation had been reached. The number of participants involved in the different
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26 types of interviewees is depicted in Table 1.
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36 Semi-structured interviews were conducted with 35 respondents face-to-face except
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38 one, via telephone. The interviews took place at private locations, for example at the
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40 institution where the interviewee or interviewer worked and were conducted by two of
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42 the authors of this paper. Each interview lasted 1-2 hours and was audio-taped with
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44 permission, apart from two which were not recorded but typewritten upon the
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46 respondents' request.
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51 Table 1 The number of participants from different types of interviewees
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| Types of interviewees | Level | Number of |
|-----------------------|-------|--------------|
| | | Participants |

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|----|---|--------------------|-----------|
| 1 | | | |
| 2 | | | |
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| 4 | Policy-makers | National | |
| 5 | | | |
| 6 | Ministry of Health | | 1 |
| 7 | | | |
| 8 | A university | | 1 |
| 9 | | | |
| 10 | | | |
| 11 | Administrators | Shanghai municipal | 4 |
| 12 | | | |
| 13 | Hospital managers | | |
| 14 | | | |
| 15 | | | |
| 16 | General hospital | Tertiary | 3 |
| 17 | | | |
| 18 | General hospital | Secondary | 3 |
| 19 | | | |
| 20 | Specialized hospital | Tertiary | 1 |
| 21 | | | |
| 22 | Specialized hospital | Secondary | 1 |
| 23 | | | |
| 24 | Private hospital | Secondary | 2 |
| 25 | | | |
| 26 | | | |
| 27 | | | |
| 28 | | | |
| 29 | Health providers | | 6 |
| 30 | | | |
| 31 | Users | | 6 |
| 32 | | | |
| 33 | | | |
| 34 | Other actors | | |
| 35 | | | |
| 36 | Municipal Health Inspection Institute | | 2 |
| 37 | | | |
| 38 | Lawyers for medical disputes | | 2 |
| 39 | | | |
| 40 | The centre that processes medical liability | | 1 |
| 41 | | | |
| 42 | | | |
| 43 | insurance | | |
| 44 | | | |
| 45 | | | |
| 46 | The People's Mediation Committee for | | 1 |
| 47 | | | |
| 48 | | | |
| 49 | Medical Disputes | | |
| 50 | | | |
| 51 | The Complaint Letters and Visits System | | 1 |
| 52 | | | |
| 53 | | | |
| 54 | 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

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4 group arrived at a consensus. Our study was approved by Institutional Review Board
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6 (IRB), School of Public Health, Fudan University.
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10 11 **Findings**

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13 This section first presents a number of approaches developed and implemented in
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15 Shanghai to handle patients' complaints. It then focuses on the approach of
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17 Negotiation between Hospitals and Complainants, identifies its barriers, and proceeds
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19 to examine and analyse these barriers.
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26 **1. Approaches and mechanisms used in managing patients' complaints**

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28 The study identifies both formal and informal approaches and mechanisms used in
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30 handling patients' complaints.
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- 36 ● Negotiation between Hospitals and Complainants

37
38 The complaint handling department within the hospital is responsible for dealing with
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40 patients' complaints, first established on February 20, 2002, in accordance with the
41
42 *Regulation on the Handling of Medical Malpractices*.^[23] Since November 2009,
43
44 these departments have been regulated by *Measures for the Handling of Patient*
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46 *Complaints in Hospitals (for Trial Implementation)*.^[17] These acts require that a
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48 medical institution establishes a department specifically for the purpose of handling
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50 and resolving medical disputes. The department is primarily responsible for receiving
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52 patients' complaints- via calls, letters, visits, and/or cases referred from other
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4 departments and institutions. Their role also includes counselling and communicating
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6 with patients, verifying and documenting disputes as well as resolving disputes.
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11 ● Administrative Mediation and Civil Lawsuits
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14 If the hospital is unable to resolve certain conflicts through negotiation, these cases
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16 may be referred to an external body such as the health administrative department. Or
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18 they may be settled in the court by means of litigation. The *Tort Law of the People's*
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20 *Republic of China*, adopted at the twelfth session of the Standing Committee of the
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22 Eleventh National People's Congress on December 26 2009, provided a new legal
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24 definition of liability for medical malpractice, liability presumption and
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26 exemption.[24]
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34 ● Complaint Letters and Visits System
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37 In February 2007, *Measures for the Complaint Letters and Visits System for*
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39 *Healthcare* came into force.[25] Its purpose is to protect the legal rights and interests
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41 of citizens, legal entities and other organizations, regulate behaviour and maintain
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43 order within the Complaint Letters and Visits System. It requires health administrative
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45 departments to set up the Complaint Letters and Visits office at different levels. These
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47 offices are responsible for receiving, assigning and transferring matters as appropriate,
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49 as well as supervise in the handling of various issues and complaints.
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56 ● People's Mediation- a form of Third-Party Facilitated Mediation
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4 In July 2008, the Shanghai Justice Bureau and Health Bureau issued *Opinions on*
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6 *Regulating People's Mediation Organizations to Participate in Medical Dispute*
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8 *Mediation*, to establish the People's Mediation Committees for Medical Disputes.[26]
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10
11 Committee members mainly consist of retired judges and doctors. They serve to
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13 mediate disputes through reporting, explaining and analysing cases under the
14
15 supervision of local judiciary. In January 2010, the Ministry of Justice, the Ministry of
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17 Health and the China Insurance Regulatory Commission jointly issued *Opinions on*
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19 *Strengthening People's Mediation for Medical Disputes* to strengthen the role of
20
21 mediation in resolving medical disputes.[27] Its intent is to settle medical disputes in
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23 an effective way and maintain order within hospitals, all with a view for ensuring
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25 harmony and social stability. In July 2011, the Shanghai Justice Bureau and Health
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27 Bureau introduced *Measures on People's Mediation for Medical Disputes in Shanghai*
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29 to replace *Opinions on Regulating People's Mediation Organizations to Participate in*
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31 *Medical Dispute Mediation*. [26, 28]
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41 Further to the aforementioned channels of complaint, patients have been found to
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43 express their discontent by exhibiting disruptive behaviour within the hospital-
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45 targeting doctors and nurses or hospital managers- by way of abuse, assault and other
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47 forms of violence. Much of this has garnered media attention, resulting in bad
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49 publicity for the hospital and damaging the reputation of doctors and staff.
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56 **2. The application of different complaint approaches**

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4 There shows the complex relationships between different approaches can be seen
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6 where many actors are involved. From the aspect of solution, approaches which can
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8 resolve medical disputes are mainly negotiation and civil lawsuits, while other
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10 approaches play a part in forwarding cases, such as Complaint Letters and Visits
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12 System or easing conflicts, such as mediation. Not any of the approaches is
13
14 considered the most authoritative approach. Patients can continue to lodge complaints
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16 through the Complaint Letters and Visits System even if a decision has been finalised
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18 after a second trial in court.
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26 In the above-mentioned approaches, the hospital is the main handler for patients'
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28 complaints. First of all, it can handle patients' complaints completely independently,
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30 from reception to solution, while the other approaches have to engage hospitals in
31
32 complaint handling. Secondly, since the hospital is principally responsible for
33
34 compensation, the complainant is more inclined to directly negotiate with hospital.
35
36 From the literature it is found that the majority of medical disputes are resolved by
37
38 negotiation between hospitals and complainants.[19] Thirdly, if hospitals handle
39
40 complaints improperly, conflicts will become more volatile, resulting in serious
41
42 incidents.[29] Therefore, hospitals have become the most common receiver, handler
43
44 and resolver of disputes. (Figure 1)
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54 **3. Barriers to the effective management of patient complaints and their**
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56 **underlying causes at different stages of the complaint process**
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4 Our interviews revealed that different hospitals often use different complaint systems.
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6 For example, some hospitals operate a centralized complaints office, which may or
7
8 may not be independent of the Medical Affairs (Administration) Department. Other
9
10 hospitals have several complaints offices, each of which is responsive to different
11
12 kinds of complaints. Complaint departments are generally managed by a hospital's
13
14 deputy director, who also heads hospital complaint management. Barriers to effective
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16 complaints management varies at different stages of the complaint process- both from
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18 the sides of the user and provider.
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26 ● **Barriers to initiating the complaint process**

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

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31 Although hospital staff claimed that the complaints office was accessible to those with
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33 grievances, patients did not always feel this was the case. One user looked up the
34
35 hospital telephone number on the Internet and she said the complaint handling process
36
37 was "very easy" while others did not concur. Almost all patients being interviewed
38
39 found that signs and directions (to the complaints office) failed to catch the eye. In
40
41 some cases none could be seen at all:
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46 *I wanted to lodge a complaint, but did not know how to find the place [the*
47 *complaints office]... Because the hospital was so big, I did not know which*
48 *department [was responsible for handling complaints]. ...I simply did not know*
49 *who to turn to. You see, the complaints department was in another building [rather*
50 *than in the one in which I was treated i.e. the clinical department] (Female, Users-1,*
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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

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4 *spend more time communicating with patients, they would lose time needed to carry*
5
6 *out [clinical work]. That is to say, [doctors should be given] less [clinical] work,*
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8 *and more time to explain their work to patients. Our workload is very heavy, like a*
9
10 *battle. (Female, Health providers-1, 01-09-2011)*

Incompetence and powerlessness of complaints handlers

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19 Complaint handlers played a more important role in cooperation and coordination.
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21 Although the complaint department was specifically set up in hospitals for receiving
22
23 and handling complaints, the responsible persons in the department were mainly
24
25 part-time medical staff. In some cases, those handling staff had been found to be
26
27 inadequate- sometimes due to lack of training. Many of them had studied handling
28
29 techniques on their own and had not acquired sufficient professional skills to
30
31 appropriately analyse, assess and solve complaints.
32
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34

35
36 *Complaint handlers in the hospitals cannot solve everything. Because the*
37
38 *disciplines involved in complaints are highly specialised. I am only familiar with*
39
40 *general surgery and issues that require common sense, but [I am not familiar] with*
41
42 *professional problems in other disciplines. (Male, Hospital managers-5,*
43
44 *08-09-2011)*

45
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47
48
49 *It is difficult to recruit staff for our Medical Dispute Handling Office. No one wants*
50
51 *to come. A boy recruited in 2007 could not stand the demands of the job*
52
53 *[complicated disputes and violence] and so resigned. (Female, Hospital*
54
55 *managers-3, 31-08-2011)*

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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

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3
4 information exchange was largely limited to hospital staff. In fact, it was found that
5
6 staff at the complaints office were generally evasive towards patients who arrived
7
8 wishing to be updated with the specifics of their complaint. The complainant had no
9
10 opportunity to directly engage in the handling of the complaint or to meaningfully
11
12 participate in the process. In addition, hospitals tended to oversimplify cases,
13
14 assuming that the complainant's only desire was to report their complaint and ask for
15
16 compensation. All this implies that the entire handling process is disclosed only
17
18 among hospital staff. Therefore, the process becomes a "black box" to patients. It is
19
20 easy for the hospital to manipulate a complainant by providing limited information to
21
22 gain advantage in negotiations i.e. reduce loss from compensating patients.
23
24
25
26
27

28
29 *Sometimes you have to circumvent something and use negotiating skills. Mistakes in*
30
31 *medical services do not necessarily harm patients' health, but they can be very*
32
33 *serious for the provider [...] for example, someone may not be very careful when*
34
35 *writing a medical record and alter it by accident. But you are likely to lose a*
36
37 *lawsuit on the grounds of having tampered with records. Incidents such as these*
38
39 *clouds matter; making transparency difficult. (Female, Hospital managers-2,*
40
41 *25-08-2011)*
42
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46
47 If the incident is urgent or presents itself as a recurring problem, this incident might
48
49 be shared to educate healthcare providers. But disclosure to complainants themselves
50
51 remains limited. Only outcomes deemed to be of direct interest to patients including
52
53 compensation amounts and medical service privileges were provided. Other results,
54
55 however, including penalties imposed upon physicians and departments or
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4 improvements made to hospital services were largely withheld from patients if they
5
6 did not ask.
7

8
9 *In individual cases, what are the outcomes of their complaints? How might a*
10
11 *physician be punished/penalised/disciplined? Such information is requested by*
12
13 *patients only occasionally. (Male, Health providers-2, 16-09-2011)*

14
15
16 *I want to know how to better educate the concerned health care providers. But I*
17
18 *have not been told. (Female, Users-3, 20-09-2011)*
19

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23
24 ● **Barriers to resolving conflict and reaching agreement**

25
26 **Conflicts between relevant actors and regulations**

27
28
29 Within the complaints system, conflicts or inconsistencies can arise between the legal
30
31 system for handling complaints and the solutions determined by the hospital. As the
32
33 structure of managing patients' complaints is shown in Figure 1, different regulations
34
35 stipulate different approaches. There does not exist a unified law or guidelines to
36
37 clearly illustrate the relationships between different approaches. It results in problems
38
39 such as lack of authority or ultimate approach, uncertainty about how to apply
40
41 different regulations to one case and no clear definitions or classifications as regards
42
43 patients' complaints.
44
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48
49 *The current state of complaint management is disorderly. There are too many*
50
51 *channels. For example, many departments are involved, including but not limited to*
52
53 *Complaint Letters and Visits, online complaints etc. The Health Bureau has two*
54
55 *departments [for complaint management], each district has a mediation office, a*
56
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4 *district government website or a mayor-mail [to receive complaints], and a*
5
6 *Complaint Letters and Visits office... Far too many heads of department within the*
7
8 *health sector; it's chaos. (Male, Health providers-2, 16-09-2011)*

9
10
11 *Hospitals are required to report complaints to a lot of sectors, all of which wish to*
12
13 *understand the issue from different angles. There are not necessarily conflicts*
14
15 *between regulations, but different elements are emphasised. Hospitals are tired of*
16
17 *these kinds of bureaucracy. ...Each sector carries out their designated duties where*
18
19 *resources are not shared. The information possessed by each sector is fragmented.*
20
21

22
23
24 *You know yours, I know mine. (Male, Administrators-2, 18-08-2011)*

25
26 *Medical malpractice is defined clearly in the Regulation on Handling Medical*
27
28 *Malpractice. There are several benchmarks determining the amount of*
29
30 *compensation issued. After the Tort Liability Law of the People's Republic of China*
31
32 *was promulgated, [medical damage] was compensated for more in accordance with*
33
34 *the Tort Liability Law, because it stipulates compensation for personal injury.*
35
36
37
38
39 *(Female, Hospital managers-2, 25-08-2011)*

40 41 42 43 44 **Unjustifiable complaints by patients**

45
46 In some cases, the patient experiences inconvenience when receiving medical services
47
48 not because of poor conduct in attitude or behaviour on the part of health providers. It
49
50 may be the case of long waiting times, too little time spent with the doctor and/or
51
52 imperfect resources allocation. These are health system issues rather than problems
53
54 caused by hospitals or individual physicians. And so to a certain extent, physicians
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3
4 and hospitals have become scapegoats of the entire health system.

5
6 *At times it is not us physicians who have made a patient angry. Certain factors are*
7
8 *rooted in the fabric of health care systems, but we physicians [end up] taking the*
9
10 *blame. (Male, Health providers-3, 16-09-2011)*

11
12
13
14 *For example, should a doctor need to see sixty patients in half a day, or indeed one*
15
16 *hundred, you cannot demand that he puts on a smile for each one. A lot of patients*
17
18 *complain about doctors with a straight face, but I think it is understandable. I have*
19
20 *a very good relationship with our young doctors. They operate on a tight schedule.*
21
22 *This week someone works at outpatient's. He is friendly with patients in the first*
23
24 *month but struggles to sustain this sort of demeanour. He is not in the mood to smile*
25
26 *at patients or engage in long conversations when he only has time to attend to their*
27
28 *illnesses. (Male, Hospital managers-1, 15-12-2010)*
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36 For example, dissatisfaction voiced in the hospital may be related to health insurance
37
38 policy rather than staff behaviour. Hospitals need to follow the policies made by
39
40 Health Insurance Department. The purpose of those policies was to improve rational
41
42 use of medicines and control healthcare cost, while the patients covered by health
43
44 insurance may demand more medicines.
45
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48
49 *Chinese doctors have many rules to obey [this is to curb poor conduct]. The*
50
51 *pressures for them to perform are relatively large. For example, doctors cannot*
52
53 *prescribe too much medicine for a patient who has only [basic state-financed]*
54
55 *medical insurance, but patients always want more. A while ago, the Medical*
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4 *Insurance Bureau issued the following statement in a newspaper: The Medical*
5
6 *Insurance Bureau never limits the volume of drugs prescribed, rather it is the doing*
7
8 *of hospitals who wish to increase workload [in order to produce more statistics]. I*
9
10 *think this is really unreasonable. The Bureau does not control the quantity of drugs*
11
12 *prescribed in any given week, but there is a total quantity limit over a year. Doctors*
13
14 *try their best not to prescribe drugs which must be self-financed i.e. not covered by*
15
16 *basic medical insurance. They must also explain very clearly before prescribing*
17
18 *self-financed drugs, otherwise, patients will lodge complaints once they find out.*
19
20
21
22
23
24 *(Male, Hospital managers-1, 15-12-2010)*

25
26 *Complaints occur where the patient wants more drugs but the doctor has refuse to*
27
28 *satisfy his or her demands. Why? The health insurance institution sets a limit for*
29
30 *drug expenditure for each hospital; in turn, the hospital sets a limit for each doctor.*
31
32
33
34 *So if a doctor has too many patients drawing from their health insurance scheme in*
35
36 *any one month, he or she may very possibly have exceeded his/her limit. (Male,*
37
38 *Health providers-3, 16-09-2011)*

39
40
41 *[A patient who has] basic state-financed medical coverage is entitled to blood and*
42
43 *other auxiliary examinations. If the number of health checks prescribed exceeds a*
44
45 *certain threshold, the doctor is viewed as exploiting basic medical insurance. The*
46
47 *doctor is consequently punished. I was deducted more than seven hundred yuan*
48
49 *(RMB) because of a case like this. I feel this is simply absurd- it is [unexpectedly]*
50
51 *doctors who are to blame. Nothing seems to be wrong with the patient. ...The*
52
53 *hospital can't do anything about medical insurance. I think this kind of thing is not*
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4 *the problem at the hospital level. The complaints about medical insurance define*
5
6 *without doubt problems underlying state and society. (Male, Health providers-4,*
7
8 *16-09-2011)*
9

10
11 In addition, the safety of health providers is under threat in China today. Chinese
12
13 medical workers are often victims of terrible violence. As a consequence, some health
14
15 providers have decided not to treat patients deemed likely to assault staff, exhibit
16
17 disruptive behaviour or prove difficult to deal with. Prescribing redundant check-ups
18
19 and drugs are alternatives to properly seeing to patients.
20
21

22
23 In our interviews, fifteen interviewees mentioned “Chao” fifty-five times. “Chao” in
24
25 Chinese means to argue with hospitals for patients’ own rights and interests, while the
26
27 other meaning is wrangle fiercely in hospitals or with senior management. Most of the
28
29 hospital staff being interviewed suggest that some complainants are indeed
30
31 unreasonable and impulsive, whose sole purpose is to ask for money.
32
33

34
35 *If the case goes to court, the patient gathers a lot of people to go to the court,*
36
37 *insulting and threatening concerned health care providers and their lawyers. That*
38
39 *is not what we want to see. We want to talk about the truth, by thoroughly*
40
41 *publicizing the truth. We cannot always be too specific with terminology [for fear of*
42
43 *revealing too much]. When completely refuted, patients lose their temper. (Male,*
44
45 *Other actors-2, 15-09-2011)*
46
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48

49
50 *I feel that the widespread situation in China today is that you can do nothing if you*
51
52 *run into the unreasonable. The legitimate way of going about this is once I receive*
53
54 *your complaint, a fair decision is proposed. If complainants are not willing to settle*
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4 *for this, we then transfer their case to other departments. However, complainants*
5
6 *may not even agree to that, causing trouble and even threatening the safety of*
7
8 *health care providers. (Female, Hospital managers-2, 25-08-2011)*

9
10
11 *The claim a complainant demands goes beyond the actual problem [but for the*
12
13 *money] and he does not wish to resolve it in the legal way. ...Nowadays “Yi Nao”*
14
15 *has brought about serious social effects, and escalated the tension between service*
16
17 *users and providers. Complainants are unwilling to resolve things the legal way,*
18
19 *rather, just pestering and hassling you [health care providers or complaint handlers]*
20
21 *all day. (Male, Hospital managers-6, 01-11-2011)*
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29 ● **Barriers to post-complaint institutional changes for quality improvement**

30
31 **Weak enforcement of the regulation**

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34 The regulation for managing patients' complaints is merely a guideline, which
35
36 contains no mandatory requirements such as assessment mechanisms. Because it takes
37
38 into account the difference in local conditions throughout China, specific contents
39
40 were not stipulated. The regulation is to be interpreted according to local
41
42 circumstances and conditions. In the absence of strong public scrutiny, therefore, there
43
44 is little accountability for how best to manage patients' complaints.
45
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48
49 *There are no penalties attached to (failure to follow) regulation. For example, there*
50
51 *is no administrative aspect to the regulatory guidelines. We wanted to write a*
52
53 *penalty provision, but it was not based on the top legislation. The purpose of the*
54
55 *regulation is to emphasise self-discipline and serve as guidance for the hospital.*
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[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

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4 inspecting complaint management in hospitals from senior management and
5
6 administrative departments remains weak.
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8
9 *[Having a statistic for patients' complaints] is definitely necessary, from the aspect*
10
11 *of effective management. If this statistic is disposable, I think no problem. If the*
12
13 *statistic is routine, in fact, it will cost. (Male, Policy makers-2, 22-12-2011)*

14
15
16 *Hospitals doubt that the purpose of administration is for information management-*
17
18 *to help them better handle and solve disputes. However, if you want me to report*
19
20 *incidents but meanwhile punish me for that, then I have no incentive to report*
21
22 *anything. This contradiction stands [in the way of effective reporting]. (Female,*
23
24 *Administrators-4, 30-11-2011)*
25
26
27

28 29 30 31 **Deficient information system for managing patients' complaints**

32
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34 Although the regulations in place require collecting and analysing information, there
35
36 exists no clear classification, definitions or unified coding system. Most hospitals
37
38 have established their own systems for recording complaints and analysing cases, but
39
40 no accurate or comparable data are available.
41
42

43
44 *In fact a lot of cases should be recorded and analysed, [but] we do not even take*
45
46 *into account so-called major cases of medical malpractice, mass disturbance or*
47
48 *medical malpractice. We cannot distinguish between these concepts.... Relatively*
49
50 *speaking, it is more feasible to publicize the data on public security e.g. the number*
51
52 *of police records and people arrested, the number of crimes committed. Those*
53
54 *definitions are more explicit, whereas those concerning complaints management are*
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4 *not. Because all statistics are calculated in the hospital, we find that where*
5
6 *standards are slack, the resulting statistic is large whereas with a strict standard, it*
7
8 *will be small. There is hence great variability in our results. (Male, Policy makers-2,*
9
10 *22-12-2011)*

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12
13
14 *Identical forms are sent to two hospitals at a similar level and the reported data can*
15
16 *be quite different. ...Some hospitals only reported cases resulting in compensation*
17
18 *and some hospitals record all persons who voice a concern, while others only*
19
20 *report cases identified as medical malpractice. But it is impossible for me to verify*
21
22 *[the reported data] in each hospital. (Male, Administrators-2, 18-08-2011)*

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24
25
26 Hospitals have not publicized complaints; neither have health administration
27
28 departments. The Shanghai Bureau of Health launched a pilot project in 2005 to
29
30 publicize the complaints reported by all hospitals in Shanghai. The project was
31
32 welcomed by the public but discontinued soon after its launch due to mounting
33
34 pressure from hospitals.
35
36

37
38
39 *We already publicize complaints [medical malpractice] on our intranet for hospital*
40
41 *staff. It is unnecessary to share this information on external sites. (Female, Hospital*
42
43 *managers-4, 06-09-2011)*

44
45
46 *To my knowledge, such information was published once on the Xinmin Evening*
47
48 *News in 2005. The newspaper named hospitals that had won awards and gave*
49
50 *details of the number of medical malpractice cases inherent in each, as well as*
51
52 *feedback regarding patient satisfaction. [We felt] the pressure was very, very high.*
53
54
55
56 *It [publishing those] resulted in public outrage [from hospitals]. (Female,*
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4 *Administrators-4, 30-11-2011)*
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8
9 **Unwillingness on the part of hospitals to effectively handle complaints**
10

11 Most hospitals did not devote much effort into managing complaints. There was no
12 clear mechanism to utilize patients' complaints to improve quality of care unless
13 serious medical malpractice had occurred or complaints are found to recur.
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17
18 *Hospitals just handle complaints when complaints happen. ...We are basically*
19 *perfunctory, including hospitals, department directors and doctors. The best case*
20 *scenario for me: do not approach me for these things [complaints]. Deal with*
21 *complaints quickly and efficiently; in other words, spend money to buy peace. The*
22 *impact of managing and addressing complaints is negligible, with very little effect*
23 *on improving medical procedures and quality. (Male, Administrators-2,*
24 *18-08-2011)*
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36 Hospital directors were the key actors of complaint management in hospitals. The
37 incentive and sanction mechanisms in hospital depended on how much they pay
38 attention to complaint management. In the 1980s the government reduced subsidies
39 for public hospitals under the context of transforming the planned economy to a
40 so-called socialist market one in order to reduce inefficiencies in health care provision.
41 Hospitals had to increase service charges to generate more revenue to recoup the
42 operational costs and increase the income level of health workers. Complaint
43 management occupied nothing but a small part of quality health care, so in most
44 hospitals it failed to draw attention from senior management. Most complaints were
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4 solved on a case-by-case basis, without sufficient concern for the overall
5
6 improvement of health care services.
7

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9 *In practice, the head of department influences implementation. If he/she regards*
10
11 *this as important, then subordinates work harder of course. Now the problem is that*
12
13 *some heads of department do not pay attention to it [complaint management].*

14
15
16 *(Male, Health providers-2, 16-09-2011)*

17
18
19 *It is of course medical services that are the core of hospital work. Things such as*
20
21 *[complaint management] are boring for the hospital. To a hospital, the fewer the*
22
23 *complaints, the better. (Male, Administrators-2, 18-08-2011)*
24

25 26 27 28 29 **Conclusions**

30
31 This study examined the structure of managing patients' complaints in China and the
32
33 views of key stakeholders on the barriers to effective complaint management. It is
34
35 shown that there are no standardized systems and procedures dealing with patients'
36
37 complaints in China, due to conflicts between relevant actors and regulations. Having
38
39 experienced rapid economic growth in the last 30 years, China is undergoing a
40
41 socioeconomic transition. Like other developing countries, policies lag behind the
42
43 country's economic transition. The Ministry of Health has tried to guide health
44
45 providers by issuing special regulation, but health administrations do not apply strict
46
47 regulation to complaint management. There lacks of clear relationships between
48
49 patients' complaints and clinical outcomes or the quality of care.
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4 The hospital leader is the key determinant for complaint handling inside the hospital.
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6 However, no apparent incentives exist to push hospital leaders to put complaint
7
8 handling at a priority. The power of complaint handling department depends on how
9
10 much attention the hospital leaders pay to. Under the current situation, the hospital
11
12 leaders lack political will to manage complaint effectively. This led to inadequate
13
14 human resource put in place at the appropriate department to handle complaints. The
15
16 department also lack power to coordinate with clinical departments.
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24 The patients' complaints in many Chinese hospitals are not well managed and handled.
25
26 Most hospitals manage patient complaints on only a case-by-case basis. They lack
27
28 clear mechanisms linking patients' complaint with improving the quality of care.
29
30 Complaints are underutilised for organizational strategic planning or changing
31
32 individual behavioural and attitudes.
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40 **Policy recommendations**

41 The Chinese Ministry of Health and health authorities at provincial and municipal
42
43 level should oversee the development of national guideline on handling patients'
44
45 complaints which can be practically implemented in China. Legislation stipulates not
46
47 only the principles and regulations of patients' complaint management, but also the
48
49 responsibilities of sectors at different levels.
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56 To alleviate patient complaints related violence, the guideline should be approved by
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4 civil groups including service users and the hospital sector. In developed countries,
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6 patient's complaint management provides guidelines not only for health care
7
8 providers, but also clear guidelines for patients. This not only makes it more
9
10 convenient for patients, but also plays a positive role in helping patients' initiate the
11
12 complaint process via legitimate means. This is crucial for society to view patients'
13
14 complaint in a rational way.
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21 If patients' complaints can be better managed and rectified, the instances of failure
22
23 would be reduced and quality would be improved. Greater emphasis should be placed
24
25 on quality improvement after patients' complaints. Strategies to improve quality
26
27 following patients' complaints should be developed through a learning process. To
28
29 promote the learning process, appropriate mechanisms should be developed and
30
31 implemented to assess not only the number of patients' complaints occurring in
32
33 hospitals, but also how these hospitals have handled these complaints. For example,
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35 reporting more patients' complaints should not be necessarily punished, while
36
37 effectively handling of the patients' complaints should be appreciated.
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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.

CONTRIBUTORSHIP 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

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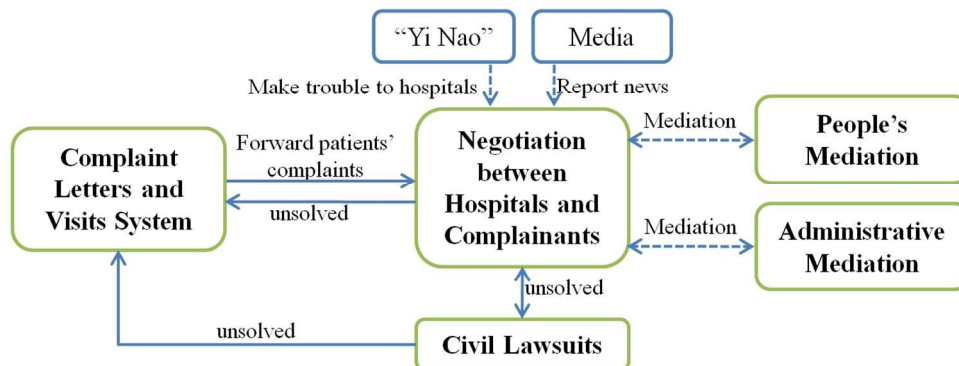


Figure 1 The structure of managing patients' complaints in China

374x174mm (96 x 96 DPI)

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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? | YES It is difficult to measure the regulation process quantitatively. |
| <ul style="list-style-type: none"> • <i>Interviews</i>: experience, perceptions, behaviour, practice, process • <i>Focus groups</i>: group dynamics, convenience, non-sensitive topics • <i>Ethnography</i>: culture, organizational behaviour, interaction • <i>Textual analysis</i>: documents, art, representations, conversations | |
| T Transparency of procedures | |
| <i>Sampling</i> | |
| 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 |
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| | <p>process.</p> <p>Different types of respondents were helpful for holistic understanding for transparency deficits.</p> <p>Key informants were interviewed by snowball sampling and saturation.</p> |
| <i>Recruitment</i> | |
| 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. |
| <i>Data collection</i> | |
| 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. |
| <i>Role of researchers</i> | |
| 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. |
| <i>Ethics</i> | |
| 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 | |
| <i>Analysis</i> | |
| <p>Is the type of analysis appropriate for the type of study?</p> <ul style="list-style-type: none"> • <i>thematic</i>: exploratory, descriptive, hypothesis generating • <i>framework</i>: e.g., policy • <i>constant comparison/grounded</i> | <p>YES.</p> <p>Analytic approach was justified.</p> |

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| <p><i>theory</i>: theory generating, analytical</p> <ul style="list-style-type: none"> Are the interpretations clearly presented and adequately supported by the evidence? Are quotes used and are these appropriate and effective? Was trustworthiness/reliability of the data and interpretations checked? | <p>YES.</p> <p>YES.</p> <p>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.</p> |
| <i>Discussion and presentation</i> | |
| 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 |

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| viewed critically. They might be fatal flaws, or they may result from lack of detail or clarity. | |

For peer review only

BMJ Open

Managing patient complaints in China: what went wrong?

