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EDITORIAL

Using patient complaints as a discovery tool

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SUMMARY
This editorial discusses the value of patients' complaints as a discovery tool in identifying planning defects and ongoing functional problems in clinics.

Key Words
GP practice; patient complaints; organisational problems

INTRODUCTION

"Why don't you organise this place better?" Many medical receptionists have been on the receiving end of outbursts like this. The response from general practitioner (GP) staff, and even more so from public outpatient departments, is typically dismissive: "We are doing the best we can with limited resources, but you are still getting top-quality care". And so on. The attitude underlying these responses is that everything will be done according to medical or institutional priorities, and that if the patient wants medical care, they have to accept it.

When the outburst is related to how the practice is run, however, it should be taken as a chance to decide if there is a real issue that has been glossed over during traditional design steps. I once saw a patient being brought into a new emergency department by ambulance, and when the trolley jammed in the corridor, the patient shouted: "Who designed this place? There isn't room to swing a cat!" Any site plan may incorporate some poor choices. Subsequently, it becomes necessary to identify ongoing problems, assess which ones must be fixed, and finds ways of doing so. The identification step should not be done by the original design team, and the assessment of severity is best done by those who work at the site—or are treated at the site. On both these grounds, patients should be accepted as observers in a unique position. Patient complaints (at least those relating to general clinic functioning) should prompt serious thought about what changes are needed. Some typical examples follow.

Space management

"Why do people already seen by the doctor keep crossing the waiting room to get to other rooms? Can't they organise this better?"

This is a regular feature of some GP clinics and outpatient departments. In many cases, it is dictated by the architecture, so good solutions are prohibited by cost. The alternative is to look carefully at the overall pattern of functions allocated to the rooms. This pattern may become more dysfunctional as the site grows, so flow patterns must be given high priority when designing new clinics.[1]

"Why can't you get someone else to deal with that difficult patient who's blocking progress at the reception desk, or is STILL in the doctor's room?"

This may have no satisfactory answer in a small clinic with only one receptionist, as a second staff member is too expensive. It is harder to explain why some larger practices also deal poorly with congestion. Reasons include understaffing, inadequate training, and poor scheduling of breaks. Architecture is a common culprit. I know a small GP clinic with this configuration (Figure 1), which looks harmless except that the flow pattern is like a vascular tree (Figure 2), and every doctor knows that a blockage in an arterial system is bad news. We need alternative pathways. Some country hospitals in Australia have enclosed verandahs that act as orbital highways

(Figure 3), and newer clinics can have purpose-built bypasses around choke points (Figure 4), creating a robust anastomotic flow pattern.

Figure 1: Configuration of a small GP clinic

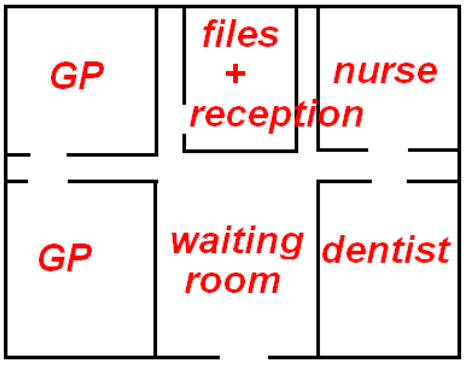


Figure 2: Embolism-prone pathways

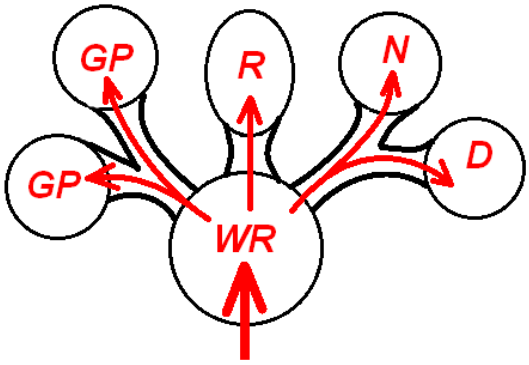


Figure 3: Orbital pathways

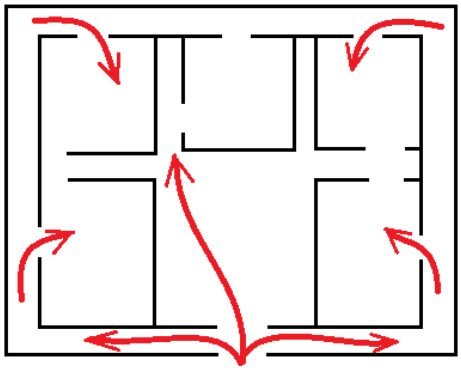
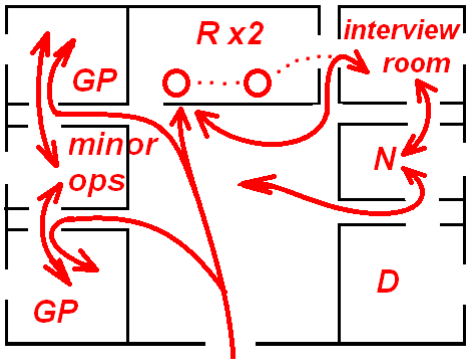


Figure 4: Anastomotic pathways



Time management

"I liked seeing the nurse to have my blood pressure (BP) and bloods taken and weight recorded. Why don't you do that every time?"

