PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Managing patient complaints in China – a qualitative study in Shanghai
AUTHORS	Jiang, Yishi; YING, Xiaohua; ZHANG, Qian; Tang, Sirui; KANE, Sumit; MUKHOPADHYAY, Maitrayee; QIAN, Xu

VERSION 1 - REVIEW

REVIEWER	Helen Smith University of Manchester, UK
REVIEW RETURNED	10-Apr-2014

GENERAL COMMENTS	Overall this study provides new insight to an important and growing health system problem in China. The findings relate to wider discussions about health system and clinical governance and go some way to understanding the processes currently in place and barriers to handling patient complaints at hospital level. However, the study is small, was conducted in Shanghai only, and it would be interesting to see further comment on how likely it is that the findings are transferable to other cities and provinces in China. Some further interpretation and re-organisation of the findings would help communicate the key messages in a more meaningful way. **Specific comments** 1. In the last paragraph of the background the authors refer to a handful of studies from China that attempt to quantify the issues around patient complaints – it would be good to include citations here and a summary of what these studies found, how the findings contribute to existing knowledge, and to better articulate what the gaps in knowledge and current debates are (i.e. provide a stronger rationale for the present study). 2. The last sentence of the background asserts that by examining the complaints system and documenting barriers to effective case handling this will lead to strengthened governance and enhanced performance of professionals…this is a big leap and I think it should be acknowledged that such a shift in policy and practice is not so straightforward. 3. It is only at the beginning of the methods we learn that this study is part of a larger EU project – this should be mentioned earlier on in the background, with a summary of that project and how the current one is linked to this. 4. The structure of the methods section is not particularly helpful – the actual methods should be emphasised in sub-

	headings rather than labelling them 'phases'. Phase 2 appears to relate to pilot testing and phase 3 data collection, and this could be made clearer. Then there is some repetition in the sub-section 'data collection and analysis' – the first paragraph describes conduct of the interviews, which could be integrated in the earlier section on interviewing. The rest of this sub-section just needs a heading 'analysis'. The literature review methods could be described in more detail – so that the search could be replicated – which databases were searched, over what time period, how were terms combined, were there any inclusion criteria etc. The authors then describe collecting 'key information and data' on handling of complaints – this seems to be a separate data collection method and demands more explanation – i.e. what were the sources of data and information, how were they obtained, how were data extracted from sources, is this a secondary data analysis? Its also not clear in which part of the results section this data is presented. 5. In the methods section the authors describe using snowball sampling – and I think the rationale for this strategy could be better justified. How and why were the hospital sites selected? Is there no sampling frame, for example, lists of patients making complaints at the selected study sites? Was it important to include patients with different types of complaint and did the authors attempt to do this or not? Where did the interviews with patients take place, and how did that location affect the conduct of the interview and validity of data collected? 6. The statement on ethics could include further description of anonymity and privacy in relation to analysis and presentation of data. 7. In the first part of the findings it's not clear where the information on approaches and mechanism was derived – is this from the lit review, or the additional 'data and information' collected (see previous comment on this)? This section seems to describe approaches and a lot of it is 'background' information – although if this information was critically analysed in some way then it could provide more insightful findings. For example, the characteristics of the approaches could be presented in a table, where it would be easier to compare and contrast the approaches according to: date established, purpose or primary responsibility, approach used to resolve disputes, level of resolution. Is there any information on processes at hospital level? This could displayed in another table, by hospital, to compare and contrast: approaches to resolution that are in place, number of staff employed to work on case handling, qualifications of complaint handlers, processes to communicate outcomes etc. 8. In the second part of the findings, this seems to be an analysis of the previous section which is then presented in figure 1. It would be easier to see this connection if the characteristics of approaches were tabulated and it was made clear how the figure was derived. The figure needs further explanation – ie how does 'yi nao' translate, what does 'make trouble to hospital' mean? You could explain some of the pathways the figure depicts. 9. The themes presented do describe some interesting insights, but it reads as though the findings have been fitted

	into an existing framework of initiating, handling and resolving complaints, but the key issues might be presented more meaningfully with further interpretation. For example, the first part of the section 'barriers in the handling process' doesn't seem to describe issues connected to the handling process, rather it documents reasons for complaints arising. In the section 'barriers to initiating the complaint process – do you have any data from other stakeholders you interviewed, to compare and contrast with the user experiences presented? In the section 'barriers to resolving conflict' the sub theme on 'unjustifiable complaints' doesn't seem to accurately describe what this theme is about, which seems to be provider views on the rationale for patient complaints. The theme 'barriers to post-complaint institutional changes for quality improvement' is a rather awkward label for this section, which seems to be about institutional challenges to implementing patient complaint management systems and responding to patient complaints. In summary, some further discussion and reflection on how the data are interpreted and presented, and whether the theme labels accurately reflect the data would I think make the findings more meaningful and the key points easier to grasp. Did patient views on the barriers vary by type of complaint? This would be interesting to explore. Reference to other literature is included in the findings, which is distracting – the findings should clearly present the data collected, and the interpretation of the data in comparison to other research should come in the discussion. There <u>discussion/conclusion</u> would benefit from a short section on the strengths and limitations of the study including a comment on how likely it is that the findings are transferable to other cities and provinces in China, also comparison of the findings to other published research on patient complaint handling in China and other HESVIC countries. Also under the recommendations, a comment on feasibility of introducing national guidelines for patient complaint handling in the context of a health system where number of complaints is used to evaluate hospital performance, which seems to present problems for transparent reporting of complaints. 10. Overall standard of written English could be improved (some emotive words and phrases, some awkward phrasing) and the manuscript would benefit from proof reading by a native English speaker.

