

ORIGINAL PAPER

[Translated article] Influence of claims on the management of an orthopaedic surgery and traumatology service



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KEYWORDS

Clinical management;
Medical claims;
Quality care

Abstract

Introduction: Claims constitute one of the main sources of information to evaluate the perceived quality in healthcare centres, being Orthopaedic and Traumatology Surgery (OTS) one of the specialties with greater probability of receiving them due to its high surgical demand generating long waiting lists.

Objectives: To display the evolution of the filed claims addressed to the OTS department, to classify the reasons stated in the complaint, and to identify the opportunities for improvement derived from the forementioned.

Methodology: Descriptive, observational and retrospective epidemiological study. The target population has been configured by those citizens who have submitted a claim addressed to the OTS Service of a University Hospital of Barcelona from 2014 to 2018. In reference with the classification of claims, it has been used the reasons established by the public service CatSalut: assistance, treat, information, organisation, documentation and hospitality/habitability/comfort.

Results: OTS service received a total of 424 claims during the study period, showing an overall rate of 3.18 claims per 100 assistance episodes considered. The main reasons for claiming were organisational (73%) and assistance (20%). No claims regarding dissatisfaction of hospitality/habitability/comfort were registered. A noticeable decrease in the number of claims submitted is observed since 2016.

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Conclusion: Actions in the management of waiting lists and standardised information procedures that improve the doctor-patient relationship have been identified as measures of improvement to reduce the claim presentation rate.

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PALABRAS CLAVE

Gestión clínica;
Reclamaciones;
Calidad asistencial

Influencia de las reclamaciones en la gestión asistencial de un servicio de cirugía ortopédica y traumatología

Resumen

Introducción: Las reclamaciones constituyen una de las principales fuentes de información para evaluar la calidad percibida en los centros asistenciales, siendo la cirugía ortopédica y traumatología (COT) una de las especialidades con mayor probabilidad de recibirlas por su elevada demanda quirúrgica que genera importantes listas de espera.

Objetivos: Mostrar la evolución de las reclamaciones presentadas en un servicio de COT, clasificar los motivos expuestos e identificar las oportunidades de mejora derivadas de las mismas.

Metodología: Estudio epidemiológico descriptivo, observacional y de orientación temporal retrospectiva. Revisión de los registros correspondientes a las reclamaciones presentadas durante el periodo 2014-2018 en el servicio de COT de un hospital universitario. Para la clasificación de las reclamaciones se han utilizado los motivos establecidos por la aseguradora pública Cat-Salut. El análisis estadístico se ha realizado mediante el programa Excel® y el software R-Project (versión 4.0.2), considerándose un nivel de significación estadística de $p < 0,05$.

Resultados: El servicio de COT ha recibido un total de 424 reclamaciones durante el periodo 2014-2018, mostrando una tasa global de 3,18 reclamaciones por cada 1.000 episodios asistenciales considerados. Los principales motivos de reclamación han sido los organizativos (73%) y los asistenciales (20%). A partir del año 2016 se evidencia un descenso en el número de las reclamaciones presentadas.

Conclusión: La implantación de procedimientos informativos estables para modular las expectativas de los pacientes incorporados a las listas de espera, y una comunicación más empática que facilite una buena relación paciente-profesional son acciones de mejora identificadas para reducir su frecuencia de presentación.

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Introduction

A medical claim is the formal and active expression of the opinion of the patient or their family and friends on healthcare they perceive as unsatisfactory and from which they expect an explanatory response.^{1,2} The different components of hospital activity that can be reflected in a claim are extremely useful for healthcare management and quality programmes,³ as they help in defining objectives, developing indicators, identifying latent problems, prioritising improvement actions, and in evaluating the effectiveness of corrective measures applied.⁴

Medical claims also constitute a citizens' right recognised under different official provisions and regulations.⁵ This administrative regulation confers on them a bureaucratic profile that sometimes makes it difficult for the agents involved to fully accept them.⁶

Not all hospital specialties receive the same number of claims. In the general analysis of specialties by the General Council of Medical Associations of Catalonia, orthopaedic surgery and traumatology (OST) is considered an area highly likely to be subject to a claim, ranking first and accounting

for 17.3% of the surgical procedures subject to a claim.^{2,7,8} Moreover, according to data provided by the Ministry of Health⁹ in 2018, this specialty has the highest number of patients on surgical waiting lists (43,178 patients in Catalonia¹⁰), which corresponds to a rate of 5.98 patients per 1000 inhabitants. The average time on the waiting list is 148 days, with 28.3% of patients on the waiting list for more than 6 months.