Patients get annoyed whenever the waiting times are longer than expected. This is non-linear: annoyance levels increase rapidly with the duration of uninterrupted waiting, so interventions by nurses or other staff have a useful effect. Much more complete BP/weight records can be compiled, and other forms of monitoring or patient education can be added during this time.

"Why can't you give us reasonable estimates of how long we have to wait? It can't be emergencies all the time behind the doctor's door."

This complaint is one of the most common, and is often very important to the patient, depending on whatever else s/he has committed to do on the day of the appointment. It highlights the fact that many doctors prioritise only according to medical need. Patients usually have quite different priorities, often social or work-related, but these are often dismissed as less important. All too often, though, when a patient says s/he must get back to work, s/he means it literally.

Clinics sometimes avoid using an efficient time-management option if they think will be seen as unfriendly or depersonalising. I spoke to patients in hospital outpatients and GP clinics about the idea of a wall screen showing "expected time to be seen", like an airport departure screen. They weren't bothered about privacy or depersonalisation: they took the view "There's no secrecy about the fact I'm here for medical treatment, and if it puts pressure on the doctors to keep to time, and gives me a concrete idea of the wait, I'm all for it."

"Why don't you put on extra staff when it's so busy?"

This question should make practice principals think, "Well, *have* we analysed our peak flow times and seasons in any detail, or tried to think of all possible ways of sharing resources and staff?" This requires a per-practice analysis, as major surveys do not include these details.[2]

"Why don't you get rid of that receptionist who melts down as soon as two or more things compete for her attention?"

The necessary skill here is "priority-stacking". Good reception staff are naturally skilled at this, but it can be a learned skill to some extent, as evidenced by the training courses given to operators such as air traffic controllers.[3] Training costs would scale down if the idea caught on.

Environment

"Why don't you have a big fish-tank like the practice down the road? It's very soothing and hypnotic to watch."

Fish tanks are, indeed, soothing.[4,5] There are now many papers[6,–11] confirming that the best ways to relax people and improve their experience of time spent in a clinic or hospital are to (a) reduce noise (turn off the TV); (b) create quiet private spaces; and (c) expose them to nature in virtually any form, whether real or simulated, animal or plant, using any of the senses (sight, sound, wind, or scent). It works even with indoor exposure to nature photographs, potted plants or window views, but is more clearly effective in the outdoors. The same benefits are reported by both staff and patients, which is confirmed by objective measures of tension (including BP, heart rate, and electromyography),[11] and the benefits are almost immediate. Only in the Intensive Care Unit is no benefit seen,[9] which is hardly surprising. Access to outside spaces with natural wind and live plants seems to be surprisingly important to patients, so that out-of-fashion architectural feature, the verandah, deserves to be revived.

"None of us want to watch that irritating program! Why don't you let us turn down the TV?"

This complaint is justifiable, especially when so many dental and medical clinics refuse to give patients in the waiting room any control over the volume and/or programming. Noise is always a stressor,[12] so clinics should have a sign saying that patients can ask for the sound to be turned down or off. I have repeatedly heard reception staff claim that "there isn't any control I can use to turn it down or off", which is hard to credit, but if true, a switch costs very little to install. It is not just a matter of volume: it is very hard to ignore any audible TV conversation, and even habitual TV watchers resent having no program choice.

"Why can't you divide up the waiting areas into different environments? Kids' play area, quiet reading area, and so on?"

Unfortunately, floor area is usually too limited. Noise pollution from the TV is the biggest problem in most waiting areas: it cannot be shut out from any subarea without actually dividing the area into separate rooms.

Added Value

"Waiting here is a waste of my time. How about an educational video? I wouldn't mind learning more about my prostate cancer."

I have attempted, in a community health centre (CHC), to interest other staff in the idea of playing educational videos. The usual response was that patients at a clinic "just want to relax till they see the doctor, and they won't want to watch anything educational". In fact, trials of alternatives showed that many patients would watch nature documentaries or even non-professionally produced medical educational material in preference to broadcast TV.

Conflicting priorities

"Why have three people who arrived after me gone in to the doctor before me?"

This particular scenario is not typical of most GP surgeries, but appointment shuffling is common in some settings such as public outpatients and some CHCs. Shuffling is much resented by patients, even when done specifically to give them a longer consultation. It illustrates an important question: whose priorities should get priority?

CONCLUSION

Patient complaints can be a guide to suboptimal functioning of a site, and complement the views of the medical and nursing staff who work there. Some issues are far more apparent from the patient's viewpoint, so complaints can also be viewed as a tool for identifying problems, which would remain invisible to other practice management tools.

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