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|---------------------------------|--|
| Journal: | <i>BMJ Open</i> |
| 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 |
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Title page

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4 8) HESVIC team authorship
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9 4. Up to five keywords or phrases suitable for use in an index (it is recommended to
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11 use MeSH terms).
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14 Qualitative Research; Patient Complaints; Complaint Handling Systems; Quality
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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

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3 unjustifiable complaints by patients during the stage of solution settlements; and weak
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6 enforcement of the regulation, deficient information for managing patient complaints
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9 and unwillingness of the hospitals to effectively handle complaints in the
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11 post-complaint stage.
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16 **Conclusions:** Barriers to the effective management of patient complaint vary at the
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18 different stages of complaint handling and from the service user and provider
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20 perspectives. Information, procedure design, human resources, system arrangement,
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22 unified legal system and regulations and factors shaping the social context all play
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24 important roles in effective patient complaint management.
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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

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4 side, as well as system issues.
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- 6 5. Information, procedure design, human resources, system
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8 arrangement, unified legal system and regulations and factors
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10 shaping the social context all play important roles in effective
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12 patient complaint management.
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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

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4 threats and assaults targeting doctors and management.[9] These incidents are only
5
6 indicative of rising expectations, burgeoning patient discontent with services and
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8 dissatisfaction towards the manner in which matters are resolved.[10] Public outcry
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10 only exacerbates the need for more effective handling of individual cases under the
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12 overarching agenda for public hospital reform in China.[11]
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19 In countries such as Australia and Britain, the state has sought to monitor complaints
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21 and complaint handling to improve and regulate the practice of health
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23 professionals.[12] A feedback system of this sort has proven instrumental in
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25 improving the quality of care. In Britain, the National Health Service (NHS) not only
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27 provides clear and transparent guidelines for both health providers and patients but
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29 also publicizes information regarding the routine reporting of patient complaints.[13]
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34 In Australia, a large study was conducted before *Guide to Complaint Handling in*
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36 *Health Care Services* was formulated and subsequently updated.[14] Annually,
37
38 statistics are compiled and published, detailing complaint trends, complaint
39
40 management and reasons for complaints. Effective handling of complaints has been
41
42 known to reduce friction between providers and consumers, with the even greater
43
44 benefit of improving quality of care. As a supplement to peer review and
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46 administration, patient complaints can provide important feedback concerning the
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48 delivery of health care services and can be a useful tool in the improvement of health
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50 care quality.[1-3, 15-18]
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4 Amidst soaring angst, the Chinese government has put in place a system for redress
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6 where grievances arise. A “complaint” is defined as *the behaviour of a patient or*
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8 *his/her representative(s) which signifies dissatisfaction towards medical services,*
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10 *nursing services, as well as treatment conditions through letters, calls or visits to the*
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12 *hospital where the purpose of these actions is to criticise the hospital and/or claim*
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14 *compensation”.*[19]
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21 Notwithstanding the alarming extent of these issues, few attempts have been made to
22
23 formally examine how hospital complaints are addressed in developing countries. It is
24
25 only recently that a handful of studies in China have sought to provide some
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27 understanding of the issue, by trying to ascertain the number of complaints and
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29 garnering patient feedback via questionnaires and interviews. A fuller understanding
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31 of the complaints system- the available channels for seeking redress, how the system
32
33 operates and the barriers to conflict resolution- will be crucial to ameliorating the
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35 often fraught relationship between health care providers and consumers. The purpose
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37 of this study has been to examine the handling system for patient complaints in China;
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39 to subsequently identify and analyse the various hospital-specific factors preventing
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41 grievances from being effectively addressed. The authors of this paper hope that such
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43 an undertaking will reduce malpractice and above all, improve health service
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45 outcomes.
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56 This study is one of the tracing cases from the "Health System Stewardship and
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4 Regulation in Vietnam, India and China" (HESVIC) research project. It was
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6 conducted by a consortium of six partners in Asia and Europe from 2009-2012, with
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8 the aim of supporting policy decisions in the application and extension of accessibility,
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10 affordability, equity and quality coverage of maternal health care in the three
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12 countries.
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15 16 17 18 19 **Methods**

20 21 *Study design*

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23 The project uses a multidisciplinary approach, drawing on multiple case studies to
24
25 examine the impact of regulation on improving equitable access to quality health care
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27 in Vietnam, India and China. In each country, three cases were selected and studied.
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29 This paper shows the findings from the case study examining the regulation on
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31 Grievance Redressal (GR) in Shanghai, China. Here, regulation encompasses the
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33 formation of rules and practices, as well as their interpretation and implementation,
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35 such as the health policy processes covered in the HEPVIC project (HEPVIC).[20]
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44 **Phase One: Literature Review**

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46 Firstly, we conducted a literature review. The relevant sources, which included
47
48 regulation documents relating to the handling of patient complaints at both the
49
50 national and Shanghai municipal levels, were used to collect legal approaches and
51
52 mechanisms used in managing patient complaints. These regulations were mainly
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54 stipulated from 2002 to 2011. To understand the application of different complaint
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4 approaches, a search of scientific literature published between 2000 and 2011 was
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6 conducted. Databases MEDLINE-PubMed and WANFANG Data were consulted. A
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8 search strategy was established based on the following keywords: *grievance redressal,*
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10 *patient complaint, health care complaint and hospital complaint, and China.* Special
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12 focus was put on patient complaint management in hospitals, as we found that the vast
13
14 majority of complaints are handled and resolved within the hospitals.[21]
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21 **Phase Two: pilot study - interviews**

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24 Based on our understanding of the current patient complaint handling system, we then
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26 performed semi-structured interviews with key stakeholders- policymakers from the
27
28 national level, administrators from the Shanghai municipal level, hospital managers,
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30 health providers, users and other related parties. We used the snowball sampling
31
32 method to identify key stakeholders and to collect important feedback from key
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34 informants from various disciplines.[22, 23]
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42 In Phase Two (October-December 2010), one key actor from each of the three
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44 administrative levels were selected and interviewed: a policymaker at the national
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46 level, a municipal administrator and a hospital manager. A pilot study was conducted
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48 to test the topic guidelines developed. These would allow us to gain a preliminary
49
50 understanding of the process of complaint management in the hospital setting of
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52 China, and refine the data collection tools. These interviews served as the basis for the
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54 design of Phase Three interviews where some of those being interviewed in the third
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4 phase were respondents recommended by Phase Two interviewees.
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8 9 **Phase Three: main data collection**

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11 Interviews in Phase Three were conducted from August-December of 2011. Key
12 stakeholders were interviewed in the selected hospitals based on location, level and
13 type. Our sample was the representative of both urban and suburban areas in Shanghai.
14
15 General hospitals and specialist hospitals were selected. Phase Three began with
16 interviews of hospital managers and health providers proposed in Phase Two. We
17 asked interviewees from Phase Two to invite patients and other relevant stakeholders
18 to contribute their views. Those invited patients had used different channels for
19 lodging their complaints. However, they all shared one thing in common: all patients
20 had first complained to the hospital. We then proceeded to interview the
21 administrators and finally a high-level policymaker. We continued to interview
22 respondents, collecting and analysing their comments and feedback until no new
23 themes emerged, i.e. saturation had been reached. The number of participants
24 involved in the different types of interviewees is depicted in Table 1.
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46 Semi-structured interviews were conducted with 35 respondents face-to-face, except
47 one via telephone. The interviews took place at private locations, for example at the
48 institution where the interviewee or interviewer worked, and were conducted by two
49 of the authors of this paper. Each interview lasted 1-2 hours and was audiotaped with
50 permission, apart from two which were not recorded but typewritten upon the
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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 |

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Medical Disputes

The Complaint Letters and Visits System

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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.

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6 We performed the above tasks using the qualitative research software NVivo 9.0. The
7
8 raw data was coded by two independent reviewers (YSJ, QZ). If some discrepancies
9
10 emerged, a third reviewer (XHY) would participate in the group discussion until the
11
12 group arrived at a consensus. There were some models for analysing complaint
13
14 management, for example, a Managerial-Operational-Technical (MOT) model was
15
16 developed to explore complaint management in hospitals.[2] In our study, we
17
18 collected data according to the complaint management process. To analyse the data
19
20 most efficiently and directly, we used the stages of the process. The stages included
21
22 receive, handle and resolve complaints.[25] As the quality improvement following
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24 complaints is very important, we added the stage of “institutional changes for quality
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26 improvement using complaints data”.[2, 16]
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36 Our study was approved by Institutional Review Board (IRB), School of Public
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38 Health, Fudan University. Access to data was restricted to approved members of the
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40 research team who signed a confidential agreement with the principal investigator.
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42 Data were stored in secure electronic locations. Data processing was kept
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44 anonymously so as to protect the identity of interviewees. The names of the
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46 respondents have been deleted from quotations.
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54 Findings

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56 This section first presents a number of approaches developed and implemented in
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4 Shanghai to handle patient complaints and their relationships. It then focuses on the
5
6 approach of negotiation between hospitals and complainants, identifies its barriers,
7
8 and proceeds to examine and analyse these barriers.
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10 11 12 13 14 **1. Approaches and mechanisms used in managing patient complaints**

15
16 The study identifies both formal and informal approaches and mechanisms used in
17
18 handling patient complaints.
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20 21 22 23 24 ● Negotiation between Hospitals and Complainants

25
26 The complaint handling department within the hospital is responsible for dealing with
27
28 patient complaints, first established on February 20, 2002, in accordance with the
29
30 *Regulation on the Handling of Medical Malpractices*.^[26] Since November 2009,
31
32 these departments have been regulated by *Measures for the Handling of Patient*
33
34 *Complaints in Hospitals (for Trial Implementation)*.^[19] These acts require that a
35
36 medical institution establish a department specifically for the purpose of handling and
37
38 resolving medical disputes. The department is primarily responsible for receiving
39
40 patient complaints- via calls, letters, visits, and/or cases referred from other
41
42 departments and institutions. Their role also includes counselling and communicating
43
44 with patients, verifying and documenting disputes as well as resolving disputes.
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50 51 52 53 54 ● Administrative Mediation and Civil Lawsuits

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56 If the hospital is unable to resolve certain conflicts through negotiation, these cases
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4 may be referred to an external body such as the health administrative department or
5
6 they may be settled in the court by means of litigation. The *Tort Law of the People's*
7
8 *Republic of China*, adopted at the twelfth session of the Standing Committee of the
9
10 Eleventh National People's Congress on December 26 2009, provided a new legal
11
12 definition of liability for medical malpractice, liability presumption and
13
14 exemption.[27]
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21 ● Complaint Letters and Visits System

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23 In February 2007, *Measures for the Complaint Letters and Visits System for*
24
25 *Healthcare* came into force.[28] Its purpose is to protect the legal rights and interests
26
27 of citizens, legal entities and other organizations, regulate behaviour and maintain
28
29 order within the Complaint Letters and Visits System. It requires health administrative
30
31 departments to set up the Complaint Letters and Visits office at different levels. These
32
33 offices are responsible for receiving, assigning and transferring matters as appropriate,
34
35 as well as supervise in the handling of various issues and complaints.
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44 ● People's Mediation- a form of Third-Party Facilitated Mediation

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46 In July 2008, the Shanghai Justice Bureau and Health Bureau issued *Opinions on*
47
48 *Regulating People's Mediation Organizations to Participate in Medical Dispute*
49
50 *Mediation*, to establish the People's Mediation Committees for Medical Disputes.[29]
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54 Committee members, mainly retired judges and doctors, served to mediate disputes
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56 through reporting, explaining and analysing cases under the supervision of local
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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.

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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 |

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4 The complex relationships between different approaches can be seen where many
5
6 actors are involved. From the aspect of solution, approaches that can resolve medical
7
8 disputes are mainly negotiation and civil lawsuits, while other approaches play a part
9
10 in forwarding cases, such as Complaint Letters and Visits System, or easing conflicts,
11
12 such as mediation. None of the approaches are considered the most authoritative
13
14 approach. Patients can continue to lodge complaints through the Complaint Letters
15
16 and Visits System even if a decision has been finalised after a second trial in court.
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22
23 In the above-mentioned approaches, the hospital is the main handler for patient
24
25 complaints. First of all, it can handle patient complaints completely independently,
26
27 from reception to solution, while the other approaches have to engage hospitals in
28
29 complaint handling. Secondly, since the hospital is principally responsible for
30
31 compensation, the complainant is more inclined to directly negotiate with the hospital.
32
33 Findings from the literature show that the majority of medical disputes are resolved by
34
35 negotiation between hospitals and complainants.[21] Thirdly, if hospitals handle
36
37 complaints improperly, conflicts will become more volatile, resulting in serious
38
39 incidents.[32] Therefore, hospitals have become the most common receiver, handler
40
41 and resolver of disputes. (Figure 1)
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51 **3. Barriers to the effective management of patient complaints and their** 52 **underlying causes at different stages** 53 54

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56 Our interviews revealed that different hospitals often use different complaint systems.
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4 For example, some hospitals operate a centralized complaints office, which may or
5
6 may not be independent of the Medical Affairs (Administration) Department. Other
7
8 hospitals have several complaints offices, each of which is responsive to different
9
10 kinds of complaints. A hospital's deputy director, who also heads hospital complaint
11
12 management, generally manages complaint departments. Barriers to effective
13
14 complaints management vary at different stages of the complaint process- both from
15
16 the sides of the user and provider.
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24 ● **Barriers to receiving the complaints**

25
26 **Low awareness of users about the handling system for patient complaints**

27
28 Although hospital staff claimed that the complaints office was accessible to those with
29
30 grievances, patients did not always feel this was the case. One user looked up the
31
32 hospital telephone number on the Internet and said the complaint handling process
33
34 was "very easy" while others did not concur. Almost all patients being interviewed
35
36 found that signs and directions (to the complaints office) failed to catch the eye. In
37
38 some cases none could be seen at all:
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44 *I wanted to lodge a complaint, but did not know how to find the place [the*
45
46 *complaints office]... Because the hospital was so big, I did not know which*
47
48 *department [was responsible for handling complaints]. ...I simply did not know who*
49
50 *to turn to. You see, the complaints department was in another building [rather than*
51
52 *in the one in which I was treated i.e. the clinical department] (Female, Users-1,*
53
54 *01-09-2011)*
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6 ● **Barriers to handling the complaints**
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8
9 **Poor capacity and skills of health care providers**
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11 The capacity and skills of healthcare providers in managing patient complaints is
12 critically important in problem solving. Our study found that the reasons patients
13 complain lie mainly in poor communication and factors such as the provider's attitude,
14 use of language, unprofessional behaviour, as well as dissatisfaction towards service
15 procedures.
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24 *The Medical Doctors Association carried out a survey of the nature of medical*
25 *disputes. 50 per cent of cases were a result of inappropriate attitudes in health care*
26 *delivery, 25 per cent were caused by technology misuse and the rest were related to*
27 *management. (Female, Policy makers-1, 16-12-2010)*
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34 The majority of complaints can be resolved by an explanation issued by the hospital
35 and/or a verbal apology by the offending party.[5, 33, 34] However, practitioners are
36 often too preoccupied with their clinical duties to be able to respond to patient
37 complaints.
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44 *Hospitals have not completely adhered to regulation, which is clearly outlined in*
45 *the guidelines; not because they do not have the capacity, but because doctors and*
46 *related staff are simply too busy. (Male, Administrators-1, 21-12-2010)*
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52 *Doctors are not able to devote much time to handling disputes, because clinical*
53 *work is highly demanding. [They need to attend to] many patients every day. If they*
54 *spend more time communicating with patients, they would lose time needed to carry*
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4 *out [clinical work]. That is to say, [doctors should be given] less [clinical] work,*
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6 *and more time to explain their work to patients. Our workload is very heavy, like a*
7
8 *battle. (Female, Health providers-1, 01-09-2011)*
9

10 11 12 13 **Incompetence and powerlessness of complaints handlers** 14

15
16 Complaint handlers played a more important role in cooperation and coordination.
17
18 Although the complaint department was specifically set up in hospitals for receiving
19
20 and handling complaints, the responsible persons in the department were mainly
21
22 part-time medical staff. In some cases, those handling staff were found to be
23
24 inadequate- sometimes due to lack of training. Many of them had studied handling
25
26 techniques on their own and had not acquired sufficient professional skills to
27
28 appropriately analyse, assess and solve complaints.
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34 *Complaint handlers in the hospitals cannot solve everything because the disciplines*
35
36 *involved in complaints are highly specialised. I am only familiar with general*
37
38 *surgery and issues that require common sense, but [I am not familiar] with*
39
40 *professional problems in other disciplines. (Male, Hospital managers-5,*
41
42 *08-09-2011)*
43
44

45
46 *It is difficult to recruit staff for our Medical Dispute Handling Office. No one wants*
47
48 *to come. A boy recruited in 2007 could not stand the demands of the job*
49
50 *[complicated disputes and violence] and so resigned. (Female, Hospital*
51
52 *managers-3, 31-08-2011)*
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56 *We have little time to do things other than receiving complaints. We lack staff*
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4 *members. We are responsible for receiving and processing complaints, and*
5
6 *expected- on top of this- to deal with other things, hence why we are exhausted.*
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8
9 *(Male, Health providers-2, 16-09-2011)*

10
11 Given that most complaints are handled and resolved in the hospital, it appeared that
12
13 every complaint handler interviewed felt the same way: tired and stressed. Complaint
14
15 handlers were insufficiently empowered to handle complaints. It was hard for them to
16
17 coordinate between different departments, investigate cases, organize mediation, find
18
19 solutions and then draw on patients' feedback to improve quality of care.
20
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24 *Recently, a fierce medical dispute occurred because of a possible misunderstanding*
25
26 *between administrative departments. [Abusive] words erupted. As a consequence,*
27
28 *staff members involved in this incident were distraught- to the extent that they*
29
30 *wanted to resign. Hence we need understanding and support among*
31
32 *colleagues. ...Sometimes the clinical department concerned refused to cooperate*
33
34 *when investigated. He [the clinical department] is not very serious about*
35
36 *cooperating with the investigation. (Female, Hospital managers-3, 31-08-2011)*

37
38
39 *Communication between administrative departments and clinical departments is*
40
41 *not very effective sometimes. I am not satisfied with this. (Female, Hospital*
42
43 *managers-2, 25-08-2011)*
44
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51 **Non-transparent exchange of information**

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54 In addition, the complaint handling process was not truly open to the complainant and
55
56 information exchange was largely limited to hospital staff. In fact, it was found that
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4 the staff at the complaints office was generally evasive towards patients who arrived
5
6 wishing to be updated with the specifics of their complaint. The complainant had no
7
8 opportunity to directly engage in the handling of the complaint or to meaningfully
9
10 participate in the process. In addition, hospitals tended to oversimplify cases,
11
12 assuming that the complainant's only desire was to report their complaint and ask for
13
14 compensation. This implies that the entire handling process is disclosed only among
15
16 hospital staff. Therefore, the process becomes a "black box" to patients. It is easy for
17
18 the hospital to manipulate a complainant by providing limited information to gain
19
20 advantage in negotiations, i.e. reduce loss from compensating patients.
21
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24

25
26 *Sometimes you have to circumvent something and use negotiating skills. Mistakes in*
27
28 *medical services do not necessarily harm patients' health, but they can be very*
29
30 *serious for the provider [...] for example, someone may not be very careful when*
31
32 *writing a medical record and alter it by accident. But you are likely to lose a lawsuit*
33
34 *on the grounds of having tampered with records. Incidents such as these cloud the*
35
36 *matter, making transparency difficult. (Female, Hospital managers-2, 25-08-2011)*
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41 If the incident is urgent or presents itself as a recurring problem, it might be shared to
42
43 educate healthcare providers but disclosure to complainants themselves remains
44
45 limited. Only outcomes deemed to be of direct interest to patients, including
46
47 compensation amounts and medical service privileges, were provided. However, other
48
49 results, including penalties imposed upon physicians and departments or
50
51 improvements made to hospital services, were largely withheld from patients if they
52
53 did not ask.
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4 *In individual cases, what are the outcomes of their complaints? How might a*
5 *physician be punished/penalised/disciplined? Such information is requested by*
6 *patients only occasionally. (Male, Health providers-2, 16-09-2011)*

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

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19 ● **Barriers to resolving the complaints**

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21 **Conflicts between relevant actors and regulations**

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24 Within the complaints system, conflicts or inconsistencies can arise between the legal
25 system for handling complaints and the solutions determined by the hospital. As the
26 structure of managing patient complaints is shown in Figure 1, different regulations
27 stipulate different approaches. There does not exist a unified law or guidelines to
28 clearly illustrate the relationships between different approaches, which results in
29 problems such as lack of authority or ultimate approach, uncertainty about how to
30 apply different regulations to one case and no clear definitions or classifications in
31 regards to patient complaints.
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44 *The current state of complaint management is disorderly. There are too many*
45 *channels. For example, many departments are involved, including but not limited to*
46 *Complaint Letters and Visits, online complaints etc. The Health Bureau has two*
47 *departments [for complaint management], each district has a mediation office, a*
48 *district government website or a mayor-mail [to receive complaints], and a*
49 *Complaint Letters and Visits office... Far too many heads of department within the*
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4 *health sector; it's chaos. (Male, Health providers-2, 16-09-2011)*

5
6 *Hospitals are required to report complaints to a lot of sectors, all of which wish to*
7
8 *understand the issue from different angles. There are not necessarily conflicts*
9
10 *between regulations, but different elements are emphasised. Hospitals are tired of*
11 *these kinds of bureaucracy. ...Each sector carries out their designated duties where*
12 *resources are not shared. The information possessed by each sector is fragmented.*

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19 *You know yours, I know mine. (Male, Administrators-2, 18-08-2011)*

20
21 *Medical malpractice is defined clearly in the Regulation on Handling Medical*
22 *Malpractice. There are several benchmarks determining the amount of*
23 *compensation issued. After the Tort Liability Law of the People's Republic of China*
24 *was promulgated, [medical damage] was compensated for more in accordance with*
25 *the Tort Liability Law, because it stipulates compensation for personal injury.*
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34 *(Female, Hospital managers-2, 25-08-2011)*

35 36 37 38 39 **Unjustifiable complaints by patients**

40
41 In some cases, the patient experiences inconvenience when receiving medical services
42 not because of poor conduct in attitude or behaviour on the part of health providers.
43
44 Instead, inconvenience may be due to long waiting times, too little time spent with the
45
46 doctor and/or imperfect resource allocation. These are health system issues rather than
47
48 problems caused by hospitals or individual physicians. And so to a certain extent,
49
50 physicians and hospitals have become scapegoats of the entire health system.

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56 *At times it is not us physicians who have made a patient angry. Certain factors are*
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4 rooted in the fabric of health care systems, but we physicians [end up] taking the
5
6 blame. (Male, Health providers-3, 16-09-2011)
7

8
9 For example, should a doctor need to see sixty patients in half a day, or indeed one
10
11 hundred, you cannot demand that he puts on a smile for each one. A lot of patients
12
13 complain about doctors with a straight face, but I think it is understandable. I have
14
15 a very good relationship with our young doctors. They operate on a tight schedule.
16
17 This week someone works at the outpatient facility. He is friendly with patients in
18
19 the first month but struggles to sustain this sort of demeanour. He is not in the mood
20
21 to smile at patients or engage in long conversations when he only has time to attend
22
23 to their illnesses. (Male, Hospital managers-1, 15-12-2010)
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31 For example, dissatisfaction voiced in the hospital may be related to health insurance
32
33 policy rather than staff behaviour. Hospitals need to follow the policies made by the
34
35 Health Insurance Department. The purpose of those policies was to improve rational
36
37 use of medicines and control healthcare cost, while the patients covered by health
38
39 insurance may demand more medicines.
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44 Chinese doctors have many rules to obey [this is to curb poor conduct]. The
45
46 pressures for them to perform are relatively large. For example, doctors cannot
47
48 prescribe too much medicine for a patient who has only [basic state-financed]
49
50 medical insurance, but patients always want more. A while ago, the Medical
51
52 Insurance Bureau issued the following statement in a newspaper: The Medical
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54 Insurance Bureau never limits the volume of drugs prescribed, rather it is the doing
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4 *of hospitals who wish to increase workload [in order to produce more statistics]. I*
5
6 *think this is really unreasonable. The Bureau does not control the quantity of drugs*
7
8 *prescribed in any given week, but there is a total quantity limit over a year. Doctors*
9
10 *try their best not to prescribe drugs which must be self-financed, i.e. not covered by*
11
12 *basic medical insurance. They must also explain very clearly before prescribing*
13
14 *self-financed drugs, otherwise, patients will lodge complaints once they find out.*
15
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19 *(Male, Hospital managers-1, 15-12-2010)*

20
21 *Complaints occur when the patient wants more drugs but the doctor refuses to*
22
23 *satisfy his or her demands. Why? The health insurance institution sets a limit for*
24
25 *drug expenditure for each hospital; in turn, the hospital sets a limit for each doctor.*
26
27
28
29 *So if a doctor has too many patients drawing from their health insurance scheme in*
30
31 *any one month, he or she may very possibly have exceeded his/her limit. (Male,*
32
33 *Health providers-3, 16-09-2011)*

34
35
36 *[A patient who has] basic state-financed medical coverage is entitled to blood and*
37
38 *other auxiliary examinations. If the number of health checks prescribed exceeds a*
39
40 *certain threshold, the doctor is viewed as exploiting basic medical insurance. The*
41
42 *doctor is consequently punished. I was deducted more than seven hundred yuan*
43
44 *(RMB) because of a case like this. I feel this is simply absurd- it is [unexpectedly]*
45
46
47
48 *doctors who are to blame. Nothing seems to be wrong with the patient. ...The*
49
50 *hospital can't do anything about medical insurance. I think this kind of thing is not*
51
52 *the problem at the hospital level. The complaints about medical insurance define*
53
54 *without a doubt problems underlying state and society. (Male, Health providers-4,*
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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

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

5
6 *The claim a complainant demands goes beyond the actual problem [but for the*
7
8 *money] and he does not wish to resolve it the legal way. ...Nowadays “Yi Nao” has*
9
10 *brought about serious social effects, and escalated the tension between service*
11
12 *users and providers. Complainants are unwilling to resolve things the legal way,*
13
14 *rather, just pestering and hassling you [health care providers or complaint handlers]*
15
16 *all day. (Male, Hospital managers-6, 01-11-2011)*
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24 ● **Barriers to institutional changes for quality improvement using complaints**
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26 **data**
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29 **Weak enforcement of the regulation**
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31 The regulation for managing patient complaints is merely a guideline, which contains
32
33 no mandatory requirements such as assessment mechanisms. Because it takes into
34
35 account the difference in local conditions throughout China, specific contents were
36
37 not stipulated. The regulation is to be interpreted according to local circumstances and
38
39 conditions. Therefore, in the absence of strong public scrutiny, there is little
40
41 accountability for how best to manage patient complaints.
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46 *There are no penalties attached to (failure to follow) regulation. For example, there*
47
48 *is no administrative aspect to the regulatory guidelines. We wanted to write a*
49
50 *penalty provision, but it was not based on the top legislation. The purpose of the*
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52 *regulation is to emphasise self-discipline and serve as guidance for the hospital.*
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56 *[The penalty was not enforceable,] so we decided to remove the penalty. It is indeed*
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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

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4 complaint management in hospitals from senior management and administrative
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6 departments remains weak.
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8
9 *[Having a statistic for patient complaints] is definitely necessary, from the aspect of*
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11 *effective management. If this statistic is disposable, I think no problem. If the*
12
13 *statistic is routine, in fact, it will cost [of all sorts of resources]. (Male, Policy*
14
15 *makers-2, 22-12-2011)*

16
17
18 *Hospitals doubt that the purpose of administration is for information management-*
19
20 *to help them better handle and solve disputes. However, if you want me to report*
21
22 *incidents but meanwhile punish me for that, then I have no incentive to report*
23
24 *anything. This contradiction stands [in the way of effective reporting]. (Female,*
25
26 *Administrators-4, 30-11-2011)*
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33 **Deficient information system for managing patient complaints**

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36 Although the regulations in place require collecting and analysing information, there
37
38 exists no clear classification, definitions or unified coding system. Most hospitals
39
40 have established their own systems for recording complaints and analysing cases, but
41
42 no accurate or comparable data are available.
43
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46 *In fact a lot of cases should be recorded and analysed, [but] we do not even take*
47
48 *into account so-called major cases of medical malpractice, mass disturbance or*
49
50 *medical malpractice. We cannot distinguish between these concepts.... Relatively*
51
52 *speaking, it is more feasible to publicize the data on public security, e.g. the number*
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54 *of police records and people arrested, the number of crimes committed. Those*
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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.

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4 *It [publishing those] resulted in public outrage [from hospitals]. (Female,*
5
6 *Administrators-4, 30-11-2011)*
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10 11 **Unwillingness of hospitals to effectively handle complaints**

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14 Most hospitals did not devote much effort into managing complaints. There was no
15
16 clear mechanism to utilize patient complaints to improve quality of care unless serious
17
18 medical malpractice had occurred or complaints were found to recur.
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21 *Hospitals just handle complaints when complaints happen. ...We are basically*
22
23 *perfunctory, including hospitals, department directors and doctors. The best-case*
24
25 *scenario for me: do not approach me for these things [complaints]. Deal with*
26
27 *complaints quickly and efficiently; in other words, spend money to buy peace. The*
28
29 *impact of managing and addressing complaints is negligible, with very little effect*
30
31 *on improving medical procedures and quality. (Male, Administrators-2,*
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33 *18-08-2011)*
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39 Hospital directors were the key actors of complaint management in hospitals. The
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41 incentive and sanction mechanisms in hospital depended on how much they pay
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43 attention to complaint management. In the 1980s the government reduced subsidies
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45 for public hospitals under the context of transforming the planned economy to a
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47 so-called socialist market in order to reduce inefficiencies in health care provision.
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49 Hospitals had to increase service charges to generate more revenue to recoup the
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51 operational costs and increase the income level of health workers. Complaint
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53 management occupied nothing but a small part of quality health care, so in most
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4 hospitals it failed to draw attention from senior management. Most complaints were
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6 solved on a case-by-case basis, without sufficient concern for the overall
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8 improvement of health care services.
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11 *In practice, the head of department influences implementation. If he/she regards*
12
13 *this as important, then subordinates work harder of course. Now the problem is that*
14
15 *some heads of department do not pay attention to it [complaint management].*
16
17 *(Male, Health providers-2, 16-09-2011)*
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21 *It is of course medical services that are the core of hospital work. Things such as*
22
23 *[complaint management] are boring for the hospital. To a hospital, the fewer the*
24
25 *complaints, the better. (Male, Administrators-2, 18-08-2011)*
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31 **Discussion and Conclusions**

32
33 This study examined the handling system for patient complaints in China and the
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35 views of key stakeholders on the barriers to effective complaint management. Our
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37 study provided a new dimension of understanding the complaints management system
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39 in China, a developing country. Hospitals are the most important handler and manager
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41 of patient complaints in China and similarly for other developing countries such as
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43 India and Vietnam. We explored the barriers through in-depth interviews with almost
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45 all stakeholders, not only health professionals. What we found would help develop
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47 procedures for more effective complaint management and to further improve the
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49 quality of care in China and other developing countries. The selection of participants
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51 may introduce some bias to our studies. Due to our focus on the hospital, there may be
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4 an underrepresentation of certain types of respondents.
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9 Our Findings showed that there are no standardized systems and procedures dealing
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11 with patient complaints in China, due to conflicts between relevant actors and
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13 regulations. Having experienced rapid economic growth in the last 30 years, China is
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15 undergoing a socioeconomic transition. Like other developing countries, policies lag
16
17 behind the country's economic transition. The Ministry of Health has tried to guide
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19 health providers by issuing special regulation, but health administrations do not apply
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21 strict regulation to complaint management. There lacks clear relationships between
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23 patient complaints and clinical outcomes or the quality of care.
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31 The hospital leader is the key determinant for complaint handling inside the hospital.
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33 However, no apparent incentives exist to push hospital leaders to place priority on
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35 complaint handling. The power of complaint handling departments depends on how
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37 much the hospital leaders pay attention to it. Under the current situation, hospital
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39 leaders lack political will to manage complaints effectively, leading to inadequate
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41 human resources in complaint handling departments. The departments also lack the
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43 power to coordinate with clinical departments.
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51 The patient complaints in many Chinese hospitals are not well managed and handled.
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53 Most hospitals manage patient complaints on only a case-by-case basis. They lack
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55 clear mechanisms linking patient complaint with improving the quality of care.
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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.

