CHAPTER 76

COMPLAINT MANAGEMENT

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People complain when they are dissatisfied. Add the anxiety, confusion, and potential peril of an emergency, and the number and seriousness of complaints increase. For example, a mother brings her tearful 3-year-old to the emergency department (ED) because of a wrist injury. After waiting for three hours, the child is seen by a hurried nurse, is taken to x-ray, and then is seen once (for 2 minutes) by a physician, who performs a limited examination, barely speaks to either the mother or the child, and mutters something about a fracture. The patient is discharged with a splint and written instructions. Questions are superficially answered. Two days later, the child goes to his family practitioner, who after telling the mother that the child has a broken bone, shares his own complaints about the ED care and then refers the child to an orthopedist. One month later, a very dissatisfied parent receives ED bills totaling $1,050. She is angry and on the phone waiting to speak with you.

Complaint recognition and management are critical components of the successful ED. When handled properly, a dissatisfied and angry person can achieve satisfaction. Alternatively, the improper management of a complaint can lead to a disgruntled person who seeks retribution. The benefits of effective complaint management go far beyond meeting the perceived needs of the individual complainant. Institutions and leaders that recognize the importance of the consumer seek opportunities to improve by taking steps to reduce the root cause of dissatisfaction.

Adding compliment management creates a more comprehensive and balanced system. ED leaders who recognize and publicize compliments celebrate and value the praiseworthy efforts of department members, commonly delivered but uncommonly recognized and appreciated.

THE NATURE OF COMPLAINTS

All EDs receive complaints. Inevitably, some people will voice their dissatisfaction with the quality of care, length of stay, attitude of nurses and physicians, or cost of care. The approach of the department team and the institution distinguishes the organizations seeking improvement and satisfaction from those destined to repeat mistakes. To develop an effective approach, it is necessary to first understand why people complain.

We all experience dissatisfaction with some interactions because "reasonable" expectations go unmet. The ED is particularly prone to create dissatisfaction among those who use its services. Patients, private physicians, emergency medical services providers, and staff all enter the ED with expectations of rapid, quality care by an attentive and kind staff. Unfortunately, it is impossible to always meet these expectations.

The Complainer

Why do people complain?[1,2] Generally, people are dissatisfied when their expectations go unmet. In addition, if they perceive that they have been inconvenienced and treated rudely, they are much more likely to voice their dissatisfaction in the form of a complaint.

Duration of Relationship

Although the reasons for patient dissatisfaction are myriad, certain generalizations can be made. The duration of the relationship between the health-care providers and the patient is positively correlated to patient satisfaction.[3,4] The longer the relationship, the more satisfied the patient. The relationship between emergency care staff members and the patient is measured in minutes rather than years. This brief exposure allows little opportunity to develop the bond that may exist between a patient and a private physician.

Effective Communication

Patient expectations of physicians and nurses go beyond that of clinical competence. Patients expect their practitioners to be friendly, kind, and concerned and to take the time to explain the situation and answer questions.[5,6] As Terry Canale stated in his American Academy of Orthopaedic Surgeons Presidential Address:

> *The patient[s] will never care how much you know, until they know how much you care.*[7]

In the stressful setting of the ED, the ability to develop a rapid rapport with the patient and family enhances patient satisfaction. While many patients complain about delays in care, the greatest number of complaints lodged directly against ED workers relates to attitude and poor communication.[8] It follows that those physicians and nurses who adequately explain the nature of the problem or procedure are found to score higher on patient satisfaction scales than those who do not.[3,9,10] More complete explanations create a better understanding and more realistic expectations of the course and outcome of the illness. In addition, those who are encouraged to and actually do ask questions about their condition are more satisfied.[3,5,10]

The Demographics of Complainers

A substantial amount of literature that reviews the characteristics of the complainer has been published. Considerations of age, sex, and income levels are frequently cited.[4,8,11] The relationship between age and complaint behavior is unclear. Although it has been suggested that the elderly are less likely to voice a complaint, this has not been substantiated in several studies. Women are more likely than men to register complaints, which may relate to the fact that women are more likely to make the family's health-care decisions. And those with higher incomes voice complaints more often and are more likely to choose another provider because they generally have higher expectations, greater resources, and increased options to obtain alternative providers of care.[4]

Reasons for Concern

Successful delivery of emergency care entails recognizing the responsibility to address the needs of those using the service. There are many ramifications of dissatisfied patients, peers, and customers. The ED census may drop, medicolegal cases may increase, and ultimately the ties between the practitioner and the institution may be severed. Dissatisfied patients have three choices: They may voice a complaint, choose another provider ("exit"), or continue to use the service despite being dissatisfied (remain loyal).[12] Interestingly, loyal but dissatisfied consumers are considered passive, seeming to suffer in silence.

Many dissatisfied people do not complain.[8,13-15] They don't express their dissatisfaction because they believe it is not worth their time and effort, they don't know how or where to complain, or they don't believe it will do any good. In fact, fewer than 25% of patients who are dissatisfied voice a complaint to the service provider. Note that many of these "noncomplaining" consumers still may have an impact. Although unwilling to complain

to the service provider, they may complain to friends and family, influencing their behavior and creating "negative word of mouth."[16] Further, they may seek satisfaction from third parties, such as governmental agencies or the legal system. Finally, they may choose other providers, as suggested by the following passage:

> *You know me, I'm a nice person. When I get lousy service, I never complain. I never kick. I never criticize, and I wouldn't dream of making a scene. I'm one of those nice customers. And I'll tell you what else I am. I'm the customer who doesn't come back. I take whatever you hand out because I know I'm not coming back. I could tell you off and feel better, but in the long run, it's better to just leave quietly. You see, a nice customer like me, multiplied by others like me, can bring a business to its knees. There are plenty of us. When we get pushed far enough, we go to one of your competitors.*[17]

Census Impact

Changing providers ("exiting") once a relationship is well established seems difficult and requires substantial effort.[15,18] However, literature reveals that up to 63% of patients change physicians when dissatisfied, a number that is much higher than previously believed.[15,19] Those with medical (quality of care) complaints are twice as likely to seek alternative providers as those with nonmedical complaints.[4] A nonmedical study on dissatisfaction among aging consumers shows that they are more than 12 times more likely to report an intention to switch providers than satisfied consumers.[20]

As the environment becomes increasingly competitive, patients may find the option of changing providers and institutions more attractive. This is particularly true in an ED setting, where:

- The caregiver–consumer relationship is superficial.
- Interactions occur unpredictably.
- The consumer's absence will go unnoticed.
- Many alternatives are available.

In the ED, a contraction of census will decrease the need for service, nurses, physicians, and support staff. For an emergency physician group that exists within a fee-for-service environment, a dwindling census may be devastating. For employed emergency physicians and emergency nurses, fewer patients may obviate the need for their positions.

Medicolegal Implications

Aggrieved patients frequently turn to the legal system to seek redress.[21] Multiple agencies exist to receive and respond to consumer complaints. These include the Office of Consumer Affairs, Better Business Bureau, Centers for Medicare and Medicaid Services (CMS), Office of the Inspector General, and quality-improvement organizations, medical societies, medical boards, departments of health, and so on.

Consumers have a greater tendency to seek third-party redress when they perceive that more direct interaction, such as voicing a complaint to the hospital's consumer advocate, is unlikely to lead to resolution. There is evidence that consumers perceive medical providers to be among the least responsive to complaint resolution among the service industries.[18] Only about one-third of the consumers who voiced complaints believed their problems were satisfactorily addressed.[13] By ignoring or inadequately handling complaints, ED leaders may unwittingly encourage third-party actions.

Contract/Job Security

If there is a perception of ineffective problem management, the nurse's or practitioner's (group's) relationship with the institution may become tenuous. Effective consumer-oriented

administrators expect problems to be identified and solved with the subsequent development of procedures to ensure that the problem does not recur. Department leaders are expected to supervise this improvement. Leadership nonparticipation (avoidance) is perceived as an "I don't care" attitude, which is often the reason for the complaint in the first place. Hospital administrators and medical staff leadership may react decisively against unresponsive individuals and organizations by looking for alternative contractual relationships.

