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Inpatient Complaining Behaviour: A Study on the Overt and Covert Behaviour of Inpatients in Indian Hospitals

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ABSTRACT Consumer dissatisfaction and complaining behaviour have always been a topic of discussion in educational institutes and industries alike. Whereas dissatisfaction with product purchases and subsequent returns or associated consumer responses is very common, the same in the service sector has been quite different. In India, it is not only the patient who decides, which healthcare service to opt for, because Indians are culturally embedded in a system of collective consumption where other family members or relatives or friends also influence their decision-making. This paper is an exploratory study done to comprehend the chosen behavioural responses of dissatisfied inpatients in India through a questionnaire survey. The survey followed a retrospective recall technique in which the recall window was fixed at six months. The sampling technique followed was probability sampling. The data collection tool was structured and self-administered questionnaire administered in the sampled nine districts of Kerala. A good number of respondents attributed their overt complaining behaviour to lack of cordiality of doctors, nurses or the attending staff and lack of proper care and concern from doctors or nurses. Post complaining, service recovery was found to be satisfactory for most of the complainers.

INTRODUCTION

Since its inception in the early 1920s in USA, the concept of consumerism was considered as a method of manipulating the masses. Consumerism developed as a strategy to create a democratic consumer society based on consumption of mass-produced goods. This was achieved by taking Freud's psychoanalytic theories about human beings in order to use them to manipulate the masses and how industries can make people desire what they did not need, by linking mass produced products to their unconscious wants.

Any marketing problem will find some roots in any of the three fields of consumer satisfaction, consumer dissatisfaction or Consumer Complaining Behaviour (CCB). However, CCB started gaining attention as a key area of research of the marketing theorists and researchers only since the 1970s with Hirschman studying the phenomenon within the field of Political Science, and Day and Landon in the field of product marketing. Consumer Complaining Behaviour is the set of all behavioural and non-behavioural responses portrayed by consumers, which involve the communication of negative perceptions relating to a consumption episode, and triggered by dissatisfaction with that episode (Volkov et al. 2002). Nyer (2000) observed that complaints of consumers would be useful for companies to make strategic and tactical decisions with the purpose of improving their business. Unlike the usual experience service sector, it has been observed that the complaining behaviour in the credence sector, especially, healthcare, has been minimal.

Objectives of the Study

1. To observe the behavioural response of dissatisfied inpatients.
2. To understand the complaining mode of dissatisfied inpatients.
3. To find out the reasons and impact of overt complaining behaviour.
4. To develop propositions based on inpatient complaining behaviour.

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Inpatients possess a docile and defenceless attitude, namely inpatient disempowerment, which deters them from complaining overtly, even after being dissatisfied with hospital services (Khadir and Swamynathan 2017a). Bodey and Grace (2006) observed two categories of people who indulged in various behaviours post dissatisfaction, namely, the complainers (overt complainers) and the non-complainers (covert complainers) on the basis of personality characteristics and attitude toward complaining. Responses to dissatisfaction also depend on the nature of product or service in which the dissatisfaction has occurred. Considering the service sector exclusively, consumer responses to perceived dissatisfaction may not be the same in hotels, restaurants, airlines, telecommunication services, retail services, rental services, automobile services, hospitals, etc. However, depending on credence property of the service, responses may differ.

Healthcare services are different from other services due to the abundance of credence properties possessed by this industry. Unlike search goods, information search for credence offerings can be quite lengthy, difficult, frustrating and unsatisfactory.

Smith and Royne (2010) commented about credence offerings as those that are supposed to be accepted by the consumer purely based on faith, despite the fact that the consequences of their poor choices are possibly threatening. They observed that the quality of such offerings could not be identified even after repeated purchase and use. Credence services mostly fall under the category of technical services, purchased by individuals who are unlikely to be technical experts. Patients do not behave in the same way as other consumers. They cannot test the product before consuming it. An alarming indicator to the entire industry is the fact that respondents are not ready to overtly communicate their complaints to the provider (Khadir and Swamynathan 2017b), and hence the industry may never know the consumers' mind-set to perform any sort of service recovery measures.

