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Master Thesis Service recovery in healthcare:

How to prevent medical complaints from becoming medical claims?

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Preface

The master thesis focused on ‘*Service Recovery in Healthcare: How to prevent medical complaints from becoming medical claims?*’ is hereby presented. The master thesis focuses on the aspect of investigating the causes of complaint escalation in a medical setting and what actions may be done to stop it from happening. This thesis was created to complete the Radboud University's Business Administration with a Specialization in the Marketing master's program in Nijmegen, the Netherlands.

A general interest in regard to healthcare is an interest I have experienced for a longer period of time. As my mother, a complaint officer talked about her job at home my enthusiasm as well as interest in the topic became more and more. This enthusiasm made conducting this research an enjoyable experience.

The delicate subject and the scarcity of currently available material made conducting this study a unique and engaging experience. Despite the difficulties, the research process proceeded with enthusiasm, providing fresh insights and discoveries in an understudied area. There have been numerous people who have helped me while I wrote my thesis. I want to start by sincerely thanking Dr. H.W.M. Joosten for his commitment, and insightful observations. Additionally, I would like to thank my second supervisor, I.W.A. Weeterings, for her valuable contributions to this study. I would especially want to thank Lisa Laponder and Nazlican Hayirli for the opportunity to work with them. I also like to thank all participants for dedicating time and energy to this master thesis. This study could not have been carried out without your insights. Last but not least, I want to thank my family and friends for their help and support during this process.

Anne Thijssen

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Abstract

Taking into account the complexity of healthcare, analyzing the complaint-handling process is valuable. This in order to provide high-quality care. Analysis shows medical complaints can turn into medical claims. The numerous parties involved, including healthcare organizations, healthcare professionals, patients and their families, are all significantly impacted by this escalation. Based on the value of the process and the parties involved this study examines the topic of service recovery, focussed on complaint-handling in Dutch hospitals. Three students worked together on the research project; however, every student has written their own research report.

The objective of the current study is to learn about the procedure by which complaints turn into claims and determine what efforts might be done to avoid this escalation from happening. In order to learn more about this procedure the focus is on answering the research question, which is as follows: *“What factors lead to an escalation of turning a medical complaint into a medical claim and how can this escalation be prevented?”*. Extensive literature research served as the foundation for developing a conceptual framework. Next, expectations have been formulated based on the literature review. Various factors were distinguished, namely event factors, organizational factors, characteristics of the healthcare professional, characteristics of family members, characteristics of the patient, and lastly characteristics of the complaint officer. Based on these factors, a qualitative practice-oriented study was carried out. Information from complaint officers working in Dutch hospitals was obtained through semi-structured interviews. The expectations have either been confirmed, partly confirmed, or rejected. As a next step, the researchers have jointly created a prevention escalation tool, formulated as a to-do list, for healthcare professionals, healthcare organizations as well as complaint officers. An example of a recommendation is: *“moedig zorgpersoneel aan om actief te benoemen wanneer een patient ontevreden lijkt. Door de onvrede gelijk te benoemen tijdens het contactmoment kan escalatie voorkomen worden.*

A significant side point is that all the material obtained through the interviews is based on secondary sources. An element for further research would be to conduct quantitative research to determine the extent of the elements influencing complaint escalation.

Keywords: service recovery, healthcare, complaints, claims, and escalation

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Chapter 1. Introduction

1.1 Introduction to the topic

Me, a daughter listening to her mother who is a complaint handler in a healthcare institution describing her day-to-day experiences raised my curiosity about medical malpractice. Medical malpractice is defined by Bal (2009, p.340) as: “any act or omission by a physician during treatment of a patient that deviates from accepted norms of practice in the medical community and causes an injury to the patient”. This is a field in which changes take place to prevent escalation from happening. Furthermore, changes take place to create a fit between healthcare and today’s societal needs and wants. An example of a change is the change in medical malpractice from “name and blame” to patient safety, which has been stated by Donn and McDonnell (2012). This change can be seen as a conflict between on one side a culture in which openness and transparency are valued and on the other side a legal culture in which one of the parties is seen as guilty. That is a paradox that makes the change from name and blame to patient safety more difficult (Donn & McDonnell, 2012). The change requires a redesign of the healthcare system, an establishment of performance standards, and the creation of safety expectations. The tort system and the change mentioned above are closely linked to each other (Donn & McDonnell 2012).

In the literature, much research is done on medical service recovery and therefore medical malpractice. Within medical malpractice, a distinction is made between medical malpractice complaints and medical malpractice claims. In this thesis, medical malpractice complaints are defined according to Gillespie and Reader (2016, p.2) as “an expression of grievance and dispute, typically written and communicated through a letter by a patient or their family, about the receipt of healthcare”. Furthermore, as stated before, a difference is made between a complaint and a claim which is defined by Wallace et al. (2013, p.1) as “a written demand for compensation for medical injury”.

Looking at the parties involved in medical malpractice a division can be made between ‘the plaintiff’ and ‘the defendant’. Plaintiffs are divided into family members, patients, other surrogates, hospital employees, and visitors as defined in the research done by Jerng et al. (2018). Dijkstra et al. (2022) have analyzed the impact of a medical malpractice complaint or claim process on the plaintiff. Feeling the need to be heard is the impact particularly felt by plaintiffs. In addition, plaintiffs also feel the need to have a helping impact on healthcare (Dijkstra et al., 2022). Defendants are split up into doctors, nurses, other professionals, other workers, administrative staff, and unspecified (Jerng et al., 2018). Baltesen (2019) states the

consequence of a claim on medical personnel is a serious personal impact. International research provides evidence for burn-out symptoms by medical personnel while handling a claim process.

Various actions can be taken to prevent the effects mentioned above from happening. Research by Donn and McDonnell (2012, p.65) states that “risk management can be an effective process to identify, evaluate, and address problems that may injure patients, lead to malpractice claims, and result in financial losses”. They state that implementing a risk management program needs a positive attitude, a sufficient knowledge base, and a commitment to improvement to be perceived as successful. Transparency in the disclosure of the error as well as a strategy of perspective risk management in dealing with the medical error may result in substantially fewer medical malpractice lawsuits, lower litigation costs as well as the environment becoming more conscious of its safety (Donn & McDonnell, 2012). Transparency and communication are factors of importance within the process of medical malpractice. However, Giraldo et al. (2020) state apologies and disclosure have no impact on medical malpractice litigation. In contrast, Kass and Rose (2016) elaborate on the effect that transparency and open communication lead to the mitigation of stress on the plaintiff. A win-win situation is created as it allows injured parties suitable compensation in a timeframe acceptable to both parties without the financial and emotional effect of a litigation process. However, concrete characteristics and factors preventing a complaint from escalating into a claim have not been researched and stated yet.

1.2 Objective and research question

The goal of this study is to shed light on the underlying causes of the escalation of medical complaints and to investigate potential solutions.

The research question formulated is: *What factors lead to an escalation of turning a medical complaint into a medical claim and how can this escalation be prevented?* By researching this question, the thesis contributes to the information available regarding the tort system and fills in some gaps by providing information concerning the prevention of a medical complaint turning into a medical claim. Several sub-questions have been formulated that support the process of answering the main question. These sub-questions are as followed:

1. What are medical complaints?
2. How are medical complaints treated in Dutch hospitals?
3. What are claims, and what are the effects of these?

4. How do medical complaints escalate into medical claims?
5. How can medical complaint escalation be prevented?

1.3 Academic and practical relevance

Understanding the effects of this escalation is important for academics for several reasons. Academics' understanding of the effects of this escalation on various parties, including patients, their families, and doctors, can be advanced by researching and comprehending medical complaints and claims. In non-traditional, high-risk service contexts like healthcare, there is an absence of knowledge regarding service failure and recovery, Zayer et al. (2015) claim. Due to the likelihood that medical complaints will result in more expensive claims, it is imperative to look into this gap. Having analyzed the literature available, one misses information in regard to the prevention of medical malpractice complaints turning into medical malpractice claims. In case of an escalation of complaints, it is valuable to know which factors could have prevented it or caused the escalation. By analyzing this, a contribution is made to the literature now available. A framework that will be created after finalizing this research will provide insights into the interconnectedness of the factors that could prevent the escalation of medical malpractice complaints from turning into medical malpractice claims. This framework will be presented as an escalation prevention tool, by presenting a to-do list. The relevance of this research is that a medical malpractice escalation can have a serious impact on both the plaintiff as well as the defendant. In addition, a lawsuit that might be caused by a claim is a costly process. Therefore, presenting complaint-handling experts with a practical framework can contribute to preventing a costly process as well as a difficult process for both parties involved.

1.4 Thesis outline

The thesis is separated into five chapters. The second chapter focuses on the literature review, finishing off with a visual representation of the conceptual model. In addition, expectations will be given. The third chapter describes the method used to conduct the research to provide insights into the research question formulated. Chapter four elaborates on the thorough examination of the collected data. The fifth chapter delves into the conclusion, the theoretical and managerial implications of the research and lastly, the report outlines a section on limitations and opportunities for future research.

Chapter 2. Literature review

Having introduced the topic of the thesis, Chapter 2 will focus on concretizing the topic by answering the sub-questions formulated before. An overview of literature will be presented per sub-question. After having elaborated on each sub-question a visual representation of the conceptual model will be presented. In addition, various expectations are stated.

2.1 Medical complaints

This section will focus on the provision of insights in the definition of a medical complaint as well as different classifications of medical complaints. Finalizing this section, one will choose a classification which is used within this study. Furthermore, the causes as well as the consequences of medical complaints will be shared. The sub-question being answered is: *What are medical complaints?*

According to Gillespie and Reader (2016, p.2), a complaint is defined as “an expression of grievance and dispute, typically written and communicated through a letter by a patient or their family, about the receipt of healthcare”. Van Dael et al. (2020, p. 684) defines medical complaints as: “complex narratives that report on perceived failures of healthcare delivery from the patient’s perspective”. Hospitals consider these complaints to be crucial as they offer significant insights and can uncover areas where patient care is inadequate.

The Healthcare Complaints Analysis Tool (HCAT) as formed by Gillespie and Reader (2016) presents a way to analyze healthcare complaints. The tool is built as followed:

- Clinical problems
 - Quality
 - Safety
- Management problems
 - Environment and institutional processes
 - Problems in bureaucracy
 - Waiting time
 - Accessing care
- Relationship problems
 - Listening
 - Communication and respect
 - Patient rights

Clinical problem is the first domain of the HCAT, and is defined as “issues relating to quality and safety of clinical and nursing care provided by healthcare staff” (Gillespie & Reader, 2016, p.4). In addition, the problem categories are quality and safety, defined by Gillespie and Reader (2016, p.4) as “clinical standards of healthcare staff behavior” and “errors, incidents, and staff competencies”. Management problems are the second domain and are explained by Gillespie and Reader (2016, p.4) as “issues relating to the environment and organization within which healthcare is provided (for which administrative, technical, facilities and management staff are usually responsible)”. Furthermore, the problem categories are environment and institutional processes, meaning “problems in the facilities, services, clinical equipment, and staffing levels” followed by “problems in bureaucracy, waiting time, and accessing care” (Gillespie & Reader, 2016, p.4). Relationship problems are the last domain within HCAT, described by Gillespie and Reader (2016, p.4) as “issues relating to the behavior of any specific member of staff towards the patient or their family/friends”. Moreover, the categories within relationship problems are listening, communication and respect, and patient rights. These are explained as “healthcare staff disregard or do not acknowledge information from patients” respectively “Absent or incorrect communication from healthcare staff to patients” and lastly “Disrespect or violations of patient rights by staff” (Gillespie & Reader, 2016, p.4).

Within the research of Gillespie and Reader (2016), a more detailed division between the severity of the category of complaints is presented using low-, medium- or high severity. Gillespie and Reader (2016) provide severity indicators for each problem (sub)category, which can be used to score the severity of the complaint.

Donn and McDonnell use another division of complaints. They categorize complaints into three key types, namely communication errors, diagnostic errors and treatment errors. According to Donn & McDonnell (2012) communication error include errors in translation and medical interpretation, which can happen through misunderstanding from both the patient as well as the physician. Diagnostic errors refer to medical practitioners who can commit diagnostic mistakes, including wrong diagnosis and failure to detect ailments, which can result in harmful consequences to the patient. Moreover, any occurrence that is avoidable and could result in inappropriate medication usage or harm to the patient is considered a medication error. When a drug causes injury to the patient, it is labelled an adverse drug event. Although some adverse drug events come from medication errors, most of them do not. A medication error can include multiple aspects, such as suboptimal prescription, under or over-dosing, mistakes in distribution, failure to recognize adverse effects, and the patient or

caregiver not following instructions.

The ‘Inspectie van Volksgezondheid’ uses another division of medical service error. Firstly, there are complications, these are defined as unintended and undesired outcome during or following the actions of a healthcare provider, which is so detrimental to the client's health that adaptation of the action or treatment is necessary, or irreparable damage occurs. Incidents make up the second group. Incidents are inadvertent or unanticipated occurrences that have a negative influence on the standard of care and can, will, or may cause harm to the patient. Although the caregiver's care is insufficient for unfavourable occurrences, the patient's results are not poor (for now). Sentinel incidents, the last category, are inadvertent or unanticipated occurrences that negatively affect patient care and cause serious harm or patient death. In the event of sentinel occurrences, the patient suffers as a result of inadequate care provided by the caregiver (Inspectie Gezondheidszorg en Jeugd, 2020).

Analyzing the literature various classifications of medical complaints are defined. In this thesis, the division of medical service error by the ‘Inspectie van Volksgezondheid’ is used as this thesis has its focus on Dutch healthcare institutions; therefore, this classification is most useful.

Research by Hanganu et al. (2020) elaborates on the causes of medical complaints. They state that various factors have a significant impact on medical outcomes, particularly on the occurrence of complications and the quality of the doctor-patient relationship. These factors may include informed consent, doctor's behavior, and communication. Furthermore, they state that it became obvious that families were more likely than patients to report a death or inadequacy of communication when the patient had passed away or was a new-born.

Austin et al. (2021) elaborate on various predictive factors that contribute to a higher risk of complaints. For example, high-risk specialties such as psychiatry, surgery, obstetrics and gynecology have a higher risk of receiving complaints than other specialties.

In regard to effects of medical complaints a reference will be made to the introduction in which the following statements is made: the value of a change in medical malpractice from “name and blame” to patient safety. Reader et al. (2014) state an improvement in patient safety can be achieved by patient complaints. Patient complaints offer a crucial perspective on the safety concerns that healthcare institutions are experiencing. Being aware of various flaws in the delivery of medical services, patients are able to spot issues that go unnoticed by conventional methods of monitoring such as incident reporting and retrospective case

analysis. As a result, patient complaints represent a valuable asset for healthcare organizations to enhance their patient safety standards. Moreover, studying the data on patients' negative experiences assists healthcare institutions in pinpointing systematic deficiencies in their healthcare.

Monteferrante et al. (2022) explain the effect of healthcare complaints on medical practice as a defensive medicine; this refers to the practice of medicine in a way that differs from a doctor's usual or customary method. The goal of using this strategy may be to make it less likely for patients to complain. In addition, they formulated various impacts a complaint may have on physicians' psychological well-being. These impacts range from stress, anger, anxiety, and suicidal thoughts to thoughts of self-harm; for example, 32% of the physicians experience a loss in self-confidence while handling or after handling a medical malpractice complaint.

2.2 Medical complaint handling in Dutch hospitals

Having provided insight in medical complaints one will now focus on how complaints are handled in Dutch hospitals. Firstly, an introduction to the Dutch law Wkkgz will be presented, next one will explain various places in which medical complaints can be handled. Lastly, one will elaborate on two methods of analysis a hospital can put into practice when an incident has happened. The sub-question answered in this paragraph is: *How are medical complaints treated in Dutch hospitals?*

The Dutch law 'Wet kwaliteit, klachten en geschillen zorg' (Wkkgz) obliges healthcare providers to monitor, control and improve the provided quality. The law ensures that patients can rely on good, fast, and accessible service recovery. The headlines of this law are formulated as followed: Patients are entitled to gather information on the performance of healthcare providers, in order to make a good decision between various healthcare providers. Furthermore, medical malpractices and errors must be written down in the medical record as well as communicated to the patient or client. Next, healthcare providers should have a safe environment to report and evaluate incidents. In addition, dismissal for serious dysfunction of a healthcare provider must be reported to the 'Inspectie Gezondheidszorg en Jeugd' (IGJ). Next, complaints are handled transparently and informally with the help of a complaints officer. Furthermore, healthcare providers must make a decision on a complaint within 6 weeks. Lastly, care providers must be affiliated with a recognized dispute body that issues binding rulings and can award damages (Ministerie van Volksgezondheid, Welzijn en Sport,

2023). This law forms the basis of how medical malpractice complaints are treated in Dutch Hospitals.

The process of how complaints are treated is elaborated in the section below, analyzing both the patient perspective as well as the hospital perspective.

Analyzing the article of Gillespie and Reader (2016), one should follow the next four steps in order to code a healthcare complaint: 1. connect the healthcare complaint to a problem category and if possible, a sub-category as explained above. Furthermore, one should assess the severity of the complaint. 2. One should code only the stage when a problem category took place. These stages are admissions, examination and diagnosis, care on the ward, operation/procedures, discharge/transfers, and lastly unspecified. 3. The level of experienced harm is specified, which varies from not applicable to catastrophic harm. 4. Lastly a specification of descriptive details should be made, focused on who complained, the gender of the patient, and the staff groups that are referred to in the complaint. The goal of coding a healthcare complaint using the method of Gillespie & Reader is that the complaint can be analyzed using the coding format as presented within their research.

One will now focus on the places a patient is able to voice their complaint in Dutch Hospitals. Firstly, a distribution is created in regard to places where to complain. As a next step, the strategy for service failure and recovery is explained per place using the complaint handling procedure of both Hospital St Jansdal in Harderwijk and Maastricht UMC+ as an example.

The first place a patient can go to are 'Patiëntenvoorlichters' at the Patient Service Centre. Looking at this place one is able to discuss the complaint with someone other the staff directly involved (Patiëntenservice, n.d.). Analyzing different hospitals, one should keep in mind not all hospitals provide this place. As this is the case one mostly focusses on the next three places namely, 'klachtenfunctionaris', 'klachtencommissie' and 'geschillencommissie'. If you need advice or support on the different ways to deal with your complaint, one can contact a 'klachtenfunctionaris'. The complaint officer duties include the following (Regeling klachtbehandeling voor patiënten van het Ziekenhuis St Jansdal, 2020). The complaint officer will provide support to the plaintiff on the basis of an incoming complaint by providing information, education, and advice and if possible, to initiate mediation between the plaintiff and the defendant. The complaint officer applies the principle of hearing both sides of the argument as much as possible. Furthermore, the complaint officer offers assistance and support if the plaintiff wishes to submit the complaint to the to the complaints committee.

If you want an answer on the justification of your complaint or if the options described

above did not lead to the result you wanted, you can submit a written complaint to the complaints committee. The complaints committee has the following tasks (Regeling klachtbehandeling voor patiënten van het Ziekenhuis St Jansdal, 2020). On the basis of a complaint hearing, the complaints committee makes a formulation as to whether the complaint is justified, with or without recommendations, and communicates that opinion in writing, with an explanation, to the plaintiff, the accused, and the Executive Board. This committee is impartial and independent and external members make up the complaints committee. Therefore, one is able to keep the process more unbiased.

Lastly if your complaint or claim has not been dealt with to your satisfaction, you can ask the ‘geschillencommissie’ for a judgment. Only in highly exceptional cases can you go directly to the ‘geschillencommissie’ (Regeling klachtbehandeling voor patiënten van het Ziekenhuis St Jansdal, 2020). The healthcare provider is given the opportunity to respond to the complaint, after which an expert analyzes the situation. A hearing follows, if possible, in the presence of the parties so that they can further explain their case orally and the committee members can ask them further questions. As the committee is composed of members who are up-to-date on the information of the complaint, a well-informed judgment can be made within a short period of time.

In addition to the steps as elaborated above, a hospital has various methods of analysis for analyzing an incident. One will elaborate on two methods of analysis.

The Tripod analysis serves the purpose of visualizing relationships between the danger, the incident, and its consequences and lastly the ‘victim’. Patient safety depends on learning from mistakes. The understanding is that a thorough analysis of underlying factors (typically issues with organization and management) is required to significantly enhance development in regard to patient safety (Hoofs, 2010). As a next step, the analysis points out which safety nets were ineffective or even nonexistent, which could prevent the event or the damage from the event to the victim. The final step is to analyze in greater depth the (failing/absent) safety nets with the ultimate goal of identifying the latent causes. These are mostly organizational or policy factors that contribute to human mistakes occurring more frequently and have the potential to result in major events.

The Root Cause Analysis (RCA) is focused on analyzing sentinel events; these are inadvertent or unanticipated occurrences that negatively affect patient care and cause serious harm or patient death. Hsu and Chien (2007) define an RCA Analysis as a process employed to identify basic and contributing causal factors underlying performance variations. There are

various ways to conduct an RCA analysis. The first one namely the 5 whys approach; it motivates people to think more in-depth about problems occurring by asking themselves 'why'. However, the method has some drawbacks according to Latino (2015), firstly failure takes place in a linear pattern, and secondly, the model explains that one underlying factor, and not multiple factors may actually be to blame for the undesirable result.

