Patient complaints and physician practice: the urological experience

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Roger Dmochowski investigates the relationship between patient complaints and the risk of malpractice by linking complaints to urological practice types.

The unique risk of medical malpractice claims experienced by a physician’s practice in general practice and certain surgical practice types (ie specialties) has been shown to be related to the frequency of the number of patient complaints incurred by that practice. Also, in previously reported experience, relatively few physicians have been shown to account for a disproportionate amount of medical malpractice claims.

Prior evidence from the urological literature has shown a relationship between the risk of litigation and physician behaviour and practice environment; however, in urology, the relationship between patient complaints and physician malpractice risk has not heretofore been identified. Herein is reported recent experience with complaint tracking and linkage to urological practice types.

PATIENT COMPLAINTS RELATED TO RISK

The distribution of patient complaints among physicians is not random, but rather follows a disproportionate weighting accounted for by a very small percentage of physicians. That the relationship of patient complaints is a statistically significant predictor of risk has been shown in cohorts both of specialists and community practitioners in prior reports. Patient complaints among those groups of physicians appear to be related to an increase in risk management activity and increased expenditures related to malpractice claims, and this relationship appears to be constant irrespective of clinical volume of the practice assessed.

It is known that urologists, like other surgical specialists and generalists, are at risk for practice-related patient complaints and potential risk. Heretofore though, the distribution of these complaints and resultant risk has not been established across general urology or the urological subspecialties. Our work at Vanderbilt University utilising a large database of practitioners throughout the USA has demonstrated similarities between...
urological risk exposure and prior experiences with surgeons and generalists.3,4

REPORT ON UROLOGICAL PATIENT COMPLAINTS
The data reported herein are a summary of a prior report assessing a cohort of 268 urologists practising in 15 geographically distinct healthcare systems and using 1516 unsolicited patient and family complaints that were associated with this cohort.6 Work continues on an expansion of this cohort and will be the topic of future presentations.

Patient complaint data were gathered from institutional offices of patient affairs, patient ombudsmen, patient relation departments or guest services groups that were focused on patient experience in the specific institution studied. The complaints were de-identified and linked to unique practitioners. Each complaint was catalogued and designated into a previously established coding system and included a narrative summary of the event.

Complaints were coded by trained personnel. Complaints could include a single concern or multiple embedded complaints. Complaints were coded into a five-category system: billing (finances), concern for patient’s family, access availability, communication, and care and treatment. This taxonomy has been previously validated for test-retest reliability as well as inter-rater reliability and has been shown to be reproducible. Utilising these data, a ‘complaint profile’ was generated for each physician.

The physician cohort was then assessed for general versus subspecialty domain utilising American Urological Association data and/or data provided by the healthcare institutions that formed the geographical basis for the practice. All physician personal identifiers were de-identified at this point. A third data set was then formed for urological subspecialty (or general urological practice) and patient complaint type. The resultant data set remained completely de-identified from both the patient and practitioner standpoint.

The database was then assessed for two separate types of endpoints. The first endpoint was the overall urologist’s risk score (using a previously established method derived from historic accrued experience with GPs and other specialties).

Relatively few physicians have been shown to account for a disproportionate amount of medical malpractice claims

A second endpoint was the type of complaint profile as compared to the specific urological subspecialty. A weighted sum algorithm was then established based on the number of complaints associated with each unique practitioner over a four-year timeframe. A complaint profile was established for each practitioner based on the distribution of the types of complaints across the five categories.

Urology subspecialties
The 268 urologists represented 11 urological subspecialties. Urological oncology (26 per cent) and general urology (25 per cent) were the largest groups. Other groups evaluated included: female/incontinence specialists (14 per cent), paediatric (9 per cent), renal calculi (9 per cent), neuro-urology (4 per cent), renal transplant (4 per cent), infertility (4 per cent) and others (3 per cent, inclusive of benign prostatic hyperplasia, medical urology and trauma subspecialties).

Overall, this studied group accounted for 1516 unsolicited complaints. Forty-seven per cent or 126 of the urologists experienced no complaints during this timeframe. Thirty of the urologists (11 per cent) accounted for 758 (50 per cent) of the complaints. Substantive differences were demonstrated between the cumulative distributions across the subspecialties.