The Regulatory Imperative

Regulatory agencies look at problems, the systems used to handle those problems, and the methods to prevent their recurrence. The presumption is if there is an effective system, future problems will be prevented through early recognition and resolution. The Joint Commission looks specifically at the institution's complaint-management process. Reviewers often ask for evidence of a comprehensive system. The Joint Commission requires complaint-management guidelines to be incorporated into the organization' procedures. The 2010 Joint Commission standards require that:

> *The Elements of Performance Standard RI 01.07.01 address the resolution of patients' complaints. The standards require a complaint resolution process and informing individuals about the process. The standards also require response by the organization and the organization informing patients about their right to file complaints with the state authority.*[22]

Other regulatory bodies further define the process necessary for institutional complaint management. For example, the New York State Department of Health, Code 405.7.23, states:

> *[The hospital shall ensure that all patients . . . are afforded their rights [to]]: . . . express complaints about the care and services provided and to have the hospital investigate such complaints. The hospital shall provide the patient or his/her designee with a written response indicating the findings of the investigation. The hospital shall notify the patient or his/her designee if the patient is not satisfied with the hospital's oral or written response, the patient may complain to the New York State Department of Health's Office of Health Systems Management. The hospital shall provide the telephone number of the local area office of the Health Department to the patient.*[23]

Hospitals and their leaders are responsible for developing and implementing mechanisms to promptly receive and respond to patient and family complaints. All hospitals provide their patients with a "bill of rights." Most agencies refer to a constructive complaint resolution process. The organizations must thoroughly analyze the complaints and when indicated take appropriate corrective actions. And the patients or family members making the complaint must receive responses that substantively address their complaints.[18]

Providing Patient Satisfaction

The job of leaders entails providing high-quality care while satisfying the perceived needs of those around them. It is helpful to look at patients, colleagues, staff, and others who use and interact with the ED and its services as customers. This business philosophy enables ED leadership to look closely at what patients and others want. To do this, it is necessary to first define customer service:

> *Customer service is a series of activities designed to enhance the level of customer satisfaction – that is, the feeling that a product or service has met the customer expectation.*[24]

BOX 76.1 ■ THE 4 Cs OF PATIENT SATISFACTION

- Convenience
- Caring
- Care (quality)
- Cost

Therefore, satisfaction can only occur by meeting, surpassing, or modifying expectations. And yet, so often, caregivers thoughtlessly create dissatisfaction by raising expectations. Consider:

- An emergency physician who says, "The nurse will discharge you in *a minute*."
- The emergency nurse who says, "I'll be *right back*."
- A private physician who says, "Just go to the ED and get an x-ray." The inexperienced patient may believe this will be a 20-minute excursion. If it takes 2 hours and the patient did not plan for it, every little additional delay creates frustration.

Patients are customers, and the ED offers a service. If it is not delivered properly, EDs will lose their customers.

The Definition of a Customer

Merriam-Webster defines a customer as "one that purchases a commodity or service." Unfortunately, some practitioners who work in the ED reject the concept of patients as customers. This disregard is a form of arrogance that essentially communicates, "If the patients don't like what I say or how I say it, they can go somewhere else." Patients are not fundamentally different from people who buy computers, gas, or food. The basic expectations of a person who comes for treatment of a broken bone and one who orders food in a restaurant have several similarities. While a patient will likely have a greater sense of urgency, both want what "customers" universally expect—service delivered quickly, courteously, with quality, and at a fair cost.

Patient Expectations

Patients want the same things that all customers want: the Four Cs, or convenience, caring, care (quality), and cost (**Box 76.1**).[23]

- ***Convenience*:** When patients have a choice about emergency care, they tend to choose the institution that will get them in and out most quickly. Interestingly, health-care professionals rarely have the patience to wait in the waiting room of their own EDs when they or their family members are ill. In fact, most will bypass the typical front-end triage process and go straight to the care area to get their medical problems addressed immediately.
- ***Caring*:** Emergency professionals must develop rapport quickly. The success of the treatment approach once the patient is discharged depends on the trust developed. Patients judge caregivers most often based on the level of caring rather than the level of care.[8,13,13] Caring goes beyond giving a high standard of care. The classic response, "I did everything correctly; just look at the chart," just isn't good enough. When dealing with people and complaints, the complaint manager (CM) initially must focus on how the process did not work for the patient ("complainer") rather than trying to "educate" the patient and defend the process.

- *Care*: Generally, the lay public cannot judge the quality of care provided. Consider how difficult it is for an unsophisticated consumer to assess whether the examination was complete, the testing was appropriate, or the antibiotic was correct. It is only when the outcome is poor and unexpected that questions arise, perhaps even leading to questions of competence. Therefore, it is critical to recognize the patients' expectations and meet, surpass, or modify them. It is often prudent to both say and document some form of the following: "You should improve with this treatment. If you are not better in ____ days or you get worse, I would like you to immediately see your doctor or come back here and see me or one of my partners."
- *Cost*: Value is an increasingly important issue for those who use the ED. If a patient waited for hours, was treated rudely, or had a condition that got worse in spite of treatment, the cost of care may seem inappropriate no matter how inexpensive. Conversely, patients who perceive that they received value—treated quickly, courteously, and correctly—are much more willing to accept a reasonable bill.

Complaint Prevention

Though it is not always possible to meet patients' initial expectations, ED nurses and physicians have many opportunities to modify or reset patients' expectations. In other words, unrealistically high expectations can be lowered and then met or surpassed (**Box 76.2**).

Realistic Triage

The initial interaction with the ED, which is often triage, provides the first opportunity to recognize and influence the patient's expectations. One of the most common patient complaints is related to duration of stay, perhaps based on patients' unrealistic expectations or a poor understanding of the process. The triage clinician may positively modify the patient's expectations by spending a few extra seconds to explain the process:

- Describe what will happen.
- Share (with slight exaggeration) the anticipated duration of the clinical process, perhaps lowering preconceived expectations.
- Answer questions.
- Provide satisfaction by surpassing the now lowered expectations.

For example, to a patient requiring an x-ray in a busy traditional ED, the triaging staff member could explain like this:

> *From here you will be taken to an examination room. I'll order an x-ray now, and once you're in the examining room, you will receive a more in-depth evaluation by both the nurse and the physician who will review your x-ray. The physician will determine your treatment and follow-up, and then your nurse will give you discharge instructions. Generally, the entire process takes 90 minutes. Do you have any questions?*

BOX 76.2 ■ COMPLAINT-PREVENTION TECHNIQUES

- Realistic triage
- Triage ordering
- Reset expectations
- Theory of "Yes"
- Questionably necessary test
- Closing questions

While the care might be expected to only take an hour or less, it is appropriate to add a few minutes to the estimate of the patient's duration of stay to allow for the interruptions that typically occur in an ED. If the evaluation is completed sooner, the patient is thrilled because the lowered expectation will have been surpassed.

Operational protocols that empower the nursing staff to order necessary tests and begin treatments on patients can dramatically reduce the duration of stay. As in the example above, an x-ray or lab test that has been completed by the time the patient arrives in the examining room will reduce unnecessary waits.

Resetting Expectations

While patients expect rapid care, it is not always possible to meet this expectation. There are several appropriate opportunities to modify patient expectations during the wait. After a particularly busy time, such as a resuscitation, the nurse or physician can go out to the waiting room with two or three charts in hand. An apology for and explanation of the delay, displaying respect, and providing a legitimate reason are usually very much appreciated. Then bringing two or three patients into the ED proper will confirm that the situation is improving. Once a patient is in an examining room, the same outcome can be achieved on an individual basis:

Hello, Mrs. Jones. I am Dr. Smith. I am sorry that you have had to wait. I am taking care of a very unstable patient and expect to be back with you in about 20 minutes. In the meantime, I will ask the nurse to make sure we get your evaluation started and to keep me informed.

The caveat is that if providing a specific time resets the expectation, the promising health-care professional must be there at or before the promised time. If the professional gets "tied up," he or she must send someone in to say it will be a little longer.

Just Say "YES"

It is often helpful to begin the response to a request or inquiry with a form of "YES!" The "yes" in this situation is only meant to acknowledge the point of view of the other person, not to agree to the request. Consider the following responses to a patient who asks for something unreasonable:

- "No, you don't need that." The message is "I am the trained specialist, and I know what you need better than you do." Once the response begins with "No," the communication and therapeutic relationship may deteriorate.
- Alternatively, according to the "yes" theory, one might respond by saying, "Yes (sure), I can see that this is bothering you. Let me take a closer look so that we can figure out exactly what is wrong." The communication now is one of acceptance—affirmation that the patient has a reasonable perspective. The practitioner has agreed to work with the patient to further elucidate the problem without actually agreeing to meet the unreasonable request.

The Questionably Necessary Test

The patient requests a questionably necessary test, convinced that the test is essential. When practical, a successful strategy is to involve the trusted private practitioner in the discussion. On other occasions, it may be appropriate to provide the desired test. The patient will leave satisfied and believing that the practitioner cared enough to make sure that he or she is okay. This is not substantially different from the practice of most practitioners who obtain x-rays or provide antibiotics that are of questionable necessity. Alternatively, if the practitioner successfully convinces the patient not to get the test and eventually pathology is found, the vindicated patient may be very resentful.

BOX 76.3 ■ CLOSING QUESTIONS

- Is there anything else that I can do for you?
- Have I fully addressed your medical problem?
- Have you and your family been kept fully informed?
- Have we provided you with excellent care?

Closing Questions

It is a good practice for each practitioner who participates in the discharge of the patient to routinely ask the "closing question" to ensure that nothing has been overlooked from the patient's perspective (**Box 76.3**). When given the opportunity, occasionally patients divulge their true concern only at the end of the visit, such as "Will I be okay?" or "Is it cancer?" Without that final opportunity to ask the question, the patient may leave dissatisfied. Other patients may notice or describe an additional complaint, such as "What about my . . .?," which may have been previously overlooked. Most often, the patient will respond with a "No, but thanks." Some practitioners ask a closing question to obtain feedback on their own and the staff's performance. The closing question allows the patient and the practitioner to come to a definitive closure.

