DEVELOPMENT AND APPLICATION OF A METHODOLOGY FOR THE EVALUATION OF A HEALTH COMPLAINTS PROCESS

A thesis submitted

by

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to

Faculty of Life and Social Sciences
Swinburne University of Technology

A thesis submitted in partial fulfilment of the requirements for the degree of
Professional Doctorate in Health Psychology

2007
“When complaints are freely heard, deeply considered and speedily reformed, then is the utmost bound of civil liberty attained that wise men look for.”

John Milton

(1608-1674)
ABSTRACT

The aim of the current study was to develop and test a methodology that could be applied to the evaluation of the complaints processes of regulatory bodies of health professionals in Australia including mental health regulatory bodies such as the board that the Council of Australian Governments (COAG) are planning to set up to regulate the psychology profession. The methodology was applied to the evaluation of the complaints process at the Office of the Health Services Commissioner of Victoria (HSC). There were four main research questions. The first research question related to the extent to which the methodology was able to determine how well the HSC was performing in their role of resolving health complaints. The second research question explored the implications of the findings of the evaluation of the HSC complaints process for the management of health complaints in general. The third research question related to the strengths and limitations of the methodology when applied in a practical setting and the final research question related to further improvement of the methodology for future applications. Questionnaires and telephone interviews were used to examine the experiences of 133 providers and 150 complainants whose complaints had been reviewed and closed in one year. The methodology proved successful in assessing the performance of the complaints process at the HSC. The findings of the evaluation indicated that complainants and providers were generally satisfied with the process by which their complaints were managed. However, they were in general less satisfied with the outcome. In particular the evaluation highlighted the unintended negative consequences that complaints processes can have on the complainants and respondents. It was concluded that these maladaptive behavioural responses to complaints most probably
have their origins in the negative emotional overlay attached to health complaints which has the potential to lead to unrealistic expectations of the process and outcomes on the part of complainants, and maladaptive post-complaint practices for health service providers. The findings highlight the importance of providing advocacy and support for the parties involved in health complaints as a means of minimising these maladaptive responses. Finally, it is acknowledged that these findings are specific to Australian health regulatory systems.
Acknowledgements

I have been extremely fortunate to have had such a wonderful support team. Associate Professor Ann Knowles has been a superb supervisor. She has been generous to a fault with her time and expertise. Without her wisdom, tireless patience and unwavering belief that I could ‘get the job done’, I think that I would still be trudging along now. Sincere thanks Ann, you have been an inspiration and a fabulous mentor.

I also wish to thank my second supervisor, Dr Elizabeth Hardie for her early assistance with getting my proposal up and running and for her insightful feedback on my final draft. Professor Sue Moore with her vast knowledge, experience and generosity of spirit has also been a fabulous resource for me.

Thanks also go to Meredith Rayner, friend, co-student and now colleague. Together we cajoled, comforted and dragged each other over the line, even when it felt like swimming through wet concrete. At last we will get to wear those red caps together! To Dr Lorraine Fleckhammer and Alison Dews, thanks not only for your ‘editorial support’, but also for all those times you encouraged me to keep going. Thanks also go to Helen Rayner for her supreme mastery of MS-Word and editorial skill.

Thank you to all the staff at the Office of the Health Services Commissioner, Beth Wilson, Pam Gilbert and Lyn Griffin, who provided me with the opportunity to conduct my research and willingly shared their knowledge and experience.

Of course without the loving support of my family this thesis would never have got off the ground. My parents have supported me from undergraduate, through the doctoral process in ways too numerous to count. They have been babysitters, homework supervisors, chefs, taxi drivers, financiers, motivators, proof readers and
most of all loving parents and grandparents. When you think a document is done, Dad can always find that extra typo!

My loving thanks also go to my kids, Aaron and Caitlan, who have seen more of the inside of university libraries than any other children I know, and who do not know a life without their mother studying - I’m back.

Above all I would like to thank my partner David. He was hurled into my study part way through and has willingly and wholeheartedly taken on the role of partner, best friend and step dad. Over the past few years David has provided me with unwavering support and encouragement. His generosity overwhelms me.

Finally I would like to thank the participants, who gave their time so freely and generously to talk to me about these very sensitive issues.

Someone I love once told me that finishing a thesis is a bit like walking the Kokoda Trail, trudging upwards one step at a time. This is my Kokoda Trail.
Declaration of originality

This thesis contains no material which has been accepted for the award of any other degree or diploma in any University, except where due reference is made in the text of the thesis. To the best of my knowledge this thesis contains no material previously published or written by another person except where due reference is made in the text of the thesis. I further declare that the ethical principles of the Australian Psychological Society in relation to research have been observed.

Naomi Hackworth

Date:
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Chapter 1: Public Perceptions and Expectations of the Health Professions.

1.1 Introduction and Overview of Chapter

The delivery of health services occurs within a context that includes the current economic and scientific paradigms, societal perceptions of health, illness, and health professionals’ and clients’ expectations of the health services they receive. Within the current Australian social climate there is an increasing demand for health practitioners to practice in a transparent manner and to be accountable for the outcomes of the services they deliver (Finlayson & Dewar, 2001; Hunter, 1994). This has been accompanied by a corresponding increase in the tendency for clients to complain when confronted with negative outcomes from health services, and for health services to use the content and outcomes of those complaints to improve the quality of service delivery (Kmietowicz, 2001; Neuberger, 2000). However, if complaints are to be used as a source of evidence of how best to improve the quality of service, then it is imperative to evaluate the efficacy of the complaints mechanisms, to ensure that decisions made regarding service improvement have a sound evidential basis. The current study aimed to develop and test a methodology that could be applied to the evaluation of the complaints processes of regulatory bodies of health professionals in Australia including mental health regulatory bodies such as the board the Council of Australian Governments (COAG) are planning to set up to regulate the psychology profession (Australian Psychological Society; APS, 2007).

The following chapter considers the importance of the context in which health services are delivered to public perceptions and expectations of health service providers. It reviews changes in public perceptions of the health professions over the last 20 years and discusses factors both internal and external to the health arena that
have influenced public expectations of health professionals and the manner in which
the Australian public expect health services to be delivered. In doing so it provides a
contextual framework for the development of the current evaluation methodology and
highlights the need to ground the evaluation in original data from the people with first
hand experience of the complaints handling process, that is, the complainants and the
practitioners.

The literature reviewed in Section 1.2 examines changes in societal
perceptions and expectations of health professionals. Section 1.2.1 considers factors
internal to the health arena, that have impacted on the public perception and
expectations of health professionals, such as the economic paradigm and the scientific
paradigm. Section 1.2.2 explores factors external to the health arena that have
impacted on public perceptions and expectations of health professionals, such as
developments in education and technology, the influence of the mass media and the
emergence of health consumer advocacy organisations and client charters.

The literature reviewed in Section 1.3 explores the nature and causes of
adverse medical events, including those events that have their origins in individual
error and those that result from systemic failure. Section 1.4 documents the
mechanisms currently available for resolving health complaints in Australia. Section
1.4.1 considers traditional mechanisms for handling health complaints through
litigation or registration boards, while Section 1.4.2 documents the more recent
approach to complaint resolution of Alternative Dispute Resolution (ADR). This
review of the literature is summarised and utilised to provide a contextual framework
for the current evaluation in Section 1.5.
1.2 The Nature and Background of the Health Professions

Historically the public perception of medical professionals in western society has been one of esteem, largely due to their specialist knowledge, their professional status, their income and the social and political power that these factors afforded them (Kelleher, Gabe & Williams, 1994). Throughout the twentieth century this perception was further enhanced by the fact that doctors became the gatekeepers to pharmaceutical products, certain medical technologies and specialist medical services (Giddings, 1993; Kelleher et al., 1994).

In the latter part of the twentieth century, allied health professions such as psychologists, physiotherapists and speech therapists also experienced a trend towards professionalism through the establishment of statutory regulatory bodies or representative professional organisations. These regulatory bodies were responsible for setting standards of practice and raising the level of training required of their membership. In turn, this heightened level of professionalism led to an elevation of the public perceptions of the allied health professionals that put them on a par with medical practitioners (Saks, 1994). Despite the influence and support of regulatory and professional organisations, in the 1980s and 1990s, forces from both within and external to the health arena led to a fundamental shift in the manner in which health services are delivered. This has subsequently had a follow-on effect on the perceptions and expectations that the general public has of health professionals (Garfinkel & Dorian, 2000; Kelleher et al., 1994).

1.2.1 Internal Factors Impacting on Public Perceptions of Health Professionals

A number of changes within the health sector have impacted on the public perceptions of health professionals. Such changes include a fundamental shift in the economic and scientific paradigms in which health services are delivered.
1.2.1.1 Shift in economic paradigm. In the 1990s, as part of an overarching shift in the western economic paradigm, there was a shift in emphasis of health service delivery towards a neo-liberal framework with a focus on productivity, the effective use of resources, cost effectiveness, and an emphasis on outcomes and quality (Coulter, 2004; Nancarrow & Borthwick, 2005). This was accompanied by a concomitant promotion of the users of health services as consumers of health services, rather than as passive recipients of services, and an emphasis on client choice (Baum, 1998; Garfinkel & Dorian, 2000; Hancock, 1999b; Hunter, 1994). The trend towards a more consumerist approach to health service delivery has impacted on the fundamental nature of the therapeutic relationship, transforming it to one that is better represented as a customer–provider relationship than as the traditional hierarchical doctor-patient relationship. Subsequently this has impacted on the expectations that clients have of their health service providers, and the process and outcomes of health service delivery including greater expectations of efficiency, effectiveness and quality of service (Garfinkel & Dorian, 2000; Nancarrow & Borthwick, 2005).

The change in paradigm has also led to a shift in expectations as to how health services should be administered, delivered, and regulated. The proportion of health practitioners in independent private practice is decreasing, while third party payment for health services is becoming more common. This necessarily impacts on the expectations that health service users have about the nature of the services they receive, how those services will be regulated. This in turn leads to an expectation that health professionals and the health professions will demonstrate both individual and systemic accountability (Garfinkel & Dorian, 2000).
1.2.1.2 *Shifts in the scientific paradigm.* The general shift towards consumerism in contemporary western society has also manifested itself in an increasing public concern with individual autonomy. In the health sector this has been reflected in an emphasis on patient choice. The rationale behind increased patient choice is that if patients are empowered to make decisions regarding the nature and substance of their own health care, then the overall quality of service will improve. The improvement will arise due to providers being motivated to retain clients by developing and adhering to explicit standards of health care provision, measuring their performance, and being accountable for their decisions and the outcomes of the services they provide. If providers do not do this, then according to the patient choice rationale, clients would choose to go elsewhere for their treatment (Coulter, 2004; Finlayson & Dewar, 2001; Hunter, 1994). Within this framework health service regulatory bodies have begun to operate within a scientific paradigm, through which performance can be assessed, that incorporates evidence-based clinical guidelines, a greater emphasis on accountability and evaluation of the process and outcomes of health services.

The concept of evidence-based practice originated within the framework of medicine and is the trend towards attempting to improve patient outcomes by transferring the knowledge gained through research into the development of empirically based treatments (McCabe, 2004; Straus & McAlister, 2000; Wampold & Bhati, 2004). Evidence based practice is therefore typically applied as a top-down approach where research findings about treatment outcomes are used to inform practice (Charman & Barkham, 2005).

There have generally been two streams of evidence used to inform practice, efficacy research and effectiveness research. Efficacy research looks at the efficacy
of a given treatment under highly controlled conditions. The source of evidence is usually randomised controlled trials where participants are randomly allocated either to an intervention or a placebo/alternative treatment control group and outcomes are compared across the groups (Lambert, 2001). Randomised controlled trials have high internal validity but, outside of drug research, are limited in their generalisability due to the level of control of extraneous variables.

Effectiveness research on the other hand assesses the outcomes of treatments when they are delivered in a naturalistic environment. Effectiveness research is often used to compliment efficacy research as it explores the ecological validity of the treatment, with the two coming together to provide an evidential basis for best practice (Lambert, 2001).

There are conflicting views as to the role of evidence-based practice in the improvement of the quality of service. A number of authors have documented the strengths and limitations of evidence based practice (see Chambless & Ollendick, 2001; Charman & Barkham, 2005; Deegar & Lawson, 2000; Nathan, 1998; Straus & McAlister, 2000 for reviews). Evidence based practice has been reported to facilitate training and research, increase accountability and be a more consistent and objective approach to patient care (Deegar & Lawson, 2000). However, it has also been argued that the shortage of rigorous scientific evidence upon which to base clinical decisions places serious limitations on the development of empirical based practices. Even when the evidence is available, studies often have conflicting or confusing findings, thereby making it difficult for health professionals who may have limited training in the critical evaluation of research to interpret and use as a basis for their judgments (Straus & McAlister, 2000).
Particular concerns have been raised about the use of clinical guidelines developed through the principles of evidence-based practice in the practice of psychology. Consistently in the United States, and increasingly in Australia, the organisations responsible for the funding of mental health treatments have developed clinical guidelines as to the nature and duration of therapy. The use of these guidelines is often directly linked to remuneration. Recently a number of task forces in the United States and United Kingdom were commissioned to identify empirically supported treatments and investigate the utility of evidence based clinical guidelines. In reviews of American Psychological Association task force recommendations regarding evidence-based practice in psychotherapy, it was found that in determining efficacy of treatments, task forces generally afforded greater weight to evidence from efficacy research (randomised controlled trials), than to effectiveness research which tended to be considered as supplementary evidence of outcomes (Chambless & Ollendick, 2001; Jackson, 2005). Chambless and Ollendick argued that the heavy reliance on randomised controlled trials limits the external validity of the clinical guidelines. In randomised controlled trials of psychological treatments, participants are usually not randomly selected. Trials usually have strict inclusion criteria which aim to control for extraneous variables thereby maximising the internal validity of the findings (Chambless & Ollendick; Charman & Barkham, 2005). This emphasis on internal controls however comes at the expense of external validity, as outcomes may not generalise well to the ‘real world’ of therapy, where non-specific factors such as the therapeutic alliance and clinical judgment factors have been shown to account for the majority of the variance in treatment outcomes (Edwards, Dattio & Bromley, 2004; Messer, 2004; Nathan, 1998).
Lambert (2001) argues that while effectiveness research narrows the gap between experimental conditions and the ‘real world’, the evidence is still only based on group means and there remains a problem with generalisability to individual client practice. Lambert therefore argues that a more patient-focused paradigm is required to inform practice. A patient focused paradigm seeks to find empirical evidence to improve outcomes for individual clients. It is a bottom-up approach with a quality assurance focus and considers individual feedback from patients and clinicians as an important source of outcome evidence in the quest to achieve improvement in the quality of care (Lambert). Lambert argues that a patient focused approach allows an increased emphasis on the individual consumer in the mental health industry.

It has therefore been argued that evidence based practice needs to be supplemented with practice-based evidence, a bottom up approach where best practice is also informed by clinical experience (Charman & Barkham, 2005; Lambert, 2001). For example, an impediment to evidence-based practice in the area of psychology in Australia has been the variation in training criteria for registration and practice. In Australia registration can be achieved through multiple pathways (Helmes & Pachana, 2006; Martin, 1996). It should be noted that the Australian Government is currently setting up a commonwealth body to review these issues (APS, 2007).

Despite conflicting views about the worthiness of current evidence-based guidelines, most theorists are in agreement that practice guidelines, developed on the basis of empirical evidence, are increasingly being used by regulatory bodies to make recommendations and judgments about the standard of care provided (Nathan, 1998). To maximise the utility of evidence based health care, one therefore needs to be able to measure the outcomes and evaluate the process through which decisions and
recommendations are being made (McCabe, 2004). Evaluation is therefore the cornerstone of the effective application of evidence-based practice.

1.2.2 External Challenges to the Public Perception of Health Professionals

In addition to the abovementioned internal challenges, in recent decades there have been a number of factors external to the health arena, which have impacted on public perceptions and expectations of health professionals. These changes in societal beliefs and expectations of healthcare providers have occurred within the context of changes to cultural beliefs about health and illness, an increasingly informed public through education, the mass media and through rapidly developing information technology such as the Internet, and the emergence of health consumer advocacy organisations and regulatory systems (Nancarrow & Borthwick, 2005).

1.2.2.1 Changes to cultural conceptions of health and illness. Individual experiences and perceptions of health service encounters also occur within a broader context of societal perceptions of health and illness. The distinction between health and illness is often not clear, rather health and illness occur along a continuum with a lack of clarity as to where health ends and illness begins. Health status is therefore subjective and to an extent culturally defined (Baum, Gatchel & Krantz, 1997).

Historically the concept of health has been perceived within a medical framework as an absence of illness or disease. However, as medical science has provided effective treatments and/or cures for many diseases, the normative western conceptualisation of health has evolved from a physical definition to a biopsychosocial definition, incorporating physical, social and psychological aspects. Health and illness are now conceptualised more holistically with an emphasis on well-being, rather than purely physical functioning (Baum, 2001; Baum et.al., 1997). Given that the view of health and illness has changed over time it stands to reason
that the changing views will also have an impact on perceptions and expectations of health services and health outcomes.

1.2.2.2 Developments in education. Throughout the past century the Australian population has become increasingly educated, literate and articulate, with a large proportion of the population between the ages of 15 and 25 continuing on to post-compulsory education. In the decade from 1992 to 2002, the proportion of males with a Bachelor Degree or higher increased by 6% to 17%, and the proportion of females with a Bachelor Degree or higher increased by 10.2% to 18.5% (ABS, 2004; Department of Education & Training, 2004). Higher levels of training and education mean that individuals are more than ever in a position to be better informed and to more easily access resources and understand information pertaining to their health choices and therefore assess the quality of care they receive.

1.2.2.3 Technological advances. The 1990’s also saw major technological advances including the emergence of the Internet, which allowed access to information on a vast scale. A survey conducted by the Australian Bureau of Statistics of 3200 adults randomly selected from households, revealed that over half of the households (56%) had access to a computer at home (ABS, 2000). Extrapolating from these data, the ABS concluded that Australia wide, approximately 2.7 million households have access to the Internet. This increased Internet access has meant that people now have access to a wide range of information on a global scale. The abundance of official and unofficial health related sites on the World Wide Web means that the public have access to health related information in a way that they never have before, thereby decreasing the knowledge differential between practitioner and client and placing clients in a much better position to advocate for themselves and influence their own health choices (Garfinkel & Dorian, 2000).
In a national survey of 1050 physicians across the United States, Murray et al. (2003) found that approximately 85% of physicians reported that they had experienced clients bringing in information from the Internet to discuss in relation to their treatment. Furthermore the physicians reported that the information produced had mixed value with some recommendations being accurate and appropriate for inclusion in treatment plans and other information being inaccurate and inappropriate. In addition, physicians reported feeling pressured to acquiesce to the requests from clients generated from information retrieved from the Internet, even when it was clear that this was not the most appropriate treatment. Physicians reported that the greatest pressure to adopt inappropriate Internet generated treatments was concerns for the physician – patient relationship should they deny the patient’s request (Murray et al.).

1.2.2.4 The mass media. The mass media has also played an important role in perceptions of health practitioners and health practices. The positive role of the mass media in the facilitation of health promotion activities is well documented (Bury & Gabe, 1994). However, the mass media has, in recent years, increasingly presented a challenging view of the health professions, both in terms of their professional stature and in terms of their professional practice.

Karpf (1988) in an analysis of the portrayal of medical professionals in television programming, found that television presents an increasingly challenging view of medical professionals. Karpf found that where in the 1950s and 1960s health professionals were presented in television programming as heroic and infallible figures, in the 1980s there was a trend towards the representation of health practitioners as more realistic and fallible people. Pirkis, Blood, Francis and McCallum (2006), in a review of the literature on the representation of mental illness and mental health practitioners in popular viewing, found that on-screen portrayals of
mental illness are generally negative and non-representative. Furthermore, Pirkis and
colleagues found that this misrepresentation often results in a negative public
perception of therapists and providers of mental health care, and a decreased
likelihood that people will seek help for psychological difficulties if they require it.

A second area in which the media present a challenging view of health
professionals is in the reporting of health issues and research in the media (Bury &
Gabe, 1994; Kline, 2006; Karpf, 1988; McCall, 1988; Millenson, 2002). Millenson
(2002), in a recent review of journalist reports of medical errors, argued that while
medical errors are in general under-reported in scientific publications, medical errors
and the issue of patient safety has had an increasing emphasis in the popular press.
Similarly McCall (1988), in a review of literature regarding the interaction between
scientists and journalists, and in particular the reporting of psychological research
findings in the media, concluded that press coverage of the social and behavioural
sciences tended to be less accurate than reporting of the hard core sciences. McCall
argues that this is at least in part due to the fact that social science research is less
likely to be covered by trained scientific reporters because they are perceived as being
‘common interest’ topics. MCall holds that this leads to an increased vulnerability to
misrepresentation or mistranslation of psychological information in the media. Thus
there is evidence to suggest that through the media, people are now encouraged to
question the medical dominance that was once taken for granted.

1.2.2.5 Health consumer advocacy organisations. In Australia the shift
towards the customer focus of health care has also been reflected in the emergence of
health consumer advocacy organisations. Bodies such as the Consumers’ Health
Forum of Australia (CHF) and the Health Issues Centre (HIC), that lobby for and
provide a voice for health consumers, are two manifestations of the trend toward a
more consumerist attitude to health provision. (CHF, 2004; Hancock;1999; HIC, 2002). The CHF is an organisation which comprises a number of health consumer representative groups. The CHF provides input into national health issues through the nomination and support of consumer representatives on government, industry and professional committees. They also lobby for health consumer rights through publications and media releases. Whilst the CHF are not an advocate for individual health consumers, they have successfully advocated for and supported the establishment of formal complaints mechanisms in all states and territories in Australia (CHF, 2004). Like the CHF, the HIC is a non-government organisation that provides resources for health consumers. They provide an extensive resource library in the areas of medical research and the quality and safety of health care, and lobby in various public forums for a more equitable health service (HIC, 2004).

In addition to the emergence of health lobby organisations, there has been a trend towards the development of health charters and charters of patient rights by both public and private institutions (CHF, 2004; Department of Human Services South Australia, 2001; Graham, 2001). For example both the Psychologists Registration Board of Victoria (PRBV) and the Australian Psychological Society (APS) have published Charters for the recipients of psychological services (APS, 2005; PRBV, 2006). These charters inform clients what they can expect from their psychologist in terms of trust and fair treatment; information and communication; and financial arrangements. They also present clients with an avenue through which to direct any concerns or complaints (APS, 2005; PRBV, 2006). Such charters clearly define the rights and responsibilities of the recipients and providers of health services and, as such, have reinforced the status of health service users as autonomous consumers.
The paradigm shifts outlined above, taken together, have contributed to an increasing pressure on health professionals to practice in a transparent way and to be accountable for their professional behaviour, decisions and the resultant outcomes. It has been argued that these factors have contributed, at least in part, to the recent increase in the propensity for health service users to complain when confronted with negative outcomes from medical procedures (Kelleher et al., 1994; Kimietowicz, 2001; Neuberger, 2000).

1.3 Adverse Outcomes of Medical Procedures

While the increase in training and technology has provided more prolific and effective interventions or treatment options for clients of health professionals, this has often come at the cost of an increased risk of adverse consequences in the form of physical or psychological injury (Millenson, 2002). According to Leape (1994) medical errors manifest themselves in one of two ways, as either errors of omission or errors of commission on the part of the health practitioner. Such errors result in the desired intervention outcome not being achieved, or in some form of adverse outcome for the client. Leape argues that reported adverse outcomes reflect only a small proportion of actual errors, as many errors do not result in physical or psychological injury to the client. While errors in the hospital or medical field are well documented (see Leape, 1994 for a review) there is little documentation of the incidence of physical or psychological injury in the allied health and alternative health professions.

Negative outcomes from health interventions may arise in a number of ways and situations, some of which are potentially avoidable and some of which are not. Lawton and Parker (2002) argue that there are two types of errors which potentially occur in the health arena, proactive errors and latent errors. Proactive errors are individual errors or mistakes, which are the direct fault of the person interacting with
the client. According to cognitive theory, most errors arise from aberrations in the professional’s cognitive processes (Leape, 1994). Latent errors, on the other hand, are errors that do not result from individual failures, but are systemic errors that occur as a result of the designated process or are related to management errors. Lawton and Parker (2002) argue that latent errors are not as obvious as pro-active errors and therefore often go unnoticed.

Historically little research attention has been devoted to the unintended physical or psychological injury resulting from health interventions and until recently there has been no rigorous exploration of the approach necessary to reduce risk to patients based on analysing and learning from the errors and adverse events that occur (United Kindom Department of Health, 2002). This is reflected in the dearth of research-based literature in relation to resolving and learning from the negative consequences of health interventions. In the last decade however, the issue of patient safety, medical error, patient complaints and the reporting of adverse consequences of health interventions has begun to attract a higher profile and thus become a high priority in legislative and health care systems around the world (Giddings, 1993).

Across the globe new ways are being developed to consider the impact of adverse outcomes of medical procedures. Mechanisms to handle health complaints have been developed that go beyond the traditional adversarial system and seek to not only resolve complaints but also to serve a quality improvement function.

### 1.4 Mechanisms for Resolving Health Complaints

#### 1.4.1 Traditional Means of Handling Health Complaints

In the past a wide range of methods have been used to attempt to resolve disputes between patients and their health practitioners. These have included formal investigations, reviews, internal and external inquiries and litigation. Until the last
decade however, there has been little consistency in the handling of, or the responses
to, patients’ complaints (Wilson, 1999).

Traditionally complaint resolution has focused on a top down or big stick
approach meaning that complaint resolution is directed towards the individual
provider and his/her errors rather than to the systemic problems which may lead to
ersors. Thus there has been little focus on service improvement or development
(Cornwall & Romnios, 2004; Wilson, 1999). Prior to 1984 the most common avenue
for patients to address complaints against their health care provider in Australia was
through the legal system or through professional registration boards.

1.4.1.1 Litigation as a tool for complaints resolution. The oldest form of
redress available to dissatisfied patients is the tort system (Dingwell, 1994). Tort law
rests on the premise that members of society have a duty of care to one another,
including the responsibility to take all steps necessary to avoid harming or injuring
each other. If someone fails in their duty of care, resulting in physical or
psychological injury, then the premise is that they should be liable for compensation
to the victim in order to restore them to their previous condition (Dingwell, 1994). It
has been suggested that a secondary function of the tort system is to assist the
respondents to internalise the consequences of their errors and to ensure that the
problem does not arise again (Dauer & Marcus, 1997).

Litigation is a lengthy and expensive process. It is not uncommon for
complaints to take years to resolve and resolution often occurs at great personal and
financial cost to all parties (Dauer & Marcus, 1997; Kessler & McClellan, 1997;
Morgan, Whorton & Zink, 1995; Wilson, 1999). Furthermore, there is evidence that,
even when the complainant is successful in their litigation, they may end up with
considerable financial liabilities resulting from the case (Kessler & McClellan; Wilson, 1998, 1999).

The adversarial nature of the legal system and the strategies used by litigants such as case law and legal opinion can often result in increasing the complexity and conflict rather than easing the resolution of the situation at hand (Bennett, 2001). The adversarial nature of litigation also makes the use of complaints for service improvement difficult. Duaer and Marcus (1997) argue that the litigation approach to resolving medical errors focuses on outliers (individual aberrant practitioners) rather than the systemic issues that led to the errors in the first place. This limits the usefulness of the outcomes in promoting a general improvement in health service delivery.

1.4.1.2 Registration boards as a tool to resolve health complaints. Prior to 1984 the only alternative to litigation for disenchanted health service users was to lodge complaints about registered practitioners with the relevant registration board, such as the Medical Registration Board. However, these boards were often viewed by service users as lacking impartiality and accessibility and furthermore failed to provide any method of redress for individuals with complaints against unregistered providers (Wilson, 1999).

Recently there has been recognition that the analysing of medical errors and adverse consequences of medical procedures is an essential element of improving professional practice and reducing future risk to patients (Mulcahy, 2003; Paterson, 2002; Wilson, 1999). Governments in a number of countries have responded to these concerns with the formation of a range of government bodies whose responsibility it is to receive and investigate health complaints (Daniel, Burn & Horonik, 1999). In Australia bodies for the handling of health complaints have been formed under the
auspices of the relevant health departments and in some cases afforded statutory
independence (Daniel et al., 1999; Gurley, 1997). The structure, power and authority
of these organisations varies from state to state, however the overarching goal of all
these organisations is to resolve health complaints using Alternative Dispute
Resolution techniques.

1.4.2 Alternative Dispute Resolution (ADR)

ADR as applied to the resolution of health complaints, constitutes a range of
dispute resolution processes including mediation and conciliation which act as
supplements for, or alternatives to, the traditional adversarial system of litigation
(Astor & Chinkin, 2002). Mediation is a process that involves an objective third
party mediator who acts as an impartial facilitator and assists parties in a neutral way
to reach a mutually agreed upon resolution. Throughout mediation the mediator uses
neutral, clarification-type questions and open-ended invitations to encourage parties
to isolate the core aspects of the dispute and come to a mutually agreed upon
resolution (Astor & Chinkin, 2002; Jacobs & Aakhus, 2002). Conciliation is a
similar process to mediation, however the conciliator typically plays a more active,
advisory role in the dispute resolution. As in mediation, the conciliator is a neutral
third party who assists disputing parties to identify the core issues, however the
conciliator also plays an active role in assisting them to develop options and make a
decision regarding a fair and appropriate resolution and may encourage participants to
reach a particular agreement (Astor & Chinkin, 2002).

ADR techniques have a number of advantages over adversarial processes.
First, both mediation and conciliation are non-adversarial approaches and foster an
environment of mutual agreement rather than escalating the dispute. They therefore
provide the opportunity for a win-win resolution. They also have the potential to
restore relationships between parties, which is especially important in the health arena where a person may want to continue to seek services from their health service provider. Unlike litigation that has its focus on individual error, conciliation and mediation have the potential to explore the systemic issues that surround practitioner error and therefore to impact on the improvement of overall service quality, thus resulting in a greater likelihood that errors will not occur again (Dauer & Marcus, 1997; Jacobs & Aakhus, 2002).

ADR strategies are usually less costly and therefore more accessible than litigation. Conflict resolution via these strategies also usually occurs in a much quicker time frame than the legal counterpart. Research evidence suggests that time frame is important to effective complaints resolution and that resolution is most successful when resolution occurs quickly (Estalani, 2000; Smith 1998). The resolution of health complaints by ADR also means that the dispute may be kept confidential, as most bodies charged with the resolution of health complaints work within a privileged framework (Carver & Vondra, 1994; Gurley, 1997; Smith, 1998; Wilson, 1999).

There are however some disadvantages to the use of mediation and conciliation to resolve health complaints. Mediation and conciliation by their nature are voluntary processes, and therefore may not be suitable or agreeable to all parties (Metzloff, Peeples & Harris, 1997). However the avoidance of litigation and the liabilities and personal cost that go with it, and the opportunity to resolve complaints in a safe and less adversarial environment offer significant incentives to participate (Dauer & Marcus, 1997; Metzloff et al., 1997; Smith, 1998).

Unlike the case of litigation, there are no firm standards for the structure, process, and scope of ADR and the decisions agreed upon during mediation or
conciliation are usually not binding (Smith 1998). In the case of medical dispute handling this is further fragmented by the fact that medical and allied health professionals are regulated by a range of statutory and professional bodies that do not necessarily have a coordinated approach to complaints resolution. Furthermore there is a dearth of empirical evidence as to the efficacy of such complaints processes, thus emphasising the need for evaluation of the regulatory processes.

1.5 Summary of the Chapter

The literature reviewed in this chapter revealed that health services are delivered within a context that includes societal perceptions and expectations of health professionals and the manner in which health services are delivered. These perceptions and expectations are dynamic and influenced by factors both internal (Section 1.2.1) and external (Section 1.2.2) to the health arena.

It was observed that changes to the economic paradigm (Section 1.2.1.1), the scientific paradigm (Section 1.2.1.2), and societal attitudes to health and illness (Section 1.2.1.3) have led to a fundamental shift in the way that Australian health services are delivered, and clients’ expectations of the health services they receive. This has resulted in an increased propensity for clients to complain when confronted by adverse outcomes of health encounters. In response to such changes, the means of dealing with such complaints have evolved from the traditional adversarial approaches (Section 1.4.1) of litigation and reports to registration boards, to alternative dispute resolution techniques (Section 1.4.2).

ADR techniques were reported to have a number of advantages over the traditional means of complaint resolution including offering relatively low cost, timely resolutions that allow an opportunity to reach mutually agreeable resolutions (Section 1.4.2). It was noted that whilst ADR techniques are being widely adopted
for the resolution of health complaints, there appears to be little consistency into how
the approaches are applied and little empirical evidence as to their efficacy. It is
therefore essential that regulatory processes are evaluated in order to be certain that
the decisions and recommendations being made have a sound evidential basis.
Chapter 2: Clinical Governance and the Regulation of Medical and Allied Health Professionals.