Analysis demonstrated statistical difference between various subspecialties and risk score distribution. Renal calculus and oncological subspecialists had substantially higher risk scores as compared with general urologists. However, all subspecialties followed similar type distribution curves and approximated general experience both with surgical and general specialists previously reported. When assessing those physicians at highest risk for complaint, oncologists (with 15.5 per cent total) formed the highest subspecialty risk, followed by calculus specialists (12 per cent), female specialists (10.5 per cent), paediatric (4 per cent) and general urologists (2.9 per cent).

Complaint type
When assessing complaint type and subspecialty, care and treatment accounted for the largest percentage of complaints (40 per cent). Pattern of communication was the next most frequent type of complaint at 24 per cent, with access and availability resulting in 22 per cent and concern for patient and/or family accounting for 10 per cent of all complaints.

Interestingly, billing and financial concerns accounted for only 5 per cent of the total complaint type. When looking at subspecialties, those in female urology and incontinence received more complaints about communication (28 per cent) and concern for patient family (14 per cent) than other subspecialists. Oncologists received the most complaints regarding access and availability (26 per cent).

Non-random distribution of complaints
This experience again demonstrates the non-random distribution of complaints previously demonstrated with other medical specialties. This non-random distribution of complaints (with a few
physicians accounting for a very high complaint number) was seen both with general urologists as well as urological subspecialists. As in prior experience, a substantial percentage of physicians experienced no complaints and a very small percentage (in this study, below 11 per cent) were associated with half of all complaints listed.

In spite of the variation in number and types of complaints across subspecialties, the overall subspecialty distribution scores were relatively similar. Ultimately, 30–40 per cent of urologists had zero risk scores (no complaints), while a very small percentage of urologists had a very high risk on the basis of numbers of complaints. The complaint types were similar across all subspecialties. The preponderance of these complaints centred on care and treatment (perceived or real), followed by failure of communication, access and availability, patient and family concern, and financial concerns. Interestingly, urological oncology was the only subspecialty in which access and availability complaints were more significant than communication complaints.

The differences in complaint types across subspecialties are somewhat difficult to explain. It may be that the concerns about diagnosis and treatment are more significant in some practices than others, possibly related to practice environment.

These findings do demonstrate the unequal distribution of complaints across both general urology and urological subspecialties. Some subspecialties tend to be over-represented (specifically oncology, transplant and neuro-urology) in the top complaint group. However, when assessing the type of complaints, the overall complaint profiles were similar between the high-risk and the low- and moderate-risk groups.

This non-random distribution has been previously associated with risk management outcomes. It is presumed that the early detection of risks potentially followed by direct interventions may promote behavioural changes, which may mitigate overall risk tendency.

The differences in complaint types across subspecialties are of note, specifically related to patient complaint type. This manifestation may be related to type of patient concern (malignancy versus functional) as well as practice environment (volume of patients seen, environment).

**Limitations of the study**

The results presented herein are limited in predictive capability, as the overall risk management data associated with the cohort have not been assessed. However, previously reported experience suggests that there is a relationship between risk management and patient complaint data, as demonstrated by malpractice claims and numbers of unsolicited patient complaints. This validation for urology has yet to occur, but it would be reasonable to assume that it holds true for this specialty as well.

Other limitations of this data may be that certain institutions incompletely collect their patient experience and/or complaints. Also patient or family dissatisfaction may result in the absence of response or interaction with the system rather than directed voicing of concerns, therefore incompletely reporting the overall patient experience (and artificially lowering the reported number of complaints for unique practices).

**CONCLUSION**

In conclusion, these results demonstrate the non-random distribution of complaints among practising urologists. These observations suggest that monitoring patient complaints can assist with the identification of practices at risk for malpractice claim experience. The ability of this experience to assist and inform non-punitive interventions to mitigate risks would be the ultimate goal. More work is needed with such monitoring intervention programmes to assess their ultimate value for risk decrement across the surgical subspecialties. Another goal would be to improve the patient experience and decrease professional dissatisfaction among specialists. This type of monitoring system appears to provide a critical insight into current and future risk exposure with the potential that this experience can improve practice delivery and environment.

**REFERENCES**