**ORIGINAL ARTICLE**
DOI: 10.33897/fujd.v6i1.460

# Patient Voices in Healthcare Quality: A Structured Analysis of Complaints in a Secondary Care Hospital in Pakistan

Usman Zafar[1], Farrukh Ansar[2], Muhammad Bilal Ahmad[3], Ashir Iqbal[4], Moiz Naeem Butt[5], Muhammad Suleman[6]

Received: 19 Nov 2024 / Revised: 09 Dec 2025 / Accepted: 27 Jan 2026 / Published online: 31 Jan 2026

Copyright © 2024 The Author(s). Published by Foundation University Journal of Dentistry.

**ABSTRACT**

**Objective:** This study categorizes and examines complaints in a secondary care hospital in Pakistan to identify priority areas for quality improvement.

**Materials and Methods:** Patient complaints from 2018 to mid-2024 were reviewed and categorized using the Readers taxonomy, which organizes grievances into Clinical, Management, and Relationships domains. The data excluded 2020 and 2021 due to records unavailability.

**Results:** A total of 211 complaints were collected, with a complaint rate of 1.02 per 10,000 encounters. Complaints were categorized into Management (43.1%), Relationships (39.8%), and Clinical (17.1%) domains. Key issues included institutional delays, staff attitudes, and care quality. Among the 137 complaints with resolution data, 73.7% were resolved, primarily through patient information provision and staff training.

**Conclusion:** Structured analysis of patient complaints reveals key areas for targeted improvements. Recommendations include process streamlining, communication training, and enhanced safety protocols, with the aim to provide patient-centered care.

**Keywords:** Communication Barriers, Patient Satisfaction, Quality of Health Care, Patient Complaints

[1]Associate Professor, [2,4,5,6]Medical Officer, Department of Medicine, Alkhidmat Raazi Hospital, Rawalpindi, Pakistan.

[3]Medical Officer, Department of Surgery, Quaid e Azam International Hospital, Islamabad, Pakistan.

**Corresponding author:** Farrukh Ansar, Al Khidmat Raazi Hospital 24-B-1, Chandni Chowk, Satellite Town, Rawalpindi, Pakistan.

**Email:** farrukhanser@gmail.com

**DOI:**10.33897/fujd.v6i1.460

This work is licensed under the Creative Commons Attribution-NonCommercial 4.0 International License. To view a copy of this license, visit https://creativecommons.org/licenses/by-nc/4.0/

All copyrights © are reserved with The Author(s). FUJD is an open-access peer-reviewed journal; which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if changes were made. FUJD does not allow the commercial use of any published article. All articles published represent the view of the authors and do not reflect the official policy of FUJD.

**How to cite this Article:**

Zafar U, Ansar F, Ahmad MB, Iqbal A, Butt MN, Suleman M. Patient Voices in Healthcare Quality: A Structured Analysis of Complaints in a Secondary Care Hospital in Pakistan. Found Univ J Dent. 2026;6(1):25-34

DOI: 10.33897/fujd.v6i1.460

## INTRODUCTION

Patient complaints have become an important component in assessing and improving the quality of healthcare services.[1] The feedback received from patients and their families highlights systemic gaps that impact both safety and care quality. Patient complaints provide unique insights directly from healthcare users, emphasizing the importance of patient-centered care.[2] Patient complaints contribute to a growing body of data that helps healthcare institutions identify patterns of dissatisfaction, resulting in targeted improvements.[2,3]

The importance of effectively handling patient complaints has been suggested by multiple researches. This demonstrated that ignoring or inadequately addressing patient concerns can lead to widespread public trust issues and quality failures.[4] In Pakistan, the healthcare infrastructure is complex, with public and private sectors coexisting yet differing significantly in quality, accessibility, and resource availability.[5] In Pakistan, the healthcare system faces unique challenges, including resource constraints, high patient-to-staff ratios, and varying levels of accessibility across regions.[6] These factors make patient feedback valuable, as it reflects both the structural and relational challenges faced by healthcare providers.

In recent years, the structured analysis of patient complaints has gained prominence. The standardized frameworks such as the Reader et al. taxonomy being developed to categorize complaints consistently. This taxonomy categorizes complaints into three primary domains; Clinical, Management, and Relationships. Each encompassing several categories and sub-categories that offer a comprehensive approach to analyzing patient feedback.[7] Research has shown that this taxonomy facilitates the identification of patterns in patient complaints, which can guide hospitals in developing targeted improvements.[8] Previous studies on patient complaints have demonstrated that these feedback mechanisms can reveal underlying issues that might otherwise go unnoticed in standard hospital audits.[9]

However, despite the growing international literature on structured complaint analysis, research from Pakistan remains limited. Existing local studies have largely focused on general descriptions of complaints, without applying standardized taxonomies such as the Reader et al. framework[7]. There is also a lack of detailed analyses that categorize complaints across domains and subcategories to identify targeted areas for improvement. The present study addresses these gaps by applying a validated taxonomy to systematically analyze patient complaints at a secondary-care facility, thereby providing structured evidence to guide quality-improvement efforts.

