
HOW TO RESPOND TO A FORMAL PATIENT COMPLAINT

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Dr. Noble sorts her mail while munching a quick lunch between patients. There is the usual junk, some journals, and a letter from a consultant. But one letter is like a punch in the gut. Her eyes widen as she reads.

Only 8 months into practice, Dr. Noble is happy with her working environment. After completing her residency she joined Community Primary Care Associates, one of several group practice options available to her, which is located 15 minutes from her home. She is pleased with the reimbursement package she arranged, a combination of salary and annual bonus, and she likes her coworkers. The director of the group has told her she is fitting in well, the team appreciates her clinical skills, and the business headaches are someone else's, although she feels the administration has listened to the few concerns she has expressed so far. Best of all, after a few months of adjustment she is attracting patients who appreciate her warm bedside manner.

But today her stomach churns as she discovers that a patient has filed a formal complaint against her. The letter is from Major Metropolitan Health Plan, a managed care organization (MCO) that accounts for more than half the patients seen by the physicians in her group. It is signed by a person she does not know, who is identified as a "Quality Improvement Advisor." The opening lines sound accusatory: "We are charged with maintaining the quality of care for our members..." Dr. Noble's mind races with questions. How could this have happened? What should she do?

Criticism and allegations are hardly welcome feedback from patients. But the reality of clinical practice is that patients may find reasons to complain, despite one's best efforts to provide good care. When suddenly faced with a patient complaint, a physician should be prepared to offer a constructive

response and to consider the possibility that the complaint, even if not valid, may reveal an opportunity for improvement. Patient satisfaction plays an important role in today's consumer-oriented practice environment [1-3]. Thus, it is worthwhile to take appropriate steps to address problems that may undermine the success of individual patient encounters as well as the overall health of one's practice.

An angry or unhappy patient occasionally will approach a physician or office staff member directly and express dissatisfaction. It is important to be open-minded when a patient voices a concern and to consider that she may indeed be right. Furthermore, she may have something useful to offer, such as insight into how to communicate more effectively. Addressing the patient's concern appropriately usually does not require great effort and will likely ensure that the patient leaves happy and therefore will return.

Less commonly, a physician may receive a formal, written patient complaint through an official third party, such as an MCO that the physician or group practice has a contract with or the medical licensing board of the state where the physician practices. Estimating from the volume of formal complaints received in the author's office and anecdotes from practicing physicians, a typical physician might receive one of these complaints every few years. A formal patient complaint by nature is unnerving for the physician who receives it and may easily incite anger, fear, and a defensive response. To put such complaints to rest and get on with one's work, a physician must be able to respond quickly and effectively.

This article focuses on the process typically followed when MCOs handle formal written complaints against individual physicians in ambulatory practice and offers advice about writing an effective response without undue time and effort. The medical literature offers few research findings regarding formal patient complaints about physicians. This article, thus, draws heavily from the author's experience as a managed care medical director, whose office receives many patient complaints about physicians each week and whose work has taken him inside many MCOs nationwide. Having read hundreds of physicians' letters, the author shares the elements of a good response that is most likely to resolve the matter. Although confidentiality constraints prohibit reprinting the text of actual patient or physician

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letters, the fictitious scenarios and examples offered are typical of what the author has seen in actual practice.

The Formal Patient Complaint

As Dr. Noble reads the letter (**Figure 1**), she notes that she is asked to respond in 10 days. Attached to the letter is a photocopy of the patient's brief, hand-written complaint, which reads as follows:

Dear Sir or Madam:

I'd like to let you know about a bad experience I had with Dr. Noble, one of the doctors in your network, because I don't think she should be allowed to treat people the way she treated me. I saw her twice, and the first time I went to her I thought she was going to help me. The second time, I had the feeling she just wouldn't listen to me. I had to talk her into doing an x-ray. How was she supposed to know what was wrong with me without it? What if I had cancer? I hope you look into this and take this doctor off your approved list.

Thank you,

Hubert Baxter

Why Patients File Formal Complaints

Based on the author's experience, several factors may motivate a patient to file a formal complaint against a physician (**Table 1**). Most patients raise a legitimate issue from the health care consumer's point of view. Some may be well-meaning citizens who sincerely hope to save someone else from suffering at the hands of a "bad doctor." For example, a mother who believes her baby's ear infection was misdiagnosed might complain, thinking that the proper authorities can educate or discipline the physician and prevent another baby's unnecessary suffering. Other patients may want to draw attention to something that could be improved, such as a chilly examination room, just as one might notify a hotel about a dripping faucet. Occasionally, a patient may be trying to retaliate, perhaps for a doctor's rudeness or failure to listen.