REVIEWER	James W. Pichert and Marbie Sebes Center for Patient and Professional Advocacy Vanderbilt University Medical Center Nashville, Tennessee United States of America
REVIEW RETURNED	18-Apr-2014

GENERAL COMMENTS	The written English needs to be improved throughout. Nevertheless, the content of the article is sufficiently comprehensible--and of interest to a segment of BMJ's worldwide readership--to be considered for publication with substantial editorial assistance. The article could surely be better written and organized. It needs to be substantially more succinct. Redundancies abound. The discussion would benefit from a succinct summary of findings. Nevertheless the article represents a genuine and important attempt to address the complex challenges faced by Chinese hospitals to better serve patients and professionals alike. Because the authors did not offer specific recommendations for next steps, we have framed our comments not so much as a critique of the paper but a commentary. The study and analysis do not need to be redone, so we have characterized our recommendation as a "minor" revision, but major revisions will be required in the writing and organization for BMJopen's audience. Patients and families are well positioned observers of their healthcare experiences, and evidence shows they can promote healthcare quality and institutional safety [1-4]. These findings appear to generalize across diverse and worldwide populations [5]. In “Managing patients’ complaints in China: What went wrong?,” Jiang and colleagues share perceptions of key informants from Shanghai hospitals about the Chinese government’s system for inviting and addressing patients’ complaints. Beginning only relatively recently (2002), and motivated by increasing numbers of patient complaints, lawsuits, and incidents of physical violence against healthcare professionals, Chinese hospitals were charged to establish departments for handling and resolving medical disputes. Goals of the initiative are to improve overall quality of care and reduce rising numbers of medical malpractice claims. The article describes the initiative’s intentions and progress related to engaging patients, providing “service recovery” when patients express concerns, and aggregating complaints to identify and address high-complaint systems and professionals. The article also discusses why the initiative has stalled short of its goals, identifying four major barriers: 1) low patient/family awareness of how and where to share their observations; 2) need for service recovery skills and data sharing among key

stakeholders; 3) hospital leader commitment to pursue complaint resolution; and 4) shared accountability for ongoing improvements in the system. In fact, hospitals worldwide face similar barriers, and many system leaders, hospital administrators, and frontline professionals struggle to address them. Therefore, all policy makers, hospital leaders, health professionals, and patient advocates need a plan for maintaining momentum in pursuit of their complaint management initiatives' important, valuable goals.

At Vanderbilt, we use a "Project Bundle" tool to monitor progress on institutional safety/quality improvement and risk reduction initiatives [6]. In brief, to assess when (or whether) quality improvement initiatives are ready to launch, or, as in the case of managing patient complaints in China, a project appears to have stalled, we examine the adequacy of key project elements of three types: A) Commitment from key people, B) Organizational supports, and C) Learning systems. The findings by Jiang et al, suggest that to move forward and continue to improve complaint handling, all stakeholders will need to address important questions in each area:

A. Commitment from People
    1. Have key leaders made (or will they now make) public commitments to address patient/family concerns, and are those leaders prepared to address the systems and healthcare professionals associated with patient dissatisfactions? If not, what might persuade them to do so because leadership commitment is essential. Without strong leadership, the initiative has very limited chances of achieving its goals.
    2. Are project champions identified (and held accountable) at each hospital, i.e., people who have the ability to motivate, inspire, and hold others accountable to overcome barriers and accomplish goals? What key data do they have—and do they not have—access to?
    3. Complaint management is the responsibility of a hospital department formed for this purpose. What is the makeup of each hospital's departmental "project team," how much team time is actually dedicated to hearing, addressing and documenting patient complaints, and how are team members working with (or

expected to work with) frontline hospital managers and other professionals to address and resolve complaints?

B. Organizational Supports

4. Are this mandated project's goals clearly and truly aligned with each hospital's other major goals and leadership incentives? What needs to happen to increase alignment?
5. Does each hospital have policies and procedures that support (or conflict with) the initiative to manage patient complaints? If yes, who is accountable for their routine and reliable use? If not, who in each hospital (and policy-making body) is in the best position to create and gain acceptance of new policies and procedures?
6. Does each hospital have a plan for implementing graduated interventions for addressing healthcare professionals and systems that overly dissatisfy patients and families? [6-8].
7. Are the resources being provided sufficient to achieve the goals?

C. Learning Systems

8. What formal and informal measurement and surveillance tools are available (and are being used) for tracking complaints and their resolution? What tools provide a safe, secure transfer of complaint data for aggregated analysis? How will progress be tracked, to whom does feedback need to be transparently delivered, and who will be accountable for the results?
9. Who reviews the data and how do they report it in ways that promote quality and safety?
10. What kinds of multi-level professional training are required for implementing and managing a complaints management initiative? For example, if senior leaders do not understand that the number of complaints actually reported represent the mere tip of an iceberg, they need to learn that complaint capture should *increase* for many years, *not* decrease. Increases permit more timely and reliable identification of individual professionals and hospital units that stand out in the wrong direction. In addition, have all hospital department staff

and their leaders had expert training on how to perform their important roles in complaint handling? Finally, have all been taught best practices for service recovery and documentation [9]? Training is important, but it is last in this list to suggest that training alone will not be effective without good (not necessarily perfect) robustness of the other project bundle elements.

Every question should be considered honestly, but not every question must be fully answered for progress to be made in complaint management, service recovery, and use of data. Jiang and colleagues, and especially the persons interviewed for this study, have provided their local colleagues and national leaders important feedback. If critical elements of the Project Bundle are able to be addressed in Shanghai hospitals (and hospitals everywhere), we look forward to future reports about the next decade's progress in these areas and achievement of program goals.

References

1. Hickson GB, Federspiel CF, Pichert JW, Miller CS, Gauld-Jaeger J, Bost P. Patient complaints and malpractice risk. JAMA. 2002;287(22):2951-57.
2. Hickson GB, Pichert JW. Identifying and Addressing Physicians at High Risk for Medical Malpractice Claims. In: Youngberg, BJ, editor. Principles of Risk Management and Patient Safety. Sudbury, MA: Jones and Bartlett Publishers, Inc; 2012 p. 347-68.
3. Vincent C, Davis R. Patients and families as safety experts. CMAJ. 2012;184(1):15-16.
4. The Health Foundation: Involving patients in improving patient safety, London, UK, January 2013. http://www.health.org.uk/public/cms/75/76/313/3998/Involving%20patients%20in%20improving%20safety.pdf?realName=sVAlBL.pdf (last accessed April 14, 2014).
5. Hibbard JH, Greene J. What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs. Health Aff. 2013;32(2):207-14.
6. Hickson GB, Moore IN, Pichert JW, Benegas M Jr. Balancing systems and individual accountability in a safety culture. In: Berman S, editor. From the front office to the front line: essentials issues for healthcare leaders, 2nd ed. Oakbrook Terrace, IL: Joint

Commission Resources, Inc. 2012. p. 1-36.

7. Hickson G, Pichert JW, Webb LE, & Gabbe SG. A complementary approach to promoting professionalism: Identifying, measuring, and addressing unprofessional behaviors. Acad Med. 2007 Nov;82(11):1040-48.

8. Pichert, JW, Hickson, GB, Moore, IN. Using patient complaints to promote patient safety: the patient advocacy reporting system (PARS). In: Henriksen K, Battles JB, Keyes MA, Grady ML, editors. Advances in patient safety: new directions and alternative approaches. Bethesda, MD: Agency for Healthcare Research and Quality (AHRQ) 2008. p. 421-30.

