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Patient Complaints in General Practice seen through the lens of professionalism

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Abstract

Background

Professionalism is a key competence for physicians. Patient complaints provide a unique insight into patient expectations regarding professionalism. Research exploring the exact nature of patient complaints in general practice, especially focussed on professionalism, is limited.

Aim

To characterise patient complaints in primary care and to explore in more detail which issues with professionalism exist.

Design and setting

A retrospective observational study in which all unsolicited patient complaints to a representative out-of-hours general practice service provider were analysed over a 10-year period (2009–2019).

Method

Complaints were coded for general characteristics and thematically categorised in themes using the CanMEDS framework as sensitising concepts. Complaints categorised as professionalism were subdivided using open coding.

Results

Out of 746,996 patient consultations (telephone, face-to-face and home visits) 484 (0.065%) resulted in eligible complaint letters. The majority consisted of two or more complaints, resulting in 833 different complaints. Most complaints concerned GPs (80%); a minority (19%) assistants. Thirty-five percent concerned perceived professionalism lapses of physicians. We found a rich diversity in the wording of professionalism lapses, where “not being taken seriously” was mentioned most often. Forty-five percent related to medical expertise, such as missed diagnoses or unsuccessful clinical treatment. Nineteen percent

related to management problems, especially waiting times and access to care. Communication issues were only explicitly mentioned in 1% of the complaints.

Conclusion

Most unsolicited patient complaints are related to clinical problems. A third, however, concerns professionalism issues. Not being taken seriously was the most frequent mentioned theme within the professionalism category.

Keywords

general practice; out-of-hours medical care; patient complaints; retrospective observational studies; professionalism; professional development; professional identity formation

How this fits in

Research exploring the exact nature of patient complaints in general practice, especially focussing on professionalism, is limited. We found that a third of unsolicited patient complaints concerned professionalism issues. In addition, a rich diversity in the wording of professionalism lapses was found, where “not being taken seriously” was mentioned most often. By staying close to the words that patients use, the richness of lessons that can be learned from patient complaints can be preserved. These lessons provide important opportunities to improve GP care and GP training.

Introduction

Professionalism is a key competence for all physicians.(1) Lapses in physicians' professionalism may affect health outcomes, therapeutic relationships and the public's perception and trust in the medical profession.(1-8) Perceived professionalism lapses are part of patient complaints in all healthcare settings.(6, 9-13) General Practitioners (GPs) are especially vulnerable to patient complaints.(13-16)

Patient complaints provide unique and important insights into people's expectations, especially as unsolicited complaints contain spontaneously provided information reflecting issues that are of high importance to patients and are not being captured otherwise.(5, 6, 10, 17). Complaints reflect patients' expectations about provided care, especially concerning professionalism. Therefore, complaints are increasingly recognised as a potentially valuable source of information for improving health care quality.(6, 7, 9, 18-20) However, the exact relationship between complaints and quality of care is complex. Not all adverse events or all instances of patient dissatisfaction lead to complaints.(20, 21) Moreover, patient dissatisfaction may lead to complaints even when provided care has been exemplary.(20, 21) A further challenge in research on patient complaints is that professionalism issues may appear in many guises and can even be reflected in complaints if not explicitly mentioned. (4, 7, 9-11) Moreover, when coding complaints using a standardised format, there is a danger of losing the richness of lessons that can be learned from patient complaints.(10, 22) Research on patient complaints has the potential to address these challenges.

The exact nature of professionalism lapses often goes unnoticed because a universally agreed upon definition of professionalism is missing.(23-30) Aspects of professionalism have been defined in terms of virtues (the good physician as a person of character) or behaviour (the good physician as a person who demonstrates competence)(27, 29, 31). In our view, the CanMEDS Physician Competency Framework (CanMEDS), the General Medical Council (GMC) guidance and the Ottawa Working Group on Professionalism provide sufficient direction for research on professionalism, as does research that describes and classifies unprofessional

behaviours.(32-36) However, what *people* expect of physicians regarding professionalism and what they consider lapses in professionalism needs to be researched.

