How to Respond to a Formal Patient Complaint

Spencer H. McCleave, MD, MBA

Going through her mail one morning at the medical group practice where she works, Dr. Beatrice Noble finds the following letter:

Dear Dr. Noble:

Major Metropolitan Health Plan is charged with maintaining the quality of care for our members and as such must investigate any concerns they have about the physicians in our network. Please review the attached copy of a letter we received from one of our members, and respond. Your response will be confidential and will not be shared with the member, although it may be used in quality improvement efforts and referred to our Physicians’ Clinical Practice Committee. You may include any pertinent medical records that relate directly to the member’s concerns. We must have your written response within 10 days, in order to ensure that we meet important deadlines.

Sincerely,

Jane Clark
Quality Improvement Advisor
Major Metropolitan Health Plan

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 a managed care organization (MCO) or state medical board. Estimating from the volume of formal complaints received in the author’s office and anecdotal information, a typical physician might receive 1 of these complaints every few years. It may be unnerving for a physician to receive a formal patient complaint, and it may incite anger, fear, and a defensive response. This article offers advice on how to respond to a formal patient complaint filed through an MCO. As the medical literature offers few research findings on this topic, the author draws heavily on his experiences as a managed care medical director, whose office receives many patient complaints about physicians each week.

The Formal Complaint

Why Do Patients File Formal Complaints?

Many factors may motivate a patient to file a formal complaint against a physician (Table). From a health care consumer’s perspective, most issues patients raise are legitimate. Some may be well-meaning citizens who hope to protect others 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 (eg, 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; however, 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

From the Patient Management Department, Aetna US Healthcare, Middletown, CT.
FORMAL PATIENT COMPLAINTS

Table. Reasons Why Patients Might File a Complaint

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

not be generalizable to patients who file formal complaints. Some 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].

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].

Complaint Handling Within an MCO

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, 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.

In Dr. Noble’s case, the patient sent the MCO a written complaint (Figure 1). 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 [16]. 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 1 or 2 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...
Preparing to Respond

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, Mr. Baxter, is a man in his 40s. The thin record documents only 3 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 this point, Dr. Noble can take some constructive first steps.

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 3 stages: initial impact, conflict, and resolution; during the first stage, they feel shocked, panicked, out of control, and indignant toward patients. 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 1 or 2 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 earn 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 1 or 2 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. Dr. Noble could ignore the letter, hoping that the problem will 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.

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. 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
There is a benefit to be gained in writing 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. Further, a clinical practice is like a business in many ways, and effectively handling complaints helps 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—not only the one who complained but also relatives, friends, and coworkers of the patient who may be (or will be) regular patients. A disgruntled patient usually shares her problem with someone and may be 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) [19]. Formal procedures for dismissing a patient exist and are usually defined by the state medical board.

Other Considerations
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 [20]. 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 [21]. 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 [21]. 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 there an impending lawsuit? 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.

Responding Effectively
Gather the Facts
After the cooling off period, the first step in preparing a response 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 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
When responding to complaints, physicians can benefit from the practical advice offered by quality experts in other industries. John Groocock, former Vice President for Quality at the international technology and manufacturing firm TRW, Inc., recommends a commonsense approach that is courteous and professional [22]. Mistakes should be corrected, apologies should be offered, and questions should be answered straightforwardly [22]. One should assume that the quality complaint is justified, because even if it is not, offering a professional response is a goodwill gesture that may lead to the same results in either case—a satisfied patient who is more likely to return. Of course, if the physician in fact agrees that the complaint is justified and correct, an apology for lapses and medical mistakes should be offered, and questions should be answered professionally [22]. One should assume that the quality complaint is justified, because even if it is not, offering a professional response is a goodwill gesture that may lead to the same results in either case—a satisfied patient who is 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 [23], 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 position if I did not have the respect of my fellow physicians. My enclosed resume speaks for itself.

**How Dr. Noble Handles the Complaint**

Having examined some of the mechanics of how a formal complaint is handled 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 writes a first draft, trying to stick to the facts. She does not mention Mr. Baxter’s visit for gonorrhea. 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 1 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 1 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 reason to think
that she was not listening. She cannot think of anything, but she makes a mental note to pay more attention to how she communicates with patients. She decides that she should 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 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.

The Value of Patient Complaints

It is a useful strategy to consider complaints as a guide to improving practice [24]. 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 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.

Most patients, like customers of any business, never express their dissatisfaction to physicians. Therefore, feedback should be actively encouraged to find out what patients think [25]. To obtain the opinions of those who may be too timid to speak to their physicians directly or too busy to write a letter, office staff can be instructed 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 that will be gathered. Patient surveys are another way of gathering feedback [26–29].

Insights gained from patient complaints should be shared with everyone within the organization. Using a continuous quality improvement model, interventions can be designed to address identified problems. Berwick and others [2] have argued that service to patients is a major issue that deserves much more attention from health care providers. Patient complaints can serve not only as a measure of quality of service, but as a strategic tool to improve.

References