2.1 Overview of Chapter

The previous chapter reported on changes in societal perceptions of health service providers and the impact that this has had on expectations of how health services are delivered and regulated in Australia. The current chapter will consider the development, nature and roles of regulatory bodies in the health professions, and the development of the processes of clinical governance through which the health professions are made accountable.

Section 2.2 defines the concept of clinical governance including the aspects of clinical competence, clinical effectiveness, clinical audit and clinical risk management. In section 2.2.1 consideration is given to the impact of the development of the health professions on the nature of clinical governance structures in place. Section 2.3 outlines different models of regulation that have evolved in the health professions, including self-regulation (Section 2.3.1), and statutory regulation (Section 2.3.2), while Section 2.3.3 discusses the regulatory difficulties that arise with unregistered providers.

Section 2.4 describes the current and impending status of the regulation of health professions in the State of Victoria, including the development of regulatory processes for Psychologists (Section 2.4.1.1) and the roles of the Australian Psychological Society (Section 2.4.1.2) and Psychologists Registration Boards (Section 2.4.1.3).

In Section 2.5 the functions of registration boards in handling complaints is discussed particularly in relation to the complaints process of the Psychologists Registration Board of Victoria. Section 2.6 highlights the limited avenues for complaint against unregistered health providers and finally the role of the Office of
the Health Services Commissioner in resolving health complaints that are not suited to resolution by registration boards complaints processes is discussed in Section 2.7.

2.2 Clinical Governance

Clinical Governance is a regulatory process that aims to ensure a high quality of healthcare, training and practice. Clinical governance has as its goal continuous improvement in health care through improvement in organisational and individual practitioner performance, accountability and responsibility (Ramsey, 2001). Ramsey posed a model of clinical governance as a multi-dimensional concept that incorporates clinical competence, clinical effectiveness, clinical audit and risk management.

Clinical competence relates to the individual characteristics of service providers that impact on the quality of service such as qualifications, training, clinical experience, knowledge, and communication skills. Clinical competence is usually managed through a code of conduct, professional development programs, formal training, peer review and ultimately regulatory bodies (Ramsey, 2001). Clinical effectiveness refers to the effectiveness of specific clinical interventions and is usually assessed within the framework of the scientist-practitioner model which holds that interventions should only be used when there is empirical evidence to support their effectiveness. Clinical effectiveness therefore is closely related to evidence-based practice. Clinical competence and clinical effectiveness then become the yardstick for clinical audit, which is a retrospective process that relates to the review of performance against agreed standards of best practice through regulation, complaints management and evaluation. Risk management is a proactive approach that includes the steps that can be taken to target and prevent predictable adverse outcomes (Ramsey, 2001). Taken together these four aspects form a framework
within which health consumers’ complaints can be assessed and decisions can be made as to how best to improve the overall quality of health care.

Clinical governance manifests itself differently in the different health professions. The form of clinical governance adopted by the individual health professions usually relates to the origin of that particular health profession and the evolution of the regulatory systems in those professions.

2.2.1 Health Professions

A profession can be defined as an occupation in which specialist knowledge and skills are used to address problems posed by a specific clientele (Sheehan, 1984). Sheehan outlined several characteristics of good professions. According to Sheehan the criteria for a good profession are: practice and behaviour that is motivated by a sense of social responsibility; the promotion of competence and best standards of practice, often embodied in a code of conduct; the seeking of improvement through research and an emphasis on ongoing training and professional development; the promotion of a healthy balance between research, teaching and application; and maintaining close regulation of members.

Historically, health professions have evolved in one of two ways. Either they have evolved out of the need to add scientific rigour to, and regulate the practice of, specific health related procedures (such as has happened in the medical profession), or they have evolved out of an academic or theoretical framework, which has then been applied to deal with specific issues in the community (such as is the case in the psychology profession) (Martin, 2004). The differences in how the different health professions evolved is reflected in differences in the way the professions are regulated and governed.
2.3 Modes of Regulation of Health Professions

Currently in Australia several models for the regulation of medical and allied health practitioners are in existence. These models include self-regulatory models, and statutory regulation models including statutory registration of title only, and statutory registration of title and the specific practices associated with that title (Carlton, 2003).

2.3.1 Self-regulation

Self-regulation involves the regulation of practitioners by their relevant professional body. Usually membership of the professional body is voluntary and those individuals who choose not to become a member are not precluded from practicing in that area. Under the self-regulation mode, practitioners are not subject to legislative requirements. The professional body may have disciplinary jurisdiction, however this power can only be exerted over practitioners who are members of the body and therefore sanctions are limited. Self-regulation applies to all health professions in Australia that are not subject to statutory registration requirements, such as social workers, speech therapists or dieticians (Carlton, 2003).

2.3.2 Statutory Regulation

Statutory regulation occurs when either the professional title or practices are governed and regulated by an act of parliament. In Victoria there are 12 health professions that are regulated through Acts of State Parliament. They are the Chinese Medicine Registration Board, the Chiropractors’ Registration Board, the Dental Practice Board, the Medical Radiation Technologists’ Board, the Medical Practitioners’ Board, the Nurses’ Board, the Optometrists’ Registration Board, the Osteopaths’ Registration Board, the Pharmacy Board, the Physiotherapists’
Registration Board, the Podiatrists’ Registration Board and the Psychologists Registration Board (HSC, 2004).

2.3.2.1 Registration of title. This mode of regulation applies to the majority of registered health professions in Australia and involves a statutory limitation to the use of the title of that profession to members who are registered with the appropriate state registration board. Within this framework, the profession is regulated by a statutory authority (registration board) that has the responsibility to protect the public by developing standards for the profession, by investigating complaints of unprofessional conduct, and by administering the appropriate sanctions (Carlton, 2003). This mode of regulation applies to all registered health professions in Victoria, with the exception of dental providers, optometrists and pharmacists.

2.3.2.2 Regulation of title and practice. Within this mode of regulation people are prohibited from using the relevant title and from practicing in the field if they are not a registered practitioner (Carlton, 2003; Howse, Naksock, Halstead, & Honigman, 2004). In the area of optometry and pharmacy, both the titles and some core practices are subject to registration requirements, while in dentistry the whole of practice is subject to registration (Carlton, 2003).

2.3.3 Unregistered Providers.

Currently there are two broad categories of allied health practitioners, registered and un-registered practitioners. In Australia, anyone can administer medical or health related treatment, providing it is not subject to statutory regulation and they do not practice under a title that is restricted by state law (Carlton, 2003). It has been agued that there are two main groups of unregistered health service providers: those that practice within the ‘mainstream’ health service sector such as occupational therapists, speech therapists; and those that practice in the area of
complimentary or alternative therapies, such as massage therapists and herbalists (Department of Human Services Victoria, 2000). Because of the lack of statutory regulation, the ethical practice of unregistered health providers is reliant on their voluntary compliance with standards of practice, as they are exempt from legislative requirements and practice outside rigorous structures of accountability.

In a recent discussion paper the New South Wales Health Department (2002) noted the generic risks associated with un-registered health practitioners. Such risks included unsubstantiated claims of therapeutic benefits of treatments, risks of failure to detect underlying medical or psychiatric conditions, professional misconduct, financial exploitation and the absence of effective complaints resolution processes.

Whilst the general difficulty of creating structures of accountability for unregistered health practitioners has been well documented in health forums, it is an issue that has also received considerable debate in the area of psychology (Carlton, 2003). Currently, it is legal for anyone in Australia to practice psychology, on the proviso that they do not practice under the title of Psychologist (PRBV, 2004a). An issue of current concern to the Psychologists Registration Board of Victoria is that of psychologists who have been de-registered but who continue to practice under the title of Counsellor or Psychotherapist or similar titles. Those individuals who choose to practice under such titles currently fall outside the regulatory powers of both the Psychologists and the Medical Practitioners’ Registration Boards and therefore outside the structures of accountability.

The absence of a body to ensure the competence of these practitioners means that they are not subject to the same standards of training and practice as registered psychologists, and do not have the benefit of the professional development opportunities and guidance that is offered by the Registration Boards and the
Australian Psychological Society (APS). In addition, there is no body to respond to the physical or psychological impairment of these practitioners, and limited avenue for recourse in incidents of professional misconduct. Protection of the public against practitioners in these fringe areas of service is therefore very difficult as it falls outside the auspices of professional regulatory bodies.

2.4 Regulation of Health Professionals in Victoria

As mentioned in Section 2.3.2, in the state of Victoria, there are 12 registered health professions, each of which has a registration board established by an act of State Parliament. Each of these boards has the overarching goal to protect the public over and above the needs of the profession. In general the function of the boards is not to serve the registrants, but rather to protect the interests of the public (Crook, 2004).

In general the statutory requirements of registration boards are to ensure that registered professionals meet the qualification requirements for registration and to stipulate how complaints should be handled and the scope and nature of sanctions to be applied in the event of a finding of unprofessional behaviours. The means by which the registration boards are required to handle complaints is specified within the relevant legislation. In addition the boards are responsible for the regulation of the standards of practice and the generation and application of guidelines on practice (Carlton, 2003; Crook, 2004; Health Services Commissioner, 2004). All registration boards are comprised of a number of members including members of the profession, members of the community and legal representatives (Carlton, 2003).

In Australia health registration boards have progressed through a continuing evolutionary process that has paralleled the development of the professions as a whole. As such the registration boards tend to compliment the role and functions of
other regulatory bodies in the profession. One example of this is the historical progression of the profession of psychology.

2.4.1 The Historical Progression of the Regulation of the Profession of Psychology

2.4.1.1 Emergence of psychology as a profession. In Australia, as in other English speaking countries, clinical psychology emerged in the mid-twentieth century, out of an academic core (Gray, 1984; O’Neill, 1977). Unlike the profession of medicine, where academic courses were introduced to supplement and enhance existing clinical practice, psychology practice evolved out of the real world application of psychological and philosophical theories of behaviour (Martin, 2004; O’Neill, 1977).

In Australia, the psychology profession was initially self-regulated, largely through the APS, however in recent decades individual states have adopted legislation that regulates the title of Psychologist. Currently all Australian psychologists are regulated by individual state registration boards, however as mentioned earlier (Section 1.2.1.2), this is currently under review. Those psychologists that choose to be members are also supported and regulated by the APS at a national level.

2.4.1.2 The Australian Psychological Society (APS). The APS was founded in 1966 and had as its initial role to define the qualifications that were required for membership and to contract members to practice within an ethical framework. The APS established their first Code of Conduct in 1966, which embodied the three principles of client welfare over the welfare of the psychologist; the importance of maintaining the integrity of the profession; and objectivity and honesty (Gray, 1984). This Code, with accompanying Ethical Guidelines, remains a work in progress, and is constantly being adapted to reflect the changing and expanding roles of psychologists. In addition to providing guidance for psychologists, the Code of Conduct and Ethical
Guidelines, form a yardstick against which the professional conduct of psychologists may be evaluated (Gray, 1984).

With the foundation of registration boards, the APS has, in recent years, expanded its regulatory and operational functions to include more strategic functions such as representing the profession of psychology on relevant government committees and in political forums, and through liaison with state registration boards. The APS performs significant educational functions including course accreditation and the provision of professional development training, and also has a major role in promoting public acceptance and awareness of psychology as a profession (Martin, 2004). The APS regulates membership through strict membership criteria which are currently more stringent than criteria for registration as a Psychologist with any of the relevant state Registration Boards (Crook, 2004; Martin, 2004).

2.4.1.3 Psychologists Registration Boards. Historically, the Victorian Government was the first to give a statutory definition of psychologists in their Psychological Practices Act (1965; Smith, 1984), and then later under the Psychologists Registration Act (2000) and accompanying regulations (Parliament of Victoria, 2000a; 2000b).

The Psychologists Registration Act (2000) established the Psychologists Registration Board of Victoria (PRBV) and outlined the requirements for registration as a psychologist and the functions and responsibilities of the PRBV. The primary function of the PRBV was to protect the public by registering only those persons who meet the registration requirements of the Psychologists Registration Act (2000); by approving courses of study and supervision programs that are requirements for registration as a psychologist; by regulating the standards of professional practice; and by investigating complaints regarding the conduct of psychologists and
notifications of impairment of the physical or psychological functioning of psychologists (Parliament of Victoria, 2000a; PRBV, 2004a). Currently however, the regulatory climate for Psychologists in Australia is undergoing major changes.

2.4.2 Impending Changes to Registration of Health Professionals in Victoria

Health regulation has recently undergone a further review in the State of Victoria. In 2003, the Victorian government commissioned a review of the regulation of the health professions in Victoria in order to ensure that the 12 registration boards provided a satisfactory mechanism through which to protect health consumers, and to address issues arising from changes to the way health services are being delivered in terms of the trend toward health service delivery by multidisciplinary teams (Carlton, 2003). As a result of the review recommendations were made as to how to improve the accountability, transparency, fairness, effectiveness and efficacy of the boards, and how to ensure a greater consistency in handling of health complaints. The review resulted in the drafting of the Health Professions’ Registration Act (2005), which was subsequently passed in Parliament and became effective on 1 January 2007 (Parliament of Victoria, 2005).

Under the Health Professions’ Registration Act (2005) the 12 Victorian registration boards remain but have their statutory requirements legislated under one single Act. A particular focus of the Health Professions’ Registration Act is on increasing the accountability, transparency, consistency and responsiveness of the regulatory bodies, and their membership. A second goal of the Health Professions’ Registration Act is the streamlining of complaints management (Department of Human Services of Victoria, DHS, 2006).

In very recent developments, the Council of Australian Governments (COAG) has further proposed the development of a national system for registration of health
professionals and for the accreditation of their training and education programs. The new model, which is yet to be clarified, will encompass new national registration boards for each of the currently state-registered health professions. This means that instead of there being separate registration boards for psychologists in each Australian state there will be one new psychology board to coordinate and oversee the registration and accreditation of all Australian psychologists (APS, 2007).

2.5 Function of Registration Boards in Handling Complaints.

All Victorian State Registration Boards have as part of their function to resolve complaints pertaining to unprofessional conduct of registrants. The means by which complaints are to be administered, investigated, arbitrated and resolved are stipulated within the relevant registration acts. The complaint handling procedure is similar for most registration boards and involves a graduated process through which complaints are investigated and heard, with more serious complaints escalating to a higher level of the complaints process (Carlton, 2003).

For example, the Psychologists Registration Board of Victoria has the statutory power to receive, investigate and adjudicate complaints made regarding the professional conduct of psychologists. Complaints to the Board must be lodged in writing, and copies of the complaint are then sent to the psychologist with a request for a written response. All complaints of professional misconduct are then subject to a preliminary investigation process, in which the Board assesses the nature of the allegations and the psychologist’s response and decides whether further action is required (PRBV, 2004a). Once the preliminary investigation is complete the Board will either find that no further action is required, that the complaint should be referred to an informal hearing, or that the complaint should be subject to a formal hearing (PRBV, 2004a: 2003).
Informal hearings are usually required for complaints of an intermediate level of seriousness. Informal hearings are conducted by a panel of three board members and are not open to the public or the media. In informal hearings the complainant and psychologist are interviewed separately and the psychologist does not have the right to legal representation. If at the end of the informal hearing, the Board finds that the psychologist has engaged in unprofessional conduct they have a number of sanctions available to them, including that the psychologist must attend counselling, the psychologist may be cautioned or reprimanded; or the psychologist may be referred for further education (PRBV, 2004a; 2003).

Formal hearings are required for complaints of a high level of seriousness. Formal hearings are conducted in a public forum that is open to the public and the media. In formal hearings both the complainant and the psychologist are present, and the psychologist has the right to legal representation. Following the formal hearing, if the Board rules that the psychologist has engaged in serious professional misconduct, the Board has a number of disciplinary options available to them. The Board may direct the psychologist to undergo counselling, caution or reprimand the psychologist, require the psychologist to undergo further education, place restrictions on the psychologist’s ability to practice, suspend the registration of the psychologist for a stated period of time or de-register the psychologist. Findings of formal hearings are made available to the public through publication on the Board’s website (PRBV, 2004a, 2003).

Under the new *Health Professions’ Registration Act (2005)*, the complaints handling procedures have been reviewed. The new legislation requires a greater degree of openness by boards regarding the decisions they make, and the boards have a legislative requirement to provide complainants with written reasons for the
decisions and explain their right of appeal. There are also additional powers for the boards to investigate complaints, and processes in place for the boards to settle less serious complaints if they are able to reach a settlement that is agreeable to the board, complainant and provider (DHS, 2006).

One of the major reforms encompassed in the *Health Professions' Registration Act (2005)* is the separation of powers in the disciplinary process. Instead of each registration board being responsible for all stages of the complaints process in their domain, the more serious matters (those appropriate for Formal Hearings) are to be transferred to the Victorian Civil and Administrative Tribunal. Taken together, the goal of these changes is to foster greater accountability, fairness, transparency and independence in complaints handling (DHS, 2006).

2.6 Avenues for Complaints Against Unregistered Providers

Whilst all registration boards have the power to adjudicate on matters relating to professional misconduct, registration of health professionals does not give the public protection from all individuals who offer less than professional services. While the legislation does prohibit such services being delivered under certain titles, registration boards do not have the power to adjudicate on matters relating to the professional misconduct of practitioners who have never registered or have been deregistered but continue to practice under similar titles, such as Counsellor or Psychotherapist (Carlton, 2003).

Currently registration boards do not have the power to resolve disputes or facilitate settlements between complainants and health service providers (Carlton, 2003). In Victoria, when complaints fall outside the jurisdiction of the registration boards or relate to matters that are appropriate for a conciliatory response rather than
professional misconduct, complainants are referred on to the Office of the Health Services Commissioner.

2.7 The Office of the Health Services Commissioner of Victoria

The Office of the Health Services Commissioner (HSC) of Victoria is an independent statutory authority established to receive and resolve complaints about health service providers. The HSC was established by the Health Services (Conciliation & Review) Act, 1987 following the findings of an all-party Parliamentary Social Development Committee which deemed that existing complaints mechanisms were inadequate (Wilson, 1999). Thus the Committee argued that there was a need for an independent, impartial body with a broad jurisdiction for handling complaints (Wilson, 1999).

Under the statutory requirements, the role of the HSC is to provide an accessible and impartial mechanism by which to receive, investigate and resolve complaints from health service consumers; to support health care services in providing quality health care and to assist them in resolving complaints. The legislation also requires that information gained from these complaints should be used to improve the standards of health care and prevent breaches of these standards.

The HSC deals with complaints against health service providers in both the public and private sectors, against registered providers such as doctors and medical specialists, dentists, psychologists, and physiotherapists; unregistered practitioners, such as psychotherapists and masseurs; and alternative therapists, such as acupuncturists hospitals and nursing homes or any providers of a health services. The HSC works in a complimentary fashion with registration boards, in that when complaints are received by either party discussions take place between the relevant board and the HSC as to which organisation is the most appropriate to handle the
complaints. If the matter is one of provider misconduct, then it is referred to the registration board. If the matter is not one of misconduct and is appropriate for settlement and/or conciliation, then the matter is handled by the HSC.

2.8 Summary of the Chapter

This chapter has provided an overview of the regulatory processes that are currently in place to monitor the training, professional development and ongoing practice of health professionals in Victoria. The chapter has also discussed the impending changes to the model of health regulation in Victoria and complaints processes that are available to health service users who are unhappy with the health services they receive. However, while there are a number of bodies responsible for the regulation of health professionals in Victoria, currently there is not a coordinated or consistent approach to how these bodies respond to concerns about the practices of the professionals who are registered within their domain. The *Health Professionals Registration Act (2005)* should address some of the concerns regarding consistency, however it is important that steps are also taken to empirically evaluate the processes that are in place to ensure that they are operating as is intended by the legislation and to provide evidential support for their effectiveness. This can only be achieved through a rigorous, scientific evaluation framework.
Chapter 3: The Quality of Health Service Delivery and Subsequent Complaining Behaviour.

3.1 Overview of the Chapter

The previous two chapters reviewed the social, economic and scientific context in which health services are delivered and the influence that this has on client perceptions and expectations of how health services will be delivered and regulated. In addition the ongoing development of regulatory systems within the health professions was discussed and mechanisms for complaints management explored. The following chapter will explore client perceptions of satisfaction with health service encounters and the quality of health service delivery, the antecedents and barriers to lodging a complaint against a health service provider, and the factors that impact on effective complaint resolution and post-complaining behaviour.

Section 3.2 is a review of the literature relating to factors that have typically been considered to be indicators of service quality. Literature presented in Section 3.2.1 reviews factors impacting on client satisfaction and client perceptions of service quality such as client expectations and the nature of outcomes of service delivery. In Section 3.3 literature relating to the antecedents to lodging a complaint will be considered, including motivation to complain, perceived capacity to lodge a complaint and perceived opportunity to complain. Following this, in Section 3.4, the factors that impact on the effective resolution of complaints will be discussed and the positive and negative impact of the complaints process on complainants and service providers engaged in the complaints processes will be considered in Section 3.5. Finally, in Section 3.6, the usefulness of complaints as a vehicle to improve the quality of service delivery will be discussed.

Much of the research reviewed in this chapter has been conducted within the marketing and consumer research areas, which examine consumer attitudes and
behaviour in terms of the purchase of material goods or the delivery of tangible services. However the current chapter will draw parallels and apply the findings from the traditional services research to the health services industry.

3.2 Indicators of Service Quality

With the current emphasis on practitioner accountability, there has been a growing recognition that monitoring and improving health service quality are essential components in the provision of high standard, evidence based health care. Three factors have consistently been explored as indicators of quality of service provision: customer satisfaction, customer perceptions of the quality of service delivery, and the frequency and severity of customer complaints.

3.2.1 Client Satisfaction and Perceptions of Service Quality as Indicators of Actual Service Quality.

In the research literature, service quality has almost exclusively been measured from the perspective of the consumer, and conceptualised as client satisfaction or client perception of quality. In the health arena, client satisfaction and perceptions of health service quality have been shown to be multifaceted concepts. However, there has been considerable debate as to how they are conceptualised and operationalised and whether or not consumer satisfaction and perceived quality of service are distinct constructs (see Bittner & Hubbert, 1994 and Finn & Kayande, 1998 for reviews). Some argue that service satisfaction and perceived service quality are two aspects of the overall evaluation of a service, with quality being a cognitive evaluation and satisfaction being an affective response to the service (Iacobucci, Ostrom & Grayson, 1995; Oliver, 1980). Others argue that quality is an overall attitude to the service provider or organisation as a whole, while satisfaction is a situation specific concept that relates to the individual encounter (Bitner & Hubbert, 1994). Research indicates that along many dimensions clients do not distinguish
between the level of satisfaction with a service as a whole and their perception of the quality of that service (Finn & Kayande, 1998; Iacobucci et al.). Iacobucci and colleagues explored the distinction between quality and service as judged by consumers. They found that while they were judged differently across some dimensions, perceptions of quality and judgments of satisfaction impacted equally on post-complaint behaviours and decisions to use the service again in the future.

Client judgments of satisfaction have been shown to be related to characteristics of the client, such as the expectations they bring to the health encounter, characteristics of the problems that arise, and characteristics of the setting in which the service is delivered.

3.2.1.1 Expectations. Research exploring the determinants of consumer satisfaction with health services has indicated that satisfaction is usually related to a confirmation of expectations (Lytle & Mokwa, 1992; Oliver, 1980; Taylor, 1994). For example, when consumers receive an outcome that is consistent with their expectations of the service, they tend to be more satisfied. Oliver posed a cognitive model of the antecedents to satisfaction decisions whereby a client brings a set of expectations into the health encounter and these expectations form a frame of reference against which subsequent outcomes are compared and evaluated. According to Oliver these appraisals are influenced by the context in which the service is delivered, the individual characteristics of the recipient of the service and the nature of the discrepancy from expectations. Within this framework both the confirmation or disconfirmation of expectations and the level of expectations that the client brings to the service impact on the degree of satisfaction expressed about the service received, rather than the absolute nature or value of the outcomes (Oliver 1980; 1997).
Like Oliver (1980; 1997), Lytle and Mokwa (1992) also emphasised the role of client expectations in satisfaction with health services, but argued that in evaluating their satisfaction with a service or judging the quality of a service there are three levels of decision making that consumers apply. They evaluate the health service encounter prior to the encounter (pre-encounter phase), during the encounter (encounter phase) and following the actual encounter (post-encounter phase).

The pre-encounter phase of decision making involves the expectations that the consumer brings to the encounter. These include expectations regarding the nature and quality of interaction with the health service provider and expectations about the outcome of the service. Decision making during the encounter stage includes consideration of the perceived nature and quality of the actual interaction between the client and service provider while the post-encounter phase includes perceptions of the outcomes, both tangible and intangible that result from the service encounter (Lytle & Mokwa, 1982).

The process and outcomes of the latter two phases may or may not be consistent with the expectations that the client brings to the situation. When the comparison of pre-encounter expectations with the process and outcomes of the encounter and post-encounter stages is unfavourable, clients are more likely to report being dissatisfied (Lytle & Mokwa, 1992). Yim, Gu, Chan and Ti (2003) argued that it is necessary to incorporate perceptions of equity into the expectancy disconfirmation model. They found that in making assessments of satisfaction with a service, consumers compare their expectations of what the organisation will do and normative standards of what the organisation should do against the actual organisational response. Yim et al. found that reported satisfaction was related to the
perceived fairness not only of the outcome of service delivery, but also to the process through which that service was delivered.

Donabedian (1988) posed a model for how clients go about evaluating the quality of health service they receive. Donabedian proposed that consumers of a health service assess quality across three components of the health encounter: the structure, process and outcomes of health service delivery. The structure of service delivery includes all aspects of the context in which the service is delivered such as the legislative framework, the organisational policies that define procedures and the built environment (Donabedian; Fowler et.al., 1999). The process includes the nature of the service encounter between client and provider, such as the perceived effectiveness and competence of the provider and the interpersonal interface between the provider and the consumer. Outcomes include both the tangible and intangible products of the service. According to Donabedian’s model, each of these dimensions has an impact on perceptions of quality of care.

3.2.1.2 Tangibility of outcomes. In the case of health services, it is often difficult for consumers to assess the quality of service, because the service outcomes are not always tangible. For example in the case of chronic illness, where a cure is not possible, a positive outcome may be linked to a more intangible concept such as a sense of improved well being. Similarly in the case of psychotherapy, improvements may be incremental and ill-defined, thereby making evaluation highly subjective. Similarly the client may not have the specialist knowledge required to judge whether the outcome is acceptable or whether the practitioner has acted appropriately (de Ruyter & Wetzels, 1998; Mulcahy, 2003). Furthermore, in the health arena, outcomes have the potential to be influenced by a variety of variables that are independent of the health service delivered in relation to that illness (Mulcahy, 2003).
In such cases where the outcome is intangible, clients have been shown to rely more heavily on the quality of the interaction with the service provider when evaluating the overall quality of service provided (de Ruyter & Wetzels, 1998). Research findings have emphasised the importance of the practitioner-client interaction to satisfaction with health services, independent of the client outcomes. Brown and Swartz (1984) in a large scale survey of attitudes to malpractice litigation found that out of service delivery, doctor competence and the medical environment, the quality of the interaction between the client and provider was the most important factor in determining patient satisfaction with the health service. Similarly Iacobucci et al. (1995) found that judgments of quality and satisfaction with service delivery were higher when the interpersonal relationships between the consumer and provider were good in terms of empathy and friendliness of the staff. Furthermore, research also indicates that the service delivery process is even more crucial to client evaluations in the face of negative outcomes. Lytle and Mokwa (1992) in a study of 559 female patients at a fertility clinic found that the process of health service delivery was more important to patient evaluations of the service in the face of unsuccessful outcomes (no pregnancy achieved) than when outcomes were successful (pregnancy achieved).

In an experimental study, de Ruyter and Wetzels, (1998) explored two aspects of service quality, service process (how the service is delivered) and service outcome (what the client receives as an outcome) and how they impacted on subsequent evaluations of the health service provided where outcomes were either tangible (e.g., a cure) or intangible (e.g., chronic disease management). Participants were presented with a number of scenarios that manipulated the quality of the process and outcome of service delivery. De Ruyter and Wetzels found that a favourable process positively
impacted on the evaluations of the service encounter. Furthermore they found that a favourable process had a positive impact on satisfaction whether or not the outcome was perceived as favourable. In addition, when outcomes were intangible, the process was more strongly related to the overall satisfaction with the health service provided.

3.2.2 Customer Complaints as Indicators of the Quality of Service

When consumers are dissatisfied with the health services they have received there are a number of options available to them. The first is to take no action in relation to their dissatisfaction. Alternatively they may choose to take some form of private action, where they either change health service providers and/or use word of mouth to warn friends and acquaintances about their experiences with that provider (Day & Landon, 1977; Huppertz & Mower, 2003; Singh, 1989). If they do not receive a satisfactory response from the provider, a further option is to take some form of public action, such as seek redress directly from the provider, take legal action to claim redress or enlist a third party, professional body or government agency to seek redress on their behalf (Day & Landon; Huppertz & Mower).

However the decision as to whether or not to complain and to whom is not clear cut. In fact research indicates that the majority of clients who are not satisfied with the health services that they receive choose not to complain to the health service provider or seek redress through legal channels or third party organisations (Chebat, Davidow & Codjovi, 2003; Dolinsky, 1995; Kolodinsky, 1993; Schlessinger, Mitchell & Elbel, 2002).

Schlessinger et al. (2002) surveyed 2500 adults about their experiences dealing with their health care provider. They found that approximately half of the participants reported that they had experienced a problem with their health service
provider. However, of those who reported negative experiences, only half had voiced their concerns to their provider. More disturbing however was the finding that less than 17% of those who reported serious problems with their health service (problems that caused a serious decline in health) voiced a formal complaint. Similarly Kolodinsky (1993) surveyed 1500 adults about their satisfaction with their current physician and any negative experiences that they had experienced in their medical care. Kolodinsky found that of those who had experienced negative outcomes in their medical care, less than half voiced their complaint and of those only 8% voiced their complaint formally through a third party organisation. This research indicates that complaints that are voiced may only constitute the tip of the iceberg of problems experienced by consumers of health services.

The observation that dissatisfied consumers are less likely to complain to a third party organisation than they are to complain to the service provider (Hogarth, English & Sharma, 2001; Kolodinsky, 1993) may be due to a number of reasons. First, they may not be aware of the existence of a third party organisation to deal with the complaint, and second, third party complaints usually come at a high cost to complainants in terms of the time and effort that are required to submit and follow through with the complaint (Hogarth et al.).

Singh (1989) proposed and tested a model of the processes underlying the decision by dissatisfied health service users to submit complaints to a third party organisation. In a sample of 166 health consumers who reported having had a dissatisfying experience, Singh found that dissatisfaction was a necessary pre-requisite for complaining to a third party but not predictive of whether or not the complaint would be submitted. Instead Singh found that the decision to complain to a third party related to normative beliefs about complaining, the perceived probability
of success and prior experience of third party complaints. Participants, who held the attitude that complaining is an acceptable form of redress, as opposed to being a negative response, were more likely to lodge a complaint. In addition participants who perceived that they had a high probability of achieving the outcome that they desired from their complaint, or who had previous experience of complaining to third parties and who perceived that the benefits of complaining would outweigh the perceived costs of complaining, were more likely to have lodged a complaint. Of these, Singh found that attitude to complaining was the most influential factor in the decision to complain.

It is therefore important to take into consideration both motivations to complain and barriers to complaining when considering the usefulness of complaints as an indicator of service quality.

3.3 Motivation for and Barriers to Lodging a Complaint

The issue of why people do and do not complain when dissatisfied with a service has been relatively extensively researched within the marketing literature (see Singh, 1988 for a review). Some research has indicated that the greater the discrepancy between expectations and actual result, the more motivated clients are to complain (Donabedian, 1988; Lytle & Mokwa, 1992; Oliver 1980, 1997), others argue that consumers complain with specific goals in mind, such as compensation, sympathy, apology or understanding (Mulcahy, 2003). However, evidence suggests that the decision as to whether or not to complain is a complex one and dependent on a number of factors including the characteristics of the complainant, the problem, the setting in which the problem occurred and finally the characteristics of the complaints process itself (Kolodinsky, 1993; Schlesinger et al., 2002).
Morel, Poiesz and Wilke (1997) found that the decision to lodge a complaint was dependent on a combination of motivational factors, perceived capacity to complain and perceived opportunity to complain. Morel et al. presented 225 participants with scenarios in which they were confronted with unsatisfactory service delivery. They found that participants were most likely to report that they would complain when their motivation was high, operationalised in terms of low quality and high dissatisfaction; when they perceived that they had the capacity to complain, operationalised in terms of knowledge and previous experience; and when they perceived that there was the opportunity to complain, operationalised in terms of the circumstances and time available.