It should be acknowledged that professionalism can have different meanings in different contexts.(6, 28, 37-40) Most research on what is perceived as (un)professional behaviour has hitherto been conducted in hospital settings.(2-7, 41) These studies found that most complaints are about medical, organisational and communication issues as well as lapses in professionalism.(2, 4-7, 19) Whether these findings are generalisable to settings outside the hospital is under-researched.(2-7, 41) Especially research focussed on professional lapses in the general practice (GP) context needs broadening and deepening, as previous research lacks the qualitative richness that patient complaints deserve.(13, 19, 42-45) Because in out-of-hours general practice (OOH GP) GP care neither patient nor GP can benefit from a - in regular GP patient care commonly existing - long-lasting relationships, we expect that professionalism lapses that may go unnoticed in regular GP care emerge more clearly in the OOH setting. The OOH context requires the utmost of a GP' professionalism.(19, 44, 46, 47)

Summarising, the exact nature of patient complaints, in particular the perceived professional lapses, often remains enigmatic and unexplored, especially in the GP context. This study therefore aims to answer the following research questions:

1. How can patient complaints in the GP setting be characterised?
2. What elements of physicians' professionalism do patients address in these complaints?

Method

To investigate the exact nature of patient complaints in OOH GP care, with a special focus on perceived professionalism lapses of physicians, we performed a detailed content analysis of original unsolicited patient complaints lodged at an out-of-hours general practice (OOH GP) centre. We used the original patient complaints in order to stay close to the words that patients used, aiming to preserve the richness of lessons that can be learned from patient complaints.

Study context

The Dutch health care system is funded by a combination of tax contributions and a compulsory health insurance consisting of a per capita payment and fee-for-service. GPs are responsible for patients enlisted in their practice 24/7. On weekdays between 8:00 AM and 5:00 PM, primary medical health care is delivered by the GP practice. Outside office hours, care is outsourced to the local OOH GP centres. Here, GPs answer emergency calls, offer consultations and arrange home visits.(48) The OOH GP cooperative in the present study (GP Services Rijnland) consists of three OOH GP care clinics. These clinics provide care for patients enlisted in GP practices in eight municipalities in both rural and (sub-)urban areas, adding up to 325,000 inhabitants. These three clinics provide 75,000 calls, consultations and home visits annually. If patients are dissatisfied with their care, they can lodge a complaint, either written, by email, telephone, a form on the website or face-to-face, in a robust complaint system managed by a complaints officer.

Study design and procedure

In this retrospective observational study, we performed a content analysis of all unsolicited healthcare complaints lodged at the OOH GP centre between 2009 and 2019 and all related relevant correspondence. For the purpose of this study, a complaint letter was defined as “a letter (or transcript of a telephone or face-to-face encounter) which addresses one or more type of wrong doing, offence, grievance or resentment arising from the offered OOH GP service”. A complaint was defined as “every separately distinguishable type of wrong doing, offence, grievance or resentment which could be distilled from a complaint letter”.

The original complaint letters were retrieved from storage, anonymised and digitalised by the OOH GP complaints officer.

Excel software was used to organise the data. Descriptive statistics were used for quantitative analysis of the codes and categories. We used the STROBE guidelines in the conduct and reporting of this study.(49) The study was performed in three steps.

The members of the research team were purposefully sampled to prevent blind spots in the analysis. All authors work as educational researcher and medical educator. Four authors are clinicians., Three are GPs. WvM is an intensivist. GE is a psychologist and VN is a health scientist specialised in health behaviour.

Data analysis step 1: General characteristics

Where identifiable, the OOH GP complaints officer recorded the gender and age of the patient whom the complaints concerned; whether the complainant was the patient in question, a relative or another person involved (e.g. the patient's legal representative); to whom the complaint was directed (GP, GP resident, or the assistant); and how the complaint was submitted (by letter, mail, telephone or face-to-face).

