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Service Recovery in Healthcare

How to prevent medical complaint escalation?

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Acknowledgement

I hereby proudly present my Master's thesis, *'Service Recovery in Healthcare: How to prevent medical complaint escalation?'* The focus is on researching the factors that cause medical complaints to escalate into claims and what can be done to prevent this from happening. This thesis was necessary to complete the master's program in Business Administration in marketing at Radboud University in Nijmegen. The research for this thesis started in January 2023 and ended in June 2023.

Conducting this research was an interesting experience because my family, particularly my brother, was affected by a medical service failure in 2020. Furthermore, the sensitive nature of the topic and the limited literature made the research process challenging. However, these challenges provided me with valuable opportunities to improve my research and learning skills. Without the appropriate support, I wouldn't have navigated this process without difficulties. Therefore, I would like to thank the following people who helped and supported me during my thesis journey. My sincere gratitude goes out to my thesis advisor, Dr. H.W.M. Joosten, for his guidance and expertise. I am grateful for his valuable contributions and insights, which helped me complete my thesis. Additionally, I want to express my sincere appreciation to Lisa Laponder and Anne Thijssen, with whom I had the honor of working. I would also like to thank the respondents for their time and effort in participating in this research. Finally, I would like to sincerely thank my parents and fiancé for their moral support and for helping me through all the difficulties.

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Abstract

Service recovery is receiving more and more attention in the healthcare sector as the importance of quality care increases. To provide this high-quality care, healthcare organizations must focus on patient dissatisfaction and prioritize effective complaint-handling procedures. However, due to various factors, patient dissatisfaction can sometimes escalate into legal proceedings. Such escalation has a significant and often negative impact on different parties involved, including healthcare organizations, healthcare professionals, and patients and their families. Therefore, this study aims to explore the factors that contribute to the escalation of complaints into claims and to develop prevention strategies.

To achieve these goals, the following research question was created: "*What are the contributing factors that result in medical complaints escalating into claims, and how can this escalation be prevented?".* Three researchers worked together to develop a conceptual framework and expectations for studying the factors influencing medical complaint escalation. These factors were divided into categories such as characteristics of the healthcare professional, event, patient, family, complaint handling, and organizational factors. Based on these categories, qualitative practice-oriented research has been conducted, involving semi-structured interviews with 26 complaint-handling experts working in Dutch hospitals.

The insights gathered from these interviews have led to the confirmation, rejection, or partial confirmation of expectations. Additionally, new and interesting effects have been discovered. An interesting effect is that when healthcare organizations prioritize a one-size-fits-all approach rather than patient-centered care, this increases the risk of complaint escalation. Another notable effect is that patients often escalate complaints when they feel unheard or unseen. Furthermore, this study is one of the first to demonstrate the significant indirect effect of cultural diversity on complaint escalation. The study's results enabled the development of theoretical and managerial implications, as well as limitations and suggestions for further research. Moreover, an escalation prevention tool has been developed to help healthcare organizations, healthcare professionals, and complaint-handling experts effectively prevent complaint escalation.

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

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Chapter 1: Introduction

1.1 Introduction to the topic

It is commonly known that all humans are naturally prone to making mistakes, regardless of their education or motivation. Therefore, it's not uncommon for services provided by humans to have a failure rate. Regardless of the type of error, organizations must address and recover from mistakes that occur, as these have the opportunity to result in 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). Existing literature on service failure and recovery in firms states that service failure can lead to high costs for the firm (Meuter et al., 2000). Furthermore, the customer's satisfaction with the current service is a determinant of their loyalty (Buttle & Burton, 2002). To resolve the negative impacts of service failure, firms must prioritize service recovery. This is because customers who have experienced service failures are more emotionally involved and focused on the steps taken to solve the problem (Berry & Parasuraman, 1991). Service recovery can be defined as "the integrative actions a company takes to re-establish customer satisfaction and loyalty after a service failure, to ensure that failure incidents encourage learning and process improvement, and to train and reward employees for this purpose" (Michel et al., 2009, p. 267).

In certain contexts, the process of service recovery can be relatively straightforward. For instance, in the case of a service failure in the retail sector, this issue can be resolved by effectively communicating with the customer or offering a gesture of goodwill. However, in the realm of healthcare, service recovery is considerably more complex (Osborne, 2003). The healthcare sector is characterized by high uncertainty and risk (Calnan & Rowe, 2008). The recovery of these errors is often complex, and sometimes recovery is not even possible, for instance, in the case of a wrong amputation. Medical errors refer to deviations from the standard of care that might harm the patient (Reason, 2001). These errors are also known as medical service failures, medical negligence, tort system, and medical malpractice.

The Netherlands, like other countries in the world, is struggling with medical errors. In 2021, Dutch healthcare institutions received 15,460 medical complaints (Ministerie van Volksgezondheid, Welzijn en Sport, 2022). Over the years, healthcare organizations have made improvements to provide better care. For instance, currently, Dutch hospitals are obligated to report serious incidents to the inspectorate and to be transparent (Ministerie van Volksgezondheid, Welzijn en Sport, 2022). Despite the rules and regulations, which are constantly updated to improve patient safety, errors still happen.

Unfortunately, I have witnessed the impact that a medical service failure can have. In December 2020, my brother was involved in a violent car accident as a passenger. He was kept in a coma for several days and spent two weeks in the intensive care unit. This incident took place during an unexpected global

health crisis, namely COVID-19 (World Health Organization, 2023). The Netherlands went into a strict state of lockdown to reduce the number of contacts (Ministerie van Algemene Zaken, 2022). Every patient in the hospital, including my brother, was required to be tested for the coronavirus. After my brother was diagnosed with corona, my parents were not allowed to visit him. However, after a few weeks, it became clear that there was a misdiagnosis. He did not have corona, but instead, he had a collapsed lung. Different parties who were involved, such as my brother, my parents, and I, suffered emotionally as a result of this medical error. My parents filed a complaint against the hospital. However, this was not properly handled by the personnel. Due to all the emotional damage, they did not continue the complaint in a legal process.

This above real-life scenario shows that medical service failures result in patient dissatisfaction, which in turn can increase the likelihood of medical complaints. A medical complaint can be defined as "an expression of grievance and dispute, typically written and communicated through a letter by a patient or their family, about the receipt of healthcare" (Gillespie & Reader, 2016, p. 2). The increasing body of literature and research concerning service failure and recovery in healthcare has yet to result in a significant number of studies directly focused on medical errors, complaints, and their prevention. However, complaints can sometimes escalate into claims. Medical claims can be defined as "a written demand for compensation for medical injury" (Wallace et al., 2013, p. 1). In recent literature, little attention has been given to figuring out what the factors are that contribute to medical complaint escalation and how to prevent such an escalation. This is important to study as it may affect various parties, such as healthcare organizations, healthcare professionals, and patients. The lawsuits based on those claims are often lengthy and involve complex cases. The healthcare organization can experience a loss of reputation as a result of these lawsuits (Mello et al., 2007). Furthermore, being part of a medical lawsuit impacts healthcare professionals' mental and physical well-being (Rappaport & Selbst, 2019). Lastly, the patient's involvement in these lawsuits can worsen the emotional distress of the patient or family (Zimmerman & Amori, 2007). To conclude, avoiding legal action is in the best interest of the healthcare organization, healthcare providers, and patients.

1.2 Objective and research question

The current literature focuses on service failure and recovery in healthcare but lacks comprehensive information on how to avoid the escalation of medical complaints into unnecessary legal proceedings. Therefore, the purpose of this study is to provide insights into the factors that lead to the escalation of medical complaints and to explore ways to prevent such an escalation. To achieve these objectives, the following research question was developed:

What are the contributing factors that result in medical complaints escalating into claims, and how can this escalation be prevented?

To provide a comprehensive answer to the main question, several sub-questions have been formulated, which are as follows:

1. What are medical complaints?
2. How are medical complaints treated in Dutch hospitals?
3. What are medical claims, and what are their effects on different stakeholders?
4. When and how do medical complaints escalate into legal claims?
5. How can the escalation of medical complaints into claims be prevented?

1.3 Academic relevance

To highlight this study's academic relevance, it is important to place it within the broader research landscape. This study builds on the research done by Zayer et al. (2015), who found that there is limited information on service failure and recovery in high-risk non-traditional service contexts, such as healthcare. Additionally, Grégoire and Mattila (2021) emphasize that the healthcare sector is a priority to study since many errors occur and, in most cases, the recovery of these errors is complex. Furthermore, this study contributes to the study by Klemann et al. (2022), which identified the necessity for further research into medical claims. These authors state that between 2007 and 2021, medical claim costs in the Netherlands increased by four times. Therefore, future research should focus on investigating the factors that contribute to medical claims in the Netherlands. The study at hand may help to fill this research gap by exploring the factors that contribute to the escalation of medical complaints in the Dutch healthcare system. Another study by Herhausen et al. (2022) shows that it is important to understand which complaints pose the greatest risk of turning into claims. The authors suggest that future research is needed to measure the difference in consequences based on the severity of service errors.

Overall, this study complements the previous studies by providing a deeper understanding of the factors that contribute to the escalation of medical complaints, which is an important area for academic research. By conducting this research, the objective is to enrich the current literature on service recovery within the healthcare context. Specifically, this study has the potential to develop a theoretical framework that enhances academics' understanding of the complex interplay of factors that cause medical complaint escalation.

1.4 Practical relevance

This study has not only academic relevance but also practical relevance for different parties. Firstly, this study is relevant for *society as a whole*, as understanding the factors contributing to complaint escalation can help create a transparent healthcare system that promotes patient safety and trust.

Secondly, *healthcare organizations* benefit from this study since it helps identify areas for improvement and provides quality care. Furthermore, healthcare organizations can lower the high expenses associated with medical claims. According to Mello et al. (2007), medical claims have a great economic impact on healthcare organizations due to the high insurance premiums they need to pay. Furthermore, this research is important for *healthcare professionals*. By understanding the causes of complaint escalation, healthcare providers can enhance their skills and identify areas for improvement. This is important as legal proceedings have a negative impact on the care provider's stress, time, and reputation (Albano et al., 2019). Currie and Macleod (2008) state that healthcare providers who perform their tasks without any fear of medical claims achieve more profitable and less time-consuming outcomes. Additionally, this research directly benefits *complaint-handling experts* since they are the ones responsible for receiving, investigating, and managing complaints within Dutch healthcare organizations. These individuals can use the study's results to effectively handle complaints and prevent them from reaching the legal stage. Lastly, this research is relevant for *patients* who have experienced medical service failures. By understanding the factors leading to complaint escalation, patients gain insight into their rights and available options for resolution. This will help patients make informed decisions about handing in claims. It also enhances patient empowerment, which results in increased patient satisfaction and trust (Charmel & Frampton, 2008).

1.5 Outline of the report

In order to structure this report, it is divided into five chapters. The theoretical framework is covered in the following chapter, which provides information from the current literature about medical complaints and claims. The conceptual framework and expectations are presented at the end of the chapter. Chapter 3 describes the methodological choices of this study, followed by an explanation of how research quality and ethics are covered. In Chapter 4, the results of the study are presented. The final chapter presents the conclusion and discussion. The conclusion addresses the pre-formulated expectations and additional effects, while the discussion focuses on the theoretical and managerial implications, limitations, and suggestions for further research.

Chapter 2: Theoretical framework

The sub-questions mentioned in the previous chapter are used to organize this chapter. It starts by describing medical complaints, their causes, and their effects. This is followed by an explanation of the Dutch complaint-handling process. Additionally, medical claims and their impact on different stakeholders are discussed. Furthermore, the factors that contribute to complaint escalation are investigated. Lastly, the chapter ends with a description of how to prevent complaint escalation and de-escalation techniques.

2.1 Medical complaints

This paragraph focuses on the following question: *'What are medical complaints?'*. It provides a comprehensive understanding of the classification of medical complaints. Furthermore, it delves deeper into the causes and consequences of medical complaints.

2.1.1 Classification of medical complaints

Medical complaints can be defined as "an expression of grievance and dispute, typically written and communicated through a letter by a patient or their family, about the receipt of healthcare" (Gillespie & Reader, 2016, p. 2). Making a distinction between medical negligence and medical malpractice is important to provide a more comprehensive understanding of complaints. According to different law firms (Manchin Law, 2020; Mithoff Law, 2021; Morelli Law, 2022), medical negligence does not involve the term 'intent'. It happens when a physician makes a mistake in treating a patient caused by carelessness and not intentional harm. On the other hand, medical malpractice involves the term 'intent', which means that the physician was aware of the potential risk of harm that could be caused. Medical malpractice can be defined as "an act of omission or commission in planning or execution that contributes to or could contribute to an unintended result" (Bal, 2009, p. 340). As professionals are expected to provide a higher level of care compared to non-professionals, medical malpractice can also be viewed as professional negligence (Kass & Rose, 2016).

The Dutch Ministry of Health, Welfare, and Sport classified complaints according to the type of event: complications, incidents, and calamities (Inspectie Gezondheidszorg en Jeugd, 2020). Complications refer to any unintended and negative outcome that occurs during or after the actions of healthcare providers. Incidents, on the other hand, are defined as unintended or unexpected events that relate to the quality of the care and have led to or could lead to damage to the patient. Lastly, calamities are the most severe category and are described as unwanted or unexpected events that cause a patient's death or have serious negative impacts on a patient. It is important to note that all these types of complaints can include communication or diagnostic errors. Communication errors are situations leading to misunderstandings or missed information due to a lack of clear communication between the patient and the physician,

whereas diagnostic errors are mistakes made by physicians during treatment that lead to harm to the patient (Donn & McDonnell, 2012).

Despite the diversity of medical complaints, there is one thing in common: everything that is perceived as a service failure by the patient, their relatives, or employers can turn into a complaint (Austin et al., 2021). Therefore, this study does not limit its research to a specific type of complaint but rather examines all factors that may contribute to the escalation of medical complaints into claims.

2.1.2 Causes of medical complaints

After describing the different types of complaints in the existing literature, it is important to understand the underlying causes of medical complaints. A recent study conducted by Hanganu et al. (2020) showed that most of the medical complaints were linked to the patient-primary care provider relationship (i.e., lack of informed consent, deficiencies in information, and inappropriate language) and technical aspects of medical care (i.e., complications, delay in examination, lack of diagnosis, and diagnostic errors). The study found that the most frequently reported complaints were related to complications, and women were more likely to make such complaints than men. Diagnostic errors were the second most common complaint. These errors were frequently reported by men compared to women (Hanganu et al., 2020). Additionally, another study by the American College of Surgeons (ACS) found poor communication to be a prevalent issue, accounting for 22% of medical malpractice complaints in their study (Griffen et al., 2008). Furthermore, Kass and Rose (2016) noted various medical malpractice complaints, including misdiagnoses, faulty selection of technical execution procedures, incorrect medication administration, failure to adequately follow up with patients, and failure to obtain proper informed consent.

2.1.3 Consequences of medical complaints

In addition to understanding the causes, it is important to examine the consequences of medical complaints. Patient complaints provide a valuable source for healthcare organizations to observe and improve patient safety (Reader et al., 2014; Weingart et al., 2005). Some healthcare professionals see medical complaints as a wake-up call or a great learning experience (Bourne et al., 2016). Given the importance of patient complaints in shaping healthcare, healthcare professionals must acknowledge the capabilities of patients and take their perceptions into account. Charmel and Frampton (2008) note that promoting patient-centered care, in which patients and their relatives are welcomed as partners in their care, results in increased patient satisfaction and fewer claims. However, it is important to acknowledge the potential negative impact of medical complaints. Kazemi and Riahi (2018) state that medical complaints may lead to psychological consequences for the physician, such as depression and anxiety. This is important because the physician's well-being and the quality of care they provide are interdependent (Tan & Chen, 2019). Several studies show that physicians lose confidence in their medical knowledge as a result of receiving a medical complaint (Brody & Hermer, 2011; Renkema et

al., 2014). This feeling leads to defensive medicine by the accused healthcare professionals, who demand additional consultations, excessive caution, and frequent questions about the correctness of the medical procedures performed (Hanganu & Ioan, 2022). Furthermore, Bourne et al. (2016) state that sometimes, after receiving a complaint, physicians even consider a career change. Another study by Bourne et al. (2017) highlights that physicians who have recently gone through a complaint procedure are twice as likely to experience high levels of anxiety compared to physicians who have not been involved in any recent complaint procedure.