The next procedure is the fishbone diagram. The key aspect of this analysis tool is the timeline of the incident. The method uses six cause categories namely man, method, management, material, machine, and measurement (Latino, 2015). The RCA team considers all possible scenarios for each category to determine what may have happened there to result in the undesirable result. This is used to recreate the occurrence and determine the cause(s) of the negative outcome. The fishbone approach has other flaws as well, the primary one being that there is no cause-and-effect relationship between the undesirable result and the causes; brainstorming only occurs inside the causes, and therefore no linkages between causes are created. However, it's possible that the real reason is outside of the categories for causes, in which case the root cause(s) won't be found. Yet, the approach can locate several root reasons.

The last method is the logic tree or the cause-and-effect RCA approach. To create a timeline of the incident's circumstances, deductive reasoning is used. The events and modus (how something was done or happened) that make up the tree's base, must be supported by substantial evidence (Janssen, 2018). As a next step 'How could?' questions are asked to come to the upcoming levels of the tree. This generates a variety of theories of the origin of the incident. These are either confirmed or rejected based on the data gathered during the investigation phase. Janssen (2018) states that the collected evidence consists of five categories, namely parts, position, people, paper, and paradigms. Furthermore, he states that "Hypotheses found to be true are continuously drilled down while false hypotheses are crossed off (to visualize that they have been checked but were untrue)" (Janssen, 2018). Checking hypotheses goes on until a human interaction is found since it is likely that at some time, a bad choice was made that resulted in the physical effects. A chance in question then occurs from 'How could' to 'Why'; this in order to gain information in regard to why the choice seemed right at the time it was made. The arguments behind this choice demonstrate the flaws of the current system, which are seen as the root causes.

2.3 Medical claims and their effect

This paragraph focusses on medical claims. Firstly, one will be provided with a definition of medical claims. Next, an elaboration of the effect of claims on the different parties involved in a claim process will be provided. The sub-question answered in this paragraph is: *What are claims, and what are the effects of these?*

As mentioned before claims are seen as “a written demand for compensation for medical injury” (Wallace, 2013, p.1). Klemann et al. (2022) has defined the purpose of analyzing claims, as over the past few decades, there has been a growing focus on medical malpractice claims, particularly in the United States where a "claim culture" has contributed to an increase in both the volume and expense of such claims, leading to growing insurance premiums.

According to Kass and Rose (2016) a claim should consist of four elements to be considered a claim. These elements are: 1. the physician had a duty to the patient; 2. the physician was negligent in his or her execution of the duty, (i.e., by breaching the standard of care); 3. the physician’s negligent action was the proximate cause of the patient’s injuries; 4. the patient’s injury resulted in damages, whether economic or other. As mentioned in the introduction claims have an effect both on the plaintiff as well as the defendant. Texas A&M University (2022) formulates that the effect on patients can be substantial, as potential patients may be put off by news on medical malpractice, making them hesitant about the needed treatment. Furthermore, patients’ worries about negligence might prevent a healthy relationship between patient and doctor due to a lack of trustworthiness (Texas A&M University, 2022). Dijkstra et al. (2022) formulate that plaintiffs overall feel the need to be heard and that they want to have a positive impact on healthcare.

Analyzing the defendant’s side during a claim process, Baltesen (2019) states that, as mentioned in the introduction, medical malpractice claims have a serious personal impact; international research provides evidence for burn-out symptoms by medical personnel while handling a claim process. This is also supported by the research of Rappaport and Selbst (2019).

Baltesen (2019) also explains the effect of medical malpractice claims on hospitals. As more people file medical malpractice claims, more money needs to be paid out. Furthermore, the amount of money paid out for a medical malpractice claim has risen (Baltesen, 2019). Therefore, expenses for hospitals are increasing. In its turn, this also has an effect on healthcare-specialized insurance companies.

Patients as well as healthcare providers both experience financial-, psychological- and

social impacts of medical malpractice claims. A hospital may sustain irreparable harm from the departure of key employees and the bad press that comes with malpractice lawsuits. A hospital or medical practice's success and sustainability may also be significantly impacted by the growing cost of malpractice insurance (Texas A&M University, 2022).

Hospitals as well as healthcare institutions are rooting for standard operating procedures and an international accreditation system in response to rising demands to improve patient safety and the level of service (Alkhenizan & Shaw).

2.4 Prevention and escalation of medical complaints and claims

This paragraph will dive deeper in the concrete factors that seem to contribute to the prevention and the escalation of a medical complaints turning into a medical claim. The sub-question answered in this paragraph is: *How do medical complaints escalate into medical claims?*

The first factors being analyzed is **organizational factors**. Research by Howard et al. (2013) states the plaintiff want to play an active role when handling a medical malpractice process. This as they have a clear indication of what is perceived as a good healthcare services and bad healthcare services. A main concern and the most significant factor which contributed to escalation within the research by Howard et al. (2013) was ineffective communication. Plaintiffs did not feel like there were being listened to. Furthermore, they experienced not to be supported.

The second element is **healthcare professional characteristics**. Analyzing the research of Austin et al. (2021) 23 risk variables have been formulated for physicians at risk of medical malpractice claims or medical malpractice claims. These risk factors are age, gender, ethnicity, marital status, mental health, personality, burnout, physical health, diet, substance use, fatigue, cognitive performance, medical training location, specialty, certification and registration status, clinical workload, skills, time in practice, claim history, insurance, doctor spending, clinical practice setting or sector and lastly geographic location (Austin et al., 2021). Not one element was a good indicator of the likelihood of medical malpractice complaints or medical malpractice claims. A de-escalation factor of physicians is the practice of defensive medicine. According to Monteferrante et al. (2022), defensive medicine refers to the practice of medicine in a way that is different from a doctor's regular or customary technique. This concept is used to describe the impact of healthcare complaints on

medical practice. Making patients less prone to complain may be the aim of this tactic.

The third element is **patient/ family characteristics**. Gorney (2002) worked out various characteristics of so-called trouble-prone patients. These profiles are explained below.

- Great expectations
Patients with great expectations have a distorted idea of the path of a surgical journey and find it extremely difficult to accept the truth that any major surgical treatment contains some level of risk.
- Excessively demanding patients
Highly demanding patients have very little flexibility in allowing the surgeon to work below their standards, as this does not fit with the expectations formed by themselves.
- The indecisive patient
In case the choice to undertake surgery is based on the inside and not based on being 'sold', the less likely recriminations that are the next step after having experienced an unsatisfactory result.
- The immature patient
If the degree of change made does not match the expectations of an immature patient, one frequently reacts in an unsettling or even aggressive way after having had surgery. The expectations are often too unrealistic and therefore not achievable.
- The secretive patient
This attitude, namely to keep the treatment a secret, is a clear sign that the patients may be feeling guilty about the surgery they had done. There is a larger chance of expressing further discontent as a result.
- Familial disapproval
Family disapproval such as reactions like "I told you so" result in feelings of guilt as well as dissatisfaction, therefore the chance of filing a claim rises.
- Patients you do not like
Regardless of how well the postoperative result turned out, a personality conflict for whatever cause will inevitably have an impact on the case's conclusion. No matter how "difficult" the situation may seem, it is always preferable to say no.

Research by Howard et al. (2013) explained that anger was not the most dominant emotion identified within this research. Howard et al. (2013) identified anxiety as the most dominant emotion. The care provider should be alerted by the awareness that patients do not always

show anger when they are unhappy, and that instead, focus should be directed toward finding other predictors of unhappiness, such as signs of fear (Howard et al., 2013).

As mentioned in Paragraph 2.2 relatives frequently complain in case of a communication error which occurred during the process of healthcare. However, this is done mostly in case of passing and malpractice experienced on a new-born.

The fourth element is **event factors**. Research by Kritzer (2011) explains that there is a significant factor that influences whether or not people seek redress for their difficulties, namely the nature of the problem. The study demonstrates that the formulation of problem subtypes is the primary predictor of claiming behavior (Kritzer, 2011).

Lastly, the fifth element is **complaint officer characteristics**. According to Gorney (2002) a patient's sense of confidence is influenced by the doctor's expertise, reputation, and other intangible variables, the professional relationship between the two is built on open and truthful communication. Most frequently, poor communication sets off the vicious cycle that results in patient dissatisfaction, anger, frustration, reactive hostility, defensiveness, and arrogance on the side of the doctor, growing patient rage, and eventually, a trip to the lawyer. Furthermore, he formulates that avoiding patients who are angry or unsatisfied is one of the biggest mistakes one can make when dealing with them. A more suitable and effective approach is to actively participate in the process (Gorney, 2002). This pro-active approach is both valuable for healthcare professionals as well as complaint officers. Furthermore, showing empathy and naming emotions can be of value during a mediation conversation.

2.5 De-escalation techniques

The information below focusses on the aspect of de-escalation techniques that can be used. Firstly, one is provided with a definition of de-escalation. Next, five different techniques for de-escalation will be discussed. The sub-question answered in this paragraph is: *How can medical complaint escalation be prevented?*

De-escalation is defined by Hallett and Dickens (2017, p.13) as “a collective term for a range of interwoven staff-delivered components comprising communication, self-regulation, assessment, actions, and safety maintenance which aims to extinguish or reduce patient aggression/agitation irrespective of its cause, and improve staff-patient relationships while eliminating or minimizing coercion or restriction”.

Ringberg et al. (2007) state a chance to further analyze the notion of **adaptive recovery**, in which the effectiveness of different recoveries to different plaintiffs is examined.

Offering the ability to repair medical malpractice with various recoveries can be seen as a factor preventing escalation and is therefore valuable to analyze.

Bowers (2014) explains another de-escalation technique, namely **the Safewards model**. Six categories of originating variables are represented by this Safewards Model: the staff team, the physical environment, outside the hospital, the patient community, the patient characteristics, and the regulatory framework. Gerdtz et al. (2020) specifies that the Safewards Model was primarily created for use in mental health services, but it has now been applied to various healthcare settings to reduce conflict and contain it. Bowers (2014) explains that within these domains possible flashpoints can come up. He defines flashpoints as: “Flashpoints are times or situations when things could go wrong. They arise out of the originating domains, and they’re like ‘triggers’ or ‘tipping points’ that signal and precede potential conflict” (Bowers, 2014, p1). Furthermore, both patient modifiers, as well as staff modifiers are included in the model. Bowers (2014) explains patient modifiers as ways in which patients interact and behave that can affect the likelihood of conflict and/or its containment (e.g., anxiety management). Staff modifiers are characteristics of the staff as a person or team, as well as the activities the staff takes to manage patients or their surroundings (Bowers, 2014).

The **CALM de-escalation technique** is another technique used to prevent escalation. However, this technique is specifically focused on recognizing emotional flashpoints, and therefore preventing escalation. It consists of the following four points: 1. Observing your own body language 2. Providing people with personal space 3. Listening 4. Keeping negative filters out (Ko Aweta, 2019).

The Dix and Page model is the fourth technique that will be explained. There are three fundamental parts to it: assessment, communication, and tactics (IAHSS Foundation, n.d.). The theory of Frude is used to recognize a patient’s aggression. He states five factors that are used to successfully recognize a patient’s aggression and as a next step prevent escalation namely situation, appraisal, anger, inhibitions, and aggression (IAHSS Foundation, n.d.).

The last and fifth de-escalation technique to discuss is the **Turnbull et al. Model**, which emphasizes flexibility. They state ten learning objectives that can be used within training to prevent escalation. These are “legal aspects (such as the “right to restrain”), theories of aggression, triggers of aggression, de-escalation skills, disengagement breakaways (strangleholds, disarming, bear hugs, etc.), basic control and restraint (wrist locks, bear hugs, etc.), advanced control and restraint (the three-arm team, removal, relocation, etc.),

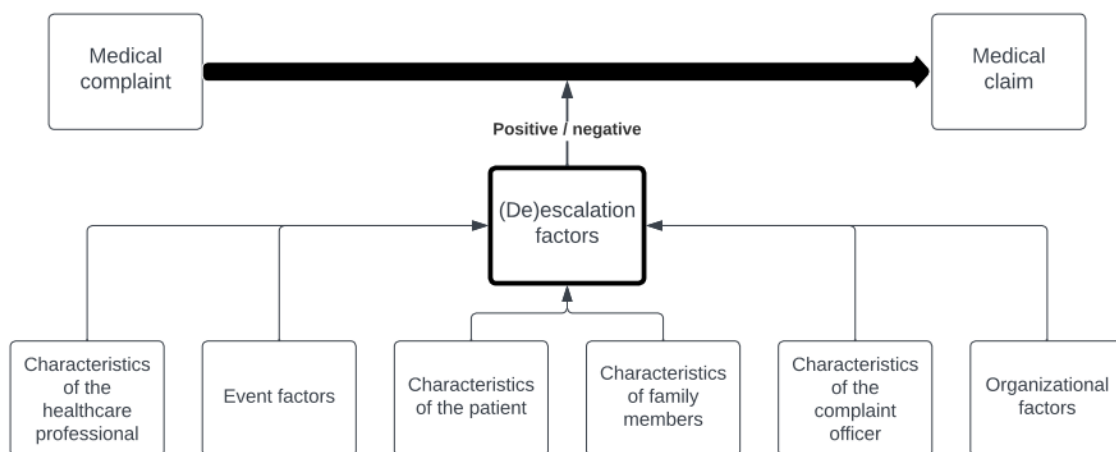
integration of de-escalation and control and restraint, guidelines for practice, and reporting incidents” (IAHSS Foundation, n.d., p.4)

2.6 Conceptual model

Having analyzed all sub-questions, a conceptual model was made. This conceptual model provides a visual representation of the interconnectedness and interrelatedness of the main elements regarding this thesis topic. The framework, as presented below, was tested in further research by conducting various interviews. Additional factors either de-escalating or escalating were added later on if they appeared during further research. The various concepts included in Figure 1 are based upon the literature review of Chapter 2.

Figure 1

Conceptual framework



Expectations have been developed based on the material given and additional information discovered by the other two researchers; some expectations therefore do not have direct sources cited since they were developed together with other researchers. The escalation effect will be the subject of these predictions, which will be made in light of the influence the variables have on it.

Characteristics of the healthcare professional

E1: Female healthcare professionals are expected to have a higher risk of escalation than male healthcare professionals.

E2: Older healthcare professionals are expected to have a higher risk of escalation than younger healthcare professionals.

E3: Some medical specialties are expected to have a higher risk of escalation than other specialties.

E4: When healthcare professionals have received previous claims, they are expected to have a higher risk of future complaint escalation.

E5: When healthcare professionals have better communicative skills, the risk of escalation is expected to be lower than when professionals have poor communicative skills.

E6: When healthcare professionals disclose service failure, the risk of escalation is expected to be lower than when professionals do not disclose service failure.

E7: A good patient-practitioner relationship is expected to reduce the likelihood of complaint escalation.

Event factors

E8: Diagnostic errors are expected to have a higher risk of escalating into a claim than communication errors.

Characteristics of the patient

E9: Patients with a higher socio-economic status are expected to have a higher risk of complaint escalation than patients with a lower socio-economic status.

E10: Patients with previous negative experiences in healthcare are expected to have a higher risk of complaint escalation than patients without previous negative experiences.

E11: Patients that show much emotion during the complaint handling process are expected to have a higher risk of complaint escalation than patients who do not show emotion.

Characteristics of family members

E12: The involvement of family members in the complaint handling process is expected to lead to a higher risk of escalation.

Characteristics of the complaint officer

No expectations have been formulated as there is limited information available in regard to this topic and the influence it has on complaint escalation. They are nevertheless a part of the conceptual model since in the Netherlands they serve as the main point of contact for complaint procedures. One expects them to have an effect on the (de)-escalation process.

Organizational factors

No expectations have been formulated as there is limited information available in regard to this topic and the influence it has on complaint escalation. Nevertheless, organizational factors are included in the conceptual model as, based on the experience of the three researchers as business administration students, organizational factors do influence performance. Furthermore, based on literature on service failure and recovery in firms, this performance as mentioned above seems to influence customers satisfaction. As a result of the above-mentioned information, one has chosen to include organizational factors in the conceptual model. In addition, one expects organizational factors to have an effect on the (de)-escalation process.

Chapter 3. Methodology

3.1 Method of research

As a follow-up on the literature review more research is conducted. This is done in order to provide an answer on the research question as formulated in the introduction. Myers (2013, p.6) defines research as followed: “an original investigation undertaken in order to contribute to knowledge and understanding in a particular field. Research is a creative activity leading to the production of new knowledge. The knowledge produced is new in the sense that the facts, the interpretation of those facts, or the theories used to explain them might not have been used in a particular way before in that specific discipline”. Additionally, he defines two divisions most commonly used within research, namely qualitative and quantitative research methods. Qualitative research, according to Myers (2013), has been developed so that scientists can investigate social and cultural processes. Examples of qualitative research are action research, case study research, and grounded theory (Myers, 2013). Various sources of qualitative data can be distinguished such as participant observation, interviews, questionnaires, document and text analyses, and feelings and responses of the researcher. In contrast to qualitative research, quantitative research is used to investigate natural phenomena. Survey techniques, lab tests, formal techniques, and numerical techniques like mathematical modeling are a few examples of quantitative approaches that are now widely used in the social sciences (Myers, 2013). Within this thesis, a choice is made to focus on qualitative research as a social process is being analyzed. In addition, the goal of the current thesis is to acquire in-depth data from complaint specialists on the elements that contribute to the escalation of complaints.

Furthermore, a division can be made between inductive and deductive research. According to Soiferman (2010), deductive research starts with the general and ends with the particular. In contrast, inductive research moves from the specific to the general. The goal of the current study is to strengthen complaint-handling procedures in Dutch hospitals. As there is limited existing literature on the subject of the escalation of complaints in the Netherlands the results of empirical data can be utilized to examine the existing concepts. A conceptual model can be created when a thorough analysis of theory has taken place. Taking the above-mentioned characteristics into consideration, they are most compatible with a deductive research strategy (Doorewaard et al., 2019).

Practice-based research is a key strategy in a deductive analysis that makes use of a theoretical framework. Practice-based research seeks to contribute to the solutions of a problem in practice, as opposed to theoretical research, which strives to fill a theoretical gap

(Doorewaard et al., 2019). The research's objective is to support the Dutch healthcare system by offering a guidance to prevent needless legal actions. As of this objective practice-based research takes place.

Different categories of practice-oriented research, namely problem analysis, diagnosis, design, implementation and evaluation are distinguished in Doorewaard's et al. work (2019). According to Doorewaard et al. (2019), design- and implementation-oriented research is frequently less suitable for qualitative research. Problem analysis, which is frequently used as a pre-investigation for diagnostic research, has the only purpose of defining the organizational problem (Doorewaard et al., 2019). Diagnostic research seeks to pinpoint the precise nature of the issue, identify areas that may be addressed, and identify the causes of the less-than-ideal state (Doorewaard et al., 2019). Researchers do evaluative research to assess if previously established changes are executed adequately and whether the pre-formulated aims are met. The goal of the current study is to better understand how complaints escalate to claims and which factors contribute to this process. In addition, one wants to uncover the reasoning behind the claim procedure as well as how to prevent making unnecessary claims. Analyzing the goals as mentioned above diagnostic research aligns best.

Opinion research and gap analysis are the two main methods used in practice-oriented diagnostic research (Doorewaard et al., 2019). The purpose of gap analysis is to show the differences between the intended and actual state (Doorewaard et al., 2019). The purpose of opinion research is to determine how various participants see and have an opinion about a problem (Doorewaard et al., 2019). The current study is an opinion analysis because its primary objective is to obtain insights into the various viewpoints of complaint-handling professionals.

To conclude the study can be characterized as practice-oriented qualitative deductive research with a focus on diagnostic opinion analysis.

3.2 Data collection

An overview of the primary methods for gathering data in qualitative research are interviews, focus groups, and observations (Barrett & Twycross, 2018). Within this research a choice is made to focus on interviews with experts within medical complaints such as complaints officers working in Dutch hospitals. The goal of the research interviews is to examine people's perspectives, experiences, beliefs, and/or motives about particular issues (Gill et al., 2008; Silverman, 2000). Interviews offer the ability to gain a deeper knowledge of social processes, which is the goal of the current study. Research interviews can be classified as

either structured, semi-structured, or unstructured. Structured interviews are verbally presented questionnaires with little to no variation and little room for follow-up questions. As a result, they are quick and simple to administer and could be especially helpful if certain questions need to be clarified. However, because of their limitations in terms of participant replies, they are not particularly useful when "depth" is needed (Gill et al., 2008; Silverman, 2000). Some essential questions are included in semi-structured interviews to help outline the topics to be covered, but they also give the interviewer or interviewee the freedom to go off course to delve deeper into a concept or response (Britten, 1999; Gill et al., 2008). Semi-structured interviews can be tightly framed to give the researcher more control, thus turning them into questionnaires with vocal replies in place of written ones (Barrett & Twycross, 2018). Unstructured interviews are conducted with little to no organizational process beforehand and therefore do not reflect on any predetermined concepts (Gill et al., 2008; May, 1991). Unstructured interviews can be challenging to manage and engage in since there is typically little direction on what to say because there are no predefined interview questions. Thus, their utilization is typically only taken into account when sufficient "depth" is necessary (Gill et al., 2008; May, 1991).