Little research has been done on the subject of why patients file formal complaints, although some indirect conclusions might be drawn from the literature on patient satisfaction. Several studies have sought to reveal reasons for poor patient satisfaction [4–12]. It should be noted, however, that the findings from these studies are quite variable and may not be generalizable to reasons for filing formal complaints. Some of the factors that have been linked to patient dissatisfaction include

service problems (eg, difficult encounters or poor communication with the provider, rudeness of the office staff, long wait times) [6,7], unmet patient expectations (eg, tests not done, medications not prescribed, specialty referrals refused, information not provided) [8,11], and patient perception of provider interpersonal behavior [9].

Outpatient service problems are common reasons for formal complaints in the author's experience. In particular, patients often complain about long waits to be seen or alleged rudeness of a provider or office staff member. The author also has seen many complaint letters suggesting the occurrence of a misunderstanding, a miscommunication, or a failure of a physician to listen carefully enough to understand a patient's true desires.

Clearly one cannot hope to eliminate complaints by simply doing whatever patients want. However, striving for effective communication is a worthwhile goal for improving overall patient satisfaction [13,14] and for avoiding the risk of communication breakdown that is so severe that an angry patient files a malpractice claim [15].

Agencies that Handle Formal Complaints

In this article, a formal complaint is distinguished from an informal one by the fact that it comes indirectly from the patient to the physician, in writing, through an official third party acting on behalf of the patient. Some patients may prefer going through a third party to avoid directly confronting the physician with a complaint, or because a third party may have more clout than the patient acting alone.

In the author's experience, individuals with gripes about physicians usually send written complaints to organizations and officials perceived as having some legitimacy or authority. Some complaints go to officials with little direct connection to health care administration, such as the Better Business Bureau, local mayors, congressional or state legislators, nationally prominent politicians, and the press. Many of these officials have no direct authority to investigate and act upon patient complaints about physicians, but will follow up as a courtesy to the complainant or because the agency sees its mission as helping to resolve disputes. When sent somewhere inappropriate, a patient complaint often is redirected to an agency better able to deal with the individual's immediate concerns.

Several agencies familiar to physicians have authority to investigate and act on formal complaints, including MCOs, the administrative offices of physician organizations, state licensing boards, and Medicare. A third party's authority depends on what stake it has in the dispute, what right or obligation it has to become involved,

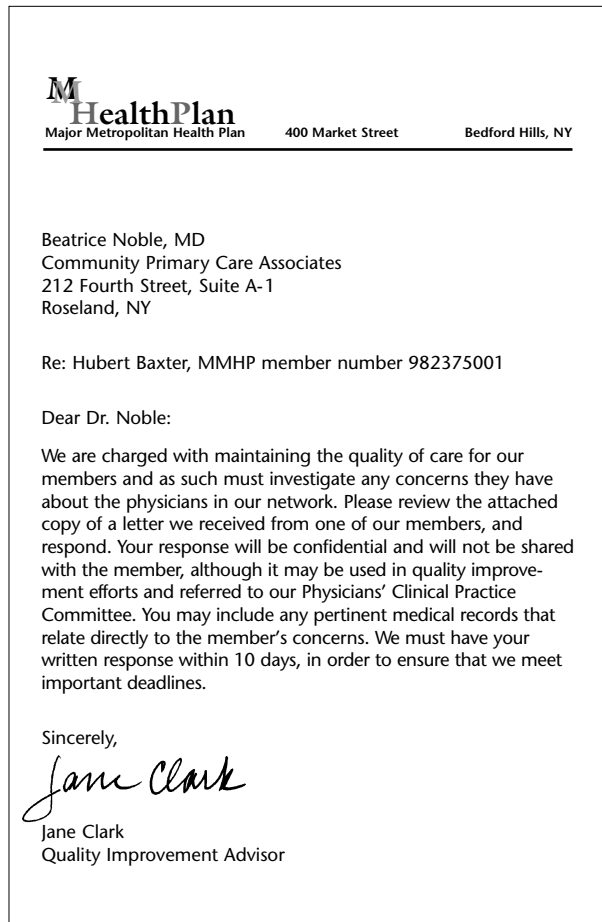


Figure 1. Sample letter from a managed care organization requesting that a physician respond to a patient complaint.

and what relationship it has with the patient and the physician. The major agencies that routinely handle patient complaints have an obligation to convey the problem to the physician, to get a response, and to assist in resolving the immediate issue.