2.2 Medical complaint-handling in the Netherlands

This paragraph focuses on the following question: *'How are medical complaints treated in Dutch hospitals?'*. The paragraph starts by describing the process that patients must follow when submitting a complaint. Furthermore, it presents the research procedures within Dutch hospitals. Lastly, it delves deeper into the perceptions of patients regarding complaint-handling procedures.

2.2.1 Patient Complaint Protocol

The Healthcare Quality, Complaints, and Disputes Act (in Dutch: Wet Kwaliteit, Klachten en Geschillen Zorg) obliges healthcare organizations to draw up a complaints procedure and to meet the requirements set up by them (Ministerie van Volksgezondheid, Welzijn en Sport, 2023). These requirements only serve as a general guideline because healthcare organizations themselves determine the specific complaint-handling procedures they follow.

Patients who want to file a complaint can follow the protocol that is created by the Ministry of Health, Welfare, and Sport (in Dutch: Ministerie van Volksgezondheid, Welzijn en Sport). If a patient is not satisfied with the care, they are first advised to discuss it with the healthcare provider. Should the issue remain unresolved, the patient can ask for the assistance of a complaints officer. The complaints officer helps to find a solution together and advises on the various authorities a patient can turn to with a complaint. In the Netherlands, it has been mandatory since 2017 for healthcare organizations to have a complaints officer who is free of charge to patients (Ministerie van Algemene Zaken, 2022). Once the complaint is forwarded to the complaints officer, the formal complaint-handling procedure begins. At this point, the patient or their representative officially files the complaint regarding the medical care they received. If the patient fails to agree with the healthcare provider, with or without mediation by the complaints officer, he or she can file a lawsuit. However, before this happens, there is also the option to go to a Dispute Resolution Body (in Dutch: Geschillencommissie). Since 2017, every healthcare institution has been obliged to join a dispute body, which issues a judgment that the healthcare providers must comply with. In the Netherlands, the dispute body is authorized to award damages of up to €25,000.

In cases where the complaint is specifically directed to a healthcare provider, a patient can also seek help through the Disciplinary Tribunal for Healthcare (in Dutch: Centraal Tuchtcollege voor de Gezondheidszorg). At these disciplinary tribunals, patients can file complaints about conduct that falls under the disciplinary standards of healthcare. Examples include (1) misdiagnosis or incorrect treatment; (2) issuing an incorrect statement or report; (3) prescribing or dispensing incorrect medication; and (4) providing inadequate information about treatment (Centraal Tuchtcollege voor de Gezondheidszorg, 2022). If the patient is still dissatisfied with the outcome, the National Health Reporting Center (in Dutch: Landelijk Meldpunt Zorg) can be contacted, which provides information and advice regarding the next steps to be taken. Any complaints that they receive are immediately forwarded to the Health and Youth Care Inspectorate (in Dutch: Inspectie Gezondheidszorg en Jeugd). The inspection looks at the complaint to improve care and provide patient safety; it does not give compensation for damages. If the inspectors notice that the organization receives a lot of complaints, they will investigate the issue. During such an investigation, the inspectors will discuss the complaint with the organization, which is then obligated to determine what went wrong and decide how to solve the error. If the inspectors notice that the healthcare organization's investigation is not being carried out properly, they will start their investigation. If the outcome of the investigation shows that the hospital must make changes, then they are obliged to do so. The inspection will monitor the implementation of these changes to be sure that they are carried out carefully to enhance the quality of care (Ministerie van Volksgezondheid, Welzijn en Sport, 2022). To summarize, Figure 1 in Appendix I shows the overall process of the complaint-handling procedure.

2.2.2 Research procedures Dutch hospitals

Medical service failures can also be investigated by the healthcare organization itself. There are different research techniques available for organizations to use. One method to investigate medical service failure is the *RCA* (Root Cause Analysis), which aims to find out what happened, why it happened, and what they can do to prevent it from happening again (Uberoi et al., 2004). The RCA is generally used to uncover errors underlying a sentinel event. According to Williams (2001), there are different ways to conduct the RCA approach, such as the 'ask why five times' technique, the 'causal tree' in which the worst thing that happened is placed at the top, or the 'fishbone diagram' (Ishikawa diagram), which uses a visual representation to identify the potential causes of an issue.

Another method to analyze medical errors is the *TRIPOD* (Transparent Reporting of a multivariable prediction model for Individual Prognosis or Diagnosis). This method investigates and analyzes incidents with harmful consequences for the patient to prevent them from happening in the future (Hoofs, 2010). The starting point for this analysis is the mapped relationship between the danger (e.g., misdiagnosis), the event and consequences (e.g., worsening of the patient's health), and the victim (e.g., patient). This TRIPOD analysis is mostly used in the analysis of complex systems, such as healthcare

and manufacturing (Hoofs, 2010). More specifically, in healthcare, the approach can be used to research incidents, identify areas for improvement, and develop strategies for preventing those incidents. As it focuses on identifying the system's problems rather than trying to find someone to blame, this analysis is known as 'no blame, no shame'. Overall, the RCA, as well as the TRIPOD, aim at learning from the error and ensuring that the patient receives proper communication and care.

2.2.3 Patients' perception on complaint-handling procedures

In addition to the complaint-handling procedures, it is also important to identify how patients and their relatives experience them. A noticeable finding by Friele et al. (2008) is that less than one-third of the patients had the feeling that they were fairly treated during the complaint-handling process. This experience was not caused by the complaints committee, but by the treatment of the hospital and the healthcare professionals themselves. There was a discrepancy between the patient's expectations and the actions of the professionals and the hospital. Professionals did not admit that they had made a mistake, and healthcare organizations did not provide the patients with information about the medical error. Those discrepancies resulted in patient dissatisfaction with the hospital and the professionals. Furthermore, Skär and Söderberg (2018) describe that patients perceived a lack of communication during the complaint-handling process, and this was present in all departments within the healthcare organization. Another study conducted in the Netherlands showed that the expectations of patients or their families were not met, and they had the feeling that they were not being heard by the dispute committee, which was explained by a perceived power imbalance (Dijkstra et al., 2022).

2.3 Medical claims

The current paragraph delves deeper into the concept of medical claims and examines their impact on healthcare organizations, physicians, and patients. The focus of this paragraph is therefore on the following question: *'What are medical claims, and what are their effects on different stakeholders?'*.

2.3.1 The process of medical claims and its elements

Medical claims can be defined as "a written demand for compensation for medical injury" (Wallace et al., 2013, p. 1). The lawsuits arising from these claims do not just arise immediately. It gradually develops as a series of different steps. Kritzer (2011) calls this process of development 'naming, blaming, and claiming'. Naming refers to the injurious experience that is recognized by the injured party; blaming refers to the injured party attributing the responsibility of the service failure to another party; and claiming refers to holding the other party responsible for the harm and filing a claim.

It is important to investigate the claiming process in the Netherlands, since it may differ depending on the country. The Jurisdiction (in Dutch: De Rechtspraak) is a Dutch organization that provides information about procedures in court cases, rulings, and the organization of the judiciary from the

perspective of the plaintiff and defendant (De Rechtspraak, n.d.). The legal process can differ according to the compensation. With claims less than €25,000.00, patients must go to the district court, while with a claim above this amount, a lawyer has to be hired by the patient, and it will go into civil proceedings (De Rechtspraak, n.d.). In extensive proceedings, the civil court gives a final judgment and can decide whether the healthcare provider or institution is liable for the damage. Moreover, he or she can determine the amount of compensation (De Rechtspraak, n.d.). The cost of these legal proceedings may differ depending on the type of proceedings and can include lawyer and mediation fees, court fees, and the fees of witnesses and experts (Ministerie van Justitie en Veiligheid, 2016).

However, it is important to notice that not every medical error leads to a claim, and not in every claim there is a real medical incident. According to het Juridisch Loket (n.d.), the following elements must be present when a patient or their relatives take legal action:

1. The healthcare provider made a mistake.
2. Most other healthcare providers would not have made this mistake.
3. The patient must prove that damages, such as loss of income, unusual pain, or significant disability, were caused by the harm.
4. This damage is the result of the healthcare provider's failure.

2.3.2 Healthcare organizations' perspective on claims

Medical claims can have a significant and often negative impact on healthcare organizations. Firstly, a medical lawsuit can result in negative publicity for the hospital (Mello et al., 2007). This negative publicity could potentially harm a hospital's reputation and lead to a change in hospital staff's emotions and behavior towards the hospital (Mello et al., 2007). Secondly, according to Thornton (2010), under the principle of vicarious liability, a professional can be held responsible for the failures made by other staff members, even if the professional is not directly involved in the incident. The author notes that sometimes office-based professionals were confronted with medical errors that were made by other professionals within the same hospital. This, in turn, led to reduced productivity, anxiety, and, in more extreme cases, key personnel quitting their jobs. Furthermore, medical claims can increase the cost of healthcare organizations. In recent years, hospitals have paid high premiums for insurance policies to protect themselves from the legal and financial consequences of medical lawsuits (Mello et al., 2007). Additionally, Centramed and Medirisk, which are insurance agencies in the Netherlands, observed a significant rise in the number of claims (Baltesen, 2019). The cost of medical claims in the Netherlands increased from €9.029.850 in 2007 to €40.938.960 in 2021 (Klemann et al., 2022). The high payments may be the result of the increase in the deductible. As a result, hospitals have had to set aside more money for compensation, which ensures that there is less money left over to invest in the quality of care. Lastly, in some extreme medical failure cases, which result, for instance, in the death of the patient, hospitals are obliged to pay burial costs to the patient's relatives (Mello et al., 2007).

2.3.3 Physicians' perspective on claims

From the perspective of physicians, claims can have a major impact, particularly if they are found to be valid. Physicians perceive claims as not being genuine and damaging to the healthcare system (Kass & Rose, 2016). Furthermore, being involved in a medical lawsuit results in a harmful experience in terms of their professional lives (Moore et al., 2000). The economic damage that arises due to these claims is much greater for physicians than for patients (Williams, 2003). Data from a study by Lakdawalla and Seabury (2012) showed that medical malpractice payments for physicians grew from $2.3 billion to $3.8 billion from 1991 to 2002. In contrast, Currie and MacLeod (2008) state that physicians face little risk of economic damage from medical malpractice claims. Zeiler et al. (2007) state that physicians are insured for medical malpractice claims, and it is rare for these claims to exceed the amount physicians are insured for. Sometimes physicians even transfer to other states in search of lower insurance premiums (Durrance, 2010). Here, the question arises as to why physicians are concerned about medical claims. This is because there are also non-insurable costs, such as the time and psychic costs of the legal process (Currie & MacLeod, 2008). However, the direct costs are not the only expense for physicians; there are also indirect costs of such claims, such as the physician's stress, time, and loss of reputation (Albano et al., 2019). Vizcaíno-Rakosnik et al. (2020) note that these types of lawsuits can have serious impacts on the physician's psychological well-being due to their long duration and uncertainty. This stress could, in turn, affect the physician's professional performance (Gómez-Durán et al., 2018). Additionally, there is a link between burnout symptoms among physicians and medical malpractice lawsuits (Rappaport & Selbst, 2019). Sometimes those lawsuits can lead to physicians changing their profession or even their discharge (Silverman, 2004). Based on numbers shared by the Health and Youth Care Inspectorate (IGJ) in 2021, 230 medical errors led to the discharge of medical professionals in the Netherlands (Ministerie van Volksgezondheid, Welzijn en Sport, 2022).

The physician's fear of medical claims can cause them to practice defensive medicine (Kessler & McClellan, 2002; Miziara & Miziara, 2022). Defensive medicine can be defined as "a medical practice performed primarily to limit the future risk of a successful lawsuit against the physician and only secondarily to adhere to the medical standard of care" (Kass & Rose, 2016, p. 300). However, this approach can lead to negative consequences, such as providing harmful or unproductive care (Kass & Rose, 2016). Furthermore, defensive medicine did not decrease medical service failures or prevent them from happening (Williams, 2003).

2.3.4 Patients' perspective on claims

In addition to the impact of claims on healthcare organizations and physicians, they can also have serious effects on patients. These effects can be distinguished into economic and non-economic damages. Economic damages are losses of monetary value, such as medical expenses, loss of income, and other tangible financial losses. Non-economic damages focus on factors outside financial losses, such as pain,

suffering, and emotional distress (Durrance, 2010). These damages are challenging to assess in terms of objectivity, as they involve intangible injuries and refer to losses (American Tort Reform Association, 2016).

Weingart et al. (2005) note that patients lack the capability to identify medical errors and file a medical claim due to their illness, confusion, or overwhelming behavior. Nevertheless, Klemann et al. (2022) show the opposite and report that harmed patients filed 20,726 medical claims between 2007 and 2021 in the Netherlands. Patients view those claims as a protection against the risk of harmful treatment and as a means for compensation (Kessler, 2011). However, the involvement of a patient in a medical lawsuit results in a destructive personal experience (Moore et al., 2000). Those lawsuits are often lengthy due to the complexity of the cases and the rules that lawyers must follow, which can result in more emotional distress for the patient. Moreover, malpractice claims can contribute to the patient's unwillingness to seek medical help in the future and a loss of trust in the healthcare provider (Texas A&M University-Corpus Christi, 2022). The patient's fear and hesitation have the potential to affect their overall health in the long term. Furthermore, claims can even result in the patient's loss of income, and they can become temporarily or permanently unfit for work or have to switch professions (Mello et al., 2007). Additionally, it can result in extra costs for the patient, such as the costs that arise due to additional health-care services, for instance, nursing home care and treatment, to mitigate the harm caused by the medical error.

To conclude, as reviewed in the literature, claims can have serious impacts on patients, physicians, and hospitals, and avoiding this legal process is in the best interest of all of them.

2.4 Factors contributing to escalation

This paragraph provides deeper insights regarding the factors that may lead to the escalation of medical complaints into claims. Therefore, it concentrates on the following question*: "When and how do medical complaints escalate into legal claims?".*

The first potential factor that could contribute to complaint escalation is the *type of error* associated with the complaint. These errors can be distinguished into two categories: communication errors and diagnostic errors (Donn & McDonnell, 2012). Indirect communication is a factor that motivates patients to take legal action after a medical error (Vincent et al., 1994). Patients who are unable to effectively express their concerns and complaints as a result of this indirect communication do not feel heard or taken seriously (Howard et al., 2013). Furthermore, communication problems cause patients to get disappointed and frustrated with the professional, which leads them to take legal action (Gorney, 2002). Additionally, when the communication between the professional and the patient is insufficient, it can lead to poor relationships. Healthcare providers with poor patient-primary care provider relationships

are sued more often compared to providers with good relationships (Moore et al., 2000). However, Saber Tehrani et al. (2013) state that diagnostic errors are the leading type of claim. This latter study demonstrated that diagnostic errors resulted in the highest proportion of costs and risks for patients.

