COMPLAINT MANAGEMENT IN THE HEALTH CARE ORGANIZATION

Mary C. Gilly, University of California, Irvine
William B. Stevenson, University of California, Irvine

ABSTRACT

Complaint management involves understanding the processes by which organizational members resolve complaints. Complaints may be immediately resolved or passed forward for others to take action. In this paper, an innovative research design for tracing the management of complaints throughout the organization is described and results of a pretest are presented.

INTRODUCTION

Typically, the consumer satisfaction/dissatisfaction and complaint behavior (CS/D&CB) literature focuses on the consumer: what causes satisfaction/dissatisfaction, who complains, and how complainants react to the complaint response they receive. The little research that has focused on organizational handling of complaints has looked at this issue in terms of how complaints are handled: what response is given (if any), how timely it is, if a refund was given, etc. But in order for an organization to make full use of the information provided by consumers when they complain, an approach Fornell and Westbrook (1979) called "complaint management" must be adopted. According to these authors, in addition to handling individual consumer complaints, an organization practicing complaint management deals with consumer dissatisfaction at "an aggregate level by finding and removing origins of collective consumer dissatisfactions" (p. 95). Landon (1979) also recognized this dual function of complaint management in his article on consumer affairs departments. He said, "It can be seen that the consumer affairs unit must manage more than the correspondence with the consumer; the unit must also manage the flow of information from the consumer throughout the company" (p. 93).

Despite the obvious importance of disseminating information about consumer dissatisfaction to members of the organization who can take steps to prevent future problems, this aspect of CS/D&CB has been virtually ignored in the eight years following the Fornell and Westbrook and the Landon articles. This paper proposes to call attention to this under-researched problem by examining the issue within the health care arena, by proposing an innovative research method for studying complaint management, and by presenting the results of a pre-test of this research method.

LITERATURE REVIEW

In 1980, Swan and Carroll put together an extensive review of patient satisfaction research from 1965-1978. This patient satisfaction research had been conducted virtually independently of consumer satisfaction research, although the similarities are obvious, as pointed out by Swan and Carroll (1980). In spite of the increasing interest in health care marketing today, there remains little cross-fertilization of ideas between consumer and patient satisfaction research.

Organizational responsiveness to patient perceptions of needs has been recognized as important by researchers in the health care field. Carey and Posavac (1982) and Uhlmann, et al. (1984) saw both humanistic and practical advantages to obtaining information from patients regarding satisfaction/dissatisfaction and acting upon it. First, health care organizations want patients to be as worry free as possible because this is a healthy state. Finding out patients' perceptions concerning their care is vital to achieving this goal. Weisman and Nathanson (1985) found patient satisfactions to influence compliance behavior. Second, health care administrators want former patients to return when requiring medical care at a future date and to recommend the organization to other potential patients. If patients perceive the health care providers as being responsive to their needs, their evaluation of their experiences will be more positive. Given the growing competitive situation among health care providers, the importance of complaint management (rather than mere complaint handling) is increasing.

Organizational responsiveness, then, needs to be studied in terms of not only how patients' complaints are addressed and resolved, but also how information about patient satisfaction/dissatisfaction is transmitted through the traditional formal methods of complaint handling and patient satisfaction surveys, and through the less frequently considered informal networks between patients, nurses, doctors, technicians and administrators.

Patients most typically come in contact with health care providers and admissions/records personnel. During these interactions, information concerning satisfaction/dissatisfaction may be provided by the patient. Do these patient contact personnel pass along relevant information to patient relations people to handle and track? Are administrators kept apprised of patient satisfaction/dissatisfaction by the patient contact personnel, the patient relations department, or both? The patient relations department may receive information from patients directly through complaints or patient satisfaction surveys. Is this information shared with the patient contact personnel? the administrators? Thus, there are many opportunities for information about patient satisfaction/dissatisfaction to flow between units in the health care organization. But there is also the great potential for breakdown in communication between these units.