Indeed, they often have difficulty gauging the quality of care even after experiencing it. Obtaining information about the appropriate medical care for their ailment is not easy for patients chiefly because medical knowledge is rather difficult to acquire and comprehend. As consumers, patients know considerably less than the provider, and place trust in their healthcare provider. Patient credulousness means to trust, believe, obey and be submissive to the doctor. Hospitals may devise measures to encourage overt complaining behaviour so that they realise the reasons of dissatisfaction of their inpatients and subsequently devise measures to reduce the same (Khadir and Swamynathan 2016). Because of the strong credence property of the healthcare sector in general and hospital services in particular, consumer complaining behaviour in hospitals is different from that of other sectors. This research explores the various responses of inpatients post dissatisfaction.

Most of the extant literature concentrates on complaining behaviour in banks, restaurants and airlines. However, very little have been documented about patient dissatisfaction and complaining behaviour, especially in India. Though the consequences of lacunae in services and inadequate hospital services have been well published, no systematic studies have been made so far to understand, in a thorough manner, the complaining behaviour of patients. Sodani et al. (2010) observed patient satisfaction to be one of the most important goals of any health system. Unfortunately patient perceptions regarding healthcare systems seem to be ignored by providers in developing countries. Agrawal (2006) noted that measuring clinical and non-clinical outcomes of care did influence patient satisfaction.

Khadir et al. (2016) investigated the antecedents of inpatient complaining behaviour and identified four factors using factor analysis, namely, hospitality and cordiality, patient care and concern, amenities and technical competence. Jenkinson et al. (2002) identified factors such as quality of clinical services provided, availability of medicine, behaviour of doctors and other health staff, cost of services, hospital infrastructure, physical comfort, emotional support and respect for patient preferences to be the determinants of patient satisfaction. McKinley and Roberts (2000) found that patient dissatisfaction occurs when there is a mismatch between patient expectation and service received. Different problems encountered in healthcare services range from treatment done incorrectly, long waiting times, repeated visits necessary to have the problems corrected, time and inconvenience, billing for treatment not done, dishonesty, incompetence, error, difference of

opinions, lack of patient knowledge and poor communication between patients and healthcare personnel (Binder 2013).

The physical, psychological and overall quality of human life in any nation is inextricably linked with the quality of health services pertaining to preventive, curative, promotional and rehabilitative aspects of the healthcare system (WHO 2005). Healthcare services are different from other service industries like banking, retail, communication, education, hospitality, travel, tourism and recreation. Consumers of healthcare initiate the service interaction with the provider of care in a situation of discomfort. It is a high-involvement personal service where the consumer is the direct recipient of the service and the physical presence of the consumer increases the tangibility of the service.

Indian consumers are less demanding and very often engage in accommodative behaviour compatible with the norms they are habituated into in a sellers' market where they have been systematically discriminated against. Also given the fact that, unlike the West, the chunk of consumers do not belong to the set of literate and knowledgeable people (UNESCO 2012), there is very often lack of awareness regarding the availability and the modes or channels of complaining and the processes by which such complaints have to be operationalised. There are barriers to complaining like lack of motivation, lack of confidence on account of failed episodes, misperception of legal rights and above all, self-inflicted modesty.

Consumer complaining behaviour is an important phenomenon for the industry and academics, and must be understood by everyone who is in the business of providing service to their customers (Tronvoll 2007). The study of patient complaining behaviour would help the providers with significant information regarding the improvement of patient requirements and basic necessities. Moreover, data with regard to negative patient experiences would enable the providers to identify problems in their existing systemic services.

India has witnessed enormous progress in its economic scenario since the globalisation in the 1990s (Deloitte 2014). The fast-paced growth of the country in the fields of education, healthcare and information technology has placed it in the global arena. Healthcare is an important sector, which has undergone dynamic structural shifts on account of the distinct changes brought about by economic reforms (KPMG 2011). With the advent of corporate hospitals and medical tourism in India, this sector has grown immensely. It has also witnessed drastic changes in the form of technological upgradation, innovation, diversification and novelty. Over the last couple of decades, the improvement in the quality of healthcare services in the country has been remarkable as quoted by KPMG (2010). Their study revealed that the healthcare indicators like life expectancy at birth, infant mortality rates, maternal mortality rate, etc. have significantly improved over this period.

The problem being researched is consumer complaining behaviour in hospitals. Due to the inherent credence property of this sector, it would be pertinent to look into the behaviour of consumers, their propensity to complain when they are dissatisfied and the reaction of the hospital management and staff to their complaining behaviour. This study would concentrate only on inpatients of private and cooperative hospitals because unlike the government hospitals, these two sectors are interested in revenue generation, and hence the significance of patient satisfaction.