9. Hayden AC, Pichert JW, Fawcett J, Moore I, Hickson GB. Best Practices & Advanced Skills in Healthcare Service Recovery Programs. Joint Comm J Qual Improv & Pt Safe. 2010;26(7):310-18.

REVIEWER	Sophie Hsieh
REVIEW RETURNED	22-Apr-2014

GENERAL COMMENTS	1. There are lots of simliar studies done in this subject. It needs more discussion on barriers to complaints management in the literature review section which might provide a "good model"of complaints handling. 2. No theoretical framework.

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1
Reviewer Name Helen Smith
Institution and Country University of Manchester, UK
Please state any competing interests or state ‘None declared’: None declared

General comments
Overall this study provides new insight to an important and growing health system problem in China. The findings relate to wider discussions about health system and clinical governance and go some way to understanding the processes currently in place and barriers to handling patient complaints at hospital level. However, the study is small, was conducted in Shanghai only, and it would be interesting to see further comment on how likely it is that the findings are transferable to other cities and provinces in China. Some further interpretation and re-organisation of the findings would help communicate the key messages in a more meaningful way.
Thank you for this overall comment. It is true that this study was mainly carried out in Shanghai. However, the Chinese handling system for patient complaints was mostly based on the regulations at the national level. The barriers identified in our study were very similar to ones in other places in China. We agree that we should have a better interpretation in the discussion part to help readers

understand more clearly. Please refer to the discussion and conclusion section of the revised manuscript.

Specific comments
1. In the last paragraph of the background the authors refer to a handful of studies from China that attempt to quantify the issues around patient complaints – it would be good to include citations here and a summary of what these studies found, how the findings contribute to existing knowledge, and to better articulate what the gaps in knowledge and current debates are (i.e. provide a stronger rationale for the present study).
Yes, we agree with that. We also tried to include some valuable research findings in China in this part, albeit not much found.

2. The last sentence of the background asserts that by examining the complaints system and documenting barriers to effective case handling this will lead to strengthened governance and enhanced performance of professionals…this is a big leap and I think it should be acknowledged that such a shift in policy and practice is not so straightforward.
Thank you. We agree. We have now deleted the sentence.

3. It is only at the beginning of the methods we learn that this study is part of a larger EU project – this should be mentioned earlier on in the background, with a summary of that project and how the current one is linked to this.
Thank you. We have done as you suggested.

4. The structure of the methods section is not particularly helpful – the actual methods should be emphasised in sub-headings rather than labelling them 'phases'. Phase 2 appears to relate to pilot testing and phase 3 data collection, and this could be made clearer. Then there is some repetition in the sub-section 'data collection and analysis' – the first paragraph describes conduct of the interviews, which could be integrated in the earlier section on interviewing. The rest of this sub-section just needs a heading 'analysis'.
Thank you very much for this good suggestion. We have re-arranged the subheading, per your suggestion.

The literature review methods could be described in more detail – so that the search could be replicated – which databases were searched, over what time period, how were terms combined, were there any inclusion criteria etc. The authors then describe collecting 'key information and data' on handling of complaints – this seems to be a separate data collection method and demands more explanation – i.e. what were the sources of data and information, how were they obtained, how were data extracted from sources, is this a secondary data analysis? Its also not clear in which part of the results section this data is presented.
Thank you for pointing this for us. This review method is a source of secondary data, producing the findings of approaches and mechanisms used in managing patient complaints and the application of different complaint approaches. We have now described the method more specifically and accurately.

5. In the methods section the authors describe using snowball sampling – and I think the rationale for this strategy could be better justified. How and why were the hospital sites selected? Is there no sampling frame, for example, lists of patients making complaints at the selected study sites? Was it important to include patients with different types of complaint and did the authors attempt to do this or not? Where did the interviews with patients take place, and how did that location affect the conduct of the interview and validity of data collected?
Patient complaints are sensitive in China, since most of hospital managers think they are scandals and would not provide information concerned. Therefore, the study had to select only a few hospitals including general and speciality ones representing the areas of both urban and suburban Shanghai.

Then we asked the interviewees in Phase Two to invite potential interviewees in Phase Three. As for the study patients, we didn't select patients from a sampling frame. It is difficult to get the whole name list of complainants from hospitals. What we only can do was to ask them to recommend some patients and then we selected some samples. Of course it is important to include patients with different types of complaints, we totally agree with that. However, there are not unified classifications for complaints. We didn't explore the classification for complaints in our study. Three interviews with the patients took place in each responding hospitals. These three patients all got satisfied resolutions. The other three interviews with patients took place in their respective homes. They were dissatisfied with the resolutions. So we think the locations didn't affect the conduct of the interview. They can express themselves in those locations.

6. The statement on ethics could include further description of anonymity and privacy in relation to analysis and presentation of data.
Thank you. We have done as you will see in the revised manuscript.

7. In the first part of the findings it's not clear where the information on approaches and mechanism was derived – is this from the lit review, or the additional 'data and information' collected (see previous comment on this)? This section seems to describe approaches and a lot of it is 'background' information – although if this information was critically analysed in some way then it could provide more insightful findings. For example, the characteristics of the approaches could be presented in a table, where it would be easier to compare and contrast the approaches according to: date established, purpose or primary responsibility, approach used to resolve disputes, level of resolution. Is there any information on processes at hospital level? This could displayed in another table, by hospital, to compare and contrast: approaches to resolution that are in place, number of staff employed to work on case handling, qualifications of complaint handlers, processes to communicate outcomes etc.
The first part of findings- approaches and mechanisms used in managing patient complaints was derived from the literature review. We added a table (Table 2) to describe the characteristics of the approaches.

8. In the second part of the findings, this seems to be an analysis of the previous section which is then presented in figure 1. It would be easier to see this connection if the characteristics of approaches were tabulated and it was made clear how the figure was derived. The figure needs further explanation – ie how does 'yi nao' translate, what does 'make trouble to hospital' mean? You could explain some of the pathways the figure depicts.
Thank you. We have added Table 2 as we address the previous comment.

9. The themes presented do describe some interesting insights, but it reads as though the findings have been fitted into an existing framework of initiating, handling and resolving complaints, but the key issues might be presented more meaningfully with further interpretation. For example, the first part of the section 'barriers in the handling process' doesn't seem to describe issues connected to the handling process, rather it documents reasons for complaints arising. In the section 'barriers to initiating the complaint process – do you have any data from other stakeholders you interviewed, to compare and contrast with the user experiences presented?
We referred to a guideline, which describes the stages of complaint management. It is Complaint Management Guidelines (Document Number GL2006_023), publicised by Department of Health, NSW. It divides the complaint management process into four stages: receive, assess, investigate and resolve the complaints. There is not definite assessment in complaint management in China, so we remained the other three processes. We edited the subheadings to express them more accurately. The points in the first part of the section 'barriers in the handling process' are not only the reasons for complaints arising, but also the failures of the handling process when complaint were lodged.
We have other stakeholder's views. As we said in the first sentence of the part, "hospital staff claimed

that the complaints office was accessible to those with grievances". They said it was very easy for patients to lodged complaints.