Data analysis step 2: Themes

The first round of content coding of the anonymised original letters was open, inductive and done with an iterative, constant comparison approach. GE and PCB analysed 25 randomly chosen transcripts and discussed their initial open coding. Distinct codes were assigned to each remark referring to different contents of the complaint. If a complaint letter concerned more than one aspect of care, each complaint was coded separately. Hereafter, PCB analysed all 2009 and 2010 complaint letters (90 in total) and the open coding was discussed again. Together with GE, PCB sought and found consensus on the axial coding scheme, which was then cross-checked with two other researchers (MN and AK). Subsequently, GE and PCB performed selective coding, categorising the different codes into more abstract themes. Consensus on the themes was reached within the whole research team after two rounds of discussion. As the abstract themes paralleled the CanMEDS competencies, these competencies were used as sensitising concepts in a second round of deductive coding.(33) We decided to assign all complaints that could not clearly be categorised in one of the other

six CanMEDS competencies to professionalism in order not to miss any authentic patient information.

Although data saturation was reached prior to finishing coding, all complaints were coded to ensure that the results accurately represented the frequencies and themes of the patient complaints.

Data analysis step 3: Professionalism

In order to answer research question 2, a deeper open analysis was conducted of the complaints coded as professionalism. We also analysed whether these professionalism-related complaints stood on their own or were mentioned in combination with other complaints and vice versa.

Results

Over the 10-year study period 746,996 patient consultations took place. The annual number varied between 70,853 (2013) and 84,410 (2018). These telephone contacts, face-to-face GP consultations and home visits resulted in 493 complaint letters lodged. Three proved registrations of adverse events, five were addressed to healthcare professionals not in OOH GP care service, and one lacked detailed information, hampering further analysis. Consequently, nine complaint letters were excluded and 484 original complaint letters (concerning 0.065% of total consultations, annual percentage ranging from 0.059% to 0.161%) were analysed.

General characteristics

The vast majority of the complaints (362) was submitted by letter or email (75%), 116 by telephone (24%) and six in a face-to-face meeting (1%) (Table 1).

Table 1. General characteristics of complaints. *(see appendix)*

Complaints were submitted by patients themselves (41%), their parents (30%), their partners (13%) or their children (11%). The remaining 5% were lodged by other relatives and colleagues. Most complaints were about GPs (80%). In 19%, the OOH GP care centre assistant was involved. Ten percent was directed against the organisation of the OOH GP care centre. In six complaints (1%), the GP resident was explicitly mentioned as transgressing. The gender of the patient was not mentioned in 19 complaints (4%). Of the remaining 465 complaints, 259 (56%) related to female patients and 206 (44%) to male patients. The age of the patient was known in 331 complaint letters (68%). Of these, 104 were aged 0 – 18 years (31%), 150 were aged 19 – 64 (45%) and 77 were 65 years or over (23%).

After an initial decline in the number of complaints, an increase was observed from 24 complaints in 2013 to 79 complaints in 2018 (Figure 1). This absolute increase was accompanied by an increase in relative numbers.

Figure 1. Number of complaints per year. *(see appendix)*

Half of the complaint letters (49%) concerned one single complaint. The other half concerned two or more complaints. In six cases there were up to five different complaints lodged at the same time. In total, out of the 484 analysed complaint letters, 833 different complaints could be distilled.

Themes

Table 2 shows all complaint themes except those about professionalism. Three hundred seventy six concerned medical expertise (45%), e.g. missed diagnoses (predominantly missed fractures, myocardial infarction and appendicitis), insufficient medical examination, poor or unsuccessful clinical treatment (such as incorrect placement of catheters or sub-optimal stitching) and outdated, wrong or absent advice. One hundred nineteen pertained to management issues (14%), e.g. long waiting time for care, refusal to visit or consult and finance and billing. Five were solely about communication (1%), e.g. not being called back. The remaining 333 complaints (40%) could not be clearly categorised in the abovementioned CanMEDS competencies, i.e. medical expert, manager and communicator, nor in the competencies collaborator, health advocate or scholar and were preliminary coded as professionalism. After analysing all 2009 and 2019 complaint letters (90 in total), no new themes emerged.