Complaining literature has long focused on the dissatisfaction of consumers and the reasons of dissatisfaction, predominantly representing the Western developed countries. According to Phau and Sari (2004), very little has been studied about what consumers do after the occurrence of the dissatisfaction episode, especially in the healthcare sector in developing Asian countries. Around forty percent dissatisfied customers complain that this needs to be empirically analysed across product and services sector in general and credence services in particular. India has an average of 0.6 doctors per 1000 population against the global average of 1.23 (KPMG 2011, CII Technopak report). According to extant literature, providing affordable quality care was a big challenge in India, the second populous country after China, because eighty percent healthcare centres, both public and private, were located in urban areas, which would serve merely thirty percent of the total population. The study also found a huge discrepancy in the demand for quality care and the actual supply of it in the country. Another alarming finding was that majority of the healthcare centres were understaffed, had poorly main-

tained medical equipment and lacked necessary laboratory support.

Khadir and Swamynathan (2014) while studying the deterrents of complaining among the non-complaining inpatients found that the most frequently quoted reason for non-complaining was their apprehension that no positive outcome might be received post complaining. Another set of non-complainers had declared their decision to visit another hospital in the future rather than complaining. While some others did not have any interest in creating conflict with staff or authorities during their hospital stay, another set of respondents reported lack of confidence to go against big establishments like hospitals. The rest of them had a feeling that similar problems, like the one they faced, would occur in any hospital they visited. The authors in their study ranked the various non-complaining reasons into four factors, namely, 'perceived relative inability', 'perceived negative consequences', 'personal factors' and 'environmental factors' in the order of respondent priority.

Khadir (2012) analysed dual failures, which resulted from double deviation scenarios in the service sector. The words 'dual' or 'double' resulted from the customer being dissatisfied twice, one with the service and the other with the provider's response to the complaint. In that study, the author tried to analyse the presence of a power asymmetry in which the buyer is a powerless party and the seller is a powerful one. This asymmetry is prominent among the vulnerable and disadvantaged consumers. The more the asymmetry, the higher is the degree of service failure and hence the double deviation scenario. Hence, it is also necessary to study the service recovery patterns in the healthcare sector, especially in hospitals, after complaints have been registered.

Studies on patient dissatisfaction in the Western countries have been gaining momentum in the recent years, as it gives a chance to the providers to improve their services. Even though patient feedback is not systematically used, it gives providers a chance to understand the patient perceptions and hence a better outlook about the services to be rendered. Mahapatra (2013), Agrawal (2006), Jenkinson et al. (2002) and McKinley and Roberts (2000) have analysed the importance of studying patient dissatisfaction, with a focus on economic and managerial implications of the research. Extant literature has also established many socio-economic and demographic variables as significant predictors of patient satisfaction.

India has witnessed the speedy growth of the healthcare sector, especially hospitals. Private and cooperative hospitals have spent largely on medical technologies for enabling and supporting speedy recovery of patients, those with even serious medical complaints. They work more like an organisation with a mission to reduce the time taken for treatment, control costs and to render high quality services, but with a huge price tag to the beneficiary (Verma 2006). Due to these reasons, patient satisfaction is an area, which needs to be explored. The quality of hospital services can be a significant variable to measure the performance of hospitals, be it diagnostic services, ambulance services, accommodation for inpatients, nursing services, catering services, pharmacy services or laboratory services.

Promotion of health is given the topmost priority in the annual budget of every country. Mere relief from ailment does not ensure satisfaction. It is embedded in other factors like human interaction between expert and patient about ailment and recovery as well as machine-patient interaction. Patient action after a dissatisfying episode or a series of episodes is an area of concern to the hospitals. The activities of a dissatisfied patient or bystander have not received much prominence in extant literature. For a collectivistic society like India (Chadda and Deb 2013), how they react in such situations would be of interest to the hospital management and the Consumer Complaining Behaviour theorists.

METHODOLOGY

In order to achieve the objectives of the research, an exploratory research design was followed. As similar studies from the developed Western countries could not be adopted in a country like India due to the differences in the characteristics of the industry and population, this study has followed an exploratory design. Many consumer complaining studies in developed countries in general and patient satisfaction studies from India in particular were reviewed. However, inpatient complaining studies in the Indian context were hard to find and hence the exploratory design.

