Radboud University

Master Thesis

Service recovery in healthcare:

Preventing medical complaint escalation

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Master Thesis
Business Administration – Marketing
June 23, 2023
2022-2023

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Preface

Presented to you is the master thesis 'Service Recovery in Healthcare: Preventing medical complaint escalation'. The focus of this master thesis is on exploring the factors that contribute to complaint escalation in a medical context, and what can be done to prevent escalation from happening. This thesis was written to complete the master's program in Business Administration with a specialization in marketing at the Radboud University. The study took place between November 2022 and June 2023.

Before conducting the study, I was already interested in the topic of medical service failure and recovery, as my mom suffered from breast cancer. She has personally experienced the effects medical service failures can have on patients, and therefore, I wanted to find out how this process was designed in Dutch hospitals. During this master's thesis, I only became more motivated to learn more about the topic. Therefore, I would describe the conduction of the study as interesting and very valuable. What has been even more challenging is the topic's sensitivity and, in some cases, the lack of literature available. Despite the challenges faced, I have experienced the personal encounters with the complaint experts as very pleasant and valuable, as they have provided novel insights into an understudied field of research.

During this thesis, there have been many people that have supported me. Firstly, I want to express my heartfelt thanks to Dr. H.W.M. Joosten for his dedication, expertise, meaningful insights, and personal style of supervising. It has been a pleasure working together. I also want to express my gratitude towards my second supervisor, I.W.A. Weeterings MSc, for providing valuable insights that have strengthened this study. A special thanks go out to Nazlican Hayirli and Anne Thijssen, with whom I had the pleasure to work. Your valuable insights and support have helped me a lot throughout my thesis journey. Furthermore, I want to thank all participants for making time and putting effort into this master thesis. Without your insights, conducting this study would not have been possible. Last but not least I want to thank my family and partner for their support during this process. Their caring and loving support has helped me through the challenges this thesis has provided me with.

Lisa Laponder
Nijmegen, June 2023

Abstract

Providing healthcare is a complex and sensitive interaction between the organization, healthcare professionals, and patients. To provide and improve the quality of healthcare, it is important to obtain feedback from patients. Organizations should be aware of the importance of complaint-handling practices and prioritize this within the organization. In some cases, patient dissatisfaction can lead to complaint escalation. This type of escalation greatly impacts all parties involved. Therefore, the current study investigates service recovery in a medical context.

The goal of this study is to understand the process of complaint escalation to find out how to prevent it. Formally stated, the research question of this study is: *What are the factors contributing to the escalation of medical complaints to claims, and how can this escalation be prevented?'*. The main goal is to develop an escalation prevention tool that can be used by healthcare organizations to prevent complaint escalation. Based on a thorough literature review, a conceptual framework and expectations have been created. This has been done collaboratively by three researchers, who have worked together, but all wrote individual research reports. A qualitative, practice-oriented study has been conducted to gain information from complaint experts working in Dutch hospitals. The experts provided in-depth information, which led to valuable insights and knowledge about the factors influencing the escalation process and what could be done to prevent escalation from happening.

Based on the gathered data, an analysis was conducted. This analysis has led to the confirmation, rejection, or partial confirmation of the pre-formulated expectations. Based on the results of the study, the researchers have collaboratively developed practical recommendations. These practical recommendations include a tool for healthcare organizations, healthcare professionals, and complaint officers on how to prevent complaint escalation. The current study reveals some interesting insights. For example, it was found that a patient-centered manner of healthcare appears to be highly effective for preventing complaint escalation. Furthermore, results showed the huge impact of culture on complaint escalation.

Keywords: Service failure and recovery, healthcare, complaints, claims, escalation

Content

Chapter 1: Introduction

1.1 Introduction

In industries where human interaction is a large part of daily operations, there is a chance that mistakes will be made. Organizations must act when mistakes occur, as these mistakes can lead to service failure. Service failure can be defined as 'activities that occur as a result of customer perceptions of initial service delivery behaviors falling below the customer's expectations' (Holloway & Beatty, 2003, p. 93). To ensure that customers remain satisfied, complaints must be resolved satisfactorily. Organizations can do so by providing service recovery, which can be defined as 'the organizational actions of seeking and dealing with a failure in service delivery' (Van Vaerenbergh & Orsingher, 2016, p. 328). Although medical service failure is a well-studied theme in research, organizations still seem to have difficulties with certain aspects of service recovery management (Van Vaerenbergh & Orsingher, 2016). Service recovery appears to be a paradoxical topic, as on the one hand it is often considered to be one of the most well-studied research areas in service management (Kunz & Hogreve, 2011). However, on the other hand, there are still a lot of organizations struggling with service recovery (Michel et al., 2009), which suggests that the available literature does not seem to have much effect on the practical reality regarding complaint handling.

In traditional service industries like hospitality, service recoveries are often quite straightforward. Restitution or a future discount is often sufficient to satisfy customers. However, there are also industries in which this process is not as straightforward, for example in healthcare. Healthcare can be defined as a service industry in which the best interests of the patient are a priority. As a patient, you rely on the competence of the medical staff. Medical professionals, in good conscience, provide the care that appears best to them under all possible circumstances. However, where people work, mistakes are made, and failure is inevitable. During any treatment or surgery, there is a risk of things going wrong. In situations where medical treatment is not successfully performed, one speaks of a medical service failure. Medical service failure is more difficult to restore compared to a service failure in hospitality, as the consequences of service failure in healthcare can vary from minor inconveniences to death. Therefore, it requires a different strategy to restore medical service failure compared to, for example, hospitality service failures.

As mentioned previously, service failure and recovery are well-studied themes in research. However, most research is related to traditional service context rather than non-traditional service context, like for example healthcare (Zayer et al., 2015). Furthermore, service failures in healthcare appear to be more common than in traditional service contexts, and service recovery is often more complex (Grégoire & Mattila, 2020). In the available literature, there is often overlap in the use of terms. A good example of this is the term 'error'. Due to the frequent use of the term error in literature, there is some ambiguity and overlap regarding the meaning of error in medical literature. Therefore, based on existing literature about medical errors, Hofer et al. (2000) created the following definition: 'failed processes that have been rigorously demonstrated to cause adverse outcomes' (p. 261). Another

perspective on the term ‘error’ has been created by Bal (2008), who defined medical malpractice 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 injury to a patient’ (p. 340). In the current thesis, these two definitions will be used when discussing medical malpractice.

Medical malpractice can appear in many forms. One of the characteristics of medical malpractice cases is that they involve patient safety. Given the fragility of the human body and the emotions involved, patients already have many concerns when they visit a hospital. When healthcare professionals do not provide service in a way that meets a patient’s expectations, it can lead to unnecessary stress and frustration. From personal experience, I have learned how important service can be to patients in health care. When my mother was diagnosed with cancer, she underwent several treatments that took their toll both physically and mentally. When mistakes were made during treatment, it greatly impacted the way she felt. After informally voicing her dissatisfaction to healthcare professionals, she received limited responses about measures taken to prevent these errors from happening again. My mother has decided not to file a complaint against the hospital or particular practitioners, but patients do have a right to do so.

To allow patients to provide feedback, hospitals have complaint procedures. These complaint procedures in hospitals are put into place to enable patients to voice discontent regarding the care they have received and to allow for peer review. In theory, the purpose of filing a complaint is to improve the quality of healthcare, resulting in improved patient safety. Therefore, reporting errors should be of high importance when it comes to patient safety programs. In practice, however, a lot of patients choose not to share their complaints (Donn & McDonnell, 2012). According to Leape et al. (1995), this has to do with patient fear and mistrust that complaining has no effect. Another fear patients can have can be grounded in previous negative experiences with legal procedures following medical service failures (Laarman & Akkermans, 2018). This fear can lead to mistrust, which in turn can lead to complaints or claims.

However, filing complaints is not solely concerned with patient safety but can also aim to address medical malpractice or raise legal concerns (Monteferrante et al., 2022). These legal proceedings are dealing with the medical professional’s damage, injury, or failure to a patient (Dahlawi et al., 2021). Initiating legal proceedings can be impactful for all parties involved, as it can induce extensive stress, including detrimental effects on the mental and physical well-being of service providers (Rappaport & Selbst, 2019). Rappaport and Selbst (2019) found that there is a link between burnout symptoms among healthcare providers and malpractice lawsuits.

Due to fear of complaints and claims, medical professionals may behave differently than under normal circumstances to reduce the likelihood of receiving a complaint, which is referred to as ‘defensive medicine’ (Monteferrante et al., 2022). Receiving complaints affects not only the physical actions of medical professionals but also their psychological well-being. According to Austin et al. (2021), 14 to 28% of doctors who receive a complaint have experienced complaints in the past, and

there is a greater risk of lower performance when the doctor has previous experience with malpractice. Other psychological problems that occur are issues concerning self-confidence, stress, anger, anxiety, and even suicidal behavior or self-harm tendencies (Monteferrante et al., 2022). Not only healthcare professionals are affected by legal actions, but hospitals as well. According to Baltesen (2020), hospitals are spending more and more money on medical liability. Both hospital insurance premiums and deductibles are increasing, but so are claim payments (Baltesen, 2020). Due to criminal and financial liability for medical malpractice and increasing demands to improve patient safety and quality of care, hospitals and healthcare facilities are opting for standardized procedures and an international accreditation system (Alkhenizan & Shaw, 2011). Yet, despite national and international efforts to certify hospitals and health centers by acknowledged accreditation boards, patients' safety continues to fall beneath acceptable levels (Dahlawi et al., 2021). Accreditation appears to have limited effects on patient performance, organizational culture, and reliability (Brubakk et al., 2015), and therefore might not be the best solution.

Some complaints escalate into legal actions because the complainant is entitled to it. However, it would be good to avoid this process whenever possible because of the major impact of legal proceedings on all parties involved. When adverse events are communicated through a hospital safety- or peer review committee instead of through complaint officers, patients and their relatives are often not made aware of the incident (Donn & McDonnell, 2012). Yet, according to a study by Giraldo et al. (2020), there is increased interest and demand for open procedures around medical errors. In response to several concerns, many healthcare professionals and hospitals have adopted disclosure policies (Donn & McDonnell, 2012). Unfortunately, only having a policy is not enough to provide disclosure to patients. Giraldo et al. (2020) found that although many policies intend to stimulate disclosure, only 10% of patients receive an explanation after medical malpractice. In many of these cases, disclosure and apologies did not influence the number of medical lawsuits (Giraldo et al., 2020). The crux remains that when medical professionals disclose, there is a chance that the information given will be used against them in court. On the one hand, healthcare professionals and organizations should promptly and sincerely express sympathy to patients, but on the other hand, they should not admit responsibility for errors until the event is carefully investigated (Donn & McDonnell, 2012).

1.2 Objective and Research Question

While reviewing the literature, claims appear to be impactful for all parties involved. However, based on the current literature, it remains unclear what measures can be taken to prevent medical complaint escalation. The objective of this study will be to identify the factors contributing to complaint escalation. By identifying the factors involved, the main goal is to help hospitals improve patient safety and reduce costs currently incurred on claims. Not only hospitals but also insurance companies will benefit from a decrease in legal fees, allowing the savings to be spent directly on the quality of

care. Improving the quality of care will also impact patients and their relatives. Therefore, the main question is as follows:

> *'What are the factors contributing to the escalation of medical complaints to claims, and how can this escalation be prevented?'*

To provide a theoretical framework that can help provide an answer to the research question, Chapter 2 has been structured using five underlying questions to build a theoretical framework. The questions are formulated below:

1: What are medical complaints?

2: How are Dutch hospitals dealing with medical complaints?

3: What are medical claims, and what are their effects on stakeholders?

4: When and how do medical complaints escalate and become claims?

5: How can this escalation be prevented or de-escalated?

1.3 Academic relevance

The goal of this study is to determine the factors that contribute to complaint escalation and how to prevent this. There has been limited research on the context of medical service failure and recovery (Zayer et al., 2015). Healthcare is a sector that is sensitive to errors, and recovery from errors appears to be complex (Grégoire & Mattila, 2020). During the literature review, it became apparent that there was a great deal of information about the occurrence and effects of medical malpractice complaints and claims (Austin et al., 2021; Leape et al., 1985; Monteferrante et al., 2022; Rappaport & Selbst, 2019). In contrast, there is limited research available that identifies whether, and if so, how it is possible to prevent medical complaints from escalating. Although not every complaint that a hospital receives will lead to a medical claim, it is important that when a complaint does escalate, hospitals, healthcare professionals, and complaint officers know which factors are contributing to escalation. By providing an overview of factors that contribute to medical complaint escalation, this study will contribute to the existing literature by providing a framework that can be used to clarify the complex interaction of factors that lead to the escalation of complaints.

Since 2017, the WKKGZ has been introduced in the Netherlands, which is a law that aims to provide a low-threshold way of handling complaints for both patients and employees of healthcare facilities (Ministerie van Algemene Zaken, 2022). Because of this law, every healthcare institution in the Netherlands must have at least one complaint officer. In the Netherlands, complaint officers are often the ones examining the complaints, and in some cases the claims a hospital receives. In research, it is often the perspective of medical professionals or patients when discussing complaints and claims. Therefore, this study focuses on Dutch complaint experts to provide new insights for research.

1.4 Practical relevance

The current study also has practical relevance. By providing information about factors contributing to complaint escalation, and what can be done to prevent escalation, the goal is to provide practice-oriented recommendations. These recommendations can contribute to improvements to the healthcare system, which can result in a higher quality of healthcare. This will be beneficial for society at large.

Another important stakeholder group is the healthcare organizations. Complaints, and especially claims, can be very costly for hospitals (Klemann et al., 2022). The main goal is to create an escalation prevention tool for healthcare organizations to reduce the chance of complaint escalation, resulting in lower litigation costs, which eventually can lead to lower insurance costs for hospitals. By providing a tool that identifies the best practices currently used in Dutch hospitals to prevent escalation or encourage de-escalation, the goal is to contribute to the reduction of claim expenses for hospitals and insurance companies.

In theory, the purpose of filing a complaint is to improve the quality of healthcare, resulting in improved patient safety. However, according to Michel et al. (2009), a lot of organizations are struggling to use customer complaints to improve the processes that caused the service failure and fail to adequately support and train employees to deal with complaint handling. Therefore, it seems relevant to investigate the influence of patient complaints on service recovery in a practice-oriented setting, so organizations can improve their complaint-handling processes and the quality of healthcare. Therefore, in the current thesis, a practice-oriented approach will be used to determine the factors that contribute to or can prevent complaint escalation. Furthermore, the current study can make patients aware of the complaint-handling process and the effect of their behavior during the complaint-handling process. The current study informs patients about how to make decisions when it comes to claims and can help to enhance patient empowerment. In turn, this can affect the patient satisfaction level and trust in the healthcare system (Charmel & Frampton, 2008).

The escalation process can be seen as stressful for healthcare professionals, which can influence the actions, physical, and mental health of healthcare providers (Austin et al., 2021; Monteferrante et al., 2022). According to Michel et al. (2009), organizations provide limited resources to train employees in complaint handling. Therefore, this study might help provide insights for improvements in complaint-handling strategies for healthcare professionals and healthcare organizations.

Finally, this study has practical relevance for complaint-handling officers, as in the Netherlands they are responsible for receiving, investigating, and handling complaints. By making a practice-oriented tool in which the factors that contribute to escalation are provided, complaint officers can use the information and share this with other parties involved via training or briefings. Being aware of the contributing factors might lead to the prevention of unnecessary complaint escalation.

Chapter 2: Theoretical framework

To formulate a suitable answer to the research question, more information is needed. This chapter will provide an overview of the literature, intended to build a framework that will contribute to formulating an answer to the research question. This chapter is structured using the different theoretical sub-questions provided in Chapter 1. In the upcoming chapters, the method of data analysis, results, and conclusions will be discussed.