The *healthcare professionals' personal or demographic characteristics* could be another risk factor that contributes to the escalation of complaints (Austin et al., 2021). Various studies state that healthcare professionals who were involved in a prior medical lawsuit are roughly twice as likely to face additional claims (Gómez-Durán et al., 2018; Monteferrante et al., 2022). This finding is in line with other studies that state that previous claims are signals for future claims (Austin et al., 2021; Bismark et al., 2013; Moore et al., 2006; Weycker & Jensen, 2000). Additionally, Stelfox et al. (2005) state that physicians who had low ratings for patient satisfaction had a higher risk of malpractice lawsuits compared to physicians who had high ratings. Austin et al. (2021) describe physicians' years in practice, the number of hours worked per week, the number of patients seen, and their age as warning signs for future legal actions. In the context of age, older professionals were generally found to be at higher risk of malpractice claims when compared with younger doctors (Alam et al., 2011; Azab, 2013). Furthermore, research shows that male professionals are more likely to be sued than female professionals due to their higher exposure to risk (Troxel, 2019). More specifically, male professionals are approximately two times as likely to be involved in medical lawsuits as female professionals (Baker et al., 2013; Brooks et al., 2013; Weycker & Jensen, 2000). This difference in risk exposure could be due to the superior communication and interpersonal skills of female professionals when interacting with their patients (Sloan et al., 1989; Taragin et al., 1992). It is also important to understand which *medical specialties* pose a higher risk of being involved in a medical lawsuit. Hanganu et al. (2020) focus on exploring which medical specialties were most sued in Romania. Based on the results, the most reported medical specialties were emergency medicine, general surgery, obstetrics and gynecology, and traumatology. In another study conducted in China, obstetrics and gynecology, orthopedics, and general surgery accounted for the majority of medical malpractice claims (Li et al., 2014). In the Netherlands, general surgery, orthopedics, and gynecology are the top three medical specialties regarding the number of claims (Klemann et al., 2022).

Another probable reason for complaint escalation is *patients' emotions.* Patients who experience medical failures could feel a sense of revenge, which might motivate them to take further legal action (Bousnina & Zaiem, 2019; Chiu, 2010). In other studies, anger is identified as an important factor in individuals' claiming behavior (Chebat et al., 2005; Gorney, 2002; Howard et al., 2013). Next to anger and revenge, mistrust is also a concept noted in the literature. Medical mistrust between the patient and professional may lead to an increase in medical negligence, complaints, and lawsuits against healthcare providers (Choy & Ismail, 2017; Phillips-Salimi et al., 2012). The *patient's socio-economic status* is another factor that could contribute to the escalation of medical complaints. McClellan et al. (2012) found that low-income patients are less likely to file a claim against a care professional, which is

explained by the fact that they lack access to legal resources and the unforeseen expenses of those types of claims. This is also in line with the study by Moore et al. (2000), in which they report that wealthier patients are more likely to file medical malpractice claims than those with low socio-economic status. Furthermore, several academic researchers have noted that *patients' cultural backgrounds* could be an explanatory variable for differences in patients' motivations to sue. Berlinger and Wu (2005) indicate the importance of gaining knowledge about patients' cultural expectations regarding responses to medical malpractice. For instance, this could help healthcare providers choose the most appropriate approach in a way that is in line with the patient's and relatives' needs and preferences. Joosten's (2023) study found that in the Netherlands, individuals perceive physicians as intrinsically motivated to offer high-quality care to their patients. However, in other countries, such as Saudi Arabia and the United Arab Emirates, patients view healthcare professionals as less motivated, and it is common for a patient to give gifts (in Arabic, baksheesh) to them to get better care (Hutchinson et al., 2018). Lastly, patients' concerns about *previous negative experiences* after a medical error have led to potentially drastic legal claims and processes in the Netherlands (Laarman & Akkermans, 2018).

Next to the harmed patients, the *patient's family members* may also contribute to complaint escalation as they also experience emotional distress. These feelings, in turn, change their attitude toward the professional. Those family members' emotions and motivations to hand in a claim differ according to their relationship with the patient (Hickson et al., 1992). For instance, parents are more protective towards their children, which can lead to a different reaction than that of other people, as shown in the example presented in Chapter 1. Furthermore, when parents realize that their child will have no future due to medical malpractice, they are more likely to sue the professional (Hickson et al., 1992). The relatives' extreme emotions can make it more difficult for them to understand and objectively evaluate the situation. These extreme emotions can arise from the fact that family members may argue that the physician or nurse could have treated the patient differently, which would not have led to harm (Joosten, 2023). Another interesting aspect is that the majority of claims regarding lack of communication were reported by family members rather than the patient (Hanganu et al., 2020). Lastly, Moore et al. (2000) highlight the role of interpersonal interaction between patients and physicians during medical malpractice. During the treatment, the physician and patient can develop a strong relationship, which is not the case for the patient's relatives. The lack of a personal relationship with the professional may make family members more motivated to file a claim.

2.5 Prevention of complaint escalation and de-escalation techniques

This paragraph focuses on measures to prevent such an escalation or to de-escalate when a claim has already been made. As a result, it focuses on the following question: *"How can the escalation of medical complaints into claims be prevented?"*

Prevention of complaint escalation

Healthcare organizations can prevent complaint escalation by making patients *feel heard and taken seriously*. Patients' complaints about not feeling heard or being able to express their concerns, as was previously indicated, are an important aspect of complaint escalation (Howard et al., 2013). Healthcare organizations must promote an environment of open communication and transparency where patients feel heard (Kass & Rose, 2016). To adopt this open communication, patients and healthcare providers need to change their mindset, going from a culture of 'name and blame' to aiming for patient safety (Donn & McDonnell, 2012). An example is that healthcare professionals should disclose medical errors by apologizing and taking responsibility for their actions (Howard et al., 2013; Lazare, 2006). As a result, this will increase the number of patients, and such disclosure and apology may even result in reduced motivation among patients to file claims after medical errors (Berlinger & Wu, 2005; Donn & McDonnell, 2012). A study conducted by the Healthcare Complaints Directive (in Dutch: Klachtenrichtlijn Gezondheidszorg) indicated that 25 to 40% of the complainants would not have submitted a claim if they had received disclosure information and empathy from the healthcare provider (Thomassen, 2010). According to Donn and McDonnell (2012), this disclosure also meets the needs of patients for transparency, compensation, and reassurance that such mistakes will not happen in the future. These authors stated that transparency in medical error disclosure results in a decline in medical claims. However, some healthcare professionals are afraid to disclose medical errors to patients due to the risk of losing patients' trust, a decline in patient satisfaction, and a perceived loss of social reputation (Gallagher et al., 2007). Furthermore, Giraldo et al. (2020) state that disclosure and apology did not affect the number of medical lawsuits. These results raise the question of how transparency can be maintained when a medical error does occur and highlight the need for further research in this field.

Additionally, in the context of medical service failures, healthcare providers must emphasize the *patient's cultural background* (Berlinger & Wu, 2005). By learning about the cultural norms and values of patients, healthcare professionals can better adapt their care to the patient. By implementing personalized care rather than a one-size-fits-all approach**,** healthcare professionals can identify individuals' unique needs (Ringberg et al., 2007). This personalized care approach reduces the gap between patients' expectations and the actual delivery of their care (Berlinger & Wu, 2005). Furthermore, a patient-centered care approach by the direct care provider can result in the prevention of further escalation of complaints (Thomassen, 2010).

Patient involvement is another factor that can help prevent the escalation of complaints. Patient involvement has significant implications for patient behavior, such as the patient's decision to return to a particular healthcare provider (Nelson & Niederberger, 1990). This involvement can be enhanced by offering patient satisfaction surveys (Nelson & Niederberger, 1990). Patient dissatisfaction, as previously mentioned, raises the risk of escalation (Stelfox et al., 2005). Based on patient satisfaction

scores, healthcare professionals can reduce the risk of complaint escalation by identifying patient dissatisfaction early in the process (Stelfox et al., 2005).

Lastly, the *patient-primary care provider relationship* might affect complaint escalation (Moore et al., 2000). To prevent complaint escalation or de-escalation, trust must be established. If trust is built within the patient-primary care provider relationship, this could lead to a decrease in patient dissatisfaction and, in turn, a decrease in claims. Building trust between patients and healthcare providers is seen as essential to improving healthcare quality (Choy & Ismail, 2017). Medical trust refers to a relationship that is formed between a patient and a healthcare provider when there are shared goals and mutual respect (Bova et al., 2006; Murray & McCrone, 2015).

De-escalation techniques

De-escalation can be defined as "a combination of strategies, techniques, and methods intended to reduce a patient's agitation and aggression" (The Joint Commission, 2019, p. 1). Various researchers have investigated de-escalation strategies in healthcare. However, there is limited existing literature regarding the de-escalation of claims. Therefore, some of the techniques described are not entirely associated with claim de-escalation. However, the information in these studies is sufficiently reliable to align with medical claims.

One way to de-escalate is by using the *Dix and Page model***.** This model describes assessment, communication, and tactics (ACT) as fundamental drivers of effective de-escalation. This model was originally developed for mental health institutes, although it is currently used as a de-escalation tool in hospitals. It incorporates five factors: situation, judgment, anger, inhibitions, and aggression. Situation refers to the incidents that made the patient show aggressive behavior; judgment is the patient's understanding of the situation; anger is the emotional response to the incident; inhibitions are the patient's attitude toward managing his or her aggression; and lastly, aggression is the actual behavior of the patient due to the incident (The Joint Commission, 2019). Another model for de-escalation is the *Safewards model,* which was developed to promote a safer environment within healthcare settings (Bowers, 2014). It incorporates five aspects: staff modifiers, patient modifiers, flash points, conflict, and containment. Staff modifiers refer to the way that key staff acts in managing patients or their environment, while patient modifiers focus on the way patients interact. Conflict refers to patient behavior that threatens the safety of others. Furthermore, containment refers to all the things staff do to avoid conflict or negative consequences. Lastly, flashpoints are "times or situations that arise out of the originating domains, and they are 'triggers' or 'tipping points' that signal and precede potential conflict" (Bowers, 2014, p. 1). This model has been tested multiple times in practice, and its interventions resulted in a 15% decrease in the level of conflict and a 24% decrease in the level of containment (Safewards, 2014). Furthermore, the *CALM de-escalation model* is an approach used within healthcare to prevent

escalation when there are emotional triggers involved. CALM stands for communication, assertiveness, look, and measured tone. This model helps healthcare providers identify emotional escalation and de-escalate it. For instance, harmed patients may change their tone of voice, body language, and way of speaking. When the situation escalates, CALM model techniques can be used. These techniques include the following: (1) being aware of your body language and avoiding defensive body language; (2) giving individuals personal space; (3) actively listening to the patient; and (4) aiming for a positive outcome and avoiding negative filters (Ko Aweta, 2019).

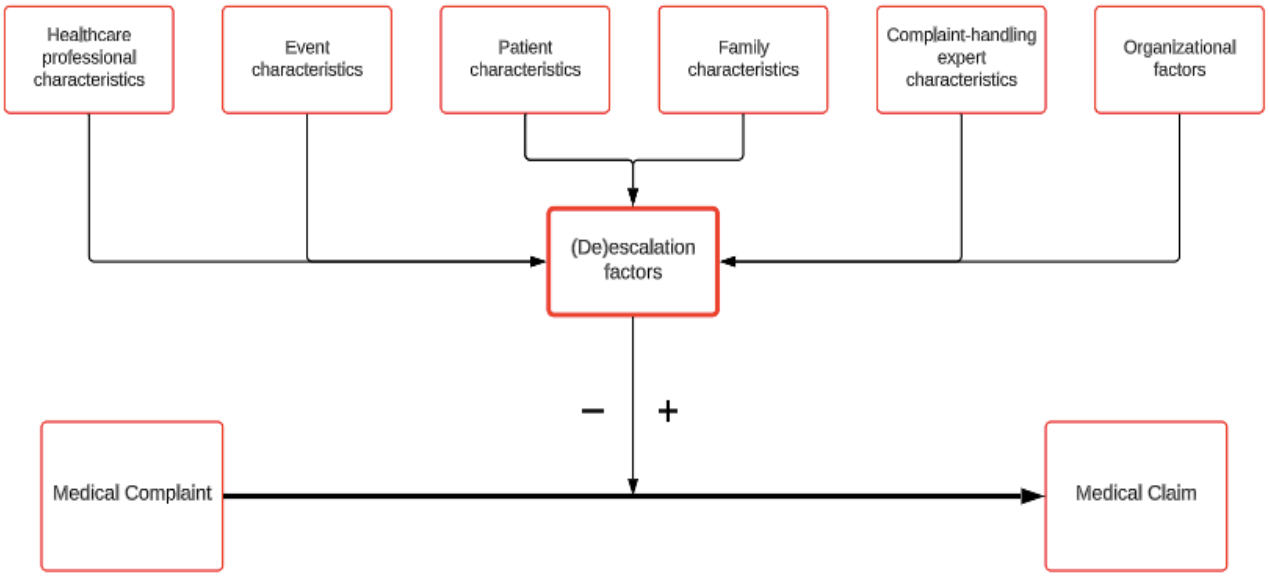
When reviewing the above-mentioned models, it can be concluded that effective communication plays an important role in the context of de-escalation. McClellan et al. (2012) state that healthcare professionals should have a range of communication skills to effectively interact with patients who have experienced harm. By utilizing the four key skills—involvement, empathy, enlistment, and guidance — professionals can reduce the risk of patients submitting claims. Involvement refers to actively listening to the patient, involving them in decision-making, and making them feel heard (Gorney, 2002; Howard et al., 2013; Zimmerman & Amori, 2007). Empathy refers to sharing and understanding the feelings of another person, which creates trust and decreases the risk of medical errors (Hannan et al., 2019). Furthermore, enlistment refers to involving other parties in the patient's treatment, such as their relatives. They can play an important role in noticing any potential health issues in the patient early on during the treatment (McClellan et al., 2012). Lastly, guidance focuses on providing knowledge to the patient about their health, which will make them well-informed (McClellan et al., 2012).

2.6 Conceptual Framework

The conceptual framework, shown in Figure 2, was developed by three researchers. This conceptual framework shows that the relationship between complaints and claims can be positively or negatively influenced by different factors. To understand how particular factors influence the complaint escalation process, expectations have been formulated. The literature mentioned in Chapter 2 served as the foundation for these expectations, which have been developed in collaboration with two other researchers. Additional aspects that emerge from the data collection and are not discussed in the literature may also be included as additional effects.

Figure 2

Conceptual Framework



Healthcare professional characteristics

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

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

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

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

E5: When healthcare professionals have better 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 escalation 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-handling expert characteristics

This category contains no expectations as there is limited literature about complaint-handling experts concerning the likelihood of complaint escalation. However, they are mentioned in the conceptual model as they are the primary point of contact when it comes to complaint processes in the Netherlands. As a result, it is expected that they have an impact on the (de)escalation of complaints.

Organizational factors

In this category, there are no expectations formed because there is limited existing literature concerning the likelihood of complaint escalation. However, according to current literature on service failure and recovery in firms, organizational performance has an impact on customer satisfaction. Additionally, organizational culture is expected to have an impact on performance based on the researchers' previous experience as business administration students.

Chapter 3: Methodology

This chapter delves into the justification for the chosen research method, data collection, and analysis procedure. At the end of the chapter, there is an explanation of how research quality and ethics are addressed. When requested, the researchers can provide the invitation letter, the initial and written version of the questionnaire, and interview transcripts.

3.1 Research method

One of the most common research methods is quantitative and qualitative research (Myers, 2020). Quantitative research focuses on collecting figures and uses a structured design to study a social phenomenon (Bleijenbergh, 2015). On the other hand, qualitative research focuses on collecting and analyzing material to provide an in-depth understanding of a phenomenon in a natural setting (Myers, 2020). Qualitative researchers concentrate on exploring the meaning and motivations underlying cultural symbols, personal experiences, and an understanding of processes in the social world (Kalof & Dan, 2008). Since this study has the objective of exploring and comprehending the experiences and perceptions of complaint-handling experts in Dutch hospitals, the qualitative approach seems the most relevant.