Table 2. Complaint themes except professionalism. *(see appendix)*

Professionalism

The 333 complaints coded under 'professionalism' were explored in more detail. Of these 333 complaints, 290 were indeed about perceived lapses in physicians' professionalism. The remaining 43 complaints were all found to be directed specifically against the organisation of the OOH GP care centre (e.g. unhygienic working environment, insufficient or unclear signage, non-medical advertising brochures in the waiting room) or the OOH GP care centre assistant (e.g. unclear information about the clinic's address and asking more information

than necessary). These complaints were not investigated further, as they fell outside the scope of this study.

Patients articulated the perceived lapses in physicians' professionalism in different terms. Examples include not being taken seriously, being patronised, being unpleasantly spoken to, getting inappropriate comments, perceiving a lack of empathy, perceiving the physician as being rushed, a physician who does not introduce himself or herself, not shaking hands, who appears arrogant or uninterested or displays physical harshness or unwanted intimacy. Table 3 shows explanatory quotes. The theme most frequently found within the professionalism category was "not being taken seriously" (N= 88), mostly in regard to the health issue itself, the urgency, or the perception that one was seen as being overprotective.

Of the 484 complaint letters, 213 letters contained complaints concerning lapses in professionalism, which in 87 (41%) cases was the only complaint. In 61 (29%) cases, it was combined with missed diagnoses, in 38 (18%) cases with insufficient medical examination and in 19 (9%) cases with long waiting time for care.

Table 3. Explanatory quotes about complaints pertaining to professionalism *(see appendix)*

Discussion

Summary

We thoroughly analysed all patient complaint letters lodged at an out-of-hours general practice (OOH GP) centre with a special focus on perceived unprofessional behaviour of physicians. We found that 746,996 OOH GP consultations over a 10-year period resulted in 484 complaint letters pertaining to healthcare professionals. Over a third (35%) of the patient complaints concerned perceived lapses in physicians' professionalism. We found a rich diversity in the wording of professionalism lapses, of which not being taken seriously was mentioned most often.

Strengths and limitations

The present study is the first to use content analysis of patient complaints in the context of primary care focussed on GPs' professionalism lapses. Moreover, the study period of a decade and the large number of complaint letters which could be analysed (484) are unique. The OOH GP centre under study covers a large, diverse and representative population of patients, which contributes greatly to generalisability of the results.

A few limitations should be noted. Notwithstanding the robust complaint system, not all adverse events or instances of patient dissatisfaction may lead to complaints.(20, 21) Moreover, complaints may be biased by negative health outcomes, as these outcomes may lead to patient dissatisfaction even when provided care has been exemplary.(20, 21) As in every analysis, information can get lost in translation to abstract themes. However, using a two-step analysis using both inductive and deductive methods and multiple coding added to the rigour of this study.

Comparison with existing literature

Our data show a steady increase in patient complaints since 2013. This is in contrast with a recent study by Wallace et al. on patient complaints in OOH GP in which a relatively stable annual rate was seen of around 0.061% over a 5-year period, but it is in line with other studies.(19, 50, 51) Reasons for a potential increase, as mentioned in the literature, include a broader cultural change in society, including: changing expectations, nostalgia for a 'golden

age' of healthcare, and the desire to raise grievances altruistically.(52, 53) This is in line with the many statements made in the complaint letters in our study about the 'desire for openness' and the 'hope that this won't happen to others in the future'. The other general characteristics (medium, complainant and aim) are consistent with the existing literature.(4, 6, 9, 10, 19) This also applies to the frequency distribution we found, with most complaints being about the medical expert role followed by complaints about professionalism and management.(5, 7, 10, 13)