2.1 Medical complaints

This section will attempt to provide a clear understanding of a medical complaint using various sources in current literature. The causes and consequences of medical complaints will be discussed as well. In the end of this section, sub-question 1: *'What are medical complaints?'* will be answered.

Definition of a medical complaint

When medical care provided is not up to standards or when resulting in bad patient outcomes, there is a possibility that a complaint will be filed. These complaints can be filed directly by patients, or through acquaintances that are concerned with patient well-being but do not have the authority to take direct measures themselves (Austin et al., 2021). Medical complaints can be defined as 'complex narratives that report on perceived failures of healthcare delivery from the patient's perspective' (Van Dael et al., 2020, p. 684). In hospitals, complaints are considered to be important as they provide valuable data and can reveal pressure points in which patient care falls short (Gillespie & Reader, 2016).

In medical service recovery literature, authors use different terms to classify complaints. Donn and McDonnell (2012), for example, distinguish between diagnostic- and communication errors. The main difference is that treatment errors are mistakes in diagnosis or lack of diagnosis that can be linked directly to failures made by the medical professional during treatment, whereas communication errors are defined as flaws in communication between the healthcare professional and patient, often resulting in misunderstandings.

In practice, there are three terms used to distinguish between the events leading up to medical complaints, namely complications, incidents, or sentinel events (Inspectie Gezondheidszorg en Jeugd, 2020). A complication can be described as an unintended side effect of treatment, resulting in a negative outcome. Incidents are defined as unintentional or unanticipated incidents relating to the quality of care that has led to or can lead to patient harm. A sentinel event is the most severe medical error, in which one can also speak about unintentional or unanticipated incidents, but the outcomes of these types of incidents are much more severe, possibly resulting in adverse consequences or even death.

What the classifications described above (Donn & McDonnell, 2012; Gillespie and Reader, 2016; 1nspectie Gezondheidszorg en Jeugd, 2020) have in common is that they all relate to the events

proceeding complaints. All types of complaints will be included to be able to properly examine the different factors that can contribute to complaint escalation.

Causes of medical complaints

To understand the complaint escalation process, it is important to understand the underlying causes of complaints. One of the most reported causes of complaints is a communication error, in which there are deficiencies in the interaction between the doctor and the patient or relatives of the patient (Hanganu et al., 2020) In some cases, these communication errors can be linked to translation, as not all patients have the same language proficiency. Another common communication error is misunderstandings due to the interpretation of medical terms. Even though patients speak the same language as medical professionals, they might not have a proficient understanding of medical terms, which can lead to misunderstandings. Another common service error causing complaints is treatment error, which can be defined as adverse outcomes or injuries stemming from the process of healthcare (Naveh et al., 2005). What the different errors have in common is that they all concern patient safety.

Even though all medical service failures concern patient safety, not all failures will lead to a complaint (Austin et al., 2021). According to Leape et al. (1995), many patients worry that complaining will not result in improvements, which, according to the authors, is a sign of patient mistrust in both healthcare professionals and the healthcare system. However, not only patients are reluctant to file a complaint, but healthcare professionals seem to struggle as well. Many healthcare professionals have concerns about confidentiality and fear of increased litigation risk for themselves, colleagues, or the hospital when reporting severe adverse events, and therefore might not always choose to report (Donn & McDonnell, 2012). Other factors contributing to hesitation to report errors made by other healthcare professionals are fear of punishment and sanctions (Donn & McDonnell, 2012).

Past research has identified several predictive factors that can contribute to a higher risk of complaints for healthcare professionals (Austin et al., 2021). Examples of such factors are the country of original training, clinical workload, practice setting and specialty (Austin et al., 2021; Stelfox et al., 2005). Austin et al. (2021) found that psychiatry, surgery, obstetrics, and gynecology were high-risk specialties for receiving complaints. However, there are also demographic characteristics of medical professionals that might contribute to the formation of complaints, namely age, sex, mental state, geographic location, and number of complaints (Austin et al., 2021; Bismark et al., 2013). An interesting finding is that an individual practitioner's risk of complaints is not determined by patient characteristics or complexity, but rather by complaints about the medical professional's competence and the interpersonal component of healthcare (Stelfox et al., 2005). According to Stelfox et al. (2005), there seems to be a negative correlation between patient satisfaction scores and the number of complaints received, suggesting that healthcare professionals with a high likelihood of receiving complaints may be identified using patient satisfaction scores. The content of these complaints often

relates to interpersonal issues of communication rather than complaints about care and treatment, as these are less likely to be investigated thoroughly by risk managers (Hickson et al., 2002).

Effects of medical complaints

As mentioned before, medical complaint handling is introduced in healthcare to improve the quality of hospital care and prevent medical malpractice. Both in practice and theory, complaints have been identified as a precious source for monitoring and improving patient safety (Reader et al., 2014). The analysis of data on negative patient experiences can strengthen the ability of healthcare organizations to identify systematic problems in care (Reader et al., 2014).

When a complaint is made to raise legal concerns, this might have negative consequences for the people involved, of which one of the most well-studied groups is the healthcare professionals. In a study conducted to find out the effects of complaints on healthcare professionals, Montferrante et al. (2022) found that one of the most reported effects among medical professionals is defensive medicine. This can be described as a more conscious way of acting after receiving a complaint, to reduce the chance of receiving another (Monteferrante et al., 2022). Medical professionals might order treatments, tests, and procedures not based on finding a diagnosis or treatment, but to help protect themselves from liability (Hermer & Brody, 2010). This fear of complaints often results from previous experiences of medical professionals with claims. Bourne et al. (2017) revealed that 85% of physicians who have recently received a claim, and 80% of a total of 3.889 physicians who have previously received a complaint, indicated to have changed the way they practiced medicine due to fear of receiving complaints. It was also discovered that medical professionals who have recent experience with a complaint procedure were two times more likely to experience high anxiety levels compared to medical professionals who did not have any (recent) complaint experience (Bourne et al., 2017). These statistics further indicate the relevance of investigating factors that influence the complaint process.

2.2 Medical complaint-handling in the Netherlands

In the following subsection, the medical complaint-handling process in the Netherlands will be discussed. This section will provide an answer to sub-question 2: *'How are medical complaints handled in the Netherlands?'*

Medical complaint handling in the Netherlands

Internationally, a shifting political perception of governance and regulation has led to a change from centralized to decentralized systems, with governments placing responsibility for decision-making with experts in the field (Bouwman et al., 2016). In the Netherlands, this international shift was visible in the adoption of the Quality Act created in 1996, in which the Dutch government placed responsibility for healthcare quality directly with care providers (Bouwman et al., 2016). A health care inspectorate (IGJ) has been assigned as a branch of the Ministry of Health, Welfare, and Sport, and is tasked with monitoring and regulating the quality of health care. The inspection monitors whether

legal obligations are fulfilled, assuming healthcare providers are intrinsically motivated to act rationally and socially responsible (Bouwman et al., 2016).

As there was a lot of dissatisfaction about how care providers dealt with complaints, the Dutch government introduced the Healthcare Quality, Complaints, and Disputes Act (WKKGZ), which should provide for better, faster resolution of complaints, individual reporting of incidents by care workers without fear of reprisal, strengthen patients' right to information and extension of care providers' reporting obligation (Ministerie van Volksgezondheid, Welzijn en Sport, 2016). It can be argued that the core components of the WKKGZ law are widely supported (Friele et al., 2021). However, there are also parts of the law and real-world situations created by the law that need some more attention, like for example, the implementation of complaints and disputes which in some respects did not bring what was intended by the legislature (Friele et al., 2021).

There are multiple places a patient can go to voice their complaint. UMC Utrecht (2020) has developed a guideline for patients that can be followed once they have a complaint. The first step patients can take is to voice their discontent with the respective care provider. If this does not work, or a patient needs guidance, a complaint officer can help. The complaint officer will listen to the wishes of the patient, will inform and advise the patient concerning the different approaches there are, and can help formulate the complaint. If the complaint officer is approached, he or she will contact the manager of the department with the request to investigate and, if necessary, act. When a patient is dissatisfied with the result of the mediation of the complaint officer, or when this service is not wanted, one can consider presenting a claim to a judging committee. This committee consists of a chairman and vice-president that are in no way connected to the hospital, to keep the process as unbiased as possible. The other members of the commission are working in various departments in the hospital. In some cases, a hearing is necessary in which the patient can verbally explain the details of their complaint. After this process, the patient will receive a written judgment concerning the complaint.

For patients, it is also possible to voice a complaint to the health care inspectorate. When a medical error has occurred, hospitals are obliged to investigate this error using the guidelines provided by the IGJ and report their results to the Dutch authorities. The inspectorate's legal duties do not allow them to voice individual judgments about complaints but rather use complaints for general risk analyses (Bouwman et al., 2016). The inspectorate has specific requirements that need to be met for a claim to be considered, which are as follows: (1) serious deviation from applicable professional standards by medical professionals or other employees within the institution, (2) serious failure or absence of an internal quality system in an institution, (3) serious harm to health or a high probability of recurrence of the problem (Bouwman et al., 2016; IGZ, 2013). If the complaint meets one of these criteria, the inspectorate requests the care provider to investigate the matter, which might be followed by an investigation of the Inspectorate when deemed necessary (Bouwman et al., 2016). Other bodies to which patients can voice their dissatisfaction about healthcare-related incidents are the regional

board for Healthcare (Regionaal Tuchtcollege voor de Gezondheidszorg), Zorgbelang Nederland, or Joint Commission International.

In the Netherlands, hospitals can also decide to proactively investigate medical errors before patients file a complaint. Different methods can be used, like for example the Root Cause Analysis (RCA) or the TRIPOD analysis (Transparent Reporting of a multivariable prediction model for Individual Prognosis or Diagnosis). Both analyses are created to investigate the situations surrounding the incidents using analyses, to prevent incidents in the future. In the current study, the focus will be on the complaint-handling process from a patient's view, rather than the actions a hospital can take. Therefore, the different methods are not explained thoroughly. More in-depth information about the different types of analyses can be found in Joosten (2020), Latino (2015), Muurling (2020), and Maastricht UMC+ (n.d.).

2.3 Claims

The upcoming section will provide an overview of what claims are, the process of claiming in the Netherlands, and the effects claims can have. This section will therefore provide an answer to sub-question 3: *'What are medical claims, and what are their effects on stakeholders?'*

Definition of claims

A medical claim can be defined as a civil action against a healthcare professional, employee, or hospital that arises out of a medical diagnosis, care, or treatment of a patient. Claiming can be done by sending a written request to the board of directors of a hospital in which a patient states what has happened and what the damages are. The written request for compensation will be discussed with the liability insurer of the hospital, after which the Legal Affairs department will inform the patient about the method of settlement. The extent of the claim will be determined based on different factors, considering the additional costs of care, the legal fees, and the loss of income due to the incident (Baltesen, 2019).

When considering filing a claim against a practitioner or a hospital, it is important to look into the legal accountability that is connected to the type of incident. According to legal institutions, a distinction can be made between medical negligence and medical malpractice, which relates to intention (Ben Crump, 2022; Manchin Law, 2020). Medical negligence is described as a situation in which a healthcare professional makes a mistake resulting in an action that fails to meet the medical standard of care due to carelessness, which cannot be defined as intent. Medical malpractice, however, can be defined as intended since the medical professional was well aware of the potential risk of harm that could be caused by an act. When a healthcare professional makes a deliberate choice that results in patient harm (i.e., medical malpractice), the patient may choose to pursue legal action. In literature, there is not one overarching term that includes all aspects of medical malpractice. In the current thesis, the following definition will be used: 'an act of omission or commission in planning or execution that contributes or could contribute to an unintended result' (Grober & Bohnen, 2005, p. 42).

Process of claiming in the Netherlands

According to de Rechtspraak (n.d.), if a patient decides to file a claim, they must send a registered letter to the practitioner and/or medical institution. In this letter, the patient needs to explain how he or she is holding the doctor and/or medical institution accountable for the personal injury. This letter will probably be forwarded to the insurance company by the hospital or the practitioner. If the different parties do not agree, a court procedure can be started. If the amount of the claim is €25.000,00 or less, patients should go to the district court. If the claim concerns more than €25.000,00, a civil procedure should be started. With civil procedures, patients are obliged to approach a lawyer.

The costs of juridical proceedings vary based on the type of procedure that is started. When a patient chooses to start a civil law proceeding, it involves a range of costs, varying from lawyer and mediation fees, bailiff's fees, legal costs (if the court rules so), court fees, and expenses incurred by witnesses and experts (Ministerie van Justitie en Veiligheid, 2016). The costs of civil procedure can be quite expensive for the party that is ruled against.

In the Netherlands, patients need to prove the following things in court to have a chance at financial compensation (Het Juridisch Loket, n.d.):

1. The healthcare provider made a mistake
2. Most other healthcare providers would not have made this mistake
3. There has been financial damage, and how much damage there is.
4. This damage has been the consequence of a mistake by the healthcare provider.

Effects of medical claims

In the last few decades, medical claims have received a lot of public attention, especially since in the United States there appeared to be a 'claim culture' which led to rising numbers and the cost of malpractice claims, resulting in high insurance premiums (Klemann et al., 2022). A similar increase in numbers and costs associated with medical claims has been feared among European healthcare professionals, insurance companies, and policymakers (Klemann et al., 2022). It is noteworthy that, despite the decreased number of claims filed and a stable number of finished claims, the cost of claims increased rapidly in the Netherlands, from a total cost of €9.029.850 in 2007 to €40.938.960 in 2021 (Klemann et al., 2022). This increase is not visible in the median costs of claims but can be related to rare cases with a higher payout, for example, birth-related damages (Klemann et al., 2022). The specialties that yearly receive the most claims and costs are general surgery, orthopedics, plastic surgeons, traumatology, and gynecology (Gómez-Duran et al., 2018; Klemann et al., 2022)

The legal costs of claims are a struggle for hospitals. Hospitals use liability insurance to cover their financial and legal obligations to their healthcare providers if they are sued for medical malpractice (Baltesen, 2019). MediRisk, which, together with Centramed, handles practically all liability claim insurance in the Netherlands, has calculated that the claim amount increased substantially (Baltesen, 2019). The high payouts may be related to the rapidly rising deductible, which

is forcing hospital boards to set aside larger sums of money to cover claims, which will result in less money available to invest in the quality of care.

Not only for the hospital but also for the healthcare professionals, claims have a big impact. Medical professionals who were previously sued are reported to have a 1.9 times greater risk of receiving another claim (Gómez-Durán et al., 2018; Monteferrante et al., 2022). According to Monteferrante et al. (2022), claims can affect the psychological well-being of medical professionals, ranging from stress, anger, anxiety, or even suicidal thoughts or self-harm tendencies. The psychological effects of malpractice lawsuits also influence the way medical professionals practice medicine, resulting in increased levels of defensive medicine (Monteferrante et al., 2022; Vizcaíno-Rakosnik et al., 2020).

Also, patients are suffering from lawsuits due to the high legal costs, time investment, and stress that comes with medical malpractice and court. Due to the high risks and serious consequences of medical malpractice, patients and their families are already under a lot of stress. A medical lawsuit can result in a destructive personal experience for a patient, in which the patient is repeatedly confronted with the traumatic experience of medical malpractice (Moore et al., 2000). The last thing they want is to invest time and effort into litigation when they can also focus this time, resources, and energy on their recovery or in adapting to a life with possible limitations. Therefore, it would also be in the patient's best interest to avoid legal steps if possible.

2.4 Escalation of complaints to claims.

In the following section, the complaint escalation will be discussed. At the end, sub-question 4: '*When and how do medical complaints escalate and become claims?'* will be answered

Complaint escalation process

When a patient has damages as a result of medical treatment, does not feel like filing a complaint is sufficient, and wishes to be compensated according to their damages, a patient can decide to file a claim. It is important to be aware that not every complaint will eventually lead to a claim. According to information provided by the American Board of Professional Liability Attorneys (2022), to prove medical malpractice under the law, a claim should consist of three specific elements, namely breach of standard care, injury of the patient, and significant damages.