Within qualitative research, there is a difference between inductive (theory-building) and deductive analysis (theory-testing). Within the inductive approach, patterns, themes, and analysis categories emerge from the data rather than being defined in advance, which allows approaching the field as openly as possible (Bleijenbergh, 2015). This type of analysis can be defined as exploratory, as it starts with gathering and exploring data (Myers, 2020). On the other hand, the deductive approach starts with gathering existing theory and making observations that are aimed at testing and possibly disproving the theory (Bleijenbergh, 2015). This type of analysis can be defined as confirmatory, as it uses existing theory to come up with expectations and collects data to support the theory (Myers, 2020). In this study, the purpose was to obtain more in-depth information from complaint-handling experts regarding the concept of complaint escalation. There is limited existing research available on this topic, specifically focused on the Dutch healthcare system. However, several contributing or mitigating factors to complaint escalation have already been identified in the existing studies. These studies were an important source of information for the development of the conceptual model and expectations. Doorewaard et al. (2019) state that deductive research involves an in-depth investigation of the literature to determine whether research has previously been done on the subject. This makes a deductive approach more appropriate for the current study compared to an inductive approach.

When conducting deductive research that draws on existing literature, a practice-based approach is preferred over a theory-based approach (Doorewaard et al., 2019). The main difference between the two approaches is that theory-oriented research concentrates on solving a gap in existing theory, whereas

practice-oriented research is more focused on solving an issue that arises in practice. In this study, a practice-based approach is used because it aims to improve the Dutch healthcare system by offering recommendations on how to prevent unnecessary medical claims.

It is important to indicate that there are different types of practice-oriented research: problem analysis, diagnosis, design, implementation, and evaluation, each of which has a specific focus and objective (Verschuren & Doorewaard, 2015). Design-oriented and implementation research are less common in qualitative research (Doorewaard et al., 2019). With problem analysis, the objective is to identify an organizational problem, and this analysis serves mostly as the basis for diagnostic research (Doorewaard et al., 2019). Diagnostic research focuses on finding the causes of the problem and assessing whether there are opportunities for improvement. Finally, evaluative research looks at the effects of previously implemented changes (Doorewaard et al., 2019). Diagnostic research was more appropriate for this study, as the goal of this study is to explore the underlying factors that contribute to complaint escalation and provide prevention strategies. By conducting this kind of research, it became possible to gain in-depth insights that led to recommendations for the prevention of unnecessary claims.

Finally, in practical diagnostic research, there are two common approaches: opinion research and gap analysis (Doorewaard et al., 2019). Gap analysis focuses on examining the discrepancy between desired and actual situations. On the other hand, opinion research focuses primarily on identifying the different opinions regarding the problem under study. In this study, opinion research is more appropriate, as the main purpose is to gain an understanding of the different opinions of complaint-handling experts. To conclude, this study can be defined as a *qualitative, deductive, practice-oriented, diagnostic opinion analysis.*

3.2 Data collection

Data collection method

Once the research method is provided, it is important to understand how the data is collected. In qualitative research, there are different data collection methods, such as fieldwork, interviews, and case studies (Bleijenbergh, 2015). In this study, primary data was collected from interviews with complaint-handling experts. By investigating the complaint process across different healthcare organizations, the aim was to explore which factors lead to the escalation of complaints and to identify potential differences or similarities among various hospitals. Interviews are a widespread technique to collect information, and they involve engaging in conversations with respondents by actively listening to their responses (De La Croix et al., 2018). Furthermore, interviews provide an opportunity to obtain in-depth and detailed information about the respondents' experiences (Hox & Boeije, 2005). Within interviews, there are different types, such as structured, semi-structured, and unstructured interviews (Myers, 2020). In

structured interviews, pre-formulated questions are used, and the order in which they are asked is closely adhered to (Myers, 2020). This may lower the flexibility of the research because it is not possible to ask follow-up questions. In contrast to structured interviews, unstructured interviews allow the researcher to talk about anything they wish without being constrained by pre-formulated questions. However, uniformity between interviews is not guaranteed. Within semi-structured interviews, there are preformulated questions that are not strict and formalized, and during the interview, there is room for new or follow-up questions (Bleijenbergh, 2015; Myers, 2020). As a result, the semi-structured approach seemed the most promising for this research. This approach enabled the researcher to select specific information from Chapter 2 that should be discussed during the interview. This existing literature was used to develop a topic list that was used to formulate the interview questions.

The questionnaire was developed in cooperation with two other researchers. A preliminary version of the questionnaire was sent to an expert in the field of complaint handling and a researcher in service failure recovery to make sure the questions were relevant to the respondents. The interview questions were in Dutch because this is the primary language used by complaint-handling experts. As a result, respondents were able to explain their opinions and experiences without having to translate them. In this way, maximum understanding and effective communication were enhanced. During the interviews, respondents were not restricted to questions from the questionnaire, which allowed them to provide additional information where needed. This resulted in more detailed information and further improvements to the questionnaire, enhancing the internal validity of the study (Bleijenbergh, 2015). Furthermore, during the interviews, it became clear that cultural aspects can be challenging to discuss, as respondents may have a fear of being misunderstood. To handle this matter, one of the researchers, who came from a different background, gave confidence to the respondents that they were free to openly express their thoughts on the topic. This approach enabled the creation of a comfortable and open environment, motivating respondents to share their experiences openly.

The final version of the questionnaire consisted of four parts, which can be found in Appendix 2. The first part incorporated a short introduction to the study and a clarification of the key concepts: medical complaints and claims. Explaining the key concepts of the study before starting the interview ensured that respondents understood the study's scope and were able to give relevant and accurate information, which enhanced the validity of the study. After this, the respondents were asked for their permission to record the interview. It was explained that all information would be anonymized, and they would receive a copy of the transcript. This led to an open environment where respondents could speak freely. The second part focused on gaining general information about the respondents (e.g., function within the organization, number of years employed, type of organization). The third part was about exploring the factors contributing to the escalation of complaints, categorized into seven categories (e.g.,

characteristics of the patient, organizational factors, and de-escalation techniques). The final part entailed the closing section and the debriefing.

Sample

In this study, the sample consisted of complaint-handling experts who are working in Dutch hospitals. These respondents were chosen based on their ability to provide comprehensive information from many perspectives, as they are directly involved in interacting with the involved parties during the complaint-handling process. This aligns with Doorewaard et al. (2019), who state that in qualitative semi-structured interviews, it is important to choose respondents who can provide information on the topic of interest from a variety of angles. The majority of the respondents were working in different Dutch hospitals, which led to insights from multiple organizations. As the aim was to speak to complaint-handling experts, not every individual in the population has an equal chance to be included. This technique is called the non-probability technique, in which it is unknown which individuals will be selected as a sample, and it will depend on non-random criteria such as availability (Noordzig et al., 2010).

To find respondents, an invitation letter was developed and sent by email to various Dutch hospitals. This letter included personal information about the researchers, detailed information about the study, and its relevance. In practice-oriented research, researchers mostly interview 15–20 respondents, as this is doable within the allocated time for graduation (Doornewaard et al., 2019). In the current study, 27 respondents have been recruited, of which 19 were recruited through the invitation letter, while six were recruited through referrals, which is called snowball sampling (Sharma, 2017). The respondents were given the freedom to choose the time and place of the interview, which enhanced maximum flexibility. The interviews took place either at the hospital, via video conferencing, or via a written version of the questionnaire. Two respondents decided to use the written version. However, this version was left out of further analysis because it did not meet the research standards. This led to a total of 25 in-depth interviews. Table 1 in Appendix 1 provides little information about the respondents to ensure their anonymity.

Information saturation was reached during the last interviews because no new information was offered by the respondents, and their answers showed a lot of similarities. According to Doornewaard et al. (2019), information saturation is more likely to occur when the respondents have many similarities. Regarding this study, information saturation was enhanced by the fact that all respondents work in Dutch hospitals and have knowledge about the complaint-handling process.

3.3 Data analysis

After the interviews were conducted, several steps were taken to ensure the data analysis was systematic. Firstly, the interviews were recorded and transcribed manually. The decision was made not to translate the transcripts from Dutch to English, as this could have led to a loss of information and the meaning of every aspect of the interview may not be fully maintained. The technique that is used within qualitative content analysis is 'summarizing analysis', which is also described as directed content analysis (Hsieh & Shannon, 2005). In this type of analysis, the goal is to gradually transform the complicated and dispersed information into clear and structured data that is related to the factors derived from the theoretical framework. However, this study extends beyond the theoretical framework, as respondents frequently provided additional information during the interviews. 'By-catch' is a term used to describe information that is not directly requested but that is favorable and unique (Doorewaard et al., 2019). During the interview, an interesting by-catch was gathered regarding the professional profile of complaints officers released by 'de Vereniging van Klachtenfunctionarissen in de gezondheidszorg' (Panis et al., 2018). This secondary data was used to examine whether the experiences and perspectives shared by the respondents aligned with the factual insights from the reported data.

Within directed content analysis, there are two methods to summarize the collected information: within-case analysis and across-case analysis. In the within-case analysis, researchers summarize the different themes from each respondent's point of view (Doorewaard et al., 2019). On the other hand, the across-case analysis examines all responses to a certain topic on a more overarching level (Doorewaard et al., 2019). Analyzing how the respondents differ and overlap on a certain topic is part of this process. For this study, an across-case analysis has been adopted since it allows for the identification of patterns that are relevant to the topic as well as a comprehensive perspective on the respondents' opinions.

3.4 Research quality

Evaluating the quality of the research is important if the findings are to be used in practice and incorporated into healthcare services (Noble and Smith, 2015). However, a problem in qualitative research is '*multi-interpretability'* because the information obtained is analyzed based on interpretation (Doorewaard et al., 2019). To minimize the effect of multi-interpretability, several techniques were used, including the 'four-eye' principle, expert opinion, feedback to respondents, and cautious reporting. In this study, three researchers worked together under the supervision of an expert in service recovery and failure, so there were 12 eyes involved. Furthermore, the expert assessed whether the data was represented concretely. In addition, the transcripts were sent to the respondents to avoid misunderstandings and ambiguities. Finally, this study's results are only based on the interviews and literature and do not make overly strong assumptions, which is defined by Doorewaard et al. (2019) as 'cautious reporting'.

Furthermore, internal validity and external validity are the two types of validity used in qualitative research. Internal validity examines if you measure what you want to measure and allows trustworthy answers to the research question in the study (Andrade, 2018; Bleijenbergh, 2015). On the other hand, external validity refers to the assessment that the findings of this study are also valid in other contexts (Doornewaard et al., 2019). In order to ensure the validity of the results, investor triangulation is applied as several researchers try to answer the same questions (Verhoeven & Verhoeven, 2018). By applying this type of triangulation, the researchers were able to compare and contrast different perspectives, which enhanced the trustworthiness of the results. Additionally, the semi-structured approach of this study has increased its *internal validity*, as the researcher could ask follow-up questions and respondents were able to add additional information (Doorewaard et al., 2019). Moreover, two experts in complaint-handling and a researcher in service failure recovery checked whether the topics used in the questionnaire were relevant, which increased the quality of the questionnaire. Lastly, the choice of the respondents has improved the internal validity, as they provided rich information about the subject and shed light on different sides of it (Doornewaard et al., 2019). As the investigated situations and unexamined scenarios will never be identical, it is difficult to make claims about the *external validity of* qualitative research (Doornewaard et al., 2019). However, given the size of the respondents, it is likely that other situations will show similar characteristics. As a result, this study may help future researchers develop a more realistic image of complaint escalation in Dutch hospitals from the viewpoint of complaint-handling experts.

Confirmability is another key aspect of qualitative research, which emphasizes the researcher's capacity to show that the data reflect respondents' responses without any bias (Cope, 2014; Tobin & Begley, 2004). By explaining how the claims resulted from the collected data, this study improved confirmability. Furthermore, Lumsden (2022) states that in qualitative research, the researchers should support claims with quotes from the respondents. The key claims in Chapter 4 are supported by several insightful quotes from the respondents, which enhanced the confirmability. The last aspect that enhanced the confirmability of this study was the respondents' assessment of their interview transcripts.

3.5 Research ethics

Qualitative research requires the personal involvement of respondents, which can raise ethical challenges (Sanjari et al., 2014). Thus, it is important to follow ethical principles to address these problems to meet the purpose of the research and maintain the rights of the respondents (Orb et al., 2001). The first important principle is to ensure informed consent and transparency. This was done by explaining to the respondents what the researcher's role is and how their data will be used. Additionally, written approval was requested from the respondents for using the interview transcripts. This ensured

that the respondents had the opportunity to review the content. Secondly, respondents had the right to withdraw from research immediately and could revoke their data. To prevent this, respondents were provided with a set of detailed interview questions, and medical service failure was not openly discussed. Thirdly, since the topic of patients' complaints and claims is sensitive and personal, the respondents were asked if the researcher could make audio recordings. Anonymity was strictly maintained throughout the study by not mentioning the hospital or respondent names. Moreover, the citations used are not traceable to any specific healthcare organization or respondent. By following these ethical principles, this study aimed to protect the rights and well-being of the respondents while gathering valuable insights. Lastly, as debriefing plays an important role in research, the respondents will receive parts of the final thesis before their personal data is deleted.

Chapter 4: Results

In this chapter, the most important results gathered from the interviews are presented. It starts by providing general information regarding complaints and claims. Thereafter, it is discussed how the factors depicted in the conceptual framework in Figure 2 influence complaint escalation. These factors are: characteristics of healthcare professionals, event characteristics, characteristics of patients and their family, characteristics of complaint-handling experts, and organizational factors. This is followed by an elaboration on de-escalation techniques. Almost all paragraphs will follow the same structure, beginning with a description of the similarities and differences between the results, followed by additional findings and unique perspectives, and ending with a short summary of the results. Some subheadings may be omitted if no information on these aspects is gathered.

Before reporting the results, it is important to discuss the characteristics of the respondents. A total of 25 in-depth interviews were conducted with complaint-handling experts from 19 different Dutch hospitals. The majority of these respondents had prior experience in other Dutch hospitals, which resulted in information on a wide range. Furthermore, the respondents consisted mainly of women, except for one male complaint officer. In addition, the majority of the respondents had a Dutch cultural background. Lastly, in terms of their educational background, the majority of the respondents have backgrounds in healthcare, with the legal sector coming in second.

4.1 General information about complaints and claims

At the beginning of each interview, the definitions of complaints and claims were presented to the respondents. By taking this step, the researchers and respondents had a shared understanding, and their perspectives were in line with the primary concepts of this study. The majority of respondents agreed with the definitions suggested by Gillespie and Reader (2016) and Wallace et al. (2013). Furthermore, the interviews revealed that almost all the respondents shared the same perspective on when the complaint-handling process starts, namely in direct response to a medical service failure.

After defining the primary concepts, the research question was presented. While most respondents agreed with the question, a few expressed criticism and misunderstanding. The respondents disagreed with the term ‘escalation’ for two reasons. First, the term ‘escalation’ was misunderstood by some of the respondents because they connected it to extreme escalation of patient behavior against healthcare providers, such as aggression. However, within the context of this study, the term refers to the progress and advancement in a process in which something moves to the next stage. More specifically, it refers to situations in which a complaint escalates into a claim due to various underlying factors. Secondly, respondents believed that not every complaint has the potential to result in a claim. They pointed out that different situations lead to filing a claim. The first circumstance is that the patient has experienced

a (potential) medical service failure, in which case it is appropriate to file a claim. The majority of the respondents stated that in these types of circumstances, it is best to encourage and help patients who have a right to compensation. The second circumstance is when the patient is demanding and makes it clear from the start that they want a claim. De-escalation in these kinds of situations is difficult, according to the respondents. The last circumstance mentioned by the respondents is when a patient first has a complaint, but due to several underlying factors, it escalates into a claim. There are different de-escalation techniques for these kinds of situations, which will be covered in further detail later in this chapter. The following quote reflects these findings:

> *"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*

4.2 Characteristics of healthcare professionals

This paragraph provides information on the key findings about the characteristics of healthcare professionals who are directly involved in the medical treatment of patients.