The survey followed a retrospective recall technique in which the recall window was fixed at six months. Though many Western studies had considered a three-month period, this study opted for a longer recall window due to the huge size of the population. Clarke et al. (2008) have established that there is no general answer for the duration of optimal recall windows, as it depends on the primary objective of the data collection.

Questionnaires for pilot study were administered to 75 respondents, of which 59 filled ones were found useful for further analysis. The researcher wanted to confirm that the patients or their bystanders had the ability to recollect their respective dissatisfaction episode(s) that happened in the 0-6 month period after being discharged from the hospital. Valuable insights were expected to be gained from observing their responses, the frequency of doubts asked while filling in or after filling in the questionnaire. The preliminary questionnaire was also sent to five experts in the academics and marketing field for their opinion and review. Their comments and suggestions were incorporated while drafting the final version of the questionnaire.

The behavioural response of inpatients to dissatisfaction episodes was measured with the question, 'what action did you resort to when dissatisfied during your stay' using dichotomous scale bearing options 'complained' and 'did not complain'. The reason for their dissatisfaction causing them to complain was collected using an open-ended question. The non-complainers alone were asked to choose the most suitable reason(s) for their decisions to stay away from complaining.

The population of the study was the patients or bystanders who availed various services of any private or cooperative hospital in Kerala during the 0-6 months of the data collection period and were dissatisfied with any of the services of that hospital. 'Kerala' was chosen due to the higher rate of literacy as well as the NITI Aayog's highest ranking for it as the "healthiest state in the country" according to the State Health Index. It included evaluation of neo-natal mortality rate, under-five mortality rate, birth weight of babies at the time of birth, etc. (Business Line, June 2019). The sampling technique followed was probability sampling. The data collection tool was a structured and self-administered questionnaire administered in the sampled nine districts of Kerala. The first stage or primary sampling unit was each of the three zones to which the entire state of Kerala was divided into, namely northern, central and southern zones. This classification was made by the researcher particularly for this study. The second stage or secondary sampling units were the districts in each of these zones. The districts randomly selected were Kannur, Kozhikode and Wayanad in the north, Thrissur, Ernakulam and Kottayam in the centre, and Alappuzha, Kollam and Thiruvananthapuram in the south. The third stage or the tertiary stage was to identify the private and cooperative allopathic hospitals in these districts having a minimum of 100 beds. The hospitals were randomly selected from each of these classifications using random sampling and the patient data was accessed from the database maintained by the selected hospitals. At times, the researcher's personal connections with the Public Relations Officer or any personnel holding similar positions had to be used to access data from certain hospitals. In order to ensure unbiased data, every 10^{th} patient's contact details were taken using systematic random sampling from the inpatient list. Hence, a good number of patient data was sourced so that around 40-45 samples from each of the chosen districts could be finally used for the study.

Patients were contacted through personal and mail surveys, where in the latter method, self-addressed stamped envelopes were sent to the respondents. Follow-up calls were made to non-respondents two weeks after the dispatch. As this is a post-purchase behaviour study, patients admitted at the time of data collection were not included in the survey. The sample size was 405, with almost equal distribution from the three zones. Out of the 405 questionnaires distributed, only 353 were found useful, as the rest 52 were returned because those respondents were either not dissatisfied with any of the hospital services or not available (death, not able to locate or outstation) or non-response after a maximum of three reminder calls. Out of the 353 questionnaires, only 312 were finally used for data analysis, as the rest 41 were found unsuitable due to missing responses, non-cooperation from respondents, and/or their inability to either recollect or judge the services. Hence, the response rate was seventy-eight percent.

Primary data was collected through a survey method using the self-report questionnaire. While a part of the fieldwork was done directly by the researcher, field workers were appointed for collecting data from those geographical areas to which the researcher could not travel. They were given training on how to approach the respondent and handle their queries. They were also cautioned to have an unbiased approach to the data collection process. The quality of data collection was ensured by checking data on the spot and counter-checking entries at random, mostly for error rectification and incorporation of missing data.

RESULTS

The first objective was to study patients' behavioural responses to dissatisfaction episode(s). Studies by Mensah and Nimako (2012) and Salo and Makkonen (2014) have presented evidence to the fact that dissatisfied consumers need not necessarily complain. A substantial number of dissatisfied consumers never complain, rather they exit and resort to negative word of mouth behaviour. In many cases, negative word of mouth occurs either prior to complaining or after complaining.