Gill et al. (2008) explain that semi-structured interviews would be most suitable, as it gives participants some direction on what to talk about, which is considered pleasant within an interview with a healthcare professional. Using this method, the researcher was able to choose particular details from Chapter 2 that should be covered during the interview. The interview guide was created using these topics (see Appendix 2). According to Boeije (2014) it is important to develop a list of subjects for deductive qualitative research that provides an adequate framework and leaves opportunity for further information exchange. An expert in the field of complaint management as well as a researcher specialized in the field of service failure and recovery examined a draft of the interview to ensure that the questions were acceptable to the intended audience. As Dutch is the primary language used by complaint officers at work, the whole interview guide was written in this language. Participant misconceptions and unintentional translation problems could be avoided by not requiring them to translate their thoughts. In addition, transcripts made of the interview, after having received consent from the respondent, are also not translated into English as this may lead to a loss in details as well as distortion of the meaning. Furthermore, one was provided with the chance to share extra information that they felt was of value to the research. As a result, the interview guide has been further modified during the interview process. In Appendix 3, the final version of the interview guide can be found. The interview guide consists out of four

parts. All interviews began with a brief introduction that included details about the research and a description of the term's complaints and claims. This explanation is provided to guarantee that participants and researchers are in agreement with the two key concepts that underlie the study, strengthening the validity of the findings. All participants have been informed that the talk will be recorded for analysis after this introduction. After that, they were asked a series of in-depth personal questions about their position within the company, their level of experience, and the kind of hospital they now work for. The questions in the next section of the interview were on the process of complaints becoming claims. These were divided into seven categories. The interview ended with an analysis of the research question as well as a conclusion.

Respondents for an interview can be gathered through two sorts of sampling, namely probability sampling and non-probability sampling. Probability sampling ensures that each case within the population has an equal chance of being chosen (Shorten & Moorley, 2014). Examples of probability sampling are sampling, systematic sampling, stratified sampling, and cluster sampling (Berndt, 2020). Non-probability sampling techniques adopt a strategy in which the sample is chosen based on the researcher's judgment rather than through a selection based on randomness (Elfil & Negida, 2017). Examples of non-probability sampling are quota sampling, purposive sampling, self-selection sampling, and snowball sampling (Berndt, 2020). Non-probability sampling is used in this thesis. One utilized snowball sampling which is a method by which one is able to gather respondents for the interviews. A convenience sample of the original subject is used to start a snowball sampling (Etikan, 2016). The sample grows wave by wave, like a snowball swelling in size as it rolls down a hill. This type of sampling is especially appropriate when the target group is difficult to contact. Complaint officers served as the study's data sources, as they are involved in the complaint handling procedures. Since it was intended to talk with specialists at Dutch hospitals, not every member of the public had an equal opportunity to be included in this research. This method, known as the non-probability methodology, depends on non-random factors such as availability. In order to find participants an invitation letter was developed and sent to potential respondents; this letter is shown in Appendix 4. 19 of the 27 respondents who were interviewed responded on the letter sent by e-mail. The remaining part was recruited by other referrals, which can be defined as snowball sampling. The average number of participants that researchers interview for practice-oriented research is between 15 and 20, after this amount information saturation would come up. To ensure maximum flexibility, the experts were allowed to determine the day, time, and location of the interview. The interview was

completed either in person at the hospital, through video conference, or in writing. The written version can be found in Appendix 5. Two respondents in total decided to complete the questionnaire as a pair using this written form. This version was excluded from the following analysis because it was not finished in line with research guidelines. Therefore, one can state that a total of 25 in-depth interviews has taken place. In order to maintain the respondents' privacy, minor details about them are provided in Appendix 1, Table 1, however seeing this table one has a general view on the respondents.

Within the process of data collection one can experience relevant moments. An example of this relevancy is that it became clear from the interviews that culture is a delicate subject. Some participants seemed to find it difficult to openly discuss culture because they felt concerned that their words might be misinterpreted or distorted. Participants first appeared to have difficulty discussing culture, particularly when a researcher from a different cultural background was present. But once participants were assured by the researchers that culture could be openly addressed without bias, they spoke freely about how they saw the relationship between culture and complaint escalation. This method of handling delicate matters helped to foster an atmosphere where everyone felt comfortable speaking their minds.

3.3 Data analysis

After finalizing the interview stage, the next step was analyzing the gathered data. According to Wong (2008) qualitative data analysis entails reading a great deal of transcripts, comparing and contrasting them, and then identifying themes and creating categories. The interviews were recorded and after that manually transcribed. The choice was made not to convert the transcripts from Dutch to English since doing so would have resulted in information loss and may not have fully preserved the meaning of every component of the interview. This was done to guarantee the integrity and richness of the data.

After the interviews were transcribed, three researchers performed the analysis. During the data analysis, a directed content analysis was used. The analysis can be described as summarizing analysis, which is also known as directed content analysis. This is a method that is frequently employed in qualitative content analysis (Hsieh & Shannon, 2005). The objective of this kind of analysis is to progressively convert complex and dispersed information into organized, comprehensible data that is connected to the elements deduced from the theoretical framework. However, because respondents frequently gave extra information during the interviews, by-catch can be found. By-catch is a word used to refer to information which is gathered during the interview that is not specifically desired

(Doorewaard et al., 2019). During one of the interviews, an interesting by-catch was acquired, namely information on the profession of complaint officers as published by the Association of Healthcare Complaints Officers (de Vereniging van Klachtenfunctionarissen in de gezondheidszorg) received from respondent 10. The information acquired from the interviews was paired with this secondary data. The goal was to see if the respondents' experiences and viewpoints matched the factual conclusions drawn from the data that had been provided.

Within-case analysis and across-case analysis are two techniques that may be utilized in directed content analysis to condense the data gathered. Researchers synthesize the many themes in the within-case study from the perspective of each responder (Doorewaard et al., 2019). Conversely, across-case analysis investigates all of the replies to a specific issue on a more comprehensive level (Doorewaard et al., 2019). Part of this approach is examining how the respondents' opinions on a certain subject vary and overlap. An across-case analysis has been used in this study because it enables the discovery of topical trends and provides a thorough understanding of the respondents' viewpoints.

3.4 Research ethics

Dooly et al. (2017), state various points to take into account in regard to research ethics.

1. An assessment should be made by the researcher if any possible risks to those included in the study exist;
2. Participants will always be provided with enough information from the researcher to properly understand the scope of any scientific topic;
3. Before starting a research project, the researcher must have the approval of all people engaged in the study;
4. Consent is of large value as participants should be provided the chance to decline to participate in the study. To prevent this from happening due to a lack of information or an uncomfortable feeling the participant received an invitation letter before the interview began, which made them able to familiarize themselves with the subjects and feel more at ease;
5. Before starting the data collection procedure, the informants will receive a detailed explanation of the data processing approach. This will be done by providing the respondents with a detailed introduction before conducting the interview.

Furthermore, as the subject of complaint handling involves sensitive information concerning personal information respondents were asked in advance if they consent to the interview being audio recorded. In addition, anonymization of the respondent's personal information is done. All respondents have been made aware that the data will be completely anonymized because the theme of the interviews can be viewed as a sensitive subject. As a result, neither a participant nor the hospital will be able to be identified from the information

acquired. After having finished the transcripts of the interview the respondents have received it. This is done to make sure the transcript reflects the opinion of the respondent on the topics addressed. In addition, he/ she will receive a finalized version of a combination of the theses made by two fellow students and myself. After having shared this information, all audio files and other personal data will be deleted.

3.5 Research quality

It is crucial to consider the quality of the data received while collecting data. The ability of the methodology and data collecting and analysis procedures used to enable the researcher to make justifiable judgments given the scope of the study may be characterized as one of the quality metrics for data (Doorewaard et al., 2019).

An element which provides insight in the research quality is reliability. As reliability is defined as the extent to which researchers may presume that repeat of the interviews may provide the same dataset, it might be difficult to achieve in this form of qualitative study (Doorewaard et al., 2019). Investigator triangulation occurs when numerous researchers try to address the same research problem. The researchers' capacity to compare and contrast many points of view as a consequence of using this sort of triangulation increased the results' reliability and trustworthiness.

Internal validity and external validity are typically the two forms of validity in research. Internal validity refers to the accuracy of the findings, interpretations, and suggestions for the context of the study (Doorewaard et al., 2019). To increase the internal validity, it was planned to conduct interviews with respondents who had an extensive amount of knowledge about various perspectives on the complaint escalation procedure (Doorewaard et al., 2019). These respondents offer the research a broad perspective as they have knowledge in regard to both patient perspective as well as healthcare professional perspective. The internal validity of the current study has been strengthened by expert consultation in both consultation in the field of medical complaints as well as research. The conceptual model as well as the interview guide have been examined by the experts.

As a next step one analyses the external validity which is referred to as the amount to which you may generalize a study's conclusions to different circumstances, subjects, locations, and metrics. Within the research taken place the external validity is perceived as low. This as the investigated situations will not exactly overlap with other uninvestigated situations. However, it is possible given the size of the respondent group that was interviewed that comparable characteristics would emerge in other contexts.

According to a study by Lumsden (2022), researchers should use quotes from respondents to support their arguments while doing qualitative research. The key statements in Chapter 4 are supported by statements from the interviews. This can be seen as increasing the results' confirmability. Confirmability is seen as “the extent to which the findings of a study reflect the respondents' opinions and experiences rather than the researchers' biases, motivations, or interests”. (Kynge et al. 2020, pp. 41-48, Abstract).

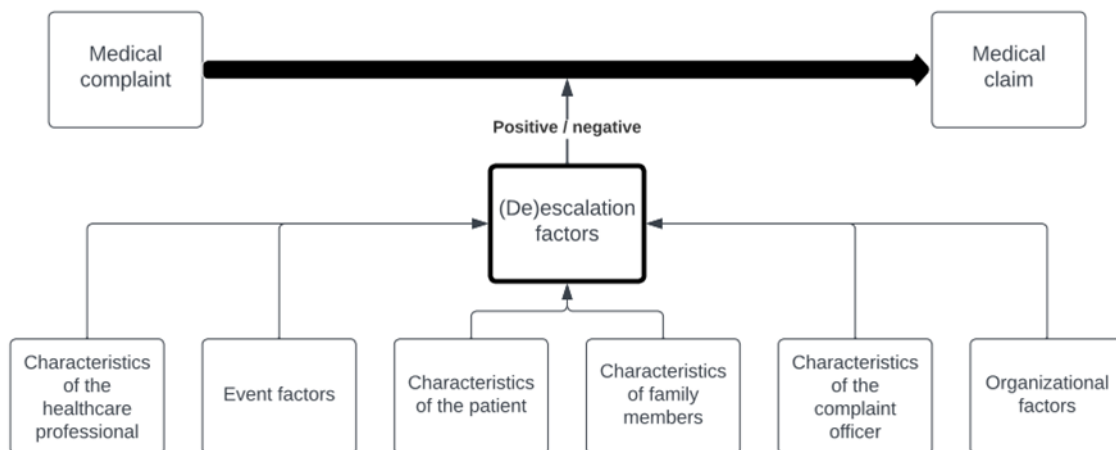
Chapter 4. Results

Information in regard to the sample will be shared before providing one with the key findings on the factors shown in the conceptual model. The 25 responders come from 19 various hospitals around the Netherlands. With the exception of one male complaint officer, the respondents were primarily female. Additionally, most of the respondents had jobs in the medical field prior to beginning their careers as complaint officers. The rest had a background in either law or theology. An overview of the characteristics of the respondents is presented in Appendix 1, table 1.

The structure of this chapter is divided in an analysis of similarities and differences followed by addition findings and unique cases found during the interviews, lastly a summary will be given. The interview findings, which are arranged in line with the various factors in the conceptual framework, will be discussed in this chapter. As visible below, where one can see the conceptual model, the factors that will be discussed are: characteristics of the healthcare professional, event factors, characteristics of the patient, characteristics of family members, characteristics of the complaint officer and lastly organizational factors.

Figure 2

Conceptual framework



4.1 Description of complaints and claims

A choice was made to firstly, before focusing on the factors, agree on the terms of complaint and claim. Analyzing the definition and understanding of the definition of both complaints and claims the majority of the respondents agreed with both. However, some additional

clarifications have been added during various interviews. An example of an addition provided during an interview is:

“Het is een uiting van, van onvrede van een patiënt en of inderdaad een familielid. Maar daarbij wil ik wel graag toevoegen dat het gaat over dat dat alleen een patiënt klacht gerechtigd is, want die heeft een behandelrelatie met het ziekenhuis en het kan wel namens een patiënt ingediend worden, maar dan werken wij wel met een machtiging om ook echt zeker te weten dat de patiënt zelf erachter staat dat er een klacht is ingediend.” – Respondent 9.

Additional findings and unique cases

Looking at the research question, some respondents disagreed with the term ‘escalation’, arguing that when claims appear to be legitimate, the patient has the right to file a claim. A respondent stated the following:

“Ik ben altijd een beetje allergisch als je zegt, hoe kan je claims voorkomen en daar ben ik echt tegen. Als het een terechte claims, mogen mensen ook bij ons aankloppen en we helpen ze op weg ik dat hoor het niet. En, als je dat al in je achterhoofd hebt, dan deug je niet als klachtenfunctionaris.” – Respondent 21.

Furthermore, one experiences the term escalation as not right because of a misunderstanding in regard to the essence of the word. Various respondents associate escalation with a form of aggression. The term, however, is used to describe how something advances to the next step of a process. More particularly, it applies to circumstances where a complaint develops into a claim as a result of many underlying elements. In addition, one should keep in mind that little complaints have the tendency to turn into complaints.

Another additional element shared during interviews is the element of customization of the complaint handling process. According to all respondents, every hospital has a standard protocol or complaints handling system. Additionally, the interviews made clear that hospitals and/or complaints officers must adhere to specific rules set out by the ‘Wet kwaliteit, klachten en geschillen zorg’ (WKKGZ). The interviews revealed that most hospitals still maintain complaints committees even though they are no longer required to have one. In order to stop patients from taking further action and to address the issue internally inside the institution, this is done. Generally speaking, practically all respondents said that while standards serve as a hold, customisation is ultimately crucial. This as, every patient's and doctor's scenario are

unique. As a result, it was thought that the capacity to enable customisation was crucial to the complaint-handling procedure.

4.2 Characteristics of the healthcare professional

The characteristics are divided into personal characteristics and demographic characteristics. While personal characteristics refers to intangible aspects of one's personality or capability, demographic characteristics are the features of a population that have been classified according to specific criteria are known as demographics, and they are used to research the traits of a particular group. Examples of demographic characteristics are age, gender or socio-economic status.

Similarities and differences

The majority of respondents said that personal characteristics of doctors are more significant than their demographic characteristics when asked what features of healthcare professionals led to the escalation of complaints. Failures in healthcare can have a significant effect on patients, and when they are not acknowledged, complaints are likely. Furthermore, while dealing with patient unhappiness, medical professionals need to show empathy. The majority of responders noted that the likelihood of complaint escalation decreases when patients feel like they are understood. Additionally, respondents say that transparency plays a big role in the escalation process. In order to ease communication, healthcare professionals should be approachable to both patients and their peers. Being open and honest with the patient about the processes may be extremely helpful not only for the de-escalation of claims but also for the prevention of complaints. The respondents contend that this transparency should be present in both the disclosure of processes and the handling of errors. Furthermore, one can conclude that personal attention is of large value for patients. This as they do not want to be treated like a number. It might be challenging to provide each patient with individualized treatment because healthcare personnel work under a lot of pressure and typically only have 10 minutes planned for a consultation. A combination of high workload and a shortage in staff results in a difficulty for healthcare professionals to deliver personalized care. In order to minimize the escalation of complaints, patients should receive individualized care.

Analyzing the demographic characteristics of the healthcare professional the majority states characteristics such as gender are not linked to the chance of escalation. However, one is able to see that the vast majority of all respondents links the character of the healthcare

professional to the chance of escalation and not the demographic characteristics. Statements that support this are:

“Nou, als je weinig kan meebewegen in wat de patiënt heeft ervaren, dus als je heel erg ja, als ik het richt op de karakter van de dokter, dan is het bepaalde rigiditeit, stukje arrogantie.” – Respondent 10

“Enerzijds is het dat je dus de patiënt aankijkt doorvraagt, dat je ja ook betrokken bent, dat je in ieder geval als iemand iets vertelt dat je nou ja ook ziet en zodat je, echt contact hebt dat dat zijn dingen die ik vind. Maar dat heeft zegt nog niet zoveel over de karakteristieken van de specialist, maar in ieder geval wel dat je de patiënt met zijn verhaal ziet.” – Respondent 18

However, the demographic characteristic of age is an element which is seen as a characteristic that varies in influence in regard to communication. Nearly all of the respondents indicated that there appeared to be less complaints about communication with younger doctors than with older doctors, suggesting that there may be a difference between younger and older healthcare professionals in terms of patient engagement. The respondents said that this could be because younger physicians are exposed to complaint management and social contact during their schooling, but senior doctors have not. An elaboration on this variation is provided by the statement below:

“Klopt, ja, ja dat zie ik heel duidelijk. Ik zie een heel groot verschil daartussen en, dat is zeker, dat heeft zeker ook met opleiding te maken. Het heeft te maken met de hiërarchische cultuur die altijd heel erg is blijven bestaan rondom die oudere specialist. Ik ben de dokter, dus ik bepaal het, hè.” – Respondent 10

“We zien het eigenlijk allebei. We zien ook jonge artsen die zich toch nog zo opstellen van nou, ik ben dokter, en we zien ook oude artsen die heel erg empathisch zijn en de patiënt heel erg meenemen in het beslissingsproces. Oude artsen hebben gewoon natuurlijk, oud, oud, maar mensen die lang werken hebben gewoon meer werkervaring en, en schrikken daardoor vaak wat minder, omdat ze ook al hebben ervaren dat een klacht ook niet het eind van de wereld is.” – Respondent 19

In regard to medical specialty, surgical specialisms receive relatively more complaints in comparison to diagnostic specialisms. Furthermore, the emergency care is a department with relatively many complaints, due to the fastness of decisions that need to be made. Lastly the gynecology professional group is a department with relatively many complaints, this due to expectations in regard to birth. All of the abovementioned specialties include actions that have higher risks and need quick choices, which frequently results in treatments being carried out without giving patients or families a full explanation beforehand. It is suggested that the sort of healthcare professional who is interested in practicing these specializations would exhibit different personality qualities from medical professionals who belong to the more contemplative disciplines. Medical professionals who work in contemplative disciplines tend to be more interested in talking with patients.

Nearly all respondents stated that the patient-healthcare professional relationship is a crucial component of complaint-handling. The respondents had differing ideas on the effects of this link when asked. The majority agreed that a positive patient-healthcare professional relationship can lessen the possibility of an escalation. A specific example various respondents talked about is the relationship between chronic patients and the healthcare professional. These patients share empathy towards the healthcare professional and are more willing to communicate with the professional and cooperate in finding a solution. A few responders, nevertheless, pointed out that a positive patient-provider connection might potentially have the opposite impact and raise the possibility of an escalation. More precisely, this might cause further disappointment if the healthcare professional does not meet the patient's expectations. This dissatisfaction may manifest itself in altered patient behavior, which inevitably escalates the claim.

Additionally, respondents emphasize how crucial it is for healthcare professionals to adjust to cultural variations. Many people from various ethnic backgrounds live in the Netherlands and the respondent experience a significant lack in ability to understand or speak Dutch. Furthermore, one has different expectations in regard to healthcare in the Netherlands. A combination of this factors may cause conflict between the patient and the healthcare professional. Discrimination is an element which is more frequently experienced by patients according to the respondents. In addition, some respondents also share insight in the aspect of cultural differences by healthcare professionals. For example, German doctors are more used to a high level of hierarchy.

The last topic within the characteristics focusses on the practice of defensive medicine. Complaints and claims are something that almost all medical practitioners wish to run into as

little as possible throughout their employment. They acknowledge it as a learning opportunity, but they also believe that the situation is not ideal. Practitioners' fear of complaints may cause them to alter their methods of providing care. The former includes performing unnecessary diagnostic tests and invasive procedure, prescribing unnecessary treatment and needless hospitalization. In regard to the implementation of the type of practice opinions vary. Furthermore, the respondents that agree to the practice of defensive medicine by healthcare professionals link this to the grow in binding nature of patients.

Additional findings and unique cases

A unique case in regard to a demographic characteristic is experienced in the characteristic of gender. When it came to gender, some of the respondents said that female doctors and other healthcare professionals tend to communicate more effectively on a personal level than male doctors, which is frequently viewed as a good thing. Patients, on the other hand, frequently have higher expectations of female physicians, which makes it easier for them to be let down by the shortcomings of a woman than with male physicians.

Another unique finding highlights that the majority of younger healthcare professionals experience more fear for claims due to pressure. These respondents stressed the need to include young doctors in conversations with their superiors on how to handle complaints in order to better prepare them for possible complaints or claims in the future.

An additional finding highlighted during an interview focusses on the greatest fear by healthcare professionals for disciplinary cases, as they are focussed on a personal level.

Summary

Analyzing the information shared during the interviews one can conclude personal characteristics have more influenced of the escalation process than demographic characteristics. The characteristics that seem to have an effect on escalation of medical complaints to claims are, gender, age, medical speciality, cultural background, language barriers, personal contact, way of communication to patients and fear of complaints and claims. However, important to state that the effect is either direct or in-direct.