The OST waiting list for outpatient consultations also ranks first with 69,487 patients waiting to be seen (rate of 9.63 patients per 1000 inhabitants).⁹

Although studies have been published in the literature on claims filed in different specialties, such as primary care,¹¹⁻¹³ or obstetrics and gynaecology,¹⁴ there is little information on the profile of claims filed against OST services. Studies in this specialty have usually focused on aspects related to the quality of the information provided,¹⁵ safe surgery, or the legal implications of malpractice and the resulting financial compensation.¹⁶⁻¹⁸

To contribute to the knowledge of the possibilities offered by studying medical claims in healthcare management programmes in the field of OST, the main aim of this

work was to identify opportunities for improvement from evaluating these claims.

Patients and methods

Retrospective descriptive epidemiological study, where the unit of analysis was the medical claims filed against the OST Service of the Hospital Clínic Universitari de Barcelona from 2014 to 2018. The inclusion criterion was a written record of the claim and its corresponding response if it was exclusively and directly associated with the activity of the OST service.

The anonymised information was obtained from the medical claim files archived in the OST service, and from the care database of the preventive medicine and epidemiology service of the same hospital.

The content of the claims was evaluated to classify them into different claim reasons. The taxonomy and definitions proposed by the CatSalut instruction 03/2004,¹⁹ updated in 2014,²⁰ were used to establish the different claim reasons:

1. *Care*: related to a healthcare activity or process undertaken in its entirety by a healthcare professional or team.
2. *Treatment*: in reference to interpersonal relations.
3. *Information*: associated with verbal or written communication, of both the care process and the institutional rules.
4. *Organisational*: related to incidents in the planning, organisation, coordination, or resolution of the different care structures and pathways.
5. *Documentation*: associated with problems with the documentation of the care process, and health status certifications, reports, and supporting documents.
6. *Accommodation/habitability/well-being*: related to the conditions of habitability, accommodation, and patient well-being.

Different, more specific, secondary codings are included in each of the 6 main reasons to help classify them appropriately.

The variables considered in the study were of different natures:

- a) *Sociodemographic*: sex, usual residence, claimant, month, and year of claim.
- b) *Claim content*: reason type and hospital area of the claim.
- c) *Claim response*: response time and improvement actions noted.
- d) *Care activity*: hospital discharges and outpatient consultation activity (first and subsequent visits) for the homogeneous calculation of rates.

Statistical analysis

The frequency distribution of each category was calculated for each qualitative variable. The number of medical claims is expressed in absolute values (n) and relative frequencies (%) over the study period and according to the year filed to analyse the evolutionary trend of the claims.

The χ^2 test was used to check whether there were differences between the study years and the claims, or Fisher's exact test if the application conditions were not met.

To assess whether the number of claims filed could be influenced by quantitative variations in the care activity undertaken, claim rates were calculated for each of the years studied, as well as the overall rate for the period (with their respective 95% confidence intervals), considering a homogeneous comparative basis for the activity undertaken (hospitalisation and total outpatient visits).

The most frequent medical claim reason types were described (n and %) according to the secondary claim reason sub-type.

Finally, the mean time and standard deviation of response to the claims over the study period were estimated.

Excel® and R-Project software (version 4.0.2) were used for the statistical analysis. The level of statistical significance was taken as $p < .05$.

Results

The claims studied for the period 2014–2018 totalled 424. Of the people affected by the claim reason, 65% were women, versus 35% men. In 95% of cases, they were residents of the city of Barcelona. A total of 67% of the claims were submitted by the patients themselves, while 33% were filed by the patients' families.