In general, lawsuits do not simply start, they follow a process of development called 'naming, blaming, and claiming' (Kritzer, 2011). A conflict starts with someone being 'injured', identified as the injured party or agent ('naming') becoming a 'perceived injurious experience' (PIE) (Kritzer, 2011). An injurious experience that is not recognized is referred to as an 'unperceived injurious experience' (unPIE) (Kritzer, 2011). According to Kritzer (2011), the change from an unPIE to a PIE includes the crossing of the 'recognition barrier. This results in the injured party needing to assign responsibility to another party involved, also known as 'blaming'. During the 'blaming' process, the

'attribution barrier' is crossed. When responsibility for the injurious experience has been externalized and a responsible party has been identified, the injured party can choose to either do nothing or to approach the other party directly or indirectly and voice a complaint or claim (Kritzer, 2011). Actual litigation occurs only when attempts to resolve problems before formal steps are taken fail, although in some situations a complainant may file a lawsuit even before an attempt is made to solve the matter (Kritzer, 2011)

Factors contributing to complaint escalation

According to the literature, several factors influence the process of complaint escalation. The most common reason for escalation is that patients do not feel like they are listened to or can voice their concerns or complaints (Howard et al., 2013). Howard et al. (2013) found that patients want to play an active role in improving healthcare services, which needs to be considered when they are voicing their opinions. The majority of the participants in the study by Howard et al. (2013) had difficulties voicing their discontent at the time of the event itself. Patients mention that they view themselves as assertive when the results show differently (Howard et al., 2013). Therefore, Howard et al. (2013) recommend patients to advocate for themselves during the event, and not just accept the care they receive. The cognitive appraisal theory reflects how humans deal with challenges and stress (Howard et al., 2013). Cognitive appraisal can be seen as a crucial factor in a person's emotional experience (Howard et al., 2013), as it supports the idea that not the event but how an event is perceived causes certain emotions and behaviors.

When patients do not feel heard, it can affect them emotionally. Anger has been identified by past studies to be one of the main accelerators for complaints, whereas resignation has been identified to be the main cause of non-complaining behavior (Bagozzi et al., 1999; Chebat et al., 2005; Gorney, 2002; Howard et al., 2013; Smith & Lazarus, 1991). For example, when patients are unsatisfied with their treatment, medical professionals must understand that this patient often acts out of fear and is trying to gain control over the situation by showing anger (Gorney, 2002). Healthcare professionals should try to acknowledge the root cause of the anger to make the patient feel heard. If not acknowledged, patient emotions can lead to lawsuits. This is in line with possible reasons provided by patients for suing a practitioner, namely the call for revenge (Bousnina & Zaiem, 2019; Kraman & Hamm, 1999).

However, not only the patient's emotions but also the emotions of relatives can lead to a higher chance of complaint escalation. For family members, medical failure can lead to the experience of emotional distress, which can affect the emotions and attitudes they have toward a practitioner. Emotions impart a primacy of control over states of readiness for action, in that they claim priority of control over behavior and experience (Scherer, 2011). This indicates that people will act out of emotion rather than rationality when confronted with emotional distress. The level of emotional distress can vary based on the relationship the family member has with the patient. Hickson et al.

(1992) indicated that parents of a child that had suffered severe consequences of medical service failure have a higher tendency to sue this practitioner. The relationship between relatives and healthcare professionals is often different from the relationship between patient and practitioner, as relatives do not have personal interactions with healthcare professionals at the same level as patients do. Whereas patient-primary care provider relationship relationships are found to diminish the risk of complaints (Moore et al., 2000), this is not the case for relatives, who file the majority of claims regarding communication errors (Hanganu et al., 2020).

Another reason for escalation is communication issues. Bad communication usually leads to an inevitable, vicious cycle that follows disappointment, anger, and frustration on the part of the patient, reactive hostility, defensiveness, and arrogance on the part of the healthcare professional, worsening anger of the patient, and finally a visit to a lawyer (Gorney, 2002). Gorney (2002) indicates that half of the malpractice claims are preventable since most of them are based on flaws in communication and/or patient selection criteria rather than technical errors. Kraman and Hamm (1999) indicate that lack of disclosure is one of the reasons why patients indicated to proceed to file a medical claim.

Understanding the risk factors that make complaints into claims will enable physician boards to evaluate healthcare professionals more objectively upon receiving a complaint and allow for better supervision of professionals who have more risk of being sued (Austin et al., 2021). According to Austin et al. (2021), risk factors for malpractice complaints or claims are probably country-specific due to differing governance structures, processes, and financing. Furthermore, their study shows that previous claims can be an indicator for future claims, just as a greater number of hours worked per week, patients seen and years in practice were (Austin et al., 2021).

Another factor influencing complaint escalation is the socio-economic status of patients. According to McClellan et al. (2012), patients with low socio-economic status are less likely to file a claim against a practitioner, due to their lack of finances and needed to start a claim procedure. This is supported by Burstin (1993), who also concluded that patients from a low socio-economic class, just like uninsured patients, are less likely to file claims.

There are also characteristics of medical professionals that can contribute to the escalation of a complaint. In the past subsections, a lot of examples are already provided and in the analysis of the data, characteristics of medical professionals will be further elaborated upon concerning complaint escalation in Dutch hospitals.

2.5 Prevention of claims and de-escalation techniques

Based on the literature, claims are proven to have a negative effect on multiple stakeholders. Therefore, it is in the best interest of all parties involved if this escalation can be prevented, or when already present a claim can be de-escalated to a complaint. In the current paragraphs, both prevention

and de-escalation techniques will be discussed. Finally, the goal is to provide an answer to sub-question 5: '*How can complaint escalation be prevented or de-escalated?'.*

Prevention of claims

An important factor in complaint escalation, according to patients, is that they do not feel like they are listened to or can voice their concerns or complaints (Howard et al., 2013). Howard et al. (2013) mentioned how patients wanted the healthcare system to change, creating more space for open communication where patients are listened to, and medical professionals can apologize and take ownership of their actions. During the aftermath of adverse events, patients and their families can benefit when healthcare professionals disclose medical errors, express their sympathy, and apologize (Finkelstein et al., 1997; Lazare, 2006). Disclosure might also diminish the intent of patients to claim (Donn & McDonnell, 2012). Many patients indicate that after a medical adverse event, transparency, possible compensation, and knowing that what happened to the patient will not happen again are the most important (Donn & McDonnell, 2012). This seems to align with why patients indicate to sue in the first place, namely, to find answers due to lack of disclosure, revenge, and the need for financial and medical help (Kraman & Hamm, 1999). Therefore, open communication from both sides might help to prevent complaint escalation.

However, this open communication can only occur when there is a change in attitude from both the patient's and the practitioner's perspective, going from 'name and blame' to patient safety (Donn & McDonnell, 2012). As mentioned in previous sections, Monteferrante et al. (2022) discovered that medical professionals tend to practice defensive medicine after receiving a complaint, which to their logic should lead to avoidance of future claims (Hermer & Brody, 2010). Although defensive medicine may lead to more cautious care, it also causes healthcare professionals to be driven by legal risk instead of medical necessity (Katz, 2019).

Healthcare professionals have an ethical duty to disclose harmful medical errors to patients, despite the risks of losing patient trust, reducing satisfaction, and increasing the risk of malpractice litigation (Buertow et al., 2013; Gallagher et al., 2007). Several factors that may prevent healthcare professionals from disclosing errors are taking responsibility for one's own mistakes, fear of losing patient trust, a perceived loss of social reputation, and shame (Gallagher et al., 2013). Many initiatives have been developed to promote the disclosure of medical errors to patients or their families, like for example legislation known as 'apology laws' that were created to reduce fear of lawsuits when patients or relatives were informed of an error, and clearly state the position governments take regarding disclosure of medical service failure (Giraldo et al., 2020). Another successful implementation of disclosure can be seen at a Veterans Affairs Medical Center, where they pursue a more active approach toward cases that can result in claims. The new policy was designed with the intention of better preparing a risk management committee for malpractice claims by detecting and examining apparent incidents of negligence (Kraman & Hamm, 1999). However, when investigating

incidents in which the patient or family was not aware of the negligence, the committee found it their responsibility to tell them even though it could have a financial impact on the organization. This practice is not only considered ethically approved but also resulted in unanticipated financial benefits to the center due to a higher settlement rate (Kraman & Hamm, 1999). Therefore, disclosure might be seen as a prevention factor for escalation.

There are also some personal factors of patients that can influence the escalation process. One of these factors is the relationship between the healthcare professional and the patient. When the patient has a personal relationship with their healthcare professional, there is a lower risk of complaints (Moore et al., 2000). A foundation of trust can be built, allowing the patient to become more satisfied with the care, which in turn will diminish the probability of medical complaints and claims. Another factor that can lead to the prevention of claims is considering the cultural characteristics of patients in communication. Berlinger and Wu (2005) found that it was important for medical professionals to learn more about a patient's culture, especially considering medical malpractice. When these medical professionals are aware of the wants and needs of patients when it comes to their treatment, they can act accordingly, allowing less room for inconsistency between expectation and reality (Berlinger & Wu, 2005).

One of the techniques to prevent escalation from happening is making sure emotional flashpoints are recognized. Flashpoints are defined by Bowers (2014) as social and psychological situations that stem from event characteristics and signal and precede upcoming conflict behavior. In the current study, flashpoints will be interpreted as triggers that can be noticed by complaint experts during the process of complaint handling. In the literature, there is limited information available about flashpoints for complaint escalation. Therefore, the goal is to obtain information about this from medical complaint experts with hands-on knowledge. As mentioned in the previous subsection, emotion, and specifically anger, is one of the main contributing factors to complaint escalation (Gorney, 2002), which is why signs of anger should be treated as a flashpoint.

The further course of events can be influenced by showing understanding, support, and encouragement when deemed appropriate to the situation. One of the biggest mistakes when handling an angry or dissatisfied patient is avoidance, as this might lead to even more frustration from the patient (Gorney, 2002). Therefore, it is important for medical professionals to adequately respond when signs of anger are visible among patients or their families to avoid escalation of complaints to claims.

As mentioned before, Stelfox et al. (2005) found that malpractice risk might be influenced by patients' dissatisfaction, making it possible to detect individual healthcare professionals with a higher risk of litigation based on their patient satisfaction scores. As most hospitals already use patient satisfaction surveys, these can be used to generate patient satisfaction assessments that are more representative and provide opportunities for intervention before dissatisfaction escalates into formal complaints or even malpractice lawsuits (Stelfox et al., 2005)

De-escalation techniques

De-escalation can be described as ‘to decrease in extent, volume, or scope’ (Merriam-Webster, n.d.). In the medical context, several researchers have conducted studies into de-escalation techniques, however, limited information is available about complaint escalation. Therefore, some studies mentioned will not completely align with the current topic. However, the studies do align sufficiently to relate their content to the field of medical claims.

Open communication has been named as one of the factors that can prevent escalation from happening. However, one should be careful when also wanting to apply disclosure as a de-escalation technique, as Giraldo et al. (2020) found that once a claim is filed, disclosure and apology do not change the litigation process. This might indicate that it is difficult to resolve a claim with disclosure once a complaint has already escalated to a claim. Therefore, it is important to make sure disclosure is provided before the point of escalation since escalation is hard to undo.

Communication errors are in many cases related to the formation of medical claims due to healthcare service failures. McClellan et al. (2012) provide four key factors that healthcare professionals should use when communicating, namely empathy, guidance, involvement, and enlistment. Once healthcare professionals follow these four key skills, the risk of claims will be diminished. Therefore, it is important to make sure medical professionals can communicate properly with patients and their families. Possible ideas to avoid communication errors are implementing communication training into the curriculum of medical professionals or providing training for staff concerning communication.

Bowers (2014) has created a model that can be used for de-escalation. The original model has been created as a de-escalation strategy in psychiatric healthcare but can also be used for claim de-escalation. Bowers (2014) shows that there is a range of causes of conflict that can lead to a specific flashpoint, which can then trigger a conflict incident that leads to containment. Factors that can influence the escalation are the staff, physical environment, outside the hospital, the patient community, patient characteristics, and the regulatory framework (Bowers, 2014). In the current study, containment can be seen as complaint escalation. The model also indicates that the staff has the power to influence the level of conflict and escalation in their department, which might also be the case for medical employees that are involved in certain steps of the process.

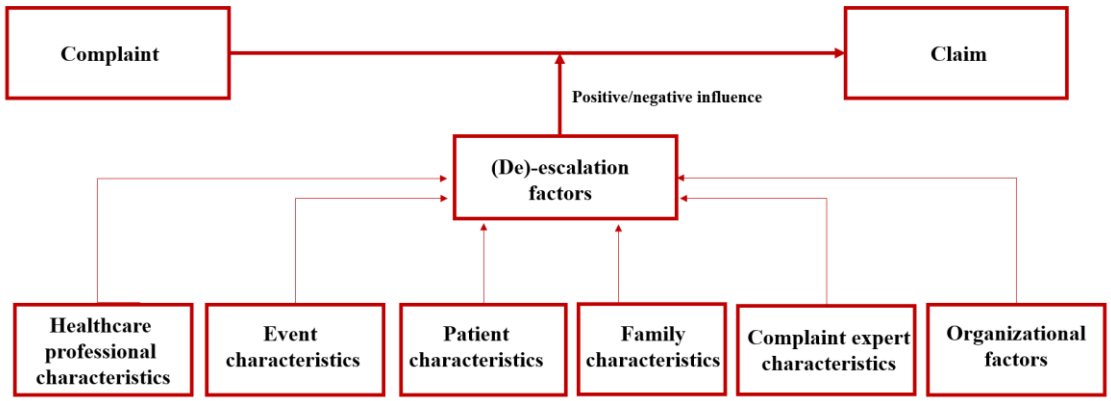
Another model for de-escalation is developed by Dix and Page (2008), which is developed for mental health units as well. The model consists of three basic units, namely assessment, communication, and tactics (i.e., ACT). They use the progression of five factors to understand and assess aggression in patients. The five factors of the model are situation, appraisal, anger, inhibitions, and aggression. Dix and Page (2008) provide the reader with quite abstract models that offer a picture of the patient-primary care provider relationship without providing a specific script. The terms used are intentionally vague, to avoid preparation which might lead to unwanted inflexibility.

What remains unclear is what factors are specifically contributing to complaint escalation, and what the specific flashpoints are. Even though there is much research conducted concerning both complaints and claims, there seems to be limited literature about factors that contribute to complaint escalation. Therefore, the current research will further investigate which factors are contributing to the escalation of complaints to claims in hospitals, and what the specific indicators are that complaints experts can use to spot escalation.

2.6 Conceptual framework

The conceptual framework in Figure 1 is derived from the literature mentioned in Chapter 2. Based on the conceptual framework, expectations have been formulated. For some expectations, there are no direct sources mentioned, as the expectations were formulated in collaboration with other researchers. However, all expectations mentioned in the current study are grounded in theory. These expectations will refer to the effect certain factors have on the escalation process. As the literature concepts are just the basis, in the next stage of research, the focus will be on the real-life influence of these factors on complaint escalation. Furthermore, if there are factors that appear to be of influence in practice but are not yet defined by the literature used, these might eventually be added to the framework as contributing or diminishing factors to medical complaint escalation.

Figure 1
Conceptual framework.



Healthcare professional characteristics

E1: Female healthcare professionals are expected to have a higher risk of escalation than male 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 communication skills, the risk of escalation is expected to be lower than when professionals have poor communication 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-primary care provider relationship is expected to reduce the likelihood of complaint escalation.

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

Patient characteristics
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 who show much emotion during the complaint-handling process are expected to have a higher risk of complaint escalations than patients who do not show emotion.

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

Complaint expert characteristics
This category contains no expectations based on literature, as there is no literature about the complaint escalation process from the complaint expert point-of-view. However, this category is mentioned in the conceptual model as in the Netherlands, complaint-handling experts are the main contact person when it comes to complaints and claims, and therefore are expected to influence the complaint escalation process.