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

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Title page

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1. Title of the article.

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

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4 8) HESVIC team authorship
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8
9 4. Up to five keywords or phrases suitable for use in an index (it is recommended to
10
11 use MeSH terms).
12

13 Qualitative Research; Patient Complaints; Complaint Handling Systems; Quality
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15 Improvement; Government Regulation; ~~China~~
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21 5. Word count - excluding title page, abstract, references, figures and tables.
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Abstract

Background: Effective management of ~~patients'patient~~ complaints is ~~to improve~~ ~~thean 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 makerspolicymakers~~, 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 patients' 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~~ ~~includeincluded service users'~~ low awareness ~~of users~~ about the systems. ~~Barriers~~ in the ~~handlinginitial stage of the~~ process ~~include~~; poor capacity and skills of healthcare providers, incompetence and powerlessness of complaints handlers and

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4 non-transparent exchange of information. ~~Barriers to~~ during the process of
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6 complaint ~~solution stage include~~ handling; conflicts between relevant actors and
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8 regulations and unjustifiable complaints by patients. ~~Barriers to post-complaint~~
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10 ~~institutional changes include~~ during the stage of solution settlements; and weak
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12 enforcement of the regulation, deficient information for managing ~~patients'~~ patient
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14 complaints and unwillingness of the hospitals to effectively handle complaints in the
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16 post-complaint stage.
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21 **Conclusions:** Barriers to the effective management of ~~patients'~~ patient complaint vary
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23 at the different stages of complaint handling, ~~and~~ and from the service user and provider
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25 ~~side, as well as system issues.~~ perspectives. Information, procedure design, human
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27 resources, system arrangement, unified legal system and regulations and factors
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29 shaping the social context all play important roles in effective patient complaint
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31 management.
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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

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4 patients' complaints and ~~identify~~identified and ~~analyse~~analysed
5
6 barriers to effective management in China.
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9 2. We carried out a literature review and semi-structured interviews
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11 with all categories of key informants.
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14 3. Hospitals undertake the most responsibility of patients' complaint
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16 handling.
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18 4. Barriers to ~~the~~ effective management of patients' complaint vary at
19
20 ~~the~~ different stages of complaint handling, from the user and
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22 provider side, as well as system issues.
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25 5. Information, procedure design, human resources, system
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27 arrangement, unified legal system and regulations and factors
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29 shaping the social context all play important roles in effective
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31 patient complaint management.
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Background

In recent years, ~~patients'~~patient complaints ~~aeross~~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 ~~eonseiousness~~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,² requiring urgent attention and immediate action at the highest level.

With no official statistics of ~~patients'~~s complaints available in Chinese records, we estimate that the number of complaints and disputes rose⁷; 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

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4 Association in 2005 suggests that of 270 hospitals surveyed, 73 per cent experienced
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6 abuse in the form of threats and assaults targeting doctors and management.[9] These
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8 incidents are only indicative of rising expectations, burgeoning patient discontent with
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10 services and dissatisfaction towards the manner in which matters are resolved.[10]
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12 Public outcry only exacerbates the need for more effective handling of individual
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14 cases under the overarching agenda for public hospital reform in China.[11]
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21 In countries such as Australia and Britain, the state has sought to monitor complaints
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23 and complaint handling to improve and regulate the practice of health
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25 professionals.[12] A feedback system of this sort has proven instrumental in
26
27 improving the quality of care. In Britain, the National Health Service (NHS) not only
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29 provides clear and transparent guidelines for both health providers and patients but
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31 also publicizes information regarding the routine reporting of patients' complaints.[13]
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36 In Australia, a large study was conducted before *Guide to Complaint Handling in*
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38 *Health Care Services* was formulated and subsequently updated.[14] Annually,
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40 statistics are compiled and published, detailing complaint trends, complaint
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42 management and reasons for complaints. Effective handling of complaints has been
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44 known to reduce friction between providers and consumers, with the even greater
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46 benefit of improving quality of care. As a supplement to peer review and
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48 administration, patients' complaints can provide important feedback concerning the
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50 delivery of health care services and can be a useful tool in the improvement of health
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52 care quality.[1-3, 15-18]
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6 Amidst soaring angst, the Chinese government ~~have~~has put in place a system for
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8 redress where grievances arise. A “complaint” is defined as *the behaviour of a patient*
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10 *or his/her representative(s) which signifies dissatisfaction towards medical services,*
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12 *nursing services, as well as treatment conditions through letters, calls or visits to the*
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14 *hospital where the purpose of these actions is to criticise the hospital and/or claim*
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16 *compensation”*.^[19]
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23 Notwithstanding the alarming extent of these issues, few attempts have been made to
24
25 formally examine how hospital complaints are addressed in developing countries. It is
26
27 only recently that a handful of studies in China have sought to provide some
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29 understanding of the issue, by trying to ascertain the number of complaints and
30
31 garnering patient feedback via questionnaires and interviews. A fuller understanding
32
33 of the complaints system- the available channels for seeking redress, how the system
34
35 operates and the barriers to conflict resolution- will be crucial to ameliorating the
36
37 often fraught relationship between health care providers and consumers. The purpose
38
39 of this study has been to examine the handling system for patients’ complaints in
40
41 China; to subsequently identify and analyse the various hospital-specific factors
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43 preventing grievances from being effectively addressed. The authors of this paper
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45 hope that such an undertaking ~~in strengthening clinical governance and enhancing~~
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47 ~~doctors’ performance~~ will reduce malpractice and above all, improve health service
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49 outcomes.
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6 This study is one of the tracing cases from The the "Health System Stewardship and
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8 Regulation in Vietnam, India and China" (HESVIC) research project. It was
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10 conducted by a consortium of six partners in Asia and Europe from 2009-2012, with
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12 the aim of supporting policy decisions in the application and extension of accessibility,
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14 affordability, equity and quality coverage of maternal health care in the three
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16 countries.
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24 **Methods**

25 *Study design*

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27 The project uses a multidisciplinary approach, drawing on multiple case studies to
28
29 examine the impact of regulation ~~in~~on improving equitable access to quality health
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31 care in Vietnam, India and China. In each country, three cases were selected and
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33 studied. This paper shows the findings from the case study examining the regulation
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35 on Grievance Redressal (GR) in Shanghai, China. Here, regulation encompasses the
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37 formation of rules and practices, as well as their interpretation and
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39 ~~implementing~~implementation, such as the health policy processes covered in the
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41 HEPVIC project (HEPVIC).[20]
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52 **Phase One: Literature Review**

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54 Firstly, we conducted a literature review. The relevant sources, which included
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56 regulation documents relating to the handling of patient complaints at both the
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4 national and Shanghai municipal levels, were used to collect legal approaches and
5
6 mechanisms used in managing patient complaints. These regulations were mainly
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8 stipulated from 2002 to 2011. To understand the application of different complaint
9
10 approaches, a search of scientific literature published between 2000 and 2011 was
11
12 conducted. Databases MEDLINE-PubMed and WANFANG Data were consulted. A
13
14 search strategy was established based on the following keywords: *grievance redressal,*
15
16 *patient complaint, health care complaint and hospital complaint, and China.* Special
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18 focus was put on patients' complaint management in hospitals, as we found that the
19
20 vast majority of complaints are handled and resolved within the hospitals.[21]
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28 29 **Phase Two: pilot study - interviews**

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31 Based on our understanding of the current patient complaint handling system, we then
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33 performed semi-structured interviews with key stakeholders- ~~policy~~
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35 ~~makers~~policymakers from the national level, administrators from the Shanghai
36
37 municipal level, hospital managers, health providers, users and other related parties.
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39 We used the snowball sampling method to identify key stakeholders and to collect
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41 important feedback from key informants from various disciplines.[22, 23]
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49 In Phase Two (October-December 2010), one key actor from each of the three
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51 administrative levels were selected and interviewed: a ~~policy-maker~~policymaker at
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53 the national level, a municipal administrator and a hospital manager. A pilot study was
54
55 conducted to test the topic guidelines developed. These would allow us to gain a
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3 preliminary understanding of the process of complaint management in the hospital
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6 setting of China, and refine the data collection tools. These interviews served as the
7
8
9 basis for the design of Phase Three interviews where some of those being interviewed
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11 in the third phase were respondents recommended by Phase Two interviewees.
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16 **Phase Three: main data collection by semi-structured interviews**
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18
19 Interviews in Phase Three were conducted from August-December of 2011. Key
20
21 stakeholders were interviewed in ~~select~~the selected hospitals based on location, level
22
23 and type. Our sample was the representative of both urban and suburban areas in
24
25 Shanghai. General hospitals and specialist hospitals were selected. Phase Three began
26
27 with interviews of hospital managers and health providers proposed in Phase Two. We
28
29 asked interviewees from Phase Two to invite patients and other relevant stakeholders
30
31 to contribute their views. Those invited patients had used different channels for
32
33 lodging their complaints. However, they all shared one thing in common: all patients
34
35 had first complained to the hospital. We then proceeded to interview the
36
37 administrators and finally a high-level ~~policy maker~~policymaker. We continued to
38
39 interview respondents, collecting and analysing their comments and feedback until no
40
41 new themes emerged, i.e. saturation had been reached. The number of participants
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43 involved in the different types of interviewees is depicted in Table 1.
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54 Semi-structured interviews were conducted with 35 respondents face-to-face, except
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56 one, via telephone. The interviews took place at private locations, for example at the
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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 <u>Policymakers</u> | 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 |

| | | |
|----|---|-----------|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | Lawyers for medical disputes | 2 |
| 5 | | |
| 6 | The centre that processes medical liability | 1 |
| 7 | | |
| 8 | insurance | |
| 9 | | |
| 10 | | |
| 11 | The People's Mediation Committee for | 1 |
| 12 | | |
| 13 | Medical Disputes | |
| 14 | | |
| 15 | The Complaint Letters and Visits System | 1 |
| 16 | | |
| 17 | | |
| 18 | | |
| 19 | Total | 35 |
| 20 | <hr/> | |

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]

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4 The analysis was executed in several stages to 1) become familiar with the data; 2)
5
6 identify emerging topics; 3) develop a topic index; 4) use the index to code the data; 5)
7
8 consolidate the topics into themes; 6) further consolidate these themes into analytical
9
10 categories/clusters; and 7) translate the analysis obtained into a narrative. Written
11
12 consent was obtained from each interviewee before undertaking the interviews.
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19 We performed the above tasks using the qualitative research software NVivo 9.0. The
20
21 raw data was coded by ~~2~~two independent reviewers (YSJ, QZ). If some discrepancies
22
23 emerged, a third reviewer (XHY) would participate in the group discussion until the
24
25 group arrived at a consensus. ~~There were some models for analysing complaint~~
26
27 ~~management, for example, a Managerial-Operational-Technical (MOT) model was~~
28
29 ~~developed to explore complaint management in hospitals.[2] In our study, we~~
30
31 ~~collected data according to the complaint management process. To analyse the data~~
32
33 ~~most efficiently and directly, we used the stages of the process. The stages included~~
34
35 ~~receive, handle and resolve complaints.[25] As the quality improvement following~~
36
37 ~~complaints is very important, we added the stage of “institutional changes for quality~~
38
39 ~~improvement using complaints data”.[2, 16]~~
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49 Our study was approved by Institutional Review Board (IRB), School of Public
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51 Health, Fudan University. Access to data was restricted to approved members of the
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53 research team who signed a confidential agreement with the principal investigator.
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55 Data were stored in secure electronic locations. Data processing was kept
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4 anonymously so as to protect the identity of interviewees. The names of the
5
6 respondents have been deleted from quotations.
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10 11 **Findings**

12
13 This section first presents a number of approaches developed and implemented in
14 Shanghai to handle patients' complaints and their relationships. It then focuses on the
15
16 approach of Negotiation between Hospital and
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18 Complainants, identifies its barriers, and proceeds to examine and
19
20 analyse these barriers.
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29 **1. Approaches and mechanisms used in managing patients' complaints**

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31 The study identifies both formal and informal approaches and mechanisms used in
32
33 handling patients' complaints.
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39 ● Negotiation between Hospitals and Complainants

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41 The complaint handling department within the hospital is responsible for dealing with
42
43 patients' complaints, first established on February 20, 2002, in accordance with
44
45 the *Regulation on the Handling of Medical Malpractices*.^[26] Since November 2009,
46
47 these departments have been regulated by *Measures for the Handling of Patient*
48
49 *Complaints in Hospitals (for Trial Implementation)*.^[19] These acts require that a
50
51 medical institution establishes a department specifically for the purpose of
52
53 handling and resolving medical disputes. The department is primarily responsible for
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4 receiving patients' complaints- via calls, letters, visits, and/or cases referred from
5
6 other departments and institutions. Their role also includes counselling and
7
8 communicating with patients, verifying and documenting disputes as well as resolving
9
10 disputes.
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16 ● Administrative Mediation and Civil Lawsuits

17
18 If the hospital is unable to resolve certain conflicts through negotiation, these cases
19
20 may be referred to an external body such as the health administrative department. ~~Or~~
21
22 or they may be settled in the court by means of litigation. The *Tort Law of the*
23
24 *People's Republic of China*, adopted at the twelfth session of the Standing Committee
25
26 of the Eleventh National People's Congress on December 26 2009, provided a new
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28 legal definition of liability for medical malpractice, liability presumption and
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30 exemption.[27]
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39 ● Complaint Letters and Visits System

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41 In February 2007, *Measures for the Complaint Letters and Visits System for*
42
43 *Healthcare* came into force.[28] Its purpose is to protect the legal rights and interests
44
45 of citizens, legal entities and other organizations, regulate behaviour and maintain
46
47 order within the Complaint Letters and Visits System. It requires health administrative
48
49 departments to set up the Complaint Letters and Visits office at different levels. These
50
51 offices are responsible for receiving, assigning and transferring matters as appropriate,
52
53 as well as supervise in the handling of various issues and complaints.
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- 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.

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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 |

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4 ~~There shows the~~The complex relationships between different approaches can be seen
5
6 where many actors are involved. From the aspect of solution, approaches ~~which~~that
7
8 can resolve medical disputes are mainly negotiation and civil lawsuits, while other
9
10 approaches play a part in forwarding cases, such as Complaint Letters and Visits
11
12 System, or easing conflicts, such as mediation. ~~Not any~~None of the approaches ~~is~~are
13
14 considered the most authoritative approach. Patients can continue to lodge complaints
15
16 through the Complaint Letters and Visits System even if a decision has been finalised
17
18 after a second trial in court.
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27 In the above-mentioned approaches, the hospital is the main handler for
28
29 ~~patients'~~patient complaints. First of all, it can handle ~~patients'~~patient complaints
30
31 completely independently, from reception to solution, while the other approaches have
32
33 to engage hospitals in complaint handling. Secondly, since the hospital is principally
34
35 responsible for compensation, the complainant is more inclined to directly negotiate
36
37 with ~~the~~ hospital. ~~From~~Findings from the literature ~~it is found~~show that the majority
38
39 of medical disputes are resolved by negotiation between hospitals and
40
41 complainants.[21] Thirdly, if hospitals handle complaints improperly, conflicts will
42
43 become more volatile, resulting in serious incidents.[32] Therefore, hospitals have
44
45 become the most common receiver, handler and resolver of disputes. (Figure 1)
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54 **3. Barriers to the effective management of patient complaints and their**
55
56 **underlying causes at different stages ~~of the complaint process~~**
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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, 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 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 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

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4 *spend more time communicating with patients, they would lose time needed to carry*
5
6 *out [clinical work]. That is to say, [doctors should be given] less [clinical] work,*
7
8 *and more time to explain their work to patients. Our workload is very heavy, like a*
9
10 *battle. (Female, Health providers-1, 01-09-2011)*

Incompetence and powerlessness of complaints handlers

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19 Complaint handlers played a more important role in cooperation and coordination.
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21 Although the complaint department was specifically set up in hospitals for receiving
22
23 and handling complaints, the responsible persons in the department were mainly
24
25 part-time medical staff. In some cases, those handling staff ~~had been~~were found to be
26
27
28 inadequate- sometimes due to lack of training. Many of them had studied handling
29
30 techniques on their own and had not acquired sufficient professional skills to
31
32 appropriately analyse, assess and solve complaints.
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36 *Complaint handlers in the hospitals cannot solve everything-~~Because~~ because the*
37
38 *disciplines involved in complaints are highly specialised. I am only familiar with*
39
40 *general surgery and issues that require common sense, but [I am not familiar] with*
41
42 *professional problems in other disciplines. (Male, Hospital managers-5,*
43
44 *08-09-2011)*

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49 *It is difficult to recruit staff for our Medical Dispute Handling Office. No one wants*
50
51 *to come. A boy recruited in 2007 could not stand the demands of the job*
52
53 *[complicated disputes and violence] and so resigned. (Female, Hospital*
54
55 *managers-3, 31-08-2011)*

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4 We have little time to do things other than receiving complaints. We lack staff
5 members. We are responsible for receiving and processing complaints, and
6 expected- on top of this- to deal with other things. ~~Hence, hence~~ why we are
7 exhausted. (Male, Health providers-2, 16-09-2011)
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13
14 Given that most complaints are handled and resolved in the hospital, it appeared that
15 every complaint handler interviewed felt the same way: tired and stressful.stressed.
16
17 Complaint handlers were insufficiently empowered to handle complaints. It was hard
18 for them to coordinate between different departments, investigate cases, organize
19 mediation, find solutions and then draw on patients' feedback to improve quality of
20 care.
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28
29 *Recently, a fierce medical dispute occurred because of a possible misunderstanding*
30 *between administrative departments. [Abusive] words erupted. As a consequence,*
31 *staff members involved in this incident were distraught- to the extent that they*
32 *wanted to resign. Hence we need understanding and support among*
33 *colleagues. ...Sometimes the clinical department concerned refuserrefused to*
34 *cooperate when investigated. He [the clinical department] is not very serious ~~to~~*
35 *cooperateabout cooperating with the investigation. (Female, Hospital managers-3,*
36 *31-08-2011)*
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49 *Communication between administrative departments and clinical departments is*
50 *not very effective sometimes. I am not satisfied with this. (Female, Hospital*
51 *managers-2, 25-08-2011)*
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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 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.

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4 ~~Other~~ However, other results, ~~however~~, including penalties imposed upon physicians
5
6 and departments or improvements made to hospital services, were largely withheld
7
8 from patients if they did not ask.
9

10
11 *In individual cases, what are the outcomes of their complaints? How might a*
12 *physician be punished/penalised/disciplined? Such information is requested by*
13 *patients only occasionally. (Male, Health providers-2, 16-09-2011)*
14
15

16
17 *I want to know how to better educate the concerned health care providers. But I*
18 *have not been told. (Female, Users-3, 20-09-2011)*
19
20
21
22

23 24 25 26 ● **Barriers to resolving the complaints**

27 28 **Conflicts between relevant actors and regulations**

29
30 Within the complaints system, conflicts or inconsistencies can arise between the legal
31
32 system for handling complaints and the solutions determined by the hospital. As the
33
34 structure of managing ~~patients'~~ patient complaints is shown in Figure 1, different
35
36 regulations stipulate different approaches. There does not exist a unified law or
37
38 guidelines to clearly illustrate the relationships between different approaches. ~~It,~~
39
40 which results in problems such as lack of authority or ultimate approach, uncertainty
41
42 about how to apply different regulations to one case and no clear definitions or
43
44 classifications asin regards ~~patients'~~ to patient complaints.
45
46
47
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51
52 *The current state of complaint management is disorderly. There are too many*
53 *channels. For example, many departments are involved, including but not limited to*
54 *Complaint Letters and Visits, online complaints etc. The Health Bureau has two*
55
56
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4 departments [for complaint management], each district has a mediation office, a
5
6 district government website or a mayor-mail [to receive complaints], and a
7
8 Complaint Letters and Visits office... Far too many heads of department within the
9
10 health sector; it's chaos. (Male, Health providers-2, 16-09-2011)

11
12
13
14 Hospitals are required to report complaints to a lot of sectors, all of which wish to
15
16 understand the issue from different angles. There are not necessarily conflicts
17
18 between regulations, but different elements are emphasised. Hospitals are tired of
19
20 these kinds of bureaucracy. ...Each sector carries out their designated duties where
21
22 resources are not shared. The information possessed by each sector is fragmented.

23
24
25
26 You know yours, I know mine. (Male, Administrators-2, 18-08-2011)

27
28
29 Medical malpractice is defined clearly in the Regulation on Handling Medical
30
31 Malpractice. There are several benchmarks determining the amount of
32
33 compensation issued. After the Tort Liability Law of the People's Republic of China
34
35 was promulgated, [medical damage] was compensated for more in accordance with
36
37 the Tort Liability Law, because it stipulates compensation for personal injury.
38
39
40
41 (Female, Hospital managers-2, 25-08-2011)

42 43 44 45 46 **Unjustifiable complaints by patients**

47
48
49 In some cases, the patient experiences inconvenience when receiving medical services
50
51 not because of poor conduct in attitude or behaviour on the part of health providers.

52
53
54 ~~It~~ **Instead, inconvenience** may be ~~the case of~~ **due to** long waiting times, too little time
55
56 spent with the doctor and/or imperfect ~~resources~~ **resource** allocation. These are health
57
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4 system issues rather than problems caused by hospitals or individual physicians. And
5
6 so to a certain extent, physicians and hospitals have become scapegoats of the entire
7
8 health system.
9

10
11 *At times it is not us physicians who have made a patient angry. Certain factors are*
12
13 *rooted in the fabric of health care systems, but we physicians [end up] taking the*
14
15 *blame. (Male, Health providers-3, 16-09-2011)*
16
17

18
19 *For example, should a doctor need to see sixty patients in half a day, or indeed one*
20
21 *hundred, you cannot demand that he puts on a smile for each one. A lot of patients*
22
23 *complain about doctors with a straight face, but I think it is understandable. I have*
24
25 *a very good relationship with our young doctors. They operate on a tight schedule.*
26
27

28
29 *This week someone works at the outpatient's facility. He is friendly with patients in*
30
31 *the first month but struggles to sustain this sort of demeanour. He is not in the mood*
32
33 *to smile at patients or engage in long conversations when he only has time to attend*
34
35 *to their illnesses. (Male, Hospital managers-1, 15-12-2010)*
36
37
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40

41
42 For example, dissatisfaction voiced in the hospital may be related to health insurance
43
44 policy rather than staff behaviour. Hospitals need to follow the policies made by the
45
46 Health Insurance Department. The purpose of those policies was to improve rational
47
48 use of medicines and control healthcare cost, while the patients covered by health
49
50 insurance may demand more medicines.
51
52

53
54 *Chinese doctors have many rules to obey [this is to curb poor conduct]. The*
55
56 *pressures for them to perform are relatively large. For example, doctors cannot*
57
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3
4 prescribe too much medicine for a patient who has only [basic state-financed]
5
6 medical insurance, but patients always want more. A while ago, the Medical
7
8 Insurance Bureau issued the following statement in a newspaper: The Medical
9
10 Insurance Bureau never limits the volume of drugs prescribed, rather it is the doing
11
12 of hospitals who wish to increase workload [in order to produce more statistics]. I
13
14 think this is really unreasonable. The Bureau does not control the quantity of drugs
15
16 prescribed in any given week, but there is a total quantity limit over a year. Doctors
17
18 try their best not to prescribe drugs which must be self-financed, i.e. not covered by
19
20 basic medical insurance. They must also explain very clearly before prescribing
21
22 self-financed drugs, otherwise, patients will lodge complaints once they find out.
23
24
25
26
27
28
29 (Male, Hospital managers-1, 15-12-2010)

30
31 Complaints occur ~~where~~when the patient wants more drugs but the doctor ~~has~~
32
33 ~~refuse~~refuses to satisfy his or her demands. Why? The health insurance institution
34
35 sets a limit for drug expenditure for each hospital; in turn, the hospital sets a limit
36
37 for each doctor. So if a doctor has too many patients drawing from their health
38
39 insurance scheme in any one month, he or she may very possibly have exceeded
40
41 his/her limit. (Male, Health providers-3, 16-09-2011)

42
43
44 [A patient who has] basic state-financed medical coverage is entitled to blood and
45
46 other auxiliary examinations. If the number of health checks prescribed exceeds a
47
48 certain threshold, the doctor is viewed as exploiting basic medical insurance. The
49
50 doctor is consequently punished. I was deducted more than seven hundred yuan
51
52 (RMB) because of a case like this. I feel this is simply absurd- it is [unexpectedly]
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4 *doctors who are to blame. Nothing seems to be wrong with the patient. ...The*
5
6 *hospital can't do anything about medical insurance. I think this kind of thing is not*
7
8 *the problem at the hospital level. The complaints about medical insurance define*
9
10 *without a doubt problems underlying state and society. (Male, Health providers-4,*
11
12 *16-09-2011)*

13
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15
16 In addition, the safety of health providers is under threat in China today. Chinese
17
18 medical workers are often victims of terrible violence. As a consequence, some health
19
20 providers have decided not to treat patients deemed likely to assault staff, exhibit
21
22 disruptive behaviour or prove difficult to deal with. Prescribing redundant check-ups
23
24 and drugs are alternatives to properly seeing to patients.

25
26
27
28 In our interviews, fifteen interviewees mentioned “Chao” fifty-five times. “Chao” in
29
30 Chinese means to argue with hospitals for patients’ own rights and interests, while the
31
32 other meaning is wrangle fiercely in hospitals or with senior management. Most of the
33
34 hospital staff being interviewed suggest that some complainants are indeed
35
36 unreasonable and impulsive, whose sole purpose is to ask for money.

37
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39
40
41 *If the case goes to court, the patient gathers a lot of people to go to the court,*
42
43 *insulting and threatening concerned health care providers and their lawyers. That is*
44
45 *not what we want to see. We want to talk about the truth, by thoroughly publicizing*
46
47 *the truth. We cannot always be too specific with terminology [for fear of revealing*
48
49 *too much]. When completely refuted, patients lose their temper. (Male, Other*
50
51 *actors-2, 15-09-2011)*

52
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55
56 *I feel that the widespread situation in China today is that you can do nothing if you*
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4 *run into the unreasonable. The legitimate way of going about this is once I receive*
5
6 *your complaint, a fair decision is proposed. If complainants are not willing to settle*
7
8 *for this, we then transfer their case to other departments. However, complainants*
9
10 *may not even agree to that, causing trouble and even threatening the safety of*
11
12 *health care providers. (Female, Hospital managers-2, 25-08-2011)*

13
14
15
16 *The claim a complainant demands goes beyond the actual problem [but for the*
17
18 *money] and he does not wish to resolve it ~~in~~ the legal way. ...Nowadays “Yi Nao”*
19
20 *has brought about serious social effects, and escalated the tension between service*
21
22 *users and providers. Complainants are unwilling to resolve things the legal way,*
23
24 *rather, just pestering and hassling you [health care providers or complaint handlers]*
25
26 *all day. (Male, Hospital managers-6, 01-11-2011)*
27
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33
34 ● **Barriers to institutional changes for quality improvement using complaints**
35
36 **data**

37
38
39 **Weak enforcement of the regulation**

40
41 | The regulation for managing ~~patients'~~ patient complaints is merely a guideline, which
42
43 contains no mandatory requirements such as assessment mechanisms. Because it takes
44
45 into account the difference in local conditions throughout China, specific contents
46
47 were not stipulated. The regulation is to be interpreted according to local
48
49 circumstances and conditions. ~~In~~ Therefore, in the absence of strong public scrutiny,
50
51 ~~therefore,~~ there is little accountability for how best to manage patients' complaints.
52
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54

55
56 *There are no penalties attached to (failure to follow) regulation. For example, there*
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4 is no administrative aspect to the regulatory guidelines. We wanted to write a
5
6 penalty provision, but it was not based on the top legislation. The purpose of the
7
8 regulation is to emphasise self-discipline and serve as guidance for the hospital.
9
10
11 [The penalty was not enforceable,] so we decided to remove the penalty. It is indeed
12
13 difficult and contradictory. (Female, Administrators-4, 30-11-2011)
14
15

16 Besides the legal system, the reporting system also has its problems. Some statistics
17
18 about ~~patients'~~patient complaints and medical malpractice were utilized as a part of
19
20 assessments of hospital performance, health care quality, and so on. This meant that
21
22 the more cases that were reported, the worse the evaluations received by ~~the~~ hospitals,
23
24 so that hospitals were inclined to report selectively or report fewer cases.
25
26
27

28
29 *There are certainly no statistics for the number of ~~patients'~~ complaints. There is*
30
31 *only the data on the number of cases of medical malpractice per year from the*
32
33 *Bureau of Health, and an approximate amount of compensation issued by insurance*
34
35 *companies. In some cases, if complaints were solved just between the hospital and*
36
37 *the complainant, we have no data. (Male, Administrators-2, 18-08-2011)*
38
39

40
41 *These days, the information regarding the management of ~~patients'~~ complaints in*
42
43 *hospitals is difficult to access. Hospitals are unwilling to provide that sort of*
44
45 *information- considered confidential. We only have some profiles or the information*
46
47 *from select hospitals. (Female, Policy makers-1, 16-12-2010)*
48
49
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54 Thus, the adoption of the incentive and sanction mechanism was contradictory for
55
56 managing ~~patients'~~patient complaints. From one side, the administrative department
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3
4 wanted hospitals to report patients'patient complaints because it is important for
5
6 informing and improving the quality of care. From the other side, the more complaints
7
8 that are registered, the worse it would appear a hospital is doing. In addition to this,
9
10
11 managing patients'patient complaints remains low on the health reform agenda. The
12
13 force for inspecting complaint management in hospitals from senior management and
14
15 administrative departments remains weak.