Similarities and differences

It is important to first understand healthcare professionals' *perceptions of complaints and claims* before discussing how their characteristics contribute to complaint escalation. This is important because healthcare professionals' perceptions can impact their behavior and way of handling complaints. The majority of the respondents stated that complaints and claims are often seen as learning moments for professionals. However, each healthcare professional wants to minimize complaints and claims in their career because these can sometimes lead to fear. It appeared that in most situations, this fear originates from prior experience with claims or the disciplinary tribunal. However, these respondents stated that disciplinary cases have a greater impact on professionals' fears, as these cases point to possible violations of professional standards that have personal consequences. An interesting finding was that the professionals' *cultural background* influences their perception of complaints and claims. One example is the fact that Belgian professionals have more fear of claims. This is a result of the absence of the Care Quality, Complaints, and Disputes Act (WKKGZ) in their nation. In Belgium, complaints and claims are directly linked to disciplinary cases, which results in greater fear among these professionals. Another finding is that younger professionals are more anxious about claims as they experience more pressure. The majority of respondents highlighted that it would be helpful to better prepare younger professionals by involving them in complaint-handling discussions with their supervisors. This can help them learn how to handle patient dissatisfaction and improve communication

with patients. In cases where professionals have fear, they sometimes change their way of providing care, which is called 'defensive medicine'. An example is that they perform unnecessary tests at the request of the patient to prevent claims. The interviews revealed that the respondents' opinions on this topic varied. The majority explained that they are not aware of the existence of defensive medicine in their organization, but that, in theory, they would comprehend it.

When questioned about what characteristics of professionals contributed to the escalation of complaints, the majority of respondents stated that their personality is more important than their demographic characteristics. These respondents explained that the healthcare professionals' *personalities* determine the way they communicate and handle complaints and claims. Firstly, empathy was seen by the majority as a quality that a healthcare professional must possess to prevent escalation and deal with patient dissatisfaction. This empathy can be enhanced by the professional's involvement in the patient's care process. If the professional shows empathy, this ensures that patients feel understood and heard, which results in preventing complaint escalation. Secondly, the great majority also highlighted the significant role of disclosure, both in preventing escalation and de-escalating claims. They claimed that professionals should be transparent to patients in both the disclosure of procedures and when a service failure occurs. In cases where the professional has made a (potential)mistake, patients appreciate it when they apologize and take responsibility. The majority claim that this ensures patients' willingness to speak with the professional involved, which usually leads to the prevention of escalation and de-escalation. The following quotes reflects these findings:

> *"Maar ook dat heeft weer te maken met, met die laagdrempeligheid en de open communicatie. Als een dokter gewoon goed communiceert en dingen goed uitlegt dan zullen mensen minder snel een claim indienen dan wanneer ze helemaal geen uitleg krijgen" – Respondent 4*

> *"Als ze niet een soort schuldbekentenis. Van jeetje, het spijt me of wat vervelend dat u dat zo gevoeld heeft, of dat een soort erkenning van hun gevoelens, dan kan het escaleren naar een claim." – Respondent 12*

Another insight that the interviews revealed is that patients are more likely to escalate their complaints when they have the feeling that their dissatisfaction is not being heard. The majority of respondents highlighted the important role of *active listening* in these cases. Here, it is important that the professional not only listens to the patient and hears the words, but also comprehends the meaning and intent behind them. Additionally, professionals should provide *personalized care* to their patients. However, due to the high work pressure that healthcare providers experience, it is often difficult for them to balance their responsibilities and find time for personalized attention. The majority indicate that this personalized care is important in preventing complaint escalation, as this results in patient satisfaction where patients feel

seen and heard. Furthermore, according to these respondents, a professional should adapt this personalized care to a patient's needs and characteristics, such as their cultural background or language barrier. But a large part of the respondents indicated that this is sometimes difficult in practice because not all professionals have the same communication skills. A specific example that a few respondents stated is that cross-cultural communication is challenging as professionals and patients differ in their communication styles. This difference can lead to misunderstandings, which in turn increases the likelihood of complaint escalation. These respondents indicated that communication training is beneficial for professionals, as this results in a decrease in complaints regarding communication. The following quote reflect these findings:

> *"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

Even though the majority expressed the importance of the professional's personal characteristics in managing complaint escalation, many respondents indicated that *demographic characteristics* also impact the escalation of complaints. Demographic characteristics refer to specific features or attributes of professionals. When discussing the professionals' gender, the majority highlighted that this impacts their communication style and way of handling complaints. It became clear that, compared to male professionals, female professionals tend to communicate more effectively on an emotional level. Additionally, patients are more likely to be dissatisfied with female professionals than with male professionals because they have higher expectations for them. When questioned about the impact of age, the majority indicated that there appeared to be fewer complaints about communication with younger professionals than with older professionals, which appears to be related to the education of these professionals. These respondents explained that younger professionals are provided with more information on social aspects, communication skills, and complaint-handling during their education. Older professionals, on the other hand, tend to adopt a more hierarchical approach without rigidity, where arrogance and narcissism are more common. The following statement is a reflection of these findings:

> *"Ik zie een heel groot verschil daartussen en, dat is zeker, dat heeft zeker ook met opleiding te maken. Het heeft te maken met de hiërarchische cultuur die altijd heel erg is blijven bestaan rondom die oudere specialist. Ik ben de dokter, dus ik bepaal het, hè. Tegelijkertijd zie ik ook dat het ook wel een verharding is die ontstaan is doordat ze vaak al zoveel hebben gezien, zoveel hebben meegemaakt, dus het kan ook een soort bewapening zijn van mensen zelf." – Respondent 10*

In addition to the demographic characteristics, another factor that influences the escalation process is the *medical specialty*. The interview revealed that certain medical specialties are more susceptible to complaints and claims. The most mentioned specialties were (plastic)surgery, gynecology, orthopedics, radiology, and emergency care. This higher susceptibility to complaints and claims can be linked to the discrepancy between patient expectations and the complexity of the procedures and treatments carried out in these specialties. The majority state that these specialties incorporate fast decision-making, which causes patients and family members to not be adequately informed and guided. A remarkable example that was mentioned is childbirth. Due to the birth plan that is provided to patients, they have specific expectations, and when these are not met, this leads to patient dissatisfaction.

Furthermore, based on the interviews, it became clear that the *patient-primary care provider relationship* can influence complaint escalation. When questioned about the impact of this relationship, the opinions of the respondents were divided. The majority stated that a good patient-provider relationship can reduce the likelihood of an escalation. A specific example is that chronic patients regularly go to the same professional and build a relationship of trust. These patients feel sympathy and are more likely to talk to a professional and work on a solution with each other. However, a few respondents indicated that a good patient-primary care provider relationship can also have the opposite effect and increase the likelihood of an escalation. More specifically, when the healthcare provider fails to fulfill the patient's desires and demands, this can lead to extra disappointment. This disappointment can be expressed in changed patient behaviors and eventually leads to an escalation of the complaint.

Additional findings and unique perspectives

An additional finding that the majority of the respondents highlighted is that healthcare professionals become frustrated when they encounter patients who *perceive discrimination*. This frustration results from the fact that healthcare professionals are driven and have taken an oath to provide every patient with the best possible care. However, these respondents claimed that patients frequently file complaints due to discrimination. One respondent stated the following:

> *"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 zorgmedewerkers dan zeggen, ja, die mensen die voelen zich altijd maar gediscrimineerd terwijl het misschien in feite ook wel een beetje gebeurd, 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 of results

The findings showed that the characteristics of healthcare professionals have a great impact on the escalation process, both directly and indirectly. These characteristics can be summarized as follows:

fear of complaints and claims, way of handling complaints and claims, personality, (cross-cultural) communication skills, personalized care to patients, gender, age, cultural background, medical specialty, and patient-primary care provider relationship.

4.3 Event characteristics

In this paragraph, event characteristics that can influence the escalation process are discussed. In this regard, event characteristics refers to specific features of the event related to the perceived medical service failure.

Similarities and differences

The most often stated *types of complaints* by the respondents were medical, organizational, relational, and communication errors. The majority of respondents indicated that during the COVID period, there was a change in the type of complaints, with a greater emphasis on organizational issues that were not going well. When questioned about which type of complaint leads more to the escalation of complaints, the respondents' opinions were divided. The vast majority of respondents indicated that communication errors are the most common complaint. They stated that practically every complaint and claim involves some sort of communication issue. One respondent made the following statement:

> *"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*

On the other hand, the remaining part of respondents indicated that diagnostic errors cause fewer concerns for escalation. These types of errors are directly a claim because they are regarded as calamities in which there has been a (potential) mistake made. Calamities can be defined as "an unintended or unexpected event that affects the quality of care and has resulted in the death of or a serious adverse effect on a client" (Ministerie van Volksgezondheid, Welzijn en Sport, 2023, p. 2). In these types of cases, it is challenging to de-escalate and it is best to support and assist patients.

Additional findings and unique perspectives

When questioned about the impact of event characteristics on the complaint-handling process, a unique finding occurred. The minority of the respondents indicated that the *duration of treatment* has an indirect impact on complaint escalation as it directly influences the patient-primary care provider relationship. A common example highlighted by these respondents is chronic patients. These patients are often in the hospital and are usually treated by the same professional. This enables them to build a long-term relationship, which, as mentioned earlier, can have a positive impact on the complaint-handling process. The following quote reflects these findings:

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

Another unique finding was that the *duration of the complaint-handling process* directly influences complaint escalation. A prolonged process is more likely to have a negative effect on the degree of satisfaction and raise the risk of escalation. More specifically, patients may feel ignored and frustrated when the process takes longer than expected.

The last additional finding was that a few respondents highlighted the importance of understanding the *subjective severity of the event,* as this has a greater impact on patient satisfaction compared to objective severity. Patients and family members can sometimes stay calm in situations involving serious injuries, but there are also simpler cases that spiral out of control. These respondents state that if the focus is mainly on the objective severity and the emotional impact is ignored, it can contribute to complaint escalation.

Summary of results

Based on the results, it can be assumed that event characteristics influence the escalation process, such as the type of complaint, the objective and subjective severity of the event, and the duration of treatment and the complaint process.

4.4 Characteristics of patients

This paragraph provides information about patients' characteristics. Within this context, these characteristics refer to the patients' attributes or traits that influence the complaint escalation process.

Similarities and differences

In the complaint escalation process, patients are important because the interviews revealed that most often they are the primary complainants. According to the majority of respondents, patients' demographic characteristics refer to their specific features or attributes that reveal the broader factors that contribute to complaint escalation. When questioned about the impact of the patient's *gender* and *age,* the majority highlighted that these aspects do not determine the escalation of a complaint. However, they noted that it can affect the patient's communication style. In the context of gender differences, some respondents said that men tend to be more direct and aggressive, whereas women are more accommodating and friendlier during the process. Age was noted as another aspect that may affect the patients' way of communicating. The difference between younger and older individuals is that younger individuals are more direct and assertive in expressing their dissatisfaction. Another characteristic

related to the patients' demographics is their *socio-economic status.* The interviews revealed that, similar to gender and age, this does not directly influence the escalation process but rather influences communication styles and behaviors. More specifically, the majority indicated that individuals with a higher status often need less support from, for instance, complaint-handling experts and are more familiar with the procedures. Due to this, they threaten more quickly with follow-up steps, such as legal actions. On the other hand, individuals of lower socio-economic status are often more verbally aggressive because they don't understand the process completely. For these types of patients, money and rising healthcare costs can be motivations to escalate complaints. One respondent stated the following:

> *"Je hebt te maken met de hoger opgeleiden die die heel erg op feiten niveau zitten en die dan dus om hun klacht meteen al willen. Ja, die die die die beginnen eigenlijk meteen te dreigen, met als de dokter dit niet doet, of als ze als ik niet binnen een week een gesprek heb, dan ga ik de dokter voor de tuchtrechter daar." – Respondent 10*

Based on the interviews, patients' *cultural backgrounds* also seem to be important for the escalation process. Each individual is rooted in his or her cultural background, norms, values, and beliefs, which affect their expectations and communication style with healthcare providers. The majority indicated that individuals with a non-Western background often have different expectations of care. A result of this is that those individuals experience friction when dealing with Dutch care standards and procedures. One specific example is that within the Islamic cultural background, individuals are dissatisfied with their care because they compare it to the healthcare system in their country of origin. In these situations, de-escalation is more challenging. The following quotes are a reflection of these findings:

> *"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*

> *"Mensen bijvoorbeeld van Turkse en Marokkaanse afkomst. Het kost zeeën van tijd. En we merken aan de dokters dat ze veel te veel tijd al in die patiënten gestoken omdat ze zuigen. Maar zij vragen het uiterste en we doen het nooit goed. Het leidt altijd tot een claim, altijd terecht of onterecht, en dan kan je bemiddelen, wat je wil." –* Respondent 5

These cultural differences can sometimes lead to *misunderstandings*, which in turn enhances the likelihood of complaint escalation. The majority indicated that they regularly hear from healthcare providers that patients from other cultural backgrounds are considered to have unpleasant and demanding communication styles. However, what is frequently forgotten is that in the Netherlands, there are individuals from different cultural backgrounds who do not speak the language fluently. A specific

example that is mentioned a few times is that Turkish people can sometimes seem intimidating to healthcare providers due to their language barriers and differences in communication styles. This, in turn, leads to tension in the patient-primary care provider relationship. The following quote is a reflection of these findings:

> *"Ik merk dan dat mensen die dus niet zo goed de Nederlandse taal machtig zijn die zitten met de commanderen. 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*

Next to the patients' demographic factors, the interviews showed that *the patients' emotions and behaviors* are other aspects that indicate or drive complaint escalation. The majority explained that patients' emotions are negatively impacted when they get the impression of not being heard. The most mentioned emotional responses were threats, screaming, excessive crying, and anger. Another emotional response that is often mentioned by the majority is the need for revenge. Patients who feel mistreated by a healthcare professional or organization may escalate their complaints in order to seek revenge. Such an escalation could result from current dissatisfaction as well as past negative experiences. Another issue that is frequently brought up by the respondents is the possibility that these bad experiences can increase patients' mistrust. The majority highlighted that patients' mistrust greatly impacts the relationship between all the parties involved and contributes to complaint escalation. A specific example that is mentioned by one of the respondents is that there is a great deal of mistrust among Syrian refugees since they are unfamiliar with the Dutch healthcare system. The following statement reflects this example:

> *"En nog een ander voorbeeld daarvan is dat wij mensen uit Syrië hebben gehad, vluchtelingen die helemaal niet een gezondheidszorg op hoog niveau kennen en op het moment dat je dan vertelt: wij gaan dit onderzoeken, wij praten met iedereen en gaan dan op zoek naar waar is de waar, de verbetering mogelijk, dat die dat helemaal niet vertrouwen, dat die dat niet gelooft en dat die zegt: ik wil dat de politie komt, snap je dus niet en dat is gewoon ook het referentiekader vanuit Syrië." – Respondent 4*

Additionally, another aspect that is closely related to patients' emotions is caring. This is an emotion that comes from a strong sense of obligation to look out for the welfare of others. The majority of the respondents indicated that some patients feel the responsibility to protect others from the same negative experience, and are therefore motivated to take further legal steps. Furthermore, the interviews revealed that a change in patients' behavior indicates and contributes to complaint escalation. The majority of respondents noted that when a patient suddenly becomes more formal and changes the tone during conversations, this may be a sign that a complaint is threatening to escalate. Furthermore, detachment

from the process or not showing emotions are also signals of complaint escalation. One respondent made the following statement:

> *"Nee eerder het gebrek aan emoties die er zit niet tonen van enige emotie. Dus enorm afstandelijkheid. Dat zou voor mij. Dat is ook een aanleiding om te zien dat, want dan was iemand in zijn emoties zit, dan kan je, dan kan je iets mee als ze er niet niet tonen, niet willen tonen, wat voor reden dan ook of niet kunnen tonen, dan is de kans op escalatie groter." – Respondent 15*

In addition to patients' emotions that drive complaint escalation, the majority of respondents also indicated that fear results in patients not submitting a complaint or claim. The reason for this is that patients are afraid of concerns about how the patient-primary care provider relationship could be affected. Usually, older individuals have this problem more often than younger individuals. This can be due to the fact that the older generation lived in a time in which it was seen as disrespectful or inappropriate to disagree with a healthcare professional's decisions.