Inpatient Behavioural Responses When Dissatisfied

It was of interest to investigate the type of behaviour indulged in by dissatisfied inpatients. The question given to the respondents had dichotomous alternatives, namely, 'complained' and 'did not complain'. The responses are tabulated below in Table 1.

Table 1: Distribution of respondents based on action resorted to when dissatisfied

Patient action	*Frequency*	*Percent*
Complained	71	22.8
Did not Complain	240	76.9
No response	1	.3
Total	312	100.0

It is evident that more than three-fourth of the respondents (76.9%) comprising 240 dissatisfied inpatients were covert complainers whereas 71 were overt complainers contributing to 22.8 percent. Hence, the hypothesis is retained and there is evidence to state that patients generally do not complain in hospitals when dissatisfied.

The results are in congruence with earlier studies by Richins (1983) and Stephens and Gwinner (1998), which found that about two-thirds of customers do not report their dissatisfaction. Moreover, they may either take action or stay silent.

Modes of Complaining

In order to study the modes of overt complaining, two sets of questions were posed exclusively to complainers, namely, 'through whom' they complained and 'how' they complained. Sections 2.1 and 2.2 respectively, discuss the data pertaining to the two enquiries. For analysing the covert complaining, how they behaved post dissatisfaction was posed exclusively to non-complainers as discussed in Section 2.3.

Through 'Whom' The Complaints Were Lodged

This section presents findings on enquiries related to the manner in which complaints were put forth. The voicing behaviour in a hospital scenario pertains chiefly to two aspects – the 'whom' and 'how' of complaining.

The first section covers investigation pertaining to the person/authority, that is, through whom the complaints were lodged by the aggrieved users of hospital services. To achieve this objective, the respondents were asked a direct question bearing five alternative responses, namely, 'complained to the attending doctor', 'attending nurse', 'management', 'third party', and 'to the legal authorities'. The respondents could opt for more than one alternative. The findings are presented in the Table 2.

Table 2: Distribution of overt complainers based on 'whom' the complaints were lodged

Person/authority to whom the complaint was lodged	*Frequency*	*Percent*
To the attending doctor	29	32.6
To the attending nurse	25	28.1
To the management	28	31.5
To third party	2	2.2
To legal authorities	5	5.6
Total	89	100.0

Though the overt complainers were only 71 in number, the total responses of public action are 89 since respondents could select more than one response action. There is evidence to state that nearly one-third of the complaints went to the attending doctor (32.6%) and 31.5 percent reported that they lodged the complaint to the management. While 28.1 percent of the respondents reported their complaint to the attending nurse, only 5.6 percent preferred to seek legal redress. An insignificant proportion of the respondents (2.2%) said that they tried to resolve their problem through third party interventions.

'How' The Complaints Were Lodged

Aggrieved patients complain in different ways in order to get their issues appropriately addressed and resolved. The manner in which complaints were presented was studied by asking the respondents to choose from among the four options, namely 'by self (orally)', 'through bystander (orally)', 'in writing' and 'through third party intervention'. The results of analysis are given in Table 3.

Table 3: Distribution of overt complainers based on 'how' they complained

Methods of lodging complaints	*Frequency*	*Percent*
By self (orally)	48	60
Through bystander (orally)	17	21.2
In writing	15	18.8
Total	80	100.0

As far as the methods of lodging complaints are concerned, it is found that as high sixty percent of the overt complainers preferred to express their dissatisfaction orally by themselves. Those who chose to complain through their bystanders orally formed 21.2 percent and 18.8 percent had lodged written complaints. No respondent was found to complain through third party intervention.

Reasons and Impact of Overt and Covert Complaining Behaviour

Private Action/Covert Responses

Aggrieved inpatients need not engage in overt complaining behaviour always. After studying the responses of complainers, data from the rest of the dissatisfied inpatients, that is, the non-complainers, were studied. The manner in which they reacted post dissatisfaction was studied by asking the respondents to choose from among the four options, namely, 'silent exit', 'switching behaviour', 'negative word of mouth with friends and relatives' and 'sharing with other inpatients'. The results of analysis are given in Table 4.