MCOs. All MCOs are licensed by the state governmental department that regulates insurance, and almost half are accredited by the National Committee for Quality Assurance (NCQA) [16]. Most states require MCOs to respond to their members' complaints, and most state insurance regulators can get involved if the complaint is not handled properly. Typically, the goal of such state oversight of MCOs is to prevent abuse of the consumer by the MCO, with improved clinical care as a secondary consideration. NCQA requires MCOs that seek its accreditation to accept complaints from MCO members, to investigate them, and to seek to resolve them [17]. In addition, NCQA accreditation encourages MCOs to review

Table 1. Possible Factors Motivating a Formal Patient Complaint

- To improve health care and service
- To exercise one's civic duty to protect others from "bad doctors"
- To correct an error, such as an incorrect bill
- To express frustration, outrage, or anger at a physician
- To gain leverage on a specific issue by using the offices of a more powerful agent
- To avoid confronting a physician directly about some issue
- To punish a physician for some wrong suffered (real or perceived)
- To influence others to achieve an end (eg, to obtain insurance coverage for a medical procedure)
- To distract attention from one's own bad behavior (eg, an outburst of loud swearing in the waiting room)

complaints it receives to find systematic problems that can be improved. For example, if MCO members in a certain geographic area complain often about how difficult it is to find an obstetrician, the MCO might try to find more obstetricians to serve its members in that area. MCOs are required by their state regulators—and if accredited, by NCQA—to respond to and investigate complaints within specified time frames. For a physician, the most severe adverse consequences that could result from a complaint to an MCO include termination of the physician's contract, which could impact revenue, and reporting of certain serious problems to the National Practitioner Data Bank [18] and to state licensing authorities.

Physician organizations vary from small group practices, to independent practice associations with hundreds of employed physicians, to contracted arrangements between hospitals and local practices. The diverse nature of these organizations does not permit a meaningful discussion of how they handle formal complaints. Generally speaking, the authority to act on formal complaints may vary, depending on the organization's legal relationship with the physician. This authority might derive from an organization being a physician's employer or may be stated in a contract that a physician signs to become a partner or member of the organization.

State medical boards have defined areas of jurisdiction and specific legislative mandates. For example, the Texas State Board of Medical Examiners has a responsibility to review patient complaints looking for violations of the Texas Occupations Code, which is a specific set of state regulations governing the licensing and activities of

health care professionals. This code requires the Texas State Board of Medical Examiners to investigate when a physician may be impaired (eg, due to substance abuse, a cognitive disorder, or some other problem); however, it does not investigate complaints that do not directly affect the physician's ability to provide good medical care [19]. Therefore, a patient who complains that her doctor was drunk will get the Board's attention, whereas a patient who complains that the office has no convenient parking likely will not. State boards tend to investigate allegations of significant clinical care problems (eg, misdiagnosis of a myocardial infarction), substance abuse, sexual misconduct, and fraud (eg, lying to obtain a medical license). Physician impairment deserves and receives attention from state medical boards, and a physician who is found to have seriously violated state statutes could lose his license or even face criminal prosecution.

Medicare has defined authority over Medicare-participating physicians and takes complaints about health care fraud from consumers, inviting patients to compare their Medicare statements with the services received from their providers [20]. For example, if a patient saw on his statement that Medicare was billed for a colonoscopy that he did not have, he could contact Medicare and report it as possible billing fraud. Medicare cannot revoke a physician's state license, but it can prosecute for various offenses and can restrict a physician's ability to be paid for seeing Medicare patients.

Complaint Handling Within an MCO

A few words about the jargon of complaint handling are in order. The correspondence a physician receives from a third party may contain terms that have specific meaning, but perhaps only to that agency. For example one third party may call a patient's written complaint a *concern*, yet refer to oral comments coming in by telephone as *complaints*. An *appeal* generally refers to a request for an MCO to change a coverage decision it made, but not every complaint is an appeal. Although the jargon can be confusing, one does not need to know the jargon to respond.

In Dr. Noble's case, the patient complained to an MCO. MCOs typically route written complaints about physicians in their provider networks to a specific person or office within the MCO for investigation. A large MCO may have a department dedicated to handling formal complaints and a database or system for keeping track of the correspondence involved in the complaint-handling process. Patients' letters are scrutinized for signs that a clinical care problem occurred. An example would be a complaint from a patient who came to her physician's office while having a severe asthma attack

and then waited 2 hours before being told the physician had been called out on an emergency.

Many physicians express concern that a patient complaint may lead to termination from an MCO's provider network [21]. In actuality, typical MCO procedures include safeguards against frivolous termination of a provider contract. Formal complaints are reviewed by a medical director within the MCO, who has experience in patient care and who therefore understands that not every complaint is an indication of substandard care. Then, even if a clinical care problem is uncovered (eg, a patient on prolonged digoxin therapy with no monitoring of drug levels), the MCO medical director will likely refer the matter to a peer review committee inside the MCO. In an NCQA-accredited plan, this committee includes MCO-appointed practicing physicians of varied specialties, who are in the MCO's network but not employed by the MCO. This helps ensure that the physician's interests, not just those of the patient and the MCO, are protected. When an MCO peer review committee examines a case of a possible clinical mishap or substandard care, the MCO usually gathers any available information about other complaints against the physician. It is unlikely that such a committee will censure a physician for one or two complaints about inconvenience in the waiting room or alleged rudeness. However, if a serious problem is identified (eg, substance abuse affecting clinical care, grave errors in treatment), the peer review committee is obligated to take some action, not simply because of its relationship to the MCO but because of its ethical duty to protect patients and the legal requirement to report serious problems to state licensing authorities.