Additional findings and unique perspectives

One respondent revealed an interesting finding, namely that hospitals deal with three types of *language barriers:* not understanding medical terms, not being fluent in the Dutch language, and not knowing how the human body functions. This aspect was later included in the questionnaire as it can impact the complaint escalation process. The majority indicated that all types of language barriers can lead to misunderstandings and increased tension between the patient and healthcare provider, which in turn increases the risk of complaint escalation.

Furthermore, *discrimination* is another aspect that can influence the escalation process. According to the majority of the respondents, discrimination can take various forms in the care context, such as racism and unequal treatment based on personal characteristics. These respondents state that experiencing discrimination can provoke feelings of anger, frustration, and injustice among patients, causing the complaint to escalate.

Additionally, the interviews revealed that there has been a *change in patient behavior* in recent years, with an emphasis on aggression. Many respondents highlighted that patients have become more assertive and dare to make their voices heard more. These individuals become demanding towards the professionals and advise them about the treatments they have to do, even if they lack any medical expertise. The *increased expectations and demands* increase the risk of complaint escalation and are a result of a concept referred to as 'manageability of life'. Patients often compare healthcare to fixing a broken bicycle, emphasizing their belief that their lives are manageable. Those individuals struggle with accepting the possibility of declining health. As a result, they become more demanding, and when there

is a mistake, they are immediately triggered to take further legal steps. One respondent made the following statement:

> *"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*

The last insightful insight observed by almost all respondents is the increase in complaints by patients with *mental health issues*. They claim that this is a result of the expanding mental healthcare issues in the Netherlands. The respondents state that these individuals do not receive the necessary care. These types of patients are usually motivated to file a complaint and talk to someone who actively listens to them. The patient's restlessness has also been linked to mental health issues. The majority of the respondents indicated that in recent years, patients have had less confidence in their care and are therefore more motivated to express their dissatisfaction.

Summary of results

The results of the interviews showed that patient characteristics drive or indicate complaint escalation. These factors are: age, gender, socio-economic status, culture, language barriers, patients' emotions like revenge and mistrust, patients' behavior, increased demands and expectations, and discrimination.

4.5 Characteristics of family members

This paragraph provides information about the characteristics of the patients' family. These characteristics refer to specific attributes or traits of family members who assist in the treatment or support of a patient.

Similarities and differences

The interviews revealed that, in most cases, the patient is the primary complainant. However, it is important to emphasize that family members also have the opportunity to file a complaint and participate in the complaint process. The majority of respondents indicated that healthcare organizations often require a statement of consent from the patient if the family wishes to file a complaint. When questioned about the impact of family members' on complaint escalation, the respondents' opinions were divided. The majority of the respondents believed that family members have an escalating effect on the process, while the remainder said that they can de-escalate the situation. Those respondents explained that family members sometimes make *unrealistic demands* because they do not have the necessary context and

understanding of the medical situation due to late participation. Often out of love for the patient, their participation leads to more conflicts and tensions between family members and healthcare providers. One respondent made the following statement:

> *"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 vind 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*

On the other hand, the minority states that family members can have a de-escalating effect as they can be seen as a *source of support and mediation*. Those respondents explain that patients are strongly involved in an emotionally loaded situation, which can make it harder for them to make the right choices. In this way, family members can support, comfort, and help the patient understand the different stages of the process.

Additional findings and unique perspectives

An unexpected finding from the interviews is that family members can contribute to escalation due to the *absence of a personal relationship with the healthcare professional.* This absence makes them less sensitive to the circumstances and their effects on the treatment plan. As a result, for family members, the threshold for escalating a complaint is lower.

Furthermore, the majority of respondents stated that it is also important to consider the *relationship between the patient and family* in order to determine their influence on the escalation process. There is more risk of complaint escalation when family members are advocating on behalf of their child, elderly parent, or spouse. These respondents noted that they notice gender differences between spouses and children. Husbands feel more responsible, have trouble listening, and communicate more aggressively, while wives, on the contrary, often communicate openly and show more empathy. In the context of children, it became clear that daughters are more likely to react emotionally, and sons behave more arrogantly and impolitely.

Furthermore, a few respondents indicated that it is important to take the family's *cultural background* into account. Especially in non-Western cultures, it is more common for family members to participate in the care process. This arises from deeply rooted family standards of love and care. In these cultures, family members are seen as protectors and are expected to stand up for the patient's interests. One respondent made the following statement:

> *"Het zijn wel typischer klachten met allochtonen en autochtonen bij allochtoon zie je wel vaker dat er een grotere familie achter zit, hè? Dat het meer de wijk cultuur is van de allochtonen, terwijl in de autochtonen, dan komt er een dochter mee of een vader of een man, terwijl allochtonen heb je twee mensen aan tafel zitten, maar dan weet je dat er een hele sliert aan tot in Turkije of Marokko." – Respondent 20*

Lastly, the interview revealed that, in addition to family members, there are other *external influences.* It became clear that sometimes patients base their further actions on the ideas and opinions of acquaintances who are not aware of the context. In addition, television, social media, and the internet can also impact the escalation process. Nowadays, everyone's best friend is Google, and this can hinder the complaint-handling process. These respondents stated that as soon as the patient obtains negative information about the healthcare professional, they become insecure, and this insecurity makes them more likely to take further steps in the process, such as legal proceedings. The following quote reflects these results:

> *"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 of results

Based on the results, it can be assumed that certain factors of family members have an impact on complaint escalation. These factors are a lack of contextual information, the relationship between family members and professionals, cultural background, and the relationship between the patient and family members. Next to family, external influences (e.g., social media, acquaintances, and television) influence complaint escalation.

4.6 Characteristics of complaint-handling experts

This paragraph provides information on the characteristics of complaint-handling experts, specifically complaint officers. These characteristics refer to specific attributes or traits of complaint officers that have an impact on the escalation process.

Similarities and differences

The interviews revealed that there are different ways to handle complaints and claims, including calling, emailing, and scheduling in-person meetings. Although the respondents' opinions differed on the best way to handle complaints, the majority indicated that *non-verbal communication* is lost if a complaint officer relies only on calling or e-mailing. These respondents state that non-verbal communication, such as body language and facial expressions are indicators of possible escalation. As a result, physical

contact and personal communication are essential for effective complaint-handling. It enables the complaint officer to capture and anticipate the non-verbal signals, enabling an immediate response to the patient's needs and concerns. The following quote reflects these results:

> *"Ik vind een fysiek gesprek beter. Kun je het hele non-verbale van alle betrokkenen kun je veel beter observeren en kun je veel beter op reageren .Op het moment dat ik dat heel zakelijk ga benaderen en niet eerst aandacht heb voor die emotie en voor datgene wat die patiënt beschrijft door te zeggen van nou goh wat naar voor u, wat een impact heeft, dit op u weet je wel, meer empathisch en erkennen dat dat die klachten er zijn."* – Respondent 1

When questioned about the *impact of complaint officers* on the complaint-handling process, almost all respondents emphasized their significant influence in either preventing or de-escalating claims. They state that even though there are certain guidelines set by the Care Quality, Complaints, and Disputes Act (WKKGZ), customization is ultimately essential. This is because each patient is unique and may have different expectations and needs. Therefore, a *personalized care approach* results in better communication and connection between the patient and the complaint officer. The remote, purely formal approach to complaints can lead to a lack of recognition and empathy, making the patient feel as if they are not taken seriously. If the complaint officer focuses primarily on dealing with complaints formally, it is likely that the patient's deeper emotions and needs will be ignored. The following statement reflects these findings:

> *"In mijn ervaring leidt een zakelijke manier van patiëntcontact eerder tot escalatie dan de empathische manier. Ik hoop dan ook dat het meer empathisch blijft dan juridisch, aangezien er een trend is dat er meer juridisch opgeleide mensen klachtenfunctionaris worden." – Respondent 18*

In addition, the majority of respondents indicated that the *independence and impartiality* of the complaint officer are important to all stakeholders (e.g., healthcare professionals, patients, and their relatives). This strengthens the confidence of the parties involved and contributes to the fair handling of the complaint. It is of the utmost importance that the complaint officer remain neutral and objective concerning the parties involved during the process. One respondent made the following statement:

> *"Nou, onafhankelijk staat bovenaan en goed kunnen luisteren, maar ook goed kunnen samenvatten wat heb ik gehoord en ik denk heel sterk, ook je kan er een verhaal aanhoren, maar je moet vooral horen: waar zit de pijn, de angel eruit kunnen halen, goed kunnen uitleggen, de informatie, formele informatie Jip en Janneke kunnen overbrengen ja, en ik denk ook gewoon wel rust uitstralen, rustig gesprek kunnen voeren, niet onzeker zijn, maar ook niet als we het dan hebben over narcistisch en vooral niet laten zien dat je het dan maar beter weet, want dat dat kan natuurlijk ook niet." – Respondent 5*

As mentioned before, patients can sometimes *mistrust* their healthcare provider. However, patients can also have mistrust towards the complaint officer. The majority indicated that this mistrust arises because complaint officers are employed by the hospital. In these cases, it is important to clearly explain the role of the complaint officer. This emphasizes the importance of disclosure to remove mistrust of the patient, which leads to another important key skill, namely *being transparent.* According to most respondents, transparency is important because patients are entitled to clear information about the complaint process, possible steps, and expected timelines. In addition, the complaint officer is responsible for properly informing the patient and removing any uncertainties. Another factor that emerged in relation to transparency is *setting boundaries*. The interviews revealed that patients, and especially family members, often have unrealistic expectations about the process, which leads to complaint escalation.

As mentioned before, patients often have the feeling of not being heard. In these cases, the majority of respondents indicated the importance of active listening. This can create an environment in which the patient feels heard and understood. Asking clarifying questions and showing genuine interest promotes effective communication and helps prevent escalation. Another key skill that the vast majority of respondents named was the ability *to ask probing questions.* The complaint officer can better identify the specific concerns and expectations of the patient by going deeper into the details of the complaints. This helps to understand the core of the complaint and enables the complaint officer to choose the right approach and explore potential solutions. Furthermore, nearly all respondents indicated that *analytical thinking* is an essential skill that a complaint officer should possess. To understand complex problems and find appropriate solutions, it is essential to think critically, analyze data, and summarize. Having the ability to think analytically enables the complaint officer to objectively assess the situation, find possible causes, and take the right steps to effectively resolve the claim.

In addition to the aforementioned skills, most respondents emphasized a *proactive approach* to complaint handling. Responding immediately to complaints shows a sense of involvement with the patient. This sense of involvement leads to another key skill, namely empathy. Showing understanding and recognition to the patient can improve the patient's emotional state and build confidence. The complaint officer can offer a supportive and empathic approach by listening to the patient's experiences and feelings. One respondent stated the following:

> *"Als dat niet lukt, bel dan proactief de klachtenfunctionaris en zeg dan weet van: goh, ik heb hier een contact gehad. Dat gaat niet helemaal lekker. Wil je gewoon dus even vrijblijvend contact opnemen en want misschien moet je dat dat ook even aankondigen bij die patiënt van goh. Dat zou een proactieve manier kunnen zijn waarop je ook escalatie in een heel vroeg stadium al voorkomt." – Respondent 4*

Additional findings and unique perspectives

In addition to the above-mentioned skills, there was one that was unique and interesting. One respondent highlighted the significant role of *changing communication styles* at the moment that a complaint is going to escalate. More specifically, the respondent stated that when patients become aggressive, you have to speak gently, which in turn makes the patient more calm because he or she has to focus on what the complaint officer says. The following statement reflects this example:

> *"Kijk op het moment dat iemand echt heel boos is en ik me bijvoorbeeld onprettig zou voelen, dan ga ik steeds zachter praten. Het effect daarvan is dat die ander meer moet gaan luisteren en die wordt vanzelf rustiger." – Respondent 18*

Another interesting finding is that there are *differences in the working methods* of complaint officers with different educational backgrounds. For example, it turned out that lawyers often take a more formalized approach with an emphasis on following rules, while respondents with a medical background take a more personalized approach with an emphasis on empathy. Furthermore, most of these respondents followed a training program to become a complaints officer. However, the majority indicated that this training showed flaws and that most knowledge is acquired in practice. One respondent made the following statement:

> *"Maar ik denk dat als mensen voelen dat je het ook uit integriteit zegt en uit oprechte betrokkenheid, zeg maar dan. Ik heb nog nooit gemerkt dat het niet goed valt, maar ik heb in de opleiding geleerd dat het absoluut niet mag, maar ik doe het gewoon wel, want als het kan helpen dan denk ik ja. Ook een beetje mijn hart erin." – Respondent 6*

Lastly, the majority of respondents emphasized the *well-being of complaint officers* alongside that of patients and healthcare professionals. Sometimes it is difficult to maintain a work-life balance because complaint officers handle situations daily that are both emotional and complicated. An example is when they are dealing with a family member who has a complaint about the death of a loved one. In this situation, there are many emotions involved, and the complaint officer can develop a kind of compassion. These respondents stressed the importance of having supportive colleagues with whom they can consult directly. This makes it possible to share emotional burdens, discuss complex issues, and get different perspectives. As a result, it can be assumed that a collective approach is preferred over an individual approach, as this can contribute to the complaint officer's overall well-being.

Summary of results

To summarize, complaint-handling experts have an influence on the escalation process because they are directly involved. Table 2 shows the frequently mentioned skills that a complaint officer should possess in order to effectively handle complaint-handling processes.

Table 2

Complaint-handling expert skills

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

4.7 Organizational factors

This paragraph provides information about organizational factors. These factors refer to specific aspects within an organization that can influence medical complaint escalation.

Similarities and differences

The interviews revealed that the respondents' perspectives on the importance of organizational factors in the complaint-handling process vary. The *organizational location* is important to include in the analysis, as this reveals the familiarity of healthcare providers with different cultures. The interviews revealed that, compared to urban hospitals, regional hospitals have healthcare providers with less experience with cultural diversity. As mentioned before, these cultural differences may have an impact on the expectations and behaviors of patients. In some regions, it is also less typical to escalate or submit a complaint because patients exhibit greater reluctance. However, there are also regions where patients are more empowered and demanding. As a result, it is important to highlight that the location of the organization does not directly determine or escalate a complaint. Instead, it influences how patients in certain areas express their dissatisfaction. One respondent stated the following:

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

Another factor that was often mentioned during the interviews was the *organization's size.* The majority of the respondents indicated that in larger hospitals, patients may feel lost due to the different layers, and it can be harder for them to be heard. This can make them feel like they are just part of a larger

system and can lead to patient dissatisfaction. Furthermore, in larger hospitals, patients are more likely to experience continuous changes in healthcare providers, which may lead to patient confusion. Additionally, because these healthcare professionals see a variety of patients, they are less likely to recall a patient's name or the specifics of their situation. As a result, it is challenging to provide personalized care, which makes the patient feel unheard or unimportant. One respondent made the following statement:

> *"Maar ik, ik kan me voorstellen voor patiënten dat dat de cultuur van een organisatie zeker van invloed kan zijn. Waardoor een patiënt zich niet gehoord, wellicht voelt of de grootte ervan enorm groot en zich daarin ja zich verloren voelt en al sneller, geïrriteerd of sneller geneigd is om boos te worden of een klacht in te dienen. Ik denk dat dat invloed kan hebben daarop." – Respondent 1*

When questioned about the impact of the *organizational culture* on complaint escalation, the majority indicated that this can have a great impact. According to these respondents, it is important to have a low-threshold at all organizational levels in order to encourage healthcare providers to openly discuss and disclose medical service failures. Furthermore, an organization with a strong hierarchical structure limits communication channels between different departments, which leads to complaints not being communicated effectively and information being lost. Additionally, this structure makes it harder for patients and complaint officers to reach the healthcare professional they need directly, which can extend the handling of complaints. The majority of the respondents indicated that patients' frustration increases if complaints are not addressed quickly, as they have the feeling that they are not taken seriously. According to these respondents, healthcare organizations can solve this in several ways, including informal and personal ways of complaint-handling. However, in practice, this is sometimes difficult as some healthcare organizations incorporate legal departments that handle parts of the complaint-handling process formally. Additionally, the interviews revealed that transparency between employees within an organization may influence the complaint-handling process. An open communication culture in which employees work together to resolve complaints can make a major contribution to preventing complaint escalation.