Organizational factors
In this category, there are no pre-formulated expectations, as there is limited literature available about organizational factors regarding the escalation process from complaints to claims. However, based on the experience of all three researchers as business administration students, organizational culture is expected to influence performance. Existing literature on service failure and recovery in organizations states that organizational performance can affect customer satisfaction, which might be related to complaints and claims in hospitals

Chapter 3: Methodology

In the following chapter, the type of research, justification of methods, and data collection and analysis procedures will be discussed. The choices regarding the methodology are made in collaboration with two other researchers and an expert researcher in the field of service failure recovery. When wished for, the researchers can provide additional documentation like the initial and written version of the questionnaire, the interview transcripts, and the invitation letter.

3.1 Method of conducting research

When conducting research, one of the most common distinctions is between qualitative and quantitative approaches (Myers, 2020). In a quantitative approach, researchers study a particular topic across many people or organizations and try to discover trends and patterns that may apply in many situations (Myers, 2020). In contrast, a qualitative approach can help researchers to study a particular subject in depth, to understand their motivations and actions, and the broader context (Myers, 2020). The main objective of this study is to gather in-depth information from complaint experts about the factors contributing to the escalation of complaints, which can be seen as an in-depth study of a social process. On these grounds, a qualitative research method seems most appropriate for this purpose.

Within the qualitative approach, a distinction can be made between inductive and deductive reasoning. This distinction relates to whether researchers want to conduct theory-testing (deductive) or theory-building (inductive) research (Myers, 2020) With deductive reasoning, researchers start 'top-down' with a theory they want to test, which can be defined as confirmatory research (Myers, 2020, p. 26). When researchers choose to include inductive reasoning, they start 'bottom-up' with empirical data from which they want to build a theory, which can be defined as exploratory of nature (Myers, 2020, p. 26). In the current research, the intention is to contribute to complaint-handling practices in Dutch hospitals and the healthcare system at large. As there has been minimal research available on complaint escalation in the Netherlands, the results of empirical data can be used to test the already existing theories. Beforehand, an in-depth study of theory has been conducted, which allowed for the creation of a conceptual model. These characteristics align best with a deductive research approach (Doorewaard et al., 2019; Myers, 2020), which will be used in the current study.

When following a deductive approach in which a theoretical framework is used, a practice-oriented approach is preferred compared to a theory-based approach (Doorewaard et al., 2019). In a theory-based approach, researchers intend to solve a lacuna in theory, whereas in a practice-oriented approach, researchers intend to solve a problem that arises in a practical setting (Doorewaard et al., 2019). As the goal of the current study is to contribute to the Dutch healthcare system by providing a guideline to avoid unnecessary legal proceedings, a practice-oriented approach will be used.

In Verschuren & Doorewaard (2015), a distinction is made between different types of practice-oriented research, which can be dedicated to problem analysis, diagnosis, design,

implementation, or evaluation. Design- and implementation-oriented research are often less qualified for qualitative research (Doorewaard et al., 2019). With problem analysis, the only goal is to define the organizational problem, which is often used as a pre-investigation for diagnostic research (Doorewaard et al., 2019). Diagnostic research intends to define what the problem exactly is or what issues can be improved and aims to find out what the reasoning behind the suboptimal situation is (Doorewaard et al., 2019). With evaluative research, researchers want to determine whether the implantation of earlier made changes is implemented well enough and whether the pre-formulated goals are achieved. In the current study, the research question is: '*What are the factors contributing to the escalation of medical complaints to claims, and how can this escalation be prevented?'*. When looking at this question and the main goal of this research, this study aims to evaluate and better understand the escalation process of complaints. Based on this realization, diagnostic research is considered the most suitable.

In practice-oriented diagnostic research, there are two common approaches: opinion research and gap analysis (Doorewaard et al., 2019). In opinion research, the goal is to investigate how different people involved think about a problem and its cause (Doorewaard et al., 2019). In gap analysis, the goal is to distinguish between the desired and factual situation and depict this by doing research (Doorewaard et al., 2019). In the current study, the goal is to gain insights into the different opinions of complaint-handling experts, which makes the study an opinion analysis. To summarize, the current study will be defined as a qualitative, deductive, practice-oriented, diagnostic opinion analysis.

3.2 Data collection

Interviews specifications

There are several data collection methods available for qualitative research, of which the most well-known are interviews, fieldwork, and using documents (Myers, 2020). In this study, the choice has been made to collect data using interviews. Interviews are a suitable way to collect in-depth information from respondents about social processes (Hox & Boeije, 2005), which is consistent with the purpose of the research. Although interviews can take many forms, there are three general types of interviews, namely structured, semi-structured, and unstructured. In structured interviews, pre-formulated questions are used which need to be strictly regulated in terms of order, as it is used to ensure consistency across interviews (Myers, 2020). Unstructured interviews can be identified as the opposite of structured interviews, as there are limited to no pre-formulated questions and interviewees have the freedom to discuss whatever he or she wants (Myers, 2020). Therefore, consistency across interviews is not ensured. In semi-structured interviews, the researchers pre-formulate questions but do not have to strictly follow them, allowing room for improvisation (Myers, 2020). As the current research intends to build a theory from real-life experience, but also aims to see whether the research available aligns with practice, semi-structured interviews were deemed the best fit.

Based on the conceptual framework, a list of topics was created which were the basis for the pre-formulated questions. Boeije (2014) mentions that in deductive qualitative research, it is important to create a list of topics that gives sufficient structure and allows for room for additional information sharing. By doing so, the data collection process will be structured. To create this desired structure in the interviews, an interview guide was created in collaboration with two other researchers (See Appendix 1). The initial version of the interview guide was examined by an expert in the field of medical complaint handling and a researcher considered an expert in the field of service failure recovery to make sure the questions were appropriate both for the target group and research standards. All information in the interview guide was written in Dutch, as this is the main language used by complaint experts at work. In this way, participants did not have to translate their thoughts, avoiding possible misunderstandings and unintended translation issues. During the interviews, participants had the freedom to share additional information that they deemed relevant to the research. This has led to additional adjustments to the interview guide during the interview process.

At the beginning of all interviews, a small introduction was given including information about the study and a definition of the concepts of complaints, and claims. This definition was included to ensure that participants and researchers have the same understanding of the two key concepts underlying the study, which strengthens the validity of the research. After this introduction, all participants have been asked for their verbal consent to record the conversation for analytical purposes. After this, several personal questions were asked regarding their role in the organization, years of experience, and the type of hospital they are working for. The next part of the interview consisted of questions related to the escalation of complaints to claims, categorized using seven different categories derived from the literature. After the questions, a small debriefing and closing word were included.

The topic of the interview can be labeled sensitive, as it concerns medical issues that are often not openly discussed due to privacy and possible negative publicity for healthcare organizations. Therefore, it might have been difficult for participants to speak freely. Before the interviews were conducted, participants were reassured that all information discussed would be anonymized to create an open environment in which participants could speak freely. Furthermore, participants were ensured that they would receive a copy of the transcript via e-mail, and if they were uncomfortable with statements made in the interview, these could be removed from the transcript. During the interviews, it became apparent that culture was perceived as a sensitive topic to discuss. Some participants appeared to find it challenging to talk openly about culture, as they seemed afraid that statements might be misunderstood or taken out of context. Especially when one of the researchers with a different cultural background was present, participants initially seemed to have difficulties discussing culture. However, when given the confidence by researchers that culture could be openly discussed without prejudice, participants freely spoke about their interpretation of the effect culture can have on complaint

escalation. By approaching sensitive subjects this way, an environment was created in which all parties appeared comfortable enough to communicate openly.

Sample

In qualitative semi-structured interviews, it is important to select participants who are expected to provide rich information (Doorewaard et al., 2019). Therefore, researchers should look for respondents that can give information on the topic of interest from multiple perspectives, in which relations between factors can be identified and where there is room for differences in points of view. The choice has been made to interview complaint experts due to their overarching perspective on both patient and healthcare professional actions, and the limited attention in research for their influence in the escalation process. As they hear both sides of the story and are trained to be neutral, they have considerable knowledge of the complaint-handling process in Dutch hospitals. The experts that were interviewed are working in different hospitals in the Netherlands, which resulted in insights from multiple organizations to be able to compare the findings across organizations. As the goal has been to speak to complaint-handling experts, not all units in a target population had equal chances to be included, which can be labeled as non-probability sampling.

The choice of participants depended on the convenience and availability of the participants rather than random criteria. When looking at practice-oriented research, researchers tend to interview between 15 and 20 participants, as in most cases this is feasible within the allotted time for graduation (Doornewaard et al., 2019). To find participants, an invitation letter has been created, including some personal information about the researchers and detailed information about the study and its relevance. This invitation letter has been sent out via e-mail to various Dutch hospitals, resulting in a response rate of 19 participants. In total, 27 respondents have been recruited, of which six were approached by other participants, which can be defined as snowball sampling. Participants had the opportunity to indicate their time and place of preference, allowing maximum flexibility. The interviews took place either at the hospital, via videoconference, or through a written version of the questionnaire complaint experts could fill in individually, without interference from the researchers. In total, 2 of the respondents chose to collaboratively fill in the questionnaire using this written version. Since this version was not completed according to research standards, it was not included in the further analysis. This resulted in a total of 25 in-depth interviews.

During the last interviews, almost no new information was provided, indicating information saturation. According to the literature, this saturation could be enhanced by the agreement between the participants, as they all were working in hospitals in the Netherlands and were familiar with the Dutch complaint-handling process (Doornewaard et al., 2019).

3.3 Data analysis

Qualitative data analysis is a process in which existing or self-generated texts are interpreted by fragmenting a text into different sections and adding labels with concepts to these sections to create meaning for the words (Bleijenbergh, 2016). After finalizing the interviews, accurate transcripts of the interviews were created manually based on the recordings. The choice has been made to not translate the interviews, as this could lead to differences in meaning due to translation, which could result in a loss of integrity of the data.

The strategy used to analyze the data from the interviews is called 'summarizing analysis', specifically the directed content analysis (Hsieh & Shannon, 2005). The principle underlying the directed content analysis is that the analysis of information is directed by the information retrieved from the theoretical framework. However, this analysis goes beyond the theoretical framework, as in interviews respondents often provide additional information, which is called the bycatch. This bycatch is also considered in the analysis of the data. One of the most interesting bycatch documents for data analysis is a professional profile and competency description for complaint officers, compiled by 'de Vereniging van Klachtenfunctionarissen in de Gezondheidszorg' (Panis et al., 2018), which translates as the Association of Complaint Officers in Healthcare. In the interview, respondents were asked which qualities complaints officers needed to possess to perform well on the job. The results of this question will be compared to the guidelines that are provided in the professional profile, to examine whether these align with the real-life experience of complaint experts.

Within the directed content analysis, there are two ways to summarize the collected data, namely within- and across-case analysis. In within-case analysis, researchers make a summary of the different topics from the perspective of one interviewee (Doorewaard et al., 2019). This form of summarization is most useful when the researcher is interested in individual opinions. An across-case analysis is when researchers make a summary per topic across all different interviewees (Doorewaard et al., 2019). In the current research, across-case analysis has been used to summarize the information retrieved from the interviews.

3.4 Research quality

During the data collection, the quality of the data retrieved needs to be monitored. One of the quality measures for data is validity, which is the extent to which the methodology, data collection, and analysis techniques are followed to enable the researcher to make justified judgments given the scope of the study (Doornewaard et al., 2019). In research, there are usually two types of validity, namely internal- and external validity. Internal validity relates to the validity of the results, conclusions, and recommendations for the situations that have been investigated (Doornewaard et al., 2019). In the current study, the internal validity has been improved by consulting experts in medical complaint handling and research. These experts have checked the relevance of factors in the conceptual model. Furthermore, the researchers have asked follow-up questions based on information about medical

terms, using the knowledge gained from the literature and experts. Researchers aimed to interview respondents with rich information to obtain knowledge of all perspectives in the complaint escalation process, to improve the internal validity (Doornewaard et al., 2019). By interviewing complaint-handling experts rather than patients or healthcare professionals, the interviews resulted in rich information, as complaint experts have extensive knowledge of the perspective of both the patient and healthcare professionals.

External validity can be defined as whether the results from a study are also representative of similar situations (Doorewaard et al., 2019). In the current study external validity is difficult to achieve, as it cannot be assumed that the situations included in the interviews are the same as the situations that were not in the interviews. However, due to the high number of interviews with similar participants, it can be expected that future situations concerning the same topic could exhibit similar characteristics. Therefore, this study could help to create a more accurate picture of the context around complaint handling from the perspective of multiple complaint experts (Doorewaard et al., 2019).

Reliability in this type of qualitative research can be seen as a challenge, as it is defined as the extent to which researchers may assume that repetition of the interviews may lead to the same dataset (Doorewaard et al., 2019). Personal characteristics, subjectivity, time and place, and the researchers' interpretation of the conversation all play a role, which can lead to high levels of multi-interpretability. As this multi-interpretability is impossible to prevent, it is good to be aware and make its effect as small as possible. The reliability of the data has been enhanced by investigator triangulation, which can be reached when two or more researchers are conducting the same study and providing observations and conclusions (Carter et al., 2014). As multiple researchers all have their viewpoints and personal interpretations, the multi-interpretability of the data will be reduced. Furthermore, the transcripts of the interviews are shared with the respondents, to ensure that their words are used in the intended context. During the interviews, the researchers have provided small summaries of statements as well, to confirm that the researchers and participants have the same understanding of what has been said. These two methods will limit the impact of multi-interpretability (Doorewaard et al., 2019). What can also be beneficial to limit multi-interpretability is to ask for expert advice (Doorewaard et al., 2019). In the current research, two experts were included in the data analysis, of which one can be seen as a medical complaint expert and the other one as a research expert. Finally, to limit the multi-interpretability, researchers should report their findings with restraint, as qualitative data alone can not be the foundation of scientific evidence (Doorewaard et al., 2019). This has been done throughout the current study.

Confirmability of the data regards whether the conducted analyses are coherent and whether the interpretations made based on the data were fair (Lincoln et al., 1985). In the current research, all claims made are formulated with restraint. In a study by Lumsden (2022), the statement was made that in qualitative research, the researchers should substantiate claims by using quotes from respondents. In

Chapter 4: Results, the most important claims are substantiated by quotes from the interviews. This can be seen as an improvement in the confirmability of the results.

Furthermore, it is difficult to make claims about external validity

3.5 Research ethics

When conducting research, there are ethical guidelines that need to be considered. One of the important ethical principles in qualitative research is informed consent, which entails that potential participants should give their informed consent to participate and are free to end their involvement at any point in time (Myers, 2020). In the current study, the participants are made aware of this during the introduction of the interview. To prevent this from happening, the researchers provided the participants with a detailed introduction about the study and the themes discussed during the interview, to make sure people were aware of the details of the study beforehand. Furthermore, researchers need to be transparent and open about their role and what is done with the collected data. This has been done both in the invitation letter and the introduction of the interview, with the addition of written approval from respondents of the transcript of the interview. As the theme of the interviews can be considered a sensitive topic, all respondents have been informed that the collected data will be fully anonymized, so the information gathered cannot be traced back to a participant or the hospital. Finally, all participants will receive the combined outcomes of the three theses, as part of debriefing. After they have received this information, all personal data will be deleted.

Chapter 4: Results

The present section will address the main results of the interviews. First, however, the characteristics of the respondents will be discussed. In total, 25 interviews have been conducted with complaint experts from 19 different hospitals in the Netherlands. Of these 25 respondents, some had previous experience in other Dutch hospitals as well. This has led to an overview of many organizations, both in size and type of organization. 24 out of the 25 respondents are female, and only one of the respondents is male. Furthermore, the vast majority of the participants had a Dutch cultural background. When considering the educational background of the respondents, the majority has a healthcare-related background, followed by a legal background. A complete overview of the characteristics of the respondents can be found in Appendix 2.