It is important to appreciate that many MCOs view patient complaints as a means to gather information with which to improve care processes in the long term and to effect change. For example, an MCO may categorize all the complaints it receives from members and find that at the end of a year, out of hundreds of complaints about physicians, 60% were about alleged rudeness. As a result, the MCO might seek to improve the communication skills of its network providers, perhaps by offering courses about techniques for handling difficult patients and situations or for improving communication approaches and increasing awareness of patients' individual desires and preferences [22].

The Physician's Response: Constructive First Steps

As the letter sinks in, Dr. Noble begins to feel angry and confused. Who is this patient? What is it that he thinks she did? Did she miss a cancer diagnosis? Is she

going to be sued? She begins to worry. The nurse who assists on outpatient visits also does not recall the patient. Dr. Noble sends her running after the medical record.

The patient who filed the complaint is Mr. Baxter, a man in his 40s. The thin record documents only three outpatient visits. The first was for gonorrhea, treated 2 years ago by a physician who has since retired. That visit does not seem relevant. On the second visit, about 4 months ago, Dr. Noble saw Mr. Baxter for acute back pain he said began while he was working under his car. The examination was unremarkable, and the treatment plan was the standard symptomatic advice Dr. Noble has given to many other patients, who seem to accept it well. She also prescribed a small quantity of narcotic analgesics. Mr. Baxter returned a few days later to visit Dr. Noble a second time, complaining that he had not improved. The examination was the same. Dr. Noble ordered a lumbosacral radiograph, which was not her usual practice for a routine back strain. She recalls that Mr. Baxter had pressured her for the study and asked for narcotics. Instead, on the return visit she prescribed a nonnarcotic, nonsteroidal anti-inflammatory drug. She sees that the medical record indicates that a colleague had called in a narcotic prescription the following day. Try as she might, she cannot remember anything said at the time that might have let her know the patient was unhappy.

Dr. Noble worries that Mr. Baxter's complaint could damage her reputation. She has no control over whom the patient talks to, but she avoids mentioning the matter to people who have no business to know. Frustrated, she speaks to another doctor in the practice, describing the scenario in general but not identifying the patient. She asks if he sees any problem with the care she had given, and he does not. He adds that he might have ordered physical therapy and wonders if the man was drug seeking. Although Dr. Noble is afraid that the MCO may leak the complaint, her colleague reassures her that the health plan is subject to the same type of patient confidentiality restrictions that they are. He says he too has had complaints like this one over the years and always finds them upsetting. He says it seems quite natural to react emotionally to the letter, but reassures her that since there were no problems with her care, the complaint is unlikely to lead to any serious consequences.

At home, she vents to her husband, again without being specific about who the patient is. Her husband urges her to concentrate on the many patients and colleagues who have said good things about her at the office. Dr. Noble sees that the letter from the MCO

asks for a response in 10 days. Swamped with paperwork, she decides to try to forget about the letter for a few days.

Cool Off and Calm Down

Most physicians respond defensively to a complaint at first. One study found that practitioners experience their reactions to patient complaints in three stages: initial impact, conflict, and resolution; during the first stage, they feel shocked, panicked, out of control, and indignant toward patients [23]. Dr. Noble avoided immediately drafting a response while she was experiencing her initial emotional reaction. Like most physicians in such a position, she was committed to providing quality patient care and felt deeply hurt that someone would think that she had done anything other than her best. A defensive reaction is natural and probably unavoidable in these situations.

Because an effective response requires some thought and calm planning, it is best to wait until the initial shock has lessened before attempting to respond. Reviewing the complaint with someone not directly involved can lessen its emotional impact and bring some objectivity to the matter, as long as patient confidentiality is not violated and one does not create new legal risks. Realizing that a single complaint is unlikely to make or break a career helps to keep the matter in perspective. In the author's experience the vast majority of complaints do not lead to dire consequences for the typical competent physician who receives only one or two formal complaints every few years and who does not establish a pattern.

Accept that a Response is Necessary

There are a few good reasons to respond to a formal complaint. For one, simple courtesy dictates that a response is essential. But even if a physician is not feeling particularly affable, she may have legal and contractual obligations to respond to a patient complaint. The obligation to a state licensing board is obvious to the physician who wants to maintain a medical license, but many physicians also have obligations to MCOs because of language routinely included in contracts, which requires participating physicians to cooperate with utilization and quality management programs. For an MCO, managing patient complaints properly can help identify problems that patients are having with its network of physicians. Such problems are legitimate arenas for improving the quality of the MCO. If the contract states that participating physicians should cooperate with efforts to improve quality, physicians are obligated at the very least to respond and to explain what happened when a patient complains.