Satisfying Other Stakeholders

The appropriate management of complaints, including trend analysis, cannot be overemphasized as one of the key tasks of ED leadership. When an effective emergency complaint-management system exists, the process of handling a complaint proceeds down a consistent pathway:

- An administrator or other hospital representative receives a complaint about the ED.
- The complaint is immediately and confidently forwarded to the ED leader/CM for rapid resolution.
- The complaint is resolved quickly and effectively.
- The ED leader/CM communicates the resolution to the administrator (in writing).
- The root cause is identified and processes are put in place—and ED personnel are immediately informed of them—to limit the occurence of similar complaints.
- The resolution of the complaint is communicated to appropriate stakeholders.

Administration

The hospital administration runs a service business. To be effective, they must listen to their customers and user groups. Included among the most influential are the patients and their insurers, who use the service and pay the bills; the primary care physicians (PCPs) and proceduralists, who control which of the paying patients will use the hospital's service; and the hospital board of trustees, the institution's governing body, which directly oversees the administrator. Note that emergency care professionals are not among the most influential groups. Administrators typically want ED staffs who:

- Are problem solvers
- Do not generate a lot of complaints
- Keep the influential customers—the patients, physicians, and the board—happy

ED Staff

The emergency staff requires leadership that solves problems. For instance, if a nurse or physician comes to the ED leader and states that there is a problem with another person or a process, it is incumbent upon the leader to investigate, attempt to resolve the problem (when appropriate), and communicate back to the person raising the issue. Staff issues generally do not go away and, if ignored, erode the confidence of the staff in the department leaders. Leaders who don't address the problem become part of the problem.

Medical Staff Members

Emergency department complaints from non-ED medical staff generally involve effectiveness of communication and quality of care.[25] Department leaders should actively seek out those complaints and the people who make them. Once made aware of a complaint, the CM should rapidly investigate it and communicate the results of the investigation. By moving quickly to resolve the concerns of the medical staff, ED leaders demonstrate that the greatest interest of the ED staff is to provide the best care possible. To achieve success, the ED leaders should articulate and promote a philosophy of partnership with the members of the medical staff.

THE COMPLAINT-MANAGEMENT SYSTEM

A positive approach to the sometimes-unpleasant task of complaint management can be the first step in improving others' perceptions of your services. People who complain are looking for something they did not get during their first interaction with the system—*satisfaction*. By calling, the complainer is providing a challenge and an opportunity to transform the previously dissatisfying interaction into a favorable one. A response that conveys the sentiment, "Oh, no, not another complaint!" will confirm the complainer's misgivings. Alternatively, an open and sincere approach that conveys the sentiment "I want to understand and address the problem" will demonstrate the caring and concern that may have been absent during the earlier encounter.

Real-Time Management

Ultimately, it is best to rectify a situation while it is occurring to achieve immediate resolution. Five minutes spent getting an acutely developing situation back on track may obviate hours of investigation and embarrassment later.

In fact, most practitioners recognize when a patient is frustrated and dissatisfied. Leaders may wish to teach team members real-time service recovery; that is, to recognize and effectively respond to escalating problems. For instance, the simple key phrase—"You seem upset. How can I help?"—may lead to a definition of the problem and the potential for resolution. As an alternative approach, the primary provider can ask a colleague to investigate the perceptions of an unhappy patient. A problem uncovered may be then resolved as it is occurring. An undisclosed and therefore unresolved problem may leave the patient dissatisfied and frustrated, which in turn can result in a complaint voiced directly to an institutional leader and to multiple friends and acquaintances.

Tripping the System

Determining which complaints require a formal process of resolution is individual to each institution. This is one of the primary reasons that it is difficult to objectively compare

("benchmark") the volume of complaints among institutions. As examples, the following complaints are considered minor in some institutions and significant and worthy of full investigation in others:

- "My patient Mrs. Smith says that she had to wait to be discharged because your emergency doctor/nurse was on the phone ordering dinner!"
- A "repeater" who often comes to the ED to get warm and sober describes being ignored and then treated rudely.
- The patient complains no one called her primary care practitioner.

How each leader differentiates legitimate from "bogus" (groundless) complaints is telling. It is similar to asking, "What is a true emergency?" Is it the leader's definition, or is it the patient's? The same dilemma exists for defining true complaints. From the perspective of the complainer, they are all legitimate. It is the contention of this author that more rather than fewer complaints should be included in the formal system of complaint management.

Handling the Complaint

Unfortunately, the staffs and leaders of many organizations react adversely to complaints, ignoring them, which in turn perpetuates the problem. Complaints are most appropriately viewed as an "asset." On one hand, complaints create additional and sometimes difficult work for the CM. On the other hand, the person who calls and lets the organization know that the service or system didn't work cares enough to let the leaders know about the failings. Only by seriously considering the complaint does that person have the potential to be satisfied and does that problem have the potential to be resolved, now and in the future.

The CM should demonstrate concern, sincerity, and empathy, conveying the feeling that the perceived problem is important to the manager. In one sense, all emergency practitioners are experts at handling complaints, because it is part of the ED routine when trying to assess and respond to the patient's medical problem. It is simply a matter of putting the same effort into managing the service complaint. The CM may be able to rapidly change the complainer's perception by starting with a positive and empathetic attitude. The message should be some form of:

Thanks for letting me know. Your experience is a real concern to me. I'm going to investigate it now and get back to you.

Complaint managers who are continually trying to improve their systems may say with sincerity:

Your call comes at an opportune time. I am looking at ways to improve our service. What happened? How is the patient doing now?

This type of attitude displayed to a complainant may actually transform the complainer's self-perception from a slighted, depersonalized object into a valued consultant. Thus, the first step in resolving the complaint has been taken.

Determining the Issue

The second step is to find out what the complainer really wants, which can be accomplished only by hearing it from the complainant's perspective. The goal is to allow the person to

BOX 76.4 ■ COMPLAINERS WANT RESOLUTION

- Respect and understanding
- Immediate investigation and follow-up
- Censure
- Assurance of nonrecurrence
- Compensation or reduction of the bill

leave the conversation thinking "I'm glad I called. I've made a difference." People who have complaints want one or a combination of the following (**Box 76.4**):

- ***Respect and understanding***: It is necessary for complainers to believe that the CM sincerely wants to hear about and resolve the issue, that it *is* important. Empathetic listening may itself provide the caring and compassion that were missing from the initial interaction, which in many cases is all the complainer wants.
- ***Immediate investigation and follow-up***: The genuine desire to address the issue can be demonstrated by simply agreeing to perform an immediate and thorough investigation and promising rapid follow-up. The powerful message conveyed by this sincere approach lets the complainer know: "You are so important that I will promptly address your issues and report back to you." A neglected person who has been frustrated by the system is now able to establish some control and a promise of action.
- ***Censure***: Some complainers have been so slighted by the process that they believe satisfaction can best be achieved by some form of punishment, reprimand, or censure. These people want to know that the responsible person "will pay the penalty." This most often occurs as the result of uncaring, inattentive, or rude behavior exhibited by a caregiver. While the CM cannot share specific actions related to a clinician, he or she can describe the general quality procedure, including investigation and action based on the results of that investigation, without describing the specific results. If convinced of the CM's sincerity, this explanation usually satisfies those looking for "censure."
- ***Assurance that the problem will not recur***: It is very satisfying to conclude an interaction knowing "I've made a difference." If the CM is able to transform the complaint into a system or a behavior change, the complainer can walk away with the feeling that he or she has improved the system and the care rendered to others who follow. Though these complainants may not themselves achieve a change in the care they personally received, they can achieve the satisfaction of their "altruistic" action: "My experience will improve the experience of others."
- ***Reduction of the bill***: Many complaints occur at the time the bill is received. For a variety of reasons, the patient may not believe the service rendered justifies the bill received. These patients will want reconsideration of the charge. Patients with a complaint about the bill may be satisfied with a negotiated reduction of the bill. Some will ask for complete elimination of the bill, and a few may even request compensation.

The Complaint Manager

To achieve the greatest success and effect the greatest system improvements, it is necessary to formalize the complaint-management process. A formal approach requires hardwiring

BOX 76.5 ■ COMPONENTS OF A COMPLAINT SYSTEM

- Complaint manager
- Situation assessment form and process
- Systematic tracking process–Log
- Follow-up and reporting mechanism

several integrated processes (**Box 76.5**). To ensure consistency, a CM should be identified to assume responsibility for the overall management of complaints. This CM should be a person with leadership skills, integrity, and the authority to effect change. By creating the position and title, the potential other recipients of a complaint (administrator, chief of staff, etc.) are prompted to immediately forward the complaint to the identified complaint handler.

Preferably, the CM will be the nursing or physician director or associate director of the department—a person with the imprimatur of leadership and authority. If a complaint is received involving the person who typically handles the complaint, then it is appropriate for another person to manage the process.