4.3 Event factors

Similarities and differences

Analyzing one's nature of the complaints all respondents agree in the nature of the complaints, namely communication errors being the nature of the complaints over diagnostic errors. This statement is supported by the following observations:

“Maar over het algemeen als wij zo'n 1000 klachten en meldingen per jaar behandelen. En dan komen daar echt niet heel veel echte gemiste diagnoses uit, maar wel veel organisatorische, maar vooral ook communicatie klachten.” – Respondent 14

“Het is dus enerzijds is het communicatie of eigenlijk ik geloof dat 99,9% van alle klachten dat daar een communicatie aspect aan ten grondslag ligt.” – Respondent 18

The majority of respondents claimed that throughout the COVID-period, there was a shift in the type of complaints, with a focus more on problematic organizational issues.

Furthermore, various respondents stated that diagnostic errors are more likely to be a claim immediately, before passing the stage of complaint. This as these types of errors as experienced as a calamity.

Additional findings and unique cases

A unique case shared by some respondents elaborates on the tendency to file a complaint as a chronic patient. They specifically mention that the patient's clinical picture may affect the patient-healthcare professional interaction, but does not always cause a larger inclination for escalation. These patients are frequently hospitalized and are typically seen by the same doctor. This makes it possible for them to establish a long-lasting bond, which, as was already indicated, may have a negative effect on the management of complaints. Their perspective is summed up in the following statement:

“En ja, het linkt ook een beetje aan dat chronische waar je het over had. Ik heb wel minder klachten over revalidatieartsen en reumatologen omdat zij denk ik ook anders in het, in hun band met patiënten staan, die hebben vaker daar contact mee, langduriger, hebben denk ik ook een iets.” – Respondent 25

Summary

Analyzing the results as discussed above one can state type of complaint, duration of treatment as well as severity of the event have an effect on the escalation process.

4.4 Characteristics of the patient

Similarities and differences

Analyzing the characteristics of the patient the majority states characteristics such as gender and age are not linked to the chance of escalation of a complaint. The manner in which

complaints are shared and talked about differs between male and female complainers. Male complainers have a more straightforward approach and may become aggressive when not given the ‘right’ answer. Female complainers are overall more friendly, but may show a devious character when not satisfied with the answer provided by the complaint officer. However, analysing the characteristic of culture most respondents agree on the influence on the escalation process. Nevertheless, the influence of culture on the escalation process differs per hospital dependent on the location. This is supported by statements such as:

“Ja ja cultuur noem je dat dat, Dat is vaak zeker wel een drijfveer voor iemand om een klacht in te dienen. En dan helpt dat zeker niet mee als dat heel erg uit elkaar zou staan.”
– Respondent 14

“Ik vind dat cultuur en dominantie wil ik eigenlijk daar wel een beetje bij mekaar neerzetten, omdat ik vaak vind dat je bepaalde culturen hebben mensen zijn ze vaak wat dominanter, hebben ze het idee dat ze ook veel meer in hun recht staan. Daarnaast blijkt er ook een cultuur. Bij cultuur zie je ook heel vaak dat de cultuur bijvoorbeeld met Marokkaanse en Turkse mensen, dat in die landen gaan mensen automatisch direct als er een probleem is naar een naar een ziekenhuis.” – Respondent 18

In addition, different cultures may have different expectations on how complaints and claims are handled. More precisely, the majority of respondents said that people from non-Western cultures frequently have different expectations of care, partly due to cultural differences between those cultures and the Netherlands. The friction these people face with Dutch care standards and processes is a result of this. An example of this is how members of the Turkish-Moroccan community have different expectation about the care provided in the Netherlands because they contrast it with the healthcare system in their own nation.

Furthermore, closely linked to the aspect of culture is the presence of a language barrier. Patients from diverse cultural backgrounds are not the only ones who have language obstacles. In addition to the language barrier of not speaking one’s language, inadequate literacy and ignorance of how the human body works are also language difficulties. The majority of respondents claimed that language problems of all kinds might cause miscommunication and heightened hostility between patients and medical professionals. Numerous hospitals have put policies in place to make sure that patients who have language challenges are assisted. All respondents state they have the ability to use the ‘Tolkentelefoon’. However, regarding other facilities to solve a language barrier in the hospital itself the results

differ. In order to deliver high-quality treatment, many respondents indicated that they think language obstacles within healthcare institutions need to be addressed more.

“Ja, nou ja, er wordt wel heel veel gewerkt met pictogrammen. Er wordt wel hé, we hebben folders in allerlei talen.” – Respondent 10

“Nou, ik vind zelf dat we wij. We hebben alleen maar informatie in het Nederlands, de folders en zo voor zover ik weet, dus dat vind ik wel eens dat we daar beperkt in zijn.” – Respondent 20

Concerning the emotions of patients, all respondents agree that emotions have an escalating effect. When patients share the statement of wanting to take legal actions, they frequently do so out of emotions such as rage, despair or fear. People sometimes want vengeance and try to make those who have offended them feel the same way. Furthermore, patients who still receive care express hesitation to make complaints, because they believe their treatment would change if they do so. Respondents express that this fear comes from a dependent relationship one has with the healthcare professional; in other words, the good patient-primary care provider relationship could become at risk. The respondents said that because younger people are more likely to speak up, this is a problem that affects older people more than younger ones. Regarding another emotional characteristic namely mistrust the vast majority has and is still experiencing mistrust on both the complaint officer side as well as on the process in the hospital. The presence of mistrust appears to be a factor in complaints' escalation since it negatively impacts both the treatment relationship and the connection between the patient and the complaint officer.

“Dat horen we wel eens dat je, dat wel aan ons gevraagd wordt van ja, maar hoe onafhankelijk zijn jullie nu eigenlijk, hè? Want jullie worden toch betaald door het ziekenhuis?” – Respondent 9

“Ja, ja, dat dat is vooral als mensen het gevoel krijgen dat de arts iets goed wil praten, dus dat ze bijvoorbeeld iets niet geloven. Maar wat de arts ook roept, ja, ze geloven het gewoon niet. En dan krijg je een vorm van wantrouwen dus. En mensen vullen soms vaak één of vaak soms hun behandelproces vinden zij momenten dat er iets niet goed gegaan was. Dan is het, dus dan ontstaat er wantrouwen. En dan zie je de. Had het helemaal escaleert richting een klacht.” – Respondent 12

Concerning the relation between patient and healthcare professional and the probability of escalation the opinions vary. The majority of respondents stated that the patient's clinical profile or length of care may have an impact on the relationship between the patient and a medical professional. Chronic patients were frequently mentioned by the responders as an example. The same doctors often treat these patients, who are frequently hospitalized. This makes it possible for them to develop a lasting bond. It is noteworthy to notice that this factor had little impact on the complaints' escalation. The treatment relationship may be impacted by a chronic illness, but this has not directly increased the likelihood that complaints would escalate into claims. The level of patient satisfaction with the care provided and the method used to handle complaints appear to have a significant impact on the progression of complaints.

“Ja, dat kan twee kanten op gaan hè, dus dat je, kijk als daar als daar heel veel vertrouwen is en er is een goeie afstemming tussen patiënt en arts. De arts kan goed aansluiten bij de verwachtingen van de patiënt kan het goed uitleggen. Je ziet ook juist wel dat mensen ja, omdat ze zelf beter, kijk patiënten met een chronische ziekte zijn heel goed deskundig op hun eigen ziekte, hè, dus die verwachten daarmee ook iets anders van de arts, hè? Die willen dan ook dat die op een ander level met hen spreekt en als dat als arts niet lukt dan kan het juist weer leiden tot ontevredenheid.” – Respondent 9

An element which is also of value within the escalation of complaints to claims is socioeconomic status. To be more precise, the majority of respondents said that those with a higher socioeconomic status often require less assistance from professionals, such as those who handle complaints, as they have more knowledge about the processes of complaint handling. Due to a larger amount of knowledge in comparison the patients with a lower socioeconomic status, patients with a higher socioeconomic status tend to file a claim more easily. In regard to patients with a lower socioeconomic status a more aggressive attitude is experienced by complaint officers. This due to a lack of knowledge concerning the process of complaint handling. These patients typically have financial gain as their primary motivation. Analyzing the escalation signals complaint officers recognize on the patient side, various signals can be seen. Many respondents pointed out that when a patient abruptly adopts a more formal way of speaking, this can be a signal that a complaint is about to escalate. Furthermore, some respondent share insight in the escalation signals by provides examples such as the tone of voice during a conversation or a change in correspondence from in person

to email. These signals are according to respondents signals of escalation on the patient side. These signals are summarized in the following statement:

“Ja ja formeleren worden. Dat is altijd een signaal. Als iemand weer met u gaat praten, als iemand weer met veel formeleren taal. Dus die neemt afstand. Iemand die stiller wordt. Het vertrouwens opeens kwijt is. U zegt wel onafhankelijk te zijn, maar wij twijfelen daaraan. Dus dat iemand letterlijk uitspreekt van aan jou heb ik ook niks. Soms is het ook letterlijk uit contact gaan, dus niet formerele worden. Dus vanaf nu neemt mijn zus het over. Dus iemand die gewoon zegt zoek het uit. Die haakt letterlijk af en dan weet je ook dat is niet goed. Ook dat je bijvoorbeeld altijd belt en opeens krijg je een mail en die is dan heel zakelijk. Dan is het opeens een hele andere toon van spreken.” - Respondent 4

Additional findings and unique cases

A unique case in regard to escalation signals is shared by some respondents, namely the absence of emotions. Respondents experience this as a sign of possible escalation.

An additional finding provided by respondents focusses on the increase of patients with mental health issues that file a complaint. The complaint officers in hospitals are frequently the ones who receive complaints from this kind of patient because they want to be heard. This rise in patients who are mentally unstable appears to be related to the increasing issues with mental healthcare in the Netherlands.

Another additional finding elaborates on the aspect of discrimination experienced by patients who have another cultural background. According to most respondents, discrimination can make patients feel as though they are not being heard, understood, or taken seriously. Emotions like highlighted above, may come up during the process of complaint handling when feeling discriminated. A presence of these emotions, like feeling unfairly treated or anger, may result in escalation of a complaint.

The last additional finding explains a change in patient behavior. Many respondents emphasized that patients had grown more self-assured. Furthermore, respondents highlight the trend of an increase in empowerment and therefore feeling the need to speak up. One can see a clear trend in that patients have higher expectations and share these by having a demanding attitude. An external influence, like Google, plays a role in this trend as patients search for information online and therefore see themselves as an expert in the field of healthcare. Various respondents share insight in this trend by providing the example of a comparison between healthcare and a car manufacturer. This comparison is used as it elaborates on the

increasing believes of patients that their lives are manageable and the aspect that one can fix all problems.

Summary

Based on the result, one can state characteristics such as emotions, culture, patient-healthcare professional relationship, mistrust, expectations, external influences like internet, discrimination and language barriers have an effect on the escalation process.

4.5 Characteristics of family members

Similarities and differences

Most respondents state the influence of family as escalating rather than de-escalating. The majority of the respondents state that when family members have a de-escalating role this is not visible or noticeable for the complaint officer. However, within mediation conversations complaint officers sometimes experience family members to have an escalating character. All respondents elaborate on the fact the consent of the patient itself is needed in regard to complaints and as a result this is checked within every medication conversation. In addition, taking into account different cultures the role of family is stated as larger. This as both close family members as well as family that still lives in the home country is of value within the process of complaint handling as all information concerning the topic is shared.

In addition, respondents have shared unrealistic demands are made out of the love one experiences for the loved ones. However, due to this connection, a conflict or escalation is seen more frequently if the loved one has not received the care one sees as 'right'. Furthermore, a shortage in information contributes to the chances of escalation. Respondents elaborate on this element by saying it happens as family joins the process of complaint handling at a later moment in time. In addition, not always the same family member is present during a mediation conversation. Family members unlike patients do not have a healthcare-based relationship with the healthcare professional. As of this, the family members are less concerned about the relationship between the primary care provider and the patient.

The importance of considering a relative's cultural background was another intriguing discovery. Families are more likely to take part in the process, particularly in non-Western societies. In these cultures, relatives are expected to defend the patient's best interests and therefore act as the protector of the patient. As various respondents are not familiar with this

form of engagement, this engagement and the way of handling this involvement may be an escalating factor.

Additional findings and unique cases

An additional finding is that one has to take into account the patient's relationship with the family member that joins the mediation conversation. Looking at the element of gender and age one can see different attitudes. Husbands overall feel more responsibility, struggle to listen, and communicate more aggressively whereas wives are more talkative and generally speaking show a higher level of empathy. One can also experience a difference in attitude looking at sons and daughters of the patient. Girls could be more inclined to respond emotionally, whilst males would show a higher level of arrogance.

The involvement on the complaint handling process or the process before sharing a complaint or claim goes beyond family members. Direct surroundings, like friends present at birthday parties, are places where one can discuss personal life. Unfounded opinions can result in the step of patients or former patients filing a complaint or claim.

Summary

Characteristics such as the relationship between the patient and family, culture, lack of contextual information, and the gender of the family involved in the complaint-handling process have an impact on the escalation process. Furthermore, external influences such as acquaintances also influence complaint escalation.

4.6 Characteristics of the complaint officer

Similarities and differences

Characteristics that are mentioned as being of great importance within the profession of a complaint officers are: being empathic, good communication skills both verbal communication as well as online communication, being analytic, being able to derive the essence within a mediation conversation and being independent. The characteristics shared within the interviews will be compared to the characteristics shared within the 'beroepsprofiel klachtenfunctionaris' shared by respondent 10.

In addition, looking at the role of the complaints officer the vast majority of the respondents see their role in de-escalation process as large. However, most respondents state patients have the right to file a claim, and therefore do not want to keep them away from doing so. Nevertheless, the characteristics as shared above as well as elaborating on the

process of complaint and claim handling are seen as abilities to de-escalate a complaint from turning into a claim. All respondents share the above-mentioned characteristics; however, one can see a difference in the amount one shows these characteristics depending on the educational background of the complaint officer. Complaint officers with a background in medicine tend to adopt a more personal approach and in addition show a higher level of empathy. Furthermore, they are more informed about the medical processes that take place, however not forming an opinion about the medical process seems difficult. Complaint officers with a legal background frequently take a more structured approach focused on formality as they are generally more focused on rules and therefore find it easier to stay neutral. Another factor taken into account in the topic of characteristics of the complaints officer is noticing the signals of escalation. The statement as presented below described signals mentioned within the interviews.

“Ja ja formeleren worden. Dat is altijd een signaal. Als iemand weer met u gaat praten, als iemand weer met veel formeleren taal. Dus die neemt afstand. Iemand die stiller wordt. Het vertrouwens opeens kwijt is. U zegt wel onafhankelijk te zijn, maar wij twijfelen daaraan. Dus dat iemand letterlijk uitsprekt van aan jou heb ik ook niks.” – Respondent 4

However, not all respondents agree to having experienced these signals, but the vast majority of the respondents agrees to the possibility of these signals coming up during the process of escalation from a complaint into a claim. Furthermore, the vast majority see the expression of extreme emotions as a sign of escalation. However, one also states the lack of emotions could also be a sign of escalation.

The table below provides insights in the various characteristics the respondents said a complaint officer should have.

Table 2
Complaint officer skills

Skills that a complaint officer should possess:	
Provide personalized care	Active listening
Independence and impartiality	Analytical thinking
Transparency and information disclosure	Ability for asking probing questions
Empathy	Patience and resilience
Summarizing conversations	Act proactively

Ability to raise awareness about complaint-handling among healthcare providers	Knowledge of legislation
Thoroughness in complaint-handling	Ability to set boundaries
Ability to identify complaint escalation	Attention to nonverbal communication

Additional findings and unique cases

A unique finding some respondents shared is on the challenging and delicate subject one has to deal with as a complaint officer. One respondent shared her opinion on the need for direct colleagues as she believes one is not able to perform on the job being the only complaint officer. The majority of the respondents share that having direct colleagues is experienced as pleasant both on an emotional level as well as on the work floor. This as one should be able to discuss complaints and feelings that come with the job of complaint officer.

Another additional finding explains the discrepancy between the job and the education one has to follow to become a complaint officer. An example which explains this discrepancy is the thought on sharing personal stories. One should not elaborate on this based on the information sharing during education, however various respondents have the opinion one is able to show empathy in a better way when doing so.

Furthermore, the majority of the respondents explain that being able to perform the job of complaint officer more proactively could prevent complaints for being filed. Healthcare professionals should be aware of the presence and assistance a complaint officer can offer in regard to difficulties with communication between the healthcare professional and a patient. One could ask for assistance in order to prevent a feeling of discomfort from the patient towards the healthcare professional or the other way around. In that way a complaint can be prevented.

Summary

Table 2, as presented above, provides insights in the characteristics a complaint officer should have to perform well as a complaint officer. One can conclude, these have a direct effect on the risk of escalation.

4.7 Organizational factors

Similarities and differences

According to the results of the interviews, it can be concluded that complaint officers evaluate the significance of an organization's size differently in terms of escalation of complaints. The fact that there are several organizational levels in larger hospitals might give patients the impression that they are lost in the system and unsure of where to turn for help. Additionally, patients are more likely to encounter various medical specialties at larger hospitals. As healthcare professionals see so many different patients, there will be a smaller focus on personalized care.

Organizational culture is another crucial component. The majority of respondents said that it is crucial for employees from all organizational levels to interact with one another and to be easily accessible.

In all hospitals claims are handled by the juridical department of the hospitals, which results in a more legal way of handling the process of complaints and claims. All respondents share their preference for a less formal way of dealing with complaints.

Furthermore, one should keep in mind the location of the hospital plays a part in the expectations the patients coming to the hospital might have. A statement that supports this is:

“Ik denk dat de cultuur heel erg meespeelt hè, we zitten hier natuurlijk, in X en X staan we tenminste, wel om ze gastvrijheid hè, en ik denk dat je dan toch met een heel ander soort klachten te maken hebt, soms misschien ook wat serieuzer klachten dan als je in het westen komt. Dus ik denk dat het zeker wel scheelt wat voor ziekenhuis, maar ik denk vooral ook de ligging waar je zit” – Respondent 5

In addition, the level of knowledge how to serve patients with a different cultural background varies. Per hospitals the facilities were different in regard to pamphlets in different languages, training one is provided with based on other cultures, or possibilities to eat food one is familiar with, such as Halal food. However, one should keep in mind the location of the hospitals does not directly contribute to the chances of escalation.

An element all respondents agreed on is the presence of support for healthcare professionals. As one could experience difficulty with receiving a complaint or claim hospitals offer assistance from within the organization. Healthcare professionals could turn to, for example peer support and other colleagues. Furthermore, communication training can be provided. When starting as a healthcare professional most respondents explain that they are

present during the introduction talk. This in order to provide the just started healthcare professional with tools where to turn to if needed.

Additional findings and unique cases

Linked to the location of the organization and the presence of different cultures within the hospital the organization should be able to offer the preferred facilities for a pleasant healthcare process when present at the hospital. An example shared by a respondent elaborates on this element:

“Ja, ja, de imam bijvoorbeeld binnen de X had een hele belangrijke rol. Juist ondersteuning naar die zorgprofessionals toe, hè? Want als het soms op leven en dood aankwam en als iemand bijvoorbeeld hersendood verklaard werd, dan kwam die imam om de hoek van die wist vertaalslag te maken vanuit die arts naar de naar de naar de familie toe.” – Respondent 22

Summary

Analyzing the information from the interviews, one can state factors that might influence escalation are organizational culture, education and training opportunities for healthcare professionals, location, cultural differences and healthcare with a personal approach.

Chapter 5. Conclusion and discussion

The conclusion provides insight in the answers to the research question, which is: “*What factors lead to an escalation of turning a medical complaint into a medical claim and how can this escalation be prevented?*”. The structure is based on the expectations as formulated in Chapter 2. This chapter follows the structure of the book by Doorewaard et al. (2019), namely providing one with a general conclusion, conclusion per topic, recommendations and finally a critical reflection. In order to determine if the expectations from the theory can be confirmed in a real-life environment, the conclusion includes a comparison between the literature obtained and the data collected from the interviews.

5.1 General conclusion

The goal of the study as mentioned overview of the paragraph is to provide an answer to the research question. There are a number of things that might cause a complaint to escalate or are signs that a complaint is about to escalate. Table 3, as visible below, offers a concise summary of the expectations as formulated in Chapter 2. Furthermore, it provides insights on the aspect if these expectations have been confirmed, partly confirmed or rejected.

Table 3

Overview of Expectations

Expectations		
E1	Female healthcare professionals are expected to have a higher risk of escalation than male healthcare professionals.	Rejected
E2	Older healthcare professionals are expected to have a higher risk of escalation than younger healthcare professionals.	Rejected
E3	Some medical specialties are expected to have a higher risk of escalation than other specialties.	Confirmed
E4	When healthcare professionals have received previous claims, they are expected to have a higher risk of future complaint escalation.	Rejected
E5	When healthcare professionals have better communicative skills, the risk of escalation is expected to be lower than when professionals have poor communicative skills.	Confirmed
E6	When healthcare professionals disclose service failure, the risk of escalation is expected to be lower than when professionals do not disclose service failure.	Confirmed
E7	A good patient-primary care provider relationship is expected to reduce the likelihood of complaint escalation.	Partly confirmed
E8	Diagnostic errors are expected to have a higher risk of escalating into a claim than communication errors.	Rejected
E9	Patients with a higher socio-economic status are expected to have a higher risk of complaint escalation than patients with a lower socio-economic status.	Rejected

E10	Patients with previous negative experiences in healthcare are expected to have a higher risk of complaint escalation than those without negative experiences.	Confirmed
E11	Patients who show much emotion during the complaint-handling process are expected to have a higher risk of complaint escalation than patients who do not show emotion.	Partly confirmed
E12	The involvement of family members in the complaint-handling process is expected to lead to a higher risk of escalation.	Partly confirmed

5.2 Conclusion per topic

This paragraph is structured following the factors as shown in the conceptual model. A more detailed elaboration per topic is presented.