Additional findings and unique perspectives

Although the complaints committee is no longer mandatory in the Netherlands, most healthcare organizations still have one, which is an interesting finding shared by the majority of respondents. This is done to prevent patients from taking further action and to solve service failures internally within the organization. These respondents claim that when external parties get involved, it is harder to effectively solve a medical service failure. Furthermore, healthcare organizations differ in the *way they handle complaints*, with some having legal departments and others relying solely on complaint officers. The

majority of respondents explained that organizations with legal departments rely more on the formal way of handling complaints compared to organizations without such departments.

An additional finding was that there are different *employee support programs* offered in hospitals to support healthcare professionals. Examples of such programs are peer support, complaint management training, communication training, and introduction sessions on complaint-handling. Within those introductory sessions, it is important to encourage healthcare providers to contact complaint officers when they need further help.

Another additional finding was that *cultural diversity* plays a significant role in healthcare organizations, particularly when it comes to effectively serving patients from various cultural backgrounds. To provide qualitative care, an organization must be able to acknowledge and accept this diversity. For instance, many hospitals have implemented measures to ensure that patients with language barriers are supported. A few examples of measures are the use of interpreters, the translation of brochures, a list of staff members who speak multiple languages, and notes in patient files about language barriers. A unique insight related to cultural diversity is the *inclusion of spiritual caregivers* that some hospitals have implemented. These caregivers are trained to provide spiritual guidance and act as an intermediary between the patients, their relatives, and the healthcare providers. They can effectively communicate and connect with patients and their relatives differently as a result of their knowledge. Patients and their relatives can benefit from their presence by feeling respected and heard. Furthermore, it can help healthcare providers offer care that is sensitive to cultural diversity. Some of these respondents noted that a spiritual caregiver can contribute to de-escalating the situation. However, a lot of respondents said that they believe cultural diversity needs to be given more consideration within healthcare organizations to provide quality care and prevent escalations. One respondent made the following statement:

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

A unique finding from the interviews was that the word 'complaint' should be avoided within the healthcare organization since it has negative connotations. A few respondents highlighted that using more neutral and positive terminology helps to effectively handle the complaint-handling process.

Summary of results

In summary, organizational factors that affect the complaint escalation process include the organization's location, size, and culture; training and support regarding complaints and claims; methods of solving complaints and claims; and recognition of cultural diversity.

4.8 Prevention of complaint escalation and de-escalation techniques

This paragraph provides information about techniques that can be used to de-escalate claims. One noteworthy side note is that, in some cases, these techniques are also useful in preventing an escalation.

Similarities and differences

Different techniques help in the de-escalation of claims. The majority of the respondents indicated that in each case, it is important to understand the patient's objective before applying the appropriate de-escalation technique. As previously mentioned, escalation often arises from patients' feelings of not being heard and taken seriously. The majority indicated that a mediation meeting between the patient, healthcare professional, and complaint officer may help in de-escalation. Additionally, in cases where patients express intense emotions, it is important to acknowledge these emotions, as this contributes to the patient's sense of being heard. Here, having communication skills for both the professional and the complaints officer is an important aspect. Active listening and empathy are examples of these skills. They ensure that patients feel heard and are more willing to engage in conversation with the physician after making a claim anyway. Moreover, the majority of respondents indicated that in circumstances where patients have the feeling of not being treated fairly, it is important to encourage transparency and openness by showing understanding and providing disclosure, especially from the healthcare professional. In these cases, providing comprehensive and understandable information about the service failure can result in de-escalation. The following quote reflects these findings:

> *"Nou ja, wat ik dan natuurlijk wel probeer, is alle betrokkenen bij elkaar te krijgen. En wat ik dan natuurlijk wel als ik het van alle partijen terug hoor is van ja, ja, dat had wel anders gemoeten. En op het moment dat een patiënt of familie van een patiënt dat terug hoort en dus eigenlijk erkenning krijgen voor wat ze gevoeld te hebben, dan zie je eigenlijk vaak wel dat het de-escaleert. Ja." – Respondent 10*

The interviews also revealed that in some cases, de-escalation is challenging or not possible. Examples of such cases are when there has been a (potential) diagnostic error or when the patient has been focused from the beginning on filing a claim. The majority indicated that in these types of cases, it is better to support the patient and provide comprehensive information on the claim process. When the complaint officer tries to avoid these patients through interference, this results in more frustration from the patient. Even though, there are some situations where informal complaint-handling is more effective compared

to legal proceedings. In these situations, it is important to provide open and transparent information about why a complaint is more beneficial than a claim.

Additional findings and unique perspectives

An interesting finding is that during the interviews, it became clear that almost all respondents placed a higher importance on preventing complaint escalation than focusing on de-escalation techniques. The majority of the respondents explained that the role of complaint officers is to take a proactive approach to address complaints quickly. This is more effective compared to the de-escalation of already escalated complaints.

Another unique finding that a few respondents revealed is that de-escalation is challenging when patients have an 'Americanized' perception of healthcare. These patients think that they will get great financial compensation when, in reality, they usually do not. A specific example is that patients sometimes think they will get reimbursements for minor complications, such as a bruise after a blood draw. One respondent made the following statement:

> *"Binnen onze organisatie worstelen wij er ook een beetje mee, enerzijds dat mensen sneller roepen dat ze dat ze hun geld in mensen zijn natuurlijk ook soort van ja gevoed, misschien door de Amerikaanse beeld hè?" – Respondent 11*

Furthermore, the majority of the respondents indicated that culture influences the escalation process, and therefore it is important to recognize cultural diversity as an organization, healthcare professional, and complaint officer. For instance, an additional finding that the interviews revealed was that in some cultures, it is more common to file a claim than a complaint. By providing a proper explanation of how complaints and claims are handled in the Netherlands, de-escalation can occur. In addition, in non-Western cultures, family members are heavily involved in the complaint-handling process. A unique finding that was shared by a few respondents is that when escalation is observed, it is important for a complaints officer to explain that they appreciate that the family is so involved. This appreciation can make both the patient and family members willing to re-engage in conversation. As a result, acknowledging and respecting the role of the family helps to de-escalate the situation. One respondent made the following statement:

> *"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*

Summary of results

To summarize, de-escalation can be difficult in some cases; therefore, most respondents highlight the importance of preventing complaint escalation. However, when de-escalation is an option, the following techniques can be useful: acknowledging and mentioning the patient's emotions; transparency and open communication; providing disclosure about service failure; and recognizing cultural diversity.

Chapter 5: Conclusions and Discussion

This chapter delves into the conclusion and discussion of this study. Conclusions are drawn in order to determine whether the expectations from Chapter 2 have been confirmed or not. Any additional insights that emerged from the interviews are also described. The discussion focuses on the study's theoretical and managerial implications, limitations, and suggestions for further research.

5.1 Conclusions

This study was conducted to answer the following question: *"What are the contributing factors that result in medical complaints escalating into claims, and how can this escalation be prevented?".* As mentioned previously, to answer this question, expectations were made based on existing literature from Chapter 2. In this paragraph, it is determined if the expectations can be confirmed or not, followed by any additional effects for each topic. The evaluation of the expectations is summarized in Table 3 in Appendix 1.

Characteristics of healthcare professionals

The results of this study showed that the characteristics of healthcare professionals have a great impact on the complaint escalation process. Expectation 1 indicated that female healthcare professionals are expected to have a higher risk of escalation than male healthcare professionals. However, the study's results revealed that healthcare professionals' *gender* does not directly impact the escalation of a complaint, which contradicts the findings of Baker et al. (2013), Brooks et al. (2013), and Weycker & Jensen (2000). This indicates that **Expectation 1 is rejected**. In contrast, a professional's gender affects their communication style, with female professionals communicating more effectively on an emotional level when interacting with their patients compared to male professionals. This is in line with the findings of Sloan et al. (1989) and Taragin et al. (1992). Another insight that emerged is that patients have higher expectations of female professionals compared to male professionals. Due to these expectations, patients experience more dissatisfaction and disappointment toward female professionals. Patient dissatisfaction with healthcare professionals increases the risk of complaint escalation, which is in line with the findings of Stelfox et al. (2005). In addition, the professional's *age* does not determine the risk of complaint escalation, which contradicts the findings of Alam et al. (2011) and Azab (2013). These findings suggest the **rejection of Expectation 2,** which predicted that older healthcare professionals have a higher risk of escalation compared to younger professionals. Instead, it influences the professional's communication style and their way of handling complaints. Younger professionals have fewer complaints related to communication compared to older ones due to their educational backgrounds. Another insightful result is that older professionals adopt a more hierarchical approach to complaint handling, which results in arrogance.

Moreover, Expectation 3 predicted that the type of *medical specialty* influences the risk of complaint escalation. Based on the results, **Expectation 3 is confirmed.** Specifically, all types of surgery, gynecology, orthopedics, radiology, and emergency care are more sensitive to complaint escalation compared to other specialties. The study revealed that this higher risk of escalation can be attributed to the discrepancy between patient expectations, the time pressure, and the complex treatments offered by these specialties. These findings are in line with Klemann et al. (2022). However, an interesting finding is that emergency care was only mentioned in a study by Hanganu et al. (2020) in Romania and not earlier in the Netherlands.

Furthermore, based on the findings of Austin et al. (2021), Expectation 4 indicated that healthcare professionals with *previous claims* have a higher risk of future complaint escalation. The study's results did not provide evidence to support this expectation, which means that **Expectation 4 is rejected**. In contrast, the results showed that the disciplinary tribunal creates anxiety for professionals. This fear leads professionals to perform defensive medicine to avoid future complaints or claims, which is in line with the findings of Hanganu and Ioan (2022). It was interesting that the disciplinary tribunal creates fear among healthcare professionals, as this has been understudied in literature. An additional effect is that the *professionals' cultural background* influences their fear of claims. Professionals from countries like Belgium have more fear because, in these countries, complaints and claims are directly disciplinary cases. Another interesting finding was that this fear of professionals is also influenced by their *age*. Younger professionals have more anxiety regarding claims due to the pressure they experience.

The study findings' also showed that professionals can reduce the likelihood of complaint escalation. One way is by providing *open and direct communication*. This includes showing empathy, guidance, involvement, and enlistment. This was also described in the study by McClellan et al. (2012), in which they state that these are key communication skills that a healthcare professional should possess to prevent escalation. As a result, it can be concluded that **Expectation 5 is confirmed**, which indicates that healthcare professionals with good communication skills are less likely to experience complaint escalation compared to professionals with poor communication skills.

Furthermore, Expectation 6 indicated that the risk of escalation is lower when healthcare professionals *disclose service failures* than when they do not. Based on the results, it can be stated that **Expectation 6 is confirmed**. The study's findings revealed that transparency and disclosure help prevent or de-escalate claims. This transparency ensures that patients are more aware of potential complications and that unrealistic expectations are avoided. As a result, providing patients with clear disclosures about medical procedures and service failures makes patients less likely to take further legal steps, as also confirmed by Donn & McDonnell (2012) and Thomassen (2010). One additional effect is that sympathy and apology after a medical service failure help prevent escalation and de-escalation, which contradicts

the findings of Howard et al. (2013) and Lazare (2006). Another additional effect is that when the professional provides personalized care, this diminishes the risk of complaint escalation.

The last factor that prevents complaint escalation is the *patient-primary care provider relationship*. A strong relationship can be characterized by trust and clear communication. This can lead to two parties working together to find solutions regarding medical service failure. This aligns with the findings of Moore et al. (2000), in which the importance of a strong patient-primary care provider relationship is emphasized. However, the study also highlighted the opposite effect, where this relationship can lead to extra disappointment and frustration from the patient, which in turn contributes to complaint escalation. As a result, it can be concluded that **Expectation 7 is partially confirmed**, which stated that a good patient-primary care provider relationship is expected to lower the likelihood of complaint escalation.

Event characteristics

The study's findings showed that certain event characteristics are related to complaint escalation. An important insight is that the *type of complaint* can indicate a greater risk of escalation. More specifically, communication errors more often result in escalation due to misunderstandings between patients and professionals. On the other hand, it appears that when a diagnostic error occurs, it usually results directly in a claim rather than a complaint, which makes it challenging to de-escalate. As a result, it can be concluded that diagnostic errors do not follow the typical path from complaint to claim, and communication errors have a higher risk of complaint escalation. This indicates that **Expectation 8 is rejected**, which points out that diagnostic errors have a higher risk of complaint escalation compared to communication errors. In addition to the type of complaint, the findings also resulted in additional effects that increase the risk of complaint escalation. For example, the *duration of the treatment* has an indirect effect on complaint escalation because it directly influences the patient-primary care provider relationship. Another example is the *duration of the complaint-handling procedure*. When a complaint-handling process takes longer than expected, this can cause frustration and feelings of not being taken seriously by the patient. This, in turn, increases the risk of complaint escalation.

Characteristics of patients

The results showed support for the idea that certain patients' characteristics increase the risk of complaint escalation. Expectation 9 indicated that the patient's *socio-economic status* determines the risk of complaint escalation. Based on the discussed results, it can be stated that **Expectation 9 is rejected.** This also contrasts the findings of McClellan et al. (2012) and Moore et al. (2000). In contrast,

it can be concluded that socio-economic status directly influences a patient's communication style and behaviors. While individuals with higher status come across as threatening, individuals with lower status are often reluctant to engage in mediation interviews.

Furthermore, the results showed that *previous negative experiences* after a medical service failure lead to a higher risk of complaint escalation. Patients experience mistrust after a service failure, which in turn contributes to complaint escalation. This is in line with previous findings by Laarman and Akkermans (2018). This mistrust can lower a patient's threshold for taking further legal action and contribute to complaint escalation. From these findings, it can be concluded that **Expectation 10 is confirmed**, which indicates that patients with previous negative healthcare experiences are more likely to escalate their complaints compared to patients without such experiences.

Based on the results, it can be concluded that there is a higher risk of complaint escalation when patients feel they are not being heard. These feelings in turn have a negative impact on the patients' *emotions*, which either contributes to or indicates complaint escalation. This is in line with Chebat et al. (2005), Gorney (2002), and Howard et al. (2013). Anger and feelings of revenge are two examples of such emotional reactions, as also confirmed by Bousnina and Zaiem (2019) and Chiu (2010). However, not showing emotions and detachment from the process were also described as indicators of escalation. This **partially confirms Expectation 11**, which indicated that patients who express a lot of emotions during the complaint-handling process have a higher risk of complaint escalation compared to patients who do not.

In addition to the above-mentioned factors, the results showed some additional effects that were understudied in the literature. One of these effects is that the patient's *cultural background* has a great indirect impact on the escalation process because it affects the way patients interpret and express their experiences. Furthermore, the study's results indicated that patients' *increased demands and expectations* contribute to complaint escalation. This is caused by the degree of manageability experienced by patients.