The Situation Assessment

A sample situation assessment form is provided in **Figure 76.1.** (Note: The form is presented as a single page for the convenience of the reader. An actual completed situation assessment form might be longer because specific sections require expansion to thoroughly document all aspects of the complaint.)

Identifying Information

Using this form, the patient name and medical record number are placed on the top of the sheet, as well as a unique identifying number particular to the tracking system ("log"). Practitioners may also be identified by a number, rather than by name, when referring to them in the body of the situation assessment. For instance, in the example that follows, Dr. Smith is referred to as "emergency physician #107," and Nurses Jones and Peters are referred to as "emergency nurses #2214 and #1020," respectively.

Dates

Delineating the dates of service, complaint, and resolution is valuable because it gives an indication of the type of complaint, as well as helps to track the responsiveness of the system. A complaint expressed immediately after care is rendered implies a problem with the care or caring. A complaint articulated weeks later may be related to the receipt of the bill. A review of the average time between date of complaint and date of resolution will measure the efficiency of the system. It might be appropriate to have an additional line for "date complaint received," particularly in institutions that do not immediately forward complaints to the ED CM.

Types of Complaints

Differentiating the type of complaint into various subtypes, such as quality, attitude, and length of stay, allows data trending. The trends may then be used to create a focus of individual or system improvement and monitor the success of those efforts. A single complaint may involve more than one subtype.

Sources (Initiated By)

Anyone can be the source of a complaint, so access to the system should be easy. The complaint can arise from a patient (oral or written), physician (directly or by word of mouth),

FIGURE 76.1 ■ Situation Assessment Form

ABC Hospital Emergency Department
Performance Improvement program
Situation Assessment

Patient ____________ **ID#** ____________ **LOG#** ____________

Type of Complaint

Date of Service ______	___ Attitude	___ Cost of Care
Date of Complaint ______	___ Documentation	___ Follow-Up Instruction
Date of Receipt ______	___ Length of Stay	___ Other (Specify)
Date of Resolution ______	___ Quality of Care	____________

Initiated by:	**NAME**	**DATE**
___ Chart Review	____________	______
___ Hospital Administration	____________	______
___ Nurse	____________	______
___ Patient	____________	______
___ Physician	____________	______
___ Billing Rep	____________	______
___ Other	____________	______

Sources of Information: ____________

Issue: ____________

____

Investigation: ____________

____

____

Assessment: ____________

____

____

Discussed with:	**NAME**	**DATE**
___ Emergency Nurse	____________	______
___ Emergency Physician	____________	______
___ Patient (Family)	____________	______
___ Private Physician	____________	______
___ Hospital Representative	____________	______
___ Billing Representative	____________	______

Rating: Standard of Care Met ___Yes ___+/- ___No

Adverse Patient Outcome __0 __1 __2 __3 __4 __5

Investigated By:	**Signature**	**Date:**
____________	____________	______

Practitioner:		
____________	____________	______

or a staff member. Other sources include legal inquiries and routine chart reviews, such as 72-hour return visits, that may uncover possible problems of care and become an entry point into the system.

Assessment

The actual assessment generally contains three components: the issue, the investigation, and the resolution. The assessment may at times require in-depth documentation of the information gathered.

The issue: The issue is ascertained by discussion with the complainant and review of the records. The perspective of the complainant should be documented in an objective manner. For instance, a patient might state, "The doctor was a jerk and treated us like animals!" This could be documented as: "The patient was angry and felt emergency physician #107 was rude and uncaring." The issue section should be brief, concisely describing enough detail to understand why the complaint is being lodged and to direct the subsequent investigation. Occasionally, the complainant describes several issues. Each should be delineated in this section and then addressed in the subsequent process of investigation and resolution.

The investigation: This investigation section of the form should begin with a description of the sources of the investigation and end with the results of it; for example, "The following sources were used to investigate this case: the patient, the medical record, emergency physician #107, emergency nurses #2214 and #1020, and *The ABC Textbook of Emergency Medicine*."

The investigation is driven by the desire to objectively determine what actually occurred. To be effective, the CM must gather information without preconceived notions of right or wrong. It is normal to empathize with the point of view of the complainant; however, the complainant, no matter how compelling, represents one side of the story. It is inappropriate to adopt any point of view that would cloud objectivity during the investigative portion of the complaint-management process. Investigation is not meant to assess blame but rather to clarify perceptions and performance. In other words, when approaching the practitioner, the query should be without reproach or criticism; for example, "It was Mrs. Smith's perception that her care was . . . What happened?" Each person implicated or with substantive information to add should get an opportunity to describe the occurrence from his or her own perspective.

The resolution: The resolution must address each concern raised in the previous sections of the form. The goal is to educate, improve performance, and correct inappropriate behaviors, faulty perceptions, and misinformation. Follow-up and feedback are critical to the complaint-management and behavioral modification process. It is incumbent on the CM to communicate to both the complainant and to the complaint recipient that the process has been completed. Complaint-specific resolutions are presented in detail later in this chapter. **Table 76.1** lists problems with typical resolutions. Complaints may require specific actions to effect a change in behavior, fill a knowledge gap, etc.

However, the CM will also determine that many complaints, after investigation, do not require any change in the system or individual behavior. Follow-up and feedback from positive

TABLE 76.1 ■ Potential Problems and Solutions

Problem	Example Resolution
Misread x-ray	Review x-ray; if trend or significant misread, read chapter and spend time with radiologist
Misunderstood process (i.e., referral)	Perform in-service (by complaining practitioner)
Delay in care	Improve lab reporting system Decrease door to doctor time Shorten triage process Implement staffing change
Perceived but not actual incorrect care	Explanation to patient, supportive feedback to practitioner
Behavioral issue	Coaching practitioner with expected standards of behavior

TABLE 76.2 ■ Standard of Care Assessment

Symbol	Standard of Care
+	Met
+/−	Questionable
−	Deficient

assessments are particularly valuable. The CM not only satisfies the complainer by a thorough investigation and follow-up but also supports the caregivers by a positive conclusion.

Signature

The final sections of the form identify the individual caregivers, rate the care, and provide an opportunity for feedback by the caregiver. It may be judicious to complete these sections on a subsequent page to avoid having ratings visible to all who might read the complaint and its investigation. The CM or person investigating the complaint determines a rating and then signs the form. The involved physician or nurse reads, signs, and may make a comment on the form. This process ensures that the practitioner has knowledge of the complaint, investigation, and conclusions. Occasionally, the CM may draw a conclusion that is erroneous or lacks complete information. In these cases, the review by the practitioner allows appropriate modification.

Full disclosure is another reason for practitioner review. Since the complaint file resides in the practitioner's file, it is inappropriate to hold this information without knowledge of the involved person. Concealing the information limits the opportunity to change and improve. Further, if the information only surfaces subsequently when the practitioner is applying for another position, the CM might be subjected to legal scrutiny.

Rating

The rating system describes the final appraisal of the issue's significance. The rating should incorporate two elements. First, the CM must judge whether the standard of care has been met (**Table 76.2**). If the standard of care has not been met, there must then be a determination of whether an adverse patient outcome (APO) occurred as a direct result of the deficiency (**Figure 76.2**). If the standard of care was met and the patient has a poor outcome unrelated to the standard of care, the rating will not reflect an adverse outcome. (Examples are illustrated in **Table 76.3.**)

FIGURE 76.2 ■ Adverse Patient Outcome Grid

Symbol Type	Change in Patient Outcome/ Management	Examples (management changes directly attributable to a deficiency in standard of care)
0	None	
1	Minor-temporary	Additional visit, splint antibiotics
2	Minor-permanent	Facial scar, decreased function fifth digit
3	Major-temporary	Ruptured appendix, pneumothorax, ICU care
4	Major-permanent	Loss of functional use of limb, cardiac cripple
5	Death	

TABLE 76.3 ■ Rating System Demonstrating Relationship of Standard of Care (SoC) and Adverse Patient Outcome (APO)

Issue	SoC	APO	Explanation
Iatrogenic pneumothorax	– (deficient)	3 (major, temporary)	Deficient SOC caused APO
[a]Patient death	+ (met)	0 (no negative outcome related to SOC deficiency)	SOC met, even though patient did not survive resuscitation
Poor documentation requiring re-evaluation	– (deficient)	1 (minor, temporary)	Deficient SOC caused APO, leading to additional patient care
[a]Rude practitioner	– (deficient)	0 (no change in outcome)	No resultant adverse outcome

[a] In these cases, there was either no APO or the APO was unrelated to a deficient SoC (The previously published example).

The Tracking Log

The log is a tracking mechanism used to document in a single and consistent manner the essential data and status of all complaints (**Figure 76.3**). Information entered directly into the log correlates with information on the situation assessment form. At minimum, the log should be used as a tracking system to identify the patient, nature of the complaint, its current status, and resolution.