3.3.1 Motivation to Complain

Motivation refers to the need or desire to engage in the complaints process (Morel et al., 1997). Chebat and colleagues (2003) proposed a cognitive-emotional model to explain motivations to complain or not complain when confronted with negative service outcomes. They suggested that when confronted with an adverse outcome, clients go through a primary appraisal of the magnitude, severity and importance of the adverse event. They then go through a secondary appraisal as to the personal responsibility of the service provider. These preliminary cognitive appraisals lead to emotional responses. Chebat et al. found that when the situation was appraised as being of greater severity, and where the service provider was perceived as having greater personal responsibility for the negative outcome, clients were more likely to experience negative emotions such as anger or disgust and to lodge a complaint about the event. Conversely when the situation was appraised as being of lower severity, and the service provider was perceived as being less personally responsible for the outcome, clients were more likely to report emotions
such as sadness or resignation and less likely to lodge a complaint. Within this framework, complaining can be viewed as a coping strategy that complainants use for the management of their emotions. The motivation for the complaint thus becomes the seeking of psychological compensation.

Brown and Swartz (1984) explored consumer variables that were likely to impact on whether or not consumers would be motivated to take legal action when confronted with an adverse medical event. Brown and Swartz presented a random sample of 1000 health service consumers with two scenarios, one in which they were the patient and their own physician had made an error, and another scenario where their partner or spouse had died as a result of physician error. They asked participants to report how likely they would be to engage in malpractice litigation if confronted with these situations. Brown and Swartz found that those who reported that they would and would not be motivated to seek redress could be distinguished on the basis of certain personal characteristics. Those that reported they were likely to sue, when compared with those who reported they would not sue, tended to be younger, were more likely to be male, and attributed more personal responsibility for the problem to the physician. In addition, Brown and Swartz (1984) found that the motivation to seek legal redress when dissatisfied with adverse medical outcomes was related to the magnitude and duration of the problem. The more severe the adverse outcome and the more permanent the negative consequences, the more likely participants were to report that they would take legal action. Clients also reported being more motivated to sue if they perceived that their health practitioner had a higher degree of personal responsibility for the error.

When considering the most serious adverse events (for example the scenario that involved the death of a partner), Brown and Swartz (1984) found that there were
two main factors that discriminated between those who reported they would be likely to sue and those who did not. They were the quality of patient-physician communication and the amount of time spent by the physician explaining the potential problems associated with the treatment. Those who perceived that their physicians had taken the time to explain the circumstances and effectively communicated the potential complications of procedures reported being less motivated to seek redress in the event of an adverse outcome (Brown & Swartz).

Therefore while consumer variables are an important determinant of whether or not a client is motivated to lodge a complaint, the process and setting in which the health services are delivered are also important determinants of whether or not a person is motivated to complain.

Much of the research that has explored the impact of setting on complaint motivation has been conducted from a marketing perspective which explores complaints in relatively straightforward service delivery settings. However health settings are functionally different to other service delivery settings in a number of ways related to the nature of the goals, outcomes and interactions that occur in the health service delivery encounter. In the health industry more than other service industries the goals and outcomes of service delivery are closely linked to achievement of personal well being. The interactions between health service user and provider are highly personalised and furthermore the outcomes of health services tend to extend beyond the individual and impact on the support networks of the client, who may in turn influence evaluations of the quality of service provided (Mulcahy, 2003). This emotional overlay has the potential to create a greater emotional investment in the outcomes of the health service encounter and a more personalised response when expectations are not met. Research indicates that a high level of personal investment
in outcomes has the potential to lead to an escalation of issues and in turn may increase the motivation to complain (Shoorman & Holahan, 1996).

3.3.2 Perceived Capacity to Complain

Perceived capacity refers to the individual’s perception of their skill, knowledge and their ability to successfully negotiate the complaints process (Morel et al., 1997). Two factors have been shown to be important influences on an individual’s perceived capacity to negotiate the complaints process: perceived effort and disempowerment.

Complaining is a complex process and it takes effort to lodge and follow through the process of a complaint. Huppertz and Mower (2003) put forward an effort model of complaining that posits that in deciding whether or not to complain about a service, consumers weigh up the nature and severity of the problem and the attributions of fault against the physical, cognitive, temporal and emotional effort required to complain. Huppertz and Mower proposed that to voice a complaint requires physical effort and usually also involves a large time commitment. In addition complaining also usually involves a considerable cognitive effort in order to decide whether to complain, how to go about lodging a complaint and how to negotiate the complaints process. Within this model, the decision to complain therefore becomes a careful weighing up of the effort required to complain against the perceived benefits associated with the expected outcome of the complaint and the value placed upon that outcome (Huppertz & Mower). Feick (1987) explored the complaint responses of 2949 dissatisfied customers and found that responses could be hierarchically arranged into either easy or hard responses. Easy responses involved minimal effort and entailed complaining to the service provider or choosing not to purchase the service again. ‘Hard” responses, on the other hand, required
considerably more effort on the part of the consumer such as complaining to a third
parry agency or taking legal action. Similarly, Voorness, Brady and Horowitz (2006),
in a study of 149 consumers who had experienced service failure, but chosen not to
complain, found that the major reasons given for not complaining were the time and
effort required to complain.

The effort required is further magnified if the complainant is marginalised due
to a power or knowledge differential. In the health setting there is an inevitable
knowledge asymmetry that exists between health service provider and client
(Mulcahy, 2003). Health service clients usually lack the specialist knowledge of the
practitioner and therefore may feel disempowered or frightened to complain. Clients
may also not understand what to expect from their health service and not have the
specialist knowledge required to know when a service has not been adequately
delivered (Freckelton & List, 2004; Mulcahy). In the mental health arena
complainants may be particularly disempowered because they are often emotionally
vulnerable or may lack credibility due to their psychological or psychiatric condition
(Freckelton & List, 2004; Wood, 1996).

In a theoretical argument, Wood (1996) explored the factors that may impact
on the effectiveness of complaints processes in the mental health area and suggested
that an understanding of power relations is imperative when considering the
effectiveness of a complaints system. Wood argued that three aspects of power may
influence complaints including: a) aspects of the decision making process (such as
perceptions of client credibility); b) barriers that may keep issues away from the
decision making process (e.g., fear of making a complaint) and c) processes that
prevent decisions being made or issues being named (e.g., inadequate or inaccessible
means for redress). Wood argued that in the interaction between practitioner and
client there is a power imbalance, which may also influence those making decisions regarding complaints.

Sbarini and Carpenter (1996) explored Wood’s (1996) model further by conducting a survey of 222 mental health service users, Sbarini and Carpenter found support for Wood’s model in that the reported barriers to making a complaint included fear of being seen to be less credible than the service provider, and fear of retribution. Other barriers reported were a perception that it would be pointless to complain or too difficult to negotiate the complaints process. Conversely, Sbarini and Carpenter found that those participants who reported that they felt that they were able to work with their health professionals and express their views more freely, were more satisfied with their health service but also more willing to make a complaint if necessary.

3.3.3 Perceived Opportunity to Complain

Perceived opportunity refers to the extent to which external factors inhibit or facilitate the lodging of a complaint. Research has supported the proposition that one of the key determinants of complaining is accessibility of the complaints process. Sbarini and Carpenter (1996) found that in a study of 222 participants who had been clients at a mental health service for over 10 years, only 35% knew that the service had an official complaints mechanism. Similarly Voorness et al. (2006) found that accessibility of the complaints mechanism played an important part in the decision to complain. In a survey of 149 dissatisfied consumers, who had chosen not to lodge a complaint, they found that lack of organisational responsiveness to complaints in terms of a lack of complaints handling processes or perceived unresponsiveness of those processes was an important factor in the decision not to complain about services when dissatisfied.
Taken together, the above research indicates that in considering patient evaluations of a health service it is important to take into consideration satisfaction with both the process and the outcome of the service delivery in addition to the emotional aspects of the context that may be driving or creating barriers to the complaint.

In the same way that clients have expectations of the process and delivery of their health services, expectations can also be expected to play an important role in satisfaction or dissatisfaction with the complaints process. Oliver (1997) termed this secondary satisfaction. Oliver argues the process of complaint satisfaction or dissatisfaction follows exactly the same process as the initial dissatisfaction. The client comes to the complaint process with expectations about what this form of redress should offer them. The organisation/complaints body provides a response that may or may not be consistent with the expectations the client has when lodging the complaint. This then leads to an appraisal of secondary satisfaction (Oliver). According to Oliver the initial dissatisfaction primes the complainant to interpret the outcome of their complaint within a negative framework. Gilly and Gelb (1982) found that the complaints resolution mechanism directly impacts on secondary satisfaction through both the outcome of the complaint and the process in which the complaint is handled.

An essential part of effective complaints resolution is therefore to manage the expectations of the complainant effectively throughout all stages of the complaints process and to be cognisant of the factors that may escalate complaints or negatively impact on their resolution. A number of factors have been found to impact on the resolution of health complaints.
3.4 Factors that Impact on the Resolution of Health Complaints

Research indicates that complaints about health services are less likely to reach resolution than complaints about other services or products (Kolodinsky, 1993). In addition, problems that are more tangible, such as faulty goods or breakages have been found to be more likely to be resolved to the customer’s satisfaction than are those with less tangible outcomes such as improvement in well being (Gilly & Gelb, 1982). While the issue of why people do and do not choose to complain about health services has been relatively well researched, less attention has been given to the complaints process itself and how the process and outcomes impact upon subsequent post-complaint attitudes and behaviour (Davidow, 2003). However, how organisations respond to complaints has the potential to dramatically impact on post-complaint behaviour and attitudes.

Estalani (2000) in a survey of 279 adults who had complained about goods or services, explored the procedural determinants of satisfaction and dissatisfaction with complaint outcomes. Estelani found that the three main factors that impacted heavily on complainants’ evaluations of complaint outcome were the degree of compensation offered, the behaviour of the employee responsible for handling the complaint and the promptness of complaint resolution. Complainants reported being more satisfied with the outcomes when they were offered compensation in the form of money, goods or services; when they felt the person handling their complaint was empathic, understanding and polite; and when they felt that the complaint had been handled in a timely fashion.

A number of researchers have demonstrated the importance of procedural justice to complainants’ satisfaction with complaints processes. Procedural justice is the perceived fairness of the decision-making processes (Thibaut & Walker, 1975;
Tyler, 1989: Schoefer 2000)). Thibaut and Walker (1975), in their seminal work, found that people’s reactions to third party mediated disputes were related to their perception of the perceived fairness and the perceived level of control that individuals had over the decision making processes. Tyler (1989) interviewed 652 adults who had experienced some form of dispute within the legal context. Tyler, like Thibaut and Walker (1975), found that perceived control was important in judgments of procedural fairness. However perceived neutrality and trust of the third party were stronger predictors of perceived fairness than were procedural or decisional control or outcome favourability.

Perceived procedural fairness has been found to have a positive impact on how people react to their outcome. Van den Boss, Lind and White (1997) asked 157 students to imagine that they were participating in an experiment alongside another person. Participants were either given a chance to voice their opinion or not voice their opinion in relation to the experiment. The outcome that they received was either better, worse or the same as the perceived other participant or they were unaware of the outcome of the perceived other. They found that in situations where participants were unaware of the outcomes of the perceived other, they found it difficult to judge the fairness of the outcome and therefore relied more heavily on the process for judgments of satisfaction and fairness of the outcome. Where participants were aware of the outcome of the perceived other, they made satisfaction and fairness judgments on the basis of the favourability of the outcome in relation to the outcome of the other. Therefore it is anticipated that where outcomes are intangible, or where there is no equivalent standard with which to compare the outcome process becomes an important determinant of perceived fairness and outcome satisfaction.
Studies have also found that people prefer dispute resolution mechanisms that give them an opportunity to have their experiences and viewpoint heard. When people are given the opportunity to have their opinion heard during a dispute, they tend to rate both the process and outcome as being more favourable and fairer (Lind, Kanfer & Earley, 1990; Shestowsly, 2004).

In a review of 60 empirical studies examining the effects of organisational complaint management strategies, Davidow (2003) identified six dimensions of the complaint handling interaction that have been widely found to impact on subsequent post-complaint attitudes and behaviour: timelines, facilitation, redress, credibility, attentiveness and apology.

3.4.1 Timelines

Timelines refer to the speed with which complaints are responded to. Research indicates that the speed with which organisations deal with complaints has varied impact on post-complaint attitudes or behaviour. Out of 18 studies reviewed by Davidow (2003) that explored the relationship between satisfaction with complaint resolution and speed of resolution, nine reported a positive relationship between perceived response speed and post-complaint behaviour (re-purchase of services and word of mouth), three reported no relationship and six reported mixed findings. Estelani (2000) on the other hand found that response speed had a significant positive effect on the level of satisfaction with the complaint outcome, but was not reported as a determinant of dissatisfaction with the complaint outcome. There are mixed findings in relation to time lines.

3.4.2 Facilitation

Facilitation refers to the policies and procedures that an organisation has in place to help people complain. Davidow (2003) found that those studies that
explored the organisational policies and procedures that impacted on post-complaint behaviour generally found that where organisations had an accessible complaints process through which it was simple and convenient to lodge a complaint, and where staff were also accessible, this was associated with a higher level of satisfaction with the complaint outcome. Similarly Hogarth et al. (2001) explored factors associated with satisfaction with third party redress through a federal complaints agency. They found that greater accessibility, in terms of both ease of access and user – friendliness of the complaints process was associated with higher levels of complainant satisfaction.

3.4.3 Redress

Redress refers to the outcome of the complaint, including both tangible and intangible outcomes. The general principle behind redress is that the customer at the end of the redress process should be returned to a position that is the same or better than where they were before the unsatisfactory event. This is not always a possibility in the case of an adverse event that relates to health services.

When some form of monetary compensation is offered, customers are more likely to be satisfied with the outcome of their complaint and display more positive post-complaint behaviour, such as re-purchase or positive word of mouth (Clark, Kaminski & Rink, 1999). However research also indicates that that complainants who receive less than their desired level of redress are less likely to engage in negative post-complaint behaviour, such as expressions of dissatisfaction or bad word of mouth, if they perceive the staff handling the complaint as being highly attentive (Davidow, 2003).
3.4.4 Credibility

Perceived credibility refers to the perception that the provider has taken responsibility for the incident and provided an adequate and clear explanation of why the incident has occurred and what steps will be taken to ensure that it does not happen again. Research has emphasised the importance of adequate explanation in perceptions of fairness with complaint outcomes (Dunning & Pecotich, 2000; Fisher, Garrett, Arnold & Ferris, 1999; Shapiro, Buttner & Barry, 1994). Shapiro and colleagues found that explanations that were perceived as being adequate enhance the perceptions of justice and reduced the likelihood that employees who had been negatively affected by managerial decisions would complain. In addition the perception of fairness was most enhanced when the explanation was given verbally rather than in writing (Shapiro et al.). However, Shapiro and colleagues found that the perceived adequacy of explanations was also found to be less with more severe outcomes, in that the more severe the outcomes were, the harder it was for providers to provide an explanation that was judged as adequate.

3.4.5 Attentiveness

Attentiveness refers to the amount of care and attention that the person perceives that they receive from the person handling the complaint. Research indicates that a courteous empathic response is associated with greater satisfaction with complaint outcomes (Davidow, 2003). Fisher, Garrett, Arnold and Ferris (1999), explored determinants of satisfaction and dissatisfaction with complaints processes of a variety of services. They found that attentiveness factors had a significant positive influence on complainant perceptions of satisfaction, fairness, and on subsequent re-purchase behaviour. Similarly, Hogarth et al. (2001) and Reiboldt (2003) found that consumer perception of the responsiveness of a third party
organisation in handling complaints was a significant factor in satisfaction and their expectations of re-use of that service.

3.4.6 Apology

Apology refers to the willingness of the organisation or individual to apologise for what has happened. Apologies have been defined in a variety of ways in the literature, ranging from expressions of regret, to admissions of liability. Apologies may be issued by the individual who has committed the transgression or by their organisation, and may or may not incorporate an attempt at reparation (Allan, 2007; Ristovski & Wertheim, 2005; Robbenolt, 2003).

A large proportion of people who complain about services, report that they are seeking an apology, however only a minority actually receive one (Fisher et al., 2000; Mulcahy, 2003). Within a legal context, it has been argued that the reason that people may be reluctant to offer an apology is that they fear that their apology may be perceived as an admission of guilt and therefore have legal ramifications (Allan, 2007). Apology has been shown to enhance perceptions of fairness and justice in the complaints process (Fisher et al., 1999; Goodwin & Ross, 1992). It has been suggested that an apology is a form of psychological compensation (Clark et al., 1992; Fisher et al., 1999), particularly in the face of intangible losses (Allan, 2007). As was mentioned earlier in Section 3.2.1.2, outcomes of health complaints are often intangible and bear an emotional overlay of grief or loss. It seems probable that the genuine proffering of an apology may therefore be beneficial in the resolution of health complaints by offering psychological compensation where practical compensation is not possible or sufficient.

In addition to its compensatory properties, apology is thought to facilitate conflict resolution by fostering a sense of empathy within the recipient that in turn
promotes forgiveness (McCullough, Fincham & Tsang, 2003; Ristovski, & Wertheim, 2005; Robbenolt, 2003). However, the association between apology and forgiveness has been shown to be strongest when the apology is perceived as a sincere expression of sorriness, rather than as a hollow admission (Allan, Allan, Kaminer & Stein, 2006; Robbenolt, 2003). Forgiveness has been shown to be related to a range of positive outcomes for the victim, including a reduction in stress, anger and grief (McCullough, Pargament, & Thoresen, 2000; van Oyen Witvliet, Ludwig & van der Laan, 2001) and therefore to a reduction in negative victim behaviours such as grudge-holding (van Oyen Witvliet et al., 2001).

Whilst there are several factors that have been found to impact on the ease of, and satisfaction with, the complaints resolution process, complaints also have the capacity to impact on the post-complaint behaviour of both complainants and providers.

3.5 Impact of Health Complaints on Complainants and Providers

Paterson (2002) emphasises that there is a potential for both positive and negative side effects to arise from health complaints which can have both long and short term impact on the post-complaint behaviour of both the complainant and the health service provider.

3.5.1 Positive Impact of Health Complaints

Health complaints have been reported as having the potential to impact positively on both complainants and health service providers or health organisations. Complaints have been found to benefit complainants in a number of ways. The complaint may result in apology or explanation which in turn increases the complainant understanding of what has occurred and reassures complainants that the same thing will not happen again (Brown & Swartz, 1984; Paterson, 2002). Some
have argued that complaints processes can also function as a strategy for complainants to vent negative emotions, seek psychological redress and therefore provide the complainant with an opportunity for catharsis (Chebat et al., 2005; Mulcahy, 2003).

Health complaints, if viewed constructively can also be used to improve the quality of service delivery (Paterson, 2002; Mulcahy, 2003, Wilson, 1999). Health complaints give the service provider the opportunity to rectify the problem at the individual practise level and to explore the systemic difficulties such as policies and levels of funding that may have contributed to the adverse event, thereby providing the opportunity to ensure that problem does not re-occur (Huppertz & Mower, 2003; Paterson; Wilson).

3.5.2 Negative Impact of Health Complaints

Health complaints, by their nature, have a degree of emotional overlay and are often characterised by experiences of grief or anger at adverse outcomes for the complainant and fear, anxiety and trauma for the provider (Cull, 2001). This can be associated with a range of negative post-complaint behaviours for both complainants and providers.

3.5.2.1 Impact on the complainant. Chebat and colleagues (2003) emphasised the importance of the negative emotions provoked by customer dissatisfaction in decisions as to whether or not to complain. Such negative emotions have also been shown to play a role in negative post-complaint behaviours such as consumer grudge-holding or escalation behaviours.

Consumer grudge-holding is a relatively under-researched aspect of dissatisfied consumer behaviour that has been observed as a maladaptive coping response in the face of negative outcomes (Aron, 2001; Hunt & Hunt, 1988, van
Grudge-holding is usually precipitated by a strong emotional reaction to a negative outcome, or ‘flashpoint’, which in turn provokes a strong negative attitude and negative behavioural responses to the service provider (Aron, 2001; Hunt & Hunt, 1988). Grudge-holding may have a number of manifestations including a lack of forgiveness, a refusal to use a service again, negative word of mouth or retaliation in the form of escalation of complaints (Aron, 2001; van Oyen Witvliet, Ludwig & van der Laan, 2001).

Researchers who have examined the escalation of conflict have used the theory of escalation bias to explain the observation that when people choose a course of action (or make a decision) and are personally responsible for the negative outcomes of that decision, they consistently commit a greater amount of resources to that failing course of action (Shoorman & Holahan, 1996). A number of explanations have been put forward for the escalation bias. First it has been argued that people who choose a course of action and feel personally responsible for the outcomes of that action become psychologically committed to the choices made. The second is that the receipt of negative feedback (or realisation that the course of action has failed) stimulates a process of self-justification, where people either psychologically defend themselves against the recognition of error in their choices, or seek to escalate their commitment to their choices by investing further resources (Shoorman & Holahan, 1996).

Bobocel and Meyer (1994) in a study of group decision making, found that individuals who felt personally responsible for initiating an action and the resultant outcome, escalated their commitment in forthcoming actions, even when there was clear evidence that the course of action had failed. Further more, Bobocel and Meyer observed that the process of justifying their actions to others (by providing a rationale
for their decisions) increased the level of commitment to, and persistence with, the failed course of actions. Bobocel and Meyer argued that the process of justifying actions or decisions to others acted to reinforce the self-justification of the appropriateness of the course of action.

Bobocel and Meyer explained this in terms of greater ego involvement leading people to be more motivated to engage in self-justification in an attempt to reduce cognitive dissonance. Schoorman and Holahan (1996) found that the escalation bias is not limited to choices made by the individual. They examined individuals’ reactions to outcomes of decisions made by others when their own decisions had been overridden in favour of others. Schoorman and Holahan found that, when individuals had had their suggested actions overridden by others, the escalation bias was observed most in those situations where the alternative course of action resulted in positive outcomes. It appeared that the favourable outcomes from the alternative course of action, translated into the perception of failure of the initial course of action, which then resulted in an escalating commitment to that first (although untested) course of action. Schoorman and Holahan observed that the escalation bias was greatest when the outcomes were in contrast with the individuals’ expectations.

Whilst the theory of escalation bias is not documented in terms of complaint behaviour, it seems reasonable that it may apply. It could be that when complainants’ complaints are rejected, or when the outcomes of the complaint are different to that which they expect, they may become even more strongly committed to the course of action (i.e., pursuing the complaint) using a process of self-justification to reduce their cognitive dissonance.

3.5.2.2 Impact on provider. Whilst it has been established that adverse events do not always result in a complaint (Brown & Swartz, 2001; Kolodinsky, 1993;
Leape, 1994; Schlessinger et al., 2002), the converse is also true, in that complaints do not always equate with an adverse event (Mulcahy, 2003). In addition the majority of complaints received by regulatory bodies are not related to malpractice or misconduct (Mulcahy, 2003; Paterson, 2002; Wilson, 1999). Regardless of the frequency, substance or nature of complaints, providers usually report being the subject of a complaint or litigation as being stressful and traumatic.

The majority of health service providers who find themselves complained against or the subject of malpractice litigation report experiencing a range of negative emotions (Charles, 1996; Montgomery, Cuprit, & Wimberley, 1999; Schoenfeld, Hatch & Gonzalez, 2001; Wilbert & Fulero, 1988). Montgomery and colleagues (1999), in a survey of psychologists who had been subject to either a complaint with their state licensing board or a malpractice suit, found that the vast majority of psychologists reported that they had had severe emotional responses to the complaint including shock, anger, worry, fear, and depression. Similarly, Schoenfeld and colleagues (2001) conducted a survey of 240 licensed psychologists in Texas, who had had a complaint filed against them, half of whom were found to have committed a violation and the other half whom the board had ruled that there had been no violation. They found that both groups of psychologists (violation found and no violation determined) reported experiencing increased negative affect in terms of anxiety, depression and anger throughout the course of the complaint. Furthermore regardless of whether they had been found to commit a violation, psychologists reported increased somatic symptoms throughout the course of the complaint, although the severity of symptoms was greatest in the group of psychologists who were found to have violated their ethical requirements. Schoenfeld et al. also found that the degree of complaint resolution also impacted on the providers’ reactions to
the complaint. Where complaints were resolved quickly participants reported experiencing less negative affective symptoms.

There is also evidence that being the subject of a complaint or malpractice litigation, or even the threat of malpractice litigation can lead to inappropriate behavioural responses such as the adoption of defensive practices or the hiding of errors (Allsop & Mulcahy, 1998; Freckelton & List, 2000; Lawton & Parker, 2002; Mulcahy, 2003).

Defensive practice occurs when a practitioner changes the way they practice in a way that may not be beneficial to the client, as a means of avoiding complaints or protecting themselves should a complaint arise (Cook & Neef, 1994). A number of studies have reported on the increased tendency for health practitioners to practice defensively following a complaint or litigation against them. Medical practitioners have been found to show an increased tendency to order further testing, refer clients on, or to refuse to do certain high risk procedures or see clients who they believe pose a high risk of complaining (Charles, 1996; Charles, Warnecke, Wilbert, Lightenberg & DeJesus, 1987; Shapiro, Simpson, Lawrence, Talsky, Sobocinski & Schiedermayer, 1989; Summerton, 1995). Research has indicated that even where practitioners have never had a complaint against them, the perceived risk of complaint or litigation is adequate to trigger defensive practices (Charles et al., 1987; Shapiro et al., 1989; Wilbert & Fulero, 1988) or create a reluctance to report adverse incidents, especially when they result in negative outcomes (Freckelton & List, 2000; Lawton & Parker, 2002). This has led to a call for professional organisations to set up formal and informal support structures to assist health service providers to cope with the negative impact of having a complaint lodged against them (Charles et al., 1987; Morrissey & Reddy, 2006).
### 3.6 Complaints as a Tool for Improving the Quality of Service Delivery

The frequency and severity of complaints about health service providers or organisations is frequently considered to be an indicator of the quality of service provided. In particular, it has been argued that complaints against health service providers provide a rich source of quality assurance data that should be used in a top-down fashion to inform clinical practice and foster ongoing improvement of health service delivery (Cornwall & Romios, 2004; Paterson, 2002; Wilson, 1999).

There are a number of concerns about the use of health complaints as an indicator of service quality. The first is the finding that the majority of those health service users who are dissatisfied with the health service they receive choose not to complain (Brown & Swartz, 2001; Dolinsky, 1995; Kolodinsky, 1993; Schlessinger et al., 2002). Therefore little is known about the experiences of those who choose not to complain, but who may choose to behave differently following their negative interaction (Davidow, 2003; Huppertz & Mower, 2003; Mulcahy 2003).

The second concern about using health complaints as an indicator of the quality of service is that to date there has been little empirical evidence as to whether or not dissatisfaction with health service or patient perceptions of quality of service are correlated with objective measures of health service quality (Bitner & Hubbert, 1994; Finn & Kayande, 1998; Ostram & Iacabucci, 1995; Rust & Oliver, 1994). Much of the analysis of health complaints has been reported in the organisational reports rather than in peer reviewed literature and therefore has not been subject to independent scrutiny. In addition little empirical research has focused on the occurrence of errors in the health service industry. If health complaints are to be used as an instrument of quality improvement then there needs to be a systematic and
scientific documentation of adverse events which provides an evidential basis for subsequent decision making (Ovetviet, 2000).

Finally, traditionally complaints have been viewed as an individual dispute between health service user and provider. However this approach ignores the systemic nature of service failure and the policies or processes that may contribute to practitioner error. If complaints are to be used for the improvement of health service delivery, then there is a need to go beyond this view of complaints as an individual transgression, and to explore the systemic difficulties that allow adverse medical events to occur (Cornwall & Romios, 2004; Paterson, 2002).

3.7 Summary of the Chapter

The literature reviewed in this chapter revealed that client satisfaction with health services they receive is generally highest when the process and outcomes of the service encounter are consistent with the client’s expectations. Furthermore, where outcomes are less tangible (as is the case in health service encounters), client satisfaction is closely linked to their perceptions of the interpersonal encounter with the service provider (Section 3.2).

One option available to dissatisfied customers is to lodge a formal complaint. However, research indicates that the majority of people who are dissatisfied with their health services choose not to complain (Section 3.2.2). The decision to complain has been shown to depend upon the magnitude of the discrepancy between what the client’s expectations and the service they actually receive, the client’s beliefs about complaining, the degree to which clients predict the complaint will be successful and their prior experience with formal complaints mechanisms (Section 3.3). Clients are most likely to complain when the severity of the adverse outcome is high, when the service provider is perceived to bear a greater personal responsibility for the negative
outcome, and when they perceive that there is an accessible complaints process that they have the ability to successfully negotiate.

Complainant satisfaction with complaint processes has been found to be influenced by the promptness and user-friendliness of the complaints process, the outcome of the complaint, the attentiveness of the staff member handling the complaint, and the willingness of the service provider to take responsibility for or to offer an apology for the incident (Section 3.4).

There is evidence to suggest that complaints can have a negative effect on both complainants and the health service providers. The emotional overlay in health complaints has been associated with the display of negative post-complaint behaviours such as grudge-holding and escalation behaviours in complainants (Section 3.5.2.1) and the tendency towards defensive practice and a range of psychological symptoms in health service providers who find themselves the subject of a complaint (Section 3.5.2.2).

While evidence obtained from health complaints is frequently argued to offer insight into how best to improve the quality of health service delivery, the use of complaints in this way can be questionable due to the research evidence that suggests that very few people who are dissatisfied with their health services actually complain, and the observation that complaints processes tend to have an individual rather than systematic focus (Section 3.6). If complaints are to be used to improve the quality of health service delivery, it is therefore essential that the processes are effectively evaluated, and efforts are made to tap the experiences of the ‘silent majority’ that choose not to complain.
Chapter 4: Evaluation Theory and Practice

4.1 Overview of Chapter

The previous three chapters have explored the social and economic context in which health services are delivered and the influence this has on public perceptions and expectations of health professionals. The modes of regulation of the health professions have been explored, including the mechanisms for the management of health complaints. In addition factors influencing client perceptions of the quality of health service delivery were explored along with the antecedents and barriers to lodging complaints and the factors affecting complaint resolution. The importance of complaints as an indicator of service quality was discussed along with the use of complaints as a source of evidence to inform evidence-based decisions about service improvement. Finally, emphasis was given for the need to evaluate health complaints processes in order to ensure that decisions about service improvement are made on a sound empirical basis.

The following chapter will explore evaluation theory from a historical perspective. Section 4.2 offers an historical overview of the development of evaluation as a scientific and professional practice. Section 4.2.1 defines the concept of evaluation, and in particular program evaluation, while Section 4.2.2 discusses the emergence of evaluation as a scientific pursuit. Section 4.3 reviews theories of evaluation across a number of dichotomous dimensions including formative versus summative evaluation, qualitative versus quantitative evaluation, and outcome versus process evaluation. Section 4.4 considers current approaches to evaluation practice and the dimensions across which different approaches to evaluation conceptually vary, including the nature of the program to which they are applied, conceptions as to
the role that values, the evaluator and the stakeholders should play in the evaluation, and the way in which evaluation findings are to be used.

Section 4.5 reviews four evaluation designs that are commonly applied in evaluation research, including Theory-based evaluation, Mixed-method designs, Improvement focused designs and Utilisation-focused designs. Section 4.6 explores the extent to which evaluation theory actually guides the practice of evaluation in the “real world”. Finally Section 4.7 discusses evaluation as it is currently applied in the evaluation of health services, while Section 4.8 discusses the evaluation of complaints processes. Section 4.9 considers the particular difficulties associated with evaluation in the health sector.

4.2 History of Evaluation

4.2.1 Definition

Evaluation is a term that encompasses a range of formal and informal assessment activities. In the broadest sense evaluation is an informal activity that humans regularly engage in as part of their daily lives. Part of the human condition is to continually assess the stimuli available, piece together and reflect on the available evidence and to make judgments as to the relative value of options and the most appropriate course of action. Informal evaluation therefore forms the basis of most of the decisions that are made within an individual’s daily life (Albaek, 1998; Ovretviet, 1998; Owen & Rogers, 1999).