In the section 'barriers to resolving conflict' the sub theme on 'unjustifiable complaints' doesn't seem to accurately describe what this theme is about, which seems to be provider views on the rationale for patient complaints. The theme 'barriers to post-complaint institutional changes for quality improvement' is a rather awkward label for this section, which seems to be about institutional challenges to implementing patient complaint management systems and responding to patient complaints.
The "unjustifiable complaints" actually was a very complicated issue. In fact they contained two levels of meanings: 1) Sometimes hospitals and doctors thought that they just become scapegoats of the whole health system, though patients might not think the same way. It is difficult for the hospitals to solve that kind of complaints, as all these are beyond their controls. 2) Some patients were very emotional and aggressive. Some countries studied the type 2 workplace violence in hospitals.[1-4] Although the prevalence can't be compared directly, the severity seems higher in China.
1. Kitaneh M, Hamdan M. Workplace violence against physicians and nurses in Palestinian public hospitals: a cross-sectional study. BMC Health Serv Res. 2012;12:469.
2. Chen KP, Ku YC, Yang HF. Violence in the nursing workplace - a descriptive correlational study in a public hospital. J Clin Nurs. 2013;22(5-6):798-805.
3. Hahn S, Muller M, Hantikainen V, Kok G, Dassen T, Halfens RJ. Risk factors associated with patient and visitor violence in general hospitals: results of a multiple regression analysis. Int J Nurs Stud. 2013;50(3):374-85.
4. Pompeii L, Dement J, Schoenfisch A, Lavery A, Souder M, Smith C, et al. Perpetrator, worker and workplace characteristics associated with patient and visitor perpetrated violence (Type II) on hospital workers: a review of the literature and existing occupational injury data. J Safety Res. 2013;44:57-64.

A good complaint management system should have a learning process to use the complaint data to improve service quality. To reduce the ambiguity, we edited the subheading as "Barriers to institutional changes for quality improvement using complaints data".

In summary, some further discussion and reflection on how the data are interpreted and presented, and whether the theme labels accurately reflect the data would I think make the findings more meaningful and the key points easier to grasp.
Thank you! Please refer to the new subheadings used.

Did patient views on the barriers vary by type of complaint? This would be interesting to explore.
Yes, it is an interesting issue. We read the transcripts of patient interviewees again. Most of their views were similar, which were described in our manuscript.

Reference to other literature is included in the findings, which is distracting – the findings should clearly present the data collected, and the interpretation of the data in comparison to other research should come in the discussion.
Yes, it's true. Thank you. We just used literatures in the first and second parts of the findings, since they were derived from the literature.

There discussion/conclusion would benefit from a short section on the strengths and limitations of the study including a comment on how likely it is that the findings are transferable to other cities and provinces in China, also comparison of the findings to other published research on patient complaint handling in China and other HESVIC countries. Also under the recommendations, a comment on feasibility of introducing national guidelines for patient complaint handling in the context of a health system where number of complaints is used to evaluate hospital performance, which seems to present problems for transparent reporting of complaints.

Please refer to the discussion and conclusion parts.
Thank you for proposing the problem of transparency. We also consider that. The last sentence is “For example, reporting more patient complaints should not be necessarily punished, while effectively handling of the patient complaints should be appreciated.” We didn’t directly suggest abolishing the assessment using number of complaints, which may not be acceptable for the government. But other kinds of assessment should be considered, such as punishment for failure to report all complaints.

10. Overall standard of written English could be improved (some emotive words and phrases, some awkward phrasing) and the manuscript would benefit from proof reading by a native English speaker.
Thank you. A native English speaker has edited the manuscript.

Reviewer: 2
Reviewer Name James W. Pichert and Marbie Sebes
Institution and Country Center for Patient and Professional Advocacy
Vanderbilt University Medical Center
Nashville, Tennessee
United States of America
Please state any competing interests or state ‘None declared’: None declared

The written English needs to be improved throughout. Nevertheless, the content of the article is sufficiently comprehensible--and of interest to a segment of BMJ's worldwide readership--to be considered for publication with substantial editorial assistance.
Thank you very much!

The article could surely be better written and organized. It needs to be substantially more succinct. Redundancies abound. The discussion would benefit from a succinct summary of findings. Nevertheless the article represents a genuine and important attempt to address the complex challenges faced by Chinese hospitals to better serve patients and professionals alike. Because the authors did not offer specific recommendations for next steps, we have framed our comments not so much as a critique of the paper but a commentary. The study and analysis do not need to be redone, so we have characterized our recommendation as a "minor" revision, but major revisions will be required in the writing and organization for BMJopen's audience.
Thank you! We tried our best to refine our findings, as you will see in the revised manuscript.

Patients and families are well positioned observers of their healthcare experiences, and evidence shows they can promote healthcare quality and institutional safety [1-4]. These findings appear to generalize across diverse and worldwide populations [5].

In “Managing patients’ complaints in China: What went wrong?,” Jiang and colleagues share perceptions of key informants from Shanghai hospitals about the Chinese government’s system for inviting and addressing patients’ complaints. Beginning only relatively recently (2002), and motivated by increasing numbers of patient complaints, lawsuits, and incidents of physical violence against healthcare professionals, Chinese hospitals were charged to establish departments for handling and resolving medical disputes. Goals of the initiative are to improve overall quality of care and reduce rising numbers of medical malpractice claims. The article describes the initiative’s intentions and progress related to engaging patients, providing “service recovery” when patients express concerns, and aggregating complaints to identify and address high-complaint systems and professionals.

The article also discusses why the initiative has stalled short of its goals, identifying four major barriers: 1) low patient/family awareness of how and where to share their observations; 2) need for service recovery skills and data sharing among key stakeholders; 3) hospital leader commitment to pursue complaint resolution; and4) shared accountability for ongoing improvements in the system. In

fact, hospitals worldwide face similar barriers, and many system leaders, hospital administrators, and frontline professionals struggle to address them. Therefore, all policy makers, hospital leaders, health professionals, and patient advocates need a plan for maintaining momentum in pursuit of their complaint management initiatives' important, valuable goals.