In the following chapter, the interview results will be discussed, which are organized according to the different factors in the conceptual framework (Figure 1) that are expected to influence complaint escalation, namely organizational factors, characteristics of the healthcare professionals, event characteristics, characteristics of the patient, characteristics of the family members, complaint-handling expert characteristics.

Furthermore, respondents were asked for de-escalation techniques, which are also discussed in the current chapter. All the subparagraphs are structured using three different subheadings, namely 'similarities and differences', 'additional information and unique perspectives and 'summary'. This choice has been made to provide a clear structure in the results section. When there is no information available, subheadings can be left out.

4.1 Characteristics of healthcare professionals

Complaints and claims can be filed based on the behavior of everyone involved within the hospitals, from the receptionist to the medical professionals. In the following subsection, the focus will be on the behavior of the medical professionals, who are directly involved in the medical treatment of patients.

Similarities and differences

In the interview, respondents were asked about characteristics of healthcare professionals that might contribute to the escalation of complaints to claims. Most of the respondents indicated that the *personality* of the healthcare professional was more important than their demographic characteristics. According to the respondents, how healthcare professionals deal with patients when complaints and claims arose is important for the course of the escalation process. Medical service failures can have a major impact on patients, and if this is not recognized, the likelihood of complaints is high.

According to the majority of the respondents, the *communication and people skills* of healthcare professionals are deemed important in the escalation process. An example of this is that healthcare professionals must show empathy when dealing with patient dissatisfaction. The majority of the respondents mentioned that when patients feel like they are understood, the chance of complaint

escalation diminishes. Furthermore, respondents indicate that disclosure is very important in the escalation process. When patients have a feeling that healthcare professionals are not upfront and open about their medical situation, there appears to be a higher escalation risk. Being transparent to patients about procedures and complications beforehand can be very useful in the prevention of complaints, but also for the de-escalation of claims. According to the respondents, this transparency should be present both in information about procedures and when a mistake has been made.
Furthermore, respondents indicate that healthcare professionals should be approachable to both patients and colleagues to make communication run as smoothly as possible. Hierarchy among healthcare professionals is indicated to have a positive effect on complaint escalation.

Based on the interviews, *personal attention* also seems to be important for patients. Respondents indicate that patients value a personal approach to healthcare, as they do not want to feel like a number. As healthcare professionals have a job with high pressure where there are generally just 10 minutes scheduled to do a consult, it is not always easy to give personal attention to all patients. The high workload, in combination with the staff shortage, makes it even more difficult for healthcare professionals to both do their job and make time for personal attention. Even though it might be difficult to achieve, providing patients with personal attention can help prevent complaint escalation. Respondents indicate that such customization of the complaint-handling process can be beneficial to prevent escalation. This can be achieved by considering the personal characteristics of the patient during contact moments, like, for example, a language barrier or cultural difference that needs attention for the patient to feel understood. Healthcare professionals need to empathize and adapt to the level at which the patient communicates to communicate effectively. However, this seems to be difficult to always incorporate in practice, as not all healthcare professionals possess good people skills. One of the respondents made the following statement:

> *'Ja, ik denk dat het te maken heeft met het snelle denken, hè? Het zijn natuurlijk over het algemeen intelligente mensen die heel snel heel kunnen denken en ook altijd vanuit een bepaald gedachtegoed werken en je ziet mensen die zich moeilijk kunnen inleven in mensen die dat niveau niet hebben, dat je soms ook daarin een andere uitleg moet geven, hè dat je daar al een eerste communicatiestoornis kunt hebben, hè?' – Respondent 23*

According to respondents, *cross-cultural communication* can be a problem for healthcare providers. As healthcare providers often use different types of communication than people with other cultural backgrounds, resulting in miscommunication. These miscommunications can contribute to the escalation process. One of the respondents indicated that when employees received training about cross-cultural communication, the number of complaints about communication issues related to culture decreased, indicating that training could be beneficial to prevent escalation.

> *'Wat ik heel mooi vond om te zien was toen ik daar zeg maar een stukje scholing in had gegeven dat ik ook echt zag dat dat soort klachten afnamen, dus dat er dus geen boze dochters aan de telefoon had of boze zonen van mijn moeder is afgeblaft met dat ze niet zo moet commanderen. En nou, daar heb ik dus, dat is, dat is heel goed om dat in ieder geval te doen, dus ik. Maar ik denk wel dat het zeker invloed heeft helaas.' – Respondent 10*

Yet, many respondents indicated that personal and demographic characteristics of healthcare professionals seem to contribute to the escalation of complaints. When discussing *gender*, a minority of the respondents indicated that female healthcare professionals tend to communicate better on the level of feelings than male doctors, which is often seen as something positive. However, patients tend to have higher expectations of female doctors, which results in a higher risk of disappointment towards female doctors when service failures occur. When looking at *age*, there also seems to be a difference between younger and older doctors in terms of patient interaction. Almost all the respondents indicate that there seem to be fewer communication-related complaints about younger doctors than about older doctors. According to the respondents, this might have to do with the inclusion of complaint handling and social interaction in the education process of younger doctors, which has not been present for older doctors.

Also, the *culture* of the healthcare professionals seems to play a role in the escalation process. This can result in healthcare professionals from a different culture showing differences in behavior compared to Dutch healthcare professionals, which can be a ground for complaints and possible escalation. Some interviewees provided an example of the difference between Dutch and German doctors, where the German doctors showed more of a hierarchical attitude than the Dutch. Another example was the difference between doctors from the Netherlands and Flanders regarding their response to claims. In Belgium, there is no such law as the 'WKKGZ'. In Belgium, when a complaint is filed, it immediately becomes a disciplinary case, which is something medical professionals want to avoid at all costs. This resulted in Flemish doctors being more afraid of claims than Dutch doctors. Based on these results, culture can be expected to be a relevant factor in the escalation process.

Next to the demographic factors, another characteristic that almost all respondents said influences the escalation process is *medical specialty*. Specialties cited as more viable for complaints and claims are any type of surgery, gynecology, orthopedics, emergency care, and radiology. All the specialties mentioned involve higher-risk procedures and decisions that must be made at a rapid pace, which often results in procedures being performed without a thorough prior explanation to patients or families. According to respondents, the type of physician interested in practicing such specialties exhibits different personality traits than medical specialists belonging to the more contemplative disciplines, who are more likely to be interested in communicating with patients and have more time to do so. One of the respondents describes it as follows:

> *'een chirurg bijvoorbeeld die op het moment dat iemand op de tafel ligt en er heeft een zware bloeding, dat vraagt dat je het direct ingrijpen. Het is een heel ander type dokter een chirurg die echt op dat moment het besluit moet nemen'- Respondent 18*

In the interview, a question about medical malpractice was included. During the interviews, almost all medical professionals see complaints and claims as something they hope to minimize in

their careers. Despite most medical professionals recognizing complaints as a learning experience, claims appear to be seen as something that should not be required in an optimal situation. Fear of complaints among healthcare professionals can also lead to changes in the way they practice medicine. This phenomenon is called **'***defensive medicine'*, which entails that healthcare professionals tend to perform treatment that is not medically necessary but is wished for by the patient. In the interviews, there appears to be a divide in the opinion of the complaint experts, as only a few of them recognize the existence of defensive medicine in the hospital they are working in. Some indicate that this does not happen in their organization, but that in theory, they would understand it. Based on the interviews, it became clear that in the Netherlands, doctors are not personally liable when a claim is filed. They are only personally responsible when they have a disciplinary case, which is something that all medical professionals fear. Especially after having a disciplinary case, doctors tend to be more hesitant when practicing medicine and, in some cases, tend to perform defensive medicine. However, complying with all wishes of the patient instead of following what is medically relevant often has a negative effect, as this appears to be a never-ending cycle. Therefore, some complaint experts also inform and train medical professionals on this subject.

The respondents were then asked about the influence of the *relationship between the patient and the healthcare professional* on the escalation process. For a relationship between a patient and a healthcare provider to work, respondents indicate that there needs to be some kind of chemistry between the two. Overall, a good relationship between the two is recommended to diminish the chance of complaint escalation. When there is a good relationship, this might prevent the patient from filing a formal complaint and encourages speaking to the practitioner directly when there is dissatisfaction. However, when the relationship is good and the practitioner fails to meet the wants and needs of a patient, this might also lead to extra disappointment and a higher tendency of escalation. Most of the complaint experts that were asked mentioned that they have experience with both options.

Additional information and unique perspectives

Multiple respondents indicated that there is a lot of frustration among healthcare professionals when patients from different cultural backgrounds state that they feel *discriminated* against, especially when they make this statement after one of their wishes is not met by staff. As healthcare professionals have taken an oath to always perform the best possible care, they often feel offended when accused of racism. Yet, this appears to be a common reason for patients to file a complaint. In one of the interviews, the following statement was made:

> *'En ja, en dan komt het ziekenhuis en die zegt nee, mogen er maar twee komen en wat je dan ziet, is dat de mensen zich vaak gediscrimineerd voelen. En wat je dan ziet, is dat de dat de zorgmedewerkers dan zeggen, ja, die mensen die voelen zich altijd maar gediscrimineerd terwijl het misschien in feite ook wel een beetje gebeurt, omdat we omdat men zich soms niet helemaal realiseert hoe belangrijk het is voor die familie om te laten zien dat ze er zijn.'*
> *-Respondent 10*

Summary

Based on the interviews, it can be assumed that how healthcare professionals deal with patients, their communication, personal attention to the patient, way of dealing with cultural differences and language barriers, training in cross-cultural communication, gender, age, medical specialty, cultural background of the healthcare provider and fear of complaints and claims all influence the escalation process.

4.2 Event characteristics

During the interviews, there has been limited response to the questions about event characteristics. Therefore, the subparagraph about event characteristics is not as elaborately explained as other subparagraphs. However, the factors that were indicated to influence the escalation process of complaints are described below.

Similarities and differences

There are different *types of complaints*, of which medical, relational, organizational, and communicative are the ones that are most often mentioned. When questioned about which type of complaint has the highest risk of escalation, participants seemed to be divided. The majority of respondents indicated that communication errors are more common than diagnostic errors. One of the respondents even made the following claim:

> *'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*

A lower number of participants indicated that diagnostic errors more often directly lead to claims, as they are seen as calamities. Diagnostic errors are therefore seen as errors that can have severe consequences. In most cases, patients have the right to start a legal process and therefore, de-escalation is deemed more difficult. Participants also indicated that when an event is described as an emergency or sentinel event, there is a high risk of it becoming a claim, as these are also impactful events for patients and their relatives. In situations like this, patients often have the right to ask for financial compensation, and then complaint officers do not try to stop patients from claiming.

Additional findings and unique perspectives

A minority of respondents indicated that the *duration of treatment* appears to influence the patient-primary care provider relationship. For example, there is much more personal contact between patients with chronic illness and healthcare professionals, as they tend to see each other regularly. As a personal connection is established, this is indicated to influence the relationship between the patient and the healthcare provider. As these types of relationships are more long-term oriented, it is more

important for the quality of the relationship to be good. However, this relationship between chronic patients and the healthcare professionals treating them is not indicated to be of influence on the escalation of complaints to claims.

Summary

Factors related to the event that are mentioned to influence the escalation process are the degree of severity of the event and the duration of treatment.

4.3 Characteristics of patients

In the following subsection, characteristics of patients that can contribute to the escalation of complaints are discussed.

Similarities and differences

Patients play an important role in the complaint escalation process, as the ones the complaint or claim concerns. According to most respondents, demographic factors like the *gender* and *age* of patients seem to play no substantial role. The only difference between male and female complainers is how they voice their complaints. Whereas women tend to be more friendly at first and are more likely to be devious, male patients are more direct in approach but are more likely to become aggressive. According to the respondents, the *socio-economic status* of patients is not having a direct effect on the complaint escalation process. However, once again, how they approach complaints and claims is different. As people with higher socio-economic status are often familiar with legal and medical procedures and more likely to have acquaintances working in one of these fields, they tend to make more verbal threats. People with lower socio-economic status are more likely to respond emotional and sometimes even (physical) aggression.

The majority of the participants indicated that *culture* could have an impact on the complaint escalation process. Many respondents note that it appears to be more difficult to de-escalate situations when it concerns people with an Islamic cultural background. Especially patients that have a Turkish or Moroccan background seem to be responding differently to the complaint-handling process, as in these cultures it is common to file a claim right away. Based on the interviews, it can also be stated that a lot of these patients feel discriminated against in the healthcare process. One of the reasons often mentioned for this is their value of family interaction, which is often not understood by Dutch healthcare professionals, as they do not have this value in their culture. Furthermore, Turkish patients seem to lack trust in the healthcare system in the Netherlands as they compare it to the healthcare system in Turkey, where treatments are conducted when patients pay for them rather than when they are prescribed by doctors. This way of practicing medicine does not align with the Dutch practice, which often leads to complaints and claims. One of the respondents made the following statement:

''Nou kijk X dient voornamelijk inderdaad de Turkse gemeenschap en die trekken nog wel heel vaak de vergelijking naar hun naar de hun eigen land, hè? Dus dat als het hun hier niet bevalt, dan halen ze een second opinion in Turkije, maar dan verwachten ze eigenlijk wel dat het hier opgevolgd wordt' – Respondent 22

Another example in which cultural differences can lead to escalation is *miscommunication***.** Many of the respondents receive feedback from employees that patients with diverse cultural backgrounds tend to communicate differently, which is often perceived as demanding and rude by healthcare professionals. However, what is often forgotten is that in the Netherlands, there are a lot of inhabitants with different cultural backgrounds that do not have sufficient knowledge of the Dutch language. In turn, this results in a less extensive vocabulary of patients, which can lead to less nuanced statements being made than by someone whose native language is Dutch. This can lead to friction between the healthcare professional and the patient, leading to tension in the treatment relationship. The following statement shows the perspective of one of the respondents:

'ik merk dan dat mensen die dus niet zo goed de Nederlandse taal machtig zijn die zitten met de commanderen. En en toen heb ik bijvoorbeeld uitgelegd van nou ja, ik denk niet dat het commanderen is. Ik denk dat ze niet de woordenschat hebben de of in ieder geval niet de Nederlandse woordenschat te hebben om volledig met alle nuances die wij in onze Nederlandse taal gebruiken te vertellen.' – Respondent 10

The *emotions* of patients are frequently mentioned as an indicator of upcoming escalation. Patients who loudly voice that they are going to take legal action are often doing so out of emotion, like for example, anger or sadness. Another emotion that can play a role is fear. According to the complaint experts, some patients indicate that they are afraid to file a complaint, as they expect to be treated differently after voicing their dissatisfaction. In many cases, this fear is related to the patient-primary care provider relationship. According to the respondents, this is more of an issue among older people than younger people, as younger people tend to be more outspoken. Another emotional response that is often showcased in complaints and claims is the call for revenge. When people feel like they are victimized by the hospital or healthcare professionals, they tend to seek revenge and make those who hurt their feelings experience the same. In some cases, complaints and claims can be filed due to negative emotions or experiences in the past. The complaint or claim they are filing is therefore not the real sting, as it often lies with a past event they are scarred by.

` A factor that is closely related to the emotions of patients is *mistrust.* There is a bit of controversy among complaint experts about their experiences with mistrust. The majority have experienced mistrust, both towards the medical professional and the complaint officer. The existence of mistrust seems to contribute to the escalation of complaints, as it deeply affects the treatment relationship and the relation between the complaint officer and the patient. As there is mistrust, all de-escalation attempts appear to be pointless. In some cases, mistrust can be related to culture and faith.