October, with a total of 48 claims (11.32%), saw the highest number of claims, followed by July ($n = 43$; 10.14%), and December ($n = 42$; 9.91%). If we consider their distribution by quarter, the fourth quarter (October–December) and the second quarter (April–June) were the periods in which the highest number of claims were filed: 118 (27.83%) and 114 (26.89%), respectively. This was followed by the third quarter (July–September) and the first quarter (January–March) at 99 (23.35%) and 93 (21.93%) claims, respectively.

The care areas with the highest frequency of claims were surgery (37%) and outpatient (36%), followed by emergency (20%) and inpatient (7%).

Table 1 shows the distribution of claims by year and reason considered; it should be noted that, as no claim reason was identified for the accommodation/habitability/well-being group, this category is not included in the table.

Out of the total number of claims recorded, for the vast majority the reason was organisational ($n = 305$; 71.9%), followed by care ($n = 83$; 19.6%), treatment ($n = 19$; 4.5%), information ($n = 9$; 2.1%), and, finally, documentation ($n = 8$; 1.9%). This pattern was not constant over the years; there were statistically significant differences ($p < .001$) between the reason and the years of study. Although it should be noted that organisational claims were the most frequent for all the years reviewed, showing their highest frequency in 2014 (69/305; 22.62%) and fewer in 2017 (37/305; 12.13%). It should be noted that 2017 was the year with the most claims regarding care, 2014 was the year with the fewest claims about treatment and, finally, there was an increase in the number of claims about documentation in 2018, compared to the rest of the period. The distribution by year of the overall 424 claims filed was as follows: 18.9% in 2014, 21.2% in 2015, 26.7% in 2016, 15.8% in 2017, and 17.5% in 2018.

Table 1 Description of overall claims and by reason for the claim, by year.

	2014		2015		2016		2017		2018		Total	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Care	10	12.5	16	17.8	17	15.0	24	35.8	16	21.6	83	19.6
Treatment	1	1.3	5	5.6	2	1.8	5	7.5	6	8.1	19	4.5
Information			2	2.2	5	4.4			2	2.7	9	2.1
Organisation	69	86.3	65	72.2	89	78.8	37	55.2	45	60.8	305	71.9
Documentation			2	2.2			1	1.5	5	6.8	8	1.9
Total	80	18.9	90	21.2	113	26.7	67	15.8	74	17.5	424	100.0

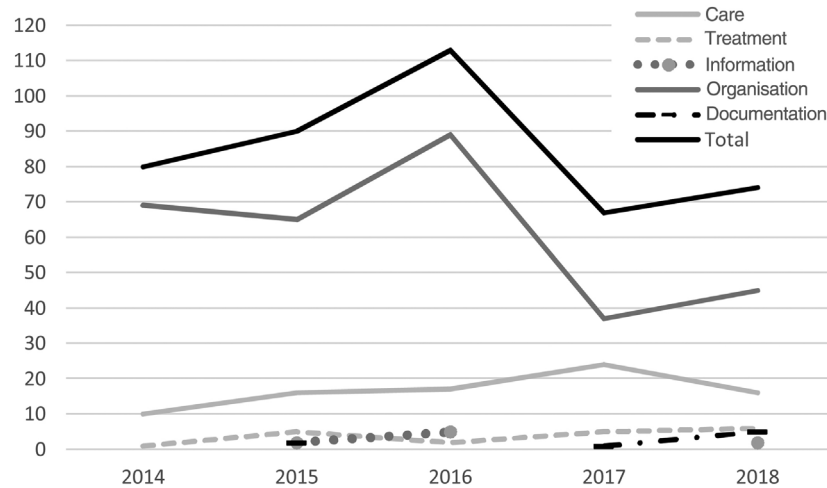
**Figure 1** Evolution of the overall frequency of claims and by type of claim reason, by year.

Fig. 1 shows the temporal evolution of the frequency of claims for the total and according to the type of claim.

The overall trend is conditioned by the large number of organisational claims, with a growing pattern observed during the first 3 years of the study, with a sharp decrease in 2017 and a slight upturn in 2018. Claims about care maintained an increasing trend over the first 4 years, but decreased in the last year. And finally, claims about treatment maintained an upward trend in all years except 2016.