THE HOSPITAL INFORMATION PROJECT

A study is currently underway which is designed to examine the flows of patient satisfaction/dissatisfaction information within health care organizations. The study involves an innovative technique which is a variation on the Small World studies conducted in the social network field. The Small World technique was devised and first tested by Milgram (1967).

In traditional Small World studies, a target person is identified by name, address, occupation, and other relevant characteristics. Starter people are given this information and asked to give a folder to someone they know who would be more likely to know the target person. Then the second person gives the folder to someone they know that might be even closer to the target person, and so on, until the folder reaches the target person. For example, Travers and Milgram (1969) selected a Boston stockbroker as their target person. They compared chains

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created by three types of starter people: Nebraska stockholders, random Nebraska residents, and random Boston residents. Korte and Milgram (1970) introduced the variable of race into their Small World study, looking at both intra- and inter-racial chains. These and other Small World studies conclude that surprisingly few social links connect one individual to another, hence the "Small World" appellation.

One Small World study has been conducted within the organizational setting (Lundberg 1975). He compared two structurally different organizations to see how the degree of bureaucratization affected the chains. As in the Small World studies conducted in society, a target person and their characteristics were given to starters.

Our study's research design differs from previous Small World studies in that there is no target person specified. Instead, members of the health care organization are given a folder containing a scenario about a patient complaint. Folders are sent to a randomly selected sample of doctors, nurses, administrators, technical people and staff of the cooperating health care organization. The starter person reads the hypothetical scenario and then decides on one of two courses of action:

1. The respondent may be able to handle this complaint.
   A. The respondent would write what s/he would do to respond to this complaint in the folder.
   B. S/He would return the folder to us.
2. The respondent cannot handle the complaint or believes someone else should be informed.
   A. The respondent would put his/her name on a roster within the folder.
   B. S/He would tear out a one-page questionnaire with questions asking why s/he would pick the specific other person as the person to receive the folder, fill out the questionnaire, and send the questionnaire to us.
   C. S/He would forward the folder to a person that s/he believed could handle the problem.

Through this process, the folder would circulate around the hospital until it reaches the person or persons who believe they can handle the complaint. At this point the folder would be returned to the investigators. This procedure permits analysis of three types of information about patient complaints. First, an analysis of why one person passes the folder to another will provide an understanding of how information flows through the hospital. Second, the resulting length of the chain from the first person who receives the folder until the last person returns it will also provide information on information flows. Third, the outcome of the complaints in terms of who believes they are responsible for a particular complaint, how many people believe they are responsible, and how they would handle that complaint will provide information on how patient complaints are managed.

Scenarios about consumer complaints have been used in other studies, but not in quite the same way. For example, Dwyer and Dornoff (1981) had consumers evaluate complaint letters concerning ladies' shoes and recommend responses. These responses were then compared to what the manufacturer said about how those complaint scenarios would be handled. Similarly, Resnik and Harmon (1983) asked consumers to examine complaint letters about building materials and the manufacturer's responses. Both these studies were concerned with complaint handling rather than complaint management. The study described above will examine this latter problem.

Thus, this research method offers the advantage of following complaints through the organization from receipt to resolution, and hopefully, beyond. Comparisons of the study's results to what the hospital believes should happen will be useful in identifying possible barriers to communication, and to complaint management. Of course, the use of scenarios, no matter how realistic, introduces a certain amount of artificiality. But one could argue that, if anything, recipients of the folders will be trying to do what they perceive they should do, and if these perceptions are inaccurate, the organization can take the necessary steps to correct misperceptions.

While the results of the hospital informatin project are not yet available, a pretest of the research method has been completed. The pretest is described and the results are presented and discussed below.

RESEARCH METHOD

The Research Site

In order to test this research method, a student health clinic was selected as a pretest site. This clinic of 90 employees provides outpatient medical and dental services to a campus population of 13,000. All employees are located in a series of offices in a one-floor building, making contact between the employees relatively easy.