Our results match well with Reader's taxonomy for patient complaints and their ensuing Healthcare Complaints Analysis Tool (HCAT).(10, 22) Previous research using the HCAT for patient complaints in an OOH GP setting confirms the usability of this taxonomy in the (OOH) GP setting, although it is primarily based on research in hospital settings.(10, 19, 51) However, the 290 complaints about perceived lapses in physicians' professionalism could be placed in at least four categories of the HCAT (respect and patient rights, listening, communication, and quality). (10, 22) Therefore, we performed a deeper analysis of patients' rich vocabulary regarding professionalism aiming to explore what people expect of physicians regarding professionalism and what they consider lapses in professionalism. We aimed to stay close to the words that patients used (not being taken seriously, being patronised, being unpleasantly spoken to etc.) to avoid losing the essence of the complaint in the translation to more abstract predefined themes. This provides unique and important insights into patients' expectations and their feelings about the provided care, especially concerning professionalism, which allows us to learn from these complaints.(4, 6, 7, 9-12, 19, 20)

The percentage of what we considered lapses in professionalism (35%) is average and in line with the existing literature. Mattarozzi et al. found relationship aspects to be the cause of complaint in 52.8% cases.(7) Wofford et al. found disrespect, with 36%, their most identified category.(4) In their extensive review on 59 studies, reporting 88,069 patient complaints, Reader et al. found that 29.1% related to healthcare staff-patient relationships. Contrarily, Schnitzer et al. found that only a relative proportion of 9.3% of complaints were about the physician-patient relationship.(9) However, we think the percentage of lapses in

professionalism might even be higher because professionalism can be expressed via the performance of other competences.(54) This could explain the relatively high percentage of combinations of competencies that were complained about in one complaint letter.

Implications for research and practice

In line with most of the other literature on patient complaints, our results show that unmet expectations were a driver for many complaints.(5-7, 11, 13, 19, 41, 44, 55) Therefore, GPs and future GPs have to be informed that they need to actively address patient expectations during consultations. They need to communicate about examination, treatment, potential complications and prognosis.(19)

In PGME and CME training, attention should be paid to the fact that professionalism lapses often occur and that these lapses can have a wide range of devastating consequences.(1-8) By analysing patient complaints using the CanMEDS framework, we want to facilitate the implementation in GP training. The findings of this study provide direction and underline the utter importance of (bidirectional) direct observation of residents by their supervisors in the OOH GP setting.(56)

Further research should focus on deeper analysis of complaints concerning the container concept professionalism, because perceived lapses in professionalism are frequently complained about but are articulated by patients in different ways. In-depth interviews are needed to further investigate the subtilties of how lapses in professionalism are perceived.(54)

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Competing interests: The authors have declared no competing interests.

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Figure 1. Number of complaints per year.