As shown in Fig. 2, 2016 had the highest rate of claims (4.19‰) and 2017 the lowest (2.47‰), resulting in an overall mean rate of 3.18 claims per thousand care episodes over the entire study period. The evolution of the rates shows the same pattern, with an increase in the first 3 years, a sharp decrease in 2017 and a slight upturn in 2018, although no statistically significant differences by year were observed.

Fig. 3 shows the frequency of claims for organisational reasons according to their two most frequent subtypes: waiting list delay and suspension/cancellation of consultation, surgical intervention, complementary testing, admission, or surgical treatment.

Most of the claims for organisational reasons were due to waiting list delay (211/305; 69.2%), especially in the first 3 years of the study, although in 2017 they fell sharply to less than half the trend observed in previous years, and finally in 2018 they increased again, although not to the levels of the first years. This is followed by suspension/cancellation

claims (62/305; 20.3%) peaking in 2016 but decreasing in the following years.

Table 2 describes the claims for organisational reasons due to waiting list delay for different care activities.

Most of the claims due to waiting lists were motivated by consultations ($n=97$; 46.0%) or surgical interventions ($n=83$; 39.3%) and, although both decreased in 2017, the former continued downward while the latter showed an upward trend at the same frequency as previous years.

However, most of the claims for organisational reasons due to activity suspension/cancellation corresponded to surgical cancellations with a total of 52 (52/62; 83.9%) claims filed (data not shown).

Regarding claims for reasons of care, the highest frequency was found in dissatisfaction with the care received (62/83; 74.7%), followed by possible or potential negligence (8/83; 9.6%). The frequency of both subtypes remained stable during the study period, except in 2017 with a peak in claims due to dissatisfaction with the care received (Fig. 4).

Finally, the claim response time averaged 9.68 days ($SD \pm 9.45$) for the overall period studied, which is below the maximum standards established for healthcare service providers (15 days).¹⁹

Discussion

A total of 424 complaints were recorded in the OST Department of the Hospital Universitario Clínic de Barcelona

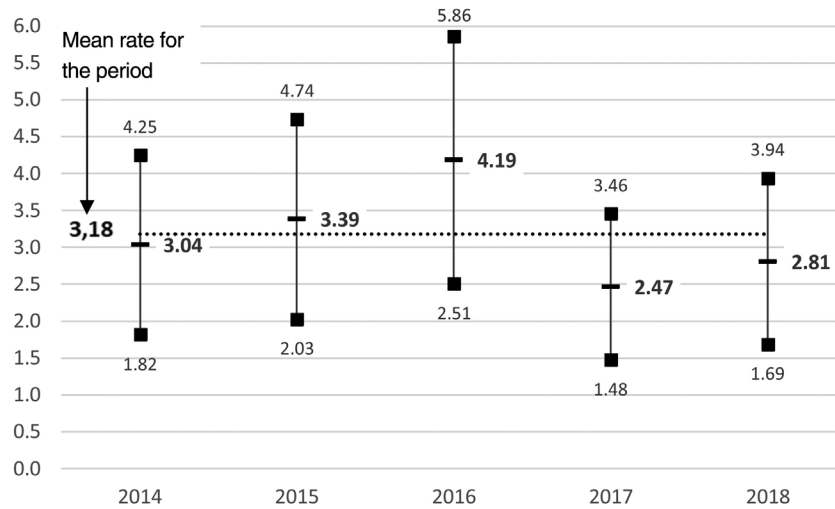


Figure 2 Evolution of claim rates %c based on activity (inpatient and outpatient consultations) for the study period: 2014–2018.