For perspective, it is important to note that MCOs receive complaints not only about their physicians but about all aspects of their business activities, such as their coverage limits, formularies, marketing materials, telephone service, and claims paying processes, to name just a few examples. They also receive complaints from physicians. An MCO that is responsive to its customers takes note of all complaints it receives and deals with them effectively.

Recognize the Value of a Good Response

An inappropriate or clumsy response can, at the least, prolong the matter's resolution and consume more of the physician's time later on, when the MCO needs more information or writes to remind the physician that the initial letter went unheeded. One option Dr. Noble had was to ignore the MCO's letter altogether, perhaps hoping the problem would go away. This passive approach will not work, however, because of the MCO's obligation to follow up when a physician fails to respond. In some cases, the physician's lack of a response becomes a separate issue worthy of investigation, aside from the initial complaint, only creating more paperwork and trouble for the physician.

A good response can be crafted in a short time. A clinical practice is like a business in many ways; handling complaints well does much to keep a business functioning and growing. One has a reputation to protect; but beyond that, a well-handled complaint can help keep patients in the practice—including the one who complained, as well as with any relatives, friends, or coworkers of the patient who may also be, or will be, regular patients. A disgruntled patient usually shares her problem with someone and may be conspicuously vocal about how a dispute with a doctor was handled. In rare cases, it may be best to dismiss a patient from a practice, if the physician-patient relationship cannot be maintained because of persisting irreconcilable issues such as hostility or serious behavior problems (eg, violence) [24]. Formal procedures for dismissing a patient exist and are usually defined by the state medical board.

The Physician's Response: Taking Action and Responding Effectively

Things to Consider

It is important to note that two responses may be necessary: a written response to the agency handling the formal complaint and some action to restore the patient's confidence and meet legitimate needs. For example, if a patient complained that a physician failed to mail in a form for her daughter's summer camp physical examination, it would not be enough to write a deft reply to

the MCO handling the complaint. The physician should find the form and mail or fax it in as soon as possible.

What is the deadline for responding? Most official correspondence will mention a deadline for the physician, because the agency has a deadline of its own, sometimes imposed by state law. This can mean that the agency may choose to complete its investigation without the physician's response, rather than miss a deadline. It is better to be sure one's own side of the story is reviewed and on file.

Is patient confidentiality at risk? Patient confidentiality is widely recognized as a fundamental element of the physician-patient relationship [25]. Before responding to a complaint, a physician must be certain that the response will not violate patient confidentiality. When a patient complains to a third party and asks for assistance, it is implied that the patient is consenting to the MCO's investigation and the disclosure of information pertinent to the investigation by the physician. The consent is made more explicit in some cases if the patient signs a general release of liability or consents to have records transferred to others as needed in the course of medical care, as is typical when a patient is admitted to a hospital or joins an MCO. The safest procedure is to check with the MCO to see whether the patient has signed such a form and if not, the physician should ask for and receive signed consent from the patient before responding. When responding to the complaint, only the minimum information needed for the purpose at hand should be disclosed.

New national standards for the privacy of medical records, gradually going into effect over the next 2 years, will influence how much and what kind of information can be disclosed as part of quality assurance activities such as dealing with formal patient complaints [26]. Federal regulations derived from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require that patients' medical records (in any form, including written hard copies or electronic data) be used only for health purposes, such as health care treatment, payment, and operations [26]. Health care operations in this context refers to the administrative running of health care facilities and activities; thus, the disclosure of medical records for a legitimate quality improvement purpose is permitted, provided that various restrictions that HIPAA specifies are followed. It appears that, after the full implementation of the HIPAA privacy rules, a physician will still be able to respond to requests from agencies related to patient complaints and to include pertinent medical records.

Is a lawsuit impending? Infrequently, a complaint is the first indication of an oncoming malpractice lawsuit,

the warning signs for which include a significant loss, injury, or damage sustained by a patient; a very angry patient; or correspondence from an attorney indicating a direct threat of a lawsuit. In the author's experience, most complaints have no realistic potential for developing into a lawsuit, because most incidents described in patient complaints do not have the prerequisite characteristics. First, although any patient can sue—at least theoretically—about anything, before the lawsuit can materialize a lawyer must be found to take the case. To be pursued, there must be an injury or loss, such as a severe drug reaction with permanent sequelae or blindness from failure to diagnose herpetic keratitis. The loss or injury does not need to be severe, but one cannot establish malpractice without some adverse consequences suffered by the plaintiff. Next, the injury or loss must be related to a negligent act or omission on the part of the physician, such as misdiagnosis or failure to treat. However, a claim of medical malpractice will wither on the vine if the harm or loss cannot be linked somehow to the physician's conduct or treatment of the patient.

If a patient alleges to an agency that some damage occurred and a physician is implicated, that physician should discuss the matter with his insurer or legal advisor without delay. He may still be obligated to respond to the complaint, but the insurer may give advice about what to say and what actions to avoid.