A more sophisticated log can be used to trend data and extract a variety of information about the caregivers and the provision of care in the institution. For instance, a comprehensive log can be used to determine the number of complaints, types of complaints, and outcome data. The number and types of complaints broken down by individual can be used to create comparative data. When comparing individual caregivers, it is important to factor in the variations in practice, that is:

- Number of patients cared for and hours worked by each health-care professional—the denominator
- Types of shifts worked (days, nights, swing, fast track)
- Complaint type, severity, and patient outcome

FIGURE 76.3 ■ Example of a Complaint-Management Log

Name	Date of service	Date of complaint	Date of resolution	Type	Investigator	Provider number	Assessment complete	+/- 0-5	Comment
R Jones	6/6/12	6/8/12	6/11/12	Attitude	RS	27	✔	-/0	Provider counseled
W Clinton	5/4/12	6/13/12	6/15/12	Quality	GN	19	✔	-/1	CME required
A Einstein	5/11/12	6/19/12	6/19/12	Cost	RS	36	✔	+/0	No action required
M Jordan	6/18/12	6/25/12	6/28/12	Quality	RS	44	✔	+/0	Follow up with orthopedist (complainant) - in service
M Ghandi	7/1/12	7/1/12		Attitude	GN	27	✔		

Over time, an effective tracking mechanism can expose or confirm system and individual problems such as delays, attitude, quality, and cost-of-care issues. Attention to the outcome data may quickly identify individuals whose care is associated with poor outcomes or a "particular type" of poor outcome. For example, a caregiver with several complaints and an APO of 0 may be delivering high-quality care but low-quality caring. Alternatively, a professional who has more than one case per year with an APO of 2 or greater is likely to have significant quality of care problems.

Follow-Up and Reporting

The complaint-management process is not concluded until the appropriate stakeholders are notified of a resolution and the completion of the investigation is documented in the institution's quality management system.

When possible, the CM should contact each complaint source. While not all persons registering a complaint will achieve complete satisfaction, it is usually possible to provide them with the gratification of knowing that their issue was reviewed and addressed quickly and with respect and sincerity.

Further, it may be appropriate to send a letter to the complaining party thanking him or her for sharing the issue with you. An example of such a letter:

> *Dear Mr. Jones:*
>
> *Thank you for taking the time to let us know how we can better serve you. Your direct feedback about our services is vital to us. Though we closely monitor the medical care in our department, evaluating the perceptions of the patients and their families is more difficult to assess. Letters (feedback) such as yours are the best means we have of determining how well we are achieving our goal of providing excellent medical care in a caring manner. I am encouraged that part of your experience was positive. I hope that should you or your family need emergency care in the future that you again consider _____ Hospital.*
>
> *Sincerely,*
>
> _____
>
> *Director, Department of Emergency Medicine*

Joseph E. F. Shanahan, MD, personal communication,
ED Medical Director, Chicago, IL

Caregiver Follow-Up (Monitoring Performance)

Comparisons of performance against individual benchmarks and within the group are measured and trended over time. Initially, it may be necessary to compare practitioners with their cohorts to persuade them to change. Some practices openly share this information. In the long run, it is more important for practitioners to be made aware of their own strengths and weaknesses so that they can recognize and address individual areas for improvement. Regular feedback can also demonstrate progress and provide positive reinforcement.

An effective monitoring system identifies practitioners with particular types of deficiencies. When a trend is noted, the CM should provide direct feedback to the individual caregiver and, when appropriate, develop a plan of corrective action. This should be communicated and agreed to in both orally and in writing.

Reporting and Confidentiality

The complaint-management process is an essential part of the overall performance improvement program. Practitioner complaint data can be incorporated into the credentialing and reappointment process. When discussing, documenting, and reporting

situation assessments, it is imperative to avoid specifically referring to the practitioner. Names should not appear on any circulated data. Many systems use coded numbers to identify staff members. To maintain the tightest security, some EDs have their own coding system separate from the hospital's system, which can only be decoded by quality management personnel in the institution.

As with all performance improvement materials, situation assessments should never be circulated except on a limited "need-to-know" basis. If these materials are widely available, they lose the protection of confidentiality usually afforded to peer-review activities. Situation assessments should not appear in e-mails, either by reference or attachment, unless part of a secure intrafacility system. In some institutions, situation assessments are distributed for discussion during departmental performance improvement meetings and collected at the conclusion of the meeting. Participants in the process, including the support personnel who gather the materials and enter data, must be made aware of the significance, sensitivity, and confidential nature of these documents and processes.

The Four Phases of Implementation

When first implementing a complaint-management system, the CM should be prepared for the four typical phases, including preimplementation (planning and communication) and testing.

Preimplementation

The CM should promote the new, improved, and perhaps, more comprehensive system. Explaining the "enhanced" program at executive committee and the nursing directors' meeting has the potential to positively change the clinical leaders' perceptions of the ED. Beyond the general announcement, it is beneficial for the CM to meet individually the chief medical officer, chief nursing officer, chief of staff, department chairs, and other institutional leaders to accomplish two goals:

- Share information about how to use and activate the program (trip the system).
- Gain commitment from the leader to both utilize the system and encourage others who complain to communicate their issues directly to the CM. Rather than sympathize with the colleague, they can say, for example, that the doctor or nursing director is looking for ways to improve the ED services and "why don't you share your experience with her."

Once a new complaint-management system is implemented, the CM should be prepared for three typical phases of utilization: testing, high utilization, and steady state.

Testing Phase

Some older complaints that were previously ignored or unrecognized will be sent. Complainants who may have had particularly difficult encounters may angrily share their negative experiences, even though some are remote, perhaps occurring months or even years ago. They will be testing the sincerity of the CM and the effectiveness of the system.

High Utilization

A moderate increase in the number of complaints may follow the first phase. Positive experiences will encourage clinical colleagues to express their concerns about how they or their patients were handled. While this phase might seem burdensome, system users are giving the ED the chance to address their issues and improve the services.

Steady State

If the complaints are managed effectively and the "root causes" of the complaints are addressed, CMs will enter a low-utilization steady-state phase.

CHANGING PERCEPTION AND BEHAVIOR

This section provides examples of and reviews the most common ED complaints and then describes the basic techniques for resolving these complaints. After defining the issue, the resolutions will be examined from two perspectives. The "retrospective solution" will deal with the complaint that has already been voiced. This process focuses on damage control and satisfying a dissatisfied person. The "prospective solution" will describe prevention strategies, specifically examining the behavior or the system that has been identified as a problem.

The common complaints that will be reviewed in this final section of this chapter are listed in **Table 76.4.** Every CM will confront these issues.

Managing Actual Complaints

When possible, the CM should collect relevant information before talking with the complainant. Responding to a complaint without information is like walking in a minefield. If an assistant answers the phone, that person should make arrangements for the CM to return the call. Prior to the call back, the CM should obtain the chart and critically review the records with an eye for the appropriateness of the medical care. If it is not possible to prepare for the complaint in advance with a copy of the chart, the following approach will create the necessary time to review and respond to the complaint:

- Take all of the information.
- Empathize: "Given what you are describing, I can understand why you might be upset."
- Promise to call back after an investigation.

Dr. Zippy: He only saw me for 30 seconds!

"He never touched me" or "He only saw me for 30 seconds and his bill was $400. That means he's making $48,000 per hour! No wonder health care is so expensive!"

TABLE 76.4 ■ Typical Complaints Received by ED Leaders

Focus of Blame	Perceived Issue
Dr. Zippy	"He only saw me for 30 seconds . . ."
Molasses General Hospital	"I waited so long . . ."
Mercedes Medical Center	"Your charge was way too much . . ."
Dr. Frankenstein	"But he was dead when he got there . . ."
Nurse Jerkyl	"The nurse yelled at me for coming to the ED . . ."
Dr. Vesuvius	"He blew his stack at the nursing station again."
Dr. Terry Bradshaw	"The Monday morning quarterback"
Dr. Blunder	"He missed my child's broken bone . . ."

At Issue

This patient is expressing concern about one of three problems:

- Lack of caring and thoroughness
- Possible missed problem
- Expense of the bill.

To respond effectively to the actual concern, the CM must listen carefully and ask questions to determine the true nature of the patient's complaint. If the review demonstrates a consistent pattern of complaints related to a particular practitioner, a clinician-specific problem may exist.

"Dr. Zippy" appears in a variety of forms (**Figure 76.4**). He or she may be lazy, unconcerned, or simply lack an understanding of what patients want. Some practitioners are good "openers"; they evaluate the patient near the beginning of their emergency visit but don't provide closure. They do not tell the patient the results of test, summarize, or provide the opportunity for the patient to ask questions. Instead, these physicians send in another professional (such as a discharging nurse) to act as a designee.

Other physicians may be good "closers," only arriving to meet the patient for the first time after the decisions have been made. Such a doctor may believe the patient has come to the ED for a simple answer to a simple question, "Is it broken?" or "Do I need to be admitted?"

Patients want more than an answer. They want time and touching. They want caring, compassion, and consideration.