Characteristics of the healthcare professional

According to the findings of the interview a healthcare professional's **gender** has no impact on the chances of escalation. This is supported by the source of Austin et al. (2021) which states gender is not a good predictor of escalation from com complaints into claims. However, it is contradictory to information mentioned in sources like Baker et al. (2013) and Troxel (2019) which are used by a fellow-researcher. The **communication style** however differs per gender. Female healthcare professionals overall communicate more effectively and more on an emotional level. **Empathy** is seen as a good indicator for escalation; therefore, the communication style is also of importance when analyzing factors that contribute to escalation. Another finding was that patients have higher expectations of female professionals than of male professionals in regard to **communication skills**. As of these expectations' patients are more likely to complain about the lack of skills in communication of female healthcare professionals in comparison to male healthcare professionals. As a conclusion one can state that unhappiness about the healthcare professional results in a higher chance of escalation. **Expectation 1, female healthcare professionals are expected to have a higher risk of escalation than male healthcare professionals, is not confirmed.**

Analyzing the findings of the interview one can state **age** does not have a direct effect on the risk of escalation. This is supported by the source of Austin et al. (2021). However, it is contradictory to information mentioned in the study by Azab (2013) used by a fellow-researcher. One can see an effect of age on the communication style as well as attitude towards practicing healthcare. Due to an increased expertise in social skills, one can see fewer complaints related to communication on younger healthcare professionals. Furthermore, as stated above older healthcare professionals have another attitude towards practicing healthcare. One can conclude this attitude is more hierarchical. Analyzing all information

mentioned above a healthcare professional's communication style is a good indicator of complaint escalation. **Expectation 2, older healthcare professionals are expected to have a higher risk of escalation than younger healthcare professionals, is not confirmed.**

The information from the interviews shows that **specialties** like surgery, gynecology, emergency care, orthopedics and radiology are at higher risk of escalation. All of the mentioned specializations include procedures that come with increased risks and they call for hasty decisions, which frequently leads to treatments being put into practice without fully informing patients or their families first. Klemann et al. (2022) supports the findings from the interview by elaborating on the medical specialties that receive more claims than other specialties. According to Klemann (2022) these are gynecology, orthopedics and surgery. **Hypothesis 3, some medical specialties are expected to have a higher risk of escalation than other specialties, is confirmed.**

According to the findings of the interview, one is not able to say that healthcare professionals who have received **claim previously** are at higher risk of complaint escalation at a later moment in time. Though one can see anxiety by those who have previously received a complaint or claim. **Defensive medicine** is likely to happen as a result of this anxiety (Monteferrante et al, 2022). However, the findings of the interview show a diverse answer to the question if one sees that healthcare professionals perform defensive medicine. In addition, the anxiety as stated above is mainly focused on disciplinary cases. **Hypothesis, when healthcare professionals have received previous claims, they are expected to have a higher risk of future complaint escalation, is not confirmed.**

Looking at the information shared during the interview one is able to state that the **communication skills** of healthcare professionals are a good predictor of complaint escalation. Gorney (2022) and Howard et al. (2013) support the statement by elaborating on the effect of good communication on patient confidence. The most common cause of the vicious cycle that leads to patient unhappiness, anger, frustration, hostility, defensiveness, and arrogance on the part of the doctor, increasing patient rage, and finally a trip to the lawyer is inadequate communication. One mistake one can make while interacting with patients, according to Gorney (2022), is to avoid those who are angry or dissatisfied. Actively taking part in the process is a more suited and efficient strategy. **Hypothesis 5, when healthcare professionals have better communication skills, the risk of escalation is expected to be lower than when professionals have poor communication skills, is confirmed.**

The information gathered during the interviews shows that **disclosure** lessens the chance of escalation of a complaint. Analyzing the information from both literature review as

well as the interviews one can conclude transparency about healthcare service failures has a positive effect on patient satisfaction. Research by Howard et al. (2013) elaborates on the effect that emotions of the patient are a good predictor of risk of escalation. Ineffective communication was a major issue and the main element that led to escalation in the research by Howard et al. (2013). Plaintiffs did not feel as though their concerns were being heard. Furthermore, linked to the expectation formulated above Giraldo et al. (2020) explain that apologies and disclosure have little effect on medical malpractice lawsuits. Contrary to Giraldo et al. (2020), Kass and Rose. (2016) assert that openness and transparency result in the plaintiff's stress being reduced. **Hypothesis 6, when healthcare professionals disclose service failure, the risk of escalation is expected to be lower than when professionals do not disclose service failure, is confirmed.**

Analyzing the information from the interviews one can say that the **relationship between the patient and healthcare professional** can both have an escalating as well as a de-escalating effect. Mainly when the relationship serves a longer period of time the patient can feel particularly displeased and frustrated with the healthcare professional if the result does not meet the expectations one hoped to achieve. In contrast, one can conclude that a patient-healthcare professional relationship which is seen as good can reduce the risk of escalation. This as one trusts one another. Communication in regard to solving a service failure is therefore easier **Hypothesis 7, a good patient-primary care provider relationship is expected to reduce the likelihood of complaint escalation, is partly confirmed.**

As one stated above various items have an impact on the relationship between the patient and the healthcare professional, namely age and gender. Furthermore, in the interviews one noticed a discrepancy between way of working and attitude between healthcare professionals from different countries.

Event factors

The information of the interviews highlights, contradictory to the information gathered in the literature review, that when patients experience a **diagnostic error** they file a claim instead of a complaint. Therefore, the escalation process cannot take place. Furthermore, one sees that categorizing the complaints most focus on the aspect of communication. This has a higher chance of escalating as misunderstanding can take place between patient and healthcare professional. To conclude one can state that **communication errors** have a higher risk of escalating into claims than diagnostic errors. **Hypothesis 7, diagnostic errors are expected**

to have a higher risk of escalating into a claim than communication errors, is not confirmed.

Characteristics of the patient

Information received during the interview shows that **socioeconomic status** influences the attitude one has during a mediation conversation. Patients with a lower socioeconomic status tend to have a higher focus on the financial aspects of a complaint or claim. On the other hand, patients with a higher socioeconomic status are more likely than patients with a lower socioeconomic status to take legal actions. One cannot see a direct effect of socioeconomic status on the chance of escalation. **Hypothesis 8, patients with a higher socio-economic status are expected to have a higher risk of complaint escalation than patients with a lower socio-economic status, is not confirmed.**

Another characteristic of the patient focusses on the chance of escalation linked to a **previous negative experience** a patient may have had. One can see a direct link between these elements as previous negative may lead to **mistrust**. Since it has a negative effect on both the patient-complaint officer relationship and the treatment relationship, the existence of mistrust appears to be a contributing element in the complaints' escalation. **Hypothesis 10, patients with previous negative experiences in healthcare are expected to have a higher risk of complaint escalation than patients without previous negative experiences is confirmed.**

The last characteristics explains an escalating and de-escalating link between **emotions** and the risk of complaint escalation. In addition to emotions adopting formal behavior can also be seen as a signal of possible escalation. Formal behavior focusses on the aspect of a discrepancy is tone of voice, writing style and speaking style. Furthermore, lack of emotion and detachment are an addition to the escalating factors. Due to the absence of emotions the relationship between complaint officer and patient can experience difficulties, as the empathy aspect is of importance within such a conversation. Looking at escalating emotions the patients may show during a mediation conversation one is able to see anger, revenge and sadness as the most common ones. These emotions are supported by Howard et al. (2013). **Hypothesis 11, patients that show much emotion during the complaint-handling process are expected to have a higher risk of complaint escalation than patients who do not show emotion is partly confirmed.**

The degree of **manageability** is seen as an additional factor in regard to escalation of a complaint into a claim. This increase in believes one has about the degree of manageability

has resulted in different expectations resulting in unrealistic demands. An increased risk of escalation occurs from not being able to satisfy these needs.

An additional factor, which is not escalating, however of importance looking at expectations is **culture**. Furthermore, it affects the communication style as well as the behavior a patient shows. When patients experience **discrimination**, it can lead to feelings of unfairness and frustration. **Language problems** can also result in miscommunications and escalating tensions between patients and healthcare professionals. As one already noted the relationship between patient and healthcare professional is of importance.

Characteristics of family members

According to the information gathered during the interviews one is able to partly state that **family** has an escalating effect. Both an escalating effect as well as a de-escalating effect is highlighted during the interviews. An important aspect one should keep in mind during the mediation conversation is the relationship between family members present and the patient. This as this aspect has an effect on the attitude and behavior one expresses. Furthermore, one should focus on the aspect of cultural context of family members, as various cultures have other expectations about healthcare and complaint handling. In addition, there is often a discrepancy in regard to knowledge about the process in the hospital, resulting in unrealistic expectations and demands. As family members have no personal connection with the healthcare professional family is more likely to file a claim. This as one does not have to worry about effect on possible still ongoing treatment. Gorney et al. (2002) supports the escalating character of family by elaborating on various characteristics of so-called ‘trouble-prone patients. One of these characters focus on the role of family. **Hypothesis 12, the involvement of family members in the complaint-handling process is expected to lead to a higher risk of escalation, is partly confirmed.**

Organizational factors

In regard to organizational factors and their contribution to escalation limited research was found. Therefore, no expectations were formulated concerning this factor. However various aspects do have an influence on escalation based on the information from the interviews. The fact that there are several **organizational levels** at larger hospitals may make patients feel lost in the system and unclear of where to go for assistance. Furthermore, patients will see and be helped by different healthcare professionals at larger hospitals, therefore one is not able to establish a good **patient-healthcare professional relationship**. As a result, personalized care

is more difficult. Another important factor is the **culture** of the organization. Communication and accessibility amongst employees at all organizational levels is experienced as valuable by the patients as well as healthcare professionals. In addition, a **proactive approach** by healthcare professionals to include complaint officers in the process is preferred in order to prevent complaints. Making yourself known and the function of a complaint officer is also of great value.

Characteristics of the complaint officer

Looking at this factor it was not possible to formulate a concise expectation as limited research in regard to this topic is available. Analyzing the interviews however one is able to formulate the importance of the role of complaint officer as high as they have a key role in trying to prevent escalation from happening. The information gathered during the interviews show a variety of **skills and competences** a complaint officer should have to do their work effectively. A comparison between the list of competences and skills a complaint officer should have according to the professional profile released by The Association of Healthcare Complaints Officers and the information one received during the interviews is shown below in Table 4 (Panis et al., 2018). A few discrepancies can be found.

Table 4

Comparison complaint officer skills

Skills a complaint officer should possess:	
Interview findings	Professional profile?
Able to provide personalized care	X
Independence and impartiality	X
Transparency and information disclosure	X
Empathy	X
Summarizing conversations	X
Ability to raise awareness about complaint-handling among healthcare providers	
Thoroughness in complaint-handling	X
Ability to identify complaint escalation	X
Active listening to	X

Analytical thinking	X
Ability to ask probing questions	
Patience and resilience	X
Act proactively	X
Knowledge of legislation	X
Ability to set boundaries	
Attention to nonverbal communication	X

Analyzing the goal of the research the formulation of the goal was as followed: to identify the underlying factors that contribute to the progression of medical complaints as well as look into potential solutions. As visible the goal consists of two parts, namely identifying the factors as well as analyzing prevention tools. Table 5 as visible below is an overview of the factors that contribute to complaint escalation. In the last column one sees if the factor is a new effect or based on the expectations as formulated in Chapter 2.

Table 5

Factors contributing to complaint escalation

Factor	Effect	New effect?
Medical specialty	Certain medical specialties have a higher risk of complaint escalation than other specialties.	
One-size-fits-all approach	When healthcare professionals or complaint officers use a one-size-fits-all approach, there is a higher risk of complaint escalation.	X
Patient-primary care provider relationship	When there is a poor patient-primary care provider relationship, there is a higher risk of complaint escalation.	
Empathy	When healthcare professionals do not show empathy, there is a higher risk of complaint escalation.	
Disclosure	When healthcare professionals do not disclose during medical treatment or after a service failure, there is a higher risk of complaint escalation.	
Sympathy and apology	When healthcare professionals do not sympathize and apologize after a service failure, there is a higher risk of complaint escalation.	X
Type of complaint	Communication errors seem to be more sensitive to complaint escalation than other types of complaints.	

Duration of the complaint-handling process	When the complaint-handling process takes a long time, there is a higher risk of complaint escalation.	X
Duration of treatment	The duration of treatment influences the patient-primary care provider relationship, which in turn has an impact on complaint escalation.	X
Subjective severity	When the subjective severity of the event is not addressed, there is a higher risk of complaint escalation.	X
Expectations	The higher the discrepancy between patients' expectations and reality, the higher the risk of complaint escalation.	X
Increased demands	The higher the demands of the patients, the higher the risk of complaint escalation.	X
Mistrust	When patients show signs of mistrust, there is a higher risk of complaint escalation.	
Previous negative experience	When patients have previous negative experiences with service recovery in healthcare, there is a higher risk of complaint escalation.	
Socio-economic status	The socio-economic status of the patient influences their communication style, potentially leading to a higher risk of complaint escalation.	
Language barrier	When patients have a language barrier, there is a higher risk of complaint escalation.	X
Discrimination	When patients have the feeling they are discriminated against, there is a higher risk of complaint escalation.	X
Cultural differences	Cultural differences impact patients' expectations and communication styles, potentially leading to a higher risk of complaint escalation.	X
Not feeling heard	When patients have the idea that their dissatisfaction is not heard and acknowledged, there is a higher risk of complaint escalation.	X
Emotions	When patients show high levels of emotion, there is a higher risk of complaint escalation.	
Lack of emotions	When patients show a lack of emotions in the complaint-handling process, there is a higher risk of complaint escalation.	X
Behavior change	When patients showcase different behaviors, such as communicating formally, there is a higher risk of complaint escalation.	X
Detachment	When patients detach themselves from the complaint-handling process, there is a higher risk of complaint escalation.	X

Involvement of the family	When the family is involved in the complaint-handling process, there is a higher risk of complaint escalation.	
Relationship between family and patient	When the patient and family members have a close relationship, there is a higher risk of complaint escalation.	X
Relationship between family and professional	When the professional and family member do not have a personal relationship, there is a higher risk of complaint escalation.	X
Cultural context of the family	When the cultural background of the family is ignored, there is a higher risk of complaint escalation.	X
External influences	External influences, like social media and the internet, increase the risk of complaint escalation.	X
Organizational size	In larger organizations, the risk of complaint escalation is higher compared to smaller organizations.	X
Hierarchy	High-hierarchy organizations have a higher risk of complaint escalation compared to low-hierarchy organizations.	X

Analyzing the second part of the goal, namely prevention, Table 6 is created, which shows the factors that have an influence of the prevention of complaint escalation. A more detailed elaboration on the factors is presented in paragraph 5.3.

Table 6

Overview of the factors influencing claim prevention or de-escalation

Factors that contribute to prevention or de-escalation of claims		
Communicate transparently and directly	Empathize, guide, involve and enlist	Build trust
Provide information and disclose before medical treatment and after service failure	Listen actively	Make sure patients feel heard and taken seriously
Be aware and pay attention to warning signs of escalation.	Involve family early on in the medical process	Ask clarifying questions and communicate effectively
Provide patient-centered care	Support and educate healthcare providers in complaint-handling, communication, and cultural diversity	Make low-threshold contact
Foster an open environment	Show sympathy and apologize	Establish a strong patient-primary care provider relationship

Understand and recognize the root of patients' emotions	Acknowledge the impact of cultural diversity and language barriers	Act pro-actively
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5.3 Recommendations

As the goal of this research is to identify the underlying factors that contribute to the progression of medical complaints as well as look into potential solutions a to do list is created with provides a guideline in order to prevent escalation. This prevention tool is included in Appendix 6. Recommendations have been formulated on various levels namely the healthcare professionals, the complaint officer and lastly the healthcare organization. The overview of the recommendations is included in Table 7, Table 8 and Table 9.

Table 7

Healthcare professional recommendations

Transparency and disclosure	Trust can be achieved by providing the patient with a feeling of transparency and disclosure. Closely linked to this is communication, and having the feeling of being informed. In this way, one is able to lower the risk of complaint escalation.
Recognition of cultural diversity	One should take into account the culture a patient has and the customs the patient is therefore used to; one should focus on the needs and wants of one's culture. In case one shows respect and adapts to these one is able to lower the risk of complaint escalation.
Pro-active approach	In case the healthcare professionals experiences difficulties in regard to communication one should discuss this pro-actively by mentioning the difficulties one is experiencing. Furthermore, one should be familiar with the assistance a healthcare professional is able to ask. By acting pro-actively, one is able to lower the risk of complaint escalation.
Demonstrating empathy	By demonstrating empathy, one is able to lower the risk of complaint escalation. This as, by showing empathy, one dives into the aspect of concerns a patient might experience. Analyzing one's verbal as well as non-verbal communication is an aspect of importance. By doing so a patient feels taken seriously.
Provide personalized care	By providing personalized care one is able to lower the risk of complaint escalation. Healthcare is seen as a complex process in which healthcare professionals want to provide high-quality care. By providing personalized care the patient is able to experience high-quality care more easily. Furthermore, a patient has the feeling of being heard. Furthermore, the patients feel more pleasant as one is provided with care specialized to your needs and wants.

Table 8*Complaint officer recommendations*

Involvement of family members	One is able to lower the risk of escalation by actively involving family member in the process of complaint escalation. Connected to this involvement is the opportunity to create an equal amount of contextual knowledge.
Recognition of cultural diversity	Analyzing the aspect of cultural diversity as mentioned above within the role of healthcare professionals, complaint officers should also respect this aspect. In this way one is able to lower the risk of escalation.
Setting boundaries	Looking at the mediation conversation, the complaint officer should set clear boundaries. As believes in manageability have increased overtime demands have changed. When communication in regarding to boundaries are made one is able to lower the risk of complaint escalation.
Creating awareness	In case complaint officers create awareness about the role they have one is able to lower the risk of complaint escalation. Healthcare professionals should have the opportunity to ask a complaint officer for advice, however being aware that the opportunity is there is an aspect in which investment is needed. This as complaint officers play a large role in the de-escalation process.

Table 9*Healthcare organization recommendations*

Open environment	One is able to lower the risk of complaint escalation by having an open environment. This as an open environment results in a comfortable place patients can go to to share their dissatisfaction or discomfort; as a result, patients have the feeling that they can speak more freely.
Clear guidelines and procedures	By providing patients with clear guidelines and procedures the demands of the patient can be managed more clearly. As a result, possible misunderstanding or lack in knowledge can be managed.
Recognition of cultural diversity	By taking into account cultural diversity, one is able to lower the escalation of complaints. This as patients feel more comfortable when their wants and needs are respected. Additionally, communication is closely linked to this aspect. In this way healthcare can be specialized to the specific values of one's culture. Communication can therefore take place more effectively.
Decentralized structure	In case of a flattened hierarchical structure the chance of complaint escalation will be lower. One is able to communicate more effectively in case of a flattened structure, because healthcare professionals are more

	approachable. This open communication has a direct effect on the risk of escalation.
Providing training programs	One is able to lower the risk of complaint escalation by realizing the same level of skills in regard to, communication and cultural awareness. In this way a healthcare organization is able to provide high-quality care, Furthermore, healthcare professionals should be schooled to gain knowledge in regard to complaints and claims and how to handle them.
Adopt recovery strategies	Having the opportunity to offer a thoughtful gesture, such as a voucher or flowers, lowers the risk of complaints escalation, as one focuses on the aspect of service recovery. In this way, patients feel respected as well as taken seriously. By doing so, one is able to resolve dissatisfaction.

5.4 Critical reflection

Managerial implications

This research seeks to identify the underlying factors that contribute to the progression of medical complaints. Furthermore, the research looks into potential solutions. By providing a practical tool, for complaint management specialists, as included in paragraph 5.3 and in Appendix 6, the escalation prevention tool can help to avoid a time-consuming and expensive procedure that is also difficult for all parties. By implementing this escalation prevention tool hospitals are able to improve their way of complaint-handling. Furthermore, unnecessary escalation can be prevented. The choice has been made to formulate the to do list in Dutch, as the research is focused on Dutch Hospitals. In addition, the to-do list is specialized on three levels, which covers a large part of the complaint-handling process.

The recommendations as presented above in paragraph 5.3 describe how the different aspects can be implicated focused on the three different levels, namely organizational level, healthcare professional level and lastly, complaint officer level.

Theoretical implications

After studying the existing literature, one finds that there is little information that might help avoid medical malpractice complaints from becoming claims. Looking at the managerial implications it is valuable to know what factor or characteristics may prevent or cause escalation of a complaint into a claim. This analysis adds to the amount of currently known literature.

Furthermore, one is able to use the conceptual model as well as the findings from the research as a starting tool for further research, as little research is available in regard to the

topic of complaint escalation in Dutch Hospitals. As more factors than originally anticipated were found during the interview period an extensive overview of factors contributing to complaint escalation has been formed.