However evaluation also occurs in a more formalised, systematic and research oriented sense. One area of formalised evaluation that has emerged is that of program evaluation. Program evaluation is a systematic process whereby an assessment is made of the value of a given service. This assessment may include an assessment of the need for the service, an assessment of the effectiveness and efficiency of the
structures and processes of the service or an assessment of the outcomes or outputs of that service. Program evaluation may also include an assessment of what steps need to be taken to make the service more responsive to, and more effective in, meeting the needs of the recipients of the service (Cook & Shadish, 1986; Owens & Rogers, 1999; Posavac & Cary, 1997).

4.2.2 Emergence of Evaluation as a Scientific Process

The historical origins of evaluation go back to the sixteenth and seventeenth centuries with the emergence of the scientific movement (Ovretviet, 1998). Such early evaluations arose out of a need to clarify the effectiveness of various scientific and medical practices. Early evaluative techniques tended to rely heavily upon intuition, anecdotal evidence and the subjective assessment of individual case studies by health professionals (Jenkinson, 1997; Owen & Rogers, 1999). Later, in the nineteenth century, in the wake of the industrial revolution, a number of reforms were made to social policies regarding education, labour laws, orphanages and hospitals, producing a corresponding need to assess the value of such policies. Such initiatives usually involved non-systematic forms of evaluation and assessed a narrow range of outcomes of the program. Evaluation techniques employed ranged from the informal and impressionistic to formal government inquiries and commissions (Madaus, Stufflebeam & Scriven, 1983).

Early evaluations therefore stemmed from varying motivations, showed little consistency of approach, and lacked theoretical grounding (Madaus et al., 1993). However, over the subsequent century the practice of evaluation evolved from being a relatively subjective and non-systematic activity to what is currently recognised as a theoretically grounded scientific practice and profession in its own right.
Evaluation theory and practice, in its current form, became a recognised specialist activity in the 1960s. In the 1960s and 1970s most OECD countries experienced a period of relative affluence which resulted in a rise in government spending on welfare and education and a corresponding increase in the number of government funded programs. Out of the increased spending arose a need to ensure that the funds were being distributed appropriately and that the programs being funded were effective. In such a climate evaluation became an important aspect of policy development but also an integral aspect of the accountability process (Albaek, 1998; Hanes, 1977; Madaus, et al., 1983; Ovretviet, 1998, 1999; Posavac & Cary, 1997). As a result, over the past 30 years evaluation has become an institutionalised practice within westernised countries and is now commonly used as a tool to negotiate agreements, assess policies and monitor performance in all areas requiring government funding (Hancock, 1999; Madaus et al.; Posavac & Cary, 1997).

Initially program evaluation and research were conceptualised as two separate entities. Traditionally research comprised an experimental, scientifically driven line of inquiry, while evaluation was conceptualised more in terms of a series of ad hoc exploratory practices rather than as a rigorous line of inquiry (Hanes, 1977; Madaus et al., 1983). However as evaluation evolved and became recognised as a scientific pursuit, research methodology with an emphasis on the experimental design was adopted in an attempt to inject scientific rigour into the evaluation process. Evaluation and research however, can be distinguished by their goals. The goal of research is scientific inquiry, while the goal of evaluation is to make a value judgment about a service and to generate practical suggestions for improvement (Ovretveit, 1998). Evaluation findings then became an important facet of evidence based
practice providing a rich source of evidence as to which programs do and do not work effectively (Bonner, 2003).

4.3 Theoretical Approaches to Evaluation

Scriven (1996) argues that theoretical approaches to evaluation vary along a number of dichotomous dimensions including: summative versus formative evaluation, outcome versus process evaluation and quantitative versus qualitative approaches.

4.3.1 Summative versus Formative Evaluation

It is widely argued in the evaluation literature that there are two broad forms of evaluation, summative and formative (Hames, 1977; Jenkinson, 1997; Posavac & Cary, 1997; Ovretviet, 1998; Owen & Rogers, 1999; Rossi et al., 1999). Summative evaluations are usually intended to accumulate data from which a judgment of whether or not a set of specific program goals are being met and are therefore generally conducted retrospectively (Rossi et al., 1999). Summative evaluations are most often used to evaluate programs which are in a mature or settled stage of operation. They most usually involve an assessment of the impact or outcomes of a given program or treatment (Hanes, 1977; Owens & Rogers, 1999; Rossi et al., 1999).

In summative evaluation either a questions approach or methods approach to evaluation is adopted (Stufflebeam, 2001). A questions approach aims to examine a narrow set of questions usually generated from the stated goals of the program, while the methods approach seeks to apply a particular design, most usually an experimental design, that explores a limited range of variables or outcomes. Both questions and methods approaches tend to be outcomes focused, look at key performance indicators and focus on accountability (Posavac & Carey, 1997; Rossi et
al., 1999; Stufflebeam, 2001). The problem with summative evaluations is that they give little indication of why the observed outcomes have been achieved.

Formative evaluations on the other hand, are evaluations that are undertaken with the purpose of providing information on how to improve the design and delivery of a service (Rossi et al., 1999). Formative evaluation is most often applied in the developmental stages of a program and has a strong improvement focus. Formative evaluations can commence prior to or in the early stages of program development and often seek to clarify the internal structure of a program or policy in a similar fashion to an accreditation process (Hanes, 1977; Owens & Rogers, 1999).

4.3.2 Quantitative versus Qualitative Measures

Another issue on which the evaluation community is divided is in the type of methodology best applied. Some argue for an experimental line of inquiry that involves the collection of quantitative data in a controlled manner, while others argue that the collection of qualitative data is essential for conducting a meaningful evaluation. The randomised controlled trial (RCT) forms the ‘gold standard’ of the experimental approach to evaluation. RCTs involve the comparison of the actual and expected outcomes of a program. In a RCT participants are randomly assigned to two groups, one of which receives the intervention and one of which does not (the control group). Typically, measurements are made before and after the intervention and the relative changes of the two groups are assessed. The reported strength of an RCT is in its strong internal validity due to the level of control of extraneous variables (Weiss & Rein, 1983). However there is much debate in the literature as to the worth of RCTs in program evaluation. Many evaluation theorists have begun to question the value of RCTs arguing that they lack external validity and therefore have little applicability to the real-life world of evaluation. A number of theorists have argued
that purely experimental evaluation designs are a ‘black box’ approach in that they focus too heavily on causality and the outcomes of programs while giving little indication of the process, why the program does or does not work or suggestions for program improvement (Bonner, 2003; Cook & Shadish, 1994; Cronbach, 1983; Harachi, Abbott, Catalano, Haggerty & Flemming, 1999; Stufflebeam & Webster, 1983; Weiss & Rein, 1983). Furthermore, it has been argued that purely experimental evaluation techniques fail to contextualise the evaluation in terms of the experiences of the evaluatees and the real-world recipients of the services (Stake & Migotsky, 1997).

As an alternative to the experimental design, evaluation theorists have begun to argue for the application of a more integrated model of evaluation which applies a range of quasi-experimental and qualitative approaches which therefore place less emphasis on causality and a greater consideration of how and why outcomes have occurred. The supplementation of quantitative measures with qualitative measures such as interviews, case studies and open-ended questionnaires allows for the achievement of a greater insight into the workings of the program and helps to clarify what aspects of the program impact on the outcomes to the greatest degree. It is argued that evaluation approaches that combine qualitative and quantitative measures have a greater utility in program improvement (Bonner, 2003; Chelimsky, 1998; Cook & Shadish, 1994; Cronbach, 1983; Hanes, 1977). In this sense, psychologists with their specialist training in both qualitative and quantitative research methodologies are well placed to contribute to the growing field of evaluation.

4.3.3 Outcome versus Process Evaluation

Outcome evaluation is an evaluation that assesses the degree to which a program achieves the stated goals and objectives (Patton, 1997; Rossi et al., 1999).
In an outcome evaluation performance criteria are usually developed based on the stated objectives of the program and/or the financial accountability requirements of the funding agency. The performance of the program is then assessed against the agreed upon criteria. Outcome evaluations, by definition occur at the end of program delivery. The use of outcome evaluation in isolation has been widely criticised in the evaluation literature as being a ‘black-box’ approach, as like all summative evaluation approaches, it gives little insight as to how and why the outcomes have been achieved (Rossi et al., 1999; Stufflebeam, 2001).

Process evaluation involves an assessment of the internal organisational processes, the implementation and delivery of the service, in an attempt to discover the strengths and weaknesses of the service and to give insight into possible improvements (Patton, 1997; Rossi et al., 1999; Warburton & Black, 2002). Process evaluation is therefore a formative approach to evaluation that focuses less on whether an intervention has worked and more on why that intervention was successful or not. Process evaluation often also includes the assessment of the perceptions and expectations of the stakeholders who are involved in the service (Warburton & Black, 2002).

Warburton and Black (2002) in a review of the current use of process evaluation in the evaluation of health services, argued that a process evaluation approach is particularly appropriate in the area of health evaluation because of the complex environmental, organisational and interpersonal context in which health services are delivered. However, despite considerable theoretical rhetoric as to the relative value of process evaluation, Warburton and Black claim that a large proportion of evaluations of health services continue to use outcome measures as their primary indicators. Warburton and Black argue that this stems from the reliance of
process evaluation on qualitative measures and case studies, which are sometimes viewed as lacking scientific rigour; the relative expense and time consuming nature of process evaluation; and the fact that relatively few process evaluations are reported in peer reviewed publications, thereby giving a smaller theoretical base on which to build and develop methodology.

4.4 Practical Approaches to Evaluation

Cutting across the abovementioned dichotomous theoretical dimensions are a range of methodological approaches to evaluation. While evaluation is now considered to be an integral source of evidence to guide professional practice, and there is an agreement that an integrated approach to evaluation is required, there remains a wide range of approaches to evaluation reported in the literature and a lack of consensus as to what is the preferred type of data to collect and the most appropriate evaluation.

There are a number of reasons for the diversity of approaches to evaluation practice. First, a range of disciplines are represented in the evaluation literature, each with it’s own methodological ideals and corresponding range of theoretical and practical approaches. Second, evaluations tend to vary in their degree of formality and their size and scope, depending on the nature and the purpose of the program or service being evaluated (Posavac & Cary, 1997). Therefore evaluations are by necessity tailor made within the requirements of the organisation commissioning the evaluation, and there is no possibility for a ‘one size fits all’ evaluation methodology. Third, there is no consistency in the reporting format for evaluations. The findings of evaluations are reported in a range of forums, from informal or formal reports to journal articles. Only a small proportion of evaluations go on to be reported in the
peer reviewed literature. This means that there is not an easily accessible, solid empirical basis on which to build and improve techniques.

A number of literature reviews have reported on the broad range of evaluation models currently in use (see Stufflebeam, 2001 and Rossi et al., 1999 for reviews). Such reviews have noted that the different approaches to evaluation usually vary along five broad dimensions, namely the nature of the program to be evaluated; the type of evaluative data that is deemed valid; the perception of the role that values play in an evaluation; the role that the evaluator should take in the evaluation; the role of the different stakeholders in the evaluation; and how the social and scientific findings of the evaluation should be used to improve the service being evaluated (Ovretviet, 1998; Rossi et al., 1999; Stufflebeam, 2001).

4.4.1 Nature of the Program

Different types of programs are suited to different evaluation strategies. Programs embody a range of theoretical and operational contexts about what each program intends to achieve, how the program should achieve the implicit and explicit goals, and what the intended outcomes of the service are. All of these factors impact on the choice of evaluation design and dictate the type of measures that are most appropriate to use (Cook & Shadish, 1996; Posavac & Carey, 1997; Rossi et al., 1999).

4.4.2 The Type of Evaluative Data that is Deemed Appropriate

The type of evaluation data that it is deemed appropriate to collect will depend on the reasons for the evaluation and the audience for the evaluation. Evaluations are commissioned for a number of reasons. Ovretviet (1998) identified six main motivations for evaluation: to determine resource allocation, to enhance the service recipient’s knowledge of the benefits and disadvantages of the service, to improve the
service provider’s knowledge and inform their decisions, to improve managers’
knowledge and inform their decisions, to justify further funding of the service and to
inform political decisions about the service. Each of these motivations will result in
the collection of a different type of data. For example, where the focus of the
evaluation is on resource allocation, then data collected may relate to the
effectiveness or cost effectiveness of the program, requiring the collection of outcome
data. Alternatively if the focus of the evaluation is on building professional
knowledge to inform service improvement then a combination of data relating to both
the program outcomes and they way the program is delivered may be required.

Therefore, depending on the motivation for the evaluation a decision will be
made as to whether it is more appropriate to collect qualitative or quantitative data,
whether the evaluation should be conducted by an internal or external evaluator and
which stakeholders should be included in the data collection process (Posavac &
Carey, 1997; Rossi et al., 1999).

4.4.3 The Role of Values in the Evaluation

Theorists have mixed views as to the role that values play in evaluation.
Some argue that evaluation should be a value free analysis of the evidence and should
where possible be performed by independent external evaluators such as is the case in
experimental designs (Scriven, 1983). Others argue that value free evaluation is not
possible. The process of deciding what the goals of the program are, what outcomes
are valued and whether or not the program is working all entail value judgments
about what is a desirable process/outcome, thereby rendering value free evaluation
impossible (Cook & Shadish, 1986; House, 2001).
4.4.4 The Role of the Evaluator

Theorists also have mixed views as to what role the evaluator should take in the evaluation. Proponents of the experimental approach generally argue that the evaluator should be an objective external researcher (Scriven, 1983). Others argue that a greater depth of understanding is possible when there is a high level of collaboration between the evaluator and the evaluatees, or even when evaluatees themselves have an active involvement in the evaluation design (Fetterman, 2001).

4.4.5 The Role of Stakeholders in the Evaluation

There is an increasing awareness of actively involving key stakeholders in the evaluation. Christie (2003a), in a survey of evaluation theorists and practitioners, found that despite a diversity of theoretical orientations, there was a high degree of agreement on the need to involve stakeholders in the evaluative process. Chelimsky (1994) further asserted the importance of including the beneficiaries of programs in the evaluation process. From an equity and inclusiveness point of view this allows for a greater credibility of findings and allows stakeholders who are not represented within the organisation to have their views heard.

4.4.6 How the Findings Will be Used

The form that the evaluation takes will also be dependent on the way in which it is intended to use the findings. If findings are to be used to determine whether or not a service continues, then the focus will tend to be more on outcomes. However in the ‘real world’ programs will usually continue to run. Therefore program evaluations tend to have their greatest utility in suggesting improvement (Rossi et al., 1999).
4.5 Four Commonly Applied Approaches to Evaluation

Whilst formative evaluation is currently the approach most frequently applied to evaluation, this approach encompasses a broad range of evaluative practices (see Stufflebeam, 2001 for a comprehensive summary of alternative evaluation approaches) which include theory-based approaches, mixed method designs, improvement focused designs and utilisation-focused designs.

4.5.1 Theory-based Designs

Theory-based evaluation takes into the consideration the theoretical and operational context within which a program is designed and delivered. In designing such an evaluation the implicit and explicit theories that underlie the program guide the evaluators’ decisions as to how best to conduct the evaluation, the research questions to be asked and the indicators to be used in the evaluation. The main strength of Theory-based approaches is that they explore the degree to which the program as implemented is theoretically sound, and thereby allow an understanding of why the program may or may not be working, and suggest directions for improvement (Reynolds, 1998; Rossi et al., 1999).

4.5.2 Mixed Method Designs

Formative evaluations most often apply mixed method designs to ensure reliable feedback on the program through a variety of methods. In the mixed method design, both qualitative and quantitative data are collected. The qualitative data are usually used as a means to further explore the quantitative responses and to attempt to capture the sense of the lived experiences of the participants. Therefore, in addition to the evaluation of program goals and objectives, evaluations that apply mixed-method designs are also sensitive to the experiences of the stakeholders, giving a further level of enrichment to the data.
4.5.3 Improvement Focused Designs

Improvement focused designs seek a comprehensive understanding of the structures and processes of the program in addition to the outcomes. Typically improvement focused designs involve a mixed-method approach to collecting data from key stakeholders in the evaluation. Improvement focused designs will often assess the views of the consumers of the program (Posavac & Carey, 1997; Stufflebeam, 2001). One such design is the consumer oriented approach. The consumer oriented approach is an evaluation conducted by an independent objective evaluator. This form of evaluation holds the welfare of the consumers as the primary evaluative judgment and therefore is an ethics and justice based approach. The focus of consumer-oriented evaluations is helping organisations to produce services of high quality and of high value to the recipients of those services. Moreover the evaluator directly involves the consumers of the service in the assessment of the quality and worth of that service. This assessment may be made in relation to the relative worth of the service compared with other available services (Stufflebeam, 2001).

4.5.4 Utilisation Focused Designs

Patton (1997) emphasises the need to shift the focus of evaluations beyond the simplistic generation of evaluation findings towards considering the uses to which evaluation findings are put in making decisions about programs and suggesting improvements. Utilisation-focused designs therefore take into consideration what the evaluation means for the ‘real people’ involved in the evaluation process. Evaluation by this approach involves working closely with the key stakeholders who have the power and responsibility to enact evaluation recommendations (Patton, 1997).

The philosophy behind utilisation-focused evaluation is that the intended users of the evaluation data are more likely to take a positive approach towards the
evaluation and subsequent recommendations if they are actively involved in the
evaluation and have a feeling of ownership of the evaluation process. Utilisation-
focused does not prescribe a specific methodology but rather embodies the need for
involvement of all key stakeholders in the evaluation (Patton, 1997).

It should be noted that the abovementioned approaches are a few of many
approaches commonly used in evaluation practice. Furthermore these approaches are
not mutually exclusive and are commonly used in conjunction with one another.

4.6 The Extent to Which Evaluation Theory Guides Practice

Despite considerable acknowledgement in the literature of the need to
incorporate theory into evaluations, research indicates that most evaluations are
atheoretical in nature. Christie (2003a; 2003b) in a recent study of evaluation
practice, surveyed 138 evaluators as to the degree to which they applied theory to
their practice of evaluation. Christie found that of the participants, less than 10%
reported subscribing to a particular theoretical framework within their evaluation
practice.

King (2003) argues that there are a number of reasons for the tenuous
relationship between program evaluation theory and practice. First there is a lack of
consensus about the definition of evaluation and the theoretical basis of evaluation.
Secondly, the practice of evaluation is very much an applied practice and is structured
around the needs of individual clients rather than around theory building.
Furthermore when evaluation is reported as being theory based, this most often refers
to the theories underpinning the particular program rather than the theory of program
evaluation itself. Finally, evaluation is a pragmatic pursuit, and often needs to adapt
the methodology that may be considered ‘ideal’ to the real life constraints that arise
from evaluating in the real world (King).
4.7 Evaluation of Health Services

Approaches to the evaluation of health services have evolved out of epidemiological studies and most recently the social sciences (Ovretveit, 1998). Ovretveit (1998) in his review of health intervention evaluation strategies notes that the evaluation of health interventions usually takes place within one of four perspectives: the Experimental, the Economic, the Managerial or the Developmental.

Experimental evaluations are mostly used to assess treatments. They test hypotheses regarding specific interventions and the variables under study are usually clearly defined, as such these evaluations tend to focus on the outcomes of the treatment rather than on the processes through which these outcomes are achieved (Ovretveit, 1998; Warburton & Black, 2002). Economic evaluations on the other hand tend to seek information regarding how many resources are consumed in the delivery of an intervention and the quality and cost effectiveness of the intervention. Economic evaluations are therefore most usually conducted in a financial context that deals with resource allocation (Ovretveit, 1998).

The Managerial approach to evaluation focuses on service delivery and accountability from a management perspective, with particular emphasis on the efficiency, the effectiveness and the equity of the service provided. Finally the Developmental approach to health service evaluation is an improvement focused model that applies social science principles and theories to elicit both qualitative and quantitative information about the process of health service delivery in order to enable service providers to modify and improve treatments, services and policies. Unlike the other approaches, a Developmental perspective has a practical focus and usually involves an independent evaluator working with the major stakeholders to assist service providers to better understand the process of what they do and how to
improve it (Ovretveit, 1998). Real-world evaluations of health services often include aspects of two or more of the aforementioned approaches; however there is general agreement in the current literature that the Developmental perspective, with its emphasis on process evaluation, is the most useful approach to evaluation of health services (Ovetveit, 1998; Patton, 1997; Rossi et al., 1999; Warburton & Black, 2002).

4.8 Evaluation of Complaints Processes

Most evaluations of complaints processes have been conducted in the service industry sector and the author was able to locate only a few evaluations of complaints processes in the peer reviewed literature. Much of the peer reviewed literature that has focused on formal complaints processes has focused on the efficacy of the particular dispute resolution techniques, usually in comparison to litigation, rather than on the complaints process itself or the experiences of the complainants and service providers in the system. For example the use of alternative dispute resolution techniques such as mediation and conciliation has been shown to be effective in the resolution of disputes across a range of dispute types including human rights and equal opportunity disputes (Devereaux, 1996), educational disputes (Morgan, Whorton & Zink, 1995), juvenile justice disputes (Smith & Lombardo, 2001) and medico-legal disputes (Metzloff, Peeples & Harris, 1997). Smith and Lombardo (2001) found that mediation positively and significantly impacted on the resolution of juvenile justice cases, allowing the negotiation of behaviour contacts, without the need for court intervention; while Morgan et al. (1995) found that mediation was successful in achieving favourable outcomes in special educational disputes thereby saving parties considerable time, expense and distress when compared with due process hearings or litigation.
Metzloff and colleagues (1997), evaluated the use of court ordered mediation in the resolution of medical malpractice suits in North Carolina. They reported mixed findings in relation to the benefit of mediation in the resolution of medical malpractice cases. Metzloff et al. found that mediation resulted in either the settlement of the case or considerable movement towards a settlement before the hearing in almost half of the cases. However they also found that pre-trial mediation was only beneficial when parties were already open to settlement. Where parties were not inclined to settle there was little evidence that the mediation process had any impact on the dispute or subsequent resolution. Metzloff et al also noted that mediation was most beneficial when it occurred early in the litigation process. However, litigation is by nature an adversarial process. It seems likely that a conciliatory approach may be more effective when it occurs at an earlier stage, before the complaint gets to the stage where they see no alternative to litigation for resolving their grievance.

While studies such as those mentioned above provide valuable evidence for the relative efficacy and effectiveness of dispute resolution techniques, they employ a narrow definition of success (e.g., whether or not settlement or agreement is reached) that gives little indication of the internal workings of the complaints process or of the experiences, expectations and satisfaction of the parties involved in the complaint with the process and outcomes of the complaint.

Evaluations of statutory complaints organisations have most often been reported in government or organisational reports. Such evaluations vary in motivation, methodology and scope. Devereaux (1996) in an evaluation of the operation and cost effectiveness of the conciliation process at the Human Rights and Equal Opportunity Commission, utilized case notes from 40 cases to assess the
efficacy of the complaints resolution process. Devereaux reported mixed findings. Whilst case records indicated that a sustainable and mutually agreeable outcome had been reached in those cases which progressed through the conciliation process, Devereaux also found that almost half of the cases were withdrawn by the complainant prior to resolution. Because of the secondary nature of the data, little insight was possible as to why the complaints had been withdrawn.

Hogarth and Hilbert (2004) explored the merits of using a mixed method approach to elicit the responses of complainants to the complaints process at the USA Federal Reserve Bank. Hogarth and Hilbert sent complaints questionnaires which comprised a combination of rating scales and a further opportunity for open ended responses as to their level of satisfaction with the process and outcome of their case. They found that while consumers were generally satisfied with the way the staff handled their complaint they were generally less satisfied with the outcome. Qualitative data revealed that the most often cited reasons for dissatisfaction with the complaints process were related to doubts about impartiality; dissatisfaction with the legislative constraints that limited the power of the complaints organisation to resolve the complaint or enforce outcomes; and a perception that the organisation had not fully understood the nature of their complaint. The most often cited reasons for satisfaction with the complaints process included the empowerment that came through having the complaint resolved by a third party agency, the professionalism of the staff and the time and the service received from the complaints management staff. Hogarth and Hilbert noted that while the application of a mixed-method design was beneficial, in that the qualitative data gave a greater insight as to the reasons for quantitative satisfaction ratings, the qualitative responses did not elicit any new information or themes that were not already indicated by the quantitative data.
Complaints in the banking industry are functionally different to complaints about health services. Outcomes in the banking industry are more tangible than in health service industry and it could be argued, less emotionally laden. Therefore it seems plausible that a mixed method design would be more beneficial in the evaluation of health complaints processes because of the emotional overlay and therefore the greater complexity of the complaints process.

Only a small number of public reports relating to evaluations of health complaints processes could be located. Statutory bodies charged with the resolution of health complaints usually have a legislative requirement to evaluate the services they provide on a periodic basis. However these evaluations vary in their focus and in the degree to which they involve the service recipients (complainants and health service providers) in the evaluation. Additionally such reports tend to contain minimal information regarding the statistical findings and often do not subject findings to tests of statistical significance.

The Office of Health Review in Western Australia (OHR, 2003) explored the effectiveness of their complaints mechanism by calling for submissions from a range of stakeholders including organisations and individuals in the general public who may or may not have had first hand experience with the OHR. The evaluation provided a rich source of data relating to the accessibility of the service and resulted in a number of suggested legislative reforms relating to the public profile of the OHR and the practical operations and management systems of the service. However because the evaluation did not specifically target health service consumers and providers who had been subject of a complaint, the findings did not give insight into the experiences and expectations of the individuals with first hand experience of the service (OHR, 2003).
Posnett, Jowett, Barnett and Land (2001) conducted a large scale evaluation of the United Kingdom National Health Scheme complaints procedure. In the United Kingdom complaints against health service providers are initially heard locally, and those complaints that are not resolved at the local level are referred to an independent review panel. Posnett et al. sent questionnaires (\(N=419\)) to complainants and interviewed both complainants (\(N=276\)) and NHS health service providers (\(N=39\)) who had been complained against, who had either had their complaints heard locally or by the independent review panel. There was a consistency of views expressed by complainants whose complaints had been resolved at the local and formal review level. The majority of complainants reported being dissatisfied with the complaint resolution process, with the time frame in which their complaint was resolved (approximately 80%) and with the outcome of their case (approximately 60%). In addition the majority of participants reported the complaints process as being distressing and stressful. The most frequently reported reason for dissatisfaction was the manner of the staff and a perception that the staff had not shown sufficient empathy or understanding. Factors that complainants reported would have improved their experience included a better attitude from the staff, a quicker response to the complaint, more information and support, an apology or explanation and greater independence on the part of the parties managing the dispute. The majority of health service providers who had been subject of a complaint reported being satisfied with the way that the staff handled their complaint. The one exception was that respondents reported that they did not feel that they had been kept adequately informed about the progress or outcome of their case. The majority of providers reported that they found the complaints process stressful.
The health complaints process in the UK is functionally different to that in Australia. As outlined in Chapter 2, health complaints in Victoria and most other states are generally heard by either the relevant registration board or via the statutory authority charged with responding to health complaints (such as the Health Services Commissioner in Victoria). It is not clear therefore, the degree to which the experiences and concerns of complainants and health service providers generalise across the different complaints mechanisms.

Newby, McBride, Dawson and Romios (2004), in an evaluation that focused purely on the complainant perspective, explored the experiences of health consumers who had lodged a complaint with health registration boards in Victoria. They focused solely on complainants, rather than other stakeholders, because they argued that the complainants are the most vulnerable stakeholders in the complaints process and have limited voice to have their concerns heard. Newby et al. adopted a primarily qualitative approach based on qualitative interviews with 60 complainants whose complaints had been managed by one of five Victorian registration boards in an 18 month period. They found that over half of complainants reported being dissatisfied with the complaints process of the particular registration board. Furthermore the reported level of satisfaction was related to the degree to which the complaint had progressed through the complaint process before resolution. For example complainants whose cases had closed after an initial investigation were generally less satisfied with the process than complainants whose case had closed after an informal hearing, or a formal hearing. Newby et al. found that the most frequently reported reasons cited for dissatisfaction with the complaints process included, disappointment with the boards’ processes for handling the complaint, concerns with the lengthy time frame of the complaints resolution process, concerns about the lack of communication
from the boards about the progress of the case and a lack of support during the
complaint process. Some complainants were also concerned about the degree to
which the boards could be perceived as being independent and impartial.

MSJ Keys Young ((1990), as part of a broader legislative review of the
operations and effectiveness of the Office of the Health Services Commissioner of
Victoria (HSC) explored the views of 203 complainants and 114 health service
providers with first hand experience of the HSC. MSJ Keys Young sent
questionnaires to complainants and health services providers whose complaints had
been closed within a 2 year time frame. They found that approximately half of the
complainants and one third of health service providers reported being dissatisfied
with the outcome of their complaint. The reasons for dissatisfaction with the outcome
most often cited by complainants, were that they received an outcome different to that
which they expected, or that the HSC had limited statutory power to enforce the
outcome achieved. The most frequently reported reasons for dissatisfaction by health
service providers were that they felt they had not been kept adequately informed by
the HSC as to the progress of their case, that the outcome had been different to what
they expected or that they felt the complaint was trivial and should not have
progressed thought the HSC process.

Taken together the above studies suggest common themes in reported
dissatisfaction with health complaints processes and outcomes. Complainants
generally report dissatisfaction with the outcomes achieved, particularly in relation to
a disconfirmation of their expectations regarding the outcome and with the level of
empathy or understanding displayed by those individuals managing their complaint.
For those evaluations that considered the views of the health service provider, a
common theme that emerged was concern with the level of communication regarding the progress or outcome of the case.

One limitation of the evaluations reported thus far is that evaluations that are reported in formal reports rather than in peer reviewed literature typically are written for educated lay audiences. They therefore give little detail regarding the statistical analysis applied and have not reported any data beyond descriptive statistics. While some of the studies have elicited the experiences of complainants and to a lesser degree, health service providers who have been subject of complaints, research relating to the experiences of the complainants and providers and in particular of the negative impact on post-complaint behaviours (see Section 3.5), emphasise the need to attain a greater depth of understanding the experiences of health service users and providers who have experience of formal complaints processes.

4.9 Difficulty of Evaluating Health Services in the ‘Real World’

Recent research indicates that there is considerable variation in the degree to which consistent, theoretically based principles of evaluation are applied in the real-world evaluation of health services. Hearnshaw, Harker, Cheater, Baker and Grimshaw (2003) examined the degree to which managers in National Health Services applied rigorous scientific principles to the selection of review criteria when evaluating their services. Hearnshaw et al. found that in the majority of evaluations services the principles applied to selecting review criteria were non-systematic and subjective. There are a number of methodological issues that make the evaluation of health services more complex than the evaluation of other service industries. Health services are typically delivered in a complex environment with a range of stakeholders. Stakeholders may include the government body that funds the service, service managers, those responsible for delivering the service, the service recipients
and sometimes the support people of the recipients of the service. Furthermore, recipients of health services are often from a vulnerable population. Because of this, the evaluator may or may not have access to the actual users of the service, or the types of data collected may be limited by the vulnerable nature of the clientele or by issues of confidentiality or privacy. In addition, as in other sectors, evaluation in the health services has to take into consideration the temporal, budgetary and staffing constraints imposed by the organisation (Cook & Shadish, 1986).

This means that the evaluation methodology adopted is often a pragmatic choice that balances the competing requirements of sound systematic research against the limitations of evaluation in the real world. As a consequence the development of an evaluation plan that carefully takes into consideration all the possible constrains is imperative to a fruitful evaluation (Rossi et al., 1999).

4.10 Summary of the Chapter

The literature reviewed in this chapter revealed that current theoretical approaches to evaluation vary along a number of dimensions including the degree to which the theory of evaluation is summative and therefore attempts to measure the achievement of specific program goals; or formative and therefore attempts to provide information on how to improve the program or its implementation. Theories of evaluation also vary as to the extent to which they approach either qualitative or quantitative measurement and the extent to which they consider it appropriate to assess the outcomes versus the processes of the service delivery (Section 4.3).

In the “real world” of evaluation practice, evaluators commonly apply a range of evaluation practices depending on the nature of the program to be assessed, the type of data that is available or deemed appropriate to collect; the evaluators’ perception of the role that values, the evaluators themselves, and the various
stakeholders should play in the evaluation; and the intended uses of the evaluation findings (Section 4.4).

Four approaches to evaluation are commonly reported in the literature. Theory based evaluation takes into consideration the theoretical concepts that underlie the structure and delivery of the program (Section 4.5.1). Mixed-method designs apply both qualitative and quantitative methods to ensure reliable feedback as to the programs outcomes and processes (Section 4.5.2). Improvement-focused designs usually apply a mixed-method approach to assess both the outcomes and processes of a program with the overarching goal of making meaningful recommendations as to how best improve the service (Section 4.5.3). Finally a utilisation-focused design centres around maximising the usefulness of the evaluation findings to the key stakeholders in the program to be evaluated (Section 4.5.4).