Are there practice implications? Patient complaints about fees and billing can lead to practice management dilemmas. Simple billing mistakes should be corrected. However, if a patient asks for a refund because the treatment did not work or because of an alleged misdiagnosis, it is more difficult to choose the right course of action. Businesses in other industries sometimes refund unhappy customers even when no error was made, in an effort to preserve the relationship. In certain clinical practice situations, offering a refund may be helpful, such as when the office makes a scheduling error that seriously inconveniences a long-term, loyal patient one wishes to retain. However, one should consider the risks before refunding a fee. If good medical service was provided and the result was not what the patient had hoped for, a refund may imply that one agrees that the service was substandard. If a lawsuit is a realistic possibility, one should seek authoritative advice before promising to refund or reimburse a patient.

Was physical harm threatened? Rarely, a patient complaint will contain a threat of violence or harm. A vaguely worded threat that says, "I'm going to get back at you for this," can be hard to interpret. However, if a patient is specific about what harm is threatened to whom, a physician should seek competent advice about

how to manage the security risk and take practical precautions without delay.

Gather the Facts

The first step in preparing a response, after the cooling off period, is to gather the bare facts and list them in logical, if not chronological, order. In the author's experience, many physicians load their letters with argumentative statements that help to express their feelings but do not help bring the matter to resolution. Carefully laying out the facts first makes it far easier to craft a calm and orderly description of events.

List the needs of the agency. In addition to specifying a date by which the physician should respond, the agency may ask for answers to specific questions spelled out in the letter. Surprisingly, many physicians fail to respond to direct questions, thus forcing the agent to write back for a second response. For example, an agent might write, asking, "Did you refer Mr. Scarlet to a dermatologist?" If such a specific question is not answered with a "yes" or a "no," it is hard for the agent to let the matter rest.

List the patient's issues. The specific complaints and requests of the patient also should be itemized, even if they seem irrational or unfair. By closely analyzing the patient's complaint, a physician may discover needs that are implicit but not stated. For example, a patient who complains that her physician did not send medical records to another physician may still need to have those records sent, even if that need is not explicitly stated in the patient's letter. The intention here is not necessarily to satisfy all needs and requests but simply to understand what they are. With an understanding of the facts, the needs of the agent, and the patient's issues, one can draft an appropriate response.

Draft the Response

A physician's response to a formal complaint will be kept on file by one or more of the involved parties. The tone therefore should be businesslike and calm and the facts correct. When responding to complaints, physicians can benefit from the practical advice offered by quality experts in other industries. John Grocock, former Vice President for Quality at the international technology and manufacturing firm TRW, Inc., recommends a commonsense approach that is courteous and professional [27]. Mistakes should be corrected, apologies should be offered, and questions should be answered straightforwardly [27]. One should assume that the quality complaint is justified, because even if it is not, offering a professional response is a good will gesture that may lead to the same results in either case—a satisfied patient who is

FORMAL PATIENT COMPLAINTS

Table 2. Recommended Steps to Resolving a Formal Complaint

Cool off emotionally
Gather the facts
Seek professional advice if there is a risk of a lawsuit or if physical threats have been made
Follow confidentiality rules
Understand what specific things the patient and the agent are asking for
Write a draft, using the facts and addressing the specifics
Remove irrelevancies and unnecessary defensiveness
Recognize that complaints have value, and use them to improve

more likely to return. Of course, if the physician in fact agrees that the complaint is justified and correct, an apology for lapses of courtesy or bedside manner, office inefficiencies, or service goofs are very appropriate and also likely to restore the patient's confidence.

The letter should describe any incidents or events chronologically, unless another sequence is clearer. Often it is appropriate and helpful to include medical records that pertain directly to the matter at hand. Peer review allows the inclusion of medical records, as do most managed care contracts. One way that managed care has influenced common office practice is that outpatient medical records are more likely to be read by others outside the physician's office. This is because more physicians belong to MCO networks, which have standards for outpatient medical record keeping [17], and medical records are often included in MCO quality improvement efforts.

Some things should not be included in the letter, such as a direct response to a rhetorical question posed by an angry patient. For example, if the patient wrote, "What veterinary school did this quack go to?" it might not be constructive to list one's educational qualifications. Likewise, it is not useful to try to convince the agent how wrong the patient is. Sometimes these attempts only cloud the facts, fill the letter with irrelevancies, and make the physician appear self-serving. For example, if a patient with a known penicillin allergy claimed that a physician prescribed a penicillin-related drug in error, the following explanation would not be helpful:

"I resent the implication that I made a prescribing error. In 20 years of practice I have never been sued, and I am well known in the community. As you know, I am department chief and I would not be in that posi-

tion if I did not have the respect of my fellow physicians. My enclosed resume speaks for itself."

Having examined some of the mechanics of how a formal complaint is handled (Table 2) and an appropriate response is prepared, let's see how Dr. Noble proceeded.