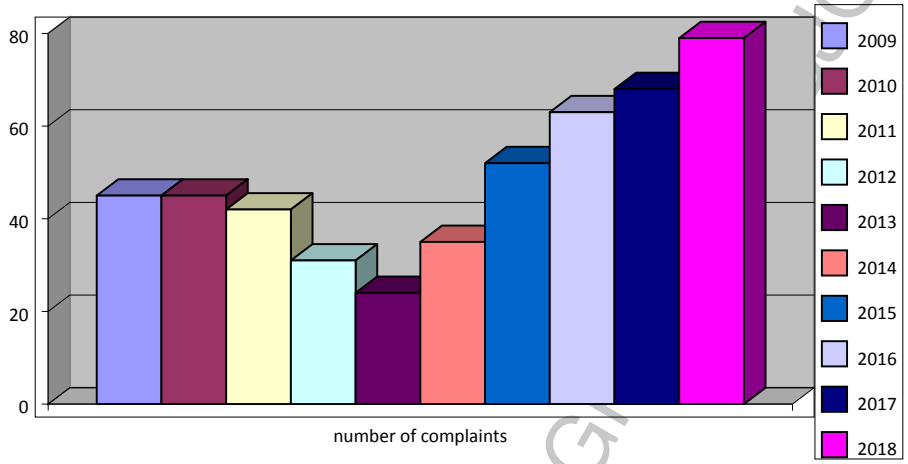

Table 1. General characteristics of complaints

Medium N (*%*)	**Complainant N (*%*)**	**Aimed at N (*%*)**	**Gender N (*%*)**	**Age N (*%*)**
(E)letter 362 (*75*)	Patient 198 (*41*)	GPs 389 (*80*)	Female 259 (*56*)	0-18 104 (*31)*
Telephone 116 (*24*)	Parents 147 (*30*)	Assistant 90 (*19*)	Male 206 (*44*)	19-64 150 (*45*)
Face-to-face 6 (1)	Partners 63 (*13*)	Organisation 49 (*10*)	Missing 19	65+ 77 (*23*)
	Children 54 (*11*)	Resident 6 (*1*)		Missing 153
	Other 22 (*5*)			
Total 484	484	484	484	484

Table 2. Complaint themes except professionalism

Sensitising concept	Theme	N (%)	Exemplary quotes
Medical expertise	Missed diagnosis	177 (21%)	*"Eventually, the toe turned out to be broken after all." (1120)*
			"Because of persistent complaints, my own doctor later referred me to the cardiologist, who diagnosed myocardial infarction." (1003)
			"The following day, my appendix was found to be inflamed and I had to have an operation immediately." (1431)
Medical expertise	Insufficient medical examination	99 (12%)	*"He only felt with two fingers whether there was a temperature difference. Furthermore, he didn't perform any physical examination." (1739)*
			"I was briefly examined and then dismissed." (1853)
Medical expertise	Poor, or unsuccessful clinical treatment	71 (9%)	*"However, placing the catheter had no effect." (1427)*
			"The anaesthetics did not go smoothly; the anaesthetic fluid came out through the wound and did not work." (1808)
Managing	Long waiting time for care	55 (7%)	*"After three hours, there was still no doctor and the pain became unbearable for my wife." (1006)*
Managing	Refusal to visit or consult	47 (6%)	*"A doctor can never make a diagnosis over the phone! After repeatedly emphasizing that it was really impossible to come to the clinic, the doctor even started a discussion." (1202)*
			"We had to wait over an hour in the waiting room." (1868)

Medical expertise	Outdated, wrong or no advice	29 (3%)	*"Further advice was not given, so a restful sleep was not an option." (0944)*
			"When asked by my own doctor, this advice turned out to be incorrect." (1739).
Managing	Finance and billing	17 (2 %)	*"She received no advice during the phone call, on the contrary, the call was broken off for no reason at all. Because of this, we are unpleasantly surprised to have to pay an amount of 25 euros and request a remission of the amount." (1823)*
Communication	Not called back	5 (1%)	*"My brother was then informed that he would be called back by the doctor within 10 minutes about the situation. However, he has not been called back at all!" (1701)*

Table 3. Explanatory quotes about complaints pertaining to professionalism

Themes	Explanatory quote
Not taken seriously	*"I am really angry that my complaint was not taken seriously." (1130)* *"I am very angry that I was not taken seriously and have been dismissed as a hysterical person." (0913)* *"Then, the doctor said: 'and what was the urgent problem again?'" (1108)* *"What are you doing here? You have only had troubles for a few days now, and the OOH GP is only for emergency care." (1452)* *"The doctor cannot find anything wrong and said: 'You just have a cry-baby.'" (1136)*
Patronised	*"Then, we were told that we were absolutely not allowed to consult the OOH GP for these complaints." (0919)*
Unpleasant spoken to	*"The doctor did not answer my questions, but barked at me." (1008)*
Inappropriate comment	*"This comment was extremely out of place at that time." (1305)*
Lack of empathy	*"She examined her with a total lack of empathy." (1105)*
Rushed	*"I got the feeling that she was in a great hurry." (1311)*
No introduction	*"The doctor did not introduce himself." (1754)*
Not shaking hands	*"He did not shake my hand upon entering." (1106)*
Arrogant	*"The doctor's attitude was arrogant and disrespectful." (1413)*
Uninterested	*"The doctor was sleepy, inattentive and uninterested." (1763)*
Physical harshness	*"The doctor was very hard-handed." (0901)*
Unwanted intimacy	*"My daughter felt she was touched in an unpleasant way." (1435)*