16
17
18 *[Having a statistic for patients'patient complaints] is definitely necessary, from the*
19
20 *aspect of effective management. If this statistic is disposable, I think no problem. If*
21
22 *the statistic is routine, in fact, it will cost- [of all sorts of resources]. (Male, Policy*
23
24 *makers-2, 22-12-2011)*

25
26
27
28 *Hospitals doubt that the purpose of administration is for information management-*
29
30 *to help them better handle and solve disputes. However, if you want me to report*
31
32 *incidents but meanwhile punish me for that, then I have no incentive to report*
33
34 *anything. This contradiction stands [in the way of effective reporting]. (Female,*
35
36 *Administrators-4, 30-11-2011)*

43 44 **Deficient information system for managing patients'patient complaints**

45
46 Although the regulations in place require collecting and analysing information, there
47
48 exists no clear classification, definitions or unified coding system. Most hospitals
49
50 have established their own systems for recording complaints and analysing cases, but
51
52 no accurate or comparable data are available.
53
54

55
56 *In fact a lot of cases should be recorded and analysed, [but] we do not even take*
57
58
59
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3
4 into account so-called major cases of medical malpractice, mass disturbance or
5
6 medical malpractice. We cannot distinguish between these concepts... Relatively
7
8 speaking, it is more feasible to publicize the data on public security, e.g. the number
9
10 of police records and people arrested, the number of crimes committed. Those
11
12 definitions are more explicit, whereas those concerning complaints management are
13
14 not. Because all statistics are calculated in the hospital, we find that where
15
16 standards are slack, the resulting statistic is large whereas with a strict standard, it
17
18 will be small. ~~There~~Hence, there is ~~hence~~ great variability in our results. (Male,
19
20 Policy makers-2, 22-12-2011)

21
22 Identical forms are sent to two hospitals at a similar level and the reported data can
23
24 be quite different. ...Some hospitals only reported cases resulting in compensation
25
26 and some hospitals record all persons who voice a concern, while others only
27
28 report cases identified as medical malpractice. But it is impossible for me to verify
29
30 [the reported data] in each hospital. (Male, Administrators-2, 18-08-2011)

31
32 Hospitals have not publicized complaints; neither have health administration
33
34 departments. The Shanghai Bureau of Health launched a pilot project in 2005 to
35
36 publicize the complaints reported by all hospitals in Shanghai. The project was
37
38 welcomed by the public but discontinued soon after its launch due to mounting
39
40 pressure from the hospitals.

41
42 We already publicize complaints [medical malpractice] on our intranet for hospital
43
44 staff. It is unnecessary to share this information on external sites. (Female, Hospital
45
46 managers-4, 06-09-2011)

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2
3
4 To my knowledge, such information was published once on the Xinmin Evening
5
6 News in 2005. The newspaper named hospitals that had won awards and gave
7
8 details of the number of medical malpractice cases inherent in each, as well as
9
10 feedback regarding patient satisfaction. [We felt] the pressure was very, very high.
11
12 It [publishing those] resulted in public outrage [from hospitals]. (Female,
13
14 Administrators-4, 30-11-2011)
15
16
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18
19

20 21 **Unwillingness on the part of hospitals to effectively handle complaints** 22

23
24 Most hospitals did not devote much effort into managing complaints. There was no
25
26 clear mechanism to utilize ~~patients'~~patient complaints to improve quality of care
27
28 unless serious medical malpractice had occurred or complaints ~~are~~were found to recur.
29
30

31
32 *Hospitals just handle complaints when complaints happen. ...We are basically*
33
34 *perfunctory, including hospitals, department directors and doctors. The best--case*
35
36 *scenario for me: do not approach me for these things [complaints]. Deal with*
37
38 *complaints quickly and efficiently; in other words, spend money to buy peace. The*
39
40 *impact of managing and addressing complaints is negligible, with very little effect*
41
42 *on improving medical procedures and quality. (Male, Administrators-2,*
43
44 *18-08-2011)*
45
46
47
48

49 Hospital directors were the key actors of complaint management in hospitals. The
50
51 incentive and sanction mechanisms in hospital depended on how much they pay
52
53 attention to complaint management. In the 1980s the government reduced subsidies
54
55 for public hospitals under the context of transforming the planned economy to a
56
57
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1
2
3 | so-called socialist market ~~one~~ in order to reduce inefficiencies in health care provision.
4
5
6 Hospitals had to increase service charges to generate more revenue to recoup the
7
8 operational costs and increase the income level of health workers. Complaint
9
10 management occupied nothing but a small part of quality health care, so in most
11
12 hospitals it failed to draw attention from senior management. Most complaints were
13
14 solved on a case-by-case basis, without sufficient concern for the overall
15
16 improvement of health care services.
17
18
19

20
21 *In practice, the head of department influences implementation. If he/she regards*
22
23 *this as important, then subordinates work harder of course. Now the problem is that*
24
25 *some heads of department do not pay attention to it [complaint management].*
26
27

28
29 *(Male, Health providers-2, 16-09-2011)*
30

31 *It is of course medical services that are the core of hospital work. Things such as*
32
33 *[complaint management] are boring for the hospital. To a hospital, the fewer the*
34
35 *complaints, the better. (Male, Administrators-2, 18-08-2011)*
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40 41 | **Discussion and Conclusions** 42

43
44 This study examined the handling system for patient complaints in China and the
45
46 views of key stakeholders on the barriers to effective complaint management. Our
47
48 study provided a new dimension of understanding the complaints management system
49
50 in China, a developing country. Hospitals are the most important handler and manager
51
52 of patient complaints in China and similarly for other developing countries such as
53
54 India and Vietnam. We explored the barriers through in-depth interviews with almost
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4 all stakeholders, not only health professionals. What we found would help develop
5
6 procedures for more effective complaint management and to further improve the
7
8 quality of care in China and other developing countries. The selection of participants
9
10 may introduce some bias to our studies. Due to our focus on the hospital, there may be
11
12 an underrepresentation of certain types of respondents.
13
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18
19 ~~This study examined the structure of managing patients' complaints in China and the~~
20
21 ~~views of key stakeholders on the barriers to effective complaint management. It is~~
22
23 ~~shown that there are no standardized systems and procedures dealing with~~
24
25 ~~patients'Our Findings showed that there are no standardized systems and procedures~~
26
27 ~~dealing with patient~~ complaints in China, due to conflicts between relevant actors and
28
29 regulations. Having experienced rapid economic growth in the last 30 years, China is
30
31 undergoing a socioeconomic transition. Like other developing countries, policies lag
32
33 behind the country's economic transition. The Ministry of Health has tried to guide
34
35 health providers by issuing special regulation, but health administrations do not apply
36
37 strict regulation to complaint management. There lacks ~~of~~ clear relationships between
38
39 ~~patients'patient~~ complaints and clinical outcomes or the quality of care.
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49 The hospital leader is the key determinant for complaint handling inside the hospital.
50
51 However, no apparent incentives exist to push hospital leaders to ~~put~~ place priority on
52
53 complaint handling ~~at a priority.~~ The power of complaint handling
54
55 ~~department~~ departments depends on how much ~~attention~~ the hospital leaders pay
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4 attention to it. Under the current situation, ~~the~~ hospital leaders lack political will to
5
6 manage ~~complaint~~ complaints effectively. ~~This led,~~ leading to inadequate human
7
8 ~~resource~~ resources in ~~place~~ at the appropriate department to handle
9
10 ~~complaints.~~ complaint handling departments. The ~~department~~ departments also lack the
11
12 power to coordinate with clinical departments.
13
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18
19 The ~~patients'~~ patient complaints in many Chinese hospitals are not well managed and
20
21 handled. Most hospitals manage patient complaints on only a case-by-case basis. They
22
23 lack clear mechanisms linking ~~patients'~~ patient complaint with improving the quality
24
25 of care. Complaints are underutilised for organizational strategic planning or changing
26
27 individual behavioural and attitudes.
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31
32

33 ~~Policy recommendations~~

34
35
36 ~~The Chinese Ministry of Health and health authorities at provincial and municipal~~
37
38 ~~level should oversee the development of national guideline on handling patients'~~
39
40 ~~complaints which can be practically implemented in China. Legislation stipulates not~~
41
42 ~~only~~ This implies that legislation should not only stipulate the principles and
43
44 regulations of patients' complaint management, but also the responsibilities of sectors
45
46 at different levels.
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53
54 To alleviate patient complaints related violence, ~~the guideline should be approved by~~
55
56 civil groups, including service users and the hospital sector, should approve the
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3 guideline. In developed countries, patient's complaint management provides
4
5
6 guidelines not only for health care providers, but also clear guidelines for patients.
7
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9 This not only makes it more convenient for patients, but also plays a positive role in
10
11 helping patients initiate the complaint process via legitimate means. This is crucial for
12
13
14 society to view patients' complaint in a rational way.

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18
19 If patients' patient complaints can be better managed and rectified, the instances of
20
21 failure would be reduced and quality would be improved. Greater emphasis should be
22
23 placed on quality improvement after patients' patient complaints. Strategies to
24
25 improve quality following patients' patient complaints should be developed through a
26
27 learning process. To promote the learning process, appropriate mechanisms should be
28
29 developed and implemented to assess not only the number of patients' patient
30
31 complaints occurring in hospitals, but also how these hospitals have handled these
32
33 complaints. For example, reporting more patients' patient complaints should not be
34
35 necessarily punished, while effectively effective handling of the patients' patient
36
37 complaints should be appreciated.
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46 Our final conclusion is that barriers to the effective management of patient complaint
47
48 vary at the different stages of complaint handling, from the user and provider side, as
49
50 well as systemic issues. Information, procedure design, human resources, system
51
52 arrangement, unified legal system and regulations and factors shaping the social
53
54 context all play important roles in effective patient complaint management.
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4 Appropriate mechanisms should be developed to link patient complaint with
5
6 improving the quality of care.
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For peer review only

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.

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4 **DATA SHARING**
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6 No additional data available.
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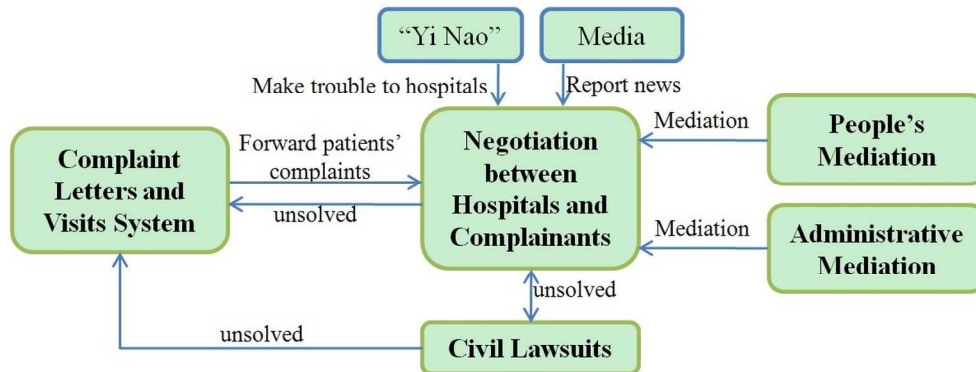


Figure 1 The structure of managing patients' complaints in China

199x90mm (300 x 300 DPI)

Peer review only

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? | YES It is difficult to measure the regulation process quantitatively. |
| <ul style="list-style-type: none"> • <i>Interviews</i>: experience, perceptions, behaviour, practice, process • <i>Focus groups</i>: group dynamics, convenience, non-sensitive topics • <i>Ethnography</i>: culture, organizational behaviour, interaction • <i>Textual analysis</i>: documents, art, representations, conversations | |
| T Transparency of procedures | |
| <i>Sampling</i> | |
| 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 |
|--|---|
| | <p>process.</p> <p>Different types of respondents were helpful for holistic understanding for transparency deficits.</p> <p>Key informants were interviewed by snowball sampling and saturation.</p> |
| <i>Recruitment</i> | |
| 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. |
| <i>Data collection</i> | |
| 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. |
| <i>Role of researchers</i> | |
| 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. |
| <i>Ethics</i> | |
| 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 | |
| <i>Analysis</i> | |
| <p>Is the type of analysis appropriate for the type of study?</p> <ul style="list-style-type: none"> • <i>thematic</i>: exploratory, descriptive, hypothesis generating • <i>framework</i>: e.g., policy • <i>constant comparison/grounded</i> | <p>YES.</p> <p>Analytic approach was justified.</p> |

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| <p><i>theory</i>: theory generating, analytical</p> <ul style="list-style-type: none"> Are the interpretations clearly presented and adequately supported by the evidence? Are quotes used and are these appropriate and effective? Was trustworthiness/reliability of the data and interpretations checked? <p><i>Discussion and presentation</i></p> <ul style="list-style-type: none"> Are findings sufficiently grounded in a theoretical or conceptual framework? Is adequate account taken of previous knowledge and how the findings add? Are the limitations thoughtfully considered? Is the manuscript well written and accessible? | <p>YES.</p> <p>YES.</p> <p>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.</p> <p>YES.</p> <p>YES.</p> <p>YES</p> <p>YES</p> <p>NO</p> |
| <ul style="list-style-type: none"> Are red flags present? These are common features of ill-conceived or poorly executed qualitative studies, are a cause for concern, and must be | <p>NO</p> |

ASK THIS OF THE MANUSCRIPT**THIS SHOULD BE
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MANUSCRIPT**

viewed critically. They might be fatal flaws, or they may result from lack of detail or clarity.

For peer review only

BMJ Open

Managing patient complaints in China – a qualitative study in Shanghai

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|---------------------------------|--|
| Journal: | <i>BMJ Open</i> |
| 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 |
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Title page

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4 8) HESVIC team authorship
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8
9 4. Up to five keywords or phrases suitable for use in an index (it is recommended to
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11 use MeSH terms).
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14 Qualitative Research; Patient Complaints; Complaint Handling Systems; Quality
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21 5. Word count - excluding title page, abstract, references, figures and tables.
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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

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

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

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3 side, as well as system issues.
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- 6 5. Information, procedure design, human resources, system
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8 arrangement, unified legal system and regulations and factors
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10 shaping the social context all play important roles in effective
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12 patient complaint management.
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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

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4 the quality of care. In Britain, the National Health Service (NHS) not only provides
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6 clear and transparent guidelines for both health care providers and patients but also
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8 publicizes information regarding the routine reporting of patient complaints.[9] In
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10 Australia, a large study was conducted before *Guide to Complaint Handling in Health*
11
12 *Care Services* was formulated and subsequently updated.[10] Annually, statistics are
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14 compiled and published, detailing complaint trends, complaint management and
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16 reasons for complaints. Effective handling of complaints has been known to reduce
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18 friction between providers and consumers, with the even greater benefit of improving
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20 quality of care. As a supplement to peer reviews and administration, patient
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22 complaints can provide important feedback concerning the delivery of health care
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24 services and can be a useful tool in the improvement of health care quality.[1-3,
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36 With no official statistics of patient complaints available in Chinese records, we
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38 estimated that the number of complaints and disputes rose, from 10,249 to 13,875
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40 claims, based on the number of first trials for medical malpractice cases between 2002
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42 and 2008.[15] Mounting dissatisfaction has been felt across the country, manifesting
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44 in increasingly hostile and violent behaviour towards providers from patients and their
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46 families.[16] An investigation carried out by the Chinese Hospital Management
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48 Association in 2005 suggested that of 270 hospitals surveyed, 73 per cent experienced
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50 abuse in the form of threats and assaults targeting doctors and management.[17] These
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52 incidents are only indicative of rising expectations, burgeoning patient discontent with
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4 services and dissatisfaction towards the way in which matters are resolved.[18] Public
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6 outcry only exacerbates the need for more effective handling of individual cases under
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8 the overarching agenda of public hospital reform in China.[19]
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14 Notwithstanding the alarming extent of these issues, few attempts have been made to
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16 formally examine how hospital complaints are addressed in developing countries. It is
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18 only recently that a handful of studies in China have sought to provide some
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20 understanding of the issue by trying to ascertain the number of complaints in the
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22 studied hospitals or garnering patient feedback via questionnaires and
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24 interviews.[20-22] A fuller understanding of the complaints system – the available
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26 channels for seeking redress, how the system operates and the barriers to conflict
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28 resolution – will be crucial to ameliorating the often fraught relationships between
29
30 health care providers and consumers. The purpose of this study has been to examine
31
32 the handling system for patient complaints in China, and to subsequently identify and
33
34 analyse the various hospital-specific factors preventing grievances from being
35
36 effectively addressed. The authors of this paper hope that such an undertaking will
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38 reduce malpractice and above all, improve health service outcomes.
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49 This study is one of the cases from the "Health System Stewardship and Regulation in
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51 Vietnam, India and China" (HESVIC) research project. It was conducted by a
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53 consortium of six partners in Asia and Europe from 2009-2012, with the aim of
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55 supporting policy decisions in the application and extension of accessibility,
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4 affordability, equity and quality of coverage of maternal health care in the three
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6 countries.
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10 11 **Methods**

12 13 *Study design*

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

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39 Firstly, we conducted a literature review. The relevant sources, which included
40
41 regulation documents related to the handling of patient complaints at both the national
42
43 and Shanghai municipal levels, were used to collect legal approaches and mechanisms
44
45 used in managing patient complaints. These regulations were mainly stipulated from
46
47 2002 to 2011. To understand the application of different complaint approaches, a
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49 search of scientific literature published between 2000 and 2011 was conducted.
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51 Databases MEDLINE-PubMed and WANFANG Data were consulted. A search
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53 strategy was established based on the following keywords: *grievance redressal*,
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4 *patient complaint, health care complaint and hospital complaint, and China. Special*
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6 focus was placed on patient complaint management in hospitals, as we found that the
7
8 vast majority of complaints were handled and resolved within the hospitals.[22]
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10 11 12 13 14 **Phase Two: Pilot Study – Interviews**

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16 Based on our understanding of the current patient complaint handling system, we
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18 performed semi-structured interviews with key stakeholders – policymakers from the
19
20 national level, administrators from the Shanghai municipal level, hospital managers,
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22 health care providers, users and other related parties. We used the snowball sampling
23
24 method to identify key stakeholders and to collect important feedback from key
25
26 informants from various disciplines.[24, 25]
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34 In Phase Two (October-December 2010), one key actor from each of the three
35
36 administrative levels was selected and interviewed: a policymaker at the national level,
37
38 a municipal administrator and a hospital manager. A pilot study was conducted to test
39
40 the topic guidelines developed. These allowed us to gain a preliminary understanding
41
42 of the complaint management process in the hospital setting, and to refine the data
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44 collection tools. These interviews served as the basis for the design of Phase Three
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46 interviews, where some of those being interviewed in the third phase were
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48 respondents recommended by Phase Two interviewees.
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56 **Phase Three: Main Data Collection**

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4 Interviews in Phase Three were conducted from August-December of 2011. Key
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6 stakeholders were interviewed in the selected hospitals based on location, level and
7
8 type. Our sample represented both urban and suburban areas in Shanghai. General and
9
10 specialist hospitals were selected. Phase Three began with interviews of hospital
11
12 managers and health care providers proposed in Phase Two. We asked interviewees
13
14 from Phase Two to invite patients and other relevant stakeholders to contribute their
15
16 views. Those invited patients used different channels for lodging their complaints;
17
18 however, they all shared one thing in common: all patients had first complained to the
19
20 hospital. We then proceeded to interview the administrators and finally a high-level
21
22 policymaker. We continued to interview respondents, collecting and analysing their
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24 comments and feedback until no new themes emerged, i.e. saturation had been
25
26 reached. The number of participants involved in the different types of interviewees is
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28 depicted in Table 1.
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39 Semi-structured interviews were conducted with 35 respondents face-to-face, except
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41 one via telephone. The interviews took place at private locations, for example at the
42
43 institution where the interviewee or interviewer worked, and were conducted by two
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45 of the authors of this paper. Each interview lasted 1-2 hours and was audiotaped with
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47 permission, apart from two which were not recorded but typewritten upon the
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49 respondents' request.
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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 |

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4 Medical Disputes5
6 The Complaint Letters and Visits System 17
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9 **Total 35**

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14 The topic guidelines for carrying out the interviews included questions on the
15 participant's experience in complaint management in the hospitals. Using probes and
16 follow-up questions, attention was directed to factors that the interviewees perceived
17 as barriers to effective complaint management, and interviewees were asked to
18 explain their reasoning. From existing literature, we identified a list of factors
19 required for effective complaint management and successful resolution of disputes.
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21 Participants were asked to provide suggestions and feedback regarding how
22 complaints could be more effectively dealt with given the barriers they had identified.
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3536 ***Data analysis***37
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39 Audiotapes recorded during the interviews were transcribed and were compared with
40 the field notes to check for accuracy. We analysed data through a process of rigorous
41 and structured analysis.[26] The analysis was executed in several stages to 1) become
42 familiar with the data; 2) identify emerging topics; 3) develop a topic index; 4) use the
43 index to code the data; 5) consolidate the topics into themes; 6) further consolidate
44 these themes into analytical categories/clusters; and 7) translate the analysis obtained
45 into a narrative. Written consent was obtained from each interviewee before
46 undertaking the interviews.
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6 We performed the above tasks using the qualitative research software NVivo 9.0. The
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8 raw data was coded by two independent reviewers (YSJ, QZ). If discrepancies
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10 emerged, a third reviewer (XHY) participated in the group discussion until the group
11
12 arrived at a consensus. There were some models for analysing complaint
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14 management;^[2, 13] for example, the Managerial-Operational-Technical (MOT)
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16 model was developed by Hsieh SY to explore complaint management in hospitals.^[2]
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18 In our study, we collected data according to the complaint management process. To
19
20 analyse the data most efficiently and directly, we used the stages of the process, which
21
22 included receiving, handling and resolving complaints.^[27] As quality improvement
23
24 following complaints is crucial, we added the stage of “institutional changes for
25
26 quality improvement using complaints data”.^[2, 12]
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36 Our study was approved by Institutional Review Board (IRB), School of Public
37
38 Health, Fudan University. Access to data was restricted to approved members of the
39
40 research team who signed a confidential agreement with the principal investigator.
41
42 Data were stored in secure electronic locations. Data processing was kept anonymous
43
44 so as to protect the identity of interviewees. The names of the respondents have been
45
46 deleted from the quotations.
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54 Findings

56 This section first presents a number of approaches developed and implemented in
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4 Shanghai to handle patient complaints and their relationships. It then focuses on the
5
6 approach of negotiation between hospitals and complainants, identifies its barriers,
7
8 and proceeds to examine and analyse these barriers.
9

10 11 12 13 14 **1. Approaches and mechanisms used in managing patient complaints**

15
16 The study identifies both formal and informal approaches and mechanisms used in
17
18 handling patient complaints.
19

20 21 22 23 24 a. Negotiation between Hospitals and Complainants

25
26 The complaint handling department within the hospital is responsible for dealing with
27
28 patient complaints, first established on February 20, 2002, in accordance with the
29
30 *Regulation on the Handling of Medical Malpractices*.^[28] Since November 2009,
31
32 these departments have been regulated by *Measures for the Handling of Patient*
33
34 *Complaints in Hospitals (for Trial Implementation)*.^[6] These acts require that a
35
36 medical institution establish a department specifically for the purpose of handling and
37
38 resolving medical disputes. The department is primarily responsible for receiving
39
40 patient complaints via calls, letters, visits, and/or cases referred from other
41
42 departments and institutions. Their role also includes counselling and communicating
43
44 with patients, verifying and documenting disputes as well as resolving disputes.
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50 51 52 53 54 b. Administrative Mediation and Civil Lawsuits

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56 If the hospital is unable to resolve certain conflicts through negotiation, the cases may
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4 be referred to an external body such as the health administrative department or they
5
6 may be settled in court by means of litigation. The *Tort Law of the People's Republic*
7
8 *of China*, adopted at the twelfth session of the Standing Committee of the Eleventh
9
10 National People's Congress on December 26, 2009, provided a new legal definition of
11
12 liability for medical malpractice, liability presumption and exemption.[29]
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19 c. Complaint Letters and Visits System

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21 In February 2007, *Measures for the Complaint Letters and Visits System for*
22
23 *Healthcare* was established.[30] Its purpose is to protect the legal rights and interests
24
25 of citizens, legal entities, and other organizations, and to regulate behaviour and
26
27 maintain order within the Complaint Letters and Visits System. It requires health
28
29 administrative departments to set up Complaint Letters and Visits offices at different
30
31 levels. These offices are responsible for receiving, assigning and transferring matters
32
33 as appropriate, as well as supervising the handling of various issues and complaints.
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42 d. People's Mediation – a form of Third-Party Facilitated Mediation

43
44 In July 2008, the Shanghai Justice Bureau and Health Bureau issued *Opinions on*
45
46 *Regulating People's Mediation Organizations to Participate in Medical Dispute*
47
48 *Mediation*, to establish the People's Mediation Committees for Medical Disputes.[31]
49
50 Committee members, mainly retired judges and doctors, served to mediate disputes
51
52 through reporting, explaining and analysing cases under the supervision of the local
53
54 judiciary. In January 2010, the Ministry of Justice, the Ministry of Health and the
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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 |

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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

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4 Our interviews revealed that different hospitals often use different complaint systems.
5
6 For example, some hospitals operate a centralized complaints office, which may or
7
8 may not be independent of the Medical Affairs (Administration) Department. Other
9
10 hospitals have several complaints offices, each of which is responsive to different
11
12 kinds of complaints. A hospital's deputy director, who also heads hospital complaint
13
14 management, generally manages complaint departments. Barriers to effective
15
16 complaints management vary at different stages of the complaint process, both from
17
18 the sides of the user and provider.
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27 **a. Barriers to receiving the complaints**

28
29 **Low awareness of users about the handling system for patient complaints**

30
31 Although hospital staff claimed that the complaints office was accessible to those with
32
33 grievances, patients did not always feel this was the case. One user looked up the
34
35 hospital telephone number on the Internet and said the complaint handling process
36
37 was "very easy" while others did not concur. Almost all the patients interviewed
38
39 found that signs and directions (to the complaints office) failed to catch the eye. In
40
41 some cases none could be seen at all:
42
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44

45
46 *I wanted to lodge a complaint, but did not know how to find [the complaints*
47
48 *office]... Because the hospital was so big, I did not know which department [was*
49
50 *responsible for handling complaints]. ...I simply did not know who to turn to. You*
51
52 *see, the complaints department was in another building [rather than in the one in*
53
54 *which I was treated i.e. the clinical department] (Female, Users-1, 01-09-2011)*
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6 **b. Barriers to handling the complaints**
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9 **Poor capacity and skills of health care providers**
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11 The capacity and skills of health care providers in managing patient complaints is
12 critically important in problem solving. Our study found that the reasons patients
13 complained lay mainly in poor communication and factors such as the provider's
14 attitude, use of language, unprofessional behaviour, as well as dissatisfaction towards
15 service procedures.
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24 *The Medical Doctors Association carried out a survey on the nature of medical*
25 *disputes. 50 per cent of cases were results of inappropriate attitudes about health*
26 *care delivery, 25 per cent were caused by technology misuse and the rest were*
27 *related to management. (Female, Policy makers-1, 16-12-2010)*
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33
34 The majority of complaints can be resolved by an explanation issued by the hospital
35 and/or a verbal apology by the offending party.[5, 35, 36] However, practitioners are
36 often too preoccupied with their clinical duties to be able to respond to patient
37 complaints.
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44 *Doctors are not able to devote much time to handling disputes, because clinical*
45 *work is highly demanding. [They need to attend to] many patients every day. If they*
46 *spend more time communicating with patients, they would lose time needed to carry*
47 *out [clinical work]. That is to say, [doctors should be given] less [clinical] work,*
48 *and more time to explain their work to patients. Our workload is very heavy, like a*
49 *battle. (Female, Health care providers-1, 01-09-2011)*
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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)

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4 Given that most complaints are handled and resolved in the hospital, it appeared that
5
6 every complaint handler interviewed felt the same way: tired and stressed. Complaint
7
8 handlers were insufficiently empowered to handle complaints. It was hard for them to
9
10 coordinate between different departments, investigate cases, organize mediation, find
11
12 solutions and then draw on patients' feedback to improve quality of care.
13
14

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16 *Recently, a fierce medical dispute occurred because of a possible misunderstanding*
17
18 *between administrative departments. [Abusive] words erupted. As a consequence,*
19
20 *staff members involved in this incident were distraught – to the extent that they*
21
22 *wanted to resign. Hence, we need understanding and support among*
23
24 *colleagues. ...Sometimes the clinical department at hand refused to cooperate when*
25
26 *investigated. He [the clinical department] is not very serious about cooperating*
27
28 *with the investigation. (Female, Hospital managers-3, 31-08-2011)*
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34 *Communication between administrative departments and clinical departments is*
35
36 *not very effective sometimes. I am not satisfied with this. (Female, Hospital*
37
38 *managers-2, 25-08-2011)*
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44 **Non-transparent exchange of information**

45
46 In addition, the complaint handling process was not truly open to the complainant, and
47
48 information exchange was largely limited to hospital staff. In fact, it was found that
49
50 the staff at the complaints office was generally evasive towards patients who arrived
51
52 wishing to be updated with the specifics of their complaint. Complainants had no
53
54 opportunity to directly engage in the handling of their complaints or to meaningfully
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4 participate in the process. In addition, hospitals tended to oversimplify cases,
5
6 assuming that the complainant's only desire was to report their complaint and ask for
7
8 compensation. This implies that the entire handling process is disclosed only among
9
10 hospital staff. Therefore, the process becomes a "black box" to patients. It is easy for
11
12 the hospital to manipulate a complainant by providing limited information to gain
13
14 advantage in negotiations, i.e. reduce loss from compensating patients.
15
16

17
18 *Sometimes you have to circumvent something and use negotiating skills. Mistakes in*
19
20 *medical services do not necessarily harm patients' health, but they can be very*
21
22 *serious for the provider [...] for example, someone may not be very careful when*
23
24 *writing a medical record and alter it by accident. But you are likely to lose a lawsuit*
25
26 *on the grounds of having tampered with records. Incidents such as these cloud the*
27
28 *matter, making transparency difficult. (Female, Hospital managers-2, 25-08-2011)*
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34 If the incident is urgent or presents itself as a recurring problem, it might be shared to
35
36 educate healthcare providers but disclosure to complainants themselves remains
37
38 limited. Only outcomes deemed to be of direct interest to patients, including
39
40 compensation amounts and medical service privileges, were provided. However, other
41
42 results, including penalties imposed upon physicians and departments or
43
44 improvements made to hospital services, were largely withheld from patients if they
45
46 did not ask.
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51 *In individual cases, what are the outcomes of their complaints? How might a*
52
53 *physician be punished/penalised/disciplined? Such information is requested by*
54
55 *patients only occasionally. (Male, Health care providers-2, 16-09-2011)*
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4 *I want to know how to better educate the concerned health care providers. But I*
5
6 *have not been told. (Female, Users-3, 20-09-2011)*
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10 11 **c. Barriers to resolving the complaints**

12 13 **Conflicts between relevant actors and regulations**

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15
16 Within the complaints system, conflicts or inconsistencies can arise between the legal
17
18 system for handling complaints and the solutions determined by the hospital. As the
19
20 structure of managing patient complaints is shown in Figure 1, different regulations
21
22 stipulate different approaches. Unified laws or guidelines do not exist to clearly
23
24 illustrate the relationships between different approaches, which results in problems
25
26 such as a lack of authority or ultimate approach, uncertainty about how to apply
27
28 different regulations to one case, and no clear definitions or classifications in regards
29
30 to patient complaints.
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36 *The current state of complaint management is disorderly. There are too many*
37
38 *channels. For example, many departments are involved, including but not limited to*
39
40 *Complaint Letters and Visits, online complaints, etc. The Health Bureau has two*
41
42 *departments [for complaint management], and each district has a mediation office,*
43
44 *a district government website or a mayor-mail [to receive complaints], and a*
45
46 *Complaint Letters and Visits office... Far too many heads of departments within the*
47
48 *health sector; it is chaos. (Male, Health care providers-2, 16-09-2011)*
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54 *Hospitals are required to report complaints to a lot of sectors, all of which wish to*
55
56 *understand the issue from different angles. Conflicts between regulations do not*
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4 necessarily exist, but different elements are emphasised. Hospitals are tired of these
5
6 kinds of bureaucracy. ...Each sector carries out their designated duties where
7
8 resources are not shared. The information possessed by each sector is fragmented.