Before testing the folder, scenarios appropriate to this test site had to be selected. Employees of the clinic and students who had used the clinic were interviewed, and complaints that had been entered into the complaint system were examined. From this information, two scenarios were selected:

1. I am a regular patient of the dental clinic. I would like to be informed when it is time for my annual checkup. (Dental Scenario)
2. I resent doctors calling me by my first name. I am over 30 years old, professional, married, have children and resent being called by my first name by a doctor who announces he or she is "Doctor so-and-so". (First Name Scenario)

The Sample

A sample of 4 employees from each of the categories of doctors, nurses, administrators, lab personnel, student volunteers, and student peer health advisors was selected. The 24 starters (first recipients of the folders) were mailed a letter advising them that they had been randomly selected to participate in the study. Then the folder was sent, followed a week later by a follow-up letter requesting their participation if they had not responded.

As shown in Table 1, this procedure resulted in an overall response rate of 67%. Unfortunately, none of the four doctors in the sample resonded to the study. This was not completely unexpected because the doctors were part-time volunteers who only worked at the clinic every few weeks and faced a large workload of patients when they worked at the clinic. Out of the 16 folders that were started by someone, all but one were returned to us.

TABLE 1
Response Rate

Profession	N	% of Folders Sent Out
Doctor	-	0
Nurse	2	50
Lab Technician	3	75
Administrator	4	100
Peer Health Student	3	75
Volunteer Student	4	100
	16	67

In terms of the future implementation of this research method, this data on response rates indicates that the first link is extremely important to the success of the project. Given that virtually all of the folders that were passed to another person were returned to us, the cooperation of the starter person is critical. This finding was confirmed in our debriefings when respondents told us that when they received a folder from someone, they felt obligated to respond either because they usually knew that person or felt some sense of social obligation because they had received the folder from a fellow employee. Furthermore, the results indicate that those with heavier workloads, such as doctors, need to be oversampled to compensate for lower response rates.

RESULTS

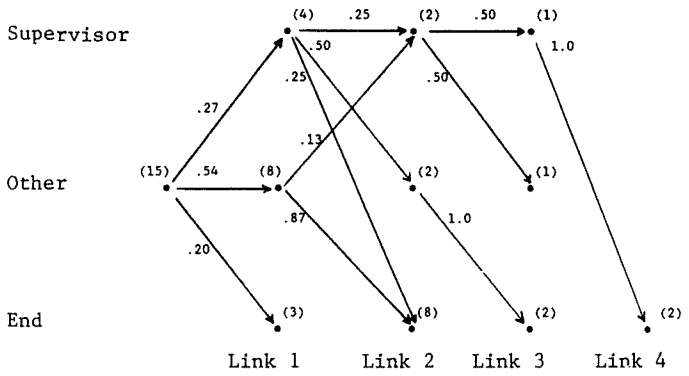
The data from the pretest provides some information on the patient concern management process in terms of how many links there are in a chain from the starter to a person who can resolve the problem, how the decision to forward is made at each link in the chain, and what the response is to the complaint. There were a maximum of four links (counting the starter) from the starter to the person who returned the folder to us, as illustrated in Table 2. Most of the dental complaint folders were sent back to us by the second person who received the folder. By contrast, the first name scenario showed more variability in chain length. This provides some indication that the first name scenario was more difficult to resolve.

TABLE 2
Number of Links to Complete

Link Number	Number of Respondents	Scenario Dental	Scenario First Name
1	3	-	3
2	8	6	2
3	2	1	1
4	2	-	2
	15	7	8

To delineate the decision making process that gave rise to the varying steps in the complaint handling process, diagrams of the decision making process from each link to the next were constructed. Figure 1 shows the overall pattern of response at each link in terms of whether a respondent sent the folder to his or her supervisor, to someone else, or regarded the problem as solved and returned the folder to us. A large number were sent from the starter to one other person and then returned to us.

FIGURE 1
The Effect of Sending a Complaint to a Supervisor



Given the previous results on chain length, it was thought that the decision making process involving the dental scenario must be contributing a disproportionate share of the early chain endings. Accordingly, the decision making process was broken down by type of scenario in Figures 2 and 3. As suspected, most of the dental scenarios were sent to someone other than the supervisor and then were directly returned to us. By contrast, in reaction to the First Name Scenario, a few individuals felt obligated to send their folders up the chain of command. This had the effect of extending the sequence of links until the folder reached someone who seemed to feel he or she could resolve the problem.