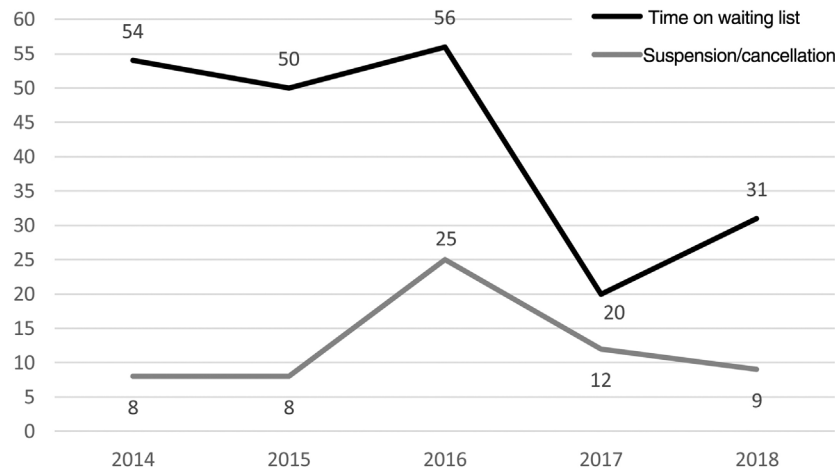


Figure 3 Annual evolution of the frequency of organisational claims, due to waiting list delays vs. suspension/cancellation of consultation, surgery, or complementary test.

Table 2 Description of organisational claims due to waiting list delays according to the care activity involved.

	2014		2015		2016		2017		2018		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Consultation	26	48.1	28	56.0	30	53.6	5	25.0	8	25.8	97	46.0
Care in emergency department	1	1.9	3	6.0	10	17.9	8	40.0	7	22.6	29	13.7
Surgical intervention	27	50.0	19	38.0	15	26.8	7	35.0	15	48.4	83	39.3
Non-surgical treatment					1	1.8			1	3.2	2	0.9
Total	54	25.6	50	23.7	56	26.5	20	9.5	31	14.7	211	100.0

between 2014 and 2018, giving a claim rate of 3.18 per 1000 care episodes considered. These results are within the expected limits in a specialty considered to have a high risk of claims, such as OST,² in the context of an internal indicator of our hospital quality programme,^{3,4} which allows for comparisons and trends adjusted according to the care activity delivered. Typically, rates of 3% for a surgical specialty and 1.5% for a medical specialty can be considered

standards against which to assess the adoption of specific, measurable improvement interventions. The evolution of claims shows an increase in claims up to and including 2016, and a decrease thereafter based on the programme's criteria.

There being more females involved in the different claim reasons (65%) is consistent with the results obtained in a previous study conducted in the same hospital, which showed

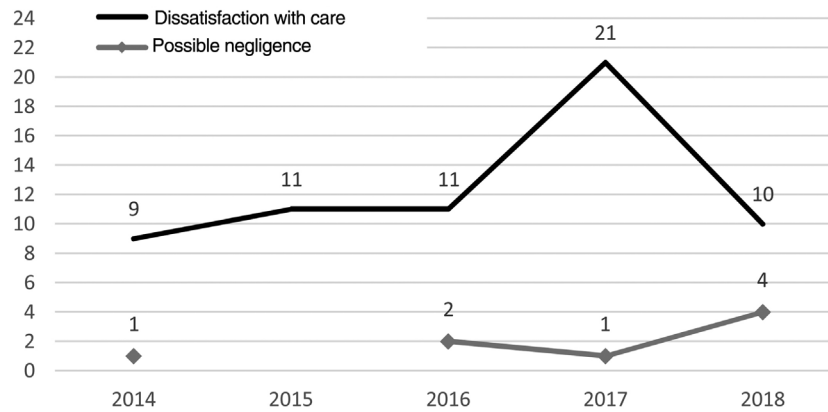


Figure 4 Annual evolution of the frequency of claims about care, due to dissatisfaction with care vs. possible negligence.

gender differences in the assessment of different dimensions associated with perceived quality.²¹ Although gender differences in levels of satisfaction with the care received show variable results in the literature, there is an established consensus in highlighting different points of view or experiences in the evaluation of the various components of care according to gender, with greater expectations and critical sense regarding the successive episodes comprising the healthcare experience of the female sex.^{22,23}

Organisational claims were the most frequent every year. This group contained, in first place, claims regarding waiting lists, showing a decrease from 2017 onwards (included). It should be noted that, since 2016, a set of measures have been introduced to manage waiting lists and waiting times with a view to improving these indicators. Thus, some patients on the waiting list for arthroscopy, hand surgery and foot surgery were redirected to another care centre with which there was a strategic alliance for orthopaedic surgery and traumatology. However, at the emergency department level and depending on the complexity, it was considered whether the patient belonged to the centre's metropolitan catchment area (Eixample Esquerra), and some cases were referred to a second centre also providing OST care services.