The goal of filling in some gaps by doing this research has been achieved, as the research focused on complaint escalation is limited. Mainly, the focus on Dutch Hospitals is valuable as research is especially on complaint-handling and prevention in foreign countries.

Limitations and suggestions for further research

The first limitation focusses on the aspect of multi-interpretability, which entails that information has been written down making use of interpretations. One has used various techniques in order to minimize the effect of multi-interpretability, namely the four-eyes principle, restrained reporting, expert advice and feedback from respondents. The four-eyes principle refers to the practice of constantly having more than one person evaluate an opinion or decision. Restrained reporting has to do with the fact that qualitative research cannot serve as the foundation for any scientific proof. As a result, it is important to have caution while making firm statements. Expert advice explains the concept of having experts in the field of the search topic shed light on the concepts made, such as a conceptual model or the results. Lastly feedback from respondents focusses on the aspect of asking the respondents of the interviews if the interpretation of the information shared is the same. Furthermore, one can share the transcriptions made in order to provide the respondents insight in the interview as well as providing them with an opportunity to add information or provide the interview with elaborations if the essence of the interview transcript is not right.

The second limitation highlights the aspect of culture. As previously mentioned, one student out of the research group has a foreign cultural background. Within various interviews respondents were careful in sharing their opinion about culture and the effect it has on escalation of a complaint to a claim.

The first suggestion for further research would be to test the data in a quantitative way. This as one, in that case, is able to analyze which of the escalation factors has the largest influence. As an effect of quantitative research, the reliability of the research would go up.

Furthermore, one could choose to interview employees of the juridical department, this as their knowledge in regard to claims and causes of claims is larger. Therefore, they are able to provide insights in regard to this topic. Another suggestion based on this topic would be to investigate the perspective of the patient and the healthcare professionals. In order to

analyze if the information given by the complaint officers align with the perspective of the patient, juridical department and patient one should interview those parties.

Lastly one could have new research focus on the effectiveness of the recommendations given in this research. By testing this one is able to provide insights if escalation of complaints into claims in Dutch hospitals can be prevented.

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Appendices

Appendix 1: Tables

Table 1
Respondent Information

Respondent	Position	Experience	Type of organization
1	Complaints Mediator and Patient Support	5 years	University Medical Center
2	Complaints Officer	16 years	Regional Hospital
3	Complaints Officer	3,5 years	Top Clinical Hospital
4	Manager Quality and Safety	6 years	Top Clinical Teaching Hospital
5	Complaints Officer	12 years	Top Clinical Teaching Hospital
6	Complaints Officer	4 years	Regional Hospital
7	Complaints Officer	28 years	Regional Hospital
8	Complaints Officer	9 years	Regional Hospital
9	Complaints Officer	2 years	Medical Centre
10	Complaints Officer	15 years	Medical Centre
11	Complaints Officer	3.5 years	Regional Hospital
12	Complaints Officer	4 years	Top Clinical Teaching Hospital
13	Complaints Officer	1,5 years	Regional Hospital
14	Complaints Officer	23 years	Top Clinical Hospital
15	Complaints Officer	1 year	Top Clinical Teaching Hospital
16	Complaints Officer	5 years	Regional Hospital

17	Complaints Officer & Lawyer employment law and privacy	2 years	Regional Hospital
18	Complaints Officer	6 years	Regional Hospital
19	Complaints Officer	7 years	Top Clinical and Week Clinics
20	Complaints Officer	1 year	University Medical Centre
21	Complaints Officer	15 years	University Medical Centre
22	Complaints Officer	14 years	Medical Centre
23	Complaints Officer & Damage contact person & Process Supervisor Incidents	12 years	Regional Hospital
24	Complaints Officer	4 years	Regional Hospital
25	Complaints Officer & Patient Care Staff Member	10 years	Top Clinical Hospital

Table 2
Complaint officer skills

Skills that a complaint officer should possess:	
Provide personalized care	Active listening
Independence and impartiality	Analytical thinking
Transparency and information disclosure	Ability for asking probing questions
Empathy	Patience and resilience
Summarizing conversations	Act proactively
Ability to raise awareness about complaint-handling among healthcare providers	Knowledge of legislation
Thoroughness in complaint-handling	Ability to set boundaries
Ability to identify complaint escalation	Attention to nonverbal communication

Table 3
Overview of Expectations

Expectations		
E1	Female healthcare professionals are expected to have a higher risk of escalation than male healthcare professionals.	Rejected
E2	Older healthcare professionals are expected to have a higher risk of escalation than younger healthcare professionals.	Rejected
E3	Some medical specialties are expected to have a higher risk of escalation than other specialties.	Confirmed
E4	When healthcare professionals have received previous claims, they are expected to have a higher risk of future complaint escalation.	Rejected
E5	When healthcare professionals have better communicative skills, the risk of escalation is expected to be lower than when professionals have poor communicative skills.	Confirmed
E6	When healthcare professionals disclose service failure, the risk of escalation is expected to be lower than when professionals do not disclose service failure.	Confirmed
E7	A good patient-primary care provider relationship is expected to reduce the likelihood of complaint escalation.	Partly confirmed
E8	Diagnostic errors are expected to have a higher risk of escalating into a claim than communication errors.	Rejected
E9	Patients with a higher socio-economic status are expected to have a higher risk of complaint escalation than patients with a lower socio-economic status.	Rejected
E10	Patients with previous negative experiences in healthcare are expected to have a higher risk of complaint escalation than those without negative experiences.	Confirmed
E11	Patients who show much emotion during the complaint-handling process are expected to have a higher risk of complaint escalation than patients who do not show emotion.	Partly confirmed
E12	The involvement of family members in the complaint-handling process is expected to lead to a higher risk of escalation.	Partly confirmed

Table 4
Comparison complaint officer skills

Skills a complaint officer should possess:	
Interview findings	Professional profile?
Able to provide personalized care	X
Independence and impartiality	X
Transparency and information disclosure	X
Empathy	X
Summarizing conversations	X
Ability to raise awareness about complaint-handling among healthcare providers	
Thoroughness in complaint-handling	X
Ability to identify complaint escalation	X
Active listening to	X
Analytical thinking	X
Ability to ask probing questions	
Patience and resilience	X
Act proactively	X
Knowledge of legislation	X
Ability to set boundaries	
Attention to nonverbal communication	X

Table 5
Factors contributing to complaint escalation

Factor	Effect	New effect?
Medical specialty	Certain medical specialties have a higher risk of complaint escalation compared to other specialties.	
One-size-fits-all approach	When healthcare professionals or complaint officers use a one-size-fits-all approach, there is a higher risk of complaint escalation.	X
Patient-primary care provider relationship	When there is a poor patient-primary care provider relationship, there is a higher risk of complaint escalation.	
Empathy	When healthcare professionals do not show empathy, there is a higher risk of complaint escalation.	
Disclosure	When healthcare professionals do not disclose during medical treatment or after a service failure, there is a higher risk of complaint escalation.	
Sympathy and apology	When healthcare professionals do not sympathize and apologize after a service failure, there is a higher risk of complaint escalation.	X
Type of complaint	Communication errors seem to be more sensitive to complaint escalation than other types of complaints.	
Duration of the complaint-handling process	When the complaint-handling process takes a long time, there is a higher risk of complaint escalation.	X
Duration of treatment	The duration of treatment influences the patient-primary care provider relationship, which in turn has an impact on complaint escalation.	X
Subjective severity	When the subjective severity of the event is not addressed, there is a higher risk of complaint escalation.	X
Expectations	The higher the discrepancy between patients' expectations and reality, the higher the risk of complaint escalation.	X
Increased demands	The higher the demands of the patients, the higher the risk of complaint escalation.	X
Mistrust	When patients show signs of mistrust, there is a higher risk of complaint escalation.	
Previous negative experience	When patients have previous negative experiences with service recovery in healthcare, there is a higher risk of complaint escalation.	
Socio-economic status	The socio-economic status of the patient influences their communication style, potentially leading to a higher risk of complaint escalation.	
Language barrier	When patients have a language barrier, there is a higher risk of complaint escalation.	X

Discrimination	When patients have the feeling they are discriminated against, there is a higher risk of complaint escalation.	X
Cultural differences	Cultural differences impact patients' expectations and communication styles, potentially leading to a higher risk of complaint escalation.	X
Not feeling heard	When patients have the idea that their dissatisfaction is not heard and acknowledged, there is a higher risk of complaint escalation.	X
Emotions	When patients show high levels of emotion, there is a higher risk of complaint escalation.	
Lack of emotions	When patients show a lack of emotions in the complaint-handling process, there is a higher risk of complaint escalation.	X
Behavior change	When patients showcase different behaviors, such as communicating formally, there is a higher risk of complaint escalation.	X
Detachment	When patients detach themselves from the complaint-handling process, there is a higher risk of complaint escalation.	X
Involvement of the family	When the family is involved in the complaint-handling process, there is a higher risk of complaint escalation.	
Relationship between family and patient	When the patient and family members have a close relationship, there is a higher risk of complaint escalation.	X
Relationship between family and professional	When the professional and family member don't have a personal relationship, there is a higher risk of complaint escalation.	X
Cultural context of the family	When the cultural background of the family is ignored, there is a higher risk of complaint escalation.	X
External influences	External influences, like social media and the internet, increase the risk of complaint escalation.	X
Organizational size	In larger organizations, the risk of complaint escalation is higher compared to smaller organizations.	X
Hierarchy	High-hierarchy organizations have a higher risk of complaint escalation compared to low-hierarchy organizations.	X

Table 6*Overview of the factors influencing claim prevention or de-escalation*

Factors that contribute to prevention or de-escalation of claims		
Communicate transparently and directly	Empathize, guide, involve and enlist	Build trust
Provide information and disclose before medical treatment and after service failure	Listen actively	Make sure patients feel heard and taken seriously
Be aware and pay attention to warning signs of escalation.	Involve family early on in the medical process	Ask clarifying questions and communicate effectively
Provide patient-centered care	Support and educate healthcare providers in complaint-handling, communication, and cultural diversity	Make low-threshold contact
Foster an open environment	Show sympathy and apologize	Establish a strong patient-primary care provider relationship
Understand and recognize the root of patients' emotions	Acknowledge the impact of cultural diversity and language barriers	Act pro-actively

Table 7*Healthcare professional recommendations*

Transparency and disclosure	Trust can be achieved by providing the patient with a feeling of transparency and disclosure. Closely linked to this is communication, and having the feeling of being informed. In this way, one is able to lower the risk of complaint escalation.
Recognition of cultural diversity	One should take into account the culture a patient has and the customs the patient is therefore used to; one should focus on the needs and wants of one's culture. In case one shows respect and adapts to these one is able to lower the risk of complaint escalation.
Pro-active approach	In case the healthcare professionals experiences difficulties in regard to communication one should discuss this pro-actively by mentioning the difficulties one is experiencing. Furthermore, one should be familiar with the assistance a healthcare professional is able to ask. By acting pro-actively, one is able to lower the risk of complaint escalation.
Demonstrating empathy	By demonstrating empathy, one is able to lower the risk of complaint escalation. This as, by showing empathy, one dives into the aspect of concerns a patient might experience. Analyzing one's verbal as well as non-verbal communication is an aspect of importance. By doing so a patient feels taken seriously.
Provide personalized care	By providing personalized care one is able to lower the risk of complaint escalation. Healthcare is seen as a complex process in which healthcare professionals want to provide high-quality care. By providing personalized care the patient is able to experience high-quality care more easily. Furthermore, a patient has the feeling of being heard. Furthermore, the patients feel more pleasant as one is provided with care specialized to your needs and wants.

Table 8*Complaint officer recommendations*

Involvement of family members	One is able to lower the risk of escalation by actively involving family member in the process of complaint escalation. Connected to this involvement is the opportunity to create an equal amount of contextual knowledge.
Recognition of cultural diversity	Analyzing the aspect of cultural diversity as mentioned above within the role of healthcare professionals, complaint officers should also respect this aspect. In this way one is able to lower the risk of escalation.
Setting boundaries	Looking at the mediation conversation, the complaint officer should set clear boundaries. As believes in manageability have increased overtime demands have changed. When communication in regarding to boundaries are made one is able to lower the risk of complaint escalation.
Creating awareness	In case complaint officers create awareness about the role they have one is able to lower the risk of complaint escalation. Healthcare professionals should have the opportunity to ask a complaint officer for advice, however being aware that the opportunity is there is an aspect in which investment is needed. This as complaint officers play a large role in the de-escalation process.

Table 9*Healthcare organization recommendations*

Open environment	One is able to lower the risk of complaint escalation by having an open environment. This as an open environment results in a comfortable place patients can go to to share their dissatisfaction or discomfort; as a result, patients have the feeling that they can speak more freely.
Clear guidelines and procedures	By providing patients with clear guidelines and procedures the demands of the patient can be managed more clearly. As a result, possible misunderstanding or lack in knowledge can be managed.
Recognition of cultural diversity	By taking into account cultural diversity, one is able to lower the escalation of complaints. This as patients feel more comfortable when their wants and needs are respected. Additionally, communication is closely linked to this aspect. In this way healthcare can be specialized to the specific values of one's culture. Communication can therefore take place more effectively.
Decentralized structure	In case of a flattened hierarchical structure the chance of complaint escalation will be lower. One is able to communicate more effectively in case of a flattened structure, because healthcare professionals are more approachable. This open communication has a direct effect on the risk of escalation.
Providing training programs	One is able to lower the risk of complaint escalation by realizing the same level of skills in regard to, communication and cultural awareness. In this way a healthcare organization is able to provide high-quality care, Furthermore, healthcare professionals should be schooled to gain knowledge in regard to complaints and claims and how to handle them.
Adopt recovery strategies	Having the opportunity to offer a thoughtful gesture, such as a voucher or flowers, lowers the risk of complaints escalation, as one focuses on the aspect of service recovery. In this way, patients feel respected as well as taken seriously. By doing so, one is able to resolve dissatisfaction.

Appendix 2: Initial version of the interview guide

Introductie

Mijn naam is ..., student aan de Radboud Universiteit, dit zijn ... en ... en vandaag zullen wij een interview afnemen dat gaat over het escalatieproces waarbij klachten in een ziekenhuis kunnen leiden tot juridische claims. Twee van ons zullen zich focussen op het stellen van de vragen en eventueel doorvragen over bepaalde onderwerpen, en een persoon zal notuleren. Dit interview heeft als doel het verzamelen van informatie over hoe klachten kunnen escaleren tot juridische claims en hoe dit voorkomen kan worden binnen Nederlandse ziekenhuizen. Alle informatie die u deelt, zal anoniem en vertrouwelijk behandeld worden. Het interview zal ongeveer 60 minuten duren en alle informatie zal vertrouwelijk behandeld worden.

Vindt u het goed als er een opname wordt gemaakt? Deze opname zal alleen gebruikt worden voor de data-analyse en wordt niet gedeeld met derden. U kunt zich op ieder moment gedurende het gesprek terugtrekken, alhoewel dit iets is wat we graag zouden willen voorkomen.

We zijn ons ervan bewust dat u op de hoogte bent van het klachtenafhandelingsproces. In ons onderzoek hebben we gekozen om onderscheid te maken tussen klachten en claims. Een klacht is een uiting van ontevredenheid van een patiënt of familielid over het ziekenhuis, die meestal door het voeren van een gesprek onderzocht en onderling opgelost kan worden. Een claim is een eis tot schadevergoeding die meestal via een juridische procedure wordt neergelegd bij het ziekenhuis. Claims hebben, zoals ook vermeld in de uitnodigingsbrief, negatieve gevolgen voor alle betrokkenen. Het is daardoor van belang om het ontstaan van claims zoveel mogelijk te voorkomen, en wanneer ze toch ontstaan ervoor te zorgen dat de situatie de-escalereert. Wanneer er binnen dit interview gepraat wordt over claims bedoelen we daarmee klachten die via de juridische weg afgehandeld worden.

Allereerst willen wij u enkele introducerende vragen stellen over uw werk en uw ervaring.

Introducerende vragen

1. Wat is uw functie binnen XXX?
2. Hoe lang bent u hier al werkzaam?
3. Hoe zou u de organisatie waarin u werkzaam bent beschrijven? (*Universitair Medisch Centrum, Categorieel, Topklinisch, Algemeen/regionaal, Expertise Centrum, anders...*)
4. Heeft u ervaring binnen een soortgelijke functie in een andere medische instelling? Zo ja, wilt u hier meer over vertellen?
5. Hoeveel klachtenprocedures heeft u behandeld?
6. Kunt u ons kort vertellen over uw achtergrond en ervaring in het werken met klachtenprocessen en claims?

Hoofdvraag

Op basis van de literatuur die te vinden is over klachtafhandeling hebben we een hoofdvraag geformuleerd voor ons onderzoek. Mocht u het op dit moment lastig vinden om deze gelijk te behandelen kunt u erop terugkomen na het invullen van de andere vragen, aangezien deze een basis kunnen vormen voor het antwoord op de hoofdvraag van ons onderzoek. Aan het einde van de vragenlijst hopen we dat u een concreet antwoord zou willen formuleren op onze hoofdvraag, welke luidt als volgt:

Wat zijn volgens u de onderliggende factoren die ertoe bijdragen dat klachten escaleren tot claims, en hoe kan deze escalatie worden voorkomen?

Deelvragen

In het volgende gedeelte van de vragenlijst zal specifiek ingegaan worden op de factoren die volgens de literatuur belangrijk zijn in het klachtenafhandelingsproces. Deze factoren zijn onderverdeeld in verschillende subcategorieën, namelijk organisatiefactoren, karakteristieken van medische specialisten, kenmerken van het incident, karakteristieken van de patiënt en familieleden, karakteristieken van de klachtenfunctionaris en de-escalatie technieken.

Karakteristieken van medische specialisten

7. Uit onderzoek blijkt dat bepaalde karakteristieken van medische specialisten bijdragen aan het escaleren van klachten. Hoe ziet u dit terug in de praktijk, en welke karakteristieken hebben volgens u invloed?

Enkele voorbeelden: Medische specialisatie, geslacht, leeftijd, werkervaring, ervaring met klachten en claims.

8. Uit onderzoek blijkt dat artsen vaak defensieve zorgverlening gaan uitvoeren vanwege angst voor claims. Defensieve zorgverlening houdt in dat artsen zich gedurende behandelingen laten beïnvloeden door angst voor claims, waardoor er eventuele onnodige onderzoeken uitgevoerd kunnen worden. In hoeverre denkt u dat dit gedrag vanuit artsen invloed kan hebben op het ontstaan van claims?

Kenmerken van het incident

Er is beperkte literatuur beschikbaar over de kenmerken van incidenten die bijdragen aan de escalatie van een klacht. Vandaar dat we graag informatie uit de praktijk ontvangen over kenmerken van incidenten die in uw beleving bijdragen aan het escaleren van klachten.

9. Maakt u zich bij het ontvangen van sommige klachten reeds meer zorgen over escalatie dan bij andere klachten? Zo ja, heeft u voorbeelden van klachten die in uw ervaring eerder leiden tot juridische claims?

10. Zijn er, in uw ervaring, specifieke gebeurtenissen die eerder leiden tot een escalatie van een klacht? Zo ja, wilt u deze gebeurtenissen beschrijven?

Enkele voorbeelden: de ernst van het incident en duur van het klachtenafhandelingsproces.

11. Kijkend naar onderzoek over incidenten is er een tweestrijd over welk type incident vaker leidt tot het escaleren van klachten. De twee type fouten die benoemd worden in literatuur zijn communicatie- en diagnose fouten. Heeft u vanuit uw ervaring een mening over welke type fout effect lijkt te hebben op de escalatie van klachten?

Karakteristieken van de patiënt of familie

12. Een andere factor die lijkt bij te dragen aan de escalatie van klachten zijn de persoonlijke kenmerken van patiënten en familieleden. Heeft u voorbeelden van karaktertrekken en persoonskenmerken die bij lijken te dragen aan dit proces?

Enkele voorbeelden: geslacht, leeftijd, cultuur, opleidingsniveau, socio-economische status, medische hulpvraag vanuit de patiënt waardoor er angst is om te klagen, of eventuele negatieve ervaringen in het verleden

13. Uit onderzoek blijkt dat wantrouwen bij patiënten een grote rol speelt in het escaleren van klachten. Heeft u hier ervaring mee? Zo ja, heeft u een idee waar dit wantrouwen vandaan komt en hoe ziekenhuizen hierop in kunnen spelen?

14. Heeft u het idee dat de relatie tussen patiënt en arts een rol kan spelen in het verloop van het klachtenproces? Zo ja, hoe zou u het effect van deze relatie beschrijven?

15. Uit onderzoek blijkt dat familieleden invloed hebben op het verloop van het klachtenproces. Herkent u dit? Zo ja, kunt u hier voorbeelden van geven?

Karakteristieken van de klachtenfunctionaris en klachtenafhandelingsproces

Als klachtenfunctionaris bent u direct betrokken bij de afhandeling van een klacht, en heeft u ervaring met klachten die escaleren. De procedures van klachtafhandeling verschillen per ziekenhuis, vandaar dat we graag informatie ontvangen over hoe dit binnen uw organisatie en voor u persoonlijk geregeld is.

16. Wat zijn volgens u de vaardigheden die een klachtenfunctionaris nodig heeft om zijn of haar werk goed uit te kunnen voeren?