Dr. Noble's unhappy patient wrote in vague terms but provided enough for her to begin to craft a response. After a few days pass and her anger subsides, she jots down the following:

The MCO asked for:

- a response
- that she meet a deadline (10 days from receipt of the complaint)

The patient:

- had the feeling she wouldn't listen
- had to talk her into doing an x-ray

She makes a first draft, trying to stick to the facts. She does not mention Mr. Baxter's visit for gonorrhoea. She starts out with an opening salvo:

"This man was drug seeking and clearly had his own agenda. I don't know why I ordered the radiograph, but it was not necessary and I think the only reason he came to see me was to see if he could get narcotics. Since neither I nor my colleagues here prescribe these drugs freely, he must have gone elsewhere."

Although she feels momentary satisfaction writing this paragraph, she decides to delete it. When she reread it, she saw that it was full of speculation on her part and did not help her meet her goal of resolving the issue. She tries again, this time confidently writing a factual account that will be helpful to the MCO and that relies upon the good care she provided to speak for itself (Figure 2).

The MCO's quality improvement advisor takes the letters from Dr. Noble and Mr. Baxter to the plan medical director. Having been in practice himself, he too has received complaints from a few disgruntled patients over the years. He scans Mr. Baxter's complaint and Dr. Noble's letter and cannot conclude that Dr. Noble committed any clinical error or failed to provide good medical care. The matter does not require referral to the plan's peer review committee. The MCO sends Mr. Baxter a letter thanking him for expressing his concerns. Because peer review laws in Dr. Noble's state forbid disclosure of the results of the MCO's investigation, Mr. Baxter cannot be told what action

the MCO takes or what conclusion it reaches about the care he received. The MCO's database now records one complaint against Dr. Noble. Because the health plan finds no violation of law, evidence of impairment, or other serious problem, it does not report the information to any governmental agency. Dr. Noble's record of one complaint does not distinguish her in any meaningful way from the other physicians in the plan's network.

Dr. Noble, rather than dismissing the complaint as that of a manipulative drug seeker, considers whether something in her attitude or demeanor gave Mr. Baxter a legitimate reason to think that she was not listening. There is no way to tell, now, what she could have done better—if anything—but she makes a mental note that, perhaps, her listening skills are not as good as she thought. She resolves to take the issue of patient communication more seriously and decides that, should she receive other feedback suggesting a weakness in her communication approach, she will seek training to improve her skills.

As this scenario illustrates, physicians should be able to resolve the matter of a formal patient complaint with minimal agonizing. The key is to take a systematic and careful approach so that one can prepare a carefully worded letter that meets the deadline, includes a factual account of what happened, does not speculate, and addresses, as well as possible, the patient's specific complaints. Dr. Noble did not promise to do anything different in the future—there was no need for her to do so in this case. Had a patient complained that her office did not have wheelchair access or something similarly specific, that would have been worth addressing, perhaps with mention of a remediation plan.

Complaints Have Value

In keeping with contemporary medicine's drive toward improved quality of care, patient satisfaction has become an important measurement for judging the success of medical services. The implications of patient complaints fit naturally into this scheme, providing feedback on patient care that can be addressed at several levels.

Individual Physician Improvements

Physicians who find clinical work frustrating because of patient complaints may provide less than the best service and care to patients. It is a better strategy to consider complaints as a guide to improving practice [28]. Physicians who have received common complaints such as "My doctor was rude to me" or "My doctor did not answer all of my questions," might benefit from training