Likewise, and according to data provided by the Ministry of Health,⁹ the number of patients on the waiting list for primary care in Catalonia has decreased. In 2016 there were 46,219 patients on the surgical waiting list (6.47 patients per 1000 inhabitants; average waiting time 206 days; 42.7% waiting more than 6 months). This reduction is reflected when we compare this with the above values for 2018 (43,178 patients; 5.98 patients per 1000 inhabitants; 148 days waiting time and 28.3% with more than 6 months waiting time).

This reduction in waiting lists, as well as in the number of claims for this reason should be seen as positive, since being on the waiting list without having an approximate idea of when the service will be provided can have physical, emotional, and economic repercussions for patients, as noted in some of the claims analysed. Although long waiting lists are not unique to OST,²⁴ there are other points where organisational management can be improved. The second most frequent type of claim in this group relates to cancellation/suspension of the visit, surgery, or complementary test. Clearly OST operating theatres are limited, and it is

not possible to foresee emergencies that may occur on a given day, but the information¹⁵ provided to patients can be improved.

It is proposed that in these cases a verbal or written information procedure be established from the moment of scheduling, advising that the visit, surgery, or complementary test could be cancelled and postponed in the event of unforeseen episodes or socio-health situations; and adequate ongoing communication of information¹⁵ should be ensured, and thus guide users' expectations.²⁵

Likewise, some organisational claims also show aspects related to the hospital service process, flagging up elements for improvement. One of the factors leading to a person making a medical claim could be the perception of depersonalised care, understood as a lack of interest on the part of the health system. This aspect warrants special attention as this may improve patients' assessment of care despite waiting times.²⁶

The most frequent healthcare claims were those related to dissatisfaction with the care received. For example, there were claims about patients who disagreed with complementary tests or proposed treatments, or claims that they had not improved after an intervention. We can make some general observations from analysing and considering the written claims about dissatisfaction with care. In many cases, the patient profile of this speciality is often conditioned by "pain" and by the expectations that diagnostic procedures and surgical interventions can bring improved health outcomes and quality of life.²⁷

The OST specialist is habitually exposed to care pressure in different settings (operating theatre, outpatient clinic, hospitalisation, on-call), and may ignore or take for granted certain explanations or aspects of care. As a result, claims are made that translate into mistrust and/or disagreement with medical indications, and the perception of a degree of helplessness, with requests for second opinions or changes of doctor. The improvement actions to be considered would be to consider standardised information procedures that guarantee good coordination between professionals and convey a message that is empathetic to the patient's requirements. The end result must be to establish a good patient-doctor relationship. A recent meta-analysis²³ establishes that the interpersonal skills and abilities of healthcare professionals are strongly associated with greater patient satisfaction.

Also noteworthy among the healthcare claims in this medical-surgical specialty are the few claims attributable to possible medical errors or negligence presented over the 5 years considered. This can be attributed to specific interventions on the healthcare professionals in this service, aimed at promoting an adequate clinical safety culture in the collective,²⁸ as well as a better perception of the information on the subject currently disseminated by the media,²⁹ showing a notable awareness on the part of professionals.

The absence of claims in relation to accommodation/habitability/well-being conditions throughout the entire period is worth noting, when this is one of the dimensions of perceived quality most highly valued by healthcare service users.²¹ Improvements in hospital facilities and conditions made by health administrations can be seen from this result.

Claims are an important source of information for assessing the perceived quality of the patients treated, and help improve care management in OST hospital services. The implementation of stable information procedures to modulate the expectations of patients on waiting lists, more empathetic communication to facilitate a good patient-professional relationship and a more individualised handling of the response through the involvement of professionals directly linked to care are the main conclusions of this work.

Considering the changes in care management brought about by the SARS-CoV-2 pandemic, we believe it is of interest to explore this line of research as applied to the specialty of OST.

Limitations of the study

Those inherent to a descriptive study conducted with a population from a single tertiary hospital.

Level of evidence

Level of evidence II.

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Conflict of interests

The authors have no conflict of interests to declare.

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