Retrospective Solution

Once the specific nature of this complaint is determined, the CM can address the issue. Perceived poor caring during the initial visit can be addressed by demonstrating compassion and concern during the current conversation. Additionally, the CM can ensure appropriate aftercare by offering to have the patient return or helping to arrange an appointment with the patient's PCP. Addressing the patient's concern may help:

- Satisfy the patient.
- Resolve any ongoing medical issue.
- Address a missed problem.

Prospective Solution

If the system identifies multiple practitioners with complaints of too little patient communication, then the staffing pattern might require review. However, an individual caregiver who regularly gets a complaint of not enough time or caring requires retraining. Education for this clinician entails teaching him or her how to provide the patient with early contact, middle contact, and late closure. With only a single visit, the patient may believe that the caregiver has only a fleeting awareness of the patient's presence. Evaluating the patient at the beginning of the visit, updating in the middle, and providing a conclusion at the end create in the patient the belief that the practitioner is aware of and concerned about the patient during the entire visit.

There are several simple techniques that this practitioner can utilize. Sitting with good eye contact will increase the perception of time spent without necessarily increasing the actual time spent. Multiple short visits to keep the patient informed will increase the perception of caring. Scripting or using a "key phrase" may be helpful (see Chapter 74). The perceptions of the patient, who might otherwise feel ignored, will improve if "Dr. Zippy" simply states, "It's important to me that I spend enough time with you to address your medical problems and answer your questions."

Molasses General Hospital

"I waited forever!" or "Those party animals! I kept waiting in pain and nothing was done. The staff was just sitting around laughing and figuring out what they were going to have on their pizza!"

At Issue

The two most important issues for patients who have a choice of where they get their emergency care are convenience and caring. Convenience means easy access and parking, efficient systems, and being evaluated and treated quickly so that they can return to their routine. However, even ED leadership and hospital administration that continually work toward implementing effective means of improving turnaround times cannot always provide efficiency.

When unable to deliver convenience and efficiency, providing a caring environment becomes even more important to patients and their families. While the quality of care is essential to those delivering it, most patients lack the sophistication to scrutinize the actual quality of care provided, and so: Emergency caregivers are usually judged more for the level of caring than for the quality of care.

Retrospective Solution

When confronted by a patient who complains about lack of caring, it is necessary to demonstrate empathy with an expression of understanding. People who complain that they were not taken care of in a timely and caring way when first seen are asking to be taken care of in a timely and caring way now. It is often enough to acknowledge and validate the concern: "Yes, it is frustrating to wait when your child is in pain. How is he doing now?" There is very little to offer other than empathy and a promise that you will investigate the delay and get back to them.

Prospective Solution

Particularly during the periods of time that the ED is unable to provide rapid and efficient care, it is necessary to provide "caring" care. Methods include the following:

- ***The sit-down approach.*** Whenever possible, when obtaining a history, practitioners should sit with the patient. Sitting often results in a more efficient communication, because patients may be more trusting and specific when the practitioner sits at eye level and appears unrushed. This approach demonstrates a willingness to spend the time necessary to complete the evaluation.
- ***The frequent touch.*** Some practitioners walk by patients as if wearing blinders. Clinicians state they are worried that if they make eye contact, the patient may try to pull the practitioner away from the important matters at hand. In fact, a comment such as "Mrs. Jones, we are waiting for your lab tests to come back. Is there anything I can do for you?" or "Are you okay?" will usually not result in a demand but rather demonstrate that the practitioner is concerned and caring. Most patients respond with a smile and a "Thanks, I'm okay." Some may request for something to make them more comfortable. Occasionally, patients may describe a change in their condition. And always they are appreciative. Patients' perceptions of caring and satisfaction are higher when multiple clinicians regularly check on them.
- ***Provide realistic expectations.*** When providing care in a busy setting, patients particularly appreciate a realistic appraisal of what to expect the duration of their visit. Many patients in an ED do not have an appreciation of the many steps

involved in rendering care. Describing the steps in the evaluation, estimating (perhaps even slightly exaggerating) the time, and providing occasional updates will both keep the patient informed and decrease the anxiety associated with not knowing what to expect.

Mercedes Medical Center

"I can't believe they charged me this much money! All they did was . . .."

At Issue

For many CMs, the majority of the complaints come at the time the patient receives the bill. However, it is a mistake to assume that this is simply a patient trying to get out of paying for service. The CM must listen carefully to discern the patient's concern. The three most common reasons for a billing complaint are limited ability to pay, perception of inappropriate bill, and dissatisfaction with care.

Retrospective Solution

When addressing these concerns, reason should prevail. If a bill is decreased or eliminated, it is important to clarify that the change in the patient charge is related to enhancing patient satisfaction rather than addressing poor quality care. The appearance of the latter could be perceived as an admission of guilt.

- ***No money***: Some patients may voice dissatisfaction with the care, the lack of care, or the cost of care because of their inability to pay the typically expensive bill generated by a visit to the ED. An uninsured or underinsured patient may have great difficulty paying a charge of $1,000. When cost is recognized as the issue, a patient may be satisfied to develop a payment plan and avoid being sent to collection. On occasion, it may be appropriate to write-off part or all of a bill. However, write-offs should be carefully considered to avoid developing a reputation as the "no charge ED" in the community. Usually, patients are willing to pay part or most of the bill, and it is reasonable after the discussion to say, "I understand that it is difficult to pay this bill, would you be able to pay . . .?" or, although somewhat more risky, "What do you think would be fair?"
- ***Inappropriate bill***: Occasionally, the bill is incorrect. Removal of a superficial tick may get coded mistakenly as a removal of a deeply embedded foreign body. When an incorrect bill is brought to the attention of the CM, it is appropriate to apologize, correct the bill, and make an immediate change in the billing process. With acknowledgment of this last step, the patient will feel like he or she made a difference. Without it, the patient may believe that the ED is trying to gouge the public and trying to get away with it.

Explanation of Charge Reduction

When a bill is decreased or eliminated for either of the two reasons above, it is appropriate to send an explanatory letter to the patient. There should be no reference to having done anything wrong in the provision of care. Instead, describe the reason for the change as a means of satisfying the patient and maintaining the patient's patronage, such as:

> *I understand that you are not satisfied with the bill you received as a result of your visit to the ED. Your satisfaction and patronage are important to us at XYZ Hospital and for that reason we have decreased your bill to $_____. Thank you for the opportunity to discuss this matter. I hope that in the event you require emergency services in the future, you will again give us the opportunity to serve you.*

Dissatisfaction With Care

The third reason a person may complain about the bill is because of dissatisfaction with the care—a quality issue that should be addressed directly. The CM should find out in what way the patient's expectations weren't met, investigate the situation, and get back to the patient quickly.

A variation on this theme arises when follow-up reveals a poor outcome, and upon review, the quality of care is questioned. Because an expensive bill may be perceived as adding "insult to injury," some CMs advocate not sending a bill in this situation. However, this practice is potentially dangerous. If it is discovered that the bill was intentionally eliminated, a plaintiff's attorney will argue that the decision not to bill is "evidence of guilt." It might be wise to obtain counsel when deciding whether or not to reduce a bill in this circumstance.

Prospective Solution

The best prospective solutions for managing the bill are to ensure compliance (accuracy and appropriateness) and deliver high-quality care and caring. An organization that effectively provides the first three of the four "Cs" **(Box 76.1)**—convenience, caring, and care—gets fewer complaints about the fourth—cost. Nonetheless, it is inevitable that an ED will receive some complaints about the cost of care. ED care is very expensive. With increasing scrutiny by various payors, each facility should review its charge structure to be certain that it remains competitive.

It is judicious for ED and administrative leaders to coordinate charge reductions both for individual patients and in general. It is unfair for the hospital administration to ask the ED to decrease its bill while continuing to charge a full facility fee. Alternatively, the ED leaders might ask the hospital to reduce its bill. The strategies for bill reduction should be well thought out and organized.

Dr. Frankenstein: But He Was Dead When He Got There

The ambulance arrived and I overhead them say there was no chance . . . but they kept working on him. I'm not sure why. And now I've got this huge bill. Why are you charging me so much? He was dead!

At Issue

This is a particularly poignant variation of "too much money." (See "Mercedes Medical Center" earlier in chapter.) Clearly, the anguish and suffering associated with the grieving process are only compounded by the receipt of the very large bill that typically follows a resuscitative effort. This situation becomes particularly distressful when the grieving party believes that "there was no chance" or that "you were working on the dead body of my loved one." Arguing with the grieving person or trying to explain how the billing process works will only reinforce the belief that the institution and its representatives are uncaring and only interested in money.

Retrospective Solution

The grieving person may be distraught and dealing with many unresolved issues. It is important to empathize, acknowledge, and validate the concern, for example, "I'm very sorry your husband died. It is difficult to deal with money at a time like this." If the CM is a good and patient listener, the grieving relative may soon be ready to listen. It then

may be appropriate to explain the situation in a way that demonstrates compassion and caring.

The resuscitation team was called. We really thought that there was good reason to try our hardest to resuscitate your husband. We performed x, y, and z just as the American Heart Association recommends, but unfortunately he didn't survive. We did the best that we could. However, I understand that what you're going through is difficult, and it is a lot of money. Let's work something out.