At Vanderbilt, we use a "Project Bundle" tool to monitor progress on institutional safety/quality improvement and risk reduction initiatives [6]. In brief, to assess when (or whether) quality improvement initiatives are ready to launch, or, as in the case of managing patient complaints in China, a project appears to have stalled, we examine the adequacy of key project elements of three types: A) Commitment from key people, B) Organizational supports, and C) Learning systems. The findings by Jiang et al, suggest that to move forward and continue to improve complaint handling, all stakeholders will need to address important questions in each area:

A. Commitment from People

1. Have key leaders made (or will they now make) public commitments to address patient/family concerns, and are those leaders prepared to address the systems and healthcare professionals associated with patient dissatisfactions? If not, what might persuade them to do so because leadership commitment is essential. Without strong leadership, the initiative has very limited chances of achieving its goals.
2. Are project champions identified (and held accountable) at each hospital, i.e., people who have the ability to motivate, inspire, and hold others accountable to overcome barriers and accomplish goals? What key data do they have—and do they not have—access to?
3. Complaint management is the responsibility of a hospital department formed for this purpose. What is the makeup of each hospital's departmental "project team," how much team time is actually dedicated to hearing, addressing and documenting patient complaints, and how are team members working with (or expected to work with) frontline hospital managers and other professionals to address and resolve complaints?

B. Organizational Supports

4. Are this mandated project's goals clearly and truly aligned with each hospital's other major goals and leadership incentives? What needs to happen to increase alignment?
5. Does each hospital have policies and procedures that support (or conflict with) the initiative to manage patient complaints? If yes, who is accountable for their routine and reliable use? If not, who in each hospital (and policy-making body) is in the best position to create and gain acceptance of new policies and procedures?
6. Does each hospital have a plan for implementing graduated interventions for addressing healthcare professionals and systems that overly dissatisfy patients and families? [6-8].
7. Are the resources being provided sufficient to achieve the goals?

C. Learning Systems

8. What formal and informal measurement and surveillance tools are available (and are being used) for tracking complaints and their resolution? What tools provide a safe, secure transfer of complaint data for aggregated analysis? How will progress be tracked, to whom does feedback need to be transparently delivered, and who will be accountable for the results?
9. Who reviews the data and how do they report it in ways that promote quality and safety?
10. What kinds of multi-level professional training are required for implementing and managing a complaints management initiative? For example, if senior leaders do not understand that the number of complaints actually reported represent the mere tip of an iceberg, they need to learn that complaint capture should increase for many years, not decrease. Increases permit more timely and reliable identification of individual professionals and hospital units that stand out in the wrong direction. In addition, have all hospital department staff and their leaders had expert training on how to perform their important roles in complaint handling? Finally, have all been taught best practices for service recovery and documentation [9]? Training is important, but it is last in this list to suggest that training alone will not be effective without good (not necessarily perfect) robustness of the other project bundle elements.

Every question should be considered honestly, but not every question must be fully answered for progress to be made in complaint management, service recovery, and use of data. Jiang and colleagues, and especially the persons interviewed for this study, have provided their local colleagues and national leaders important feedback. If critical elements of the Project Bundle are able to be addressed in Shanghai hospitals (and hospitalseverywhere), we look forward to future reports about the next decade's progress in these areas and achievement of program goals.
Thank you for providing us with very valuable literatures. We read some of them and refer them in our manuscript.

References

1. Hickson GB, Federspiel CF, Pichert JW, Miller CS, Gauld-Jaeger J, Bost P. Patient complaints and malpractice risk. JAMA. 2002;287(22):2951 PubMed -57.
2. Hickson GB, Pichert JW. Identifying and Addressing Physicians at High Risk for Medical Malpractice Claims. In: Youngberg, BJ, editor. Principles of Risk Management and Patient Safety. Sudbury, MA: Jones and Bartlett Publishers, Inc; 2012 p. 347-68.
3. Vincent C, Davis R. Patients and families as safety experts. CMAJ. 2012;184(1):15 PubMed -16.
4. The Health Foundation: Involving patients in improving patient safety, London, UK, January 2013. http://www.health.org.uk/public/cms/75/76/313/3998/Involving%20patients%20in%20improving%20safety.pdf?realName=sVAlBL.pdf (last accessed April 14, 2014).
5. Hibbard JH, Greene J. What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs. Health Aff. 2013;32(2):207 PubMed -14.
6. Hickson GB, Moore IN, Pichert JW, Benegas M Jr. Balancing systems andindividual accountability in a safety culture. In: Berman S, editor. From the front office to the front line: essentials issues for healthcare leaders, 2nd ed. Oakbrook Terrace, IL: Joint Commission Resources, Inc. 2012. p. 1-36.
7. Hickson G, Pichert JW, Webb LE, & Gabbe SG. A complementary approach to promoting professionalism: Identifying, measuring, and addressing unprofessional behaviors. Acad Med. 2007 Nov;82(11):1040-48.
8. Pichert, JW, Hickson, GB, Moore, IN. Using patient complaints to promote patient safety: the patient advocacy reporting system (PARS). In: Henriksen K, Battles JB, Keyes MA, Grady ML, editors. Advances in patient safety: new directions and alternative approaches. Bethesda, MD: Agency for Healthcare Research and Quality (AHRQ) 2008. p. 421-30.
9. Hayden AC, Pichert JW, Fawcett J, Moore I, Hickson GB. Best Practices & Advanced Skills in Healthcare Service Recovery Programs. Joint Comm J Qual Improv & Pt Safe. 2010;26(7):310 PubMed -18.

Reviewer: 3
Reviewer Name Sophie Hsieh
Institution and Country NA
Please state any competing interests or state 'None declared': none

1. There are lots of simliar studies done in this subject. It needs more discussion on barriers to complaints management in the literature review section which might provide a "good model"of complaints handling.
2. No theoretical framework.
Thank you very much for pointing this. Sorry that we didn't include the model and framework to analyse. Now we added it. Please refer to the data analysis part.