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11 You know yours, I know mine. (Male, Administrators-2, 18-08-2011)

12
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14 Medical malpractice is defined clearly in the Regulation on Handling Medical
15
16 Malpractice. There are several benchmarks determining the amount of
17
18 compensation issued. After the Tort Liability Law of the People's Republic of China
19
20 was promulgated, [medical damage] was compensated for more in accordance with
21
22 the Tort Liability Law because it stipulates compensation for personal injury.

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26 (Female, Hospital managers-2, 25-08-2011)
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31 **Unjustifiable complaints by patients**

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33
34 In some cases, the patient experiences inconvenience when receiving medical services
35
36 not because of poor conduct in attitude or behaviour on the part of health care
37
38 providers, but possibly because of long wait times, too little time spent with the doctor,
39
40 and/or imperfect resource allocation. These are health system issues rather than
41
42 problems caused by hospitals or individual physicians. And so, to a certain extent,
43
44 physicians and hospitals have become scapegoats of the entire health system.

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49 At times it is not us physicians who make patients angry. Certain factors are rooted
50
51 in the fabric of health care systems, but we physicians [end up] taking the blame.

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54 (Male, Health care providers-3, 16-09-2011)

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56
57 For example, should a doctor need to see sixty patients in half a day, or indeed one
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4 hundred, you cannot demand that he puts on a smile for each one. A lot of patients
5
6 complain about doctors with a straight face, but I think it is understandable. I have
7
8 a very good relationship with our young doctors. They operate on a tight schedule.
9
10 This week someone worked at the outpatient facility. He was friendly with patients
11
12 in the first month but struggled to sustain that sort of demeanour. He is not in the
13
14 mood to smile at patients or engage in long conversations when he only has time to
15
16 attend to their illnesses. (Male, Hospital managers-1, 15-12-2010)
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24 For example, dissatisfaction voiced in the hospital may be related to health insurance
25
26 policy rather than staff behaviour. Hospitals need to follow the policies made by the
27
28 Health Insurance Department. The purpose of those policies was to improve rational
29
30 use of medicines and control healthcare costs, while the patients covered by health
31
32 insurance may demand more medicines.
33
34
35

36 *Chinese doctors have many rules to obey [this is to curb poor conduct]. The*
37
38 *pressures for them to perform are relatively large. For example, doctors cannot*
39
40 *prescribe too much medicine for a patient who has only [basic state-financed]*
41
42 *medical insurance, but patients always want more. A while ago, the Medical*
43
44 *Insurance Bureau issued the following statement in a newspaper: "The Medical*
45
46 *Insurance Bureau never limits the volume of drugs prescribed, rather it is the doing*
47
48 *of hospitals who wish to increase workload [in order to produce more statistics]." I*
49
50 *think this is really unreasonable. The Bureau does not control the quantity of drugs*
51
52 *prescribed in any given week, but there is a total quantity limit over a year. Doctors*
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4 *try their best not to prescribe drugs which must be self-financed, i.e. not covered by*
5
6 *basic medical insurance. They must also explain very clearly before prescribing*
7
8 *self-financed drugs, otherwise, patients will lodge complaints once they find out.*

9
10
11 *(Male, Hospital managers-1, 15-12-2010)*
12

13
14 *Complaints occur when the patient wants more drugs but the doctor refuses to*
15
16 *satisfy his or her demands. Why? The health insurance institution sets a limit on*
17
18 *drug expenditure for each hospital; in turn, the hospital sets a limit for each doctor.*

19
20
21 *So if a doctor has too many patients drawing from their health insurance scheme in*
22
23 *any one month, he or she may very possibly have exceeded his/her limit. (Male,*
24
25 *Health care providers-3, 16-09-2011)*
26

27
28
29 *[A patient who has] basic state-financed medical coverage is entitled to blood and*
30
31 *other auxiliary examinations. If the number of health checks prescribed exceeds a*
32
33 *certain threshold, the doctor is viewed as exploiting basic medical insurance. The*
34
35 *doctor is consequently punished. I was deducted more than seven hundred yuan*
36
37 *(RMB) because of a case like this. I feel this is simply absurd – it is [unexpectedly]*
38
39 *doctors who are to blame. Nothing seems to be wrong with the patient. ...The*
40
41 *hospital can not do anything about medical insurance. I think this kind of thing is*
42
43 *not the problem at the hospital level. The complaints about medical insurance*
44
45 *define, without a doubt, problems underlying the state and society. (Male, Health*
46
47 *care providers-4, 16-09-2011)*
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54 In addition, the safety of health care providers is under threat in China today. Chinese
55
56 medical workers are often victims of violence. As a consequence, some health care
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4 providers have decided to not treat patients deemed likely to assault staff, exhibit
5
6 disruptive behaviour, or otherwise prove to be difficult. Prescribing redundant
7
8 check-ups and drugs are alternatives to properly seeing to patients.
9

10
11 In our interviews, fifteen interviewees mentioned “Chao” fifty-five times. “Chao” in
12
13 Chinese means to argue with hospitals for patients’ rights and interests, while the
14
15 other meaning is to wrangle fiercely in hospitals or with senior management. Most of
16
17 the hospital staff interviewed suggested that some complainants were indeed
18
19 unreasonable and impulsive with the sole purpose of claiming.
20
21

22
23
24 *If the case goes to court, the patient gathers a lot of people to go to the court,*
25
26 *insulting and threatening concerned health care providers and their lawyers. That is*
27
28 *not what we want to see. We want to talk about the truth, by thoroughly publicizing*
29
30 *the truth. We cannot always be too specific with terminology [for fear of revealing*
31
32 *too much]. When completely refuted, patients lose their temper. (Male, Other*
33
34 *actors-2, 15-09-2011)*
35
36

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38
39 *I feel that the widespread situation in China today is that you can do nothing if you*
40
41 *run into the unreasonable. The legitimate way of going about this is to propose a*
42
43 *fair decision once I receive your complaint. If complainants are not willing to settle*
44
45 *for this, we then transfer their case to other departments. However, complainants*
46
47 *may not even agree to that, causing trouble and even threatening the safety of*
48
49 *health care providers. (Female, Hospital managers-2, 25-08-2011)*
50
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54 *The claim a complainant demands goes beyond the actual problem [but for the*
55
56 *money] and he does not wish to resolve it the legal way. ...Nowadays “Yi Nao” has*
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4 brought about serious social effects, and has escalated the tension between service
5
6 users and providers. Complainants are unwilling to resolve things the legal way,
7
8 rather, just pestering and hassling you [health care providers or complaint handlers]
9
10 all day. (Male, Hospital managers-6, 01-11-2011)
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16 **d. Barriers to institutional changes for quality improvement using complaints**
17
18 **data**
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20
21 **Weak enforcement of the regulation**
22

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24 The regulation for managing patient complaints is merely a guideline, which contains
25
26 no mandatory requirements such as assessment mechanisms. Because it takes into
27
28 account the difference in local conditions throughout China, specific contents were
29
30 not stipulated. The regulation is to be interpreted according to local circumstances and
31
32 conditions. Therefore, in the absence of strong public scrutiny, there is little
33
34 accountability for how best to manage patient complaints.
35
36

37
38
39 *There are no penalties attached to (failure to follow) regulation. For example, there*
40
41 *is no administrative aspect to the regulatory guidelines. We wanted to write a*
42
43 *penalty provision, but it was not based on the top legislation. The purpose of the*
44
45 *regulation is to emphasise self-discipline and to serve as guidance for the hospital.*
46
47 *[The penalty was not enforceable,] so we decided to remove the penalty. It is indeed*
48
49 *difficult and contradictory. (Female, Administrators-4, 30-11-2011)*
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54 Besides the legal system, the reporting system also has its problems. Some statistics
55
56 about patient complaints and medical malpractice were utilized as a part of
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4 assessments of hospital performance, health care quality, and so on. This meant that
5
6 the more cases that were reported, the worse the evaluations received by the hospitals
7
8 so that hospitals were inclined to report selectively or report fewer cases.
9

10
11 *There are certainly no statistics for the number of patient complaints. There is only*
12
13 *the data on the number of medical malpractice cases per year from the Bureau of*
14
15 *Health, and an approximate amount of compensation issued by insurance*
16
17 *companies. In some cases, if complaints were solved just between the hospital and*
18
19 *the complainant, we have no data. (Male, Administrators-2, 18-08-2011)*
20
21

22
23 *These days, the information regarding the management of patient complaints in*
24
25 *hospitals is difficult to access. Hospitals are unwilling to provide that sort of*
26
27 *information – it is considered confidential. We only have some profiles or the*
28
29 *information from select hospitals. (Female, Policy makers-1, 16-12-2010)*
30
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36 Thus, the adoption of the incentive and sanction mechanism was contradictory for
37
38 managing patient complaints. From one side, the administrative department wanted
39
40 hospitals to report patient complaints because it is important for informing and
41
42 improving the quality of care. From the other side, the more complaints that are
43
44 registered, the worse it would appear a hospital is doing. In addition to this, managing
45
46 patient complaints remains low on the health reform agenda. The force for inspecting
47
48 complaint management in hospitals from senior management and administrative
49
50 departments remains weak.
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55
56 *[Having a statistic for patient complaints] is definitely necessary from the aspect of*
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4 *effective management. If this statistic is disposable, I think nothing of it. If the*
5
6 *statistic is routine, in fact, it will cost [all sorts of resources]. (Male, Policy*
7
8 *makers-2, 22-12-2011)*

9
10
11 *Hospitals doubt that the purpose of administration is for information management –*
12
13 *to help them better handle and solve disputes. However, if you want me to report*
14
15 *incidents but meanwhile punish me for that, then I have no incentive to report*
16
17 *anything. This contradiction stands [in the way of effective reporting]. (Female,*
18
19 *Administrators-4, 30-11-2011)*

Deficient information system for managing patient complaints

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29 Although the regulations in place require collecting and analysing information, there
30
31 exists no clear classification, definitions or unified coding system. Most hospitals
32
33 have established their own systems for recording complaints and analysing cases, but
34
35 no accurate or comparable data are available.

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39 *In fact a lot of cases should be recorded and analysed, [but] we do not even take*
40
41 *into account so-called major cases of medical malpractice, mass disturbance or*
42
43 *medical malpractice. We cannot distinguish between these concepts.... Relatively*
44
45 *speaking, it is more feasible to publicize the data on public security, e.g. the number*
46
47 *of police records and people arrested, and the number of crimes committed. Those*
48
49 *definitions are more explicit, whereas those concerning complaints management are*
50
51 *not. Because all statistics are calculated in the hospital, we find that where*
52
53 *standards are slack, the resulting statistic is large and where standards are strict,*
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4 *the statistic is small. Hence, there is great variability in our results. (Male, Policy*
5
6 *makers-2, 22-12-2011)*
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9 *Identical forms are sent to two hospitals at a similar level and the reported data can*
10
11 *be quite different. ...Some hospitals only reported cases resulting in compensation*
12
13 *and some hospitals record all persons who voice a concern, while others only*
14
15 *report cases identified as medical malpractice. But it is impossible for me to verify*
16
17 *[the reported data] in each hospital. (Male, Administrators-2, 18-08-2011)*
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21 Hospitals have not publicized complaints; neither have health administration
22
23 departments. The Shanghai Bureau of Health launched a pilot project in 2005 to
24
25 publicize the complaints reported by all hospitals in Shanghai. The project was
26
27 welcomed by the public but discontinued soon after its launch due to mounting
28
29 pressure from the hospitals.
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34 *We already publicize complaints [medical malpractice] on our intranet for hospital*
35
36 *staff. It is unnecessary to share this information on external sites. (Female, Hospital*
37
38 *managers-4, 06-09-2011)*
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41 *To my knowledge, such information was published once on the Xinmin Evening*
42
43 *News in 2005. The newspaper named hospitals that had won awards and gave*
44
45 *details of the number of medical malpractice cases happening in each, as well as*
46
47 *feedback regarding patient satisfaction. [We felt] the pressure was very, very high.*
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49
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51 *It [publishing those] resulted in public outrage [from hospitals]. (Female,*
52
53 *Administrators-4, 30-11-2011)*
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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

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4 *this as important, then subordinates work harder of course. Now the problem is that*
5
6 *some heads of department do not pay attention to it [complaint management].*
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8
9 *(Male, Health care providers-2, 16-09-2011)*

10
11 *It is of course medical services that are the core of hospital work. Things such as*
12
13 *[complaint management] are boring for the hospital. To a hospital, the fewer the*
14
15 *complaints, the better. (Male, Administrators-2, 18-08-2011)*
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20 21 **Discussion and Conclusions**

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24 This study examined the handling system for patient complaints in China and the
25
26 views of key stakeholders on the barriers to effective complaint management. Our
27
28 study provided a new dimension for understanding the complaints management
29
30 system in China, an emerging market country. Hospitals are the most important
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32 handler and manager of patient complaints in China and similarly for other
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34 developing countries, such as India and Vietnam.[22] We explored the barriers
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36 through in-depth interviews with almost all stakeholders, not only health professionals.
37
38 We hope that our findings will help develop procedures for more effective complaint
39
40 management and further improve the quality of care in China and other developing
41
42 countries. The selection of participants may introduce some bias to our studies. Due to
43
44 our focus on the hospital, there may be an underrepresentation of certain types of
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46 respondents. Since there are no unified classifications for complaints, we did not
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48 include patients with different types of complaints.
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3 We found that the three main project elements adopted from Hickson GB et al. were
4 relevant and useful for the discussion of our results: (A) organizational supports, (B)
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9 commitment from key people, and (C) learning systems.[13]
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11 12 13 14 A. Organizational Supports

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16 Our findings showed that there are no standardized systems and procedures dealing
17
18 with patient complaints in China due to conflicts between relevant actors and
19 regulations. Having experienced rapid economic growth in the last 30 years, China is
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21 undergoing a socioeconomic transition. Like other developing countries, policies lag
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23 behind the country's economic transition.[37, 38] The Ministry of Health has tried to
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25 guide health care providers by issuing special regulations, but health administrations
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27 do not apply strict regulations to complaint management. There lacks clear
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29 relationships between patient complaints and clinical outcomes or the quality of care.
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39 The patient complaints in many Chinese hospitals are not well-managed and handled.
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41 Most hospitals manage patient complaints on only a case-by-case basis. They lack
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43 clear mechanisms linking patient complaints with improving the quality of care.
44
45 Complaints are underutilised for organizational strategic planning or for changing an
46
47 individual's behaviour and attitude. This implies that legislation should not only
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49 stipulate the principles and regulations of patient complaint management, but also the
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51 responsibilities of sectors at different levels.[39]
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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

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4 promote the learning process, appropriate mechanisms should be developed and
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6 implemented to assess not only the number of patient complaints occurring in
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8 hospitals, but also how these hospitals have handled these complaints. For example,
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10 reporting more patient complaints should not be necessarily punished, while effective
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12 handling of the patient complaints should be appreciated.
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18 Our final conclusion is that barriers to the effective management of patient complaints
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20 vary at the different stages of complaint handling, from the user and provider side, as
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22 well as systemic issues. Information, procedure design, human resources, system
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24 arrangement, a unified legal system and regulations and factors shaping the social
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26 context all play important roles in effective patient complaint management.
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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

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DATA SHARING

No additional data available.

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7 **Title page**
8

9 1. Title of the article.

10 Managing patient complaints in China – a qualitative study in Shanghai
11 Managing
12 patient complaints in China: what went wrong?
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14

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11
12
13 4. Up to five keywords or phrases suitable for use in an index (it is recommended to
14
15 use MeSH terms).

16
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18 Qualitative Research; Patient Complaints; Complaint Handling Systems; Quality
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20 Improvement; Government Regulation

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

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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

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6 unjustifiable complaints by patients during ~~the stage of~~ solution settlements; and weak
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8 enforcement of ~~the regulations~~, deficient information for managing patient complaints
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10 and unwillingness of the hospitals to effectively handle complaints in the
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12 post-complaint stage.
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18 **Conclusions:** Barriers to the effective management of patient complaints vary at the
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20 different stages of complaint handling and perspectives on these barriers differ
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22 between~~from~~ the service users and providers perspectives. Information, procedure
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24 design, human resources, system arrangement, unified legal system and regulations
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26 and factors shaping the social context all play important roles in effective patient
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28 complaint management.
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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

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7 side, as well as system issues.

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9 5. Information, procedure design, human resources, system
10 arrangement, unified legal system and regulations and factors
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12 patient complaint management.
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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, ~~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

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

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38 With no official statistics of patient complaints available in Chinese records, we
39 estimated that the number of complaints and disputes rose, from 10,249 to 13,875
40 claimseases, based on the number of first trials for medical malpractice cases between
41 2002 and 2008, from 10,249 to 13,875.^[15] Mounting dissatisfaction has been felt
42 across the country, manifesting in increasingly hostile and violent behaviour towards
43 providers by from patients and their families.^[16] An investigation carried out by the
44 Chinese Hospital Management Association in 2005 suggesteds that of 270 hospitals
45 surveyed, 73 per cent experienced abuse in the form of threats and assaults targeting
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7 doctors and management.[17] These incidents are only indicative of rising
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9 expectations, burgeoning patient discontent with services and dissatisfaction towards
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11 the manner-way in which matters are resolved.[18] Public outcry only exacerbates the
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13 need for more effective handling of individual cases under the overarching agenda ~~for~~
14
15 of public hospital reform in China.[19]
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20 ~~In countries such as Australia and Britain, the states have has sought to monitor~~
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22 ~~complaints and complaint handling to improve and regulate the practice of health~~
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24 ~~professionals.[8] A feedback system of this sort has proven instrumental in improving~~
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26 ~~the quality of care. In Britain, the National Health Service (NHS) not only provides~~
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28 ~~clear and transparent guidelines for both health providers and patients but also~~
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30 ~~publicizes information regarding the routine reporting of patient complaints.[9] In~~
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32 ~~Australia, a large study was conducted before *Guide to Complaint Handling in Health*~~
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34 ~~*Care Services* was formulated and subsequently updated.[10] Annually, statistics are~~
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36 ~~compiled and published, detailing complaint trends, complaint management and~~
37
38 ~~reasons for complaints. Effective handling of complaints has been known to reduce~~
39
40 ~~friction between providers and consumers, with the even greater benefit of improving~~
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42 ~~quality of care. As a supplement to peer reviews and administration, patient~~
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44 ~~complaints can provide important feedback concerning the delivery of health care~~
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46 ~~services and can be a useful tool in the improvement of health care quality.[1-3,~~
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52 11-14]
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~~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

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7 Regulation in Vietnam, India and China" (HESVIC) research project. It was
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9 conducted by a consortium of six partners in Asia and Europe from 2009-2012, with
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11 the aim of supporting policy decisions in the application and extension of accessibility,
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13 affordability, equity and quality of coverage of maternal health care in the three
14
15 countries.
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19 20 **Methods**

21 22 *Study design*

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24 The project uses a multidisciplinary approach, drawing on multiple case studies to
25
26 examine the impact of regulation on improving equitable access to quality health care
27
28 in Vietnam, India and China. In each country, three cases were selected and studied.
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31 This paper shows the findings from the case study, examining the regulation on
32
33 Grievance Redressal (GR) in Shanghai, China. Here, regulation encompasses the
34
35 formation of rules and practices, as well as their interpretation and implementation,
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37 such as the health policy processes covered in the HEPVIC project (HEPVIC).[23]
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40 41 42 **Phase One: Literature Review**

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44 Firstly, we conducted a literature review. The relevant sources, which included
45
46 regulation documents relating to the handling of patient complaints at both the
47
48 national and Shanghai municipal levels, were used to collect legal approaches and
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50 mechanisms used in managing patient complaints. These regulations were mainly
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52 stipulated from 2002 to 2011. To understand the application of different complaint
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7 approaches, a search of scientific literature published between 2000 and 2011 was
8
9 conducted. Databases MEDLINE-PubMed and WANFANG Data were consulted. A
10
11 search strategy was established based on the following keywords: *grievance redressal*,
12
13 *patient complaint*, *health care complaint and hospital complaint*, and *China*. Special
14
15 focus was ~~put~~ placed on patient complaint management in hospitals, as we found that
16
17 the vast majority of complaints ~~are~~ were handled and resolved within the
18
19 hospitals.[22]
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24 25 **Phase Two: Pilot Study – Interviews**

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27 Based on our understanding of the current patient complaint handling system, we
28
29 ~~then~~ performed semi-structured interviews with key stakeholders – policymakers from
30
31 the national level, administrators from the Shanghai municipal level, hospital
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33 managers, ~~health provider~~ health care providers, users and other related parties. We
34
35 used the snowball sampling method to identify key stakeholders and to collect
36
37 important feedback from key informants from various disciplines.[24, 25]
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43 In Phase Two (October-December 2010), one key actor from each of the three
44
45 administrative levels ~~were~~ was selected and interviewed: a policymaker at the national
46
47 level, a municipal administrator and a hospital manager. A pilot study was conducted
48
49 to test the topic guidelines developed. These ~~would~~ allowed us to gain a preliminary
50
51 understanding of the ~~process of~~ complaint management process in the hospital setting
52
53 of China, and to refine the data collection tools. These interviews served as the basis
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7 for the design of Phase Three interviews, where some of those being interviewed in
8
9 the third phase were respondents recommended by Phase Two interviewees.
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11 12 13 **Phase Three: Main Data Collection** 14

15 Interviews in Phase Three were conducted from August-December of 2011. Key
16 stakeholders were interviewed in the selected hospitals based on location, level and
17 type. Our sample ~~was the representative of~~ represented both urban and suburban areas
18 in Shanghai. General ~~hospitals~~ and specialist hospitals were selected. Phase Three
19 began with interviews of hospital managers and ~~health provider~~ health care providers
20 proposed in Phase Two. We asked interviewees from Phase Two to invite patients and
21 other relevant stakeholders to contribute their views. Those invited patients ~~had~~ used
22 different channels for lodging their complaints; h. However, they all shared one thing
23 in common: all patients had first complained to the hospital. We then proceeded to
24 interview the administrators and finally a high-level policymaker. We continued to
25 interview respondents, collecting and analysing their comments and feedback until no
26 new themes emerged, i.e. saturation had been reached. The number of participants
27 involved in the different types of interviewees is depicted in Table 1.
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47 Semi-structured interviews were conducted with 35 respondents face-to-face, except
48 one via telephone. The interviews took place at private locations, for example at the
49 institution where the interviewee or interviewer worked, and were conducted by two
50 of the authors of this paper. Each interview lasted 1-2 hours and was audiotaped with
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7 permission, apart from two which were not recorded but typewritten upon the
8
9 respondents' request.

10
11 Table 1 Number of interviewees by administrative level and facility
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| 13 14 15 16 | Types of interviewees | Level | Number of 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 |
|----------------------|---|--------------------|---|
| | 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 | 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, and interviewees were~~ asked to explain their reasoning ~~why they believed this to be the ease~~. 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

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7 into a narrative. Written consent was obtained from each interviewee before
8
9 undertaking the interviews.

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13 We performed the above tasks using the qualitative research software NVivo 9.0. The
14
15 raw data was coded by two independent reviewers (YSJ, QZ). If ~~some~~ discrepancies
16
17 emerged, a third reviewer (XHY) ~~would~~ participated in the group discussion until the
18
19 group arrived at a consensus. There were some models for analysing complaint
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21 management; [2, 13] for example, ~~a~~ the Managerial-Operational-Technical (MOT)
22
23 model was developed [by Hsieh SY](#) to explore complaint management in hospitals.[2]
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25

26
27 In our study, we collected data according to the complaint management process. To
28
29 analyse the data most efficiently and directly, we used the stages of the process, ~~which~~
30
31 ~~The stages~~ included receivinge, handlinge and resolvinge complaints.[27] As ~~the~~
32
33 quality improvement following complaints is ~~very important~~crucial, we added the
34
35 stage of “institutional changes for quality improvement using complaints data”. [2, 12]
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41 Our study was approved by Institutional Review Board (IRB), School of Public
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43 Health, Fudan University. Access to data was restricted to approved members of the
44
45 research team who signed a confidential agreement with the principal investigator.

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47 Data were stored in secure electronic locations. Data processing was kept
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49 anonymously so as to protect the identity of interviewees. The names of the
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51 respondents have been deleted from ~~the~~ quotations.
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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.

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7 b. Administrative Mediation and Civil Lawsuits

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9 If the hospital is unable to resolve certain conflicts through negotiation, these cases
10 may be referred to an external body such as the health administrative department or
11 they may be settled in the court by means of litigation. The *Tort Law of the People's*
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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

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7 *Mediation*, to establish the People's Mediation Committees for Medical Disputes.[31]
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9 Committee members, mainly retired judges and doctors, served to mediate disputes
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11 through reporting, explaining and analysing cases under the supervision of the local
12
13 judiciary. In January 2010, the Ministry of Justice, the Ministry of Health and the
14
15 China Insurance Regulatory Commission jointly issued *Opinions on Strengthening*
16
17 *People's Mediation for Medical Disputes* to ~~strengthen~~ bolster the role of mediation in
18
19 resolving medical disputes.[32] Its intent is to settle medical disputes in an effective
20
21 way and to maintain order within hospitals, all with a view for ensuring harmony and
22
23 social stability. In July 2011, the Shanghai Justice Bureau and Health Bureau
24
25 introduced *Measures on People's Mediation for Medical Disputes in Shanghai* to
26
27 replace *Opinions on Regulating People's Mediation Organizations to Participate in*
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29 *Medical Dispute Mediation*. [31, 33]
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36 ~~Further~~ In addition to the aforementioned channels of complaint, patients have also
37
38 been found to express their discontent by “Yi Nao” – exhibiting disruptive behaviour
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40 within the hospital by; targeting doctors and nurses or hospital managers by way of
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42 abuse, assault and other forms of violence. Much of this has garnered media attention,
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44 resulting in bad publicity for the hospital and damaging the reputation of doctors and
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46 staff.
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~~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.

e.g. 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 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

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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

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 ~~of~~ on the nature of medical disputes. 50 per cent of cases were ~~a~~ results of inappropriate attitudes ~~is~~ 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

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7 work is highly demanding. [They need to attend to] many patients every day. If they
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9 spend more time communicating with patients, they would lose time needed to carry
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11 out [clinical work]. That is to say, [doctors should be given] less [clinical] work,
12
13 and more time to explain their work to patients. Our workload is very heavy, like a
14
15 battle. (Female, ~~Health provider~~Health care provider-s-1, 01-09-2011)
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17

18 19 20 **Incompetence and powerlessness of complaints handlers**

21
22 In comparison to health care providers, Complaint handlers played a more important
23
24 role in cooperation and coordination. Although ~~the~~ complaint departments ~~was~~ were
25
26 specifically set up in hospitals for receiving and handling complaints, the responsible
27
28 persons in the department were mainly part-time medical staff. In some cases, those
29
30 handling staff were found to be inadequate—~~sometimes~~ due to lack of training. Many
31
32 of them had studied handling techniques on their own and had not acquired sufficient
33
34 professional skills to appropriately analyse, assess and solve complaints.
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38 *Complaint handlers in the hospitals cannot solve everything because the disciplines*
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40 *involved in complaints are highly specialised. I am only familiar with general*
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42 *surgery and issues that require common sense, but [I am not familiar] with*
43
44 *professional problems in other disciplines. (Male, Hospital managers-5,*
45
46 *08-09-2011)*

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

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

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

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

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

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53 **Non-transparent exchange of information**

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7 In addition, the complaint handling process was not truly open to the complainant, and
8
9 information exchange was largely limited to hospital staff. In fact, it was found that
10
11 the staff at the complaints office was generally evasive towards patients who arrived
12
13 wishing to be updated with the specifics of their complaint. The complainants had
14
15 no opportunity to directly engage in the handling of their complaints or to
16
17 meaningfully participate in the process. In addition, hospitals tended to oversimplify
18
19 cases, assuming that the complainant's only desire was to report their complaint and
20
21 ask for compensation. This implies that the entire handling process is disclosed only
22
23 among hospital staff. Therefore, the process becomes a "black box" to patients. It is
24
25 easy for the hospital to manipulate a complainant by providing limited information to
26
27 gain advantage in negotiations, i.e. reduce loss from compensating patients.
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31 *Sometimes you have to circumvent something and use negotiating skills. Mistakes in*
32
33 *medical services do not necessarily harm patients' health, but they can be very*
34
35 *serious for the provider [...] for example, someone may not be very careful when*
36
37 *writing a medical record and alter it by accident. But you are likely to lose a lawsuit*
38
39 *on the grounds of having tampered with records. Incidents such as these cloud the*
40
41 *matter, making transparency difficult. (Female, Hospital managers-2, 25-08-2011)*
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45 If the incident is urgent or presents itself as a recurring problem, it might be shared to
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47 educate healthcare providers but disclosure to complainants themselves remains
48
49 limited. Only outcomes deemed to be of direct interest to patients, including
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51 compensation amounts and medical service privileges, were provided. However, other
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53 results, including penalties imposed upon physicians and departments or
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7 improvements made to hospital services, were largely withheld from patients if they
8
9 did not ask.