Prospective Solution

Some EDs and hospitals, by policy, do not bill for care rendered to patients who are dead on arrival (DOA). Though the definition of DOA may vary broadly, the intent is usually the same—to avoid the additional burden of an expensive bill to an already grief-stricken family. In this situation, it may be appropriate to send a letter of condolence describing your concern for the grieving spouse and your resulting determination to eliminate the bill. This practice allows the department to give solace and get credit for the good deed. The process of forgiving a bill should be done in a way that does not imply that something went wrong. (See "Mercedes Medical Center: Too Much Money" earlier in chapter.)

Nurse/Doctor Jerkyl

"She yelled at me because I came in last week for the same thing. Well, it wasn't better," or "He said that this is an ED, and that my case was not an emergency. Well, it was to me and to my own doctor, who admitted me the next day!"

At Issue

It is difficult for some practitioners to understand that everyone has his or her own definition of an emergency. Instead these practitioners are often intent on explaining how the ED works rather than listening to the patient's issue. The pedantic attitude is humiliating to the patient. Worse still, the reprimand may be dangerous if, as a result, the patient is reticent to seek appropriate care in the future.

The caregiver may justify the lecture stating that he or she is just educating the patient. The patient, on the other hand, may believe that the practitioner is arrogant, lazy, and unwilling to spend the appropriate time with the patient. There is an expression: "Jerks who are right are jerks; jerks who are wrong are defendants." When insulted, the patient may get angry. When things go wrong, the patient may seek retribution.

Retrospective Solution

Once it is determined that the complaint is about practitioner rudeness or inappropriate behavior, the CM should empathize and agree to quickly investigate and get back to the complainant. If the patient believes that the practitioner was disrespectful, the CM has the opportunity to give the patient the caring and compassion that was initially lacking. The CM may wish to describe the expected standards of behavior, including respect and courtesy. It is acceptable to admit guilt about caring, but not about care.

"It seems that you've been treated rudely, and we did not meet either your or our expectations. This type of attitude is unacceptable. Thank you for letting me know. I will investigate it and get back to you on Tuesday."

During the follow-up conversation, the CM will, ideally, apologize on behalf of the practitioner: "Nurse/Dr. Jones is sorry that you perceived him as rude. It was not intended. In fact, he was very upset that you left dissatisfied. We both appreciate that you brought this to our attention."

Prospective Solution

If this is a consistent problem of a particular practitioner, it is necessary to create a behavior change. (Changing the behavior of an individual is beyond the scope of this chapter. However, this issue is addressed more fully in Chapters 78, 103, and 119.)

Dr. Vesuvius

A private physician on staff charges up to the nursing station and blows his stack again, screaming: "I can't stand to have my patients come to this ED! You never get anything right around here!"

At Issue

Following this type of outburst, there is consistent discomfort and embarrassment among those within hearing range, including the patients. Worse, if this criticism is directed at a particular person, that person may be humiliated.

Some medical staff members had their only significant ED experience during their residency. The memory of the ED may be a wild, uncaring, chaotic environment with nobody responsible or particularly interested. The ED rotation may have been brief and distasteful, with the only intent of providing exposure or meeting a service obligation.

Further, the non-ED medical staff members may be accustomed to a supportive private office staff that responds immediately to their needs (see Chapter 77). Arriving in the more clamorous, confusing, and seemingly disorganized ED environment may be very stressful. Unfortunately, some practitioners handle high-stress situations by becoming aggressive and blaming.

Retrospective Solution

Success with this type of physician requires maintaining a respectful countenance and then creating the understanding that the ED is the emergency physician's office that is in many ways similar to his or her office. As the ED leader, it is important that the ED staff members are treated with the same courtesy and respect that his or her own staff members deserve. It might even be helpful to make an appointment and go to the physician's office, which simultaneously demonstrates respect for the physician and the seriousness of the issue. Then the ED leader can:

- ***Define the issue creating the physician's ED outburst and address it*:** Once the nature of the problem that caused the frustration is determined, it can be acknowledged, explored, and, if appropriate, rectified. The disgruntled physician's issue must be heard with a commitment to investigation and resolution before he or she will listen and address the ED leader's concern.
- ***Describe your complaint-management process*:** The ED leader should encourage the complaining physician to raise concerns immediately and directly to the leader any and every time that there is a problem with the ED or the care being rendered there. The complainant should know the importance of the ED being perceived as a user-friendly environment and that ED leadership takes very seriously any concerns about the care provided there. Once the practitioner is convinced that the problem is a concern and will be addressed, the practitioner will then be in a position to help solve the ED leader's problem.
- ***Describe the ED as the office of its providers*:** The ED leader may share that he or she:
  - Assumes responsibility for the patients and staff in the ED, just as the private practitioner does in his or her office

  - ☐ Wants to create the most positive and caring environment for those who use the facility, just as the private practitioner does in his or her office
  - ☐ Would go directly and privately to the private practitioner's staff member if a problem surfaced, just as ED leaders would expect the practitioner to do
  - ☐ Would never go to private practitioner's office and complain publicly and would expect similar behavior from the private practitioner;
- ***Gain commitment to communicate directly when problems arise.***

Prospective Solution

The person expressing his or her discontent may not recognize the inappropriateness of the behavior. If a disruptive and inappropriate expression of emotion in this public arena is occurring, the ED leader may be able to intervene by doing the following (also see Chapter 8):

- When possible, the ED leader should walk up to, stand in front of, establish eye contact with, and get the attention of the dissatisfied person.
- Once the dissatisfied person is engaged, the ED leader may quietly and firmly say, "I can see you are upset. I want to find out more about the issue, over here, in private." Then the leader should walk the other person to a more private space. Once the practitioner is engaged with the ED leader and the leader is in a position of authority, it is likely that the practitioner will follow.
- It is important to address the practitioner's issue first and then follow the steps listed in the previous section, "Retrospective Solution."

Dr. Terry Bradshaw

"My doctor said that I had a ruptured appendix and that your doctor screwed up!"

At Issue

This patient is angry and wants satisfaction. It is important to recognize that by calling, the patient may be offering the only opportunity to resolve a high-risk situation. Ignoring the issue at this point is fanning the fire. It is essential to determine what the patient wants. However, in the long run, it may be even more important to ascertain if and why the physician criticized the ED care. The private physician may be upset with the care and inadvertently have planted a seed of discontent; may be angry with the ED, an emergency physician, or the hospital; or may be implicating another for his or her own protection.

Retrospective Solution

This case requires communicating directly with both the patient for damage control and the private physician to discourage future inappropriate and inflammatory remarks to patients.

***The patient*:** When talking with the patient, the CM should immediately demonstrate concern by listening carefully to the story and seek to understand what the patient wants as a result of this discussion. Even ask: "What would you like to see happen?" **(See Box 76.4.)** Perhaps it is to make sure that this mistake does not happen again. The patient may want the practitioner to be punished ("his head on a platter!"). The CM should agree to look into the situation and get back to the patient quickly.

If the care rendered was within the acceptable standard, then the CM must address the patient's perception and expectations. It is important to avoid further complicating the situation by impugning "Dr. Bradshaw" because this criticism may lead to a battle that the

ED is likely to lose. At the very least, it is important for the CM to empathize with the patient and try to provide a satisfactory answer. One response is the following:

Yes, I've talked with Dr. Bradshaw [private physician] and understand his concern. There are several ways to evaluate and treat abdominal pain. Dr. Jones [emergency physician] was very concerned about you and your pain. He performed the correct tests and encouraged you to see your doctor or return to the ED immediately if the pain got worse. He is sorry that you continued to be ill but is very glad to hear that you did follow-up with Dr. Bradshaw as he recommended.

If the care did not meet the standard, the CM must still address the patient's perception and help to meet his or her expectations. The CM must carefully avoid making statements that the patient might subsequently use against the ED, its practitioners, or the hospital. A statement to the patient that implies that poor care was rendered is equivalent to becoming the plaintiff's witness.

Dr. Bradshaw should discuss the situation with the private physician. The CM should make an appointment to meet with the physician in his or her own office. It demonstrates a level of deference that may help while trying to enlist the support of the private physician. It is important to ascertain why the physician denounced the patient's care. This should be done in a nonaccusatory manner, such as: "It was the patient's perception that you were not happy with his care in the ED and that you thought that the emergency physician provided poor care. How might we have done better?"

Usually when directly confronted with this type of situation, the private physician will recognize the gravity and implications of his or her conversation with the patient. As with "Dr. Vesuvius" earlier in this chapter, the CM should familiarize the complaining physician with the ED's complaint-management program and further emphasize your team's desire to provide excellent care. An effort should be made to gain a commitment to call directly when a perceived problem occurs. "Dr. Bradshaw" may be drafted by a request to participate the advancement of the department. Methods include designing a clinical protocol, giving a lecture, participating in a journal club, selecting upgraded equipment, and so forth.