Characteristics of family members

According to Expectation 12, there is a higher risk of complaint escalation when family members are involved in the complaint-handling procedure. The study's findings showed that family members have a more escalating than de-escalating effect. However, in some cases they can prevent escalation or stimulate de-escalation as they can support patients and take a mediating role. According to the results, it became clear that it is important to take the *relationship between the patient and family* into account, as this helps in understanding the risk of escalation. Based on the results, it can be concluded that there is a higher risk of complaint escalation when the patient is more vulnerable to the family member, for

example, their child or elderly parent. This is in line with the findings of Hickson et al. (1992), who state that the risk of medical lawsuits is connected to the patient's relationship with his or her family. In addition, due to the *absence of a relationship with the healthcare professionals*, family members are more inclined to file complaints and take further legal action as they are not fearful of the effects of the treatment plan. Another important aspect related to family characteristics is the *family's cultural background.* The study's findings showed that in non-Western cultures, the involvement of family is considered love and caring within the family. When this is not understood, it can increase the likelihood of complaint escalation. To conclude, it can be claimed that **Expectation 12 is partially confirmed.**

In addition to family members, the study also indicated other effects that contribute to complaint escalation: *external influences*, such as television, social media, the internet, and friends or acquaintances of the patient.

Complaint-handling expert characteristics

The limited existing literature made it impossible to formulate specific expectations regarding complaint-handling experts. This is probably because not every country is obligated to have a complaint-handling expert in the healthcare organization. However, during the interviews, it became clear that complaint-handling experts have a great influence on preventing complaint escalation and de-escalation. A few respondents indicated that the professional profile of complaint officers published by the Association of Healthcare Complaints Officers (Panis et al., 2018) is an important source for them. This source shows the various skills that complaint officers should possess to effectively handle complaints. The results of this research showed various skills and competencies that complaint officers should develop to effectively manage complaints. These results are compared to the skills listed in the professional profile to determine whether they are aligned; see Table 4 for this comparison.

It can be concluded that the study revealed some *additional skills* that were not mentioned by Panis et al. (2018). One of these skills is probing questions during conversations with complainants, as this helps to find the angle of the complaint. Another skill is to set boundaries, as they can remove patients' unrealistic expectations. Lastly, the study revealed that it is important to raise awareness about complaint officers among healthcare providers to reduce complaint escalation. This awareness can result in healthcare professionals taking a proactive approach, which leads to the prevention of escalation in the early stages.

Table 4

Comparison complaint officer skills

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

Organizational factors

The impact of organizational factors on complaint escalation has been understudied in the literature. Therefore, there were no specific expectations formulated. However, the findings showed that certain organizational factors may influence the risk of complaint escalation. One of these factors is *organizational size*. In larger organizations, patients may receive less personal attention. Although it can be concluded from the study's findings that a personalized approach is preferred over a one-size-fits-all approach as it lowers the risk of complaint escalation. The preference for personalized care supports the findings of Thomassen (2010). Another factor that increases the risk of complaint escalation is *hierarchy*. This is because, due to high levels of hierarchy, there are more formal relationships between the staff members, and complaints cannot be handled quickly. Furthermore, the *organizational culture* of the organization can contribute to complaint escalation. When the healthcare organization creates a low-threshold environment where healthcare professionals are not anxious to share their perspectives, this can reduce the risk of complaint escalation. Lastly, the *organizational location* does not directly affect the degree of escalation. In contrast, it determines to what extent the organization has to deal with different cultures. From the findings, it can be concluded that in these organizations, it is important to recognize cultural diversity and actively take measures to deal with it.

Overview of factors contributing to escalation

This study's aim was to explore the factors that contribute to the escalation of complaints. The outcomes from the interviews resulted in the identification of different escalation factors and their effects, which are shown in Table 5. Additionally, the table states whether the effect is new in relation to the pre-formulated expectations.

Table 5

Factors contributing to complaint escalation

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

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

Overview of factors contributing to the prevention or de-escalation of claims

In addition to exploring escalation factors, this study also examined prevention strategies. From the study's findings, it can be concluded that certain de-escalation techniques are also useful for preventing escalation. The factors that contribute to the prevention of complaint escalation or the de-escalation of unnecessary claims are clearly outlined in Table 6. In the following paragraph, these factors will be examined in more detail.

Table 6

Overview of the factors influencing claim prevention or de-escalation

Factors that contribute to the 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

This paragraph starts by describing the theoretical and managerial implications. Thereafter, the limitations and suggestions for further research are presented.

5.2.1 Theoretical implications

This study contributes to the literature on service failure and recovery in healthcare in several ways. First, it expands on existing literature by applying concepts from service recovery in healthcare to the unique context of medical complaint escalation in the Netherlands, which has not been explored previously. This adds to the research of Zayer et al. (2015), as it deepens the understanding of service failure and recovery in healthcare. Secondly, the study's findings shed light on how the type of complaint influences complaint escalation. This supports the study by Herhausen et al. (2022), which stated that further research is needed to determine which complaints are more likely to result in claims. Furthermore, the study provides a framework of escalation factors as well as factors that can prevent or de-escalate claims. This framework provides a valuable starting point for future studies on complaint escalation in the healthcare context.

5.2.2 Managerial implications

As explained in the introduction of this study, medical claims have a great impact on different parties, such as the healthcare organization, healthcare professional, and patient. This section provides recommendations on three levels: healthcare organizations, healthcare professionals, and complaint-handling experts. This is because this study aims to provide prevention strategies against complaint escalation for the groups directly involved in these areas. For each of these groups, there is an escalation prevention tool involved that shows several to-dos that help prevent complaint escalation. These tools have been created in Dutch, as this is the primary language used by these individuals. A complete overview of these tools can be found in Appendix 3.

Healthcare organizations

Clear guidelines and procedures. All healthcare organizations, in particular large ones, should have clear guidelines and procedures for filing complaints and claims. By providing patients with clear instructions, accessible information, and guidance in this area, any confusion and frustration can be reduced. As a result, this will decrease the likelihood of complaint escalation.

Open environment. Organizations should foster an open environment where individuals can express themselves freely and feel heard. This will make it easier for patients to express their dissatisfaction and offer feedback. This promotes patient-centered care, where healthcare organizations can get valuable input into areas for improvement.

Decentralized structure. Healthcare organizations should decentralize their hierarchical structure to reduce the likelihood of complaint escalation. The promotion of openness and transparency will improve communication between all employees. Furthermore, a less hierarchical structure may help reduce healthcare professionals' fear of receiving complaints and claims and encourage them to disclose service failures.

Recognition of cultural diversity. To guarantee that all patients receive appropriate care, healthcare organizations must recognize cultural diversity. By ensuring this recognition, patients are more likely to feel appreciated and valued, which increases their satisfaction. This, in turn, prevents complaint escalation.

Providing training programs. As not all healthcare providers have the same skills, healthcare organizations should invest in training programs. These programs may cover (cross-cultural) communication, dealing with complaints and escalation, and cultural differences. By offering these training programs, healthcare organizations can prevent complaint escalation.

Adopt service recovery strategies. Healthcare organizations should provide service recovery strategies in the early stages in order to prevent complaint escalation. An example is a gesture of goodwill, such as a voucher or small gift. It is important to consider the nature and severity of the complaint when deciding on an appropriate gesture. This gesture of goodwill ensures that patients feel valued and are satisfied again with the organization.

Healthcare professional

Proactive approach. As soon as healthcare professionals notice patient dissatisfaction, it is recommended to discuss this with the patient and actively seek solutions. If this does not lead to a good solution and there is still a feeling of dissatisfaction, then it is advised to directly contact the complaints officer. By recognizing dissatisfaction early and dealing with it proactively, healthcare professionals can prevent complaints from escalating into legal proceedings.

Demonstrating empathy. Healthcare professionals are recommended to show empathy, as this makes the patient feel seen and heard. Once the professional pays attention and shows commitment and understanding, this can help build trust between the healthcare professional and the patient. As a result, there will be a lower risk of complaint escalation.

Transparency and disclosure. Transparency and disclosure in medical procedures ensure that patients are better informed about the possible complications, which will reduce unrealistic expectations. In addition, it is important to maintain transparency and disclosure once a patient has filed a complaint. By demonstrating transparency and disclosure, healthcare professionals can recover patient trust and reduce the risk of complaint escalation.

Provide personalized care. It is recommended to provide a patient-centered care approach rather than a one-size-fits-all approach. In this way, patients will feel more valued and understood, which in turn leads to the prevention of complaint escalation.

Recognition of cultural diversity. Healthcare professionals should recognize and respect patients' cultural backgrounds. In this way, healthcare providers can deal with cultural differences and patients' expectations. This results in a higher degree of satisfaction and a lower risk of complaint escalation.

Complaint officer

Setting boundaries. To prevent complaints from escalating, complaints officers are advised to set clear boundaries. Complaints officers should explain what is feasible within the complaint-handling process through open and direct communication. This prevents patients from having unrealistic expectations and reduces the risk of complaint escalation.

Recognition of cultural diversity. In addition to healthcare professionals, complaints officers should also be aware of cultural differences. In this way, they can adapt to the patient's specific needs and decrease the likelihood of complaint escalation.

Involvement of family members. It became clear that family plays an important role in the complaint escalation process. Therefore, it is recommended to involve the family from the beginning in the complaint-handling process. This helps to prevent complaint escalation because they won't miss any contextual information.

Creating awareness. Complaint officers should clarify with healthcare providers the most effective ways to deal with patient dissatisfaction and the procedures for complaint-handling. Increasing awareness helps resolve complaints more effectively and prevents complaint escalation.

5.2.3 Limitations and suggestions of further research

Like any other research, this research has limitations that need to be considered. First, the results of this study are based on second-hand information from complaint-handling experts. However, these experts can be considered a valuable source of information, as they offered rich data through their comprehensive view of the behaviors of patients and healthcare professionals. Although these experts provided valuable insights into the subject, patients and healthcare providers are the main sources of information because they are directly involved in the service failure. Therefore, an interesting area for further research is to explore the perspectives of patients and healthcare providers to see if their experiences are in line with those of the complaint-handling experts. Based on the current study, it is recommended that these insights be gathered from in-depth interviews because they provide more detailed information compared to written questionnaires.

The generalizability of this study is another limitation. As this study was conducted in the Netherlands, the findings may not be applicable to other countries. This is mainly because complaint-handling procedures can differ across countries, for example, due to differences in cultural norms. To address this, future research could focus on gathering information about complaint escalation from countries beyond the Netherlands. These researchers can use the identified escalation factors and prevention strategies to comprehend and address similar issues within their context.

Another limitation was that, due to the time restrictions, it was not possible to determine which escalation factors have a stronger impact on complaint escalation. Future research could conduct a quantitative analysis of the study's findings to address this. This would enable the examination of statistically significant interactions as well as testing the specific effect size of escalation factors.

Lastly, the time restrictions made it impossible to evaluate the effectiveness of the prevention strategies. Future research could address this limitation by assessing this tool's efficacy in preventing complaint escalation and improving the Dutch healthcare system.

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Appendices

Appendix 1: Tables and figures

Figure 1

Patient complaint protocol Netherlands

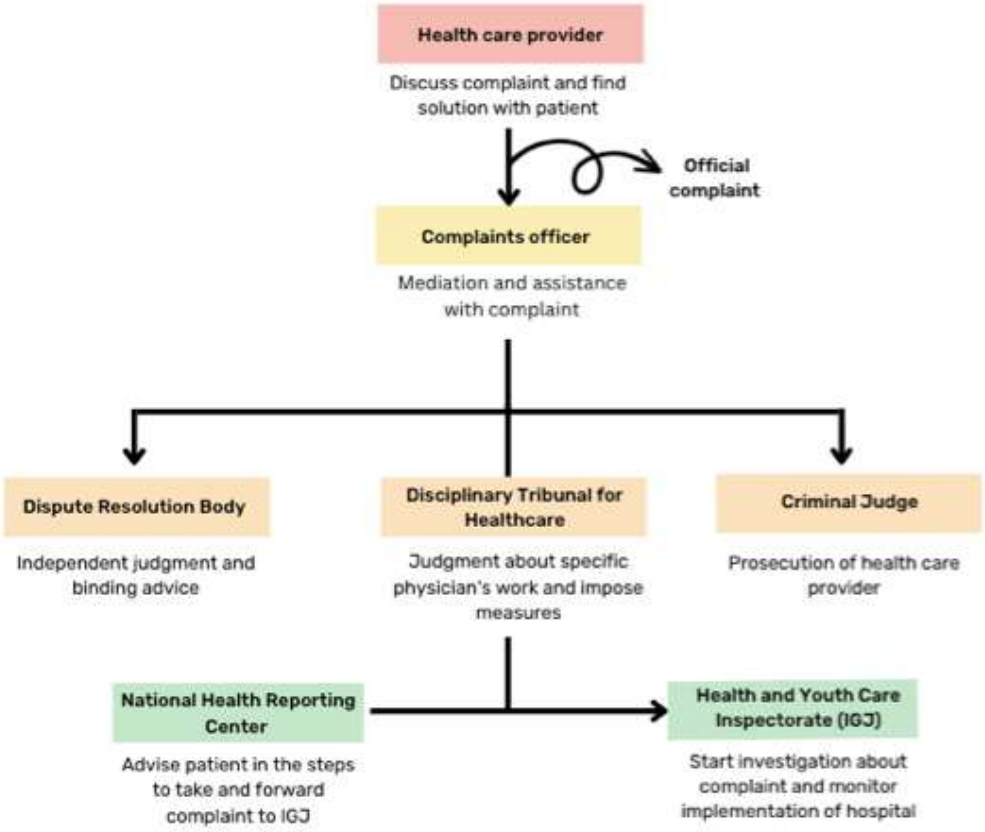

Table 1

Respondent Information

Respondent	Position	Experience	Type of organization
1	Complaints Mediator and Patient Support	5 years	University Medical Center
2	Complaints Officer	16 years	Regional Hospital
3	Complaints Officer	3.,5 years	Top Clinical Hospital
4	Manager Quality and Safety	6 years	Top Clinical Teaching Hospital
5	Complaints Officer	12 years	Top Clinical Teaching Hospital
6	Complaints Officer	4 years	Regional Hospital
7	Complaints Officer	28 years	Regional Hospital
8	Complaints Officer	9 years	Regional Hospital
9	Complaints Officer	2 years	Medical Centre
10	Complaints Officer	15 years	Medical Centre
11	Complaints Officer	3.5 years	Regional Hospital
12	Complaints Officer	4 years	Top Clinical Teaching Hospital
13	Complaints Officer	1,5 years	Regional Hospital
14	Complaints Officer	23 years	Top Clinical Hospital
15	Complaints Officer	1 year	Top Clinical Teaching Hospital
16	Complaints Officer	5 years	Regional Hospital
17	Complaints Officer & Lawyer employment law and privacy	2 years	Regional Hospital
18	Complaints Officer	6 years	Regional Hospital
19	Complaints Officer	7 years	Top Clinical and Week Clinics
20	Complaints Officer	1 year	University Medical Centre
21	Complaints Officer	15 years	University Medical Centre
22	Complaints Officer	14 years	Medical Centre
23	Complaints Officer & Damage contact person & Process Supervisor Incidents	12 years	Regional Hospital
24	Complaints Officer	4 years	Regional Hospital
25	Complaints Officer & Patient Care Staff Member	10 years	Top Clinical Hospital

Table 3

Overview of Expectations

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

Appendix 2: Final template questionnaire

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?

Antwoord op hoofdvraag

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

Slot

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

Op basis van de gegeven antwoorden zullen wij ons onderzoek naar het escaleren van klachten voortzetten. De verzamelde data zal niet gedeeld worden met derden en er zal zorgvuldig mee omgegaan worden. We zullen het transcript van dit gesprek met u delen om er zeker van te zijn dat de gedane

uitspraken overeenkomen met wat door u bedoeld is. Vandaar dat we graag een reactie ontvangen op de inhoud van dit transcript binnen een tijdsbestek van 3 werkdagen na ontvangst. Indien geen reactie gaan we ervan uit dat u het eens bent met de inhoud van het transcript. Zou u het op prijs stellen ook de eindversies van onze scripties te ontvangen? Zo ja, hoe zou u deze willen ontvangen? Zodra het onderzoeksproces is afgerond zullen we uw persoonlijke gegevens verwijderen.

Appendix 3: Escalation prevention tool

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.