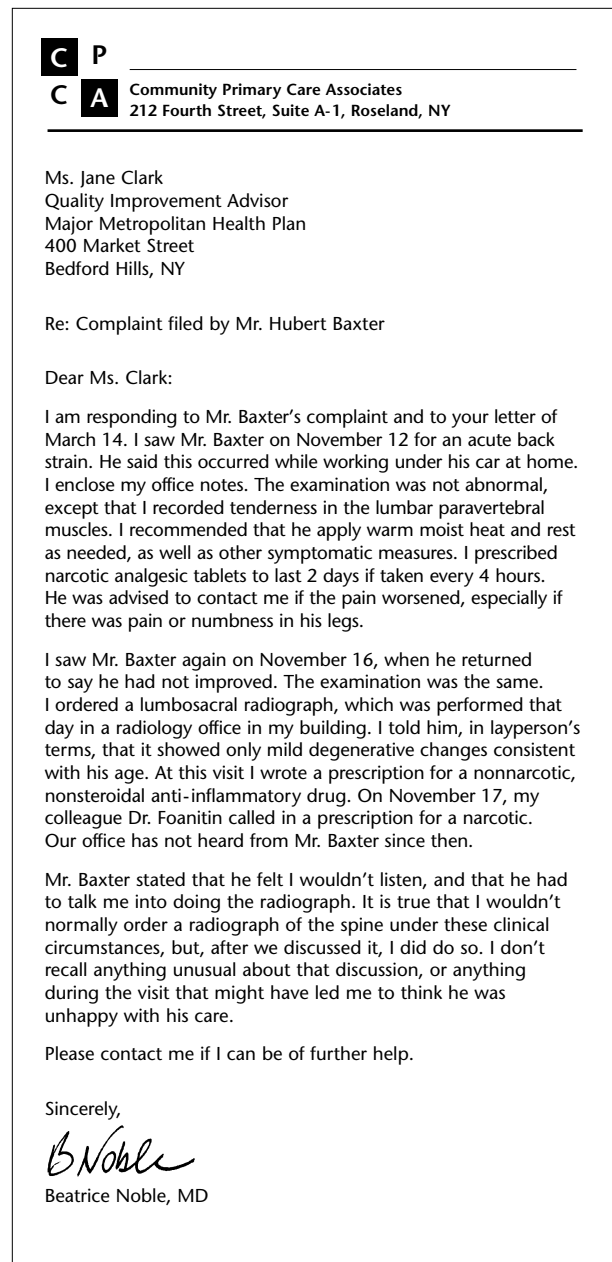


Figure 2. Sample letter from a physician to a managed care organization in response to a patient complaint.

to develop skills in effective physician-patient communication. With effective skills in communication, a physician may come to see responding to a complaint as a meaningful and satisfying method of resolving a conflict.

Several organizations such as the American Academy on Physician and Patient offer training programs to boost communication skills [22]. Minor adjustments in communication style can help physicians encourage

patients to take an active role in their health care, or convince noncompliant patients to alter their behavior. Such programs also aim to renew a physician's enthusiasm for improving skills [29] that can help maintain patients' trust [30] and loyalty [31]. More information is available than ever before about the art of communicating with patients [32,33], and its importance is not in doubt [34]. It should be noted that, although research is limited on the subject, at least one study suggests that low-intensity communication training programs are not effective in improving general patient satisfaction [35]. The authors speculate that longer, more intensive training across a broad range of skills, with ongoing performance feedback, may be needed to achieve overall patient satisfaction with office visits.

Organizational Improvements

With the advent of managed care, the profession of medicine has become more consumer oriented [36–38] and can therefore look to management procedures in other industries as a model. Like businesses in other industries, physician practice organizations should create a systematic procedure for handling patient complaints [39]. That procedure should involve investigating the complaint, having someone—either the physician or another designated person—get back to the patient (verbally or in writing, whichever is more effective), and responding as necessary to an MCO or a state licensing board. The practice should keep track of all complaints, categorize them, and seek to address the most common ones systematically. For example, if most patient complaints are related to telephone interactions with staff, improving telephone service should become a priority for the practice, which could use readily available staff training materials [40]. (For more information about complaint handling, readers are directed to the Council of Better Business Bureaus Web site at www.bbb.org.)

Because most patients, like customers of any business, never express their dissatisfaction to physicians, feedback should be actively encouraged to find out what patients think needs improvement [41]. To be sure the practice hears from those who are too timid to speak to their physicians directly or too busy to write a letter, the author recommends that office staff be trained to ask all patients if they are satisfied at the end of their visit or invite patients to write comments on a card. The more active the method, the more information will be gathered. Patient surveys are another way of gathering feedback [42–45].

Whatever insights are gained from considering patient complaints should be shared with everyone with-

in the organization. The organization, large or small, could then plan changes in problematic procedures and processes, then after implementing them, check and measure progress. The process can be adjusted further and the results checked again, until the problem is resolved to everyone's satisfaction. This systematic approach to improving the quality of work is often called "Plan, Do, Check, Act" [46], or continuous quality improvement (CQI). This powerful method of finding and implementing improvements was originally described by Walter A. Shewhart in the 1930s [48], then adopted by many leading businesses, especially in manufacturing. Donald Berwick, of the Institute for Healthcare Improvement in Boston, is an inspiring leader in the medical profession who is helping to bring such effective quality improvement methods to health care [48–50].

CQI in health care is driven by the need to contain costs while improving or maintaining the quality of care that is delivered and responds to the new trend toward consumerism. CQI embraces efforts to improve clinical outcomes, clinical efficiency, access, and service. Berwick and others [2] have argued that service to patients is a major issue that deserves much more attention from health care providers, and patient complaints in particular can serve as a measure of the quality of service. Patient satisfaction has become a major concern of health plans because of NCQA's Health Plan Employer Data and Information Set (HEDIS), a method it uses to measure the quality of MCOs, and because of the newly acquired ability to measure patient satisfaction through surveys [3,45]. These efforts necessarily filter down to the individual doctor, where care and service are administered. CQI can be applied in any organization, regardless of size. Thus, many medical practices are following the example of other types of businesses and are learning how improvement in service to patients, not just clinical care, can pay off [51,52].

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FORMAL PATIENT COMPLAINTS

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