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11 *In individual cases, what are the outcomes of their complaints? How might a*
12
13 *physician be punished/penalised/disciplined? Such information is requested by*
14
15 *patients only occasionally. (Male, ~~Health provider~~Health care providers-2,*
16
17 *16-09-2011)*

18
19 *I want to know how to better educate the concerned health care providers. But I*
20
21 *have not been told. (Female, Users-3, 20-09-2011)*
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24 25 26 **g.c. Barriers to resolving the complaints**

27 28 **Conflicts between relevant actors and regulations**

29
30 Within the complaints system, conflicts or inconsistencies can arise between the legal
31
32 system for handling complaints and the solutions determined by the hospital. As the
33
34 structure of managing patient complaints is shown in Figure 1, different regulations
35
36 stipulate different approaches. ~~There does not exist a u~~Unified laws or guidelines ~~do~~
37
38 ~~not exist~~ to clearly illustrate the relationships between different approaches, which
39
40 results in problems such as ~~a~~lack of authority or ultimate approach, uncertainty about
41
42 how to apply different regulations to one case, and no clear definitions or
43
44 classifications in regards to patient complaints.
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49 *The current state of complaint management is disorderly. There are too many*
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51 *channels. For example, many departments are involved, including but not limited to*
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53 *Complaint Letters and Visits, online complaints, etc. The Health Bureau has two*
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7 departments [for complaint management], and each district has a mediation office,
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9 a district government website or a mayor-mail [to receive complaints], and a
10
11 Complaint Letters and Visits office... Far too many heads of departments within the
12
13 health sector; it is chaos. (Male, ~~Health provider~~Health care providers-2,
14
15 16-09-2011)

16
17
18 Hospitals are required to report complaints to a lot of sectors, all of which wish to
19
20 understand the issue from different angles. Conflicts between regulations do not
21
22 necessarily exist.~~There are not necessarily conflicts between regulations,~~ but
23
24 different elements are emphasised. Hospitals are tired of these kinds of
25
26 bureaucracy. ...Each sector carries out their designated duties where resources are
27
28 not shared. The information possessed by each sector is fragmented. You know
29
30 yours, I know mine. (Male, Administrators-2, 18-08-2011)

31
32
33 Medical malpractice is defined clearly in the Regulation on Handling Medical
34
35 Malpractice. There are several benchmarks determining the amount of
36
37 compensation issued. After the Tort Liability Law of the People's Republic of China
38
39 was promulgated, [medical damage] was compensated for more in accordance with
40
41 the Tort Liability Law, because it stipulates compensation for personal injury.
42
43
44 (Female, Hospital managers-2, 25-08-2011)

Unjustifiable complaints by patients

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51 In some cases, the patient experiences inconvenience when receiving medical services
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54 not because of poor conduct in attitude or behaviour on the part of health

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6 ~~provider~~health care providers, but possibly. Instead, because inconvenience may be
7
8 ~~due to~~ of long waiting times, too little time spent with the doctor, and/or imperfect
9
10 resource allocation. These are health system issues rather than problems caused by
11
12 hospitals or individual physicians. And so, to a certain extent, physicians and hospitals
13
14 have become scapegoats of the entire health system.
15
16

17
18 *At times it is not us physicians who ~~have made~~ amake patients angry. Certain*
19
20 *factors are rooted in the fabric of health care systems, but we physicians [end up]*
21
22 *taking the blame. (Male, ~~Health provider~~Health care providers-3, 16-09-2011)*
23

24
25 *For example, should a doctor need to see sixty patients in half a day, or indeed one*
26
27 *hundred, you cannot demand that he puts on a smile for each one. A lot of patients*
28
29 *complain about doctors with a straight face, but I think it is understandable. I have*
30
31 *a very good relationship with our young doctors. They operate on a tight schedule.*
32

33
34 *This week someone workeds at the outpatient facility. He ~~was~~ friendly with patients*
35
36 *in the first month but struggleds to sustain thatis sort of demeanour. He is not in the*
37
38 *mood to smile at patients or engage in long conversations when he only has time to*
39
40 *attend to their illnesses. (Male, Hospital managers-1, 15-12-2010)*
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42

43
44 For example, dissatisfaction voiced in the hospital may be related to health insurance
45
46 policy rather than staff behaviour. Hospitals need to follow the policies made by the
47
48 Health Insurance Department. The purpose of those policies was to improve rational
49
50 use of medicines and control healthcare costs, while the patients covered by health
51
52 insurance may demand more medicines.
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7 Chinese doctors have many rules to obey [this is to curb poor conduct]. The
8
9 pressures for them to perform are relatively large. For example, doctors cannot
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11 prescribe too much medicine for a patient who has only [basic state-financed]
12
13 medical insurance, but patients always want more. A while ago, the Medical
14
15 Insurance Bureau issued the following statement in a newspaper: “The Medical
16
17 Insurance Bureau never limits the volume of drugs prescribed, rather it is the doing
18
19 of hospitals who wish to increase workload [in order to produce more statistics].” I
20
21 think this is really unreasonable. The Bureau does not control the quantity of drugs
22
23 prescribed in any given week, but there is a total quantity limit over a year. Doctors
24
25 try their best not to prescribe drugs which must be self-financed, i.e. not covered by
26
27 basic medical insurance. They must also explain very clearly before prescribing
28
29 self-financed drugs, otherwise, patients will lodge complaints once they find out.
30
31
32
33 (Male, Hospital managers-1, 15-12-2010)

34
35
36 Complaints occur when the patient wants more drugs but the doctor refuses to
37
38 satisfy his or her demands. Why? The health insurance institution sets a limit ~~for on~~
39
40 drug expenditure for each hospital; in turn, the hospital sets a limit for each doctor.
41
42 So if a doctor has too many patients drawing from their health insurance scheme in
43
44 any one month, he or she may very possibly have exceeded his/her limit. (Male,
45
46 ~~Health provider~~Health care providers-3, 16-09-2011)

47
48
49 [A patient who has] basic state-financed medical coverage is entitled to blood and
50
51 other auxiliary examinations. If the number of health checks prescribed exceeds a
52
53 certain threshold, the doctor is viewed as exploiting basic medical insurance. The
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7 doctor is consequently punished. I was deducted more than seven hundred yuan
8
9 (RMB) because of a case like this. I feel this is simply absurd – it is [unexpectedly]
10
11 doctors who are to blame. Nothing seems to be wrong with the patient. ...The
12
13 hospital can't not do anything about medical insurance. I think this kind of thing is
14
15 not the problem at the hospital level. The complaints about medical insurance
16
17 define, without a doubt, problems underlying the state and society. (Male, Health
18
19 provider Health care providers-4, 16-09-2011)
20
21

22 In addition, the safety of health provider health care providers is under threat in China
23
24 today. Chinese medical workers are often victims of terrible–violence. As a
25
26 consequence, some health provider health care providers have decided not to not treat
27
28 patients deemed likely to assault staff, exhibit disruptive behaviour, or otherwise
29
30 prove to be difficult to deal with. Prescribing redundant check-ups and drugs are
31
32 alternatives to properly seeing to patients.
33
34

35
36 In our interviews, fifteen interviewees mentioned “Chao” fifty-five times. “Chao” in
37
38 Chinese means to argue with hospitals for patients’ own rights and interests, while the
39
40 other meaning is to wrangle fiercely in hospitals or with senior management. Most of
41
42 the hospital staff being interviewed suggested that some complainants be were indeed
43
44 unreasonable and impulsive, whose with the sole purpose is to of asking for claiming
45
46 money.
47
48

49 *If the case goes to court, the patient gathers a lot of people to go to the court,*
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51 *insulting and threatening concerned health care providers and their lawyers. That is*
52
53 *not what we want to see. We want to talk about the truth, by thoroughly publicizing*
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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

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7 account the difference in local conditions throughout China, specific contents were
8
9 not stipulated. The regulation is to be interpreted according to local circumstances and
10
11 conditions. Therefore, in the absence of strong public scrutiny, there is little
12
13 accountability for how best to manage patient complaints.
14

15
16 *There are no penalties attached to (failure to follow) regulation. For example, there*
17
18 *is no administrative aspect to the regulatory guidelines. We wanted to write a*
19
20 *penalty provision, but it was not based on the top legislation. The purpose of the*
21
22 *regulation is to emphasise self-discipline and to serve as guidance for the hospital.*
23
24 *[The penalty was not enforceable,] so we decided to remove the penalty. It is indeed*
25
26 *difficult and contradictory. (Female, Administrators-4, 30-11-2011)*
27

28
29 Besides the legal system, the reporting system also has its problems. Some statistics
30
31 about patient complaints and medical malpractice were utilized as a part of
32
33 assessments of hospital performance, health care quality, and so on. This meant that
34
35 the more cases that were reported, the worse the evaluations received by the hospitals,
36
37 so that hospitals were inclined to report selectively or report fewer cases.
38

39
40 *There are certainly no statistics for the number of patient complaints. There is only*
41
42 *the data on the number of ~~eases of~~ medical malpractice cases per year from the*
43
44 *Bureau of Health, and an approximate amount of compensation issued by insurance*
45
46 *companies. In some cases, if complaints were solved just between the hospital and*
47
48 *the complainant, we have no data. (Male, Administrators-2, 18-08-2011)*
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51 *These days, the information regarding the management of patient complaints in*
52
53 *hospitals is difficult to access. Hospitals are unwilling to provide that sort of*
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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~~ ~~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

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7 Although the regulations in place require collecting and analysing information, there
8
9 exists no clear classification, definitions or unified coding system. Most hospitals
10
11 have established their own systems for recording complaints and analysing cases, but
12
13 no accurate or comparable data are available.

14
15 *In fact a lot of cases should be recorded and analysed, [but] we do not even take*
16
17 *into account so-called major cases of medical malpractice, mass disturbance or*
18
19 *medical malpractice. We cannot distinguish between these concepts.... Relatively*
20
21 *speaking, it is more feasible to publicize the data on public security, e.g. the number*
22
23 *of police records and people arrested, and the number of crimes committed. Those*
24
25 *definitions are more explicit, whereas those concerning complaints management are*
26
27 *not. Because all statistics are calculated in the hospital, we find that where*
28
29 *standards are slack, the resulting statistic is large ~~whereas and where standards~~*
30
31 *~~are with a strict standard, it will be the statistic is~~ small. Hence, there is great*
32
33 *variability in our results. (Male, Policy makers-2, 22-12-2011)*
34
35

36
37 *Identical forms are sent to two hospitals at a similar level and the reported data can*
38
39 *be quite different. ...Some hospitals only reported cases resulting in compensation*
40
41 *and some hospitals record all persons who voice a concern, while others only*
42
43 *report cases identified as medical malpractice. But it is impossible for me to verify*
44
45 *[the reported data] in each hospital. (Male, Administrators-2, 18-08-2011)*
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49 Hospitals have not publicized complaints; neither have health administration
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51 departments. The Shanghai Bureau of Health launched a pilot project in 2005 to
52
53 publicize the complaints reported by all hospitals in Shanghai. The project was
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7 welcomed by the public but discontinued soon after its launch due to mounting
8
9 pressure from the hospitals.

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

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16
17
18 *To my knowledge, such information was published once on the Xinmin Evening*
19 *News in 2005. The newspaper named hospitals that had won awards and gave*
20 *details of the number of medical malpractice cases ~~inherent~~ happening in each, as*
21 *well as feedback regarding patient satisfaction. [We felt] the pressure was very, very*
22 *high. It [publishing those] resulted in public outrage [from hospitals]. (Female,*
23 *Administrators-4, 30-11-2011)*

32 33 **Unwillingness of hospitals to effectively handle complaints**

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35 Most hospitals did not devote much effort into managing complaints. There was no
36
37 clear mechanism to utilize patient complaints to improve quality of care unless serious
38
39 medical malpractice had occurred or complaints were found to recur.

40
41
42 *Hospitals just handle complaints when complaints happen. ...We are basically*
43 *perfunctory, including hospitals, department directors and doctors. The best-case*
44 *scenario for me: do not approach me for these things [complaints]. Deal with*
45 *complaints quickly and efficiently; in other words, spend money to buy peace. The*
46 *impact of managing and addressing complaints is negligible, with very little effect*
47 *on improving medical procedures and quality. (Male, Administrators-2,*
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7 18-08-2011)

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9 Hospital directors were the key actors of complaint management in hospitals. The
10
11 incentive and sanction mechanisms in hospitals depended on how much attention they
12
13 directors pay ~~attention~~ to complaint management. In the 1980s the government
14
15 reduced subsidies for public hospitals under the context of transforming the planned
16
17 economy to a so-called socialist market in order to reduce inefficiencies in health care
18
19 provision. Hospitals had to increase service charges ~~to generate more revenue~~ to
20
21 recoup the operational costs and to increase the income level of health workers.
22
23
24 Complaint management occupied nothing but a small part of quality health care, so in
25
26 most hospitals it failed to draw attention from senior management. Most complaints
27
28 were solved on a case-by-case basis, without sufficient concern for the overall
29
30 improvement of health care services.
31

32
33 *In practice, the head of department influences implementation. If he/she regards*
34
35 *this as important, then subordinates work harder of course. Now the problem is that*
36
37 *some heads of department do not pay attention to it [complaint management].*

38
39
40 (Male, ~~Health provider~~Health care providers-2, 16-09-2011)

41
42
43 *It is of course medical services that are the core of hospital work. Things such as*
44
45 *[complaint management] are boring for the hospital. To a hospital, the fewer the*
46
47 *complaints, the better. (Male, Administrators-2, 18-08-2011)*
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49 50 51 **Discussion and Conclusions**

52
53 This study examined the handling system for patient complaints in China and the
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7 views of key stakeholders on the barriers to effective complaint management. Our
8
9 study provided a new dimension ~~for of~~ understanding the complaints management
10
11 system in China, ~~an developing country~~emerging market country. Hospitals are the
12
13 most important handler and manager of patient complaints in China and similarly for
14
15 other developing countries, such as India and Vietnam.[22] We explored the barriers
16
17 through in-depth interviews with almost all stakeholders, not only health professionals.
18
19 We hope that our findings will~~What we found would~~ help develop procedures for
20
21 more effective complaint management and ~~to~~ further improve the quality of care in
22
23 China and other developing countries. The selection of participants may introduce
24
25 some bias to our studies. Due to our focus on the hospital, there may be an
26
27 underrepresentation of certain types of respondents. Since there are not unified
28
29 classifications for complaints, we did not~~not~~ include patients with different types of
30
31 complaints.
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38 We found that the three main project elements adopted from Hickson GB et al. were
39
40 relevant and useful for the discussion of our results: (A) organizational supports, (B)
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42 commitment from key people, and (C) learning systems.[13]
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44

45 46 47 A. Organizational Supports

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49 Our ~~F~~findings showed that there are no standardized systems and procedures dealing
50
51 with patient complaints in China; due to conflicts between relevant actors and
52
53 regulations. Having experienced rapid economic growth in the last 30 years, China is
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7 undergoing a socioeconomic transition. Like other developing countries, policies lag
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9 behind the country's economic transition.[37, 38] The Ministry of Health has tried to
10
11 guide ~~health provider~~health care providers by issuing special regulations, but health
12
13 administrations do not apply strict regulations to complaint management. There lacks
14
15 clear relationships between patient complaints and clinical outcomes or the quality of
16
17 care.
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22 ~~The hospital leader is the key determinant for complaint handling inside the hospital.~~
23
24 ~~However, no apparent incentives exist to push hospital leaders to place priority on~~
25
26 ~~complaint handling. The power of complaint handling departments depends on how~~
27
28 ~~much the hospital leaders pay attention to it. Under the current situation, hospital~~
29
30 ~~leaders lack political will to manage complaints effectively, leading to inadequate~~
31
32 ~~human resources in complaint handling departments. The departments also lack the~~
33
34 ~~power to coordinate with clinical departments.~~
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40 The patient complaints in many Chinese hospitals are not well-managed and handled.
41
42 Most hospitals manage patient complaints on only a case-by-case basis. They lack
43
44 clear mechanisms linking patient complaints with improving the quality of care.
45
46 Complaints are underutilised for organizational strategic planning or for changing an
47
48 individual's behaviour and attitudes. This implies that legislation should not only
49
50 stipulate the principles and regulations of patient complaint management, but also the
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52 responsibilities of sectors at different levels.[39]
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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

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7 following patient complaints should be developed through a learning process.[42] To
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9 promote the learning process, appropriate mechanisms should be developed and
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11 implemented to assess not only the number of patient complaints occurring in
12
13 hospitals, but also how these hospitals have handled these complaints. For example,
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15 reporting more patient complaints should not be necessarily punished, while effective
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17 handling of the patient complaints should be appreciated.
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22 | Our final conclusion is that barriers to the effective management of patient complaints
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24 vary at the different stages of complaint handling, from the user and provider side, as
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26 well as systemic issues. Information, procedure design, human resources, system
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28 | arrangement, a unified legal system and regulations and factors shaping the social
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30 context all play important roles in effective patient complaint management.
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33 | Appropriate mechanisms should be developed to link patient complaints with
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35 improving the quality of care.
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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

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8 data, and analysis and interpretation of data; drafting the article; and final
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31 6) Maitrayee MUKHOPADHYAY: substantial contributions to conception and
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44 8) HESVIC team authorship

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

51 52 53 **DATA SHARING**

No additional data available.

For peer review only

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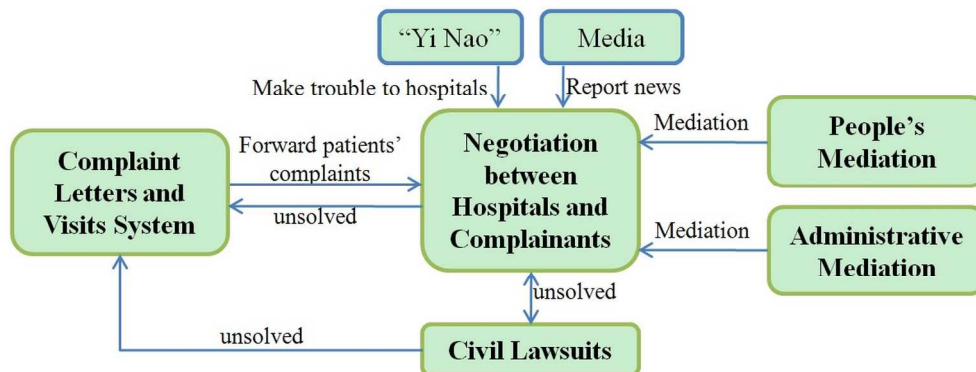


Figure 1 The structure of managing patients' complaints in China

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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? | YES It is difficult to measure the regulation process quantitatively. |
| <ul style="list-style-type: none"> • <i>Interviews</i>: experience, perceptions, behaviour, practice, process • <i>Focus groups</i>: group dynamics, convenience, non-sensitive topics • <i>Ethnography</i>: culture, organizational behaviour, interaction • <i>Textual analysis</i>: documents, art, representations, conversations | |
| T Transparency of procedures | |
| <i>Sampling</i> | |
| 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 |
|--|---|
| | <p>process.</p> <p>Different types of respondents were helpful for holistic understanding for transparency deficits.</p> <p>Key informants were interviewed by snowball sampling and saturation.</p> |
| <i>Recruitment</i> | |
| 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. |
| <i>Data collection</i> | |
| 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. |
| <i>Role of researchers</i> | |
| 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. |
| <i>Ethics</i> | |
| 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 | |
| <i>Analysis</i> | |
| <p>Is the type of analysis appropriate for the type of study?</p> <ul style="list-style-type: none"> • <i>thematic</i>: exploratory, descriptive, hypothesis generating • <i>framework</i>: e.g., policy • <i>constant comparison/grounded</i> | <p>YES.</p> <p>Analytic approach was justified.</p> |

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| <p><i>theory</i>: theory generating, analytical</p> <ul style="list-style-type: none"> Are the interpretations clearly presented and adequately supported by the evidence? Are quotes used and are these appropriate and effective? Was trustworthiness/reliability of the data and interpretations checked? | <p>YES.</p> <p>YES.</p> <p>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.</p> |
| <i>Discussion and presentation</i> | |
| 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 |

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| viewed critically. They might be fatal flaws, or they may result from lack of detail or clarity. | |

For peer review only

BMJ Open

Managing patient complaints in China – a qualitative study in Shanghai

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|---------------------------------|--|
| Journal: | <i>BMJ Open</i> |
| 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 |
| | |

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Title page

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4 8) HESVIC team authorship
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9 4. Up to five keywords or phrases suitable for use in an index (it is recommended to
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11 use MeSH terms).
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14 Qualitative Research; Patient Complaints; Complaint Handling Systems; Quality
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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

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

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14 **Conclusions:** Barriers to the effective management of patient complaints vary at the
15
16 different stages of complaint handling and perspectives on these barriers differ
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18 between the service users and providers. Information, procedure design, human
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20 resources, system arrangement, unified legal system and regulations and factors
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22 shaping the social context all play important roles in effective patient complaint
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24 management.
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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

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4 the quality of care. In Britain, the National Health Service (NHS) has not only
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6 provided clear and transparent guidelines for both health care providers and patients
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8 but has also publicized information regarding the routine reporting of patient
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10 complaints.[9] In Australia, a large study was conducted before *Guide to Complaint*
11
12 *Handling in Health Care Services* was formulated and subsequently updated.[10]
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14 Annually, statistics are compiled and published, detailing complaint trends, complaint
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16 management and reasons for complaints. Effective handling of complaints has been
17
18 known to reduce friction between providers and consumers, with the even greater
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20 benefit of improving quality of care. As a supplement to peer reviews and
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22 administration, patient complaints can provide important feedback concerning the
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24 delivery of health care services and can be a useful tool in the improvement of health
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26 care quality.[1-3, 11-14]
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36 With no official statistics of patient complaints available in Chinese records, we
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38 estimated that the number of complaints and disputes rose, from 10,249 to 13,875
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40 claims, based on the number of first trials for medical malpractice cases between 2002
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42 and 2008.[15] Mounting dissatisfaction has been felt across the country, manifesting
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44 in increasingly hostile and violent behaviour towards providers from patients and their
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46 families.[16] An investigation carried out by the Chinese Hospital Management
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48 Association in 2005 suggested that of 270 hospitals surveyed, 73 per cent experienced
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50 abuse in the form of threats and assaults targeting doctors and management.[17] These
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52 incidents are only indicative of rising expectations, burgeoning patient discontent with
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4 services and dissatisfaction towards the way in which matters are resolved.[18] Public
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6 outcry only exacerbates the need for more effective handling of individual cases under
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8 the overarching agenda of public hospital reform in China.[19]
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14 Notwithstanding the alarming extent of these issues, few attempts have been made to
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16 formally examine how hospital complaints are addressed in developing countries. It is
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18 only recently that a handful of studies in China have sought to provide some
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20 understanding of the issue by trying to ascertain the number of complaints in the
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22 studied hospitals or garnering patient feedback via questionnaires and
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24 interviews.[20-22] A fuller understanding of the complaints system – the available
25
26 channels for seeking redress, how the system operates and the barriers to conflict
27
28 resolution – will be crucial to ameliorating the often fraught relationships between
29
30 health care providers and consumers. The purpose of this study has been to examine
31
32 the handling system for patient complaints in China, and to subsequently identify and
33
34 analyse the various hospital-specific factors preventing grievances from being
35
36 effectively addressed. The authors of this paper hope that such an undertaking will
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38 reduce malpractice and above all, improve health service outcomes.
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49 This study is one of the cases from the "Health System Stewardship and Regulation in
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51 Vietnam, India and China" (HESVIC) research project. It was conducted by a
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53 consortium of six partners in Asia and Europe from 2009-2012, with the aim of
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55 supporting policy decisions in the application and extension of accessibility,
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4 affordability, equity and quality of coverage of maternal health care in the three
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6 countries.
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10 11 **Methods**

12 13 *Study design*

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16 The project uses a multidisciplinary approach, drawing on multiple case studies to
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18 examine the impact of regulation on improving equitable access to quality health care
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20 in Vietnam, India and China. In each country, three cases were selected and studied.
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22 This paper shows the findings from the case study, examining the regulation on
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24 Grievance Redressal (GR) in Shanghai, China. Here, regulation encompasses the
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26 formation of rules and practices, as well as their interpretation and implementation,
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28 such as the health policy processes covered in the HEPVIC project (HEPVIC).[23]
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37 38 **Phase One: Literature Review**

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40 Firstly, we conducted a literature review. The relevant sources, which included
41
42 regulation documents related to the handling of patient complaints at both the national
43
44 and Shanghai municipal levels, were used to collect legal approaches and mechanisms
45
46 used in managing patient complaints. These regulations were mainly stipulated from
47
48 2002 to 2011. To understand the application of different complaint approaches, a
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50 search of scientific literature published between 2000 and 2011 was conducted.
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52 Databases MEDLINE-PubMed and WANFANG Data were consulted. A search
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54 strategy was established based on the following keywords: *grievance redressal*,
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4 *patient complaint, health care complaint and hospital complaint, and China. Special*
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6 focus was placed on patient complaint management in hospitals, as we found that the
7
8 vast majority of complaints were handled and resolved within the hospitals.[22]
9

10 11 12 13 14 **Phase Two: Pilot Study – Interviews**

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16 Based on our understanding of the current patient complaint handling system, we
17
18 performed semi-structured interviews with key stakeholders – policymakers from the
19
20 national level, administrators from the Shanghai municipal level, hospital managers,
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22 health care providers, users and other related parties. We used the snowball sampling
23
24 method to identify key stakeholders and to collect important feedback from key
25
26 informants from various disciplines.[24, 25]
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34 In Phase Two (October-December 2010), one key actor from each of the three
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36 administrative levels was selected and interviewed: a policymaker at the national level,
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38 a municipal administrator and a hospital manager. A pilot study was conducted to test
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40 the topic guidelines developed. These allowed us to gain a preliminary understanding
41
42 of the complaint management process in the hospital setting, and to refine the data
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44 collection tools. These interviews served as the basis for the design of Phase Three
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46 interviews, where some of those being interviewed in the third phase were
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48 respondents recommended by Phase Two interviewees.
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53 54 55 56 **Phase Three: Main Data Collection**

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4 Interviews in Phase Three were conducted from August-December of 2011. Key
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6 stakeholders were interviewed in the selected hospitals based on location, level and
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8 type. Our sample represented both urban and suburban areas in Shanghai. General and
9
10 specialist hospitals were selected. Phase Three began with interviews of hospital
11
12 managers and health care providers proposed in Phase Two. We asked interviewees
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14 from Phase Two to invite patients and other relevant stakeholders to contribute their
15
16 views. Those invited patients used different channels for lodging their complaints;
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18 however, they all shared one thing in common: all patients had first complained to the
19
20 hospital. We then proceeded to interview the administrators and finally a high-level
21
22 policymaker. We continued to interview respondents, collecting and analysing their
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24 comments and feedback until no new themes emerged, i.e. saturation had been
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26 reached. The number of participants involved in the different types of interviewees is
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28 depicted in Table 1.
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39 Semi-structured interviews were conducted with 35 respondents face-to-face, except
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41 one via telephone. The interviews took place at private locations, for example at the
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43 institution where the interviewee or interviewer worked, and were conducted by two
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45 of the authors of this paper. Each interview lasted 1-2 hours and was audiotaped with
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47 permission, apart from two which were not recorded but typewritten upon the
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49 respondents' request.
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54 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 | | 1 |
| insurance | | |
| The People's Mediation Committee for | | 1 |
| Medical Disputes | | |
| The Complaint Letters and Visits System | | 1 |
| Total | | 35 |

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6 The topic guidelines for carrying out the interviews included questions on the
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8 participant's experience in complaint management in the hospitals. Using probes and
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10 follow-up questions, attention was directed to factors that the interviewees perceived
11
12 as barriers to effective complaint management, and interviewees were asked to
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14 explain their reasoning. From existing literature, we identified a list of factors
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16 required for effective complaint management and successful resolution of disputes.
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18 Participants were asked to provide suggestions and feedback regarding how
19
20 complaints could be more effectively dealt with given the barriers they had identified.
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28 *Data analysis*

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31 Audiotapes recorded during the interviews were transcribed and were compared with
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33 the field notes to check for accuracy. We analysed data through a process of rigorous
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35 and structured analysis.[26] The analysis was executed in several stages to 1) become
36
37 familiar with the data; 2) identify emerging topics; 3) develop a topic index; 4) use the
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39 index to code the data; 5) consolidate the topics into themes; 6) further consolidate
40
41 these themes into analytical categories/clusters; and 7) translate the analysis obtained
42
43 into a narrative. Written consent was obtained from each interviewee before
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45 undertaking the interviews.
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54 We performed the above tasks using the qualitative research software NVivo 9.0. The
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56 raw data was coded by two independent reviewers (YSJ, QZ). If discrepancies
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4 emerged, a third reviewer (XHY) participated in the group discussion until the group
5
6 arrived at a consensus. There were some models for analysing complaint
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8 management;[2, 13] for example, the Managerial-Operational-Technical (MOT)
9
10 model was developed by Hsieh SY to explore complaint management in hospitals.[2]
11
12 In our study, we collected data according to the complaint management process. To
13
14 analyse the data most efficiently and directly, we used the stages of the process, which
15
16 included receiving, handling and resolving complaints.[27] As quality improvement
17
18 following complaints is crucial, we added the stage of “institutional changes for
19
20 quality improvement using complaints data”.[2, 12]
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29 Our study was approved by Institutional Review Board (IRB), School of Public
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31 Health, Fudan University. Access to data was restricted to approved members of the
32
33 research team who signed a confidential agreement with the principal investigator.
34
35 Data were stored in secure electronic locations. Data processing was kept anonymous
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37 so as to protect the identity of interviewees. The names of the respondents have been
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39 deleted from the quotations.
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46 Findings

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48 This section first presents a number of approaches developed and implemented in
49
50 Shanghai to handle patient complaints and their relationships. It then focuses on the
51
52 approach of negotiation between hospitals and complainants, identifies its barriers,
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54 and proceeds to examine and analyse these barriers.
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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

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4 National People's Congress on December 26, 2009, provided a new legal definition of
5
6 liability for medical malpractice, liability presumption and exemption.[29]
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11 c. Complaint Letters and Visits System
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13
14 In February 2007, *Measures for the Complaint Letters and Visits System for*
15
16 *Healthcare* was established.[30] Its purpose is to protect the legal rights and interests
17
18 of citizens, legal entities, and other organizations, and to regulate behaviour and
19
20 maintain order within the Complaint Letters and Visits System. It requires health
21
22 administrative departments to set up Complaint Letters and Visits offices at different
23
24 levels. These offices are responsible for receiving, assigning and transferring matters
25
26 as appropriate, as well as supervising the handling of various issues and complaints.
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34 d. People's Mediation – a form of Third-Party Facilitated Mediation
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36
37 In July 2008, the Shanghai Justice Bureau and Health Bureau issued *Opinions on*
38
39 *Regulating People's Mediation Organizations to Participate in Medical Dispute*
40
41 *Mediation*, to establish the People's Mediation Committees for Medical Disputes.[31]
42
43 Committee members, mainly retired judges and doctors, served to mediate disputes
44
45 through reporting, explaining and analysing cases under the supervision of the local
46
47 judiciary. In January 2010, the Ministry of Justice, the Ministry of Health and the
48
49 China Insurance Regulatory Commission jointly issued *Opinions on Strengthening*
50
51 *People's Mediation for Medical Disputes* to bolster the role of mediation in resolving
52
53 medical disputes.[32] Its intent is to settle medical disputes in an effective way and to
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3
4 maintain order within hospitals, all with a view for ensuring harmony and social
5
6 stability. In July 2011, the Shanghai Justice Bureau and Health Bureau introduced
7
8 *Measures on People's Mediation for Medical Disputes in Shanghai* to replace
9
10 *Opinions on Regulating People's Mediation Organizations to Participate in Medical*
11
12 *Dispute Mediation.*[31, 33]
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14

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18 In addition to the aforementioned channels of complaint, patients have also been
19
20 found to express their discontent by “Yi Nao” – exhibiting disruptive behaviour
21
22 within the hospital by targeting doctors and nurses or hospital managers by way of
23
24 abuse, assault and other forms of violence. Much of this has garnered media attention,
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26 resulting in bad publicity for the hospital and damaging the reputation of doctors and
27
28 staff.
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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

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4 and resolver of disputes. (Figure 1)
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9 **3. Barriers to the effective management of patient complaints and their**
10
11 **underlying causes at different stages**
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14 Our interviews revealed that different hospitals often use different complaint systems.
15
16 For example, some hospitals operate a centralized complaints office, which may or
17
18 may not be independent of the Medical Affairs (Administration) Department. Other
19
20 hospitals have several complaints offices, each of which is responsive to different
21
22 kinds of complaints. A hospital's deputy director, who also heads hospital complaint
23
24 management, generally manages complaint departments. Barriers to effective
25
26 complaints management vary at different stages of the complaint process, both from
27
28 the sides of the user and provider.
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36 **a. Barriers to receiving the complaints**
37

38 **Low awareness of users about the handling system for patient complaints**
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40
41 Although hospital staff claimed that the complaints office was accessible to those with
42
43 grievances, patients did not always feel this was the case. One user looked up the
44
45 hospital telephone number on the Internet and said the complaint handling process
46
47 was "very easy" while others did not concur. Almost all the patients interviewed
48
49 found that signs and directions (to the complaints office) failed to catch the eye. In
50
51 some cases none could be seen at all:
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54

55
56 *I wanted to lodge a complaint, but did not know how to find [the complaints*
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4 office]... Because the hospital was so big, I did not know which department [was
5
6 responsible for handling complaints]. ...I simply did not know who to turn to. You
7
8 see, the complaints department was in another building [rather than in the one in
9
10 which I was treated i.e. the clinical department] (Female, Users-1, 01-09-2011)
11
12
13