One of the complaint experts mentioned that she had experienced high levels of mistrust among Syrian refugees, as they did not understand the healthcare system in the Netherlands and based their mistrust on the situation they knew in Syria. Another example given by a complaint officer is stated below:

> 'Dan krijgen we natuurlijk ook veel met culturele achtergronden. Daar zit het vertrouwen natuurlijk is nog minder soms, want dan zeggen ze. Ik had er laatst een keer die zei, ja, maar jullie ongelovigen die begrijpen het al helemaal niet. Weet je wel, dan begint het al zo dat je denkt, ja ja, daar kan ik niet tegenop. Als jij mij wegzet als iemand die ongelovig is. Ja, hoe kan je dan nog? Ja, hoe vind je dan nog vertrouwen dat je soms lukt het ook niet.'
> – Respondent 20

Additional information and unique perspectives

Additional information provided by respondents is that there is a rising level of *aggression* towards healthcare professionals in hospitals. This aggression often stems from a primary response based on emotions that cannot be controlled. This has a huge impact on healthcare professionals and hospitals, as extra precautions need to be taken. Another increase is seen in the number of complaints made by people who are experiencing mental health issues. This type of patient often files complaints to get attention from anyone who will listen, which in hospitals is often the complaint officer. This increase in mentally unstable patients seems to have been caused by the growing problems regarding mental health care in the Netherlands, which is an indication that many people are not getting the help they need.

Another interesting insight from one of the respondents, which is later added to the questionnaire, is the influence of misunderstandings caused by *language barriers.* This respondent mentioned that misunderstanding in healthcare often relates to language barriers, which can be present in three forms, namely not understanding medical terms, not being fluent in the Dutch language, and not knowing how the human body functions. When people do not understand what is said to them, or simply do not comprehend what is being said, this can lead to confusion, which, in some cases, can even lead to dangerous situations. When asked about what hospitals do to limit the effect of language barriers on the escalation process, respondents indicate that a lot of hospitals take measures to make sure patients with language barriers are supported. Examples of resources that are used to help are the use of interpreters, translation of information leaflets, lists with telephone numbers of employees who speak multiple languages, notes in patient files when a language barrier is present, allowing the family to come to appointments, and mobile applications to translate.

In some cases, language barriers also relate to *socio-economic status*. When looking at socio-economic status, people with a higher class seem to have less need for support from, for example, complaint officers than people of lower socio-economic status, as they seem to have a better comprehension of medical terms. When people with a lower socio-economic status complain, it often concerns the price of the treatment in correlation with the outcome. When needing to pay for treatments that did not deliver results, they tend to file complaints more easily. However, also for other

patients, it is difficult to accept that medical professionals only have an obligation of effort and not an obligation of result.

In the complaint escalation process, the *expectations of patients* seem to play a significant role. According to the respondents, patients are making increasing demands for care, creating unrealistic expectations that cannot be lived up to. Google is some patients' best friend, and based on what they find online, patients make suggestions to medical professionals about treatments without having medical knowledge themselves. Other platforms that seem to contribute to these expectations are social media, the internet, and television shows. As this often leads to disappointment, it is one of the often-mentioned reasons for complaints. It can be interpreted as if people seem to have difficulties accepting that their body is no longer functioning as they are used to. Some respondents call this a grieving process for the loss of health. One of the respondents described the situation as follows:

> *'Nou ja, dat we toch steeds meer in een maakbare maatschappij leven. Althans, zo lijkt het, hè? Dat mensen denken dat het leven maakbaar is en gezondheid dus ook maakbaar is. Nou ja, dat is niet altijd zo. En ja, ik hoor hier ook heel vaak vergelijkingen met hè, als ik mijn auto naar de garage breng en ik zeg dat dit gemaakt moet worden en het blijkt daarna niet gemaakt te zijn, dan krijg ik ook een schadevergoeding. Ik noem maar wat, maar ja, een auto is niet een menselijk lichaam hè?' - Respondent 23*

Respondents indicated that when patients from different cultural backgrounds feel *discriminated* against, this can contribute to the risk of escalation. According to the majority of the respondents, this happens quite often in Dutch healthcare. When patients have this feeling, they showcase higher levels of emotions, resulting in a higher risk of complaint escalation.

Summary

Based on the data gathered in the interviews, factors that seem to affect the escalation process are the way patients approach complaints and claims, emotions like fear and anger, mistrust, culture, the relation between the patient and healthcare professional, language barriers, the expectations of patients created by social media, television or the internet, and discrimination.

4.4 Characteristics of family members

In the following section, the characteristics of family members which may have an impact on the escalation process are explained.

Similarities and differences

During the interviews, many respondents indicated that family members influence the development of the complaint escalation process. In some cases, family members rather than patients file a complaint. The effect of family on complaint escalation is not either positive or negative, rather, participants indicate that it works both ways. To file a complaint, family members need the permission of a patient. As family members are often standing at the sideline in a process, they have no control over, they tend

to become more protective over the patients out of love. In some cases, family members force a negative way of thinking onto the patient, who is not experiencing any dissatisfaction. Especially children and spouses seem to be of influence in the complaint escalation process, and even more when they have a different cultural background in which protecting your family is considered essential.

The majority of respondents state that when the family has an escalating effect on the situation, this is often caused by a *lack of contextual information*. In many cases, family members are only later introduced to join conversations, which can lead to a lack of information and possible misunderstanding. As family members often feel helpless in a situation where a loved one is sick, they want to feel in control again. When they file a complaint, it can feel like the family member regains control over part of the situation. One of the respondents summarized this perspective in the following quote:

> *"Dus het besef hebben van de context. Het snappen van de relatie en het maar ook het doel wat wil je nou bereiken, komt dan onmiddellijk om de hoek. Want iemand zit er dan dus bij, die heeft er in feite niks mee te maken. Maar die wil misschien laten zien dat die het heel erg vindt wat er gebeurd is ofzo en die kiest dan die vorm. Soms heb je dus dat mensen die erbuiten zijn, dat die dan enorm gaan lopen escaleren."– Respondent 4*

The effect of family on complaint escalation is not either positive or negative, rather, participants indicate that it works both ways. However, the majority of the respondents indicated that families more often have a *negative effect* on the escalation process. When the family is considered to have a de-escalating effect on the escalation process, they are described as if they support patients. For patients, medical procedures can be scary and especially when their health is at stake, this can lead to high levels of emotions. In cases like this, family members can have the power to make the patient think rationally instead of emotionally and provide support and comfort. However, when family members have an escalating effect, they are often showing high levels of emotions and protectiveness. In cases like this, the involvement of family can easily lead to escalation. Therefore, the character of the family members also seems to play a role in the escalation process.

As mentioned before, in some *cultures*, family is perceived as one of life's most important things. In the Netherlands, it is a common practice to visit hospitals individually, and in severe cases with one family member. However, in non-western cultures, making families participate in medical processes is more common. Participants mentioned that in cultures like for example Turkish or Moroccan, it is common practice to care and stand up for family members, and in some cases serve as the spokesperson and protector of the patient. Participants indicated that healthcare professionals are not always considerate of this other form of family engagement, which can contribute to the escalation of complaints.

Additional information and unique perspectives

In terms of family characteristics, a unique finding was that the *relationship between the patient and their family member* influenced the escalation process. Respondents mentioned that for example

children of elderly people, children with parents who have a language barrier, parents, and spouses appear to influence the escalation of complaints. According to some respondents, this might have to do with the vulnerable position patients are in. As relatives often have limited control over the process of sick patients, they want to protect them in other ways, which in some cases results in complaint escalation.

Respondents also had the idea that not only relatives but also other *people in the surrounding of patients* can influence the escalation process. What was mentioned is that patients were influenced by the opinions of people in their direct surroundings, like neighbors or friends. People in direct surroundings often do not have information about the total context, which can result in unfounded opinions. According to the respondents, this can cause patients to complain despite not being dissatisfied themselves. One of the respondents made the following claim:

> *'Op verjaardagsfeestjes en partijen als daar gesproken wordt over een ziekenhuisopname met onvrede. En dan roept de familie of de kennissenkring, dat moet je niet pikken. Je moet een klacht of een claim indienen, hè? Dus in die zin doet, doet daar een stukje buitenwereld ook wel aan mee.'– Respondent 14*

Summary

To summarize, factors regarding family members that can have an impact on the escalation process are the relationship between the patient and the family member, a lack of information, the character of the family member, and the culture of the family. Furthermore, acquaintances of the patient also seemed to influence the escalation process.

4.5 Complaint-handling expert characteristics

Complaint experts are the point of contact within hospitals regarding complaints and, in some cases, claims. Therefore, the characteristics of complaint experts that influence the escalation process are discussed in the following subsection.

Similarities and differences

As mentioned previously in this thesis, complaint experts are important in the complaint-handling procedure in Dutch hospitals. In general, respondents indicate that when they are working they follow standard guidelines, but overall, the whole process is performed on a customized basis depending on the patient and the situation. For patients, there are different ways in which they can reach out to the complaint experts, varying from calling, mailing, and filling in a complaint form (online or offline). The way in which respondents file a complaint is not mentioned as a direct indicator of escalation by the participants. However, what was mentioned by participants is that when patients or family members file a complaint in writing, non-verbal expression cannot be identified. These non-verbal cues have been identified as very important for respondents, as they are signals for possible escalation. When these non-verbal cues cannot be identified, it might be difficult for complaint-handling experts to prevent escalation from happening.

During the interviews, participants were asked what qualities complaint experts must possess to be good at their job. In response, a variety of answers was given. The characteristics that were mentioned most frequently are depicted in Table 1.

Table 1:

Important characteristics of complaint experts according to respondents.

To be good at their job, a complaint officer should be:	
Independent and impartial	Good at summarizing conversations
Able to set boundaries	Incisive in the complaint investigation to find the motive of the complaint
Listening to both parties and being able to identify pressure points	Acting quickly, proactively, and thoroughly
Empathic	Raising awareness among medical professionals about their role in complaint handling
Providing acknowledgment	Able to provide a personalized approach, adapted to the patient's wishes
Asking probing questions	Able to think analytically
Transparent and disclose information	Patient and resilient
Having legislative knowledge	Attentive to nonverbal communication

A lot of the respondents were under the impression that in some cases, it was a good thing that patients filed a complaint or a claim. However, respondents also indicated that complaint experts should *not always just comply* with the wishes of patients. In some cases, patients need to own up to their role in the process instead of victimizing themselves, as this often results in nothing but misery. Therefore, taking control of the situation can improve the well-being of the patient., as it allows them to be in control again. Therefore, complaint-handling experts should set boundaries. One of the respondents made the following statement:

> *'Ik weet niet of jullie iets van die drama driehoek weten. Weet je wel dat je een slachtofferrol kan gaan aannemen? En zodra mensen in de slachtofferrol gaan zitten, ja dan ook wel weer heel goed dat je zo een bepaald moment ook hun eigen verantwoordelijkheid en dan moet je altijd mee oppassen. Maar op dat moment moet je mensen natuurlijk wel toch gaan duwen in dat ze soms ook hun eigen verantwoordelijkheid hebben en niet alleen maar kunnen zeggen van oh, dit is me allemaal overkomen en de dokter doet me dit aan en.' – Respondent 20*

In the interview, a question was asked concerning the *role of complaint officers* in escalating situations. According to the respondents, they are not always decisive within their function. An estimation of 50/50 has been made, in which some respondents indicate that a claim is something that one should learn from and should not be prevented. However, filing a claim is not always the best option for all parties involved, as it does not suit the goal the patient has with filing a claim. However, in some cases, patients choose to follow the legal path where this is not always the best, and in these situations, complaint officers can step in and try to de-escalate the situation. Different participants stated the following:

> *'Jullie schrijven dat dat jullie jullie willen voorkomen, dat klachten escaleren tot claims en hoe je dat kunt doen, en als iemand een schadevergoeding wil, en hij is het niet eens met hoe die bejegend is vind ik dat geen escalatie van een klacht want dat kan volledig los van elkaar*

staan. Sowieso vind ik het feit dat iemand geld vraagt, niet per definitie escalatie. En, dat is ook zeker iets wat ik niet per definitie wil voorkomen, niet als klachtenfunctionaris, niet als jurist en niet als zorgverlener, dus.' – Respondent 17

'Ze mogen altijd een claim indienen, dus hè, ik moet ervoor oppassen dat ik ze ervan probeer weg te houden, maar denk dat het niet altijd de dat ja meest bevredigend is voor hen om het een claim, dan komen ze in een heel juridisch traject. En ja, daar kom je bij onze jurist en die zijn heel vriendelijk, maar die kijken heel juridisch naar de naar de klacht en die zeggen ja wel of niet en het is vaker niet dan wel ja, en ben je dan tevreden? Nee, dus ik heb ja. Begin bij ons denk ik altijd, want bij ons kan je arts aan tafel zitten. Kan je nog echt hè? Je wordt veel beter gehoord, waar zit de pijn? Waar zit het probleem? Ik denk dat je bij ons meer voldoening hè meer bevrediging hebt en dan kan je daarna altijd nog zeggen van goh, Het is niet genoeg geweest.' – Respondent 20

Additional information and unique perspectives

One of the important sidenotes of the complaint experts that were interviewed was that not every complaint will result in a claim. There are certain situations in which filing a claim is the right thing to do, and complaint officers will always stimulate patients who have the right to be compensated to file a complaint. Also, there is a type of patient that comes in and demands to file a claim, and even though it is probably unsuccessful, this patient still wants to claim. In cases like this, de-escalation by the complaint officer is often not successful.

Another interesting finding that was mentioned while conducting the interviews was that in general, complaint officers have either a *medical or a legal background.* This background seems to be important in how the complaint officer functions on the job. Based on the conversations, medically trained complaint officers tend to have more information about the medical procedures and have an eye for the human aspect of complaints but seem to have more trouble staying neutral. Complaint officers with a legal background are often skilled in staying neutral and following the rules, however, tend to have less knowledge of healthcare procedures. Also, additional functions in the hospital like disclosure coach or grievance coach have an impact on the way complaint officers seem to do their job. Most of the complaint experts have followed an educational program. However, this education does not seem to align with the practice. An example of this is that in the educational program, teachers do not recommend sharing personal stories, but in practice, some complaint officers notice that this can impact the complaint process.

Participants also mentioned that not only the well-being of the patient or healthcare professional matters but also the welfare of the complaint officer. Complaint officers deal with difficult and sensitive topics daily. Therefore, they must have people to discuss their activities with and share their stories. Most complaint experts have direct colleagues, and the ones without direct colleagues indicate that it would be an addition to their work, both practically by having a backup and emotionally. Furthermore, it appears to be important that complaint officers do have empathy for the complainers, but do not take their stories home. A strict work-life balance is beneficial for the work-happiness, as one of the respondents made the following claim:

'een goede eigenschap is dat je het jezelf niet dusdanig aantrekt dat je probleemeigenaar gaat worden van al die klachten, want dan ga je er aan onderdoor.' – Respondent 14

Summary

Important characteristics of the complaint expert that can influence the escalation process are the (personal) characteristics of the healthcare professional mentioned in Table 1, whether they make patients aware of their role in the process and support the patient during the process of complaining or claiming.

4.6 Organizational factors

The following subsection will summarize the respondents' opinions about the influence of organizational factors on the escalation process of complaints to claims.

Similarities and differences

In the interview, one of the themes of interest was organizational factors. Based on the interviews, one can suggest that complaint experts have different interpretations of the importance of the *size of the organization* in complaint escalation. Respondents indicate that in bigger hospitals, patients can feel lost in the system and unsure of where to go, as there are many layers within the organizations, which can lead to patient dissatisfaction. Furthermore, in bigger hospitals, patients are more likely to encounter different medical specialists. There will be less focus on a personalized approach, simply because healthcare professionals see many varying patients, resulting in not knowing the name of a patient or remembering all details of their case. As in most cases, the chances of healthcare professionals encountering the same patient multiple times are much lower than at smaller hospitals, this personal approach is not always seen as important to the healthcare professionals. However, according to the interviews, patients do seem to value a *personal approach over a business approach*. Both in small and large hospitals, organizations must deal with shortages of staff. This makes it in general more difficult to provide a personal form of healthcare, in which healthcare professionals have time to interact with patients. Hospitals can, however, still try to stimulate a personal approach to healthcare providing.