17. Wat vindt u van de rol die u heeft binnen de klachtafhandelingsprocedures? Bent u tevreden over de mate waarin u momenteel betrokken wordt bij het proces van behandelen van medische klachten?

18. In hoeverre heeft een klachtenfunctionaris invloed op het escaleren en/of de-escaleren van een klacht? Zijn er specifieke kenmerken van de klachtenfunctionaris die het escalatieproces kunnen beïnvloeden?

Enkele voorbeelden: eerdere ervaringen van klachtenfunctionarissen, communicatiestijl en geslacht van de klachtenfunctionaris.

19. Uit onderzoek is gebleken dat er bepaalde signalen zijn waaraan een individu kan zien dat een klacht escaleert. Zijn er bepaalde signalen waaraan u kunt zien dat een klacht dreigt te escaleren? Zo ja, welke?

Enkele voorbeelden: emoties van patiënten (angst, wraak, wantrouwen, woede, boosheid, agressiviteit), emoties van familieleden, verandering in gedrag en lichaamstaal van patiënt, overgang naar schriftelijke correspondentie.

20. Hoe is het proces van klachtafhandeling nu geregeld binnen het ziekenhuis waar u momenteel werkzaam bent?

- Is er een specifiek protocol dat er gevolgd wordt? Zo ja, wilt u dit kort beschrijven?
- Wordt dit protocol op eenzelfde manier toegepast op alle patiënten, of verschilt dit per patiënt? Hoe ervaart u dit?
- Welke taken voert u uit om juridische stappen te voorkomen?
- In hoeverre worden patiënten betrokken bij de klachtafhandeling? Ervaart u dit als iets positiefs of negatiefs, en waarom?

- In hoeverre worden familieleden of nabestaanden betrokken in het proces? Ervaart u dit als iets positiefs of negatiefs, en waarom?

Organisatiefactoren

21. Zijn er volgens u kenmerken van de organisatie die ervoor kunnen zorgen dat een klacht escaleert? Zo ja, zou u enkele kenmerken van ziekenhuizen kunnen benoemen waar klachten vaker lijken te escaleren?
22. Hoe zou u het ziekenhuis waar u op dit moment werkzaam bent beschrijven qua regelgeving en aanwezige protocollen met betrekking tot de klachtenafhandelingsprocedure?
23. In hoeverre speelt de organisatiecultuur een rol in het klachtenafhandelingsproces? Heeft dit volgens u een positief of negatief effect op het proces?

De-escalatie technieken

Het vermijden van claims is belangrijk gezien de invloed die het heeft op alle betrokkenen. Uit onderzoek blijkt dat er meerdere factoren bijdragen aan de-escalatie van claims. Binnen ons onderzoek wordt het woord de-escalatie op twee verschillende manieren gebruikt. Ten eerste verwijst het naar het voorkomen van escalatie, waardoor de direct betrokkenen met elkaar in gesprek kunnen blijven gaan zonder juridische tussenkomst. Anderzijds kan de-escalatie gezien worden als het teruggeleiden van een geëscaleerde situatie, in dit geval een juridische strijd, naar een situatie waarin de betrokkenen met elkaar om de tafel kunnen om een oplossing te vinden.

24. Wat zijn in uw ervaring concrete factoren die ervoor kunnen zorgen dat een juridische claim de-escaleert tot het punt waarop een gesprek tussen beide partijen weer mogelijk is?

25. Uit onderzoek komt naar voren dat effectieve en efficiënte communicatie met de patiënt belangrijk is in het voorkomen van de escalatie van claims. Herkent u dit? En zo ja, hoe ervaart u dit in de praktijk?

Enkele voorbeelden: actief luisteren, transparantie en openheid over het incident, verontschuldiging, vermijden van negatieve filters (positief verwoorden, beginnen met het negatieve nieuws om met het positieve te eindigen), lichaamstaal van de medische specialist en/of klachtenfunctionaris.

26. Heeft u het idee dat het trainen van personeel op het gebied van de-escalatie iets is wat gebeurt in Nederlandse ziekenhuizen? Zo ja op welke manier? Zo nee waarom niet? En denkt u dat dit invloed heeft op de mate van de-escalatie?

Antwoord op hoofdvraag

27. Wat zijn volgens u de onderliggende factoren die ertoe bijdragen dat klachten escaleren tot claims, en hoe kan deze escalatie worden voorkomen?

Slot

We danken u voor uw deelname. Zijn er nog andere dingen die u nog wilt bespreken of heeft u vragen voor ons?

Op basis van de gegeven antwoorden zullen wij ons onderzoek naar het escaleren van klachten voortzetten. De verzamelde data zal niet gedeeld worden met derden en er zal zorgvuldig mee omgegaan worden. We zullen het transcript van dit gesprek met u delen om er zeker van te zijn dat de gedane uitspraken overeenkomen met wat door u bedoeld is. Vandaar dat we graag een reactie ontvangen op de inhoud van dit transcript binnen een tijdsbestek van 3 werkdagen na ontvangst.

Indien geen reactie gaan we ervan uit dat u het eens bent met de inhoud van het transcript. Zou u het op prijs stellen ook de eindversies van onze scripties te ontvangen? Zo ja, hoe zou u deze willen ontvangen? Zodra het onderzoeksproces is afgerond zullen we uw persoonlijke gegevens verwijderen.

Appendix 3: Final version of the interview guide

Introductie

Mijn naam is ..., student aan de Radboud Universiteit, dit zijn ... en ... en vandaag zullen wij een interview afnemen dat gaat over het escalatieproces waarbij klachten in een ziekenhuis kunnen leiden tot juridische claims. Twee van ons zullen zich focussen op het stellen van de vragen en eventueel doorvragen over bepaalde onderwerpen, en een persoon zal notuleren. Dit interview heeft als doel het verzamelen van informatie over hoe klachten kunnen escaleren tot juridische claims en hoe dit voorkomen kan worden binnen Nederlandse ziekenhuizen. Alle informatie die u deelt, zal anoniem en vertrouwelijk behandeld worden. Het interview zal ongeveer 60 minuten duren en alle informatie zal vertrouwelijk behandeld worden.

Vindt u het goed als er een opname wordt gemaakt? Deze opname zal alleen gebruikt worden voor de data-analyse en wordt niet gedeeld met derden. U kunt zich op ieder moment gedurende het gesprek terugtrekken, alhoewel dit iets is wat we graag zouden willen voorkomen.

We zijn ons ervan bewust dat u op de hoogte bent van het klachtenafhandelingsproces. In ons onderzoek hebben we gekozen om onderscheid te maken tussen klachten en claims. Een klacht is een uiting van ontevredenheid van een patiënt of familielid over het ziekenhuis, die meestal door het voeren van een gesprek onderzocht en onderling opgelost kan worden. Een claim is een eis tot schadevergoeding die meestal via een juridische procedure wordt neergelegd bij het ziekenhuis. Claims hebben, zoals ook vermeld in de uitnodigingsbrief, negatieve gevolgen voor alle betrokkenen. Het is daardoor van belang om het ontstaan van claims zoveel mogelijk te voorkomen, en wanneer ze toch ontstaan ervoor te zorgen dat de situatie de-escalereert. Wanneer er binnen dit interview gepraat wordt over claims bedoelen we daarmee klachten die via de juridische weg afgehandeld worden.

Allereerst willen wij u enkele introducerende vragen stellen over uw werk en uw ervaring.

Introducerende vragen

1. Wat is uw functie binnen XXX?
2. Hoe lang bent u hier al werkzaam?
3. Hoe zou u de organisatie waarin u werkzaam bent beschrijven? (*Universitair Medisch Centrum, Categorieel, Topklinisch, Algemeen/regionaal, Expertise Centrum, anders...*)
4. Heeft u ervaring binnen een soortgelijke functie in een andere medische instelling? Zo ja, wilt u hier meer over vertellen?
5. Hoeveel klachtenprocedures heeft u behandeld?
6. Kunt u ons kort vertellen over uw achtergrond en ervaring in het werken met klachtenprocessen en claims?

Hoofdvraag

Op basis van de literatuur die te vinden is over klachtafhandeling hebben we een hoofdvraag geformuleerd voor ons onderzoek. Mocht u het op dit moment lastig vinden om deze gelijk te behandelen kunt u erop terugkomen na het invullen van de andere vragen, aangezien deze een basis kunnen vormen voor het antwoord op de hoofdvraag van ons onderzoek. Aan het einde van de vragenlijst hopen we dat u een concreet antwoord zou willen formuleren op onze hoofdvraag, welke luidt als volgt:

Wat zijn volgens u de onderliggende factoren die ertoe bijdragen dat klachten escaleren tot claims, en hoe kan deze escalatie worden voorkomen?

Deelvragen

In het volgende gedeelte van de vragenlijst zal specifiek ingegaan worden op de factoren die volgens de literatuur belangrijk zijn in het klachtenafhandelingsproces. Deze factoren zijn onderverdeeld in verschillende subcategorieën, namelijk organisatiefactoren, karakteristieken van medische specialisten, kenmerken van het incident, karakteristieken van de patiënt en familieleden, karakteristieken van de klachtenfunctionaris en de-escalatie technieken.

Karakteristieken van medische specialisten

7. Uit onderzoek blijkt dat bepaalde karakteristieken van medische specialisten bijdragen aan het escaleren van klachten. Hoe ziet u dit terug in de praktijk, en welke karakteristieken hebben volgens u invloed?

Enkele voorbeelden: Medische specialisatie, geslacht, leeftijd, werkervaring, ervaring met klachten en claims.

8. Uit onderzoek blijkt dat artsen vaak defensieve zorgverlening gaan uitvoeren vanwege angst voor claims. Defensieve zorgverlening houdt in dat artsen zich gedurende behandelingen laten beïnvloeden door angst voor claims, waardoor er eventuele onnodige onderzoeken uitgevoerd kunnen worden. In hoeverre denkt u dat dit gedrag vanuit artsen invloed kan hebben op het ontstaan van claims?

9. Heeft u het idee dat de relatie tussen patiënt en arts een rol kan spelen in het verloop van het klachtenproces? Zo ja, hoe zou u het effect van deze relatie beschrijven?

Kenmerken van het incident

Er is beperkte literatuur beschikbaar over de kenmerken van incidenten die bijdragen aan de escalatie van een klacht. Vandaar dat we graag informatie uit de praktijk ontvangen over kenmerken van incidenten die in uw beleving bijdragen aan het escaleren van klachten.

10. Maakt u zich bij het ontvangen van sommige klachten reeds meer zorgen over escalatie dan bij andere klachten? Zo ja, heeft u voorbeelden van klachten die in uw ervaring eerder leiden tot juridische claims?

11. Zijn er, in uw ervaring, specifieke gebeurtenissen die eerder leiden tot een escalatie van een klacht? Zo ja, wilt u deze gebeurtenissen beschrijven?

Enkele voorbeelden: de ernst van het incident en duur van het klachtenafhandelingsproces.

12. Kijkend naar onderzoek over incidenten is er een tweestrijd over welk type incident vaker leidt tot het escaleren van klachten. De twee type fouten die benoemd worden in literatuur zijn communicatie- en diagnose fouten. Heeft u vanuit uw ervaring een mening over welk type fout effect lijkt te hebben op de escalatie van klachten?

Karakteristieken van de patiënt of familie

13. Een andere factor die lijkt bij te dragen aan de escalatie van klachten zijn de persoonlijke kenmerken van patiënten en familieleden. Heeft u voorbeelden van karaktertrekken en persoonskenmerken die bij lijken te dragen aan dit proces?

Enkele voorbeelden: geslacht, leeftijd, cultuur, opleidingsniveau, socio-economische status, medische hulpvraag vanuit de patiënt waardoor er angst is om te klagen, of eventuele negatieve ervaringen in het verleden

14. Kunt u aangeven of u in uw werk als professional te maken heeft gehad met patiënten van bepaalde culturele achtergronden die anders omgaan met het uiten van klachten of het escaleren van klachten? Zo ja, welke verschillen in gebruiken heeft u hierbij waargenomen en hoe ervaart u dit?

15. Uit eerdere interviews is gebleken dat mensen verschillende taalbarrières kunnen ervaren, waaronder het niet begrijpen van medische termen, het onvoldoende kennis hebben van de werking van het menselijk lichaam, en onvoldoende kennis van de Nederlandse taal. Herkent u zich in dat dit type patiënt eerder een klacht indient die kan escaleren gebaseerd op uw ervaringen?
16. Welke specifieke maatregelen neemt uw ziekenhuis om patiënten met een taalbarrière te ondersteunen? Kunt u per taalbarrière aangeven welke aanpak uw ziekenhuis hanteert en hoe ervaart u dit?
17. Uit onderzoek blijkt dat wantrouwen bij patiënten een grote rol speelt in het escaleren van klachten. Heeft u hier ervaring mee? Zo ja, heeft u een idee waar dit wantrouwen vandaan komt en hoe ziekenhuizen hierop in kunnen spelen?
18. Uit onderzoek blijkt dat familieleden invloed hebben op het verloop van het klachtenproces. Herkent u dit? Zo ja, kunt u hier voorbeelden van geven?

Karakteristieken van de klachtenfunctionaris en klachtenafhandelingsproces

Als klachtenfunctionaris bent u direct betrokken bij de afhandeling van een klacht, en heeft u ervaring met klachten die escaleren. De procedures van klachtafhandeling verschillen per ziekenhuis, vandaar dat we graag informatie ontvangen over hoe dit binnen uw organisatie en voor u persoonlijk geregeld is.

19. Wat zijn volgens u de vaardigheden die een klachtenfunctionaris nodig heeft om zijn of haar werk goed uit te kunnen voeren?
20. Wat vindt u van de rol die u heeft binnen de klachtafhandelingsprocedures? Bent u tevreden over de mate waarin u momenteel betrokken wordt bij het proces van behandelen van medische klachten?
21. In hoeverre heeft een klachtenfunctionaris invloed op het escaleren en/of de-escaleren van een klacht? Zijn er specifieke kenmerken van de klachtenfunctionaris die het escalatieproces kunnen beïnvloeden?
- Enkele voorbeelden: eerdere ervaringen van klachtenfunctionarissen, communicatiestijl en geslacht van de klachtenfunctionaris.*
22. Uit onderzoek is gebleken dat er bepaalde signalen zijn waaraan een individu kan zien dat een klacht escaleert. Zijn er bepaalde signalen waaraan u kunt zien dat een klacht dreigt te escaleren? Zo ja, welke?
- Enkele voorbeelden: emoties van patiënten (angst, wraak, wantrouwen, woede, boosheid, agressiviteit), emoties van familieleden, verandering in gedrag en lichaamstaal van patiënt, overgang naar schriftelijke correspondentie.*
23. Hoe is het proces van klachtafhandeling nu geregeld binnen het ziekenhuis waar u momenteel werkzaam bent?
- Is er een specifiek protocol dat er gevolgd wordt? Zo ja, wilt u dit kort beschrijven?

- Wordt dit protocol op eenzelfde manier toegepast op alle patiënten, of verschilt dit per patiënt? Hoe ervaart u dit?
- Welke taken voert u uit om juridische stappen te voorkomen?
- In hoeverre worden patiënten betrokken bij de klachtafhandeling? Ervaart u dit als iets positiefs of negatiefs, en waarom?
- In hoeverre worden familieleden of nabestaanden betrokken in het proces? Ervaart u dit als iets positiefs of negatiefs, en waarom?

Organisatiefactoren

24. Zijn er volgens u kenmerken van de organisatie die ervoor kunnen zorgen dat een klacht escaleert? Zo ja, zou u enkele kenmerken van ziekenhuizen kunnen benoemen waar klachten vaker lijken te escaleren?
25. Hoe zou u het ziekenhuis waar u op dit moment werkzaam bent beschrijven qua regelgeving en aanwezige protocollen met betrekking tot de klachtenafhandelingsprocedure?
26. In hoeverre speelt de organisatiecultuur een rol in het klachtenafhandelingsproces? Heeft dit volgens u een positief of negatief effect op het proces?

De-escalatie technieken

Het vermijden van claims is belangrijk gezien de invloed die het heeft op alle betrokkenen. Uit onderzoek blijkt dat er meerdere factoren bijdragen aan de-escalatie van claims. Binnen ons onderzoek wordt het woord de-escalatie op twee verschillende manieren gebruikt. Ten eerste verwijst het naar het voorkomen van escalatie, waardoor de direct betrokkenen met elkaar in gesprek kunnen blijven gaan zonder juridische tussenkomst. Anderzijds kan de-escalatie gezien worden als het teruggeleiden van een geëscaleerde situatie, in dit geval een juridische strijd, naar een situatie waarin de betrokkenen met elkaar om de tafel kunnen om een oplossing te vinden.

27. Wat zijn in uw ervaring concrete factoren die ervoor kunnen zorgen dat een juridische claim de-escalereert tot het punt waarop een gesprek tussen beide partijen weer mogelijk is?
28. Uit onderzoek komt naar voren dat effectieve en efficiënte communicatie met de patiënt belangrijk is in het voorkomen van de escalatie van claims. Herkent u dit? En zo ja, hoe ervaart u dit in de praktijk?

Enkele voorbeelden: actief luisteren, transparantie en openheid over het incident, verontschuldiging, vermijden van negatieve filters (positief verwoorden, beginnen met het negatieve nieuws om met het positieve te eindigen), lichaamstaal van de medische specialist en/of klachtenfunctionaris.

29. Heeft u het idee dat het trainen van personeel op het gebied van de-escalatie iets is wat gebeurt in Nederlandse ziekenhuizen? Zo ja op welke manier? Zo nee waarom niet? En denkt u dat dit invloed heeft op de mate van de-escalatie?

Antwoord op hoofdvraag

30. **Wat zijn volgens u de onderliggende factoren die ertoe bijdragen dat klachten escaleren tot claims, en hoe kan deze escalatie worden voorkomen?**

Slot

We danken u voor uw deelname. Zijn er nog andere dingen die u nog wilt bespreken of heeft u vragen voor ons?

Op basis van de gegeven antwoorden zullen wij ons onderzoek naar het escaleren van klachten voortzetten. De verzamelde data zal niet gedeeld worden met derden en er zal zorgvuldig mee omgegaan worden. We zullen het transcript van dit gesprek met u delen om er zeker van te zijn dat de gedane uitspraken overeenkomen met wat door u bedoeld is. Vandaar dat we graag een reactie ontvangen op de inhoud van dit transcript binnen een tijdsbestek van 3 werkdagen na ontvangst. Indien geen reactie gaan we ervan uit dat u het eens bent met de inhoud van het transcript. Zou u het op prijs stellen ook de eindversies van onze scripties te ontvangen? Zo ja, hoe zou u deze willen ontvangen? Zodra het onderzoeksproces is afgerond zullen we uw persoonlijke gegevens verwijderen.

Appendix 4: Invitation letter

Geachte heer/ mevrouw **NAAM**,

Wij zijn Nazlican Hayirli, Lisa Laponder en Anne Thijssen, drie master studenten van de Radboud Universiteit te Nijmegen. Op dit moment doen wij onderzoek naar het escaleren van klachten binnen Nederlandse ziekenhuizen, wat kan leiden tot het ontstaan van juridische claims. Dit onderzoek voeren wij uit onder begeleiding van Dr. Herm Joosten, universitair docent aan de Radboud Universiteit, die al veelvuldig onderzoek heeft gedaan naar klachtafhandeling, ook in een medische context.

Het doel van ons onderzoek is om te achterhalen hoe klachten van patiënten of familieleden escaleren tot juridische claims, en om te achterhalen welke factoren hieraan bijdragen of juist zorgen voor de-escalatie. In ons onderzoek staan drie vragen centraal:

- Welke factoren maken volgens u de kans groter dat een klacht escaleert?
- Waarom kunt u zien of merken tijdens de klachtafhandeling dat een klacht dreigt te escaleren tot een claim?
- Wat doet u om de escalatie in te perken of te voorkomen?

0 Welke technieken werken volgens u, en welke niet?

De focus van dit onderzoek ligt op uw visie omtrent deze vragen, evenals uw persoonlijke ervaringen en inzichten.

Voor ons onderzoek zijn wij op zoek naar deelnemers met ervaring op het gebied van klachtafhandeling die bereid zijn om deel te nemen aan een interview. Het gesprek zal gaan over uw ervaringen en inzichten als (ervarings-)deskundige in klachtafhandeling trajecten. Wij willen u dan ook graag uitnodigen om deel te nemen aan ons interview. In het vervolg van deze brief vindt u meer informatie over het onderzoek en de interview setting.

Relevantie onderzoek

Zoals bij u reeds bekend zijn er veel negatieve gevolgen verbonden aan het ontstaan van claims, zowel voor patiënt, behandelend specialist als voor het ziekenhuis. Het is dan ook van belang om het ontstaan van claims te voorkomen. Met behulp van uw expertise en *best-practices* verwachten wij een inzicht te kunnen bieden in het voorkomen en de-escaleren van juridische claims. Door uw deelname kunnen we samen een bijdrage leveren aan zowel de wetenschap als de Nederlandse gezondheidszorg. Daarnaast zullen de resultaten van dit onderzoek bijdragen aan het begrip van het escalatieproces van klachten naar claims, wat kan bijdragen aan de ontwikkeling van effectieve interventiemethoden om escalatie te voorkomen.