The extent to which evaluation theory guides practice in the real world is unclear, as there has been limited research reported in this area. However preliminary indications are that most evaluations conducted in the real world lack a theoretical grounding (Section 4.6). Approaches to the evaluation of health services vary, although there is an increasing recognition that those approaches that are improvement-focused and apply a mixed-method design are most useful in the evaluation of health services (Section 4.7).

There are a number of unique methodological difficulties associated with conducting evaluations of health services. Such difficulties are related to the complex environment in which health services are delivered; the range of stakeholders and in particular the vulnerability of the recipients of health services; and issues of confidentiality and privacy that may limit the quantity and quality of data that can be collected (Section 4.8).
Few evaluations of health complaints processes have been reported in the public domain, and those that have tend to be reported in government or organisational reports rather than in peer-reviewed publications that are subject to public scrutiny. The evidence base upon which to base further evaluations and improve methodology is therefore limited.

The literature reviewed in this chapter heralds the need for evaluations, particularly those performed in the health arena, to undergo a careful planning process. The resultant evaluation plan needs to maximise the utility of the data collected whilst being cognisant of the ethical and practical limitations imposed by the context in which the health service is delivered.
Chapter 5: The Current Research

5.1 Overview of Chapter

Previous chapters have explored public perceptions and expectations of the health professions, the regulation of health professionals and the options available to health service users who are not satisfied with the service or outcome they receive. Complaining behaviour has been explored along with the factors that facilitate or inhibit the effective resolution of complaints, and the use of health complaints as a source of evidence to improve the overall quality of health service delivery. Emphasis was given to the need for effective evaluation of complaints processes if complaints are to be used as a vehicle for quality improvement. In the light of this, evaluation theories and the theoretical and practical approaches to evaluation were discussed, along with the practical limitations of conducting evaluations of professional organisations. Furthermore, the benefits of ensuring that complaints processes are working effectively in terms of the experiences of the people who are using the service (complainants and health service providers) is emphasised.

This chapter integrates the literature reviewed in the previous chapters, thereby providing a context for the current study. The background and rationale for the study is discussed in Section 5.2. The theoretical frameworks relevant to the study are outlined in Section 5.3 including the evaluative framework (Section 5.3.1), and theories of complaining behaviour (Section 5.3.2). In Section 5.4 the current study is introduced including a presentation of the aim (Section 5.4.1) and the three research questions (Section 5.4.2) and a discussion of the design of the evaluation methodology (Section 5.4.3). Section 5.5 introduces the Office of the Health Services Commissioner of Victoria (HSC) where the current evaluation methodology was tested. Section 5.5.1 outlines the organisational structure of the HSC, Section 5.5.2
outlines the stated goals of the HSC, and Section 5.5.3 describes the complaints process. Section 5.5.4 presents relevant statistics for cases managed by the Office of the Health Services Commissioner in the year of the current evaluation. In section 5.6, the reader is alerted to some aspects of a health complaints process that pose particular methodological difficulties including confidentiality and privilege (Section 5.6.1) and the sensitive nature of health complaints (Section 5.6.2). Section 5.7 provides a summary of the current study.

5.2 Background and Rationale

As was discussed in Chapter 1, health services are delivered within an economic and social context that impacts on the expectations and perceptions that clients have of health professionals, the health services they receive, and the way in which health services should be regulated. It was noted that health practitioners are increasingly being called upon to practice in a transparent way and be accountable for the outcomes of the services they deliver (Finlayson & Dewar, 2001; Hunter, 1994). Correspondingly, health consumers have demonstrated an increasing tendency to complain when confronted with negative outcomes from the health services they receive (Kimietowicz, 2001; Neuberger, 2000).

As discussed in Chapter 2 the changes in expectations of the health professions have also impacted on the way in which the health professions are regulated. Individual registration boards within the health arena have developed formal complaints processes to manage the influx of complaints, and the Australian states have all established statutory bodies to manage complaints against a range of health practitioners (Carlton, 2003). The inception of the Health Professions Regulation Act (2005), becoming effective in July 2007, heralds a further adaptation of health regulation to the dynamic status of health service delivery (DHS, 2006).
There is currently a predominant view that health complaints offer a valuable source of evidence upon which to base reforms and therefore an opportunity to improve the overall quality of health service delivery (Cronwall & Romios, 2004; Paterson, 2002; Wilson, 1999). However there are mixed findings as to the degree to which client satisfaction and the frequency and severity of complaints about a service are related to objective measures of service quality (Bittner & Hubbert, 1994; Finn & Kayande, 1998). It is also unclear the extent to which recommendations of service improvement arising from complaints actually translate into an improvement in service delivery. There is evidence to suggest that health complaints can have a range of unintended consequences including a lasting negative impact on both complainants and service providers.

One factor that has been little recognised to date is that if complaints are to be used as an indicator of service quality, and if the outcomes of complaints are to be used as a source of evidence to improve the quality of service, then it is essential that complaints processes are evaluated. Evaluation of complaints processes ensures that the recommendations that are made with regards to service improvement are done so on a sound empirical basis, and that the experiences of the actual recipients of the complaints resolution service are being considered in order to reduce any adverse unintended consequences.

As noted in Chapter 4 there have been few evaluations of complaints processes reported in the peer reviewed literature, and even fewer evaluations of health complaints processes. Most evaluations in the health arena are reported in formal government or organisational reports and therefore have not been subject to independent peer review. Such reports tend to be pitched to the educated lay audience and therefore include little statistical detail or interpretive data. The lack of
reported evaluations in the peer reviewed scientific literature means that researchers
do not have a rigorous systematic evidence base upon which to build, and to guide
evaluation practice and service improvement (Davidoff & Batalden, 2005; Henry &
Mark, 2003). There is therefore a need for the development and application of a
consistent, theoretically justified evaluation methodology to apply to the evaluation of
health complaints processes. It has been argued that psychologists have a valuable
role to play in the research and development of such evaluation models. With their
training in qualitative and quantitative research methodology, and their understanding
of the psychosocial issues that surround such sensitive areas, psychologists are well
placed to strengthen the evaluative research (Barnes, Brook, & Johnson, 1985).

With the inception of the Health Professions Regulation Act (2005) and the
looming changes to the regulation of health professionals in Victoria, the
development of a methodology for the evaluation of health complaints processes is
timely. It is essential that any new processes are evaluated from their inception,
through a formative evaluation approach (Section 4.3.1), so that any difficulties or
inconsistencies can be responded to rapidly to ensure a smooth and effective
transition.

5.3 Theoretical Framework

5.3.1 Evaluation Framework

The current study was grounded in evaluation theory. Both summative and
formative paradigms were applied to the methodology development (Section 4.3.1).
A summative approach emphasises the importance of assessing whether specific
program goals are being met, while a formative approach emphasises the importance
of ongoing program development and improvement (Hanes, 1977; Owens & Rogers,
1999; Rossi, Freeman & Lipsey, 1999). It was considered that through application of
both approaches in parallel, greater insight would be achieved as to the current performance of the complaints process, and as to how best to improve the experiences of participants in the complaints process and therefore their satisfaction with the outcomes.

A Theory-based approach was taken, in that the evaluation methodology was grounded in the explicit and implicit theoretical context of the complaints process. Whilst complaint processes have explicit goals, usually outlined in their mission statement or the like, complaints processes also embody implicit theories of natural justice. A robust observation has been that complainants report being more satisfied with dispute resolution processes when they perceive that the process has been fair (Schoefer 2000; Thibaut & Walker, 1975; Tyler, 1989). A sense of procedural fairness has the ability to not only positively impact on the complainants’ satisfaction with the complaint outcome, but also to have a positive influence on post-complaining behaviours, thereby reducing the negative non-intended consequences of the complaint (Lind, Kanfer & Earley, 1990; Shestowsly, 2004).

Development of the methodology was Utilisation-focused (Section 4.5.4) in that emphasis was given to the intended uses of the methodology, namely to evaluate the process in order to improve the experiences of the most vulnerable stakeholders in the complaints process, the complainants and health service providers (Patton, 1997). A client focused approach was taken that sought to find empirical evidence to use as a basis to improve individual client (complainant and provider) outcomes (Lambert, 2001).

A mixed method-design was adopted employing both qualitative and quantitative measures. Whilst quantitative measures would give a measurable indication of satisfaction, it was considered that qualitative measures would give a
more in-depth understanding of the experiences of the complainants and health service providers.

5.3.2 Complaining Behaviour

Consumers’ tendency to complain was seen to be influenced by a complex array of variables including consumers’ expectations about what the outcome of the complaint would be, and the accessibility of the complaints process in terms of their perceived capacity and opportunity to complain (Section 3.3). The perspectives of the complainants in complaints processes have been widely explored. It was seen in Section 3.4 that resolution of complaints was perceived as being more satisfactory when complaints were addressed in a more timely fashion, when the staff handling the complaint played a greater facilitatory role and were attentive to the needs of the complainant; when the level of redress was perceived as fair and appropriate; and when the health service provider was prepared to take responsibility for the event by either offering an explanation or apology (Davidow, 2003).

Complainants and health service providers have differential vulnerabilities in the health complaints process. Health complainants are particularly vulnerable because of the physical, cognitive and emotional effort required to lodge a complaint and the disempowerment that comes from their lack of specialist knowledge or from their debilitated health status (Freckleton & List, 2004; Mulcahy, 2003). The vulnerability of health service providers on the other hand, stems from the immediate threat to their livelihood and professional identity that comes from being the subject of a complaint (Charles, 1996; Montgomery, Cuprit & Wimberley, 1999, Schoenfeld, Hathch & Gonzalez, 2001). It is such vulnerabilities that can lead to the emergence of a number of unintended consequences from complaints processes.
In Chapter 3 it was shown that where complainants’ expectations of the complaints process or its outcomes are not adequately managed, this can lead to a number of negative post complaint behaviours, including grudge-holding, or complaint escalation behaviours in (Section 3.2.1). Health service providers have also been shown to engage in a range of negative post-complaint behaviours such as defensive practice or the hiding of errors that have the potential to have a lasting negative impact on the delivery of future services (Cook & Neef, 1994; Freckleton & List, 2004; Lawton & Parker, 2002; Wingenfeld Hammond & Freckleton, 2006).

The demonstrated potential for complaints processes to lead to a range of negative post-complaint behaviours highlights the fact that in evaluating health complaints processes, it is essential to obtain an in depth understanding of the experiences of both complainants and health service providers who participate in the process. Consideration of the experiences of these very vulnerable stakeholders, will provide a greater opportunity to make meaningful recommendations as to how health complaints processes can be improved so as to increase the likelihood that complaints will result in an improvement in the quality of health service delivery.

5.4 The Current Study

5.4.1 The Aim of the Current Study

The aim of the current study was to design and evaluate a methodology for the evaluation of health complaints processes that aimed to elicit the experiences of the most vulnerable stakeholders, the complainants and the health service providers who have experienced the complaints process. The intention of developing such a methodology was to provide an evidential basis upon which to recommend improvements to the complaints process. Through application of the current methodology to the evaluation of the Office of the Health Services Commissioner of
Victoria, a statutory authority charged with handling complaints against health practitioners, it was intended to determine how well the methodology operated in practice and make suggestions as to how the methodology could be further refined to make it applicable in other health complaints contexts. The key rationale for developing the current methodology was to gather information that could lead to the improvement of the experiences of complainants and providers in the complaints process. It was assumed that improvement of the complaints process from the perspective of the complainants and providers would potentially reduce the negative impact of the process (in terms of post-complaining attitudes and behaviour) and therefore maximise the likelihood that complaints will lead to an improvement in the overall quality of health service delivery.

5.4.2 Research Questions

There were four research questions that related to the effectiveness of the evaluation methodology. Specifically they explored the degree to which the evaluation methodology was successful in evaluating the complaints process at the Office of the Health Services Commissioner of Victoria and the usefulness of the methodology for future applications.

The first research question related to the extent to which the methodology was able to determine how well the Office of the Health Service Commissioner was performing in its role of resolving health complaints:

*Research Question 1: Did the findings generated by the methodology indicate that the HSC complaints process satisfied its stated objectives?*

Specifically it was predicted that the methodology would assess four different aspects of the complaints process at the HSC, including the accessibility, impartiality and efficiency of the complaints process.
and whether or not participation in the complaints process led practitioners to change the way they practice.

The second research question explored the implications of the findings of the evaluation of the HSC complaints process for the management of health complaints in general:

*Research Question 2: What are the implications of the findings of the current evaluation, for the improvement of complaints processes in general?*

The third research question related to how well the methodology performed when applied in a practical setting:

*Research Question 3: What were the strengths and limitations of the methodology when applied in a practical setting?*

The final research question related to improvement of the methodology for future applications:

*Research Question 4: In what way could the evaluation methodology be improved for future applications in the evaluation of health complaint mechanisms?*

5.4.3 Development of the Methodology

As already outlined in Chapter 4 evaluations need to be tailor made so that the research questions meet the specific goals and objectives of the organisation and the stakeholders. For this study, a number of steps were taken to develop the evaluation methodology. The first was to choose an evaluation design that best reflected the overall goals. As already mentioned it is the view of this author that evaluations of health complaints processes are most useful if they consider the views of the individuals who are most directly affected by the process, that is the health service users who have lodged the complaint and the health service providers who have to respond to the complaint. As has been shown in Chapter 3, the experiences of the
complainants and providers and their perceptions of the way in which a health complaint is resolved has the potential to either positively or negatively impact on their satisfaction with the complaint process and outcomes and on their subsequent post complaining behaviour and attitudes. It was therefore considered important to adopt a mixed method design that explored the experiences of the health service users and providers with first hand experience of the complaints process, in line with the implicit and explicit goals of the complaints process. It was also determined that an improvement focused design was most appropriate, as this would not only determine the level of satisfaction and the degree to which the organisation was meeting the stated goals, but also allow for the generation of meaningful recommendations for improvement.

5.5 The Office of the Health Services Commissioner of Victoria.

An opportunity arose to test the methodology in the evaluation of the health complaints process at the Office of the Health Services Commissioner of Victoria (HSC). The HSC is a statutory body that has the legislated requirement to receive and resolve complaints against health service providers in Victoria. The methodology was therefore tailor-made to reflect the context in which the HSC delivers the complaints resolution service, including the organisational structure, stakeholders, goals and the complaints handling procedure.

5.5.1 Establishment of the Health Services Commissioner of Victoria

The Office of the Health Services Commissioner of Victoria (IHSC) is an independent statutory authority established to receive and resolve complaints about health service providers. The HSC was established by the Health Services (Conciliation & Review) Act, 1987 following the findings of an all-party Parliamentary Social Development Committee which deemed that existing
complaints mechanisms were inadequate (Wilson, 1999). Thus the Committee argued that there was a need for an independent, impartial body with a broad jurisdiction for handling complaints (Wilson, 1999).

Under the statutory requirements, the role of the HSC is to provide an accessible and impartial mechanism by which to receive, investigate and resolve complaints from health service consumers; to support health care services in providing quality health care and to assist them in resolving complaints. The legislation also requires that information gained from these complaints should be used to improve the standards of health care and prevent breaches of these standards.

The HSC deals with complaints against health service providers in both the public and private sectors, against registered providers such as doctors and medical specialists, dentists, psychologists, and physiotherapists; unregistered practitioners, such as psychotherapists and masseurs; and alternative therapists, such as acupuncturists, hospitals and nursing homes or any providers of a health service.

5.5.2 Goals and Objectives of the HSC

The preamble to the Health Services (Conciliation & Review) Act, 1987 promotes eight guiding principles of health care which establish the range of responsibilities for providers of health services and the basis upon which a person might complain that there has been a breach of standards. Within this framework the HSC has the following broad objectives: to provide an accessible review mechanism for service users; to deal with users’ complaints in an effective manner; to deal with users’ complaints in an impartial manner and to provide a means for reviewing and improving the quality of health service provision. It was anticipated that participants would distinguish between these three aspects of the complaints process when reporting their satisfaction with the service.
5.5.3 Key Stakeholders Other Than Complainants and Providers

Whilst it has been established that complainants and health service providers represent the most vulnerable stakeholders in the health complaints process, it is important to also consider the organisational context of the HSC. The Health Services Commissioner reports directly to Parliament via the Minister of Health. Whilst the Commissioner is a Governor in Council appointment and not attached to any government department, the funding to run the HSC is provided by the Department of Human Services (DHS). All staff employed at the HSC other than the Commissioner are public servants paid via the DHS. At the time of the current study there were approximately 16 staff members working under the auspices of the Health Services Commissioner. Two Conciliators, four Investigators and four Inquiry Officers are responsible for the direct handling of complaints; a Registrar performs case management and supervision tasks and liaises with the 12 health regulation boards including The Medical Practitioners Board of Victoria, the Dental Practice Board of Victoria, the Psychologists Registration Board of Victoria, the Mental Health Review Board, the Physiotherapists Registration Board of Victoria, the Pharmacy Board of Victoria, the Osteopaths Registration Board of Victoria, the Optometrists Registration Board of Victoria, the Podiatrists Registration Board of Victoria, the Chiropractors Registration Board of Victoria, the Nurses Board and the Chinese Medicine Registration Board.

5.5.4 The Complaints Process

Complaints are usually received by telephone and the Inquiry Officer has the first contact with the complainant. Complainants are asked to confirm their complaints in writing, and where appropriate to return to the service provider in an attempt to resolve the problem directly. When the completed complaint form is
returned to the HSC a copy is sent (with the permission of the complainant) to the service provider. The function of the Inquiry Officer is to handle inquiries and complaints in these early stages and to follow up on these complaints to see whether this process resolved the issues. The majority of cases are resolved at this stage of the complaints process with approximately half of the complaints never proceeding beyond a single telephone contact.

Those cases which are not adequately resolved at this stage, or that are particularly serious, are referred on to an investigator for assessment. The investigator gathers more information and evidence in order to determine whether the complaint can be solved informally by the investigator, whether the complaint should be referred on to an appropriate registration board or whether it should be referred to conciliation. Those complaints which are not resolved at the assessment level and which are deemed suitable are referred to Conciliation.

All parties enter the conciliation process voluntarily and the function of the conciliators is to assist those parties to reach a resolution in a confidential and privileged setting. The privileged nature of the setting means that information revealed or discussions occurring in conciliation cannot be presented in evidence in any subsequent legal proceedings. In conciliation the primary focus is on providing an individual remedy for each individual complaint. This usually involves meetings between parties to clarify issues, where the conciliator will list the options and sometimes suggest solutions. The conciliator also has the ability to obtain independent consultants’ opinions on complaints, which the parties can then use to negotiate a resolution, which usually includes some form of compensation. Where appropriate the conciliator will intervene in the process by providing information about the law of negligence, but the conciliator does not give legal advice. At all
stages of the complaints process the focus is on reaching a resolution that is agreeable to all parties within the complaint.

5.5.5 Case Management

Statistical records compiled by the HSC revealed that in the 1999/2000 financial year the office took 9654 inquiries of which 7300 were health complaints. Of these, 1183 (16%) were closed after a single contact and 1171 (16%) were accepted as new cases. The remaining 4946 inquiries (68%) did not proceed beyond the initial inquiry due to the complainant failing to make further contact with the office. In 1999/2000 a total of 2284 (31%) cases were closed. Of these, 1868 cases were closed by Inquiry Officers, 269 cases were closed by Investigators in the Assessment phase of the complaints process, and 67 cases were closed by Conciliators. In addition 74 cases were referred on to Registration Boards and 6 cases were referred on to other agencies (HSC, 2000). Thus the majority of cases were resolved at the earlier stages of the complaints process.

In the financial year 1999/2000, the majority of complaints (41%) were against doctors, including general practitioners and specialist practitioners. Twenty-seven per cent of complaints were against public hospitals and 5% against private hospitals, 8% of complaints were against dentists and 6% of complaints against psychiatric services. Complaints against psychiatric services included complaints against public and private psychiatric or psychological services. Of the complaints against psychiatric services, 7% (12 complaints) were against psychologists (HSC 2000).
5.6 Methodological Issues for Consideration

At the outset it is necessary to note certain methodological issues that place unique restraints when conducting an evaluation of the health complaints process in what will be referred to as ‘real-world’ settings.

5.6.1 Confidentiality and Privilege

One major limitation placed on the methodology was the confidentiality and privacy issues that arise in health complaints. Complaints by their nature have at least two parties associated with them (complainant and health service provider). It is possible, or even likely, that only one of the parties may consent to participate in the evaluation. This places limitations on the data that could be collected about the complaint. This is further complicated in the case of evaluating the complaints process at the HSC, because the complaints are also of a legally sensitive nature and the HSC operates within a privileged environment. This means that in addition to the usual confidentiality restrictions that are associated with sensitive information, the information relating to the nature and specifics of the complaints is legally embargoed and therefore cannot be released to parties outside the complaints.

Because of the issues of confidentiality and the constraints of privilege, the researcher did not have access to the participants’ details in the evaluation unless they volunteered to participate in second-stage telephone interviews. Furthermore no data could be collected about the nature of the complaint, complainant or provider nor specific information about the complaint outcomes. In fact, at all stages both health service providers and complainants were warned against releasing any defining details about their specific complaint.
5.6.2 *Sensitive Nature of Health Complaints*

Health complaints are generally more sensitive than complaints in other service industries. In addition both complainants and providers are particularly vulnerable within a health complaints process. Complainants may have undergone significant trauma or loss, including enduring injuries or the loss of loved ones. As has been outlined (in Section 3.5.2.2) health service providers who find themselves a subject of a complaint are also vulnerable, often experiencing negative emotions, including the fear for their professional livelihood. In the current evaluation it was therefore deemed unethical to subject parties to batteries of psychological measures for the sake of evaluation with little potential benefit to them.

5.7 *Summary of the Chapter*

The present study was designed to develop a methodology for the evaluation of health complaints processes that would explore the effectiveness of the organisation in managing complaints but also provide and in-depth understanding of the experiences of complainants and health service providers involved in the process. A further goal of the study was to apply the resultant methodology to the evaluation of the complaints process at the Office of the Health Services Commissioner of Victoria, in order to determine to what extent the methodology was successful in evaluating the process and to identify any limitations or difficulties associated with applying the methodology in the real life setting. Finally it was intended to determine how useful the methodology was in eliciting recommendations for future improvements to the methodology or adaptation to other health complaints settings.
Chapter 6: Method

6.1 Chapter Overview

This chapter has three main sections. Section 6.2 describes the participants and the means used for recruiting participants. Section 6.3 describes the method used to collect the data for the study. This includes a description of the questionnaire used to collect the quantitative data (Section 6.3.1) and the protocol for the semi-structured telephone interviews used to collect the qualitative data (Section 6.3.2). Section 6.4 describes the procedure used for administering the questionnaires and telephone interviews (Section 6.4.1) and for the coding of the qualitative data (Section 6.4.2).

6.2 Participants

Participants in this study were 283 health service users and health service providers who had been involved in the complaints process at the Office of the Health Services Commissioner of Victoria (HSC), and whose cases had reached closure in the 1999/2000 financial year. Participants volunteered to participate in the study after being invited by letter from the Health Services Commissioner (Appendix A) to fill in a written questionnaire and to participate in a telephone interview. A total of 1248 questionnaires were sent out, 40 of which were returned unopened and 4 of which were returned from health service providers, where the provider involved in the complaint was no longer employed within the organisation.

Respondents comprised 133 health service providers and 150 health service users. This corresponded to an overall response rate of 23%. The response rate was higher from health service providers (29%) than from health service users (19%), with the highest response rate being from health service providers whose cases had closed during the Inquiry phase (51%). The lowest response rate was from health service users whose cases had closed during the conciliation phase (11%).
Of the 133 health service providers who responded, 31 (23%) were employed in private hospitals, 6 (5%) were employed in public hospitals, 62 (48%) were private practitioners and 29 (22%) reported they were health service providers from ‘other’ arenas. Of those who categorised themselves as being ‘other’ practitioners, 20 reported being dental practitioners, two reported being optometrists, two reported being community health practitioners, one an ambulance personnel, one a chiropractor, one a nursing home worker and one reported working in private pathology (note: not all respondents reported their profession).

Of the participants, 97 health service users and 92 health service providers were from cases that were closed during the Inquiry phase of the complaints process; 33 health service providers and 44 health service users were from cases that were closed in the Assessment phase of the complaints process; and eight health service providers and nine health service users were from cases that were closed in the Conciliation stage of the complaints process.

Of the 283 participants 159 further volunteered to participate in a telephone interview. Of these 105 were health service users and 54 were health service providers. Due to the unexpectedly large number of respondents agreeing to an interview, a random sample of 70 cases was selected for telephone interviews. Of these 62 participants completed the interview. Eight participants were not able to be contacted on the telephone number they had provided. Of the 62 participants interviewed, 47 were health service users and 15 were health service providers.

6.3 Materials

Data were collected using a combination of written questionnaires and semi-structured telephone interviews.
6.3.1 Questionnaires

Because different stages of the HSC complaints process involve different staff, different processes and different outcomes, separate questionnaires were designed for health service users and providers whose complaints were closed in the Inquiry, Assessment and Conciliation phase, resulting in six different questionnaires. For each group, only survey items that were related to the particular stages of the complaints process for that group were included. For example, individuals whose complaint had been resolved with minimal contact with HSC staff were given a slightly shorter set of questions than those who had gone through all stages of the complaints process.

Questionnaires administered to health service users whose cases had closed in the Inquiry phase or Assessment phase contained 13 items. Questionnaires administered to health service users and providers whose cases had closed in the Conciliation phase contained 16 items.

The questionnaires included a mixture of rating scales and open-ended questions. The conceptualisation of the items to be included in the questionnaire was drawn from two main sources: a) Eight items were a modified and extended from the questions developed for use in the earlier evaluation conducted under the sunset clause of the Health Services (Conciliation & Review) Act, 1985 by MSJ Keys Young (1990). It was hoped that inclusion of such items would allow a comparison of the current findings with the previous evaluation findings, b) The remaining items were developed based on informed discussions with the HSC staff and close examination of the Health Services (Conciliation & Review) Act, 1985 as to the stated goals and objectives of the HSC complaints process. All items demonstrated face validity, in that they appeared to tap into participants’ perceptions of the degree to which the
HSC provides an accessible, effective and impartial means of resolving health complaints, and whether the outcomes of the complaints had translated into a potential improvement in the quality of health service delivery.

6.3.1.1 Accessibility. Accessibility was assessed along two dimensions. External accessibility was conceptualised as the breadth of the available sources of referral to the HSC. This was measured by the single item “How did you first hear of the Office of the Health Services Commissioner?” Internal accessibility, on the other hand, was conceptualised as the user friendliness of the HSC process and staff, and was assessed using three items that asked participants to report the degree to which they found the HSC staff understandable (e.g., “I found it hard to understand the information or advice I got from the Commissioner’s staff”), interested (e.g., “I felt the Commissioner’s staff took a genuine interest in the problem”) and helpful (e.g., The Commissioner’s staff were courteous and obliging”). All items were scored on a forced choice 4 point Likert scale ranging from 1 ‘strongly disagree’, to 4 ‘strongly agree’, with the item relating to understanding being reverse scored.

6.3.1.2 Effectiveness. Effectiveness was conceptualised as the degree to which the service users and providers were satisfied with both the procedures and outcomes of the complaints process. This was assessed by seven items. One item aimed at tapping the level of satisfaction with the outcome of the complaint (e.g., “How satisfied were you with the outcome?”, rated on a forced choice 4 point Likert scale ranging from 1 ‘very dissatisfied’ to 4 ‘very satisfied’); one item aimed at tapping the degree of problem resolution (e.g., “In the end to what degree was the problem you complained about resolved”, rated on a 3 point Likert scale ranging from 1 ‘fully resolved’ to 3 ‘not resolved’); three items aimed at tapping the effectiveness of the Commissioner’s staff in facilitating problem resolution (e.g.,
“The Commissioner’s staff played a useful role in helping to sort this problem out”, rated on a 4 point forced choice Likert scale ranging from 1 ‘strongly agree’ to 4 ‘strongly disagree’; and one item measured satisfaction with the time frame in which the matter was resolved (e.g., “The Commissioner’s staff acted promptly in dealing with the matter”, rated on a 4 point forced choice Likert scale from 1 ‘strongly disagree’ to 4 ‘strongly agree’). Health service users were also asked whether or not they would recommend the HSC to others as a means of health complaint resolution (e.g., “If in the future a friend or relative had a complaint about health or medical services, would you suggest they contact the Health Services Commissioner?”, measured with a ‘yes/no’ response format).

6.3.1.3 Impartiality. Impartiality was assessed by a single item asking the degree to which service users and providers perceived the HSC staff members to be impartial (e.g., “The Commissioner’s staff were unbiased and treated all sides fairly”, scored on a 4 point, forced choice Likert scale ranging from 1 ‘strongly disagree’ to 4 ‘strongly agree’). This item was only included in surveys of those groups that participated in the Assessment or Conciliation levels of the complaints process, all of whom would have had substantial contact with HSC staff.

Questionnaires for health service users and providers whose cases closed in the Conciliation phase also included items aimed at assessing the degree to which the Conciliators were perceived as being impartial, helpful and efficient in the performance of their duties (e.g., “The conciliator was unbiased and treated both sides fairly”, “The conciliator’s involvement was helpful in dealing with the problem”, “The conciliator was capable and efficient”). All items were scored on a forced choice 4 point Likert scale ranging from 1 ‘strongly disagree’ to 4 ‘strongly agree’.
In order to determine in which sector of the health industry the health service provider worked, all health service providers were asked to report whether they represented a private hospital, a public hospital, were an individual practitioner or were employed in some other health field. In order to determine whether dealing with the HSC had resulted in an improvement in the level of health service provision, health service providers whose complaints were closed in the Assessment or Conciliation stages, were asked to report whether, as a result of their dealings with the HSC, they had changed the way in which they performed their professional duties. A single open-ended question also asked them to report the nature of any reported changes.

All questionnaires comprised some items that required both a rating response and also gave the participants the option to give a further short answer clarification of their response [e.g., “If dissatisfied (with the outcome) why was that?”]. The final item on all surveys asked participants if they would be prepared to participate in a telephone interview in order to further discuss their experiences with the HSC. Interested participants were required to give their name, telephone number and a preferred time and day that they could be contacted. Full copies of the questionnaires for each of the six groups can be found in Appendix B.

6.3.2 Telephone Interviews

The objective of the interviews was to gain a deeper understanding of participants’ experiences of the HSC process, to tap into unforeseen strengths and limitations of the complaints process and to assess any unintended consequences of participation in the complaints process. The telephone interviews were semi-structured, consisting of a short set of three open-ended questions for all respondents. All participants were asked what they liked about the complaints process at the HSC
and what they did not like about the HSC complaints process. Participants were also asked in what way they believed the HSC complaints process could be improved. The semi-structured interviews were also used to follow up on any information that was not clear or any issues arising from the respondent’s written responses to the questionnaire.

For reasons of privacy and confidentiality, the interviewer contained any attempt on the part of the interviewee to discuss the specific details of the complaint, or to reveal any personal details about the other party in the complaint. On average interviews lasted for approximately 25 minutes. A full interview protocol can be found in Appendix C.

6.4 Procedure

6.4.1 Questionnaire Administration

For reasons of privilege and confidentiality, all sampling and mail-outs were performed by HSC staff. All cases that closed in the Inquiry, Assessment or Conciliation phase in the 1999/2000 financial year were considered for inclusion. Once a list of cases was generated the cases were vetted on a case-by-case basis by either an HSC Conciliator or Investigator to determine their suitability for inclusion in the final sample. Criteria for exclusion included:

1. Cases in which health service users had experienced outcomes that had resulted in extreme grief or loss (e.g., death of a family member)

2. Cases where the relevant Conciliator or Investigator believed that there was concern that the complainant may be caused undue distress by being asked to participate in the study

3. Cases in which the HSC staff deemed there may be an underlying disability or pathology that may render the health service user unsuitable
for participation (e.g., such as in the case of repetitive or vexatious
complainants, or where the complainant had an intellectual disability)

4. Cases that were closed in the very early stages of Inquiry where the health
service provider may not have been informed that there had been a
complaint lodged against them.

Wherever possible both the health service user and provider were contacted in
each case, although restrictions due to privacy issues meant that it was not possible to
match the cases.

Once the participants were selected, the HSC staff sent them a copy of the
appropriate questionnaire with a cover letter from the Health Commissioner, outlining
the purpose of the evaluation and ensuring anonymity (see Appendix A). Responses
were sent with a postage paid return envelope, addressed to the primary researcher at
Swinburne University of Technology, thus ensuring that participants’ responses
remained anonymous and were not seen by HSC staff.