Table 4: Distribution of non-complainers based on their covert responses (private action)

Private action by non-complainers	*Frequency*	*Percent*
Silent behaviour	62	19.6
Switching behaviour	106	33.5
Negative word of mouth with friends and relatives	104	32.9
Sharing with other inpatients	39	12.3
Other responses	5	1.6
Total	316	100.0

It is evident that non-complainers were mostly inclined to either switch or inform their friends and relatives about their negative service experiences. More than one-fourth of the non-complainers either had a propensity to switch (33.5%) or to engage in negative word-of-mouth (NWOM) with friends and relatives (32.9%). While 19.6 percent preferred to remain silent, 12.3 percent shared their dissatisfaction with other inpatients. A very meagre share of non-complainers opted for other actions, which they did not explicitly mention in the given space of the questionnaire.

Reasons for Overt Complaining Behaviour of Dissatisfied Inpatients

The reasons for complaining post dissatisfaction were collected from the 71 overt complainers with the help of open-ended questions. Upon analysing their responses, five categories of reasons evolved as shown in Table 5. While, for exactly three-fourth of them (75.0%), there was a solid reason or reasons to overtly complain, the rest of the complainers (8.0%) were either not ready to disclose their reasons or opted for other actions, which they did not explicitly mention in the given space of the questionnaire (17.0%).

Among the 71 overt complainers, 34.0 percent attributed their complaining behaviour to lack

Table 5: Distribution of overt complainers based on their reasons of complaining

Reasons of overt complaining behaviour	*Percent*
Lack of cordiality of doctors, nurses or the attending staff	34
Lack of proper care and concern from doctors or nurses	34
Lack of basic amenities	23
Technical inadequacy	2
General dissatisfaction- no particular reason	7
Total	100.0

of cordiality of doctors, nurses or the attending staff. For another 34.0 percent respondents, it was lack of proper care and concern from doctors or nurses that urged them to complain overtly. A little less than one-fourth of them (23.0%) blamed the basic amenities of the hospital in which they were admitted, and 2.0 percent were dissatisfied with the technical adequacy of the hospital. There were 7.0 percent of them who could not point out a particular reason, but complained because they were generally dissatisfied with the respective hospital.

Responses Received For Overt Complaints From The Hospital

Manifold reactions are possible to a consumer complaint. While the complainants expect constructive responses, it is often possible that they may receive defensive and justifying responses. The reactions to complaints of overt complainers were collected through an open-ended question. The responses were categorised as positive responses and negative responses as shown in Table 6.

Table 6: Distribution of overt complainers based on the responses received

Responses received for overt complaints	*Percent*
Positive responses	45
Negative responses	39
Missing responses	11
Prefer not to reveal	5
Total	100.0

Among the 71 complainers, a little less than one-half (45.0%) of the respondents reported that they received a positive response to their complaints, while 39.0 percent of the respondents had received negative responses. The rest of them either left the section blank (11.0%) or expressed hesitation in revealing the actual response (5.0%). However, good service recovery was obvious from the wordings of their answers to the open-ended question. A few examples of their responses are, 'listened', 'attended', 'promised', 'apologised', 'accompanied', 'resolved', 'cleaned', 'explained', 'described' and 'rectified'. Hence, it is evident that majority of the hospitals had a positive attitude towards service recovery and were ready to rectify their mistakes without much delay.

On the other hand, the negative responses that they encountered upon complaining were also reflected in the answers such as 'ignored', 'no, cold or bad response', 'shouted' and 'did nothing'.

DISCUSSION

The public to private complaints ratio, as reported in the study was almost 1:3, which contradicts with that of other services like hotels, retail, restaurants and airlines or with hospital-based studies of western countries like USA and UK, where patient satisfaction surveys are part of their routine business activities. Moreover, this ratio confirms the overall hypothesis of this study that patients generally do not complain in a hospital setting. This could be attributed to the higher level of credence property in healthcare services added to the cultural variables pertinent to the Indian subcontinent. The results of the current study bring forth two propositions:

1. Covert complaining behaviour of inpatients is a result of their disempowerment and credulousness, especially, during the period of admission, and at least until they recover completely.
2. Inpatient disempowerment and credulousness weaken the positive energy of the inpatients and subsequently their trust factor to their medical practitioner.