Some private physicians when confronted with "the patient's perception" will deny that they had criticized the ED or the care provided. You can then state that you thought it was unlikely that he or she had disparaged the ED. After all, your team sees many of the private physician's patients and you would never allow your staff to voice concerns about the care that had led to the ED visit. You can be sure you have made a point that is likely to prevent future inappropriate remarks to patients.

Prospective Solution

The only prospective solutions to this problem involve techniques of prevention. The ED leaders should seek out physicians or groups of physicians who are unhappy with the care of their patients in the ED. As their issues are ascertained, the ED leaders can work with them to seek solutions, demonstrating eagerness to continuously improve ED care for the patients and those who care for the patients, the medical staff members (see Chapter 77): They may be drafted into the development of clinical guidelines. Above all, the leaders must assure them that providing the best care to their patients is of paramount importance.

Dr. Blunder

"The doctor told me my x-ray was okay, and now you tell me that my son has a broken bone!"

At Issue

Patients expect high-quality care and accurate diagnoses. They are sometimes intolerant of what they perceive to be mistakes. As in other complaints, this is a second opportunity to provide the correct care and caring.

Retrospective Solution

There are two important strategies in the resolution of this problem. First, it is necessary to ensure that the patient has gotten or gets the necessary care for the injury. If appropriate, the CM may demonstrate concern by bringing the patient back to the ED for further care. "How is your child now? Would you like to come in now, and I'll take care of him myself?" Alternatively, the CM may take the initiative to secure definitive care for the patient by making all the necessary arrangements with the PCP, orthopedist, and so on.

The second important strategy is to assure the patient that the system "worked." The CM may admit that, though not often, the first interpretation of the diagnostic image is not always correct. That is exactly why the ED developed a sophisticated system of overreads in cooperation with the radiologists. The system ensures that a second expert, a radiologist, reviews every diagnostic image taken in the ED. The CM should be in a position to say, "I'm pleased that the system works so well."

Depending on what the patient expects, such as that it won't happen again, it may also be appropriate to add, "Our system also requires that Dr. Jones (emergency physician) review the x-ray to become an even better physician."

Prospective Solution

The prospective solution involves three components: an overread system, patient education, and performance improvement.

- *Overread system*: Develop an effective protocol for overreading diagnostic images. Elements include those listed in **Box 76.6.**
- *Patient education*: Patients evaluated in the ED should always get a thorough and caring explanation of the continued management of the injury. As part of the discharge process, it is appropriate to advise the patient that, "Though I don't see anything wrong with your x-ray, we always have the radiologist review the films in the morning." By informing the patient of the overread system before discharge, subsequent misunderstanding and anger may be averted.

BOX 76.6 ■ ELEMENTS OF AN EFFECTIVE RADIOLOGY OVERREAD SYSTEM

- Rapid identification of misread radiographs
- Immediate notification of emergency personnel
- Determination of significance, and when appropriate
- Patient and physician notification
- Arrangements for follow-up care
- Documentation
- Emergency physician review of radiograph
- Emergency physician trending, and when appropriate
- Physician education

- *Performance improvement*: The performance improvement system must identify members of the department who misread radiographs, particularly those that lead to a subsequent change in patient management. (See adverse patient outcome [APO] 1 or higher in **Figure 76.2.**) Depending on the type, frequency, and seriousness of the misread radiographs, the practitioner may require further education.

COMPLIMENT MANAGEMENT

An approach based on responding to complaints alone is only part of a complete system. Most systems concentrate so heavily on complaints and "what went wrong" that the opportunity to recognize and share "what went right" is squandered. A comprehensive approach to performance improvement includes the management and promotion of compliments. Implementing a thoughtful "compliment management system" creates balance in the process of reviewing the clinicians' quality of care and caring.

The Logistics of Sharing Compliments

The comprehensive system should look for opportunities to praise, and even celebrate, success. A compliment tracking system demonstrates to all who participate in the quality system—practitioners, administrators, and even regulatory personnel—that the system is balanced and that excellence regularly occurs in the ED. The CM should look for, document, and incorporate compliments in the practitioners' performance appraisals.

Documented compliments, such as cards, letters, and e-mails, should be gathered and sent to the CM, department director, or administrative assistant for inclusion into the system. Department members who personally receive a compliment letter should also be strongly encouraged to submit the letter for processing through the compliment management system. Explain to those who are reticent, citing humility, that these letters provide balance to staff and institutional leaders, who usually only hear about what went wrong.

Processing of the Compliment

Once a compliment letter is received, copies should be made. A copy should be:

- Placed in the caregiver's file.
- Sent directly to the practitioner with a letter of congratulations. As an example, a card could be replicated onto one of several predesigned memos that begins with a congratulation, such as: "Lauren, congratulations and thank you for once again being recognized for your stellar care and upholding the "Crest of Values" of ____ Hospital." Or "James, we are proud that you are a member of our department." The copy of the compliment letter plus the card are then sent to "Lauren" (or "James") and prominently displayed in the ED for other department members to see and to have the opportunity to personally recognize the recipient.
- Sent to each member of a predetermined distribution list. Consider who would like to receive a letter demonstrating a job well done at the hospital. The CEO is constantly addressing problems, complaints, and unhappy customers, some of which are related to the ED. Imagine the pleasant surprise of seeing a note from the ED, expecting a problem, and being delighted to see the praise of a clinician who was appreciated for a job well done. The list of those copied can be determined by ascertaining who has a stakeholder interest in the ED and its success.
- Some leaders close the loop by sending a "thank you" letter back to the person who wrote the original compliment letter.

Example Compliment Letters

The following are the contents of two actual compliment letters received by a practitioner:

Dear Dr. ______,

We know that you were instrumental in saving our son ______'s life. We can't even begin to imagine our lives without him and are so grateful that he is healing. You are a very special person, and we would like to commend you and your staff for excellence in every area. We have a long road but are progressing. You will never ever be forgotten, and we will remember you in our prayers always. Thank God you were there.

God Bless You

Our Love,

The ______'s

Dear Dr. ______,

I've never met you, but I feel a great deal of gratitude for the kind of man you are. Nearly two weeks ago, my dear father-in-law, ______ ______, was admitted to the ______ ER following a massive stroke. You admitted him in the morning and pronounced him dead in the evening. In the meantime, according to our family who were present with him, you were a clear, strong, honest, compassionate presence.

______ was a bright light for those of us in his world. He was a deep thinker, a professor of East Asian religion, a lover of poetry and music and beauty. We thank you for your help in allowing his safe and peaceful passage from this world.

With gratitude,

______ ______

These written compliments were sent to the provider with a cover letter of congratulations for a job well done. The congratulatory notes and letters were then distributed widely throughout the institution. They had an incredibly positive effect on the hospital's chief medical officer, who often deals with physician problems; the CEO, who expects the vast majority of written material to create more work; and all the others who share responsibility for the institution's success.

CONCLUSION

The management of complaints is a critical function of ED leadership that performed properly can transform angry or disappointed patients, staff members, and other important stakeholders into satisfied customers. Going further and seeking and resolving the root causes of the complaints can smooth operational inefficiencies, improve behaviors, and substantially reduce the number of complaints. Adding a robust compliment management system encourages best practices and boosts morale by recognizing and promoting the exceptional work routinely performed in the ED.

APPENDIX 76.1: SCHWAB CASE RATING SYSTEM

Richard M. Schwab, MD, personal communication, Previous ED Medical Director, Holy Name Medical Center, Teaneck, NJ

0 *No clinical issue identified*: Includes events that may be related to cost, utilization, or other factors not specific to patient outcome. Tracking data from this category may provide opportunity to identify trends useful to department or hospital-wide management.

1 *Not practitioner-related*: Includes events causally related to factors intrinsic to the patient (i.e., underlying disease, biologic/anatomic variation, hypersensitivity reaction in absence of history of allergy), institutional support (i.e., delayed turn around for lab/x-ray studies, unavailability of scans), or care provided outside of hospital. Trending data from this category may demonstrate trends useful for departmental or hospital-wide management.

2 *Practitioner-related*: The following subcategories should include those events that either individually or collectively are related to specific practitioner. Data from these categories are trended and will allow department chairpersons and practitioners to identify opportunities to enhance practice in terms of quality, effectiveness, or efficiency.

2a* *Predictable Event Within Standard of Care*: Refers to events that are widely reported in literature, may be anticipated, and are relatively frequent. "Within Standard of Care" indicates care was provided in accordance with contemporary standards of the specialty and departmental staff.

2b* *Unpredictable Event Within the Standard of Care*: Refers to events that are infrequent and not anticipated but have been described in literature to occur in cases where the standard of care is met.

2c *Marginal Deviation from the Standard of Care*: Refers to care that is "minimally" outside the contemporary standards of the specialty or expected standards of the department.

2d *Moderate Deviation from the Standard of Care*: Refers to care that is "moderately" outside the contemporary standards of the specialty or expected standards of the department.

2e *Significant Deviation from the Standard of Care*: Refers to care that is gross departure from the expected standards of the department.

*Both category 2a and 2b meet accepted standards of care.

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