14 15 16 **b. Barriers to handling the complaints**

17 18 Poor capacity and skills of health care providers

19
20 The capacity and skills of health care providers in managing patient complaints is
21
22 critically important in problem solving. Our study found that the reasons patients
23
24 complained lay mainly in poor communication and factors such as the provider's
25
26 attitude, use of language, unprofessional behaviour, as well as dissatisfaction towards
27
28 service procedures.
29
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33
34 *The Medical Doctors Association carried out a survey on the nature of medical*
35
36 *disputes. 50 per cent of cases were results of inappropriate attitudes about health*
37
38 *care delivery, 25 per cent were caused by technology misuse and the rest were*
39
40 *related to management. (Female, Policy makers-1, 16-12-2010)*
41
42

43
44 The majority of complaints can be resolved by an explanation issued by the hospital
45
46 and/or a verbal apology by the offending party.[5, 35, 36] However, practitioners are
47
48 often too preoccupied with their clinical duties to be able to respond to patient
49
50 complaints.
51
52

53
54 *Doctors are not able to devote much time to handling disputes, because clinical*
55
56 *work is highly demanding. [They need to attend to] many patients every day. If they*
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4 *spend more time communicating with patients, they would lose time needed to carry*
5
6 *out [clinical work]. That is to say, [doctors should be given] less [clinical] work,*
7
8 *and more time to explain their work to patients. Our workload is very heavy, like a*
9
10 *battle. (Female, Health care providers-1, 01-09-2011)*

Incompetence and powerlessness of complaints handlers

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19 In comparison to health care providers, complaint handlers played a more important
20
21 role in cooperation and coordination. Although complaint departments were
22
23 specifically set up in hospitals for receiving and handling complaints, the responsible
24
25 persons in the department were mainly part-time medical staff. In some cases those
26
27 handling staff were found to be inadequate due to lack of training. Many of them had
28
29 studied handling techniques on their own and had not acquired sufficient professional
30
31 skills to appropriately analyse, assess and solve complaints.
32
33
34

35
36 *Complaint handlers in the hospitals cannot solve everything because the disciplines*
37
38 *involved in complaints are highly specialised. I am only familiar with general*
39
40 *surgery and issues that require common sense, but [I am not familiar] with*
41
42 *professional problems in other disciplines. (Male, Hospital managers-5,*
43
44 *08-09-2011)*

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46
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48
49 *It is difficult to recruit staff for our Medical Dispute Handling Office. No one wants*
50
51 *to come. A boy recruited in 2007 could not stand the demands of the job*
52
53 *[complicated disputes and violence] and so resigned. (Female, Hospital*
54
55 *managers-3, 31-08-2011)*

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4 *We have little time to do things other than receiving complaints. We lack staff*
5
6 *members. We are responsible for receiving and processing complaints, and expected*
7
8 *– on top of this – to deal with other things, hence why we are exhausted. (Male,*
9
10 *Health care providers-2, 16-09-2011)*

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12
13
14 Given that most complaints are handled and resolved in the hospital, it appeared that
15
16 every complaint handler interviewed felt the same way: tired and stressed. Complaint
17
18 handlers were insufficiently empowered to handle complaints. It was hard for them to
19
20 coordinate between different departments, investigate cases, organize mediation, find
21
22 solutions and then draw on patients' feedback to improve quality of care.
23
24

25
26 *Recently, a fierce medical dispute occurred because of a possible misunderstanding*
27
28 *between administrative departments. [Abusive] words erupted. As a consequence,*
29
30 *staff members involved in this incident were distraught – to the extent that they*
31
32 *wanted to resign. Hence, we need understanding and support among*
33
34 *colleagues. ...Sometimes the clinical department at hand refused to cooperate when*
35
36 *investigated. He [the clinical department] is not very serious about cooperating*
37
38 *with the investigation. (Female, Hospital managers-3, 31-08-2011)*

39
40
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42
43
44 *Communication between administrative departments and clinical departments is*
45
46 *not very effective sometimes. I am not satisfied with this. (Female, Hospital*
47
48 *managers-2, 25-08-2011)*

53 54 **Non-transparent exchange of information**

55
56 In addition, the complaint handling process was not truly open to the complainant, and
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58
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2
3
4 information exchange was largely limited to hospital staff. In fact, it was found that
5
6 the staff at the complaints office was generally evasive towards patients who arrived
7
8 wishing to be updated with the specifics of their complaint. Complainants had no
9
10 opportunity to directly engage in the handling of their complaints or to meaningfully
11
12 participate in the process. In addition, hospitals tended to oversimplify cases,
13
14 assuming that the complainant's only desire was to report their complaint and ask for
15
16 compensation. This implies that the entire handling process is disclosed only among
17
18 hospital staff. Therefore, the process becomes a "black box" to patients. It is easy for
19
20 the hospital to manipulate a complainant by providing limited information to gain
21
22 advantage in negotiations, i.e. reduce loss from compensating patients.
23
24
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28
29 *Sometimes you have to circumvent something and use negotiating skills. Mistakes in*
30
31 *medical services do not necessarily harm patients' health, but they can be very*
32
33 *serious for the provider [...] for example, someone may not be very careful when*
34
35 *writing a medical record and alter it by accident. But you are likely to lose a lawsuit*
36
37 *on the grounds of having tampered with records. Incidents such as these cloud the*
38
39 *matter; making transparency difficult. (Female, Hospital managers-2, 25-08-2011)*
40
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44 If the incident is urgent or presents itself as a recurring problem, it might be shared to
45
46 educate healthcare providers but disclosure to complainants themselves remains
47
48 limited. Only outcomes deemed to be of direct interest to patients, including
49
50 compensation amounts and medical service privileges, were provided. However, other
51
52 results, including penalties imposed upon physicians and departments or
53
54 improvements made to hospital services, were largely withheld from patients if they
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4 did not ask.

5
6 *In individual cases, what are the outcomes of their complaints? How might a*
7
8 *physician be punished/penalised/disciplined? Such information is requested by*
9
10 *patients only occasionally. (Male, Health care providers-2, 16-09-2011)*

11
12
13
14 *I want to know how to better educate the concerned health care providers. But I*
15
16 *have not been told. (Female, Users-3, 20-09-2011)*
17
18
19

20 21 **c. Barriers to resolving the complaints**

22 23 **Conflicts between relevant actors and regulations**

24
25
26 Within the complaints system, conflicts or inconsistencies can arise between the legal
27
28 system for handling complaints and the solutions determined by the hospital. As the
29
30 structure of managing patient complaints is shown in Figure 1, different regulations
31
32 stipulate different approaches. Unified laws or guidelines do not exist to clearly
33
34 illustrate the relationships between different approaches, which results in problems
35
36 such as a lack of authority or ultimate approach, uncertainty about how to apply
37
38 different regulations to one case, and no clear definitions or classifications in regards
39
40 to patient complaints.
41
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45
46 *The current state of complaint management is disorderly. There are too many*
47
48 *channels. For example, many departments are involved, including but not limited to*
49
50 *Complaint Letters and Visits, online complaints, etc. The Health Bureau has two*
51
52 *departments [for complaint management], and each district has a mediation office,*
53
54 *a district government website or a mayor-mail [to receive complaints], and a*
55
56
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4 *Complaint Letters and Visits office... Far too many heads of departments within the*
5
6 *health sector; it is chaos. (Male, Health care providers-2, 16-09-2011)*
7

8
9 *Hospitals are required to report complaints to a lot of sectors, all of which wish to*
10
11 *understand the issue from different angles. Conflicts between regulations do not*
12
13 *necessarily exist, but different elements are emphasised. Hospitals are tired of these*
14
15 *kinds of bureaucracy. ...Each sector carries out their designated duties where*
16
17 *resources are not shared. The information possessed by each sector is fragmented.*
18

19
20
21 *You know yours, I know mine. (Male, Administrators-2, 18-08-2011)*
22

23
24 *Medical malpractice is defined clearly in the Regulation on Handling Medical*
25
26 *Malpractice. There are several benchmarks determining the amount of*
27
28 *compensation issued. After the Tort Liability Law of the People's Republic of China*
29
30 *was promulgated, [medical damage] was compensated for more in accordance with*
31
32 *the Tort Liability Law because it stipulates compensation for personal injury.*
33
34
35
36 *(Female, Hospital managers-2, 25-08-2011)*
37

38 39 40 41 **Unjustifiable complaints by patients**

42
43
44 In some cases, the patient experiences inconvenience when receiving medical services
45
46 not because of poor conduct in attitude or behaviour on the part of health care
47
48 providers, but possibly because of long wait times, too little time spent with the doctor,
49
50 and/or imperfect resource allocation. These are health system issues rather than
51
52 problems caused by hospitals or individual physicians. And so, to a certain extent,
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56 physicians and hospitals have become scapegoats of the entire health system.
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4 *At times it is not us physicians who make patients angry. Certain factors are rooted*
5
6 *in the fabric of health care systems, but we physicians [end up] taking the blame.*
7
8
9 *(Male, Health care providers-3, 16-09-2011)*

10
11 *For example, should a doctor need to see sixty patients in half a day, or indeed one*
12
13 *hundred, you cannot demand that he puts on a smile for each one. A lot of patients*
14 *complain about doctors with a straight face, but I think it is understandable. I have*
15
16 *a very good relationship with our young doctors. They operate on a tight schedule.*
17
18 *This week someone worked at the outpatient facility. He was friendly with patients*
19
20 *in the first month but struggled to sustain that sort of demeanour. He is not in the*
21
22 *mood to smile at patients or engage in long conversations when he only has time to*
23
24 *attend to their illnesses. (Male, Hospital managers-1, 15-12-2010)*
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33
34 For example, dissatisfaction voiced in the hospital may be related to health insurance
35
36 policy rather than staff behaviour. Hospitals need to follow the policies made by the
37
38 Health Insurance Department. The purpose of those policies was to improve rational
39
40 use of medicines and control healthcare costs, while the patients covered by health
41
42 insurance may demand more medicines.
43
44

45
46 *Chinese doctors have many rules to obey [this is to curb poor conduct]. The*
47
48 *pressures for them to perform are relatively large. For example, doctors cannot*
49
50 *prescribe too much medicine for a patient who has only [basic state-financed]*
51
52 *medical insurance, but patients always want more. A while ago, the Medical*
53
54 *Insurance Bureau issued the following statement in a newspaper: “The Medical*
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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

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3
4 *define, without a doubt, problems underlying the state and society. (Male, Health*
5
6 *care providers-4, 16-09-2011)*
7

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9 In addition, the safety of health care providers is under threat in China today. Chinese
10
11 medical workers are often victims of violence. As a consequence, some health care
12
13 providers have decided to not treat patients deemed likely to assault staff, exhibit
14
15 disruptive behaviour, or otherwise prove to be difficult. Prescribing redundant
16
17 check-ups and drugs are alternatives to properly seeing to patients.
18
19

20
21 In our interviews, fifteen interviewees mentioned “Chao” fifty-five times. “Chao” in
22
23 Chinese means to argue with hospitals for patients’ rights and interests, while the
24
25 other meaning is to wrangle fiercely in hospitals or with senior management. Most of
26
27 the hospital staff interviewed suggested that some complainants were indeed
28
29 unreasonable and impulsive with the sole purpose of claiming.
30
31

32
33 *If the case goes to court, the patient gathers a lot of people to go to the court,*
34
35 *insulting and threatening concerned health care providers and their lawyers. That is*
36
37 *not what we want to see. We want to talk about the truth, by thoroughly publicizing*
38
39 *the truth. We cannot always be too specific with terminology [for fear of revealing*
40
41 *too much]. When completely refuted, patients lose their temper. (Male, Other*
42
43 *actors-2, 15-09-2011)*
44
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48
49 *I feel that the widespread situation in China today is that you can do nothing if you*
50
51 *run into the unreasonable. The legitimate way of going about this is to propose a*
52
53 *fair decision once I receive your complaint. If complainants are not willing to settle*
54
55 *for this, we then transfer their case to other departments. However, complainants*
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4 may not even agree to that, causing trouble and even threatening the safety of
5
6 health care providers. (Female, Hospital managers-2, 25-08-2011)
7

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9 The claim a complainant demands goes beyond the actual problem [but for the
10
11 money] and he does not wish to resolve it the legal way. ...Nowadays “Yi Nao” has
12
13 brought about serious social effects, and has escalated the tension between service
14
15 users and providers. Complainants are unwilling to resolve things the legal way,
16
17 rather, just pestering and hassling you [health care providers or complaint handlers]
18
19 all day. (Male, Hospital managers-6, 01-11-2011)
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26 **d. Barriers to institutional changes for quality improvement using complaints**
27
28 **data**
29

30
31 **Weak enforcement of the regulation**
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34 The regulation for managing patient complaints is merely a guideline, which contains
35
36 no mandatory requirements such as assessment mechanisms. Because it takes into
37
38 account the difference in local conditions throughout China, specific contents were
39
40 not stipulated. The regulation is to be interpreted according to local circumstances and
41
42 conditions. Therefore, in the absence of strong public scrutiny, there is little
43
44 accountability for how best to manage patient complaints.
45
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48
49 *There are no penalties attached to (failure to follow) regulation. For example, there*
50
51 *is no administrative aspect to the regulatory guidelines. We wanted to write a*
52
53 *penalty provision, but it was not based on the top legislation. The purpose of the*
54
55 *regulation is to emphasise self-discipline and to serve as guidance for the hospital.*
56
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4 *[The penalty was not enforceable,] so we decided to remove the penalty. It is indeed*
5
6 *difficult and contradictory. (Female, Administrators-4, 30-11-2011)*
7
8

9 Besides the legal system, the reporting system also has its problems. Some statistics
10 about patient complaints and medical malpractice were utilized as a part of
11 assessments of hospital performance, health care quality, and so on. This meant that
12 the more cases that were reported, the worse the evaluations received by the hospitals
13 so that hospitals were inclined to report selectively or report fewer cases.
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20
21 *There are certainly no statistics for the number of patient complaints. There is only*
22 *the data on the number of medical malpractice cases per year from the Bureau of*
23 *Health, and an approximate amount of compensation issued by insurance*
24 *companies. In some cases, if complaints were solved just between the hospital and*
25 *the complainant, we have no data. (Male, Administrators-2, 18-08-2011)*
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34 *These days, the information regarding the management of patient complaints in*
35 *hospitals is difficult to access. Hospitals are unwilling to provide that sort of*
36 *information – it is considered confidential. We only have some profiles or the*
37 *information from select hospitals. (Female, Policy makers-1, 16-12-2010)*
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46 Thus, the adoption of the incentive and sanction mechanism was contradictory for
47 managing patient complaints. From one side, the administrative department wanted
48 hospitals to report patient complaints because it is important for informing and
49 improving the quality of care. From the other side, the more complaints that are
50 registered, the worse it would appear a hospital is doing. In addition to this, managing
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4 patient complaints remains low on the health reform agenda. The force for inspecting
5
6 complaint management in hospitals from senior management and administrative
7
8 departments remains weak.
9

10
11 *[Having a statistic for patient complaints] is definitely necessary from the aspect of*
12
13 *effective management. If this statistic is disposable, I think nothing of it. If the*
14
15 *statistic is routine, in fact, it will cost [all sorts of resources]. (Male, Policy*
16
17 *makers-2, 22-12-2011)*
18
19

20
21 *Hospitals doubt that the purpose of administration is for information management –*
22
23 *to help them better handle and solve disputes. However, if you want me to report*
24
25 *incidents but meanwhile punish me for that, then I have no incentive to report*
26
27 *anything. This contradiction stands [in the way of effective reporting]. (Female,*
28
29 *Administrators-4, 30-11-2011)*
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33 34 35 36 **Deficient information system for managing patient complaints**

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38
39 Although the regulations in place require collecting and analysing information, there
40
41 exists no clear classification, definitions or unified coding system. Most hospitals
42
43 have established their own systems for recording complaints and analysing cases, but
44
45 no accurate or comparable data are available.
46
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48
49 *In fact a lot of cases should be recorded and analysed, [but] we do not even take*
50
51 *into account so-called major cases of medical malpractice, mass disturbance or*
52
53 *medical malpractice. We cannot distinguish between these concepts... Relatively*
54
55 *speaking, it is more feasible to publicize the data on public security, e.g. the number*
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4 *of police records and people arrested, and the number of crimes committed. Those*
5
6 *definitions are more explicit, whereas those concerning complaints management are*
7
8 *not. Because all statistics are calculated in the hospital, we find that where*
9
10 *standards are slack, the resulting statistic is large and where standards are strict,*
11
12 *the statistic is small. Hence, there is great variability in our results. (Male, Policy*
13
14 *makers-2, 22-12-2011)*

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17
18 *Identical forms are sent to two hospitals at a similar level and the reported data can*
19
20 *be quite different. ...Some hospitals only reported cases resulting in compensation*
21
22 *and some hospitals record all persons who voice a concern, while others only*
23
24 *report cases identified as medical malpractice. But it is impossible for me to verify*
25
26 *[the reported data] in each hospital. (Male, Administrators-2, 18-08-2011)*

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31 Hospitals have not publicized complaints; neither have health administration
32
33 departments. The Shanghai Bureau of Health launched a pilot project in 2005 to
34
35 publicize the complaints reported by all hospitals in Shanghai. The project was
36
37 welcomed by the public but discontinued soon after its launch due to mounting
38
39 pressure from the hospitals.
40
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43
44 *We already publicize complaints [medical malpractice] on our intranet for hospital*
45
46 *staff. It is unnecessary to share this information on external sites. (Female, Hospital*
47
48 *managers-4, 06-09-2011)*

49
50
51 *To my knowledge, such information was published once on the Xinmin Evening*
52
53 *News in 2005. The newspaper named hospitals that had won awards and gave*
54
55 *details of the number of medical malpractice cases happening in each, as well as*
56
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4 *feedback regarding patient satisfaction. [We felt] the pressure was very, very high.*
5
6 *It [publishing those] resulted in public outrage [from hospitals]. (Female,*
7
8 *Administrators-4, 30-11-2011)*

Unwillingness of hospitals to effectively handle complaints

16 Most hospitals did not devote much effort into managing complaints. There was no
17
18 clear mechanism to utilize patient complaints to improve quality of care unless serious
19
20 medical malpractice had occurred or complaints were found to recur.

23 *Hospitals just handle complaints when complaints happen. ...We are basically*
24
25 *perfunctory, including hospitals, department directors and doctors. The best-case*
26
27 *scenario for me: do not approach me for these things [complaints]. Deal with*
28
29 *complaints quickly and efficiently; in other words, spend money to buy peace. The*
30
31 *impact of managing and addressing complaints is negligible, with very little effect*
32
33 *on improving medical procedures and quality. (Male, Administrators-2,*
34
35 *18-08-2011)*

41 Hospital directors were the key actors of complaint management in hospitals. The
42
43 incentive and sanction mechanisms in hospitals depended on how much attention
44
45 directors pay to complaint management. In the 1980s the government reduced
46
47 subsidies for public hospitals under the context of transforming the planned economy
48
49 to a so-called socialist market in order to reduce inefficiencies in health care provision.
50
51 Hospitals had to increase service charges to recoup the operational costs and to
52
53 increase the income level of health workers. Complaint management occupied nothing
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4 but a small part of quality health care, so in most hospitals it failed to draw attention
5
6 from senior management. Most complaints were solved on a case-by-case basis,
7
8 without sufficient concern for the overall improvement of health care services.
9

10
11 *In practice, the head of department influences implementation. If he/she regards*
12
13 *this as important, then subordinates work harder of course. Now the problem is that*
14
15 *some heads of department do not pay attention to it [complaint management].*
16
17
18 *(Male, Health care providers-2, 16-09-2011)*
19

20
21 *It is of course medical services that are the core of hospital work. Things such as*
22
23 *[complaint management] are boring for the hospital. To a hospital, the fewer the*
24
25 *complaints, the better. (Male, Administrators-2, 18-08-2011)*
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31 **Discussion and Conclusions**

32
33 This study examined the handling system for patient complaints in China and the
34
35 views of key stakeholders on the barriers to effective complaint management. Our
36
37 study provided a new dimension for understanding the complaints management
38
39 system in China, an emerging market country. Hospitals are the most important
40
41 handler and manager of patient complaints in China and similarly for other
42
43 developing countries, such as India and Vietnam.[22] We explored the barriers
44
45 through in-depth interviews with almost all stakeholders, not only health professionals.
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48 We hope that our findings will help develop procedures for more effective complaint
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50 management and further improve the quality of care in China and other developing
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52 countries.
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6 To reduce the heavy burden placed on hospitals, the government has tried to seek help
7
8 from other approaches aside from negotiation with hospitals. Initially, those other
9
10 approaches were frequently welcomed and praised, but they seemed to be ineffective
11
12 and inefficient. The effectiveness and efficiency of those other approaches needs
13
14 further research. The selection of participants may introduce some bias to our studies.
15
16 Due to our focus on the hospital, there may be an underrepresentation of certain types
17
18 of respondents. Since there are no unified classifications for complaints, we did not
19
20 include patients with different types of complaints. Moreover, we planned to recruit
21
22 the same number of participants in multiple settings, but the number of participants
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24 from each was imbalanced because of information saturation.
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33
34 We found that the three main project elements adopted from Hickson GB et al. were
35
36 relevant and useful for the discussion of our results: (A) organizational supports, (B)
37
38 commitment from key people, and (C) learning systems.[13]
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44 A. Organizational Supports

45
46 Our findings showed that there are no standardized systems and procedures dealing
47
48 with patient complaints in China due to conflicts between relevant actors and
49
50 regulations. Having experienced rapid economic growth in the last 30 years, China is
51
52 undergoing a socioeconomic transition. Like other developing countries, policies lag
53
54 behind the country's economic transition.[37, 38] The Ministry of Health has tried to
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4 guide health care providers by issuing special regulations, but health administrations
5
6 do not apply strict regulations to complaint management. There lacks clear
7
8 relationships between patient complaints and clinical outcomes or the quality of care.
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14 The patient complaints in many Chinese hospitals are not well-managed and handled.
15
16 Most hospitals manage patient complaints on only a case-by-case basis. They lack
17
18 clear mechanisms linking patient complaints with improving the quality of care.
19
20 Complaints are underutilised for organizational strategic planning or for changing an
21
22 individual's behaviour and attitude. This implies that legislation should not only
23
24 stipulate the principles and regulations of patient complaint management, but also the
25
26 responsibilities of sectors at different levels.[39]
27
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33 34 B. Commitment from People

35
36 The hospital leader is the key determinant for complaint handling inside the hospital.
37
38 However, no apparent incentives exist to push hospital leaders to prioritize complaint
39
40 handling. The power of complaint handling departments depends on how much the
41
42 hospital leaders pay attention to it. Under current conditions, hospital leaders lack
43
44 political will to manage complaints effectively, leading to inadequate human resources
45
46 in complaint handling departments. The departments also lack the power to coordinate
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48 with clinical departments.
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56 To alleviate patient complaints-related violence, civil groups, including service users
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4 and the hospital sector, should approve the guideline. In developed countries, patient
5
6 complaint management provides guidelines not only for health care providers, but
7
8 also clear guidelines for patients. This not only makes it more convenient for patients,
9
10 but also plays a positive role in helping patients initiate the complaint process via
11
12 legitimate means. This is crucial for society to view patient complaint in a rational
13
14 way.
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21 C. Learning Systems

22
23 If patient complaints can be better managed and rectified, the instances of failure
24
25 would be reduced and quality would be improved.[40, 41] Greater emphasis should be
26
27 placed on quality improvement after patients complain. Strategies to improve quality
28
29 following patient complaints should be developed through a learning process.[42] To
30
31 promote the learning process, appropriate mechanisms should be developed and
32
33 implemented to assess not only the number of patient complaints occurring in
34
35 hospitals, but also how these hospitals have handled these complaints. For example,
36
37 reporting more patient complaints should not be necessarily punished, while effective
38
39 handling of the patient complaints should be appreciated.
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49 Our final conclusion is that barriers to the effective management of patient complaints
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51 vary at the different stages of complaint handling, from the user and provider side, as
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53 well as systemic issues. Information, procedure design, human resources, system
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55 arrangement, a unified legal system and regulations and factors shaping the social
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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.

For peer review only

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

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- 11 4) Sirui Rae TANG: substantial contributions to analysis and interpretation of data;
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- 35 intellectual content; and final approval of the version to be published.
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41 **DATA SHARING**

42 No additional data available.

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8
9 4. Up to five keywords or phrases suitable for use in an index (it is recommended to
10
11 use MeSH terms).
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14 Qualitative Research; Patient Complaints; Complaint Handling Systems; Quality
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16 Improvement; Government Regulation
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21 5. Word count - excluding title page, abstract, references, figures and tables.
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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

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3 patients during solution settlements; and weak enforcement of regulations, deficient
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5 information for managing patient complaints and unwillingness of the hospitals to
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7 effectively handle complaints in the post-complaint stage.
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13 **Conclusions:** Barriers to the effective management of patient complaints vary at the
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15 different stages of complaint handling and perspectives on these barriers differ
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17 between the service users and providers. Information, procedure design, human
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19 resources, system arrangement, unified legal system and regulations and factors
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21 shaping the social context all play important roles in effective patient complaint
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23 management.
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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~~

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4 side, as well as system issues.
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6 ~~5. Information, procedure design, human resources, system~~
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9 ~~arrangement, unified legal system and regulations and factors~~
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11 ~~shaping the social context all play important roles in effective~~
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13 ~~patient complaint management.~~
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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

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4 the quality of care. In Britain, the National Health Service (NHS) has not only
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6 provideds clear and transparent guidelines for both health care providers and patients
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8 but has also publicizeds information regarding the routine reporting of patient
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10 complaints.[9] In Australia, a large study was conducted before *Guide to Complaint*
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12 *Handling in Health Care Services* was formulated and subsequently updated.[10]
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14 Annually, statistics are compiled and published, detailing complaint trends, complaint
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16 management and reasons for complaints. Effective handling of complaints has been
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18 known to reduce friction between providers and consumers, with the even greater
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20 benefit of improving quality of care. As a supplement to peer reviews and
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22 administration, patient complaints can provide important feedback concerning the
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24 delivery of health care services and can be a useful tool in the improvement of health
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26 care quality.[1-3, 11-14]
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36 With no official statistics of patient complaints available in Chinese records, we
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38 estimated that the number of complaints and disputes rose, from 10,249 to 13,875
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40 claims, based on the number of first trials for medical malpractice cases between 2002
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42 and 2008.[15] Mounting dissatisfaction has been felt across the country, manifesting
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44 in increasingly hostile and violent behaviour towards providers from patients and their
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46 families.[16] An investigation carried out by the Chinese Hospital Management
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48 Association in 2005 suggested that of 270 hospitals surveyed, 73 per cent experienced
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50 abuse in the form of threats and assaults targeting doctors and management.[17] These
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52 incidents are only indicative of rising expectations, burgeoning patient discontent with
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4 services and dissatisfaction towards the way in which matters are resolved.[18] Public
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6 outcry only exacerbates the need for more effective handling of individual cases under
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8 the overarching agenda of public hospital reform in China.[19]
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14 Notwithstanding the alarming extent of these issues, few attempts have been made to
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16 formally examine how hospital complaints are addressed in developing countries. It is
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18 only recently that a handful of studies in China have sought to provide some
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20 understanding of the issue by trying to ascertain the number of complaints in the
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22 studied hospitals or garnering patient feedback via questionnaires and
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24 interviews.[20-22] A fuller understanding of the complaints system – the available
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26 channels for seeking redress, how the system operates and the barriers to conflict
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28 resolution – will be crucial to ameliorating the often fraught relationships between
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30 health care providers and consumers. The purpose of this study has been to examine
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32 the handling system for patient complaints in China, and to subsequently identify and
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34 analyse the various hospital-specific factors preventing grievances from being
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36 effectively addressed. The authors of this paper hope that such an undertaking will
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38 reduce malpractice and above all, improve health service outcomes.
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49 This study is one of the cases from the "Health System Stewardship and Regulation in
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51 Vietnam, India and China" (HESVIC) research project. It was conducted by a
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53 consortium of six partners in Asia and Europe from 2009-2012, with the aim of
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55 supporting policy decisions in the application and extension of accessibility,
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4 affordability, equity and quality of coverage of maternal health care in the three
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6 countries.
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10 11 **Methods**

12 13 *Study design*

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

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39 Firstly, we conducted a literature review. The relevant sources, which included
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41 regulation documents related to the handling of patient complaints at both the national
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43 and Shanghai municipal levels, were used to collect legal approaches and mechanisms
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45 used in managing patient complaints. These regulations were mainly stipulated from
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47 2002 to 2011. To understand the application of different complaint approaches, a
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49 search of scientific literature published between 2000 and 2011 was conducted.
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51 Databases MEDLINE-PubMed and WANFANG Data were consulted. A search
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53 strategy was established based on the following keywords: *grievance redressal*,
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4 *patient complaint, health care complaint and hospital complaint, and China. Special*
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6 focus was placed on patient complaint management in hospitals, as we found that the
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8 vast majority of complaints were handled and resolved within the hospitals.[22]
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10 11 12 13 14 **Phase Two: Pilot Study – Interviews**

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16 Based on our understanding of the current patient complaint handling system, we
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18 performed semi-structured interviews with key stakeholders – policymakers from the
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20 national level, administrators from the Shanghai municipal level, hospital managers,
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22 health care providers, users and other related parties. We used the snowball sampling
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24 method to identify key stakeholders and to collect important feedback from key
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26 informants from various disciplines.[24, 25]
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34 In Phase Two (October-December 2010), one key actor from each of the three
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36 administrative levels was selected and interviewed: a policymaker at the national level,
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38 a municipal administrator and a hospital manager. A pilot study was conducted to test
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40 the topic guidelines developed. These allowed us to gain a preliminary understanding
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42 of the complaint management process in the hospital setting, and to refine the data
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44 collection tools. These interviews served as the basis for the design of Phase Three
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46 interviews, where some of those being interviewed in the third phase were
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48 respondents recommended by Phase Two interviewees.
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53 54 55 56 **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 | | 1 |
| insurance | | |
| The People's Mediation Committee for | | 1 |
| Medical Disputes | | |
| The Complaint Letters and Visits System | | 1 |
| Total | | 35 |

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

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31 Audiotapes recorded during the interviews were transcribed and were compared with
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33 the field notes to check for accuracy. We analysed data through a process of rigorous
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35 and structured analysis.[26] The analysis was executed in several stages to 1) become
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37 familiar with the data; 2) identify emerging topics; 3) develop a topic index; 4) use the
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39 index to code the data; 5) consolidate the topics into themes; 6) further consolidate
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41 these themes into analytical categories/clusters; and 7) translate the analysis obtained
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43 into a narrative. Written consent was obtained from each interviewee before
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45 undertaking the interviews.
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54 We performed the above tasks using the qualitative research software NVivo 9.0. The
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56 raw data was coded by two independent reviewers (YSJ, QZ). If discrepancies
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4 emerged, a third reviewer (XHY) participated in the group discussion until the group
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6 arrived at a consensus. There were some models for analysing complaint
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8 management;[2, 13] for example, the Managerial-Operational-Technical (MOT)
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10 model was developed by Hsieh SY to explore complaint management in hospitals.[2]
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12 In our study, we collected data according to the complaint management process. To
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14 analyse the data most efficiently and directly, we used the stages of the process, which
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16 included receiving, handling and resolving complaints.[27] As quality improvement
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18 following complaints is crucial, we added the stage of “institutional changes for
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20 quality improvement using complaints data”.[2, 12]
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29 Our study was approved by Institutional Review Board (IRB), School of Public
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31 Health, Fudan University. Access to data was restricted to approved members of the
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33 research team who signed a confidential agreement with the principal investigator.
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35 Data were stored in secure electronic locations. Data processing was kept anonymous
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37 so as to protect the identity of interviewees. The names of the respondents have been
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39 deleted from the quotations.
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46 Findings