FIGURE 2
The Effect of Sending the Dental Complaint to the Supervisor

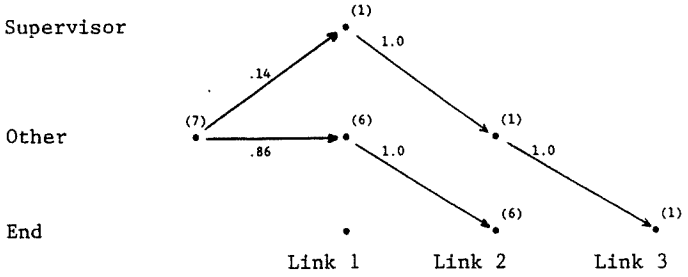
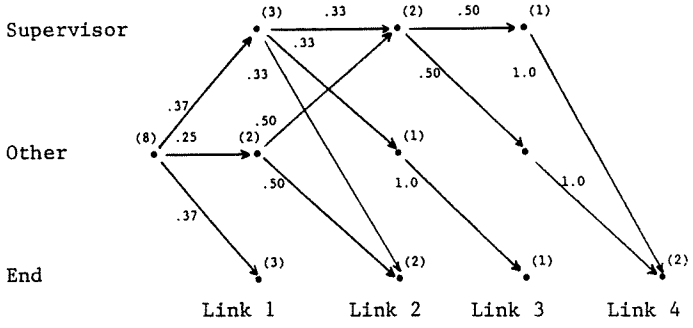


FIGURE 3
The Effect of Sending the First Name Complaint to the Supervisor



Finally, the respondent's advice to the patient, and the respondent's suggestions on how to prevent the reoccurrence of this problem in the organization was analyzed. The final link in the Dental Scenario for all folders was the office supervisor in the dental clinic. This employee's response to the patient was to tell him or her that he or she could fill out a card and be sent a reminder when it was time to have checkups. This employee's suggestion on how to prevent the problem from occurring in the future was to remind the other employees of this dental clinic policy.

Five out of eight of the final links for the First Name Scenario were to be the director of the clinic who was also a doctor. The director thought the patient should receive an apology, the complaint should be sent to the doctor, and the complaint should be filed in the doctor's personnel file. The other three last links were student volunteers who were starters and immediately returned the folder. Two of the three students recommended an apology to the patient. The other student thought the patient should tell the doctor of his or her complaint. Only one student felt that any further action was required.

Although the student did not forward this complaint, the student thought that the complaint should also be sent to the director.

There was little response to the patient from the 20 intermediate links in the chains. One Dental Scenario respondent thought that the patient should be advised to get a checkup every six months. One respondent to the First Name Scenario thought the patient's request should be recorded on their medical record, and another individual thought his or her supervisor should be informed of the First Name complaint, even though they were forwarding the complaint to someone else.

DISCUSSION

Although the goal of this pretest was to test the instrument, these results have implications for the differences in the management of complaints in this organization. The longer the length of the sequences, the greater likelihood of passing the folder up the chain of command, and the more severe reaction to the complaint indicate that the First Name Scenario was taken more seriously by the employees of the clinic. This is not surprising given that the Dental Scenario concerned a routine procedure and the First Name Scenario may be considered more serious in that this complaint involves the conduct of the doctors. Furthermore, the differences in handling of the complaints may indicate that complaints about doctors are handled more formally, with information flowing up the formal hierarchy to the director, while procedures for handling students are delegated to office personnel.

However, these results can only be suggestive. Further testing involving a variety of scenarios in which factors such as the importance of the complaint can be varied are necessary to disentangle the factors that lead to different complaint handling procedures.

To summarize, the issue of what happens to consumer complaints within the organizations which receive them is an important, yet under-researched one. It is a difficult problem to study using traditional research techniques, such as surveys or archival data analysis. An innovative research method has been proposed and is currently being tested on a large scale within the health care setting.

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