VERSION 2 – REVIEW

REVIEWER	Helen Smith University of Manchester, UK
REVIEW RETURNED	02-Jul-2014

GENERAL COMMENTS	Thank you for the opportunity to review the revised paper.The authors have addressed most of my comments. However, a few issues remain. 1. Some parts of the discussion have been revised, but there is no reference to other literature at all. This is important and needs to be addressed - the whole point of the discussion is to relate the study to other research on the topic, not only similarities or differences in findings but also methods. The sentence inserted about complaint handling in other HESVIC countries also needs supporting references and further comment from the authors. 2. the 'handful' of studies in China, referred to in the last para of the background, still needs elaborating - include citations to these studies, and summarise what they found, what the gaps in knowledge are, what are current debates - this provides the rationale for doing your present study - if there are no studies then you need to state this. 3. You have now stated that the analysis is based on a particular model of stages of the complaint process - but you need to justify this - why is this model suited as a theoretical framework for your study? 4. in your response to my original point about sampling you explain in detail why snowball approach was suitable and the reasons you didn't include patients with different types of complaint - this needs to be mentioned in the limitations section (which is rather too brief and could be further developed). 5. In my view Figure 1 is still not described in sufficient detail. I'm not sure how it was developed, how the various pathways operate, and how it relates to what you have provided in table 2. 6. Table 2 is helpful in that it summarises all of the approaches - but you need to actually refer to it in the text and explain it! don't leave it to the reader to make sense of it themselves, you need to indicate what it shows. 7. Second sentence of discussion - seems slightly misleading to describe China as a 'developing country' - its the 2nd largest economy in the world! the WB classification of countries based on income is more acceptable and China is an upper middle income country. I am not suggesting you use the term 'upper middle income' but you need to find an alternative way to describe the situation in China, an emerging economy which still faces health inequalities and parts of the heath system still need strengthening,. 8. The paper could be far more succinct and still needs a thorough edit with attention to language. I think the paper is substantially revised, but still needs some further revision, see above comments, before publication.

REVIEWER	James W. Pichert and Marbie Sebes Vanderbilt University Medical Center, USA
REVIEW RETURNED	11-Jun-2014

GENER	The written English is better in this version, but could still be improved throughout. The

AL COMMENTS	content of the article is sufficiently comprehensible--and of interest to a segment of BMJ's worldwide readership--to be considered for publication with additional editorial assistance. The article's apparent organization has been improved with the addition of headings and especially subheadings. It remains rather long. The authors added to the length by responding appropriately to comments made by another review. The paper's impact would likely be greater if it could be made shorter. Nevertheless the article represents a genuine and important attempt to address the complex challenges faced by Chinese hospitals to better serve patients and professionals alike. Because the authors did not offer specific recommendations for next steps, we have framed the following comments not so much as a critique of the paper but a commentary. Patients and families are well positioned observers of their healthcare experiences, and evidence shows they can promote healthcare quality and institutional safety [1-4]. These findings appear to generalize across diverse and worldwide populations [5]. In “Managing patients’ complaints in China: What went wrong?,” Jiang and colleagues share perceptions of key informants from Shanghai hospitals about the Chinese government’s system for inviting and addressing patients’ complaints. Beginning only relatively recently (2002), and motivated by increasing numbers of patient complaints, lawsuits, and incidents of physical violence against healthcare professionals, Chinese hospitals were charged to establish departments for handling and resolving medical disputes. Goals of the initiative are to improve overall quality of care and reduce rising numbers of medical malpractice claims. The article describes the initiative’s intentions and progress related to engaging patients, providing “service recovery” when patients express concerns, and aggregating complaints to identify and address high-complaint systems and professionals. The article also discusses why the initiative has stalled short of its goals, identifying four major barriers: 1) low patient/family awareness of how and where to share their observations; 2) need for service recovery skills and data sharing among key stakeholders; 3) hospital leader commitment to pursue complaint resolution; and4) shared accountability for ongoing improvements in the system. In fact, hospitals worldwide face similar barriers, and many system leaders, hospital administrators, and frontline professionals struggle to address them. Therefore, all policy makers, hospital leaders, health professionals, and patient advocates need a plan for maintaining momentum in pursuit of their complaint management initiatives’ important, valuable goals. At Vanderbilt, we use a “Project Bundle” tool to monitor progress on institutional safety/quality improvement and risk reduction initiatives [6]. In brief, to assess when (or whether) quality improvement initiatives are ready to launch, or, as in the case of managing patient complaints in China, a project appears to have stalled, we examine the adequacy of key project elements of three types: A) Commitment from key people, B) Organizational supports, and C) Learning systems. The findings by Jiang et al, suggest that to move forward and continue to improve complaint handling, all stakeholders will need to address important questions in each area: A. Commitment from People 1. Have key leaders made (or will they now make) public commitments to address patient/family concerns, and are those leaders prepared to address the systems and healthcare professionals associated with patient dissatisfactions? If not, what might persuade them to do so because leadership commitment is essential. Without strong leadership, the initiative has very limited chances of achieving its goals. 2. Are project champions identified (and held accountable) at each hospital, i.e., people who have the ability to motivate, inspire, and hold others accountable to overcome barriers and accomplish goals? What key data do they have—and do they not have—access to? 3. Complaint management is the responsibility of a hospital department formed for this purpose. What is the makeup of each hospital’s departmental “project team,” how much team time is actually dedicated to hearing, addressing and documenting patient complaints, and how are team members working with (or expected to work with) frontline hospital managers and other professionals to address and resolve complaints?

B. Organizational Supports
4. Are this mandated project's goals clearly and truly aligned with each hospital's other major goals and leadership incentives? What needs to happen to increase alignment?
5. Does each hospital have policies and procedures that support (or conflict with) the initiative to manage patient complaints? If yes, who is accountable for their routine and reliable use? If not, who in each hospital (and policy-making body) is in the best position to create and gain acceptance of new policies and procedures?
6. Does each hospital have a plan for implementing graduated interventions for addressing healthcare professionals and systems that overly dissatisfy patients and families? [6-8].
7. Are the resources being provided sufficient to achieve the goals?
C. Learning Systems
8. What formal and informal measurement and surveillance tools are available (and are being used) for tracking complaints and their resolution? What tools provide a safe, secure transfer of complaint data for aggregated analysis? How will progress be tracked, to whom does feedback need to be transparently delivered, and who will be accountable for the results?
9. Who reviews the data and how do they report it in ways that promote quality and safety?
10. What kinds of multi-level professional training are required for implementing and managing a complaints management initiative? For example, if senior leaders do not understand that the number of complaints actually reported represent the mere tip of an iceberg, they need to learn that complaint capture should increase for many years, not decrease. Increases permit more timely and reliable identification of individual professionals and hospital units that stand out in the wrong direction. In addition, have all hospital department staff and their leaders had expert training on how to perform their important roles in complaint handling? Finally, have all been taught best practices for service recovery and documentation [9]? Training is important, but it is last in this list to suggest that training alone will not be effective without good (not necessarily perfect) robustness of the other project bundle elements.