6.4.2 Protocol for Telephone Interviews

All interviews were conducted by the principal researcher. Participants who
consented, and were randomly selected to participate in telephone interviews were
contacted by telephone at the time that they had nominated on their questionnaire.
Participants were asked to focus on their experiences of the HSC process rather than
on the specific details of their complaint. Participants were then asked each of the
questions. Telephone interviews were not able to be taped due to issues relating to
confidentiality and privilege, therefore responses were recorded in short hand on a
response form and transcribed to long hand immediately after the interview. The
duration of the interviews was approximately 25 minutes.
6.4.3 Coding of Interview Data and Responses to Open-ended Questionnaire Data

An open coding method was used to identify themes in responses to open-ended questionnaire items and interview questions. The coding framework was developed by reading and re-reading responses from a random sample of 20 responses and identifying common themes in responses to each question. All interview transcripts were then coded within this thematic framework. Coding was performed by two independent raters, with uncertainties being resolved by discussion between raters. Inter-rater agreement was found to be adequate (>80% for all items). Themes were then categorised as either latent (relating to the structure and process of service delivery) or proactive (relating to how the individual staff member handled the case) variables (Lawton & Parker, 2002).
Chapter 7 Results: Quantitative Data

7.1 Chapter Overview

The following Chapter includes the quantitative analyses from the application of the evaluation methodology to the evaluation of the complaints process at the Office of the Health Services Commissioner of Victoria (HSC). The quantitative data are discussed in two main sections. Section 7.2 presents the preliminary analysis, including the consideration of missing data (Section 7.2.1) and the exploratory factor analysis of the questionnaire (Section 7.2.2). Section 7.3 reports the findings of the quantitative analyses relating to the questionnaire data, including the reported levels of satisfaction with the complaints process and complaint outcome, and a comparison of the reported satisfaction levels of complainants and health service providers for complaints closed across the three levels of the complaints process. Section 7.3.5 presents data collected from participants involved in the conciliation process, while Section 7.3.6 reports the number of providers who change their practice as a result of participating in the complaints process. Finally Section 7.4 provides a summary of the quantitative findings.

7.2 Preliminary Analyses

7.2.1 Missing Values.

Fifteen cases were not included in the quantitative analysis due to large amounts of missing data. Missing values analysis of the final data set revealed that there were no variables with greater than 8% missing values. Mean substitution of missing data was deemed appropriate for all analyses (Hair, Anderson, Tatham & Black, 1995).
7.2.2 Factor Analysis of the Evaluation Questionnaire.

An exploratory factor analysis using principal components factor extraction was performed to determine the underlying factor structure of the questionnaire. According to the criteria for factor analysis (Coakes & Steed, 2003; Hair et al., 1995; Tabachnick & Fidell, 2001) the data were deemed suitable for factor analysis. The sample size ($N = 270$), which included both complainants and providers, was adequate for factor analysis and Bartlett’s Test for Sphericity was adequate (1686.29 (45), $p < .001$). Furthermore the Kayser-Meyer-Olkin Measure of Sampling Adequacy (.91) indicated adequate intercorrelations among the variables and appropriateness of factor analysis.

To explore the factor structure of the questionnaire principal components extraction was used with oblique rotation, as factors were expected to show a low to moderate correlation. Factor loadings were taken from the pattern matrix and suppressed at .30 (Hair et al., 1995). The rotated factor solution showed two principal components that explained 66.9% of the variance, with Eigenvalue >1.0 as the criteria (5.58 with 55.8% of the variance, and 1.1 with 11.1% of the variance). Catell’s scree test also indicated two factors. The factor loadings (with factor loadings less than .3 suppressed) and the summary item statistics for the scale are presented in Table 7.1.
Table 7.1

*Factor Loadings and Sample Statistics for the Evaluation Scale*

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor Loadings</th>
<th>Sample Statistics</th>
<th>α if item deleted</th>
<th>Corrected item total corr.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>HSC staff were courteous</td>
<td>.83</td>
<td>-</td>
<td>3.25</td>
<td>0.75</td>
</tr>
<tr>
<td>HSC staff difficult to understand *</td>
<td>.50</td>
<td>-</td>
<td>3.13</td>
<td>0.84</td>
</tr>
<tr>
<td>HSC staff interested</td>
<td>.85</td>
<td>-</td>
<td>2.96</td>
<td>0.91</td>
</tr>
<tr>
<td>HSC staff kept me informed</td>
<td>.85</td>
<td>-</td>
<td>2.87</td>
<td>0.86</td>
</tr>
<tr>
<td>HSC staff provided prompt service</td>
<td>.76</td>
<td>-</td>
<td>2.94</td>
<td>0.84</td>
</tr>
<tr>
<td>HSC staff were impartial</td>
<td>.75</td>
<td>-</td>
<td>2.87</td>
<td>0.85</td>
</tr>
<tr>
<td>HSC staff played a useful role</td>
<td>.50</td>
<td>.52</td>
<td>2.77</td>
<td>1.00</td>
</tr>
<tr>
<td>Process was a waste of time *</td>
<td>-</td>
<td>.58</td>
<td>2.87</td>
<td>1.08</td>
</tr>
<tr>
<td>Degree of problem resolution</td>
<td>-</td>
<td>.97</td>
<td>2.16</td>
<td>0.89</td>
</tr>
<tr>
<td>Satisfaction with the outcome</td>
<td>-</td>
<td>.88</td>
<td>2.59</td>
<td>1.22</td>
</tr>
</tbody>
</table>

*N = 270

* means calculated on reverse score

As can be seen from Table 7.1 there were two interpretable factors. The six items related to satisfaction with the way the staff handled the complaint loaded on the first factor (Process Satisfaction factor), and the three items that related to satisfaction with the complaint outcome loaded onto the second factor (Outcome Satisfaction factor). The item relating to the perception of the staff playing a useful role loaded equally onto the first and second factor (.50 and .52 respectively). On the first factor (process satisfaction), loadings ranged from .50 to .85 and items had high
overall internal consistency (Cronbach’s $\alpha = .87$). For the second factor (outcome satisfaction), factor loadings ranged from .58 to .97 with moderate internal consistency (Cronbach’s $\alpha = .69$).

The factor analysis therefore revealed that, contrary to expectations, participants failed to differentiate between the aspects of the complaints process along the dimensions of accessibility, effectiveness and impartiality. Instead the factor analysis isolated two interpretable factors. The first factor related to a global satisfaction with how the HSC staff handled the complaint (Process Satisfaction Scale) and the second factor related to satisfaction with the final outcome of the complaint (Outcome Satisfaction Scale).

7.3 Analysis of Questionnaire Data

7.3.1 External Accessibility

Examination of responses to the item “How did you first hear of the HSC”, revealed that complainants ($N= 150$) reported hearing about the HSC from a variety of sources. One quarter of complainants reported being referred to the HSC by another organisation or government body (25%). Approximately 15% reported that they had been referred to the HSC by their health service provider, and 14% said that they had heard about the HSC through media reports or advertising brochures. The remaining complainants reported that they had become aware of the HSC through either their solicitor (9%), a friend or relative (9%), the telephone directory (7%), through their own professional contacts (7%), or through health industry workers known to them (6%). Approximately 9% of complainants could not recall how they had become aware of the HSC.
7.3.2 Preliminary Analysis of Health Service Provider Data

Before addressing the issue of satisfaction with process and outcomes for complainants and health service users, a preliminary analysis was required to determine whether there were differences in mean responses between different types of health service providers. Table 7.2 presents descriptive statistics for satisfaction measures for health service providers who work in private hospitals, public hospitals and in private practice or in other non-specified settings.

Table 7.2

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Process Satisfaction</th>
<th>Outcome Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>3.17</td>
<td>0.45</td>
</tr>
<tr>
<td>Public Hospital</td>
<td>3.19</td>
<td>0.27</td>
</tr>
<tr>
<td>Private Practice</td>
<td>3.12</td>
<td>0.46</td>
</tr>
<tr>
<td>Other – non-specified</td>
<td>3.18</td>
<td>0.55</td>
</tr>
</tbody>
</table>

N=123

A One-way analysis of variance (ANOVA) revealed that there was no significant difference between the different types of health service providers in mean level of satisfaction with the HSC process \(F(3,122) = .19, p=.90\) or in mean level of satisfaction with the complaint outcome \(F(3,122) = .32, p=.40\). Having established that there were no significant differences in satisfaction levels between the different types of health service providers, health service provider data were pooled for subsequent analyses.
7.3.3 Overall Satisfaction with HSC Process and Complaint Outcome

In order to determine the overall satisfaction scores, mean sub-scale scores were calculated for the Process Satisfaction Scale (PSS) and the Outcome Satisfaction Scale (OSS). Possible scores on the PSS and the OSS sub-scales ranged from 1 to 4, with a score of 4 indicating a high level of satisfaction. Because of the forced choice format of the component scales (2 = ‘dissatisfied’, 3 = ‘satisfied’), a PSS or OSS subscale score of 2.5 was therefore taken to represent a neutral position.

Examination of the mean PSS and OSS subscale scores revealed that overall, the majority of participants reported being satisfied with the way in which the HSC staff handled their complaint, with 90.3% of providers (\(M = 3.15, SD = .47, n = 124\)) and 72.6% of complainants (\(M = 2.88, SD = .76, n = 146\)) reporting PSS scores of 2.5 or above. The majority of providers were satisfied with the outcome of their complaint (80.6%; \(M = 2.97, SD = .57, n = 124\)), however, overall complainants were considerably less satisfied with the outcome of their complaint than the process, with only 40.4% of complainants reporting OSS scores of 2.5 or above (\(M = 2.16, SD = .9489, n = 146\)).

Differences Between Complainants and Health Service Providers

In order to determine whether there were differences in PSS scores and OSS scores between complainants and health service providers, mean PSS and OSS scores were calculated for complainants and health service providers for the three levels of the complaint process. Means and standard deviations are displayed in Table 7.3.
### Table 7.3

**Mean Scores on the PSS Scale and OSS Scale for Complainants and Health Service Providers at Each Level of the Complaints Process.**

<table>
<thead>
<tr>
<th></th>
<th>Complainant</th>
<th>Health Service Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td><strong>PSS scores</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complaint closed</td>
<td>2.94</td>
<td>0.75</td>
</tr>
<tr>
<td>Inquiry stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complaint closed</td>
<td>2.66</td>
<td>0.79</td>
</tr>
<tr>
<td>Assessment stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complaint closed</td>
<td>3.18</td>
<td>0.35</td>
</tr>
<tr>
<td>Conciliation stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OSS Scores</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complaint closed</td>
<td>2.27</td>
<td>0.94</td>
</tr>
<tr>
<td>Inquiry stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complaint closed</td>
<td>1.81</td>
<td>0.79</td>
</tr>
<tr>
<td>Assessment stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complaint closed</td>
<td>2.76</td>
<td>1.06</td>
</tr>
<tr>
<td>Conciliation stage</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*N*=270

A series of 2 x 3 between groups ANOVAs was conducted to determine whether there were any differences in mean scores for health service providers and complainants at the three different levels of the complaints process. Independent variables were participant status (complainant versus health service provider) and level of the complaints process at which the complaint was closed (Inquiry versus Assessment versus Conciliation). Dependent variables were mean PSS and OSS scores.
7.3.4.1 ANOVA assumptions. Analysis was performed by SPSS, weighting cells by their sample size to adjust for unequal $n$ (Tabachnick & Fidell, 1989). Examination of the distribution of the dependent variables revealed that the distributions approximated normality, but were positively skewed. This was deemed satisfactory for ANOVA given the large sample size (Hair et al., 1995; Tabachnick & Fidell, 2001). Evaluation of the assumption of homogeneity of variance revealed a difference in variances using the Levene's statistic as criteria. However, given the robust nature of the ANOVA analysis, especially for larger sample sizes, the data were deemed suitable for ANOVA.

7.3.4.2 Satisfaction with HSC staff. A 2 x 3 between groups ANOVA revealed a significant interaction between participant status and stage at which the complaint was closed for PSS scores ($F(2, 269) = 4.36, p < .05$). The main effects of participant status and stage of complaint closure were not significant ($F(1, 269) = 1.66, p = .54$ & $F(2, 269) = .632, p = .20$ respectively).

Preliminary inspection of the means indicated that, as shown in Figure 1, mean PSS scores appeared to be lower for complainants than health service providers for cases closed in the Inquiry and Assessment stages, but mean PSS scores appeared to be higher for complainants than health service providers for cases closed in the Conciliation stage.
Due to the significant interaction, a series of One-way ANOVAs was conducted to explore the differences in mean PSS scores between complainants and health service providers for cases closed at each level of the complaints process. The results indicated that complainants demonstrated a significantly lower mean PSS scores than health service users in cases closed in the Inquiry ($F(1, 179) = 4.65, p < .05$) and Assessment ($F(1, 72) = 13.75, p < .001$) stages. However, for cases closed in the Conciliation stage, the observed differences between mean PSS scores for complainants and health service providers were not significant ($F(1, 16) = 3.20, p = .09$), although there was a trend in the expected direction.

7.3.4.3 **Satisfaction with outcome.** A 2 x 3 between groups ANOVA revealed a significant interaction between participant status and stage at which the complaint was closed for OSS scores ($F(2, 269) = 10.21, p < .001$). There was also a significant main effect of participant status ($F(1, 269) = 15.10, p < .001$), however the
The main effect of stage of complaint closure was not significant \( F(2, 269) = .66, p = .52 \).

Preliminary inspection of the means indicated that, as shown in Figure 2, the mean OSS scores appeared to be lower for complainants than health service providers for cases closed in the Inquiry and Assessment stages, and the mean OSS scores appeared to be higher for complainants than health service providers for cases closed in the Conciliation stage.

Again, due to the significant interaction, a series of One-way ANOVAs was conducted to explore the differences in mean OSS scores between complainants and health service providers for cases closed at each level of the complaints process. The results indicated that complainants demonstrated a significantly lower mean OSS score than health service users in cases closed in the Inquiry \( F(1, 179) = 35.18, p \)
and Assessment ($F(1,72) = 69.78, p < .001$) stages. However, the observed differences between OSS scores for complainants and health service providers in the Conciliation stage were not significant ($F(1,16) = .75, p = .40$).

### 7.3.5 Analysis of the Conciliation Data

Due to the nature of the complaints process and because very few complaints progress through all stages of the process to Conciliation, the sample size of Conciliation data was small ($n = 17$). Despite this limitation, the Conciliation group offer insight into a different and important aspect of the complaint resolution process. They were therefore included in the analysis with an awareness of the possibility of increased Type I error and with the appropriate level of interpretive caution.

Preliminary examination of the Conciliation data revealed that responses were largely bimodal. Data was therefore recoded as such to enhance sample size in cells (Coakes & Steed, 2003). The ‘agree’ and ‘strongly agree’ categories were combined, and the ‘disagree’ and ‘strongly disagree’ categories were combined, giving two broad categories that reflected either agreement or disagreement with the statements. Following recoding, examination of descriptive statistics revealed that overall approximately half of the participants who had progressed through the Conciliation stage of complaint resolution, reported that conciliation was a useful process ($53\%, n = 17$). In addition, the majority of participants from the Conciliation group reported that they believed that the conciliator was impartial ($70\%, n = 17$), helpful ($70\%, n = 17$), and efficient ($70\%, n = 17$).

In order to explore any differences between participant status (complainant versus provider), and participant ratings of the conciliation process and staff, cross tabulations were performed. The assumptions of random sampling and independence of observations were satisfactory, however, low expected frequencies ($< 5$ in 2 cells
per analysis) mean that Chi Square statistics must be viewed with caution. Cross tabulations revealed that there was no significant relationship between participant status and the degree to which participants rated the conciliation process to be useful ($\chi^2 = 0.25, n = 16, p > .05$). Furthermore, there was no significant relationship between participant status and the degree to which the participants rated the conciliator as being impartial ($\chi^2 = 0.00, n = 14, p > .05$), helpful ($\chi^2 = 0.09, n = 16, p > .05$) or efficient ($\chi^2 = 0.27, n = 15, p > .05$).

7.3.6 Recommend/re-use the Service

Of the complainants 62.3% reported that they would recommend the HSC to others as a means of complaint resolution. In order to determine whether the decision to recommend, or not recommend the HSC to others was related to satisfaction scores, mean PSS and OSS scores were calculated for those complainants who reported that they would and would not recommend the HSC to others. The means are displayed in Table 7.4.

Table 7.4

<table>
<thead>
<tr>
<th></th>
<th>PSS Scores</th>
<th>OSS Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
</tr>
<tr>
<td>Recommend HSC</td>
<td>3.21</td>
<td>0.62</td>
</tr>
<tr>
<td>Would not recommend HSC</td>
<td>2.30</td>
<td>0.64</td>
</tr>
</tbody>
</table>

$N=144$

As can be seen from Table 7.4, those complainants who reported that they would recommend the HSC to others recorded higher mean scores on the PSS and
OSS than those participants who reported that they would not recommend the HSC to others. Separate One-way ANOVAs revealed that these differences were significant ($F(2, 143) = 34.6, p< .001$ and $F(2, 143) = 57.71, p < .001$ respectively).

7.3.7 Changes to Practice Reported by Health Service Providers After Dealing with HSC.

Of the 124 health service providers, 15 (12.4%) reported that they had changed the way they practice their profession as a result of their dealings with the HSC.

In order to explore whether there was a relationship between the type of health service provider (practitioner in a public hospital, practitioner in a private hospital, practitioner in a private practice or other unspecified practitioner) and reported change to practice as a result of dealings with the HSC, the frequency of reported change was tabulated for each provider type. The results are shown in Table 7.5.

Table 7.5

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Response Frequency</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (n, % within provider type)</td>
<td>No (n, % within provider type)</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>4 (13.9%)</td>
<td>25 (86.2%)</td>
</tr>
<tr>
<td>Public Hospital</td>
<td>0 (0%)</td>
<td>6 (100%)</td>
</tr>
<tr>
<td>Private Practitioner</td>
<td>9 (16.1%)</td>
<td>47 (83.9%)</td>
</tr>
<tr>
<td>Other – unspecified</td>
<td>2 (6.9%)</td>
<td>27 (93.1%)</td>
</tr>
</tbody>
</table>

$N= 120$
As can be seen from Table 7.5, a greater percentage of health service providers who were complained against while working in a private hospital or as an independent practitioner (either as a private practitioner or other-unspecified), reported changing their practice than did those who were complained against while working under the auspices of a public hospital. In order to determine whether this relationship was significant, cross tabulations were performed. The assumptions of random sampling and independence of observations were satisfactory, however low expected frequencies (< 5 in 3 cells) mean that the Chi Square statistics must be viewed with caution. Cross tabulations revealed that there was no significant relationship between the type of health service provider and whether or not the provider reported changing the way they practice their profession as a result of dealing with the HSC ($\chi^2 = 2.39, n= 120 \ p>.05$).

7.4 Summary of Quantitative Findings

The results indicated that contrary to predictions, participants did not distinguish between the different aspects of service delivery of accessibility, impartiality and effectiveness. Rather results indicated that participants demonstrated a more global concept of satisfaction that included two broad dimensions, satisfaction with the HSC process and satisfaction with the outcome of their complaint. Overall participants were satisfied with the HSC process, but less satisfied with their complaint outcome than they were with the complaint resolution process.

The findings indicated that complainants were significantly less satisfied than providers with both the process and the outcome of their complaint for cases closed in the Inquiry and Assessment stages of the complaints process. While health service providers were less satisfied than complainants with both the outcomes of their complaint and the process for cases closed in the Conciliation phase, these differences
were not significant, probably due to small sample sizes. Results indicated that few providers changed their practice as a result of their dealings with the HSC.
Chapter 8: Qualitative Responses to Questionnaires and Interviews

8.1 Chapter Overview

The following chapter discusses the qualitative findings from the application of the evaluation methodology to the evaluation of the complaints process at the Office of the Health Services Commissioner of Victoria (HSC). Findings are reported in two sections. Section 8.2 contains a statement of findings and preliminary discussion of the qualitative analysis of responses to the open ended questions on the written questionnaires, including reasons that participants gave for their dissatisfaction with their complaint outcome (Section 8.2.1) and ways in which providers reported changing their practice as a result of the complaint against them (Section 8.2.2).

Section 8.3 includes a statement of findings and preliminary discussion of the responses to questions in the telephone interviews including what participants liked about the HSC process (Section 8.3.1), what the participants disliked about the HSC process (Section 8.3.2) and in what way participants thought the process could be improved (Section 8.3.3). Finally Section 8.4 provides a summary of the qualitative findings.

8.2 Results and Preliminary Discussion of Responses to Open-ended Questionnaire Item.

8.2.1 Reasons for Dissatisfaction with Complaint Outcome

In order to identify the reasons for participants’ dissatisfaction with the outcomes of their complaints, a thematic analysis was conducted on the responses to the open-ended question “If you were dissatisfied with the complaint outcome, why was that?” Thematic analysis of responses revealed five common themes:
a) The perception that the problem had not reached an adequate level of resolution prior to case closure,

b) The actual outcome was different to what was expected,

c) The perception that the outcome was unfair or unjust,

d) Inadequate communication or feedback from the HSC regarding the outcome, and

e) The lack of power of the HSC to arbitrate or enforce outcomes.

Frequencies of the themes and sample responses are shown in Table 8.1. The thematic content of responses was similar for complainants and providers, however there was a difference in the pattern of responses observed between the two groups.
Table 8.1
Frequencies of Themes in Qualitative Responses of Complainants and Providers to the Item: “If you were dissatisfied with the complaint outcome, why was that?”

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sample Response</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem not resolved</strong></td>
<td>“It was a pointless exercise going to the HSC….the problem was not resolved”.</td>
<td>30</td>
</tr>
<tr>
<td><strong>Expected different outcome</strong></td>
<td>“I feel I should have been compensated”</td>
<td>28</td>
</tr>
<tr>
<td><strong>Outcome unfair or unjust</strong></td>
<td>“I felt it was handled well for (name of provider) but not for me”</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>“After the case was closed, with no finding against me proven, I received a letter implying mismanagement. The letter was based entirely on the false testimony of the complainant. No such letter should get any credence. The rules of justice should apply”</td>
<td>13</td>
</tr>
<tr>
<td><strong>Communication/feedback</strong></td>
<td>“After nine months I am still not aware of the outcome”</td>
<td>2</td>
</tr>
<tr>
<td><strong>Limited power of HSC</strong></td>
<td>“…because of the limited power the HSC has….I thought my case would be investigated, but they can only ask the doctor, and the doctor did not have to respond”</td>
<td>8</td>
</tr>
</tbody>
</table>

*User n=53  Provider n=16*

*n=69*
8.2.1.1 Complaint not resolved prior to case closure. Lack of resolution of the complaint was more frequently mentioned by complainants than providers as a reason for dissatisfaction with the complaint outcome. Lack of complaint resolution was also the most frequently cited concern with the complaint outcome for complainants.

One reason that complainants may have shown a higher level of dissatisfaction with the degree of complaint resolution than providers could be that the incidence of a complaint did not always mean that an adverse event has occurred or that the health service provider has committed a wrong doing. Thus if it is determined by the HSC that the provider does not have a complaint to answer, the complainant may interpret this as a lack of resolution, while the provider may, to the contrary, perceive this to be an adequate resolution.

8.2.1.2 Differences between the actual and expected outcome. A higher proportion of complainants than providers reported that they were dissatisfied with the complaint outcome because the actual outcome was different to the outcome they had expected. Almost one third of complainants reported that the outcome of their complaint was different to what they had expected. Examination of the responses revealed that the differences were sometimes related to a discrepancy between actual and expected outcomes resulting in a lesser than expected degree of settlement. For example

*I was claiming a $30 refund from the doctor, but I didn’t get a refund, only a letter from the doctor* (Participant 65)

A small number of participants also expressed dissatisfaction with the lack of receipt of an apology from the provider. For example:
I had hoped for an apology, but am satisfying myself with a response and improvement to policy and practices (Participant 119).

In such cases it is not clear whether differences in expectations result from participants not being adequately informed as to the possible outcomes of their case, or whether they do not attend to, or comprehend the information they receive regarding the role of the HSC and the limitations of the power of the HSC to enforce a singular outcome.

In some cases the reported expectations of the outcome were different to what could realistically be expected. For example.

I am still living with pain and the surgeon is refusing treatment with an operation (Participant 129).

or

I still have an ugly birth mark covering the left side of my face

(Participant 88).

It therefore appears that dissatisfaction with the complaint outcome is not always associated with realistic expectations of what is possible.

Health service providers were much less likely than complainants to report dissatisfaction with the outcome of the case on the basis of differences between the expected and actual outcome. It is not clear whether this observation is related to the health service providers taking greater steps to clarify their expectations, or whether they have a better understanding of the meaning of the documentation provided to them about the HSC process and the possible outcomes. It is also possible that the differences may at least partially be due to the fact that the expectations of health service providers do not become clouded by issues of grief and loss to the same extent as do those of complainants.
8.2.1.3 Outcome was unfair or unjust. An approximately equal proportion of complainants and providers reported that they were dissatisfied with the outcome of their complaint because they thought that the outcome was unfair or unjust.

8.2.1.4 Inadequate feedback from the HSC regarding the outcome of the complaint. Over one third of the health service providers who were dissatisfied with the outcome of their cases reported that they had never received any feedback from the HSC as to the outcome of their complaint. This was not the case for complainants, of whom only a very small number reported they had not been informed of the outcome.

8.2.1.5 Lack of power of the HSC to enforce outcomes. A small proportion of complainants reported being unhappy that the HSC did not have the power to follow through with their rulings. This may be further evidence of a lack of knowledge or inaccurate expectations of what the HSC can do. Alternatively it is possible that while the initial documentation given to complainants outlines the role of the HSC, complainants may either not read or attend to this documentation or that they may escalate the matter anyway because they have so much vested in it.

8.2.2 Changes to Professional Practice Reported by Health Service Providers Following their Dealings with the HSC.

In order to determine the nature of any changes to the professional practice of health service providers as a result of dealing with the HSC, responses to the item “How have your dealings with the HSC changed the way you practice your professional duties?” were examined. An open coding method was used to identify themes in responses to the question. The coding structure revealed three themes:

a) Defensive changes: The tendency to practice in a more defensive fashion as a result of dealings with the HSC,
b) Proactive changes: The tendency to take active steps to ensure that errors/difficulties do not arise or to handle concerns in a more proactive fashion, and

c) Advice: The tendency to use the HSC as an advisory resource for the improvement of policy or practice.

Frequencies of themes and sample responses are shown in Table 8.2.
Table 8.2

Frequencies of Themes in Qualitative Responses to the Question: “How have your dealings with the HSC changed the way you practice your professional duties?”

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sample Response</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defensive</td>
<td>“I view all clients as potential litigants even though there may be no justification.”</td>
<td>67</td>
</tr>
<tr>
<td>Proactive</td>
<td>“I try and resolve issues as soon as possible by inviting clients to a meeting.” “I do a phone review (with clients).”</td>
<td>25</td>
</tr>
<tr>
<td>Advice</td>
<td>“The Office (of the Health Services Commissioner) provides a point of reference for me to clarify issues and discuss ways of dealing with concerns.”</td>
<td>8</td>
</tr>
</tbody>
</table>

n = 12
As can be seen from Table 8.2 the most frequently reported change to practice was an increase in the tendency to practice defensively. A smaller proportion of health service providers reported that they actively incorporated strategies to improve their quality of service and to manage client concerns. One provider reported that they now consulted the HSC on an ongoing basis to seek advice about client concerns.

It should be noted that the number of health service providers reporting change was small ($n = 12$), therefore any generalisation of responses should be done with extreme caution.

8.3 Results and Preliminary Discussion of Responses to Telephone Interviews

An atheoretical, open coding method was used to identify common themes in responses to the interview questions. The responses of complainants and health service providers were analysed separately so as to allow comparison between the experiences of the two groups.

8.3.1 What Did You Like About the HSC?

In order to determine what participants perceived to be the strengths of the HSC complaints process, a thematic analysis of responses to the question “What did you like about the HSC?” was conducted. Thematic analysis revealed two overarching themes, Staff factors and Process factors.

Staff factors included reported strengths that related to the way the individual HSC staff members performed their role in the complaints resolution process. Process factors included those aspects of the complaints resolution procedure that were deemed to be strengths.

Frequencies of the themes and sample responses are shown in Table 8.3.
### Table 8.3

**Frequencies of Themes in Qualitative Responses to the Item: “What did you like about the HSC?”**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sample Response</th>
<th>Frequency (%)</th>
<th>User</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Efficacy</td>
<td>“The person handling the case was efficient”, “The staff gave good guidance”</td>
<td>70</td>
<td>70</td>
<td>73</td>
</tr>
<tr>
<td>Communication</td>
<td>“What they require from you is made clear”, “The HSC staff ….. kept me well informed”</td>
<td>32</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Impartiality</td>
<td>“The staff made an open attempt to be fair”</td>
<td>13</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time frame</td>
<td>“The matter was dealt with promptly”</td>
<td>21</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Outcome</td>
<td>“I felt that the HSC had actually addressed the problem, whereas the other people that I had been to had not”</td>
<td>11</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Process empowering</td>
<td>“The HSC empowered me (I) felt that if I had complained on my own the (provider) would not have responded”</td>
<td>4</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

\( N = 62 \)
As can be seen from Table 8.3, three main sub-themes of staff factors were identified:

a) Staff efficacy, the effectiveness of the particular staff member in facilitating the resolution of the complaint,

b) Communication, how effectively and the degree to which the staff kept the parties informed of the progress of the complaint, and

c) Impartiality, the degree to which HSC acted in a fair and just way in handling the complaint.

8.3.1.1 Staff efficacy. As Table 8.3 reveals, the majority of both complainants and health service providers reported staff efficacy as a strength of their dealings with the HSC. There were two aspects of staff efficacy frequently reported, generally related to the level of support offered by the staff and the perceived expertise of the staff. Participants reported that the staff were supportive and helpful. For example:

[The staff] were understanding, patient, and had expertise……..[They] gave general help and encouragement

( Participant 5).

Respondents also frequently reported that the staff were effective in their capacity to manage the complaints. For example:

[They have] a good level of expertise and are good at sorting out exactly what the issues are (Participant 47).

8.3.1.2 Staff communication. As can be seen from Table 8.3, a greater proportion of complainants (approximately one third) than health service providers (approximately one fifth) reported that staff communication was a strength of the complaints handling process. Two aspects of communication were most frequently
mentioned. First was satisfaction with the clarity of explanations, instructions and advice provided by the HSC staff. For example:

   They described the process well and the options (Participant 81).

Second was the degree to which complainants and providers reported that they had been kept informed regarding the progress of their case. For example:

   They kept me informed regarding what they did, what they could do and what they would do for me (Participant 14).

8.3.1.3 Impartiality. Table 8.3 reveals that a much larger proportion of health service providers than complainants reported that a strength of the HSC staff was their perceived capacity to act in an impartial manner.

As can be seen from Table 8, there were three sub-categories of process factors. These included the time frame in which the complaint was handled, the outcome of the complaint, and the experience of the complaints process as being empowering.

8.3.1.4 Time frame of complaint resolution. Complainants more frequently mentioned time frame as being a strength of the HSC process than did health service providers. Satisfaction with the time frame incorporated a satisfaction with the time taken to handle the case. For example:

   They were prompt in handling the matter (Participant 73).

and an acknowledgement that when there were time delays participants were kept informed of the reasons for delays, for example:

   They explained why there were delays (Participant 77).
8.3.1.5 Outcome of complaint. A greater percentage of health service providers than complainants reported the complaint outcome as being a strength of the HSC complaints process.

8.3.1.6 Process was empowering. A small proportion of both complainants and health service providers reported that the HSC process empowered them to handle a complaint that they would have found it difficult to manage on their own. Responses from complainants most frequently related to the HSC process enabling them to overcome the power differential between themselves and the provider. For example:

*The HSC was like an advocate, they gave me peace of mind that I didn’t have to deal with [the provider] directly……..I tried dealing with the provider directly but found that he was more articulate than I was and I felt intimidated.* (Participant 1)

Health service providers reported that the HSC process empowered them to deal with particularly difficult complaints. For example:

*They provided a buffer zone between [myself] and a very difficult situation* (Participant 26)

or

*I like to respond through the HSC for the very difficult cases….It is a friendly process and therefore you don’t feel intimidated by ringing them* (Participant 51).