The fact that respondents are not ready to directly communicate their complaints is an alarming indicator to the entire industry. Considering the other service sectors like restaurants, airlines and banking where the scenario is entirely different and consumer voicing is predominant, the

Table 7: Supporting literature in conformance with the findings of the study

Construct	*Definition*	*Indicators*	*Literature*
Inpatient complaining behaviour post dissatisfaction	*Overt or Public Complaining*Any customer who directly complained to the doctor, nurse, hospital management, a third party or legal body.	Attending doctor Nurses Management3rd party redressLegal as either oral or written	Heung and Lam (2003) Stephens and Gwinner (1998) Bedi et al. (2004)
	Covert or Private Complaining Any customer who remained silent, decided to switch, engaged in negative word-of-mouth with friends, relatives or other inpatients.	Remain silent Switch provider NWOM to inpatients, friends, relatives	Singh (1990) Richins (1983)

characteristics of the healthcare sector in addition to the cultural composition of the country might prevent people from engaging in public action post dissatisfaction. Studies have marked India as a collectivistic society (Chadda and Deb 2013) with lower traits of individualistic culture when compared to the Western developed nations. The results of the study are useful to the industry because majority of the respondents exhibited a higher propensity to engage in negative word-of-mouth behaviour either with friends and relatives or with other inpatients. Many of them also preferred to remain silent or switch provider. In any of these scenarios, the provider will never get a chance to know about the dissatisfaction unless until they devise an enquiry mechanism. In general, the private actions evolved from the study do give a warning signal, as the industry may never know the consumers' mind-set because these types of private actions do not directly reach the service provider.

The reasons for complaining were asked as an open-ended question because every respondent came up with a different response in the pilot study. Though the categorisation at the end of the study was not easy, it gave insights into the weightage that patients attached to the nuances of services that providers might generally label as insignificant or worthless. The findings of the study and supporting literature are summarised in the Table 7.

CONCLUSION

Though the number of active complainers was less in the study, the strong words that evolved from their open-ended responses suggest that authorities should welcome and encourage complaints and give more emphasis and focus on them. Due to complainants' openness and positive attitude to the act of complaining, it is more likely that hospitals can achieve a greater impact from them. The results also infer that patients expect their doctors and nurses to be courteous and caring in their interactions. They expect their doctor to be polite in their communication to them and their family members. Confirming earlier findings, it is observed from the above result that interaction of doctors is a major determinant of patient dissatisfaction.

RECOMMENDATIONS

Hospitals need to sensitise their staff in general, and medical staff in particular, about patient expectations, which can improve the quality of stay of inpatients in these hospitals, which in turn would lead to patient satisfaction and positive word-of-mouth. India should strengthen its legal system in similar lines of antitrust laws of developed countries like the USA, majorly because of the vast amount of consumers in the service sector. This helps empower the customer, especially in credence service industries, where the customer usually shies away from reporting their dissatisfaction formally.

Hospitals should give regular training to staff members from medical and administrative departments for handling patients and their complaints in a professional way. These could include training programs in handling customer complaints and service recovery, staff motivation strategies, crisis management, etc.

All the private actions mentioned in this study like exit, switch, negative word-of-mouth and silence are unfavourable to any organisation. As

such, proper complaint registration and subsequent service recovery can increase the frequency of public actions thereby reducing the incidence of private actions.

SCOPE FOR FUTURE RESEARCH

Consumer complaining behaviour studies form a segment of Consumer Behaviour, which is seriously under-researched. Considering the beneficial outcomes of consumer complaints, it is imperative to have an understanding of the different aspects of complaining. As such, basic and applied research is called for in this branch of consumer behaviour study. These studies are necessary from a social policy perspective also. Since consumer characteristics and perceptions are dynamic, possible variations in the nature of complaining behaviour can be studied in different contexts. More variables can be included in order to contextualise the study to particular groups or segment of buyers.

Future research may concentrate on implementation of similar research design and methodology on different populations or different designs on the same population. Another possibility for future research could be to include personality attributes like extroversion, dogmatism and self-presentational concerns, or personal variables or situational factors like severity of illness as causal factors and study their influence on inpatients' complaining propensities. The study can be extended to other states and countries to explore whether CCB differs across geographies, the results of which might contribute to the extant literature. As studies by researchers have recognised the complaining behaviour across cultures to be different, there also lies an opportunity to explore whether there is any difference in inpatient complaining behaviour across collectivistic and individualistic cultures.

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