Every question should be considered honestly, but not every question must be fully answered for progress to be made in complaint management, service recovery, and use of data. Jiang and colleagues, and especially the persons interviewed for this study, have provided their local colleagues and national leaders important feedback. If critical elements of the Project Bundle are able to be addressed in Shanghai hospitals (and hospitalseverywhere), we look forward to future reports about the next decade's progress in these areas and achievement of program goals.

References

1. Hickson GB, Federspiel CF, Pichert JW, Miller CS, Gauld-Jaeger J, Bost P. Patient complaints and malpractice risk. JAMA. 2002;287(22):2951 PubMed -57.
2. Hickson GB, Pichert JW. Identifying and Addressing Physicians at High Risk for Medical Malpractice Claims. In: Youngberg, BJ, editor. Principles of Risk Management and Patient Safety. Sudbury, MA: Jones and Bartlett Publishers, Inc; 2012 p. 347-68.
3. Vincent C, Davis R. Patients and families as safety experts. CMAJ. 2012;184(1):15 PubMed -16.
4. The Health Foundation: Involving patients in improving patient safety, London, UK, January 2013.
http://www.health.org.uk/public/cms/75/76/313/3998/Involving%20patients%20in%20improving%20safety.pdf?realName=sVAlBL.pdf (last accessed April 14, 2014).
5. Hibbard JH, Greene J. What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs. Health Aff. 2013;32(2):207 PubMed -14.
6. Hickson GB, Moore IN, Pichert JW, Benegas M Jr. Balancing systems andindividual accountability in a safety culture. In: Berman S, editor. From the front office to the front line: essentials issues for healthcare leaders, 2nd ed. Oakbrook Terrace, IL: Joint Commission Resources, Inc. 2012. p. 1-36.
7. Hickson G, Pichert JW, Webb LE, & Gabbe SG. A complementary approach to promoting professionalism: Identifying, measuring, and addressing unprofessional

	behaviors. Acad Med. 2007 Nov;82(11):1040-48. 8. Pichert, JW, Hickson, GB, Moore, IN. Using patient complaints to promote patient safety: the patient advocacy reporting system (PARS). In: Henriksen K, Battles JB, Keyes MA, Grady ML, editors. Advances in patient safety: new directions and alternative approaches. Bethesda, MD: Agency for Healthcare Research and Quality (AHRQ) 2008. p. 421-30. 9. Hayden AC, Pichert JW, Fawcett J, Moore I, Hickson GB. Best Practices & Advanced Skills in Healthcare Service Recovery Programs. Joint Comm J Qual Improv & Pt Safe. 2010;26(7):310 PubMed -18.

VERSION 2 – AUTHOR RESPONSE

Reviewer: 2
Reviewer Name James W. Pichert and Marbie Sebes
Institution and Country Vanderbilt University Medical Center, USA
Please state any competing interests or state 'None declared': None declared

The written English is better in this version, but could still be improved throughout. The content of the article is sufficiently comprehensible--and of interest to a segment of BMJ's worldwide readership--to be considered for publication with additional editorial assistance.

The article's apparent organization has been improved with the addition of headings and especially subheadings. It remains rather long. The authors added to the length by responding appropriately to comments made by another review. The paper's impact would likely be greater if it could be made shorter. Nevertheless the article represents a genuine and important attempt to address the complex challenges faced by Chinese hospitals to better serve patients and professionals alike. Because the authors did not offer specific recommendations for next steps, we have framed the following comments not so much as a critique of the paper but a commentary.
Thank you for your commentary. It is true that our manuscript is very long. An effort has been made to shorten some sections and paragraphs of the article.

Patients and families are well positioned observers of their healthcare experiences, and evidence shows they can promote healthcare quality and institutional safety [1-4]. These findings appear to generalize across diverse and worldwide populations [5].

In "Managing patients' complaints in China: What went wrong?," Jiang and colleagues share perceptions of key informants from Shanghai hospitals about the Chinese government's system for inviting and addressing patients' complaints. Beginning only relatively recently (2002), and motivated by increasing numbers of patient complaints, lawsuits, and incidents of physical violence against healthcare professionals, Chinese hospitals were charged to establish departments for handling and resolving medical disputes. Goals of the initiative are to improve overall quality of care and reduce rising numbers of medical malpractice claims. The article describes the initiative's intentions and progress related to engaging patients, providing "service recovery" when patients express concerns, and aggregating complaints to identify and address high-complaint systems and professionals.

The article also discusses why the initiative has stalled short of its goals, identifying four major barriers: 1) low patient/family awareness of how and where to share their observations; 2) need for service recovery skills and data sharing among key stakeholders; 3) hospital leader commitment to pursue complaint resolution; and4) shared accountability for ongoing improvements in the system. In fact, hospitals worldwide face similar barriers, and many system leaders, hospital administrators, and frontline professionals struggle to address them. Therefore, all policy makers, hospital leaders, health professionals, and patient advocates need a plan for maintaining momentum in pursuit of their

complaint management initiatives' important, valuable goals.

At Vanderbilt, we use a "Project Bundle" tool to monitor progress on institutional safety/quality improvement and risk reduction initiatives [6]. In brief, to assess when (or whether) quality improvement initiatives are ready to launch, or, as in the case of managing patient complaints in China, a project appears to have stalled, we examine the adequacy of key project elements of three types: A) Commitment from key people, B) Organizational supports, and C) Learning systems. The findings by Jiang et al, suggest that to move forward and continue to improve complaint handling, all stakeholders will need to address important questions in each area:

A. Commitment from People

1. Have key leaders made (or will they now make) public commitments to address patient/family concerns, and are those leaders prepared to address the systems and healthcare professionals associated with patient dissatisfactions? If not, what might persuade them to do so because leadership commitment is essential. Without strong leadership, the initiative has very limited chances of achieving its goals.
2. Are project champions identified (and held accountable) at each hospital, i.e., people who have the ability to motivate, inspire, and hold others accountable to overcome barriers and accomplish goals? What key data do they have—and do they not have—access to?
3. Complaint management is the responsibility of a hospital department formed for this purpose. What is the makeup of each hospital's departmental "project team," how much team time is actually dedicated to hearing, addressing and documenting patient complaints, and how are team members working with (or expected to work with) frontline hospital managers and other professionals to address and resolve complaints?

B. Organizational Supports

4. Are this mandated project's goals clearly and truly aligned with each hospital's other major goals and leadership incentives? What needs to happen to increase alignment?
5. Does each hospital have policies and procedures that support (or conflict with) the initiative to manage patient complaints? If yes, who is accountable for their routine and reliable use? If not, who in each hospital (and policy-making body) is in the best position to create and gain acceptance of new policies and procedures?
6. Does each hospital have a plan for implementing graduated interventions for addressing healthcare professionals and systems that overly dissatisfy patients and families? [6-8].
7. Are the resources being provided sufficient to achieve the goals?