8.3.2 What Did You Dislike About the HSC?

In order to gain an understanding of what participants perceived to be the weaknesses of the HSC process, a thematic analysis of responses to the question “*What did you dislike about the HSC?*” was conducted. Thematic analysis revealed
three higher order themes that could be further categorized into nine sub-themes. The higher order themes included Staff factors, Process factors and Structure factors. Staff factors included those weaknesses that related to the way the individual HSC staff performed their role in the complaints resolution process, such as staff communication, staff bias, staff efficacy and staff manner. Process factors included those aspects of the complaints resolution process that were deemed to be weaknesses, such as complaint outcome, process accessibility, timeframe of the complaint and the stressful nature of the complaint. Structure factors included those weaknesses that were related to the legislative framework in which the HSC operates. Structure factors were named so because they are relatively inflexible and difficult to change without major legislative intervention. The frequency of themes and sample responses are shown in Table 8.4.
### Table 8.4

**Frequencies of Themes in Qualitative Responses to the Item: “What did you dislike about the HSC?”**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sample Response</th>
<th>Frequency (%)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>User</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td>“I have never heard the conclusion of the case”</td>
<td>26</td>
<td>13</td>
</tr>
<tr>
<td><strong>Bias</strong></td>
<td>“Resolution is heavily weighted in the patient’s favour”</td>
<td>21</td>
<td>7</td>
</tr>
<tr>
<td><strong>Staff Efficacy</strong></td>
<td>“I did not really feel they cared about the problem”</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>“(name of HSC Staff member) was not really qualified to handle the complaint”</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Staff Manner</strong></td>
<td>“I did not really feel that they cared about the problem”</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>“I didn’t get what I asked for and he (the provider) wasn’t brought to account”</td>
<td>44</td>
<td>15</td>
</tr>
<tr>
<td><strong>Accessibility</strong></td>
<td>“I had trouble filling out the forms. I had to get help from (name of organisation)”</td>
<td>15</td>
<td>7</td>
</tr>
</tbody>
</table>

*N = 56*

Table 8.4 Continued on next page
Table 8.4 continued.

Frequencies of Themes in Qualitative Responses to the Item: “What did you dislike about the HSC?”

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sample Response</th>
<th>Frequency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Factors cont.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time frame</td>
<td>“when you have responded [to the complaint], it can take a long time to get the final closure on the complaint”</td>
<td>6</td>
<td>28</td>
</tr>
<tr>
<td>Process stressful</td>
<td>“It is a traumatic process in that it brought back negative thoughts….the HSC gave [me] no help with the psychological distress’”</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td><strong>Structure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited power of the HSC</td>
<td>“The HSC is hamstrung. They do not have enough power. There is no recourse via the HSC unless the provider is willing”</td>
<td>32</td>
<td>7</td>
</tr>
</tbody>
</table>

N=56
As can be seen from Table 8.4, Staff factors reported as weaknesses were further categorised into three sub-themes:

8.3.2.1 **Staff communication.** Those participants who reported that the staff communication was a weakness of the process, most frequently reported disappointment with the level of feedback given to them regarding the progress or outcome of their case. A greater proportion of complainants than providers reported staff communication as a weakness.

It should be noted that an approximately equal proportion of participants reported dissatisfaction with the level of communication as reported satisfaction with the level of staff communication. It is unclear whether this observation is due to participants dealing with different staff members, or individual difference in interactions.

8.3.2.2 **Staff bias.** As Table 8.4 shows, approximately one fifth of the complainants who participated in the interview reported that they had experienced the HSC staff as being in favour of the health service provider. Only one health service provider reported that they had experienced the HSC staff as being biased against them.

8.3.2.3 **Staff efficacy.** Staff efficacy was less frequently mentioned as a limitation of the HSC process, with a small percentage of complainants and providers expressing concern about the level of competence of the HSC staff in resolving their complaint.

8.3.2.4 **Staff manner.** Approximately 17% of complainants reported that they disliked the interpersonal manner of the HSC staff member who managed their case. Health service providers did not report staff manner as being a limitation of the process.
As can be seen from Table 8.4, participants reported dissatisfaction with four major sub-categories of Process factors. Dissatisfaction with the outcome of the case; accessibility of the complaints process; the timeframe in which the complaint was resolved and the stressful nature of the process.

8.3.2.5 Outcome. Almost half of the complainants who were interviewed reported that they disliked the HSC process because it failed to deliver a satisfactory outcome. A smaller proportion of health service providers (15%), reported outcome as being a serious limitation of the complaints process. Dissatisfaction with the outcome was most usually related to a discrepancy between the expected and actual outcome.

8.3.2.6 Time frame. A much higher proportion of health service providers (almost one third) than complainants, reported that they were dissatisfied with the time frame in which the complaint was handled.

8.3.2.7 Accessibility. A greater proportion of complainants than providers reported that lack of accessibility was a difficulty with the complaints process. This was most often reported as difficulties with internal accessibility such as negotiating the system or filling out forms.

8.3.2.8 Stress. A small but approximately equal proportion of complainants and providers reported that a limitation of the HSC process was the degree of stress that it evoked. This usually was reported in terms of a perceived lack of assistance in handling the emotional distress associated with their case.

As can be seen from Table 8.4, the Structure factor reported as being a limitation of the complaints process was the legislative restrictions placed on the HSC in terms of their ability to enforce outcomes. Approximately half of the complainants reported concerns that the HSC does not have adequate power to resolve complaints
effectively. Concerns most usually related to the lack of the HSC to enforce participation in the complaints process or to enforce the resultant recommendations and outcomes.

8.3.3 In What Way do you Think the HSC Process Could be Improved?

A thematic analysis was conducted on responses to the question “In what way do you think the HSC process could be improved?”. Two overarching themes were identified, Process factors and Structure factors. Frequencies of themes and sample responses are shown in Table 8.5.
Table 8.5

*Frequencies of themes in qualitative responses to the item: “In what way could the HSC process be improved?”*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sample Response</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>User</td>
</tr>
<tr>
<td><strong>Staff</strong></td>
<td></td>
<td>n= 47</td>
</tr>
<tr>
<td>Communication</td>
<td>“[We] need to be kept better informed”</td>
<td>6</td>
</tr>
<tr>
<td>Process</td>
<td>“If the HSC had seen me they would have understood the problem. It would have been obvious that <em>(the provider)</em> was at fault”</td>
<td>17</td>
</tr>
<tr>
<td>Face to face meetings</td>
<td>“Parties should have to meet and front each other in the presence of a mediator, so that the provider becomes aware of the whole situation”</td>
<td></td>
</tr>
<tr>
<td>Emotional support</td>
<td>“Even if the HSC can’t help you they should arrange counselling. The emotional toll is huge and people need counselling and support”</td>
<td>11</td>
</tr>
<tr>
<td>Practical support</td>
<td>“I could have used some assistance in writing my response, because it was so traumatic”</td>
<td>9</td>
</tr>
<tr>
<td><strong>Structure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase power of HSC</td>
<td>“The HSC should have more authority to force the doctor to comply”</td>
<td>23</td>
</tr>
</tbody>
</table>

*N=62*
As can be seen from Table 8.5, the most frequently mentioned improvement by health service providers was to improve the communication between the HSC staff and the parties involved in the complaint. This was usually suggested in the context of keeping parties informed of the progress of the case.

As can also be seen from Table 8.5, there were three main Process factors identified for improvement. They were the introduction of a) initial face to face meetings, b) emotional support mechanisms, and c) practical assistance.

8.3.3.1 Face to face meetings. The improvement most frequently suggested by complainants was the introduction of initial face to face meetings between the complainant, health service provider and the HSC staff. This was most usually suggested as a means of increasing the level of understanding of the problem, and/or accountability of the health service provider. Health service providers did not suggest the introduction of face to face meetings.

8.3.3.2 Emotional support. Both complainants and health service providers reported that the parties in the complaints process would benefit from the provision of emotional support throughout the complaints process. This improvement was usually suggested within the context of the stressful nature of the complaints process for both complainants and health service providers.

8.3.3.3 Practical support. A small proportion of both complainants and providers reported that the HSC process could be improved by the provision of additional practical support for complainants and providers with lodging and responding to the complaint.

As is further apparent from Table 8.5, the second most frequently suggested improvement by complainants (23%) was to give the HSC the power to arbitrate.
Increasing the power of the HSC was less frequently suggested as an improvement by health service providers.

8.4 Summary of Qualitative Findings

The qualitative responses revealed that complainants and providers reported different reasons for dissatisfaction with the outcome of their complaints. Complainants most often attributed their dissatisfaction to a perception that their complaint had not been fully resolved, or that the outcome was different to what they expected, while providers most often reported lack of feedback regarding the outcome of their complaint as their major source of dissatisfaction.

Of the few health service providers who reported that they had changed their practice as a result of the complaint against them, the most frequently reported change was a tendency towards defensive practice. Only a small proportion of providers reported proactive positive changes to their practice. Both complainants and providers reported the way in which the HSC staff handled their case as an overwhelming strength of the complaints process. However, complainants and providers perceived the time frame in which complaints were managed in opposing manners. Complainants viewed the time frame as a strength of the process, while providers viewed the time frame as a limitation of the process. A greater percentage of providers than complainants viewed the complaint outcome as a strength.

Improvements to the process most frequently suggested by complainants were to increase the power of the HSC to enforce the complaint outcomes, and the inclusion of face to face meetings between all parties to the complaint. Both complainants and providers argued for an increase in the level of practical and emotional support provided for parties as they negotiate the complaints process.
Chapter 9: Discussion

9.1 Chapter Overview

The current chapter includes an integrated summary of the findings. Section 9.2 relates to the first research question and discusses the degree to which the methodology was successful in assessing the performance of the complaints process at the Office of the Health Services Commissioner (HSC).

Section 9.2 discusses findings in relation to the first research question. Section 9.2.1 discusses the reported satisfaction of complainants and providers with the process, while Section 9.2.2 discusses the most frequently reported reasons for dissatisfaction with the complaint outcome for both complainants (Section 9.2.2.1) and providers (Section 9.2.2.2). Section 9.2.3 discusses the impact of the stage at which the complaint reaches closure on the level of reported satisfaction with the complaints process and outcomes, and discusses differences between complainants and providers in reported satisfaction at each stage. The qualitative responses to telephone interview data are discussed in Sections 9.2.4 and 9.2.5. Section 9.2.4 discusses the reported strengths and weaknesses of the complaints process, while Section 9.2.5 discusses the improvements that complainants and providers suggested to the process. Section 9.2.6 considers the evidence as to whether or not the complaints process has resulted in an improvement in the quality of health service delivery and finally Section 9.2.7 gives an overview of all the quantitative and qualitative findings from the application of the methodology to the evaluation of the complaints process at the HSC.

Section 9.3 relates to the second research question and discusses the implications of the findings of the evaluation of the complaints process at the HSC for complaints processes in general, and in particular the unintended side effects that
arise for complainants (Section 9.3.1) and health service providers (Section 9.3.2) as a result of participating in the complaints process. Section 9.3.2 discusses the implications of these unintended consequences for the management of complaints.

Section 9.4 relates to the third research question and considers how well the evaluation methodology translated into practice in a professional setting. Section 9.4.1 discusses the strengths of the methodology, including the insight it allows into the experiences of the stakeholders (Section 9.4.1.1) and the unintended impact of complaints processes on complainants and health service providers (Section 9.4.1.2); the usefulness of the methodology in the generation of meaningful recommendations for complaint process improvement (Section 9.4.1.3); the ease with which the methodology can be adapted for future use in evaluating other health complaints services (Section 9.4.1.4); and the contribution of the methodology to the empirical base for evidence-based evaluation (Section 9.4.1.5).

Section 9.4.2 considers the limitations of the current methodology as applied to the evaluation of health complaints processes, including limitations of the scope of the data that can be collected (Section 9.4.2.1) and the cost effectiveness of the methodology (Section 9.4.2.2). Section 9.5 relates to the fourth research question and outlines suggested improvements for future applications of the methodology while Section 9.6 gives a general overview of the study and draws conclusions regarding the potential uses for the methodology in the evaluation of the new Victorian health regulatory framework embodied in the *Health Professions Regulation Act 2005* which will regulate all health practitioners that are currently registered in Victoria, including psychologists.
9.2 Research Question 1: Did the Findings Generated by the Methodology Indicate that the HSC Complaints Process Satisfied its Stated Objectives?

The first research question explored the extent to which the current evaluation methodology was able to determine how well the Office of the Health Services Commissioner (HSC) was performing in its role of resolving health complaints. The evaluation methodology gave considerable insight into the experiences of complainants and health service providers involved in the complaints process at the HSC. Quantitative data indicated the level of satisfaction of participants with the complaints process and outcomes, while the qualitative data further enriched the quantitative data, allowing for a deeper understanding of the attitudes and experiences of complainants and providers and for the generation of meaningful recommendations.

9.2.1 Satisfaction

It was anticipated that that participants would differentiate between three aspects of the complaints process including the accessibility, impartiality and efficacy of the complaints resolution process. Contrary to expectations however, the findings of the current study indicated that participants, in reporting their satisfaction with the complaints process, did not differentiate between the different aspects of the service. Rather they demonstrated a more global assessment of satisfaction that included two broad dimensions, satisfaction with the staff handling of the complaints process (including all aspects of how the HSC staff handled the case) and satisfaction with the outcome of their complaint.

These findings are consistent with previous research that has found that consumers tend to develop global assessments of satisfaction with the services they receive, and often do not distinguish between satisfaction with the different elements of service delivery (Finn & Kayande, 1998; Iacobucci, Ostrom & Grayson, 1995).
Such studies have also reported that when consumers are dissatisfied with the service they receive they tend to generalise their dissatisfaction to an overall dissatisfaction with the products or outcomes they receive (Iacobucci et al., 1995). Contrary to these findings however, both complainants and providers in the current evaluation indicated a high level of satisfaction with the process by which the staff handled their complaint, even if they were dissatisfied with the outcome.

The differences between the current findings and findings of previous research may be due to the differences between the contexts in which the HSC complaints process operates and the complaint processes in other service industries. Complaints about health services have an emotional overlay that is distinct from complaints in other service industries (de Ruyter & Wetzels, 1998; Mulcahy, 2003). Furthermore, satisfaction appraisals tend to involve an affective appraisal of the service experience, while perceptions of outcome quality tend to involve a cognitive appraisal of the outcome achieved (Iacobucci et al., 1995). Given that health complaints are emotionally charged to begin with, it would therefore be anticipated that complainants may be primed towards affective appraisals, and therefore place greater emphasis on process satisfaction than outcome satisfaction, which then in turn may lead them to continue to maintain a high level of satisfaction with the way their complaint was managed, even in the light of negative outcomes.

The outcomes of health complaints are often intangible, especially where the adverse outcome is not reversible or cannot be rectified. In such circumstances, the perceived outcomes of health complaints may be linked to subjective concepts such as the perception of fairness or justice, rather than being objectively quantifiable outcomes (Thibaut & Walker, 1975; Tyler, 1989; Schoefer 2000). Furthermore, the complainant may not have the specialist knowledge to be able to objectively judge
whether the outcome is satisfactory and therefore may rely more on subjective
appraisals (de Ruyter & Wetzels, 1998; Mulcahy, 2003). Where outcomes are
intangible and cognitive appraisals of outcomes are more difficult, individuals have
been shown to rely more heavily on affective measures of satisfaction and the quality
of the interpersonal interaction with the person handling their complaint, rather than
on objective appraisals of the quality of the outcome (de Ruyter & Wetzels, 1998;

Overall complainants and health service providers were less satisfied with the
outcome of their complaint than they were with the process. While there are very few
evaluations of health complaints processes available in the public domain, such
evaluations have typically reported a much lower level of satisfaction with the way
the complaint was handled than was found in the current study (Newby, McBride,
(2001), in a large scale evaluation of the complaints process of the United Kindom
National Heath Scheme (NHS), found that the majority of complainants were
dissatisfied with both the way the NHS staff had handled their complaint and the
outcome of their complaint. Providers on the other hand reported a high level of
satisfaction with the way their complaint was managed and with the outcome.
Similarly Newby and colleagues (2004), in an evaluation that focused purely on the
views of complainants who had lodged complaints with health registration boards in
Victoria, found that the majority of complainants reported being dissatisfied with the
complaints process. The inconsistency between the current findings and the findings
of Posnett et al. (2001) and Newby et al. (2004), may well reflect differences in the
particular model of complaints resolution adopted. Both the NHS and the Victorian
Registration boards adopt a more adversarial approach to complaints resolution than
does the HSC. The HSC complaints resolution process is modelled on the principles of alternative dispute resolution and therefore applies a more conciliatory framework for complaints resolution.

These quantitative findings of the current study therefore indicate the pre-eminence of interpersonal experiences that occur throughout the complaints process in judgments of satisfaction with both the process and outcome. In particular the findings highlight the importance of fostering a positive interpersonal interaction between the staff responsible for handling the complaint and the complainants and health service providers involved in the case, particularly in the area of health complaints.

9.2.2 Reasons for Dissatisfaction with the Complaint Outcome

Qualitative reasons given for dissatisfaction with the complaint outcome differed for complainants and providers.

9.2.2.1 Complainants. Complainants’ reasons for dissatisfaction most often related to a disconfirmation of their expectations regarding the outcome of that complaint or a perception that the outcomes were unfair or unjust. Disconfirmation of complainants’ expectations regarding the complaint outcome most often manifested itself in a perception that the complaint had not progressed through the complaints process as far as they thought it should have, or that the outcome was different to that which they expected. Despite the fact the previous researchers have found support for the facilitatory impact of apology in the resolution of conflict (Allan, Allan, Kaminer, & Stein, 2006; Clarke Kaminski & Rink, 1992; Fisher, Garrett, Arnold & Ferris, 1999; Goodwin & Ross, 1992), it is of interest that very few complainants in the current study reported the presence or absence of apology as being a factor in their satisfaction ratings. In the current study, qualitative responses
were solicited through open ended questions, while previous studies have directly explored and addressed the specific issue of apology. It would be explore the potential facilitatory effect of apology further through more direct response format.

In some cases, expectations expressed by complainants were clearly beyond the powers of the HSC to achieve (e.g., they expected the HSC to go beyond their legislative powers and enforce the outcomes of the decisions made, or to issue sanctions against the providers).

The finding that complainants report a gap between their expectations and the actual outcome they receive is consistent with previous research that has found that consumer satisfaction is linked to the confirmation or disconfirmation of consumer expectations and that typically consumers who receive an outcome that is consistent with their expectations of a service are more satisfied with the outcomes (Lytle & Mokwa, 1992; Oliver, 1980; Taylor, 1994). Oliver (1980, 1997) proposed a cognitive model of the antecedents to satisfaction decisions whereby a client brings a set of expectations into the health encounter and these expectations form a frame of reference against which subsequent outcomes are compared and evaluated. Within this framework both the confirmation or disconfirmation of expectations and the level of expectations that the client brings to the service impact on the degree of satisfaction expressed about the service received, rather than the absolute nature or value of the outcomes. Lytle and Mokwa (1992) further proposed that confirmation or disconfirmation of expectations is not simply a post encounter phenomenon, but rather an ongoing continuous appraisal that occurs prior to, during and after the encounter.

The current findings may indicate that HSC complainants enter the complaints process with a preconception that their case will progress through the
system and that there will be some form of accountability and consequences for the provider to compensate for the adverse event. If their complaint does not progress according to the preconceived plan, then the result can be dissatisfaction.

Prior to lodging complaints with the HSC, complainants are given detailed written information that outlines what the complaints process does and does not have the power to achieve. The current findings indicate that despite this, complainants continued to maintain unrealistic expectations of the complaints process and of the people managing the complaint. The reasons for complainants’ continued inflated expectations is unclear. One possibility is that this tendency towards unrealistic expectations is due to an initial failure to either read or understand the limitations of the complaints process. Alternatively complainants may simply not be able to modify their pre-encounter expectations to match the constraints of the process.

There is evidence to suggest that the negative emotions evoked by an adverse event can lead to unreasonable expectations regarding the outcomes of complaints and a tendency towards escalation of the complaint (Aron, 2001; Bobocel & Meyer, 1994; Hunt & Hunt, 1988; Shoorman & Halahan, 1996). A number of explanations have been offered for this observation. First complainants make a decision to complain and may feel personally responsible and therefore psychologically committed to the outcome of that complaint. Alternatively complainants, upon realising that the complaint has failed to reach their desired outcome, enter a process of self-justification, whereby they psychologically defend their decision to complain through a process of escalation of their commitment to the complaint and the desired outcome (Shoorman & Holahan, 1996). It is therefore feasible that by the time complainants have reached the threshold where they are motivated enough to make a complaint, they have such a strong emotional and psychological commitment to the
complaint that they are unable to modify their expectations to match the functions and limitations of the complaints process.

A second reason for dissatisfaction with the complaint outcome that was frequently reported by complainants was the perception that the outcome of the complaint was unfair or unjust. Whilst the current data does not indicate why complainants experienced the outcome as being unjust, previous research indicated that where complainants feel that they have not had adequate opportunity to put forward their views, or that their views have not been adequately attended to they perceive the process to lack procedural fairness, and therefore register dissatisfaction with subsequent outcomes (Schoefer 2000; Tyler, 1989; Thibaut & Walker, 1975). This perception of unfairness or unjustness of the outcome may well then go hand in hand with the reported general perception that the complaint had not been resolved to the level that complainants desired or expected.

9.2.2.2 Providers. Unlike complainants, the reasons for dissatisfaction with the outcomes cited by health service providers did not generally relate to a disconfirmation of expectations. Therefore providers did not seem to experience as large a gap between their expectations of the complaints process and the achieved outcome as did the complainants. This may indicate that providers are better able to understand and internalise the information that is given to them about the complaints process and possible outcomes. Additionally providers typically report a high level of fear and distress at being subject of a complaint (Charles, 1996; Montgomery, Cuprit, & Wimberley, 1999; Schoenfeld, Hatch & Gonzalez, 2001; Wilbert & Fulero, 1988). It is possible that the fear associated with being the subject of a complaint may lead providers to have negative expectations relating to the complaint outcome. It is therefore possible that some providers may enter the encounter with overly
negative expectations and therefore be pleasantly surprised by the resultant process and outcome.

The reason for dissatisfaction with the outcome of their complaint most frequently cited by providers was dissatisfaction with the level of communication and feedback they received from the HSC regarding the progress and outcomes of their case. Providers generally reported that they had either not been kept adequately informed as to the progress of the case, or that they had never received notification that the case had been finalised. The tendency for health service providers to feel under-informed when involved in a complaint has been previously noted (MSJ Keys Young, 1990; Posnett et al., 2001). This again could be a function of the stressful nature of the complaints process. Research suggests that being the subject of a complaint or malpractice litigation, or even the threat of malpractice litigation, can evoke a range of negative emotional responses (Charles, 1996; Montgomery et al., 1999; Schoenfeld, et al., 2001). Furthermore, where complaints are resolved more quickly providers generally report experiencing less negative emotional symptoms (Schoenfeld et al., 2001). The current findings thus suggest that effective and timely communication is important in assisting providers to contain their anxiety about the pending outcome of their case.

9.2.3 The Impact of Stage of Complaint Closure on Satisfaction

The reported satisfaction of complainants and providers was also related to the degree to which the complaint progressed through the complaints process prior to closure. Complainants reported significantly lower levels of satisfaction than did providers with both the process and the outcome of cases that closed in the earlier stages (Inquiry and Assessment stages) of the complaints process. This observation is consistent with the findings of Newby et al. (2004), who found that complainants
who had experienced the complaints processes at Victorian health registration boards, were less satisfied with the outcome of their complaint when it closed in the earlier stages of the complaints resolution process.

There are a number of reasons that a complaint may not progress to the full extent of the complaints process. First, not all complaints equate with an adverse event, therefore complaints may be closed due to a lack of evidence that misconduct or error has occurred. In such circumstances, complainants who have become psychologically committed to their decision to complain, and who have the expectation that their complaint will progress through the system, may feel aggrieved.

The conciliation process at the HSC relies on the voluntary participation of the health service providers in the process. Complaints therefore may be closed due to an unwillingness of the provider to participate in the conciliation process, or if the HSC staff deem that the matter is not suitable for conciliation. Complainants enter the complaints process with expectations about what will be achieved as a result of their complaint and how the complaint should be managed. They probably also come in with some expectation as to how the provider will respond to the complaint. If there is a gap between these expectations and what actually happens (e.g., if the provider does not agree to participate in conciliation or the HSC makes the decision that the case is not appropriate for conciliation) then the complainants will register dissatisfaction. This supposition was supported by the qualitative data that showed that the most frequently reported reasons that complainants were unhappy with their outcomes related to the complaint not being fully resolved, or the outcome being different to the expected outcome or perceived as being unfair. Most of these relate to expectations about what would be achieved by the complaint, what the outcome would be and how the provider would respond to the complaint.
Thibaut and Walker (1975) found that complainants’ reactions to third party mediated disputes were related to their perception of the perceived fairness and the perceived level of control that individuals had over the decision making processes. Thibaut and Walker found that where complainants felt that they had had the opportunity to have their views adequately heard, their perceptions of fairness were enhanced. Furthermore, prior research indicates that complainants are generally more satisfied with the resolution of their complaint if they perceive that the outcome is fair and that justice has been done (Schoefer 2000; Tyler, 1989). Therefore when the decision is made to close a complaint in the early stages of the complaints process, the HSC complainants may perceive that they have lost control over the complaints process or that they have lost the opportunity to have their views adequately heard, thereby creating a perception of injustice.

The current findings indicated that health service providers were less satisfied with both the outcomes of their complaint and the complaint process when the complaint progressed through to the Conciliation phase than were complainants (although these differences were not significant, possibly due to small sample sizes). Complaints that progress through to the Conciliation stage often involve the negotiation of a financial settlement. They also require a significant level of engagement in the complaints process and a large time commitment from all parties. Health service providers have been shown to experience a high level of distress following a complaint, and this distress increases with the time taken to resolve the complaint (Montgomery et al., 1999; Schoenfeld, et al., 2001). Thus it is highly probable that the higher level of dissatisfaction experienced by providers when their complaints progress through the system could also be related to the distressing nature of having a complaint lodged against them and the potential threat to their livelihood.
9.2.4 Telephone Interview Data: Reported Strengths and Weaknesses of the HSC Complaints Process

Both complainants and providers reported staff efficacy as being the predominant strength of the HSC complaints process. There were mixed findings in relation to participants’ expectations regarding the level of communication with staff, with approximately equal proportions of complainants and providers reporting communication as a strength and as a weakness. Research has indicated that inadequate feedback during and following complaints can lead to feelings of injustice and dissatisfaction with the complaints process (Dunning & Pecotich, 2000).

Health service providers reported impartiality of the process as a strength, while complainants reported it as a weakness of the process. This finding is consistent with the other qualitative findings. The perceived unfairness of the complaints process reported by complainants most probably relates to their perception that the outcomes of their complaint are inconsistent with their expectations or unfair. This could then contribute to perceptions of procedural injustice (Schoefer 2000; Thibaut & Walker, 1975; Tyler, 1989).

The length of time taken to resolve complaints was perceived in opposing manners by complainants and providers, with complainants reporting the time frame as a strength of the process and providers perceiving the time frame as being too long. It may be that complainants see the extension of the time frame as being an indication of greater weight being placed on the complaint. This is further supported by the observation that complainants are less satisfied with both the outcome and process of the complaint when the complaint is closed in the early stages of the complaints process.

Evidence shows that providers respond to complaints against them with fear and anxiety (Montgomery, et al., 1999; Schoenfeld, et al., 2001), so a longer
timeframe could exacerbate these negative emotions. This was further supported by the recommendation by providers that emotional support be offered to parties throughout the complaint.

9.2.5 Telephone Interview Data: Improvements Suggested by Complainants and Providers

Complainants reported that the HSC process could be improved by the incorporation of face-to-face meetings between all parties to the complaint. Previous research indicates that complaint resolution is enhanced when there is a perception that the service provider has taken responsibility for the adverse event (Dunning & Pecotich, 2001; Fisher, Garrett, Arnold & Ferris, 1999; Shapiro, Bittner & Barry, 1994). It is possible that face to face meetings would result in a higher level of perceived credibility for the provider, and therefore facilitate a greater level of acceptance and satisfaction with outcomes by the complainant.

A significant minority of complainants also reported that the HSC process could be improved by increasing the power of the HSC to enforce the outcome of the complaints. This finding demonstrates a failure on the part of the complainant to understand the principles and philosophies of the alternative dispute resolution process, being founded on the principles of non-adversarial, non coercive, mutual agreement.

Most frequently, health service providers reported that the HSC process could be improved by increasing the level of communication and feedback provided to providers involved in complaints. This is a further reflection that providers feel the need for a high level of communication throughout the process, possibly as a means of containing their anxiety about the complaint and its outcomes.

A number of both health service providers and complainants recommended that parties to the complaint be provided with emotional support throughout the
course of the complaint. Previous studies have highlighted the stressful nature of negotiating complaints processes for both complainants and service providers (Charles, 1996; Montgomery, et al., 1999; Schoenfeld, et al., 2001) and the current findings support this contention.

9.2.6 Evidence for the Improvement in the Quality of Service Delivery

Few providers reported changing their practice as a result of complaints. Furthermore, the most commonly reported changes were of a defensive nature. This finding is consistent with previous studies that have reported an increased tendency for health practitioners to practice in a defensive manner following a complaint or litigation against them (Charles, 1996; Charles, Warnecke, Wilbert, Lightenberg & DeJesus, 1987; Shapiro, Simpson, Lawrence, Talsky, Sobocinski & Schiedermayer, 1989; Summerton, 1995). In fact some studies have found that the mere threat of litigation is enough to trigger defensive practices (Charles et al., 1987; Shapiro et al., 1989; Wilbert & Fulero, 1988). The relatively low proportion of practitioners who reported that they had changed their practice as a result of their dealings with the HSC indicates that the HSC may not be fulfilling its stated objective of using the outcomes of complaints to improve the quality of service to its full potential.

9.2.7 Summary of Findings

In summary, it was anticipated that participants would distinguish between three aspects of the complaints process (accessibility, impartiality and efficacy). Findings indicated that participants did not evaluate the service in terms of these dimensions, but instead reported satisfaction in terms of two global elements, satisfaction with the way the complaint was managed (process) and satisfaction with the outcome of the complaint. Both complainants and providers indicated a high
level of satisfaction with the way staff handled their complaint, even if they were dissatisfied with the outcome.

Complainants reported significantly lower levels of satisfaction with both the process and the outcome for cases that closed in the Inquiry and Assessment stages than did providers. This may reflect a general dissatisfaction with their complaint not progressing to the full extent. This was further supported by the qualitative findings that complainants were more likely to perceive the outcome and level of resolution of the complaint as a weakness of the process. Complaints that progress to Conciliation are generally more serious and often attract a financial settlement, therefore it would be expected that earlier closure would be more satisfactory to providers.

Both complainants and providers reported staff efficacy as being the predominant strength of the complaints process. There were mixed findings in relation to participants’ expectations regarding the level of communication with staff, with approximately equal proportions of complainants and providers reporting communication as a strength and weakness. Research has indicated that inadequate feedback during and following complaints can lead to feelings of injustice and dissatisfaction (Dunning & Pecotich, 2000).

The length of time taken to resolve complaints was perceived in opposing manners by complainants and providers, with complainants reporting the time frame as a strength of the process and providers perceiving the time frame as being too long. It may be that complainants see the extension of the time frame as being an indication of greater weight being placed on the complaint. This is further supported by the observation that complainants were less satisfied with both the outcome and process when the complaint was closed in the early stages of the complaints process. Evidence shows that providers respond to complaints against them with fear and
anxiety (Montgomery, et al., 1999; Schoenfeld, et al., 2001). It is possible that a longer timeframe could exacerbate these negative emotions. This was further supported by the recommendation by providers that emotional support be offered to parties throughout the complaint.

Few providers reported changing their practice as a result of complaints and those that did report changing their practice tended to report a shift towards more defensive practice. Whilst complaints are not necessarily found to equate to a wrongdoing, and therefore may not indicate a necessity to change, the current findings do not support the effectiveness of the complaints process as a precursor to change. The tendency towards defensive practice is most probably because of the stressful nature of complaints and a subsequent determination on the part of the provider to avoid any further complaints (Schoenfeld, et al., 2001).

9.3 Research Question 2: What are the Implications of the Findings for Complaints Processes in General?

The second research question considered the implications of the findings of the evaluation of the HSC for complaints processes in general. The findings of the current study have a number of implications for the management of health complaints in general. The findings indicate that, whilst the function of a health complaints resolution processes is to receive and resolve complaints, these processes also have a number of unintended effects on the complainants and providers who are involved in the complaints process. Furthermore, these unintended outcomes have the potential to impact in a negative way on both the complainants’ and providers’ experiences of the complaints process and their subsequent post-complaint behaviours and attitudes.

9.3.1 Implications for Managing Unintended Outcomes for Complainants

The findings of the current study indicate that despite being given considerable information about the complaints process, complainants tend to form
and maintain unrealistic expectations about what the complaints process can achieve, and how the health provider will respond to the case. Furthermore the findings indicate that the subsequent disconfirmation of these expectations can lead to range of negative outcomes for the complainant that extends well beyond the timeframe of the original complaint. Such effects include a range of negative emotional responses such as extreme dissatisfaction, anger and frustration, and a reluctance to recommend the HSC process to others or engage in the process again should it be necessary.