Another important factor is *organizational culture*. According to most of the respondents, it is important that within an organization, there is low threshold contact among employees from all layers of the organization. This can also be described as low levels of hierarchy. In some hospitals, it is a procedure that juridical departments handle parts of the complaint-handling process, which often results in a more formal approach to complaint-handling. However, based on the interviews, it appears to be the case that a more personal, informal approach can be way more successful in preventing escalation.

The interviews revealed that receiving complaints and claims can be an intense process for healthcare professionals. Therefore, providing support for employees from within the organization is

essential for employee well-being. Most of the respondents highlighted the importance of this assistance from the organization. In all organizations, some form of employee support was present, ranging from peer support, complaint training, communication training, and introductory talks on complaint handling, to support from managers and confidential advisors.

Additional information and unique insights

When respondents were asked about how they deal with *cultural differences,* some respondents also mentioned *organizational characteristics* that could play a role. Based on the interviews, dealing with cultural differences is an important factor in complaint escalation. However, the location of the hospital was indicated to play a role in the familiarity of complaint experts with different cultures. In the more rural hospitals, complaints experts generally had less experience with cultural differences than the complaint experts from more urban hospitals. This resulted in some hospitals not paying as much attention to cultural differences, as this is not deemed relevant within their organization.

Many of the respondents indicated that *culture* is one of the factors that can easily lead to complaint escalation. From the point of view of the organization, it is important to create awareness for the treatment of patients with different cultural backgrounds. Concrete examples from the interviews are that hospitals consider patients' dietary wishes regarding faith and that organizations involve spiritual caregivers in medical procedures that conflict with patients' beliefs. A spiritual caregiver can often get through to patients differently, which translates to patients and healthcare professionals easier. One of the respondents indicated the following:

> *'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*

By accommodating patients with different cultural backgrounds, a more personal approach to caregiving is applied, which might result in a lower number of cultural conflicts.

Summary

Based on the interviews, organizational factors that might play a role in the escalation process are the size of the organization, providing healthcare with a personal approach, organizational culture, support systems for employees, training and education regarding complaint escalation, location of the organization and how organizations deal with cultural differences.

4.7 Prevention of claims and de-escalation techniques

In the interview guide, the main focus has been on questions about the de-escalation of claims. Based on the interviews, a set of de-escalation techniques has been found that appears to be effective when trying to de-escalate claims to complaints. These techniques are summarized in the following chapter and supplemented with additions from respondents. However, an important sidenote provided by

respondents has been that their main focus is on preventing escalation from happening. Therefore, ways in which escalation can be prevented are also discussed.

Similarities and differences

As mentioned throughout this thesis, some complaints escalate to claims. Respondents indicated that in certain situations, de-escalation is difficult to achieve. Examples of such situations are diagnostic errors, and when patients already made up their minds about filing a claim. In situations where such types of escalation occur, complaint officers are often aware that the best they can do is to provide information about the legal process and support the patients when asked. However, respondents indicate that there are also situations in which patients want to file a claim but are better off in the informal complaint-handling process. When this is the case, this type of patient is often referred from the legal department to the complaint officers, or in hospitals where there is no legal department, complaint officers attempt to provide clear information as to why a complaint is more appropriate for the patient's intention with the claim. Participants mentioned that it is important to find out what the goal of the person filing the claim is, to adjust the de-escalation process accordingly. If the patient agrees that a complaint is indeed more appropriate, the complaint officer can help the patient through an unbiased investigation of both sides of the story, in which the medical professional can also share his or her side. As mentioned before, escalation is often caused by patients not feeling heard and understood. Respondents indicate that a mediative conversation, or in some cases even a written response from the medical professional can be enough for the patient to feel heard

Escalation can have many causes. Respondents mentioned that the combination of patients that feel like they are not heard and have difficulties controlling their emotions often results in escalation. When patients are showing verbal aggression towards the complaint officer or medical practitioner, the majority of the respondents indicate that it might help to openly mention the emotions that are seen. In this way, patients often feel acknowledged and heard, which can help to gain control over their emotions. In some situations, escalation occurs as patients feel wronged by the hospital and its professionals, or do not feel treated like an equal. In such situations, it might be good to show disclosure and openness, especially from the side of medical professionals. Clearly explaining what has happened and if something went wrong, being open about it can result in de-escalation of the situation.

In some cases, de-escalation is no longer possible. This is often the case when patients have already made up their minds about the path they want to take, or when there are high levels of patient mistrust. In such situations, it is often best to let the patient decide how to handle the situation without interference.

Additional information and unique insights

One of the interesting additions of respondents was that people from *different cultural backgrounds* where claiming is the standard are almost impossible to de-escalate. Many participants indicated that this type of patient continues to seek legal options even after mediation attempts. According to these respondents, this mainly occurs when patients have an Islamic cultural background. A few respondents indicated that they have discussed this matter with Islamic spiritual caregivers, but that they too indicate they have no concrete answer in terms of the de-escalation method. Another cultural difference that can lead to the escalation of complaints among patients and family members of Islamic backgrounds is the *involvement of family*. When family is involved in the escalation of complaints, respondents indicate it is a good thing to acknowledge and show respect for the position of the family in these cultures. One of the respondents made the following claim:

> *'Er is bepaalde categorie mensen van Turkse afkomst die gewoon meteen fel tekeer gaan. Ze zijn gediscrimineerd en daar kost het veel meer moeite om uit te leggen dat het in de Nederlandse gezondheidszorg zo werkt en dan wat vaak helpt, is dat je hen beloont door te zeggen dat je waardeert dat ze zal opkomen voor een familie. Dan merk je dat je op een hele andere manier daarmee om moet gaan.' – Respondent 18*

The majority of respondents indicated that they have to deal with verbal aggression from patients, which appears to worsen. One of the respondents provided a unique method of de-escalation that seemed very effective for her. When patients were showing a lot of emotions and, out of anger, raised their voices, the respondent continued to lower her voice. By doing so, the patients needed to lower their voices as well to be able to hear what the complaint officer was saying. In her experience, this was a good method for de-escalation.

In the preparation of the interviews, *de-escalation of* claims to complaints was considered an important topic. During the interviews, however, many respondents indicated that *preventing escalation* from happening can be more effective than de-escalating. One of the aspects that can contribute to preventing escalation is a *proactive approach* from all parties involved. Participants mentioned that when healthcare professionals have the feeling a patient is unsatisfied, they should start a conversation about this rather than ignoring it in the hope there will not be a complaint or claim. In some situations, respondents indicate that healthcare professionals have proactively consulted them to intervene in the process before a formal complaint was filed. By doing so, healthcare professionals avoid escalation before it even began, and this turns out to be an effective technique to prevent escalation.

Another factor that was mentioned related to the prevention of escalation is *social skills*. The majority of the respondents highlighted the importance of making patients feel valued and heard. If this is not achieved, patients tend to show more escalating behavior. By showing empathy and communicating transparently in all contact moments, healthcare professionals and complaint officers can show a patient that they consider them to be equal. This relates once again to the open and

accepting environment in which all parties feel free to discuss what is on their mind. By providing healthcare in such a way, escalation can be easier prevented according to the data.

Summary

When it comes to complaint de-escalation, respondents indicate that this is not their main activity. Their focus is on the prevention of escalation. Techniques that are deemed effective by the complaint experts are acknowledging the patient's emotions and feelings, openly mentioning the emotions that are present, providing disclosure and openness about the situation, lowering your voice when patients showcase verbal aggression, and showing respect for cultural differences. When it comes to the prevention of escalation, a proactive attitude towards complaints from healthcare professionals and people skills are very important. The people skills most mentioned were empathy and transparent communication.

Chapter 5: Conclusion and Discussion

In the following chapter, the conclusion and discussion are provided. The conclusion contains a comparison between the literature found, and the data gathered from the interviews, to determine whether the expectations from the theory can be confirmed in a real-life setting. The discussion provides information about the meaning, importance, and relevance of this study. It focuses on the contributions to theory, managerial implications, limitations, and provides suggestions for future research.

5.1 Conclusion

The goal of this study has been to answer the research question: 'What are the factors contributing to the process of a complaint becoming a claim in Dutch hospitals, and what actions can be taken to prevent this from happening?'. As mentioned before, expectations were formulated based on the theoretical framework described in Chapter 2. In the following chapter, the outcome of the expectations will be discussed and supplemented with additional information obtained from practice where necessary.

Characteristics of healthcare professionals

In the complaint escalation process, healthcare providers are very important as they are directly involved in the process. When asked about the *gender* of the healthcare professional, respondents indicated that this does not seem to have a direct effect on complaint escalation. This **does not align** with **Expectation 1**, which expected that female healthcare professionals would have a higher risk of escalation than male professionals. However, there does seem to be a difference in communication style between male and female healthcare professionals, where female professionals tend to communicate more effectively and on an emotional level than male professionals. Another interesting finding was that patients seem to have higher expectations of female practitioners, resulting in a higher risk of disappointment and dissatisfaction. This in turn can lead to a higher risk of escalation. According to Stelfox et al. (2005), patient dissatisfaction can eventually lead to a higher risk of litigation. Based on the gathered data, this is only the case for female practitioners.

The *age* of the healthcare professional also did not seem to affect the risk of escalation. In Expectation 2, the researchers expected that older professionals would have a higher risk of escalation than younger healthcare professionals. Based on the results, **Expectation 2 is rejected**. However, respondents indicated that communication style and way of complaint handling did vary among professionals of different ages. Younger practitioners were said to receive fewer complaints regarding communication than older practitioners, as they have gained knowledge about this in their educational program. Furthermore, older professionals tend to showcase higher levels of hierarchy, which will increase their escalation risk.

Based on the findings of the study, the type of *medical specialty* is assumed to affect the escalation risk. Specialties like surgery, gynecology, orthopedics, radiology, and emergency care are

mentioned more often when it comes to complaint escalations compared to other specialties. Respondents indicated that this might have to do with the time pressure and the complexity of the cases, which do not allow practitioners to thoroughly explain all their steps. Also, the expectations of patients, for example in plastic surgery, increase the likelihood of complaint escalation. These findings are in line with the findings of Austin et al. (2021). Expectation 3 mentioned that some medical specialties were expected to have a higher risk of escalation than other specialties. Based on the results, **Expectation 3 can be supported**.

Based on the findings of Austin et al. (2021), it has been expected that *previous claims* received are an indicator of future claims. Therefore, Expectation 4 has been formulated as 'When healthcare professionals have received previous claims, they are expected to have a higher risk of future complaint escalation'. However, based on the results of this study, this cannot be proven, leading to the **rejection of Expectation 4**. Respondents did indicate that professionals, especially after disciplinary cases, could have a lot of anxiety about receiving complaints and claims. This fear in some cases can lead to defensive medicine, which is in line with the findings of Monteferrante et al. (2022). According to the respondents, younger doctors with limited experience with claims tend to showcase higher levels of fear when receiving complaints and claims. However, this does not seem to influence their behavior when practicing medicine. What was interesting is that in the literature, there has been limited information available about the fear of practitioners for disciplinary cases in the Netherlands. This can be the case because, in the Netherlands, healthcare providers are not directly liable when receiving claims. In other countries, like, for example, Belgium, there is no such thing as informal complaint handling. Therefore, practitioners from these countries who operate in the Netherlands more often showcase fear when patients file a complaint or claim, as they are used it immediately becomes a disciplinary hearing. The fear of complaints from these foreign doctors combined with the different practices they have been thought in their country of original training can contribute to the risk of escalation. These findings relate to the findings of Austin et al. (2021) and Stelfox et al. (2005), who indicated that the country of original training can affect the escalation risk for medical professionals.

Practitioners did also provide ways in which escalation can be prevented based on the healthcare professionals. One of the provided examples was that when healthcare professionals *communicated transparently* and direct, it could prevent escalation. Connected to this type of communication are empathy, guidance, involvement, and enlistment, which were aspects described in the study by McClellan et al. (2012). McClellan et al. (2012) mentioned that when practitioners follow these skills, the risk of escalation will be diminished. Expectation 5 therefore expected that when healthcare professionals have better skills, the risk of escalation would be lower. Based on the interview results, it might be assumed that **Expectation 5 was met**.

During the interviews, respondents mentioned that *transparency and disclosure* are effective skills to prevent escalation, By disclosing information, patients will feel heard and equal to the

healthcare professionals and complaint officers and will be less likely to escalate. This is in line with the findings of Giraldo et al. (2020) and Donn and McDonnell (2012). , who indicate that there is an increasing interest in this form of healthcare. Other important skills next to disclosure are expressing sympathy and apologizing, which is in line with Finkelstein et al. (1997) and Lazare (2006). Expectation 6 expected that when healthcare professionals would disclose service failure, the risk of escalation would be lower than when failures were not disclosed. Based on these findings, it can be assumed that **Expectation 6 has been met**.

Another factor mentioned by respondents is the *patient-primary care provider relationship*. When there is a good relationship between the patient and the primary care provider, there generally is a level of trust and good communication. These two factors seem to help prevent escalation. This is in line with the findings of Moore et al. (2000), who state that patient-primary care provider relationships are found to diminish the risk of complaint escalation. However, respondents also indicated that a patient-primary care relationship can also have an escalating effect, as patients tend to have a lot of expectations of practitioners with whom they have a good understanding. When these expectations are not lived up to, this can result in even more disappointment and frustration, which will enhance the escalation risk. In Expectation 7, it has been assumed that a good patient-primary care provider relationship is expected to reduce the likelihood of complaint escalation. Therefore, **Expectation 7 is only partially met.**

Event characteristics

Respondents indicated multiple types of complaints, of which *communication and diagnostic complaints* were the most common for complaint escalation. Communication errors seem to be more common and cause escalation due to misunderstandings between patients and healthcare professionals. Diagnostic errors, in turn, often directly become a claim, as in most cases it entails more negative consequences for patients. Expectation 8 assumed that diagnostic errors were expected to have a higher risk of escalation than communication errors. Therefore, **Expectation 8 has not been met**. Participants also mentioned some additional factors contributing to the escalation process. For example, the duration of the treatment appears to influence the patient-primary care provider relationship, which in turn can affect the escalation process.

Characteristics of patients

Based on the interviews, it can be concluded that there are several factors concerning patients influencing the escalation process. Respondents indicated that the *socio-economic status of patients* does not directly influence the escalation level, unlike the findings of McClellan et al. (2012). In Expectation 9, patients with a higher socio-economic status were expected to have a higher risk of complaint escalation than patients with a lower socio-economic status. This indicates that **Expectation 9 is rejected.** However, how the different groups behave can be defined as different. Patients with

higher socio-economic status are often threatened with escalation using verbal aggression and do not want support from complaint officers in the process. People with lower socio-economic status tend to be more emotional and sometimes even physically aggressive.

Another factor that was indicated to influence the escalation of complaints is the *previous negative experiences of patients*. Expectation 10 expressed the expectation that patients with previous negative experiences would have a higher risk of escalation than patients without. According to the results, once patients have had a negative experience related to medical service errors, they tend to think of it as yet another service failure, even though the failures might not be related to one another. This can make patients more mistrustful, which eventually leads to a higher risk of escalation. These findings are in line with the findings of Laarman and Akkermans (2018) and **support Expectation 10.**

Patients' emotions are also an important determinant of complaint escalation. According to the respondents, anger can in some cases be seen as a signal for escalation. This is in line with the findings of the literature review (Bagozzi et al., 1999; Chebat et al., 2005; Gorney, 2002; Howard et al., 2013; Smith & Lazarus, 1991). When the root cause of emotions is not acknowledged, the appears to be a higher chance of escalation. This is in line with the findings of Bousnina & Zaiem (2019) and Kraman and Hamm (1999), who both indicate that emotions can lead to a call for revenge, which in turn can lead to complaint escalation. However, in the interviews, respondents also indicated that in some cases, the absence of emotions can also be seen as an escalation factor. In the experience of the respondents, this can also result in escalation. In Expectation 11, it has been assumed that patients that show much emotion in the complaint-handling stage will have a higher risk of escalation. Therefore, **Expectation 11 can only be partially confirmed**.