C. Learning Systems

8. What formal and informal measurement and surveillance tools are available (and are being used) for tracking complaints and their resolution? What tools provide a safe, secure transfer of complaint data for aggregated analysis? How will progress be tracked, to whom does feedback need to be transparently delivered, and who will be accountable for the results?
9. Who reviews the data and how do they report it in ways that promote quality and safety?
10. What kinds of multi-level professional training are required for implementing and managing a complaints management initiative? For example, if senior leaders do not understand that the number of complaints actually reported represent the mere tip of an iceberg, they need to learn that complaint capture should increase for many years, not decrease. Increases permit more timely and reliable identification of individual professionals and hospital units that stand out in the wrong direction. In addition, have all hospital department staff and their leaders had expert training on how to perform their important roles in complaint handling? Finally, have all been taught best practices for service recovery and documentation [9]? Training is important, but it is last in this list to suggest that training alone will not be effective without good (not necessarily perfect) robustness of the other project bundle elements.

Every question should be considered honestly, but not every question must be fully answered for progress to be made in complaint management, service recovery, and use of data. Jiang and

colleagues, and especially the persons interviewed for this study, have provided their local colleagues and national leaders important feedback. If critical elements of the Project Bundle are able to be addressed in Shanghai hospitals (and hospitalseverywhere), we look forward to future reports about the next decade's progress in these areas and achievement of program goals.

References

1. Hickson GB, Federspiel CF, Pichert JW, Miller CS, Gauld-Jaeger J, Bost P. Patient complaints and malpractice risk. JAMA. 2002;287(22):2951 PubMed -57.
2. Hickson GB, Pichert JW. Identifying and Addressing Physicians at High Risk for Medical Malpractice Claims. In: Youngberg, BJ, editor. Principles of Risk Management and Patient Safety. Sudbury, MA: Jones and Bartlett Publishers, Inc; 2012 p. 347-68.
3. Vincent C, Davis R. Patients and families as safety experts. CMAJ. 2012;184(1):15 PubMed -16.
4. The Health Foundation: Involving patients in improving patient safety, London, UK, January 2013. http://www.health.org.uk/public/cms/75/76/313/3998/Involving%20patients%20in%20improving%20safety.pdf?realName=sVAlBL.pdf (last accessed April 14, 2014).
5. Hibbard JH, Greene J. What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs. Health Aff. 2013;32(2):207 PubMed -14.
6. Hickson GB, Moore IN, Pichert JW, Benegas M Jr. Balancing systems andindividual accountability in a safety culture. In: Berman S, editor. From the front office to the front line: essentials issues for healthcare leaders, 2nd ed. Oakbrook Terrace, IL: Joint Commission Resources, Inc. 2012. p. 1-36.
7. Hickson G, Pichert JW, Webb LE, & Gabbe SG. A complementary approach to promoting professionalism: Identifying, measuring, and addressing unprofessional behaviors. Acad Med. 2007 Nov;82(11):1040-48.
8. Pichert, JW, Hickson, GB, Moore, IN. Using patient complaints to promote patient safety: the patient advocacy reporting system (PARS). In: Henriksen K, Battles JB, Keyes MA, Grady ML, editors. Advances in patient safety: new directions and alternative approaches. Bethesda, MD: Agency for Healthcare Research and Quality (AHRQ) 2008. p. 421-30.
9. Hayden AC, Pichert JW, Fawcett J, Moore I, Hickson GB. Best Practices & Advanced Skills in Healthcare Service Recovery Programs. Joint Comm J Qual Improv & Pt Safe. 2010;26(7):310 PubMed -18.

Reviewer: 1
Reviewer Name Helen Smith
Institution and Country University of Manchester, UK
Please state any competing interests or state 'None declared': none

Thank you for the opportunity to review the revised paper. The authors have addressed most of my comments. However, a few issues remain.
1. Some parts of the discussion have been revised, but there is no reference to other literature at all. This is important and needs to be addressed - the whole point of the discussion is to relate the study to other research on the topic, not only similarities or differences in findings but also methods. The sentence inserted about complaint handling in other HESVIC countries also needs supporting references and further comment from the authors.
Thank you for pointing out this. We have added the references in the discussion part.

2. the 'handful' of studies in China, referred to in the last para of the background, still needs elaborating - include citations to these studies, and summarise what they found, what the gaps in knowledge are, what are current debates - this provides the rationale for doing your present study - if

there are no studies then you need to state this.
There were only few studies in China to provide the number of complaints in the studied hospitals or garner patient feedback via questionnaires and interviews. There were few attempts made to formally examine how hospital complaints are addressed. Those have been told in the manuscript. We have added the citations. Please refer to that part.

3. You have now stated that the analysis is based on a particular model of stages of the complaint process - but you need to justify this - why is this model suited as a theoretical framework for your study?
There were few attempts made to formally examine how hospital complaints are addressed. So using the stages of the handling process is an efficient and direct way to analyse the data. This has been explained in the data analysis part.

4. in your response to my original point about sampling you explain in detail why snowball approach was suitable and the reasons you didn't include patients with different types of complaint - this needs to be mentioned in the limitations section (which is rather too brief and could be further developed).
We added this limitation in the discussion part. Please refer to that part.

5. In my view Figure 1 is still not described in sufficient detail. I'm not sure how it was developed, how the various pathways operate, and how it relates to what you have provided in table 2.
6. Table 2 is helpful in that it summarises all of the approaches - but you need to actually refer to it in the text and explain it! don't leave it to the reader to make sense of it themselves, you need to indicate what it shows.
Thank you for your clear comment. We present Table 2 because we would like the readers to understand the whole picture of the system. We then only show figure 1 to present the central role of hospital in the handling system because the words of this paper are limited by the journal rule. We are sorry about this.

7. Second sentence of discussion - seems slightly misleading to describe China as a 'developing country' - its the 2nd largest economy in the world! the WB classification of countries based on income is more acceptable and China is an upper middle income country. I am not suggesting you use the term 'upper middle income' but you need to find an alternative way to describe the situation in China, an emerging economy which still faces health inequalities and parts of the heath system still need strengthening,.
Thank you for your advice. It is actually controversial about whether China is still a developing country or not. So we changed the word into “emerging market country”, which may be a better description.

8. The paper could be far more succinct and still needs a thorough edit with attention to language.
Thank you. A native English speaker has edited the manuscript.

I think the paper is substantially revised, but still needs some further revision, see above comments, before publication.