Complainants enter the complaints process with expectations about how their complaint will be dealt with, how the provider will respond to that complaint and what the consequences of the complaint will be for the provider who they perceive to have acted improperly. The findings of the current study that often complainants have unrealistically inflated expectations about what the complaints process can achieve, and seem not to process information given to them about the functions and limitations of the complaints process, highlight the importance of managing the expectations of complainants from the outset and monitoring their expectations throughout the process.

If the goal of complaints processes is to resolve complaints to an enduring, mutually agreeable outcome, as is the case in settings such as the HSC that employ alternative dispute resolution techniques, then it is important to monitor and manage the expectations that the complainant has when they lodge their complaint to ensure that their expectations are realistic. One way to do this is through extra attentiveness on the part of the people handling the case. Evidence suggests that attentiveness in the form of increased communication, and a caring, empathic and understanding response from the person handling the case has a facilitative effect on complaint resolution (Davidow, 2003; Fisher, Garrett, Arnold & Ferris, 1999). Whilst it is
recognised that a high level of attentiveness is a labour intensive exercise, especially
where complainants may be particularly needy or demanding, regular verbal
communication with the complainants with a focus on increasing their understanding
of the complaints process and its limitations, should assist with the monitoring and
grounding of expectations and therefore reduce the likelihood of long term escalation
of the complaint.

As has been noted in previous research, a certain threshold of motivation has
to be achieved for an individual to lodge a complaint when they are dissatisfied with
the service they receive (Chebat, Davidow & Codjovi, 2003; Morel, Poiesz & Wilke,
1997). It is only when the individual’s cognitive appraisal as to the severity of the
incident and the provider’s personal responsibility for the outcome evoke sufficient
negative emotions, that they will lodge a complaint (Chebat et al., 2003). In fact
evidence suggests that the vast majority of those who are dissatisfied with the service
they receive never actually cross this threshold and go on to lodge a formal complaint
(Hogarth, English & Sharma, 2001; Schlessinger, Mitchell & Elbel, 2002; Voorness,
Brady & Horowitz, 2006). This suggests that by the time the person has lodged their
complaint they have a high level of emotional and psychological commitment to that
complaint, which in turn, if their expectations are not met, has the potential to lead to
an escalation of the complaint and the negative emotions attached to it (Aron, 2001;

One way to manage this escalation of emotions is to increase the level of
practical and emotional support available to parties throughout the course of the
complaint. Providing an advocate for complainants could fulfil the dual role of
assisting complainants to thoroughly understand the complaints process and therefore
develop realistic expectations and to support the complainant in management of their
emotional reactions to the adverse event and the complaint and therefore foster a greater level of acceptance of the outcomes.

9.3.2 Implications for Managing Unintended Outcomes for Providers

The findings of the current study indicate that some providers display a range of maladaptive behavioural responses to having to respond to a complaint against them. Few providers reported any change at all to their practice following the complaint. Of the small minority that did report changes, most reported a shift towards defensive practice. A number of studies have documented the tendency towards defensive practice following complaints or malpractice litigation (Cook & Neef, 1994; Charles, 1996; Charles, et al., 1987; Shapiro et al., 1989; Summerton, 1995). Most usually this tendency towards defensive practice has been seen as a reflection of the severe negative emotions that health service providers experience as a result of a complaint against them and of a determination not to be complained against again (Freckleton & List, 2004; Lawton & Parker, 2002). The feelings of stress, grief, loss, inadequacy and injustice that typically arise from having a complaint lodged against them can complicate the engagement of the provider in the complaint process and evoke defensive practices even if they are found to have done nothing wrong (Shoenfeld et al., 2001).

Whilst in some circumstances it may be a good thing to engender a higher level of caution in clinical practice, when that practice becomes defensive, this can be counterproductive to patient care. Defensive practice may ultimately result in clients being subjected to a range of precautionary, yet non-essential interventions or may even stop practitioners from performing certain procedures or seeing clients who they believe will place them at higher risk of complaints (Cook & Neef, 1994). This necessarily will impact on the ability to foster a genuine and useful therapeutic
relationship between the health practitioner and client. The current findings therefore highlight the importance of regulatory bodies taking proactive steps to contain the anxieties of the providers involved in the complaint in order to reduce the negative emotional impact on the provider and therefore the likelihood that the complaint will result in negative post-complaint practices.

The management of providers’ negative emotional responses to complaints also has implications for the use of complaints as an opportunity to improve the quality of service, as defensive practice is counter-productive to the achievement of evidence-based improvements in practice. One way to minimise the negative post complaint behaviours is to reduce the stressors that lead to those behaviours. This could be achieved through the provision of support to practitioners as they engage in the complaints process and following the closure of their complaint. A number of theorists and practitioners have argued that health regulatory bodies should play a more proactive role in managing the negative emotional impact of complaints on the practitioner. It has been suggested that professional bodies should provide practitioner support groups and educational programs that focus on complaints processes as an essential intervention for practitioners who find themselves involved in health complaints. Alternatively professional bodies could provide individual mentoring for health professionals throughout the course of the complaint and beyond (Charles et.al., 1987; Morrissey & Reddy, 2006). Furthermore it has been argued that the support from professional bodies should extend beyond the individual practitioner and that the ethics boards of health professional associations should act in an advisory capacity to the relevant registration boards to ensure that the boards retain realistic expectations of practitioners and that due process is observed (Morrissey & Reddy, 2006). If the tendency towards defensive practice is not managed, then this will
severely limit the potential for complaints to be used as a vehicle by which to improve the quality of service.

Taken together the above findings have implications for both staff recruitment and for the management of complaints. The findings indicate that staff charged with handling sensitive complaints need to be carefully selected to have strong communication skills and effective and empathic people management skills. Furthermore, to maximise the positive outcomes from complaints, complaints processes would benefit from establishing a support system to assist complainants and providers to negotiate the difficult emotions that are associated with lodging or responding to a complaint.

9.4 Research Question 3: What were the Strengths and Limitations of the Methodology when Applied in a Practical Setting?

The third research question considered the strengths and limitations of the theoretical methodology as applied in the practical setting.

9.4.1 Strengths of the Methodology

Overall the methodology translated well from theory into practice. The methodology gave meaningful insight into the experiences of the key stakeholders in the complaints process, and allowed for the generation of meaningful recommendations for improvement of complaints processes.

9.4.1.1 Insight into the experiences of stakeholders. The methodology proved successful in eliciting a in-depth understanding of the experiences of complainants and providers involved in the complaints process. The use of the mixed method design provided a quantifiable measure of the satisfaction of the health service users and providers with both the complaints process and with the outcome of their complaint. It also provided a rich qualitative understanding of the experiences of the participants. In addition to assessing the degree to which the HSC was
performing in relation to its stated goals, the methodology was able to detect a range of unforeseen impacts of the process on both complainants and providers.

The consideration of the views of both the complainants and health service users was a considerable asset of the methodology. In exploring the views of both complainants and providers involved in the complaints process the methodology was able to identify both commonalities and differences in their experiences. As has been previously noted (Section 4.8) there have been few evaluations of health complaints processes reported in the public domain and the author was unable to find any reported in the peer reviewed literature. Of the studies reported, few have given consideration to the experiences of the health service providers who have to respond to the complaints. The studies that have elicited the views of the providers have tended to do this as a secondary goal of their evaluation and therefore reported little statistical detail and provided little interpretation of the findings (MSJ Keys Young, 1990; Posnett, Jowett, Barnett & Land, 2001). The current methodology is therefore unique in its focus and in the breadth and depth of information that it can elicit regarding health complaints processes.

9.4.1.2 Insight into the unintended impacts of the complaints process. The current methodology not only proved successful in assessing the performance of the complaints processes, but it also gave insight into some unexpected and unintended effects of the complaints process on the complainants and the health service providers involved in the process. As has been outlined (Section 9.2) there were a number of unforeseen consequences for complainants and providers who engaged in the complaints process. For some, the emotional impacts of the complaint were shown to continue long after cessation of the complaints process. Whilst there have been a small number of studies that have explored the long term impact of complaints or
malpractice suits on individual providers, none of these have done so in the context of the actual complaints mechanism (Charles, 1996; Montgomery, Cuprit, & Wimberley, 1999; Schoenfeld, Hatch & Gonzalez, 2001; Wilbert & Fulero, 1988).

The ability of the current methodology to detect such effects allows for the generation of recommendations as to how to supplement the complaints process with additional supports in order to minimise this long term impact of complaints. Whilst the provision of support services is costly in the short term, the current findings indicate that the provision of such services could potentially facilitate the complaint resolution and therefore be more cost-effective in the long run.

9.4.1.3 Generation of meaningful recommendations. The depth of information elicited by the methodology enabled the generation of useful recommendations for both improvement of the complaints process and for easing the negative experiences of those involved in the complaints process. By gaining an understanding of the concerns that complainants and providers had about the service they received, and the difficulties that they had in negotiating the process, the methodology allowed for the suggestion of changes that would have a higher probability of improving the process for the stakeholders. Contrary to other evaluations in the area, recommendations were possible on the basis of the real experiences of the parties of the case, rather than relying on a limited range of stakeholders or on secondary data.

9.4.1.4 Methodology easily adapted. The methodology was designed as a generalist methodology encompassing a number of stages that could then be fine-tuned to meet the needs of the individual organisation being evaluated. Because of this the methodology is easily adapted for use in the evaluation of health complaints processes across a diverse range of health professions. Different health professions
have very different practices and different ways of interacting with clients. As such complaints may vary between the different health professions. Furthermore, there are a wide range of bodies responsible for the resolution of health complaints. The current methodology provides a template which could be easily modified for use in complaints processes in all health settings and therefore could be applied to evaluate complaints processes that deal with complaints against a range of practitioners by a range of dispute resolution techniques. The methodology also has the capacity to be adapted to evaluate complaints processes outside the health arena.

9.4.1.5 **Contributes to the empirical base for evidence-based evaluation.** A major problem of the lack of reported research relating to the evaluation of health complaints processes is that there is no sound evidential basis upon which to further develop theories and evaluation models. The current study takes a first step in offering an empirical base upon which to further develop evaluation models for investigation in this area.

9.4.2 **Limitations of the Methodology**

There were a number of difficulties experienced in applying the methodology in the real world, some of which could be foreseen (Section 5.6), others which were not foreseen.

9.4.2.1 **Scope of data collection.** For each application of the methodology, the methodology has to be customised to meet the specific needs and the limitations placed by the organisation that has commissioned the evaluation. These limitations will usually impact on the nature and scope of data that can be collected. These limitations usually relate to the organisations’ focus in relation to the evaluation, however they may also include issues related to privacy or confidentiality, or alternatively they may relate to the budgetary limitations on the evaluation.
Health complaints are unique in their level of sensitivity. Complainants have often experienced significant grief or loss or perceived psychological damage, while providers are vulnerable to a range of negative emotional experiences (Charles, 1996; Montgomery et al., 1999; Schoenfeld, et al., 2001). As was outlined in Chapter 5, because of these individual vulnerabilities, in the current application of the methodology it was deemed unethical to subject participants to batteries of psychological tests, that may have given insight into their complaining behavior and motivations, but offered little personal benefit to them (Section 5.6.2).

In the evaluation of the health complaints process at the Office of the Health Services Commissioner, the scope of data collection was further limited by the requirements of confidentiality and privilege. As has been discussed previously (Section 5.6.1), health complaints have at least two parties associated with them (complainant and provider) and both of those parties are entitled to confidentiality, and in the case of complaints to the HSC, the entire process is subject to privilege. If only one party consents to participate in the evaluation then this raises issues of confidentiality for the non-consenting party. Furthermore, privilege restricts the dissemination of any identifying information relating to the complaint. Therefore, for the purposes of the current application of the methodology, it was not possible to collect any detailed information about individual complainants, complaints or their outcomes. Only the subjective experiences of the parties could be explored. It is not possible to judge the degree to which these subjective appraisals of satisfaction relate to objective measures of service quality.

9.4.2.2 Cost of the evaluation. Practical research in the real world needs to be cost effective. Evaluations are almost always designed within a budgetary framework that, to a certain extent, dictates the methodology and the scope of data
that can be collected. The current methodology employs a mixed-method research design that includes a combination of questionnaire data and telephone interviews. Whilst telephone interviews are a relatively costly methodology, involving significant time component on the part of the evaluator to conduct the interview and record the outcomes, it was considered that such structured interviews would provide a rich source of qualitative data, thereby justifying their use. In the application of the methodology to the evaluation of the complaints process at the HSC however, a larger proportion of participants agreed to participate in telephone interviews than was expected. This meant that because of time constraints, a random sample of volunteers was selected to participate in interviews. If the evaluation was being funded by the organisation, it is probable that the financial costs of completing and processing telephone interviews would place even further limitations on the number of interviews that could be completed.

Whilst it was thought that the time and effort would be compensated by the richness of data, the researcher found that participants, particularly complainants, tended to use the telephone interviews as a vehicle to further vent their feelings about the complaint. Much of the interview time was therefore spent containing the emotions of the interviewee, the result of which was more lengthy interviews than was intended or desirable. In addition practitioners, who are inherently busy, were often difficult to contact and required several contacts before actually completing the interview. It is therefore doubtful whether the future use of telephone interviews for the collection of qualitative responses would add value to the data above and beyond the addition of a number of well targeted open ended questions to the written questionnaires. The open ended questions could be based on the themes revealed within the current evaluation.
Given that so many participants were keen to express their views in the qualitative format, as indicated by the response rate to the telephone interviews, the use of open ended questions on the end of the written questionnaire would also give all participants, rather than a select few, the opportunity to express their views and therefore expand the qualitative data pool. It is therefore recommended that for future uses of the methodology the replacement of telephone interviews with the addition of open ended questions to the written quantitative measures be trialled.

9.5 Research Question 4: In what way could the Evaluation Methodology be Improved for Future Applications in the Evaluation of Health Complaint Mechanisms?

The fourth research question considered the implications of the current findings for future applications of the methodology. The findings indicate that whilst the methodology was successful in assessing the degree to which the HSC was fulfilling its role to receive and resolve health complaints, and in giving an insight into the experiences of the complainants and providers involved in the process, a number of factors need to be taken into consideration in future applications of the methodology.

The first implication of the current findings is the benefits that could be achieved through further exploration of the unintended side effects of participation in the complaints process. One recommendation is that in future application of the methodology to the evaluation of health complaints processes, closer attention be paid to the expectations of complainants regarding the process and outcome of the compliant. It is therefore recommended that items be added to the questionnaire that ask complainants what their expectations were when they lodged their complaint, whether they modified their expectations as they progressed through the complaints
process and the nature of any discrepancies between their actual and expected outcomes.

The finding that health service providers tend not to report any change of practice following a complaint is concerning and deserves further investigation. It is therefore recommended that in future applications of the methodology consideration is given to a deeper exploration of the emotional responses of the providers to the complaint. The inclusion of a number of items relating to the level of psychological distress experienced as a result of the complaint and any steps taken to alleviate this distress could be useful as a means of tapping into factors that may reduce negative post complaint behaviours and further improvement of the complaints process in relation to these issues.

A final recommendation, as mentioned in the previous section (Section 9.4.2.2), is that in addition to the original questionnaire being extended to include the abovementioned items, a number of open ended questions asking participants to report the strengths, weaknesses and suggested improvements for the methodology are also included. It is thought that doing this would increase the cost effectiveness of the methodology without significantly impacting on the quality of the data.

9.6 Conclusions

This study provides an important contribution to evaluation research in the area of the evaluation of complaints resolution processes, and in particular the evaluation of health complaints resolution processes. The study is different to previous evaluations in the area in terms of its focus, scope and level of empirical analysis. The methodology explores the experiences of complainants and providers in a depth that has not been previously reported in evaluations of health complaints processes. In addition, reports of evaluations of health complaints processes are
scarce and have generally not been subject to peer review. As such the current study offers a unique contribution to the empirical evidence base relating to evaluation of health complaints.

The aim of the current research was to design and evaluate a methodology for the evaluation of health complaints processes. The methodology proved successful in assessing the performance of the complaints process at the Office of the Health Services Commissioner. The findings of the evaluation indicated that complainants and providers were generally satisfied with the process by which their complaints were managed, however, they were generally less satisfied with the outcome. In particular the evaluation highlighted the unintended negative consequences that complaints processes can have on the complainants and respondents. These maladaptive behavioural responses to complaints most probably have their origins in the negative emotional overlay attached to health complaints which has the potential to lead to unrealistic expectations of the process and outcomes on the part of complainants, and maladaptive post-complaint practices for health service providers. The findings highlight the importance of providing advocacy and support for the parties involved in health complaints as a means of minimising these maladaptive responses.

Overall the methodology showed considerable strengths in that it allowed for considerable insight into the experiences of complainants and providers and allowed the detection of a range of adverse side effects from the complaint process that may not have been detected through the use of a purely quantitative design. A major strength of the methodology is the ease with which it can be adapted for future uses with a range of health complaints processes. As mentioned in Section 9.4.1.4, the methodology is a generalist one, which at each stage of development has the capacity
to be specifically tailored to fit the process being evaluated. As mentioned health services are delivered within a particular economic, scientific and sociocultural context. While the methodology proved successful in eliciting the experiences of complainants and providers in the Australian setting, further research would be required to assess its utility in other cultural settings.

9.7 Future Applications of the Methodology

The proposed evaluation methodology could be of particular use at the current time with the pending changes to health profession registration that are occurring in Victoria and later Australia-wide. As has been discussed (Section 2.5) with the instigation of the Health Professions’ Registration Act 2005, there are going to be new complaints processes introduced for the management of health complaints in Victoria. All registration boards will be taken under the auspices of the new legislation, and the complaints processes will be reviewed to attain a greater consistency between boards (DHS, 2006). In addition formal hearings will all be heard by the Victorian Civil and Administrative Tribunal rather than by the individual registration boards. With the changes to complaints processes commencing in 2007, there will be a need to evaluate the new processes for their effectiveness and utility. Any such evaluation needs to be formative in nature, so that it can be responsive to any difficulties and feed back recommendations throughout the design and implementation stages to allow for process improvement. The current methodology with its generalist focus would be particularly appropriate for use in such an evaluation as it offers a consistency of approach, whilst being able to fine tune data collection to the particular types of stakeholders and complaints that are predominantly heard by each individual board.
Evaluation of the modifications to the health registration boards’ complaint processes from inception, would not only assess the effectiveness of the new regime, but also will potentially improve the experiences of the complainants and health service providers involved in the complaints. Through doing this it would be possible to achieve a complaints process that maximises the possibility for complaints to have a positive impact on the quality of health service delivery.

There is now a general view in Australia that complaints processes are an essential component of quality health care and there is a likelihood that this emphasis on the importance of complaints processes will increase in the future. The current findings, demonstrate that it is the psychological aspects of the responses of complainants and providers to the complaint that are central to the effective and enduring resolution of the complaint. These findings therefore reinforce the role of psychologists in the evaluation of health services in general, and of health complaints processes in particular.
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**Appendix A**: Letters of invitation to participate from the Health Commissioner of Victoria.

Health Service Provider

Dear

Recently you were contacted by my staff about a problem a user encountered in receiving health care. I wonder if I may seek your help now in evaluating the service we provided?

The complaints system was set up in 1988 to help resolve problems experienced by people using health services in Victoria. In the interests of maintaining and improving the quality of service we provide, we are looking for feedback from people like you who have had some contact with us.

Naomi Lillis, a Master of Arts (Health Psychology) student at Swinburne University of Technology has therefore arranged an independent survey, including a brief questionnaire, and the possibility of a short telephone interview should you desire it. I am writing to ask your help in answering those questions.

One of the members of my staff worked with you and the health service user in an effort to settle the problem. Because our process is so strictly confidential let me assure you

- that the researcher, will not have access to your file (that is why I am writing to you directly)
- only the researcher will see your response (a Freepost envelope is enclosed for you to send it to them)
- should you consent to a telephone interview, no specific details of your case will be discussed
- your answers will be used for statistical purposes only.

Even though it will take only a few minutes for you to answer the questionnaire, your reply will help greatly in planning changes or improvements in the future. Please complete the survey form as soon as possible and sent it back in the envelope supplied – no stamp is required.

If you have any questions about the survey, please contact my secretary on 8601 5222. Thank you very much for your help.

Yours sincerely

Beth Wilson
Health Services Commissioner
Dear

Recently you contacted my staff about a problem a user encountered in receiving health care. I wonder if I may seek your help now in evaluating the service we provided?

The complaints system was set up in 1988 to help resolve problems experienced by people using health services in Victoria. In the interests of maintaining and improving the quality of service we provide, we are looking for feedback from people like you who have had some contact with us.

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• that the researcher, will not have access to your file (that is why I am writing to you directly)
• only the researcher will see your response (a Freepost envelope is enclosed for you to send it to them)
• should you consent to a telephone interview, no specific details of your case will be discussed
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Even though it will take only a few minutes for you to answer the questionnaire, your reply will help greatly in planning changes or improvements in the future. Please complete the survey form as soon as possible and sent it back in the envelope supplied – no stamp is required.

If you have any questions about the survey, please contact my secretary on 8601 5222. Thank you very much for your help.

Yours sincerely

Beth Wilson
Health Services Commissioner
APPENDIX B
Appendix B: Measures

Questionnaire 2A: Health service users in completed cases resolved during the Inquiry stage.

Questionnaire 2B: Health service providers in completed cases resolved during the Inquiry stage.

Questionnaire 3A: Health service users in completed cases resolved during the assessment stage

Questionnaire 3B: Health service providers in completed cases resolved during the assessment stage

Questionnaire 4A: Health service users in completed cases resolved during conciliation

Questionnaire 4B: Health service providers in completed cases resolved during conciliation
This survey relates to the complaint which you made to the Health Services Commissioner. Please answer every question. In some cases you are just required to circle the relevant answer. You are not required to give anyone’s name.

1. How did you first hear about the Health Services Commissioner?

2. Thinking generally about the way the Health Services Commissioner handled your complaint, please circle one number on each line to show how strongly you agree or disagree with each of these statements.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</table>

   a) The Commissioner’s staff were courteous and obliging
   b) I found it hard to understand the information or advice I got from the Commission
   c) I felt the staff took a genuine interest in the problem

3a) In the end was the problem you complained about (Circle one number)

- Fully resolved ......................... 1
- Partly Cleared up ...................... 2
- Not cleared up .......................... 3

3b) How satisfied were you with the outcome? (Circle one number)

- Very satisfied .......................... 1
- Fairly Satisfied ........................ 2
- Fairly Dissatisfied ...................... 3
- Very dissatisfied ........................ 4

IF DISSATISFIED, why was that?

Please turn the page
4 In the future, if a friend or relative had a complaint about health or medical services, would you suggest they contact the Health Services Commissioner?  (Circle one response)  

Yes 1  
No 2  

5 Would you be prepared to participate in a short telephone interview with the evaluator in order to help us better understand your thoughts and experiences of the Office of the Health Services Commissioner? All interviews would be confidential.  (Circle one response)

Yes, I would like to participate in a telephone interview  
No, I would not like to participate in a telephone interview

IF YES, please print your name, telephone number and the most convenient time and day for us to call you.

Name ..................................................................................................................  
Telephone Number ............................................................................................  
Time and Day of Week to call...................................................................................  

Thank you for your participation. Please return the completed survey in the Freepost envelope provided to:

Ms N Lillis  
Swinburne University of Technology  
P O Box XX  
SURREY HILLS Vic 3127
Health Services Commissioner

Evaluation

CONFIDENTIAL

This survey relates to the complaint which the Health Services Commissioner contacted you about. Please answer every question. In some cases you are just required to circle the relevant answer. You are not required to give anyone’s name.

1. In the context of the complaint are you/do you represent (please circle one number)

   A Public Hospital........................................1
   A Private Hospital ....................................2
   An individual practitioner............................3
   Other (please specify).................................4

2. Thinking generally about the way the Health Services Commissioner handled your complaint, please circle one number on each line to show how strongly you agree or disagree with each of these statements.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
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<tr>
<td>a) The Commissioner’s staff were courteous and obliging</td>
<td></td>
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<td>1</td>
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<td>4</td>
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<td>b) I found it hard to understand the information or advice I got from the Commission</td>
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<td>c) I felt the staff took a genuine interest in the problem</td>
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Please turn the page
3a) In the end was the problem (Circle one number)  

<table>
<thead>
<tr>
<th>Fully resolved</th>
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<tbody>
<tr>
<td>Partly Cleared up</td>
<td>2</td>
</tr>
<tr>
<td>Not cleared up</td>
<td>3</td>
</tr>
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</table>

3b) How satisfied were you with the outcome? (Circle one number) 

<table>
<thead>
<tr>
<th>Very satisfied</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairly Satisfied</td>
<td>2</td>
</tr>
<tr>
<td>Fairly Dissatisfied</td>
<td>3</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>4</td>
</tr>
</tbody>
</table>

IF DISSATISFIED, why was that? 
____________________________________________________________________

4 Have your dealings with the Health Services Commissioner in any way changed the way you perform your professional duties? (Circle one response) 

Yes........1 No...........2

If YES, why? ___________________________________________________________

5 Would you be prepared to participate in a short telephone interview with the evaluator in order to help us better understand your thoughts and experiences of the Office of the Health Services Commissioner? All interviews would be confidential. (Circle one response) 

Yes, I would like to participate in a telephone interview .................Yes

No, I would not like to participate in a telephone interview ............... No

IF YES, please print your name, telephone number and the most convenient time and day for us to call you.

Name ...........................................................................................................

Telephone Number .....................................................................................

Time and Day of Week to call....................................................................

Thank you for your participation. Please return the completed survey in the Freepost envelope provided to:

Ms N Lillis  
Swinburne University of Technology  
P O Box XX  
SURREY HILLS Vic 3127
This survey relates to the complaint which you made to the Health Services Commissioner. Please answer every question. In some cases you are just required to circle the relevant answer. You are not required to give anyone’s name.

1 How did you first hear about the Health Services Commissioner?

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>
a) The Commissioner’s staff were courteous and obliging | 1 | 2 | 3 | 4 |
b) I found it hard to understand the information or advice I got from the Commissioner’s staff | 1 | 2 | 3 | 4 |
c) I felt the Commissioner’s staff took a genuine interest in the problem | 1 | 2 | 3 | 4 |
d) The Commissioner’s staff kept me informed about what was happening | 1 | 2 | 3 | 4 |
e) Involving the Health Services Commissioner in a complaint like this is just a waste of everybody’s time. | 1 | 2 | 3 | 4 |
f) The Commissioner’s staff acted promptly in dealing with the matter. | 1 | 2 | 3 | 4 |
g) The Commissioner’s staff played a useful role in helping to sort out this problem. | 1 | 2 | 3 | 4 |
h) The Commissioner’s staff were impartial and treated all sides fairly. | 1 | 2 | 3 | 4 |
3a) In the end was the problem you complained about (Circle one number)

| Fully resolved | 1 |
| Partly resolved | 2 |
| Not resolved   | 3 |

3b) How satisfied were you with the outcome? (Circle one number)

| Very satisfied | 1 |
| Fairly Satisfied | 2 |
| Fairly Dissatisfied | 3 |
| Very dissatisfied | 4 |

**IF DISSATISFIED, why was that?**

_____________________________________________________________________

4 In the future, if a friend or relative had a complaint about health or medical services, would you suggest they contact the Health Services Commissioner? (Circle one answer)

Yes ................................. 1
No................................. 2       If No, why

5 Would you be prepared to participate in a short telephone interview with the evaluator in order to help us better understand your thoughts and experiences of the Office of the Health Services Commissioner? All interviews would be confidential. (Circle one response)

Yes, I would like to participate in a telephone interview........................... Yes
No, I would not like to participate in a telephone interview...................... No

IF YES, please print your name, telephone number and the most convenient time and day for us to call you.

Name ...............................................................................................................

Telephone Number...........................................................................................

Time and Day of Week to call ...........................................................................

Thank you for your participation.

Please return the completed survey in the Reply Paid envelope provided.

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Health Services Commissioner

Evaluation

CONFIDENTIAL

This survey relates to the complaint which the Health Services Commissioner contacted you about. Please answer every question. In some cases you are just required to circle the relevant answer. You are not required to give anyone’s name.

1 In the context of the complaint are you/do you represent (please circle one number)

<table>
<thead>
<tr>
<th>Option</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Public Hospital</td>
<td>1</td>
</tr>
<tr>
<td>A Private Hospital</td>
<td>2</td>
</tr>
<tr>
<td>A private medical practitioner</td>
<td>3</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>4</td>
</tr>
</tbody>
</table>

2 Thinking generally about the way the Health Services Commissioner handled your complaint, please circle one number on each line to show how strongly you agree or disagree with each of these statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) The Commissioner’s staff were courteous and obliging</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b) I found it hard to understand the information or advice I got from the Commissioner’s staff</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c) I felt the Commissioner’s staff took a genuine interest in the problem</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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</tbody>
</table>

Please turn the page
3a) In the end was the problem (Circle one number)

<table>
<thead>
<tr>
<th>Option</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully resolved</td>
<td>1</td>
</tr>
<tr>
<td>Partly resolved</td>
<td>2</td>
</tr>
<tr>
<td>Not resolved</td>
<td>3</td>
</tr>
</tbody>
</table>

3b) How satisfied were you with the outcome? (Circle one number)

<table>
<thead>
<tr>
<th>Option</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>1</td>
</tr>
<tr>
<td>Fairly Satisfied</td>
<td>2</td>
</tr>
<tr>
<td>Fairly Dissatisfied</td>
<td>3</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>4</td>
</tr>
</tbody>
</table>

IF DISSATISFIED, why was that?
_____________________________________________________________________

4 Have your dealings with the Health Services Commissioner in any changed the way you perform your professional duties? (Circle one response)

- Yes ............................. 1
- No ............................... 2

If YES, how? __________________________________________________________

5 Would you be prepared to participate in a short telephone interview with the evaluator in order to help us better understand your thoughts and experiences of the Office of the Health Services Commissioner? All interviews would be confidential. (Circle one response)

- Yes, I would like to participate in a telephone interview ............................. Yes
- No, I would not like to participate in a telephone interview ........................... No

**IF YES,** please print your name, telephone number and the most convenient time and day for us to call you.

<table>
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<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
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<td>Time and Day of Week to call</td>
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Please answer every question. In some cases you are just required to circle the relevant answer. You are not required to give anyone’s name.

1. How did you first hear about the Health Services Commissioner?

   ____________________________________________________________

2. According to the Health Services Commissioner’s records, this complaint went to the stage of conciliation, and one of the conciliators, (Terri Punshon or Keith Jackson) helped to deal with it. Do you think the conciliation process carried out through the Commissioner was a good way of trying to resolve this problem? (Please circle one number)

   Yes ……………………………. 1  No 2

   Why? ……………………………………………………………………………………………………………………………………………………

   Please turn the page

3. Thinking specifically about the conciliation part of the process, please circle one number on each line to show how strongly you agree or disagree with each of these statements.

   Strongly Agree  Agree  Disagree Strongly Disagree

   a) The conciliator was impartial and treated both sides fairly

      1  2  3  4

   b) The conciliator’s involvement was helpful in dealing with this problem

      1  2  3  4

   c) The conciliator was capable and efficient

      1  2  3  4

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Thinking generally about the way the Health Services Commissioner handled your complaint, please circle one number on each line to show how strongly you agree or disagree with each of these statements.

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IF DISSATISFIED, why was that?

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6 In the future, if a friend or relative had a complaint about health or medical services, would you suggest they contact the Health Services Commissioner?  
(Circle one answer)

Yes........................................... 1  
No......................................... 2

If No, why? ____________________________________________

7 Would you be prepared to participate in a short telephone interview with the evaluator in order to help us better understand your thoughts and experiences of the Office of the Health Services Commissioner? All interviews would be confidential.  
(Circle one response)

Yes, I would like to participate in a telephone interview .............................Yes

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IF DISSATISFIED, why was that?

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Protocol for Conducting Telephone Interviews.

1. Build rapport
   - Introduce yourself to the client, reiterate the purpose of the evaluation and thank them for their participation
   - Assure confidentiality. Make it clear that specific details of their case cannot be discussed and that only the researchers will have access to their responses.

2. Open ended questions
   - What did you like about the Health Services Commission?
   - What did you dislike about the Health Services Commission?
   - In what way, if any do you think the process could be improved?

3. Elaborate on the person’s written survey
   - Address any ambiguities or any themes which may require further elaboration in their written responses.

4. Thank the person for their time and participation.

NOTE: For the purpose of maintaining confidentiality/privilege, if the interviewee began to reveal any case details during the course of the interview, that line of conversation was immediately contained and all references to it were removed from the tape transcript.