One of the factors that have been introduced by respondents rather than literature was the effect of *culture.* In the literature, there was limited information available about the impact of culture. However, according to respondents, this can have a great indirect impact on the escalation process. Examples like discrimination, cultural differences, and language barriers were indicated to increase the risk of escalation. Respondents indicated that when healthcare practitioners were given more information about cultural differences among patients, there were a lower number of complaints about communication errors. This aligns with the findings of Berlinger and Wu (2005), who mentioned that it was important for medical professionals to learn more about patients' cultures. When medical professionals are aware of the different cultural needs and wants, there will be less room for inconsistency between expectations and reality (Berlinger & Wu, 2005), which can be beneficial to prevent escalation. Therefore, educating healthcare professionals about cultural differences might be an effective way to prevent escalation.

Furthermore, respondents mentioned the *increased demands of patients* and their *perceived manufacturability of health* as factors that contribute to escalation. Patients tend to think about healthcare in the same way as repairing a bike, and these expectations can never be met. This way of thinking about healthcare can also increase the risk of escalation, as it causes high expectations for

healthcare providers and healthcare organizations in general. A minority of the respondents indicated that the increased demands of patients are often stimulated by external influences, such as television, social media, the internet, and friends and acquaintances of the patient. Due to the medical content on these platforms, mostly from people without actual medical knowledge, patients tend to form unrealistic expectations and demands. This in turn can result in a higher risk of escalation. To limit unrealistic expectations in patients, respondents said it is helpful to provide good information before a patient starts medical treatment. Taking time to discuss all possible scenarios can prevent disappointment, and thereby also reduce the likelihood of escalation

Characteristics of family members

Family members appear to be highly affected when confronted with the illness of patients. Sometimes, they are even the ones filing the complaints or claims. Based on the gathered data, the majority indicates that family members more often have an escalating effect than a de-escalating effect. However, in some cases, the family can also help to de-escalate the patient. In either of the situations, the respondents indicated that family members can have a high influence on the escalation process.

An important factor that, according to the respondents, contributes to escalation is that family members often *lack context*. In many situations, they are not involved in the medical process until later and often do not get to see the whole picture.

According to the interviews, the escalation risk is higher when family members are *advocating for a vulnerable patient*, like for example their child, elderly parent, or parent with a language barrier, there is a higher chance of escalation. This is in line with the findings of Hickson et al. (1992), who stated that the chance of medical lawsuits is affected by the relationship between the patient and the family member.

Another important aspect related to family characteristics is the lack of *relationships with healthcare professionals*. Whereas patients are indicated to have a patient-primary care provider relationship, family members do not. This is supported by the findings of Hanganu et al. (2020), who state that family members do not have a relationship with the healthcare provider, which often results in complaints being filed by family members. According to Moore et al. (2000), this should result in a higher risk of escalation. However, based on the data gathered in the interviews, this has yet to be proven.

The *cultural background of the family* appears to influence the risk of escalation. According to respondents, family members with a non-Western cultural background tend to be more involved in the healthcare process, often out of love and protection for the patient. When this is misunderstood, it can result in a higher escalation risk. Therefore, it is important for all parties involved to be aware of possible cultural differences regarding family members and acknowledge and respect that this might be more important for patients with different cultural backgrounds. Expectation 12 assumed that the involvement of family members in the complaint-handling process would lead to a higher risk of

escalation. Based on the information provided above, it can be assumed that **Expectation 12 is partially supported** based on the current findings.

Complaint-handling expert characteristics

In the literature, there has been limited information about the influence of complaint-handling experts. Therefore, it was difficult to formulate expectations about the role of complaint-handling experts in the escalation process. A possible explanation for this lack of literature can be that complaint-handling experts are not implemented in the complaint-handling process in a lot of countries outside the Netherlands. The available literature included a professional profile, which described the skills and qualities complaint officers should possess according to the Association of Healthcare Complaints Officers (Panis et al., 2018). During the interviews, respondents were asked about skills and traits that were essential for complaint officers to be good at their job. The provided answers were compared to the skills mentioned by the professional profile, to see whether literature and practice aligned.

The current study has resulted in some *additional skills and qualities* that were not mentioned in the professional profile by Panis et al. (2018). Respondents indicated that asking *probing questions* to complainants helps to become more aware of the actual complaint and the motives behind it, which has not been mentioned in the professional profile. Another skill that can reinforce realistic expectations is being able to *set boundaries*. According to the respondents, this is an important skill complaint officers should possess. Finally, respondents mentioned that complaint officers should provide information to medical professionals about the importance of complaint handling and make them aware of the effects of a proactive approach towards complaints that can prevent escalation before it happens.

In Table 2, an overview is provided of the skills that complaint officers should possess based on the interviews. In this table, it is indicated which skills were mentioned in the professional profile and which not, to highlight the contributions of this study.

Table 2:

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

Based on the information provided by respondents, it can be concluded that complaint officers definitively influence the escalation process. When they do their jobs according to the standards mentioned above, they can prevent and de-escalate a lot of situations in which legal proceedings are not essential.

Organizational factors

During the literature review, it became clear that the effect of organizational factors on complaint escalation needs to be studied more. Therefore, no expectations were made based on the literature. However, the interviews revealed that in practice, some organizational factors appeared to be of influence in the complaint escalation process. One of these factors is *organizational size.* Respondents indicate that the bigger the hospital, the less likely it is that patients experience personal attention. According to the respondents, a business-like approach rather than a personal approach will result in a greater risk of escalation. According to respondents, the personalized approach to healthcare can be achieved by, for example, adaptive service recovery. When the healthcare provided is personalized to the wishes of the patient, there is a lower chance of escalation.

Another factor that can be related to a lack of personal approach is hierarchy. When the organization is very hierarchical, patients tend to have a more formal relationship with the organization and its employees, which can lead to a higher risk of escalation.

Furthermore, organizational culture appears to contribute to the level of escalation. When the organization has an open character in which there is low threshold contact and where all parties involved feel free to share their perspective, the chances of complaint escalation appear to be lower. Furthermore, the inclusion of complaint officers in the healthcare process can also lead to a lower risk

of complaint escalation, as they can help healthcare professionals once signals of escalation are spotted.

Finally, respondents indicated that the location of the hospital can influence the level of familiarity with cultural differences. As cultural differences appear to have a great influence on the escalation of complaints, organizations should try to adapt their policies and include topics such as dealing with language barriers and discrimination. According to the interview data, this can have a great impact on preventing complaint escalation.

Overview of factors contributing to escalation

Throughout the interviews, several contributing factors to complaint escalation were found. These factors each have their effect on escalating complaints to claims. To provide a clear overview, the most important escalation factors and their effects are depicted in Table 3. If the effects found are new compared to the pre-formulated expectations, this is visible in the table as well.

Table 3:

Overview factors contributing to complaint escalation.

Factor	Effect	Additional 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-approach-fits-all strategy, 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 and 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 how they communicate, 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 behavior, 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**

Overview of prevention and de-escalation techniques

Another goal of this study has been to see what can be done to prevent escalation. During the literature review, de-escalation techniques were also added as they were deemed relevant for providing comprehensive recommendations. Table 4 provides a clear overview of the factors that can prevent or

de-escalate unnecessary legal proceedings. In the following paragraph, these recommendations will be discussed in more detail.

Table 4:
Overview factors contributing to prevention or de-escalation of claims

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 proactively

5.2 Discussion

The following section will discuss the theoretical and managerial implications of the study and will describe limitations and suggestions for future research.

5.2.1 Theoretical implications

The current study can be seen as a contribution to the existing literature about medical service failure and recovery. As mentioned before, there is extensive literature about medical service failure and recovery. However, there has been limited research conducted based on the Dutch healthcare system, especially including the perspective of complaint experts. The current study provides a practice-oriented approach, introducing a list of factors that either contribute to complaint escalation or can help prevent or de-escalate unnecessary legal procedures. Some factors have been already introduced in the expectations, but other factors are additional and can be investigated further in future research. The combination of the existing and additional factors can be used as a foundation for further research into complaint escalation in a medical setting.

5.2.2 Managerial implications

As mentioned in the introduction, legal proceedings can have a great impact on different parties involved, like the patient, healthcare organization, or medical professional. In the current section, recommendations will be made towards the following three parties involved: healthcare organizations, healthcare professionals, and complaint officers. As the goal of the current study is to provide the parties involved with accurate information about escalation factors and how to prevent or de-escalate,

the choice has been made to focus directly on these three groups. In the escalation prevention tool, the different groups all get recommendations that are provided to them as a to-do list. The complete set of lists for all different groups can be found in Appendix 3. The choice has been made to make these to-do lists in Dutch, as this is the language complaint officers use at work In the upcoming subparagraphs, the factors included in the lists will briefly be explained.

Healthcare organizations

Clear guidelines: For all organizations, but especially for larger ones, patients must know where they can go to voice their complaints or file claims. Therefore, the guidelines and procedures regarding complaints and claims should be clear and openly accessible to patients, which will diminish the chance of frustration and confusion.

Open environment: As one of the most important factors in complaint escalation is that patients do not feel heard, organizations should invest in an open environment in which all parties can speak freely. In this way, patients will be more stimulated to provide hospitals with feedback, resulting in valuable information for the organization.

Decentralized structure: Hierarchy is indicated to contribute to complaint escalation. Therefore, healthcare organizations should invest in decentralizing their organization. By doing so, communication will become more open, stimulating efficient complaint handling. Furthermore, it can help to prevent escalation from happening.

Recognition of cultural diversity: According to the information provided by the participants, culture is an important factor in the complaint escalation process. By recognizing the cultural diversity in hospitals and adjusting policies and training accordingly, escalation can be prevented.

Providing training programs: Healthcare organizations should invest in the skills of their employees. As not all employees have the same skills and training, it is important to (continue to) organize training programs, for example on cross-cultural communication, dealing with language barriers, or communication in general. Based on the findings of this study, training can be an effective tool in the prevention of escalation.

Adopt service recovery strategies: Healthcare organizations should include strategies for service recovery for incidents in which this is appropriate. This can be seen as a gesture of goodwill from the organization, to ensure that patients with minor complaints will be satisfied again rather than continue to think negatively about the organization. This might help recognize dissatisfaction in the early stages or to de-escalate situations in which there is dissatisfaction.

Healthcare professionals

Proactive approach: Healthcare professionals should be aware of the signals of patient dissatisfaction, so they can proactively prevent escalation. A proactive approach can result in a lower risk of complaint escalation.

Demonstrating empathy: Healthcare professionals should make sure patients feel seen and heard. An important way to do so is by demonstrating empathy. When patients feel heard and taken seriously, there is a lower risk of complaint escalation.

Transparency and disclosure: By providing transparency and disclosure, patients can feel like they are taken seriously and respected. Furthermore, it will lead to more realistic expectations among patients, which in turn can diminish the likelihood of escalation.

Provide personalized care: When practitioners adopt a patient-centered style of care rather than a one-size-fits-all approach, patients will feel more valued and understood. This can reduce the risk of escalation.

Recognition of cultural diversity: The cultural background of patients appears to be highly influential in the escalation process. Therefore, practitioners should be aware of the possible cultural differences and how to deal with these differences. This way, escalation can be prevented.

Complaint officer

Setting boundaries: Participants have indicated that setting boundaries can be highly effective when it comes to the prevention of escalation. When being direct and open about the boundaries within the relationship between the complaint officer and the patient, unrealistic expectations can be prevented, which will reduce the likelihood of escalation.

Recognition of cultural diversity: Also, complaint officers should be aware of possible cultural differences and should know how to deal with these to prevent complaint escalation.

Involvement of family members: Family seems to play an important role in the complaint-handling process. By introducing them from the beginning family members become familiar with the details, which will result in a lower risk of escalation.

Creating awareness: Complaint officers should make other parties involved aware of the importance and process of complaint handling and should inform them about the best ways to handle patient dissatisfaction to prevent escalation. Creating awareness can result in a lower risk of escalation.

5.2.3 Limitations and future research

When conducting research, there are always limitations to what can be achieved. In the current study, the perspective of the complaint experts has been used, as their voice is not yet represented in research. During the interviews, complaint experts discussed multiple perspectives, of which the majority of them consist of second-hand data. This may be seen as a limitation, however, Doornewaard et al. (2019) indicated that in qualitative semi-structured interviews, it is important to select participants that can provide information about the topic of interest from multiple perspectives, which is exactly what the complaint experts provided. In further research, researchers can investigate the perspectives of patients and healthcare providers, rather than the complaint officer, as it might be interesting to find out whether the perspective of the complaint officer aligns with the perspectives of patients and healthcare professionals.

In an intent to gather more data, a written version of the questionnaire was introduced. Only two respondents indicated that they were interested in filling in the document, however, did not manage to do so completely. Therefore, the researchers collaboratively decided not to use the data gathered from the written version of the questionnaire. Where interviewing allows researchers to ask in-depth questions and intervene when participants interpret questions differently than intended, this is not possible in a written questionnaire. Therefore, when researchers choose a qualitative approach, in-depth interviews are recommended rather than written versions of a questionnaire.

A limited amount of time was available to conduct the current study, which leaves room for future research. In future research, researchers could choose to conduct a quantitative rather than a qualitative analysis, which would allow researchers to make statements based on ordinal data. By doing so, researchers could indicate the effect size of the factors found in the current study or conduct statistical tests to see if factors have significant interactions.

Important for directed content analysis is that researchers consistently balance four different perspectives, respectively the role of the researcher, the research design, the raw data, and the used literature (Doorewaard et al., 2019). When looking into the role of the researcher, it is impossible to be completely unbiased when doing research. Being ‘subjective’ is not seen as something bad in this type of analysis, but rather as a part of qualitative data which you should be conscious about. This subjectivity is referred to as ‘multi-interpretability’ by Doornewaard et al. (2019). In the end, the researcher gives meaning to the data and provides an opinion, which unintentionally leads to influencing the results (Arksey & Knight, 1999), which is unavoidable. Therefore, it is important to be conscious of this when conducting directed content analysis, but also when reading the results of the current study. Next, the research design is something to be aware of as it affects all parts of the research process. On the one hand, it provides support and structure, but on the other hand, it can feel like a limitation because it only allows the researcher to include the dimensions and topics mentioned in the conceptual model. Therefore, it is important to interpret the results based on the chosen research design. When looking through the raw data perspective, the researcher should not be too rigorous

while selecting appropriate data. Researchers should look from the perspective of the collected data and be open to insights the raw materials can provide (Doorewaard et al., 2019). Lastly, it is good to be aware of the influence of the used literature. The conceptual model is based on this literature, and in the end, it might be the case that the initially found literature does not suit the final version of the research. Therefore, Doorewaard et al. (2019) indicate that researchers should use literature, but also should look at it from a critical perspective. This is also done throughout the study.

Another limitation of the current study is generalizability across countries. As the results obtained from the participants are personal experiences, and the situations they discuss concern unique situations, it is impossible to state that the results apply to a larger group of people or situations. The factors that are found, however, can still serve as a tool that can be used by researchers in other studies into the factors contributing to escalation and the prevention of escalation. In future research, it can be used as a frame of reference to examine similar situations but for example in other countries.

Finally, it would be interesting to conduct research into the effectiveness of the recommendations provided in the current study when it comes to the prevention of escalation. By doing so, researchers can provide insight into whether the created tool improved Dutch healthcare.

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Appendices

Appendix 1: 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-escaleert. 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, Categoraal, Top klinisch, 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 specifieker 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-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?

    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?

<u>Antwoord op hoofdvraag</u>

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 2: Participant list

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

Appendix 3: Practice-oriented to-do lists

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) klachtafhandelingsprocedures 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.