Duur en plaats

Het interview zal ongeveer 60 minuten duren en zal plaatsvinden op een voor u geschikt tijdstip en locatie (thuis, werk of elders), of via videoconferentie (Zoom, Skype of Teams). Mocht het niet lukken om het interview in te plannen is het mogelijk om de vragen schriftelijk te beantwoorden.

Privacy en anonimiteit

De gegevens verzameld in het onderzoek zijn enkel beschikbaar voor ons en de leidinggevende van het onderzoek (Herm Joosten). Deze gegevens zullen enkel gebruikt worden voor de analyse van dit onderzoek. In het onderzoek wordt uw deelname standaard geanonimiseerd, waardoor uw antwoorden niet terug te herleiden zijn naar uw organisatie of uzelf. Ten slotte wordt de transcriptie van het interview ter goedkeuring naar u verzonden.

Wanneer u akkoord gaat met het gebruik van de resultaten, worden de resultaten in het onderzoek verwerkt.

Wij kijken uit naar uw reactie en waarderen uw tijd en medewerking zeer. Als u bereid bent om deel te nemen aan het interview, kunt u contact met ons opnemen door te mailen naar Anne Thijssen (anne.thijssen@ru.nl), of door contact op te nemen met Dr. Herm Joosten (herm.joosten@ru.nl).

Hartelijk dank voor uw aandacht.
Met vriendelijke groet,
Nazlican Hayirli, Lisa Laponder en Anne Thijssen



Anne Thijssen



Lisa Laponder



Nazlican Hayirli

Appendix 5: Written version questionnaire

Introductie

Allereerst bedankt voor uw interesse in het schriftelijk beantwoorden van onze vragenlijst. Door uw deelname hopen we waardevolle kennis op te doen omtrent het klachtafhandelingproces in Nederlandse ziekenhuizen, en hopen we zowel een praktische als theoretische bijdrage te mogen leveren aan de zorg. De vragenlijst is opgesteld met als doel het verzamelen van informatie over hoe klachten kunnen escaleren tot juridische claims en hoe dit voorkomen kan worden binnen Nederlandse ziekenhuizen. Alle informatie die u deelt, zal anoniem en vertrouwelijk behandeld worden.

We zijn ons ervan bewust dat u op de hoogte bent van het klachtenafhandelingproces. In ons onderzoek hebben wij gekozen om onderscheid te maken tussen klachten en claims. Een klacht is een uiting van ontevredenheid van een patiënt of familielid over het ziekenhuis, die meestal door het voeren van een gesprek onderzocht en onderling opgelost kan worden. Een claim is een eis tot schadevergoeding die meestal via een juridische procedure wordt neergelegd bij het ziekenhuis. Claims hebben, zoals ook vermeld in de uitnodigingsbrief, negatieve gevolgen voor alle betrokkenen. Het is daardoor van belang om het ontstaan van claims zoveel mogelijk te voorkomen, en wanneer ze toch ontstaan ervoor te zorgen dat de situatie de-escalereert. Wanneer er in de vragenlijst wordt gesproken over claims spreken we van klachten die via de juridische weg afgehandeld worden.

De vragenlijst zal beginnen met enkele algemene vragen over uw werk en ervaring binnen de klachtafhandeling. Bij een aantal vragen is er extra informatie te vinden onderaan de vragenlijst. Deze informatie kunt u desgewenst lezen als de vraag niet helemaal duidelijk voor u is. Als er na het lezen van de extra informatie nog altijd onduidelijkheid is over vragen kunt u te allen tijde contact met ons opnemen. Wij proberen dan zo snel mogelijk duidelijkheid te geven. Mocht u gedurende het invullen van de vragenlijst nog informatie willen delen die niet specifiek gevraagd is, maar naar uw inzicht wel relevant is voor ons onderzoek, kunt u deze altijd toevoegen. Deze informatie is voor ons zeer welkom!

Introducerende vragen

1. Wat is uw functie binnen XXX?
2. Hoe lang bent u hier al werkzaam?
3. Hoe zou u de organisatie waarin u werkzaam bent beschrijven? Kies uit de onderstaande opties (meer opties mogelijk):
 - A. Universitair Medisch Centrum
 - B. Categorieaal
 - C. Topklinisch
 - D. Algemeen/regionaal
 - E. Expertise centra
 - D. Anders, namelijk..
4. Heeft u ervaring binnen een soortgelijke functie in een andere medische instelling? Zo ja, wilt u hier meer over vertellen?
5. Hoeveel klachtenprocedures heeft u behandeld?
6. Kunt u ons kort vertellen over uw achtergrond en ervaring in het werken met klachtenprocessen en claims?

Hoofdvraag

Op basis van de literatuur die te vinden is over klachtafhandeling hebben we een hoofdvraag geformuleerd voor ons onderzoek. Mocht u het op dit moment lastig vinden om deze gelijk te behandelen kunt u erop terugkomen na het invullen van de andere vragen, aangezien deze een basis kunnen vormen voor het antwoord op de hoofdvraag van ons onderzoek. Aan het einde van de vragenlijst hopen we dat u een concreet antwoord zou willen formuleren op onze hoofdvraag, welke luidt als volgt:

Wat zijn volgens u de onderliggende factoren die ertoe bijdragen dat klachten escaleren tot claims, en hoe kan deze escalatie worden voorkomen?

Deelvragen

In het volgende gedeelte van de vragenlijst zal specifiek ingegaan worden op de factoren die volgens de literatuur belangrijk zijn in het klachtenafhandelingsproces. Deze factoren zijn onderverdeeld in verschillende subcategorieën, namelijk organisatiefactoren, karakteristieken van medische specialisten, kenmerken van het incident, karakteristieken van de patiënt en familieleden, karakteristieken van de klachtenfunctionaris en de-escalatie technieken.

Karakteristieken van medische specialisten

7. Uit onderzoek blijkt dat bepaalde karakteristieken van medische specialisten bijdragen aan het escaleren van klachten. Hoe ziet u dit terug in de praktijk en welke karakteristieken hebben volgens u invloed?

8. Uit onderzoek blijkt dat artsen vaak defensieve zorgverlening gaan uitvoeren vanwege angst voor claims. Defensieve zorgverlening houdt in dat artsen zich gedurende behandelingen laten beïnvloeden door angst voor claims, waardoor er eventuele onnodige onderzoeken uitgevoerd kunnen worden. Herkent u dit? In hoeverre denkt u dat dit gedrag vanuit artsen invloed kan hebben op het ontstaan van claims?

9. Heeft u het idee dat de relatie tussen patiënt en arts een rol kan spelen in het verloop van het klachtenproces? Zo ja, hoe zou u het effect van deze relatie beschrijven?

Kenmerken van het incident

Er is beperkte literatuur beschikbaar over de kenmerken van incidenten die bijdragen aan de escalatie van een klacht. Daarom willen wij graag informatie uit de praktijk ontvangen over kenmerken van incidenten die in uw beleving bijdragen aan het escaleren van klachten.

10. Maakt u zich bij het ontvangen van sommige klachten reeds meer zorgen over escalatie dan bij andere klachten? Zo ja, heeft u voorbeelden van klachten die in uw ervaring eerder leiden tot juridische claims?

11. Zijn er, in uw ervaring, specifieke gebeurtenissen die eerder leiden tot een escalatie van een klacht? Zo ja, wilt u deze gebeurtenissen beschrijven?

12. Kijkend naar onderzoek over incidenten is er een tweestrijd over welk type incident vaker leidt tot het escaleren van klachten. De twee type fouten die benoemd worden in literatuur zijn communicatie- en diagnose fouten. Heeft u vanuit uw ervaring een mening over welke type fout effect lijkt te hebben op de escalatie van klachten?

Karakteristieken van de patiënt of familie

13. Een andere factor die lijkt bij te dragen aan de escalatie van klachten zijn de persoonlijke kenmerken van patiënten en familieleden. Heeft u voorbeelden van karaktertrekken en persoonskenmerken van patiënten of familieleden die bij lijken te dragen aan dit proces?

14. Kunt u aangeven of u in uw werk als professional te maken heeft gehad met patiënten van bepaalde culturele achtergronden die anders omgaan met het uiten van klachten of het escaleren van klachten? Zo ja, welke verschillen in gebruiken heeft u hierbij waargenomen en hoe ervaart u dit?

15. Uit eerdere interviews is gebleken dat mensen verschillende taalbarrières kunnen ervaren, waaronder het niet begrijpen van medische termen, het onvoldoende kennis hebben van de werking van het menselijk lichaam, en onvoldoende kennis van de Nederlandse taal. Herkent u zich in dat dit type patiënt eerder een klacht indient die kan escaleren gebaseerd op uw ervaringen?

16. Welke specifieke maatregelen neemt uw ziekenhuis om patiënten met een taalbarrière te ondersteunen? Kunt u per taalbarrière aangeven welke aanpak uw ziekenhuis hanteert en hoe ervaart u dit?

17. Uit onderzoek blijkt dat wantrouwen bij patiënten een grote rol speelt in het escaleren van klachten. Heeft u hier ervaring mee? Zo ja, heeft u een idee waar dit wantrouwen vandaan komt en hoe ziekenhuizen hierop in kunnen spelen?

18. Uit onderzoek blijkt dat familieleden invloed hebben op het verloop van het klachtenproces. Herkent u dit? Zo ja, kunt u hier voorbeelden van geven?

Karakteristieken van de klachtenfunctionaris en klachtenafhandelingsproces

Als klachtenfunctionaris bent u direct betrokken bij de afhandeling van een klacht, en heeft u ervaring met klachten die escaleren. De procedures van klachtafhandeling verschillen per ziekenhuis, vandaar dat we graag informatie ontvangen over hoe dit binnen uw organisatie en voor u persoonlijk geregeld is.

19. Wat zijn volgens u de vaardigheden die een klachtenfunctionaris nodig heeft om zijn of haar werk goed uit te kunnen voeren?

20. Wat vindt u van de rol die u heeft binnen de klachtafhandelingsprocedures? Bent u tevreden over de mate waarin u momenteel betrokken wordt bij het proces van behandelen van medische klachten?

21. In hoeverre heeft een klachtenfunctionaris invloed op het escaleren en/of de-escaleren van een klacht? Zijn er specifieke karaktertrekken en persoonskenmerken van de klachtenfunctionaris die het escalatieproces kunnen beïnvloeden?

22. Uit onderzoek is gebleken dat er bepaalde signalen zijn waaraan een individu kan zien dat een klacht escaleert. Zijn er bepaalde signalen waaraan u kunt zien dat een klacht dreigt te escaleren? Zo ja, welke?

23. Hoe is het proces van klachtafhandeling nu geregeld binnen het ziekenhuis waar u momenteel werkzaam bent?

- Is er een specifiek protocol dat er gevolgd wordt? Zo ja, wilt u dit kort beschrijven?
- Wordt dit protocol op eenzelfde manier toegepast op alle patiënten, of verschilt dit per patiënt? Hoe ervaart u dit?
- Welke taken voert u uit om juridische stappen te voorkomen?
- In hoeverre worden patiënten betrokken bij de klachtafhandeling? Ervaart u dit als iets positiefs of negatiefs, en waarom?
- In hoeverre worden familieleden of nabestaanden betrokken in het proces? Ervaart u dit als iets positiefs of negatiefs, en waarom?

Organisatiefactoren

24. Zijn er volgens u kenmerken van de organisatie die ervoor kunnen zorgen dat een klacht escaleert? Zo ja, zou u enkele kenmerken van ziekenhuizen kunnen benoemen waar klachten vaker lijken te escaleren?

25. Hoe zou u het ziekenhuis waar u op dit moment werkzaam bent beschrijven qua regelgeving en aanwezige protocollen met betrekking tot de klachtenafhandelingsprocedure?

26. In hoeverre speelt de organisatiecultuur een rol in het klachtenafhandelingsproces? Heeft dit volgens u een positief of negatief effect op het proces?

De-escalatie technieken

Het vermijden van claims is belangrijk gezien de invloed die het heeft op alle betrokkenen. Uit onderzoek blijkt dat er meerdere factoren bijdragen aan de-escalatie van claims. Binnen ons onderzoek wordt het woord de-escalatie op twee verschillende manieren gebruikt. Ten eerste verwijst het naar het voorkomen van escalatie, waardoor de direct betrokkenen met elkaar in gesprek kunnen blijven gaan zonder juridische tussenkomst. Anderzijds kan de-escalatie gezien worden als het teruggeleiden van een geëscaleerde situatie, in dit geval een juridische strijd, naar een situatie waarin de betrokkenen met elkaar om de tafel kunnen om een oplossing te vinden.

27. Wat zijn in uw ervaring concrete factoren die ervoor kunnen zorgen dat een juridische claim de-escaleert tot het punt waarop een gesprek tussen beide partijen weer mogelijk is?

28. Uit onderzoek komt naar voren dat effectieve en efficiënte communicatie met de patiënt belangrijk is in het voorkomen van de escalatie van claims. Herkent u dit? En zo ja, hoe ervaart u dit in de praktijk?

29. Heeft u het idee dat het trainen van personeel op het gebied van de-escalatie iets is wat gebeurt in Nederlandse ziekenhuizen? Zo ja op welke manier? Zo nee waarom niet? En denkt u dat dit invloed heeft op de mate van de-escalatie?

Antwoord op hoofdvraag

30. Wat zijn volgens u de onderliggende factoren die ertoe bijdragen dat klachten escaleren tot claims, en hoe kan deze escalatie worden voorkomen?

Slot

We danken u voor uw deelname. Indien u nog extra informatie wilt toevoegen die ons zou helpen met het begrijpen van uw inzichten en ervaringen, kunt u het hieronder vermelden:

Op basis van de gegeven antwoorden zullen wij ons onderzoek naar het escaleren van klachten voortzetten. De verzamelde data zal niet gedeeld worden met derden en er zal zorgvuldig mee omgegaan worden.

Zou u het op prijs stellen ook de eindversies van onze scripties te ontvangen? Zo ja, hoe zou u deze willen ontvangen? Zodra het onderzoeksproces is afgerond zullen we uw persoonlijke gegevens verwijderen.

Extra informatie m.b.t de vragen:

Onderstaande informatie kunt u gebruiken indien u er niet uitkomt met het beantwoorden van de vragen.

Vraag 7: Enkele voorbeelden waaraan u kunt denken zijn medische specialisatie, geslacht, leeftijd, werkervaring, ervaring met klachten en claims.

Vraag 11: Enkele voorbeelden waaraan u kunt denken is de ernst van het incident en duur van het klachtenafhandelingsproces.

Vraag 13: Denk hierbij aan geslacht, leeftijd, cultuur, opleidingsniveau, socio-economische status, medische hulpvraag vanuit de patiënt waardoor er angst is om te klagen, of eventuele negatieve ervaringen in het verleden

Vraag 21: Denk hierbij aan eerdere ervaringen van klachtenfunctionarissen, communicatiestijl en geslacht van de klachtenfunctionaris.

Vraag 22: Denk hierbij aan de emoties van patiënten (angst, wraak, wantrouwen, woede, boosheid, agressiviteit), emoties van familieleden, verandering in gedrag en lichaamstaal van patiënt, overgang naar schriftelijke correspondentie.

Vraag 28: Enkele voorbeelden van effectieve en efficiënte communicatie zijn: actief luisteren, transparantie en openheid over het incident, verontschuldiging, vermijden van negatieve filters (positief verwoorden, beginnen met het negatieve nieuws om met het positieve te eindigen), lichaamstaal van de medische specialist en/of klachtenfunctionaris.

Appendix 6: To-do list escalation prevention tool

Voorkomen van escalatie

Tips voor zorginstellingen:

- Ontwikkel overzichtelijke informatiebronnen over het klachtafhandelingsproces, waarin een verwachte tijdlijn en aangewezen contactpersonen vermeldt staan
- Zorg ervoor dat alle informatiebronnen toegankelijk moeten zijn voor ieder type patiënt. Hou in het taalgebruik dus rekening met mensen met een taalbarrière, en zorg ervoor dat informatie beschikbaar is in de meest-gesproken talen in Nederland.
- Zorg ervoor dat de informatiebronnen vrij toegankelijk zijn voor patiënten via verschillende kanalen, zoals de website van de organisatie, flyers, en brochures.
- Moedig patiënten aan om feedback te geven door verschillende communicatiekanalen te implementeren, zoals enquêtes gericht op feedback een fysieke ideeënbus.
- Breng de mate van hiërarchie binnen de organisatie ter sprake en neem waar nodig maatregelen om de hiërarchie te beperken. Dit zal de open communicatie op alle niveaus binnen de organisatie bevorderen, wat escalatie kan voorkomen.
- Moedig zorgpersoneel aan om actief te benoemen wanneer een patiënt ontevreden lijkt. Door de onvrede gelijk te benoemen tijdens het contactmoment kan escalatie voorkomen worden
- Zorg dat er in het ziekenhuis een lijst aanwezig is met meertalige collega's en collega's met een andere culturele achtergrond, die waar nodig patiënten met een taalbarrière of andere culturele achtergrond kunnen begeleiden.
- Zorg dat informatiemateriaal in meerdere talen beschikbaar is, zodat deze voor iedere patiënt toegankelijk is. Daarnaast moet deze informatie geschreven zijn op een manier zodat iedereen deze kan begrijpen.
- Ontwikkel, eventueel in samenwerking met andere zorgorganisaties, een trainingsprogramma over klachtafhandeling en escalatie, effectieve communicatie skills en culturele verschillen in omgangsvormen
- Zorg voor doorlopende trainingsmogelijkheden voor zorgprofessionals, zodat ze hun vaardigheden omtrent het omgaan met patiënten en klachten/claims kunnen bijhouden en verbeteren
- Zorg dat de ingevoerde trainingsprogramma's voortdurend worden gecontroleerd en geëvalueerd, bijvoorbeeld op basis van feedback van klachtenfunctionarissen en zorgprofessionals.

Tips voor zorgprofessionals:

-Zorg voor een proactieve houding omtrent klachten en ontevredenheid bij patiënten door (1) actief te luisteren naar de patiënt en te zoeken naar oplossingen, (2) het betrekken van de klachtenfunctionaris wanneer nodig

-Wanneer een patiënt die regelmatig langskomt bij een arts voor een langere periode in het ziekenhuis ligt is het goed om deze op te zoeken, om betrokkenheid weer te geven.

-Toon empathie door het tonen van compassie en begrip voor de emoties van de patiënt, wees bewust van de non-verbale signalen die een patiënt afgeeft en wees er zeker van dat de patiënt zich gehoord en begrepen voelt in interacties.

-Probeer op een effectieve manier te communiceren door duidelijke en begrijpelijke informatie te verstrekken aan de patiënt. Denk hierbij aan het vermijden van medische termen die niet tot de algemene kennis van patiënten behoren.

-Wees transparant en open over medische procedures en mogelijke risico's voorafgaand een behandeling.

-Neem de verantwoordelijkheid voor eventuele fouten of misverstanden door oprechte excuses aan te bieden, aangezien dit een positieve invloed heeft op het vertrouwen van de patiënt.

-Biedt op een persoonlijke manier hulpverlening aan en hou rekening met persoonlijke kenmerken van patiënten, zoals culturele achtergrond of taalbarrières.

-Wees je bewust dat in sommige culturen er meer wantrouwen is richting de motivatie en kennis van medisch specialisten. Dit komt vaak door ervaringen uit het thuisland van de patiënt, die in grote mate afwijken van het Nederlandse zorgstelsel.

-Neem deel aan trainingen die gericht zijn op (1) begrijpen en omgaan met verschillende culturele achtergronden, (2) klachtafhandlungsprocedures en klachtescalatie, en (3) communicatieve vaardigheden gericht op omgang met patiënten.

Tips voor klachtenfunctionarissen:

-Probeer duidelijk en transparant te zijn over de mogelijkheden van patiënten op een vroeg punt in het klachtafhandelingsproces om zo onrealistische verwachtingen tegen te gaan.

-Pas het klachtafhandelingsproces aan op de specifieke behoeftes en omstandigheden van de patiënt, en focus op maatwerk en persoonlijke aandacht gedurende het proces.

-Wees bewust van de verschillende culturele achtergronden patiënten en de gevolgen die dit kan hebben op het klachtafhandelingsproces, en pas waar nodig het klachtafhandelingsproces aan op de wensen en behoefte van de patiënt.

-Wees bewust van het belang van het betrekken van de familie van de patiënt in vroege fases van het proces.

-Wees ervan bewust dat in sommige culturen familieleden in grotere mate betrokken zijn in het medische- en klachtafhandelingsproces van een patiënt dan in andere culturen.

-Wees ervan bewust dat in sommige culturen het normaal is om gelijk een claim in te dienen.

-Probeer culturele experts of tolken te betrekken in het klachtafhandelingsproces wanneer er ingewikkelde situaties ontstaan met mensen met een andere culturele achtergrond of taalbarrière om misverstanden te voorkomen, en culturele gevoeligheid te vergroten.

-Wees ervan bewust dat in sommige culturen meer wantrouwen is naar de motivatie en kennis van medische specialisten. Dit heeft te maken met hun referentiekader vanuit hun land van herkomst.

-Wees ervan bewust dat familieleden in sommige gevallen emotioneler reageren dan patiënten omdat ze de patiënt willen beschermen. Dit komt vaker voor wanneer de patiënt een zwakke positie heeft, zoals bij kinderen van oudere patiënten, ouders van kinderen of kinderen van ouders met een taalbarrière.