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

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4 National People's Congress on December 26, 2009, provided a new legal definition of
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6 liability for medical malpractice, liability presumption and exemption.[29]
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11 c. Complaint Letters and Visits System
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14 In February 2007, *Measures for the Complaint Letters and Visits System for*
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16 *Healthcare* was established.[30] Its purpose is to protect the legal rights and interests
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18 of citizens, legal entities, and other organizations, and to regulate behaviour and
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20 maintain order within the Complaint Letters and Visits System. It requires health
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22 administrative departments to set up Complaint Letters and Visits offices at different
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24 levels. These offices are responsible for receiving, assigning and transferring matters
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26 as appropriate, as well as supervising the handling of various issues and complaints.
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34 d. People's Mediation – a form of Third-Party Facilitated Mediation
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37 In July 2008, the Shanghai Justice Bureau and Health Bureau issued *Opinions on*
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39 *Regulating People's Mediation Organizations to Participate in Medical Dispute*
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41 *Mediation*, to establish the People's Mediation Committees for Medical Disputes.[31]
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43 Committee members, mainly retired judges and doctors, served to mediate disputes
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45 through reporting, explaining and analysing cases under the supervision of the local
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47 judiciary. In January 2010, the Ministry of Justice, the Ministry of Health and the
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49 China Insurance Regulatory Commission jointly issued *Opinions on Strengthening*
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51 *People's Mediation for Medical Disputes* to bolster the role of mediation in resolving
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53 medical disputes.[32] Its intent is to settle medical disputes in an effective way and to
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4 maintain order within hospitals, all with a view for ensuring harmony and social
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6 stability. In July 2011, the Shanghai Justice Bureau and Health Bureau introduced
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8 *Measures on People's Mediation for Medical Disputes in Shanghai* to replace
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10 *Opinions on Regulating People's Mediation Organizations to Participate in Medical*
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12 *Dispute Mediation*. [31, 33]
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19 In addition to the aforementioned channels of complaint, patients have also been
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21 found to express their discontent by “Yi Nao” – exhibiting disruptive behaviour
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23 within the hospital by targeting doctors and nurses or hospital managers by way of
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25 abuse, assault and other forms of violence. Much of this has garnered media attention,
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27 resulting in bad publicity for the hospital and damaging the reputation of doctors and
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29 staff.
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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 |

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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](#)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 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](#)

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4 | [“Yi Nao”](#).^[34] Therefore, hospitals have become the most common receiver, handler
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6 and resolver of disputes. (Figure 1)
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10 11 **3. Barriers to the effective management of patient complaints and their** 12 13 **underlying causes at different stages** 14

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16 Our interviews revealed that different hospitals often use different complaint systems.
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18 For example, some hospitals operate a centralized complaints office, which may or
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20 may not be independent of the Medical Affairs (Administration) Department. Other
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22 hospitals have several complaints offices, each of which is responsive to different
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24 kinds of complaints. A hospital’s deputy director, who also heads hospital complaint
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26 management, generally manages complaint departments. Barriers to effective
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28 complaints management vary at different stages of the complaint process, both from
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30 the sides of the user and provider.
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39 **a. Barriers to receiving the complaints** 40

41 **Low awareness of users about the handling system for patient complaints** 42

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

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

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21 In comparison to health care providers, complaint handlers played a more important
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23 role in cooperation and coordination. Although complaint departments were
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25 specifically set up in hospitals for receiving and handling complaints, the responsible
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27 persons in the department were mainly part-time medical staff. In some cases those
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29 handling staff were found to be inadequate due to lack of training. Many of them had
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31 studied handling techniques on their own and had not acquired sufficient professional
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33 skills to appropriately analyse, assess and solve complaints.
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39 *Complaint handlers in the hospitals cannot solve everything because the disciplines*
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41 *involved in complaints are highly specialised. I am only familiar with general*
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43 *surgery and issues that require common sense, but [I am not familiar] with*
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45 *professional problems in other disciplines. (Male, Hospital managers-5,*
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47 *08-09-2011)*
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51 *It is difficult to recruit staff for our Medical Dispute Handling Office. No one wants*
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53 *to come. A boy recruited in 2007 could not stand the demands of the job*
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55 *[complicated disputes and violence] and so resigned. (Female, Hospital*
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4 *managers-3, 31-08-2011)*

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

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16 Given that most complaints are handled and resolved in the hospital, it appeared that
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18 every complaint handler interviewed felt the same way: tired and stressed. Complaint
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20 handlers were insufficiently empowered to handle complaints. It was hard for them to
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22 coordinate between different departments, investigate cases, organize mediation, find
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24 solutions and then draw on patients' feedback to improve quality of care.
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29 *Recently, a fierce medical dispute occurred because of a possible misunderstanding*
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31 *between administrative departments. [Abusive] words erupted. As a consequence,*
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33 *staff members involved in this incident were distraught – to the extent that they*
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35 *wanted to resign. Hence, we need understanding and support among*
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37 *colleagues. ...Sometimes the clinical department at hand refused to cooperate when*
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39 *investigated. He [the clinical department] is not very serious about cooperating*
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41 *with the investigation. (Female, Hospital managers-3, 31-08-2011)*

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

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56 **Non-transparent exchange of information**
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4 In addition, the complaint handling process was not truly open to the complainant, and
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6 information exchange was largely limited to hospital staff. In fact, it was found that
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8 the staff at the complaints office was generally evasive towards patients who arrived
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10 wishing to be updated with the specifics of their complaint. Complainants had no
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12 opportunity to directly engage in the handling of their complaints or to meaningfully
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14 participate in the process. In addition, hospitals tended to oversimplify cases,
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16 assuming that the complainant's only desire was to report their complaint and ask for
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18 compensation. This implies that the entire handling process is disclosed only among
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20 hospital staff. Therefore, the process becomes a "black box" to patients. It is easy for
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22 the hospital to manipulate a complainant by providing limited information to gain
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24 advantage in negotiations, i.e. reduce loss from compensating patients.
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31 *Sometimes you have to circumvent something and use negotiating skills. Mistakes in*
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33 *medical services do not necessarily harm patients' health, but they can be very*
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35 *serious for the provider [...] for example, someone may not be very careful when*
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37 *writing a medical record and alter it by accident. But you are likely to lose a lawsuit*
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39 *on the grounds of having tampered with records. Incidents such as these cloud the*
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41 *matter, making transparency difficult. (Female, Hospital managers-2, 25-08-2011)*
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46 If the incident is urgent or presents itself as a recurring problem, it might be shared to
47
48 educate healthcare providers but disclosure to complainants themselves remains
49
50 limited. Only outcomes deemed to be of direct interest to patients, including
51
52 compensation amounts and medical service privileges, were provided. However, other
53
54 results, including penalties imposed upon physicians and departments or
55
56
57
58
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60

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3
4 improvements made to hospital services, were largely withheld from patients if they
5
6 did not ask.
7

8
9 *In individual cases, what are the outcomes of their complaints? How might a*
10
11 *physician be punished/penalised/disciplined? Such information is requested by*
12
13 *patients only occasionally. (Male, Health care providers-2, 16-09-2011)*

14
15
16 *I want to know how to better educate the concerned health care providers. But I*
17
18 *have not been told. (Female, Users-3, 20-09-2011)*
19

20 21 22 23 24 **c. Barriers to resolving the complaints**

25 26 **Conflicts between relevant actors and regulations**

27
28
29 Within the complaints system, conflicts or inconsistencies can arise between the legal
30
31 system for handling complaints and the solutions determined by the hospital. As the
32
33 structure of managing patient complaints is shown in Figure 1, different regulations
34
35 stipulate different approaches. Unified laws or guidelines do not exist to clearly
36
37 illustrate the relationships between different approaches, which results in problems
38
39 such as a lack of authority or ultimate approach, uncertainty about how to apply
40
41 different regulations to one case, and no clear definitions or classifications in regards
42
43 to patient complaints.
44
45
46
47

48
49 *The current state of complaint management is disorderly. There are too many*
50
51 *channels. For example, many departments are involved, including but not limited to*
52
53 *Complaint Letters and Visits, online complaints, etc. The Health Bureau has two*
54
55 *departments [for complaint management], and each district has a mediation office,*
56
57
58
59
60

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4 *a district government website or a mayor-mail [to receive complaints], and a*
5
6 *Complaint Letters and Visits office... Far too many heads of departments within the*
7
8 *health sector; it is chaos. (Male, Health care providers-2, 16-09-2011)*

9
10
11 *Hospitals are required to report complaints to a lot of sectors, all of which wish to*
12
13 *understand the issue from different angles. Conflicts between regulations do not*
14
15 *necessarily exist, but different elements are emphasised. Hospitals are tired of these*
16
17 *kinds of bureaucracy. ...Each sector carries out their designated duties where*
18
19 *resources are not shared. The information possessed by each sector is fragmented.*

20
21 *You know yours, I know mine. (Male, Administrators-2, 18-08-2011)*

22
23
24
25
26 *Medical malpractice is defined clearly in the Regulation on Handling Medical*
27
28 *Malpractice. There are several benchmarks determining the amount of*
29
30 *compensation issued. After the Tort Liability Law of the People's Republic of China*
31
32 *was promulgated, [medical damage] was compensated for more in accordance with*
33
34 *the Tort Liability Law because it stipulates compensation for personal injury.*
35
36
37
38
39 *(Female, Hospital managers-2, 25-08-2011)*

40 41 42 43 44 **Unjustifiable complaints by patients**

45
46 In some cases, the patient experiences inconvenience when receiving medical services
47
48 not because of poor conduct in attitude or behaviour on the part of health care
49
50 providers, but possibly because of long wait times, too little time spent with the doctor,
51
52 and/or imperfect resource allocation. These are health system issues rather than
53
54 problems caused by hospitals or individual physicians. And so, to a certain extent,
55
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3
4 physicians and hospitals have become scapegoats of the entire health system.

5
6 *At times it is not us physicians who make patients angry. Certain factors are rooted*
7
8 *in the fabric of health care systems, but we physicians [end up] taking the blame.*

9
10 *(Male, Health care providers-3, 16-09-2011)*

11
12
13
14 *For example, should a doctor need to see sixty patients in half a day, or indeed one*
15
16 *hundred, you cannot demand that he puts on a smile for each one. A lot of patients*
17
18 *complain about doctors with a straight face, but I think it is understandable. I have*
19
20 *a very good relationship with our young doctors. They operate on a tight schedule.*

21
22
23
24 *This week someone worked at the outpatient facility. He was friendly with patients*
25
26 *in the first month but struggled to sustain that sort of demeanour. He is not in the*
27
28 *mood to smile at patients or engage in long conversations when he only has time to*
29
30 *attend to their illnesses. (Male, Hospital managers-1, 15-12-2010)*

31
32
33
34
35
36 For example, dissatisfaction voiced in the hospital may be related to health insurance
37
38 policy rather than staff behaviour. Hospitals need to follow the policies made by the
39
40 Health Insurance Department. The purpose of those policies was to improve rational
41
42 use of medicines and control healthcare costs, while the patients covered by health
43
44 insurance may demand more medicines.

45
46
47
48 *Chinese doctors have many rules to obey [this is to curb poor conduct]. The*
49
50 *pressures for them to perform are relatively large. For example, doctors cannot*
51
52 *prescribe too much medicine for a patient who has only [basic state-financed]*
53
54 *medical insurance, but patients always want more. A while ago, the Medical*
55
56
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4 *Insurance Bureau issued the following statement in a newspaper: “The Medical*
5
6 *Insurance Bureau never limits the volume of drugs prescribed, rather it is the doing*
7
8 *of hospitals who wish to increase workload [in order to produce more statistics].” I*
9
10 *think this is really unreasonable. The Bureau does not control the quantity of drugs*
11
12 *prescribed in any given week, but there is a total quantity limit over a year. Doctors*
13
14 *try their best not to prescribe drugs which must be self-financed, i.e. not covered by*
15
16 *basic medical insurance. They must also explain very clearly before prescribing*
17
18 *self-financed drugs, otherwise, patients will lodge complaints once they find out.*
19
20
21
22
23
24 *(Male, Hospital managers-1, 15-12-2010)*

25
26 *Complaints occur when the patient wants more drugs but the doctor refuses to*
27
28 *satisfy his or her demands. Why? The health insurance institution sets a limit on*
29
30 *drug expenditure for each hospital; in turn, the hospital sets a limit for each doctor.*
31
32
33
34 *So if a doctor has too many patients drawing from their health insurance scheme in*
35
36 *any one month, he or she may very possibly have exceeded his/her limit. (Male,*
37
38 *Health care providers-3, 16-09-2011)*

39
40
41 *[A patient who has] basic state-financed medical coverage is entitled to blood and*
42
43 *other auxiliary examinations. If the number of health checks prescribed exceeds a*
44
45 *certain threshold, the doctor is viewed as exploiting basic medical insurance. The*
46
47 *doctor is consequently punished. I was deducted more than seven hundred yuan*
48
49 *(RMB) because of a case like this. I feel this is simply absurd – it is [unexpectedly]*
50
51 *doctors who are to blame. Nothing seems to be wrong with the patient. ...The*
52
53
54 *hospital can not do anything about medical insurance. I think this kind of thing is*
55
56
57
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1
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4 *not the problem at the hospital level. The complaints about medical insurance*
5
6 *define, without a doubt, problems underlying the state and society. (Male, Health*
7
8 *care providers-4, 16-09-2011)*
9

10
11 In addition, the safety of health care providers is under threat in China today. Chinese
12
13 medical workers are often victims of violence. As a consequence, some health care
14
15 providers have decided to not treat patients deemed likely to assault staff, exhibit
16
17 disruptive behaviour, or otherwise prove to be difficult. Prescribing redundant
18
19 check-ups and drugs are alternatives to properly seeing to patients.
20
21

22
23 In our interviews, fifteen interviewees mentioned “Chao” fifty-five times. “Chao” in
24
25 Chinese means to argue with hospitals for patients’ rights and interests, while the
26
27 other meaning is to wrangle fiercely in hospitals or with senior management. Most of
28
29 the hospital staff interviewed suggested that some complainants were indeed
30
31 unreasonable and impulsive with the sole purpose of claiming.
32
33

34
35
36 *If the case goes to court, the patient gathers a lot of people to go to the court,*
37
38 *insulting and threatening concerned health care providers and their lawyers. That is*
39
40 *not what we want to see. We want to talk about the truth, by thoroughly publicizing*
41
42 *the truth. We cannot always be too specific with terminology [for fear of revealing*
43
44 *too much]. When completely refuted, patients lose their temper. (Male, Other*
45
46 *actors-2, 15-09-2011)*
47
48

49
50
51 *I feel that the widespread situation in China today is that you can do nothing if you*
52
53 *run into the unreasonable. The legitimate way of going about this is to propose a*
54
55 *fair decision once I receive your complaint. If complainants are not willing to settle*
56
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4 *for this, we then transfer their case to other departments. However, complainants*
5
6 *may not even agree to that, causing trouble and even threatening the safety of*
7
8 *health care providers. (Female, Hospital managers-2, 25-08-2011)*

9
10
11 *The claim a complainant demands goes beyond the actual problem [but for the*
12
13 *money] and he does not wish to resolve it the legal way. ...Nowadays “Yi Nao” has*
14
15 *brought about serious social effects, and has escalated the tension between service*
16
17 *users and providers. Complainants are unwilling to resolve things the legal way,*
18
19 *rather, just pestering and hassling you [health care providers or complaint handlers]*
20
21 *all day. (Male, Hospital managers-6, 01-11-2011)*
22
23
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29 **d. Barriers to institutional changes for quality improvement using complaints**
30
31 **data**

32
33
34 **Weak enforcement of the regulation**

35
36 The regulation for managing patient complaints is merely a guideline, which contains
37
38 no mandatory requirements such as assessment mechanisms. Because it takes into
39
40 account the difference in local conditions throughout China, specific contents were
41
42 not stipulated. The regulation is to be interpreted according to local circumstances and
43
44 conditions. Therefore, in the absence of strong public scrutiny, there is little
45
46 accountability for how best to manage patient complaints.
47
48

49
50
51 *There are no penalties attached to (failure to follow) regulation. For example, there*
52
53 *is no administrative aspect to the regulatory guidelines. We wanted to write a*
54
55 *penalty provision, but it was not based on the top legislation. The purpose of the*
56
57
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4 regulation is to emphasise self-discipline and to serve as guidance for the hospital.

5
6 [The penalty was not enforceable,] so we decided to remove the penalty. It is indeed
7
8 difficult and contradictory. (Female, Administrators-4, 30-11-2011)
9

10
11 Besides the legal system, the reporting system also has its problems. Some statistics
12
13 about patient complaints and medical malpractice were utilized as a part of
14
15 assessments of hospital performance, health care quality, and so on. This meant that
16
17 the more cases that were reported, the worse the evaluations received by the hospitals
18
19 so that hospitals were inclined to report selectively or report fewer cases.
20
21

22
23
24 *There are certainly no statistics for the number of patient complaints. There is only*
25
26 *the data on the number of medical malpractice cases per year from the Bureau of*
27
28 *Health, and an approximate amount of compensation issued by insurance*
29
30 *companies. In some cases, if complaints were solved just between the hospital and*
31
32 *the complainant, we have no data. (Male, Administrators-2, 18-08-2011)*
33
34

35
36 *These days, the information regarding the management of patient complaints in*
37
38 *hospitals is difficult to access. Hospitals are unwilling to provide that sort of*
39
40 *information – it is considered confidential. We only have some profiles or the*
41
42 *information from select hospitals. (Female, Policy makers-1, 16-12-2010)*
43
44
45
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48

49 Thus, the adoption of the incentive and sanction mechanism was contradictory for
50
51 managing patient complaints. From one side, the administrative department wanted
52
53 hospitals to report patient complaints because it is important for informing and
54
55 improving the quality of care. From the other side, the more complaints that are
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3 registered, the worse it would appear a hospital is doing. In addition to this, managing
4
5 patient complaints remains low on the health reform agenda. The force for inspecting
6
7 complaint management in hospitals from senior management and administrative
8
9 departments remains weak.
10
11

12
13 *[Having a statistic for patient complaints] is definitely necessary from the aspect of*
14
15 *effective management. If this statistic is disposable, I think nothing of it. If the*
16
17 *statistic is routine, in fact, it will cost [all sorts of resources]. (Male, Policy*
18
19 *makers-2, 22-12-2011)*
20
21

22
23 *Hospitals doubt that the purpose of administration is for information management –*
24
25 *to help them better handle and solve disputes. However, if you want me to report*
26
27 *incidents but meanwhile punish me for that, then I have no incentive to report*
28
29 *anything. This contradiction stands [in the way of effective reporting]. (Female,*
30
31 *Administrators-4, 30-11-2011)*
32
33
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38

39 **Deficient information system for managing patient complaints**

40
41 Although the regulations in place require collecting and analysing information, there
42
43 exists no clear classification, definitions or unified coding system. Most hospitals
44
45 have established their own systems for recording complaints and analysing cases, but
46
47 no accurate or comparable data are available.
48
49

50
51 *In fact a lot of cases should be recorded and analysed, [but] we do not even take*
52
53 *into account so-called major cases of medical malpractice, mass disturbance or*
54
55 *medical malpractice. We cannot distinguish between these concepts.... Relatively*
56
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4 speaking, it is more feasible to publicize the data on public security, e.g. the number
5
6 of police records and people arrested, and the number of crimes committed. Those
7
8 definitions are more explicit, whereas those concerning complaints management are
9
10 not. Because all statistics are calculated in the hospital, we find that where
11
12 standards are slack, the resulting statistic is large and where standards are strict,
13
14 the statistic is small. Hence, there is great variability in our results. (Male, Policy
15
16 makers-2, 22-12-2011)
17
18
19

20
21 Identical forms are sent to two hospitals at a similar level and the reported data can
22
23 be quite different. ...Some hospitals only reported cases resulting in compensation
24
25 and some hospitals record all persons who voice a concern, while others only
26
27 report cases identified as medical malpractice. But it is impossible for me to verify
28
29 [the reported data] in each hospital. (Male, Administrators-2, 18-08-2011)
30
31
32

33
34 Hospitals have not publicized complaints; neither have health administration
35
36 departments. The Shanghai Bureau of Health launched a pilot project in 2005 to
37
38 publicize the complaints reported by all hospitals in Shanghai. The project was
39
40 welcomed by the public but discontinued soon after its launch due to mounting
41
42 pressure from the hospitals.
43
44

45
46 We already publicize complaints [medical malpractice] on our intranet for hospital
47
48 staff. It is unnecessary to share this information on external sites. (Female, Hospital
49
50 managers-4, 06-09-2011)
51
52

53
54 To my knowledge, such information was published once on the Xinmin Evening
55
56 News in 2005. The newspaper named hospitals that had won awards and gave
57
58
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4 *details of the number of medical malpractice cases happening in each, as well as*
5
6 *feedback regarding patient satisfaction. [We felt] the pressure was very, very high.*
7
8 *It [publishing those] resulted in public outrage [from hospitals]. (Female,*
9
10 *Administrators-4, 30-11-2011)*

Unwillingness of hospitals to effectively handle complaints

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19 Most hospitals did not devote much effort into managing complaints. There was no
20
21 clear mechanism to utilize patient complaints to improve quality of care unless serious
22
23 medical malpractice had occurred or complaints were found to recur.
24

25
26 *Hospitals just handle complaints when complaints happen. ...We are basically*
27
28 *perfunctory, including hospitals, department directors and doctors. The best-case*
29
30 *scenario for me: do not approach me for these things [complaints]. Deal with*
31
32 *complaints quickly and efficiently; in other words, spend money to buy peace. The*
33
34 *impact of managing and addressing complaints is negligible, with very little effect*
35
36 *on improving medical procedures and quality. (Male, Administrators-2,*
37
38 *18-08-2011)*

39
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42
43
44 Hospital directors were the key actors of complaint management in hospitals. The
45
46 incentive and sanction mechanisms in hospitals depended on how much attention
47
48 directors pay to complaint management. In the 1980s the government reduced
49
50 subsidies for public hospitals under the context of transforming the planned economy
51
52 to a so-called socialist market in order to reduce inefficiencies in health care provision.
53
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55
56 Hospitals had to increase service charges to recoup the operational costs and to
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4 increase the income level of health workers. Complaint management occupied nothing
5
6 but a small part of quality health care, so in most hospitals it failed to draw attention
7
8 from senior management. Most complaints were solved on a case-by-case basis,
9
10 without sufficient concern for the overall improvement of health care services.
11

12
13
14 *In practice, the head of department influences implementation. If he/she regards*
15
16 *this as important, then subordinates work harder of course. Now the problem is that*
17
18 *some heads of department do not pay attention to it [complaint management].*

19
20
21 *(Male, Health care providers-2, 16-09-2011)*
22

23
24 *It is of course medical services that are the core of hospital work. Things such as*
25
26 *[complaint management] are boring for the hospital. To a hospital, the fewer the*
27
28 *complaints, the better. (Male, Administrators-2, 18-08-2011)*
29

30 31 32 33 **Discussion and Conclusions**

34
35
36 This study examined the handling system for patient complaints in China and the
37
38 views of key stakeholders on the barriers to effective complaint management. Our
39
40 study provided a new dimension for understanding the complaints management
41
42 system in China, an emerging market country. Hospitals are the most important
43
44 handler and manager of patient complaints in China and similarly for other
45
46 developing countries, such as India and Vietnam.[22] We explored the barriers
47
48 through in-depth interviews with almost all stakeholders, not only health professionals.
49
50 We hope that our findings will help develop procedures for more effective complaint
51
52 management and further improve the quality of care in China and other developing
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4 countries.

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9 To reduce the heavy burden placed on hospitals, the government has tried to seek
10 help from other approaches aside from negotiation with hospitals, to reduce the heavy
11 burden placed on hospitals. Initially, those other approaches were frequently
12 welcomed and praised at the beginning, but they seemed to not to be ineffective or and
13 inefficient. The effectiveness and efficiency of those other approaches needs further
14 research. The selection of participants may introduce some bias to our studies. Due to
15
16 our focus on the hospital, there may be an underrepresentation of certain types of
17
18 respondents. Since there are no unified classifications for complaints, we did not
19
20 include patients with different types of complaints. Moreover, we planned to recruit
21 the same number of participants in multiple settings, but the number of participants
22 from each was imbalanced because of information saturation.
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39 We found that the three main project elements adopted from Hickson GB et al. were
40 relevant and useful for the discussion of our results: (A) organizational supports, (B)
41 commitment from key people, and (C) learning systems.[13]
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49 A. Organizational Supports

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51 Our findings showed that there are no standardized systems and procedures dealing
52 with patient complaints in China due to conflicts between relevant actors and
53 regulations. Having experienced rapid economic growth in the last 30 years, China is
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4 undergoing a socioeconomic transition. Like other developing countries, policies lag
5
6 behind the country's economic transition.[37, 38] The Ministry of Health has tried to
7
8 guide health care providers by issuing special regulations, but health administrations
9
10 do not apply strict regulations to complaint management. There lacks clear
11
12 relationships between patient complaints and clinical outcomes or the quality of care.
13
14

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16
17
18 The patient complaints in many Chinese hospitals are not well-managed and handled.
19
20 Most hospitals manage patient complaints on only a case-by-case basis. They lack
21
22 clear mechanisms linking patient complaints with improving the quality of care.
23
24 Complaints are underutilised for organizational strategic planning or for changing an
25
26 individual's behaviour and attitude. This implies that legislation should not only
27
28 stipulate the principles and regulations of patient complaint management, but also the
29
30 responsibilities of sectors at different levels.[39]
31
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39 B. Commitment from People

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41 The hospital leader is the key determinant for complaint handling inside the hospital.
42
43 However, no apparent incentives exist to push hospital leaders to prioritize complaint
44
45 handling. The power of complaint handling departments depends on how much the
46
47 hospital leaders pay attention to it. Under current conditions, hospital leaders lack
48
49 political will to manage complaints effectively, leading to inadequate human resources
50
51 in complaint handling departments. The departments also lack the power to coordinate
52
53 with clinical departments.
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6 To alleviate patient complaints-related violence, civil groups, including service users
7
8 and the hospital sector, should approve the guideline. In developed countries, patient
9
10 complaint management provides guidelines not only for health care providers, but
11
12 also clear guidelines for patients. This not only makes it more convenient for patients,
13
14 but also plays a positive role in helping patients initiate the complaint process via
15
16 legitimate means. This is crucial for society to view patient complaint in a rational
17
18 way.
19
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26 C. Learning Systems

27
28 If patient complaints can be better managed and rectified, the instances of failure
29
30 would be reduced and quality would be improved.[40, 41] Greater emphasis should be
31
32 placed on quality improvement after patients complain. Strategies to improve quality
33
34 following patient complaints should be developed through a learning process.[42] To
35
36 promote the learning process, appropriate mechanisms should be developed and
37
38 implemented to assess not only the number of patient complaints occurring in
39
40 hospitals, but also how these hospitals have handled these complaints. For example,
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42 reporting more patient complaints should not be necessarily punished, while effective
43
44 handling of the patient complaints should be appreciated.
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54 Our final conclusion is that barriers to the effective management of patient complaints
55
56 vary at the different stages of complaint handling, from the user and provider side, as
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4 well as systemic issues. Information, procedure design, human resources, system
5
6 arrangement, a unified legal system and regulations and factors shaping the social
7
8 context all play important roles in effective patient complaint management.
9
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11 Appropriate mechanisms should be developed to link patient complaints with
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14 improving the quality of care.
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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

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DATA SHARING

No additional data available.

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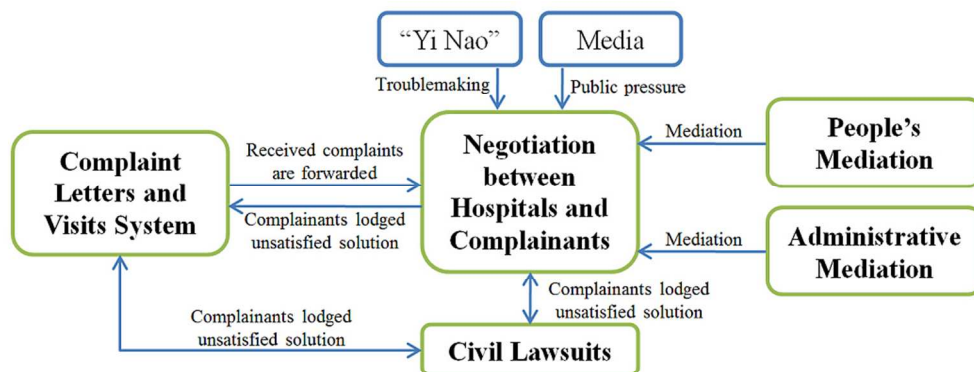


Figure 1 The structure of managing patient complaints in China

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er review only

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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? | YES It is difficult to measure the regulation process quantitatively. |
| <ul style="list-style-type: none"> • <i>Interviews</i>: experience, perceptions, behaviour, practice, process • <i>Focus groups</i>: group dynamics, convenience, non-sensitive topics • <i>Ethnography</i>: culture, organizational behaviour, interaction • <i>Textual analysis</i>: documents, art, representations, conversations | |
| T Transparency of procedures | |
| <i>Sampling</i> | |
| 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? | |

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| | <p>process.</p> <p>Different types of respondents were helpful for holistic understanding for transparency deficits.</p> <p>Key informants were interviewed by snowball sampling and saturation.</p> |
| <i>Recruitment</i> | |
| 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. |
| <i>Data collection</i> | |
| 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 |
|---|---|
| <p>and setting clear?</p> <p>Why and when was data collection stopped, and is this reasonable?</p> | <p>role/group on the regulation process.</p> <p>YES. The principle of saturation was used.</p> |
| <i>Role of researchers</i> | |
| <p>Is the researcher(s) appropriate? How might they bias (good and bad) the conduct of the study and results?</p> | <p>YES. Our research group is multidisciplinary, including social science, clinical medicine and public health.</p> |
| <i>Ethics</i> | |
| <p>Was informed consent sought and granted?</p> | <p>YES. Informed consent process was explicitly and clearly detailed.</p> |
| <p>Were participants' anonymity and confidentiality ensured?</p> | <p>YES.</p> |
| <p>Was approval from an appropriate ethics committee received?</p> | <p>YES. Ethics approval was cited.</p> |
| S Soundness of interpretive approach | |
| <i>Analysis</i> | |
| <p>Is the type of analysis appropriate for the type of study?</p> <ul style="list-style-type: none"> • <i>thematic</i>: exploratory, descriptive, hypothesis generating • <i>framework</i>: e.g., policy • <i>constant comparison/grounded</i> | <p>YES.</p> <p>Analytic approach was justified.</p> |

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| <p><i>theory</i>: theory generating, analytical</p> <ul style="list-style-type: none"> Are the interpretations clearly presented and adequately supported by the evidence? Are quotes used and are these appropriate and effective? Was trustworthiness/reliability of the data and interpretations checked? | <p>YES.</p> <p>YES.</p> <p>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.</p> |
| <i>Discussion and presentation</i> | |
| 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 |

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| viewed critically. They might be fatal flaws, or they may result from lack of detail or clarity. | |

For peer review only