The current study aims to contribute to the limited body of research on structured complaint analysis in Pakistan by examining patient complaints at a secondary care facility in Rawalpindi, Pakistan. By analyzing the frequency and distribution of complaints across different domains and sub-categories, this study will help identify specific areas where improvements can be made to enhance patient satisfaction and safety at the hospital.

## MATERIALS AND METHODS

This retrospective study analyzed patient complaints collected from Al-Khidmat Raazi Hospital, a secondary care facility in Rawalpindi, Pakistan. Data were drawn from the years 2018, 2019, 2022, 2023, and the first half of 2024. Due to data loss and incomplete records, complaints from 2020 and 2021 were unavailable, resulting in a two-year gap in the dataset. This study received exempt status from the institutional review board of AKRH (Approval ID # ERB/01/24). The study duration was two months (September to October, 2024).

This retrospective descriptive study included all formally registered complaints, encompassing grievances submitted through various channels. These complaints were submitted either through the suggestion and complaint box, filed directly with the Administration office, verbally lodged by patients or their families and subsequently transcribed, or received through social media platforms.

Inclusion criteria comprised all patient complaints that were formally documented in the hospital records, including written complaints submitted through the suggestion/complaint box, complaints filed directly with the Administration Office, and verbal complaints that were transcribed by staff and entered into the official complaint register. Complaints received through social media were included only if the administrative team formally logged them. Exclusion criteria included incomplete, illegible, or undocumented verbal grievances that were not entered

DOI: 10.33897/fujd.v6i1.460

into the official register. To avoid duplication, complaint registers were reviewed for repeated entries related to the same incident; in such cases, only the earliest or the most complete version of the complaint was retained for analysis.

For data collection, complaint registers were retrieved and reviewed in detail. Three co-authors independently examined each complaint, classifying them into 26 subcategories as per the Reader et al. taxonomy. These subcategories were organized within 7 thematic categories, which were further consolidated into three primary conceptual domains: Clinical, Management, and Relationships. In cases where classification disagreements arose, the principal author acted as a consultant to reach a consensus. A final review by the principal author ensured consistency in classification across all complaints. Inter-rater reliability for the independent classifications was excellent, with a Cohen's kappa value of 0.94.

The Reader et al. taxonomy categorizes patient complaints into three primary domains: Clinical, Management, and Relationships. Each domain includes specific categories and sub-categories. In the Clinical domain, complaints are categorized under Quality and Safety, with sub-categories like Patient Journey, Treatment, Error in Diagnosis, Medication Error, Safety Incidents, and Skills and Conduct. The Management domain includes Institutional Issues and Timing and Access, with sub-categories such as Environment, Finance and Billing, Service Issues, Staffing and Resources, Access and Admission, Delays, Discharge, and Referrals. In the Relationships domain, the categories are Communication, Humaneness, and Patient Rights, with sub-categories including Communication Breakdown, Incorrect Information, Patient-Staff Dialogue, Respect, Dignity and Caring, Staff Attitudes, Abuse, Confidentiality, Consent, and Discrimination.

The rate of patient complaints was calculated per 10,000 patient encounters, with rates standardized irrespective of the number of clinician contacts or the duration of hospitalization. Descriptive statistics, including frequencies, proportions, averages, and standard deviations, were applied to describe patient demographics and complaint characteristics. Descriptive statistics were used because the aim of the study was to summarize the distribution and characteristics of patient complaints rather than to evaluate associations or test hypotheses. The complaint data consisted of categorical classifications without continuous predictors, making descriptive analysis the most appropriate and methodologically consistent approach for this dataset. Data management and statistical analysis were carried out using IBM SPSS Statistics, Version 24 (IBM Corp., Armonk, NY, USA).

## RESULTS

A total of 211 complaints were collected over a period of four and a half years, spanning 2018, 2019, 2022, 2023, and the first half of 2024. Over the period from 2018 to mid-2024, (excluding 2020-21) AKRH recorded a total of 2,062,533 patient encounters and 211 complaints. This results in an overall complaint rate of approximately 1.02 complaints per 10,000 encounters. The patient encounter data from 2018 to mid-2024 shows a notable trend in the rate of complaints over time. In 2018, with 225,457 patient encounters, there were 73 complaints, resulting in a complaint rate of 3.24 per 10,000 encounters. By 2019, patient encounters increased to 284,806, while complaints slightly decreased to 71, leading to a reduced complaint rate of 2.49 per 10,000 encounters. This trend of improvement continued into 2022, with a rise in encounters to 530,378 and a significant drop in complaints to 19, yielding a complaint rate of 0.36 per 10,000 encounters. In 2023, hospital recorded 670,202 patient encounters and 33 complaints, with a complaint rate of 0.49 per 10,000 encounters compared to 2022. The data available for 2024, up to June, reflects 351,690 encounters and 15 complaints, with a complaint rate of 0.43 per 10,000 encounters. Overall, the results show a steady decline in the complaint rate from 2018 to 2022, suggesting an improvement in service quality or complaint resolution processes.

The complaints were categorized into three main domains: Clinical, Management, and Relationships, with each domain encompassing specific sub-categories. Of the total complaints, 155 were classified as personal (73.5%) and 56 as general (26.5%). Personal complaints refer to grievances related to an individual patient's own care experience, whereas general complaints describe broader concerns about hospital processes or services that were not specific to a single patient encounter. Table 1 illustrates the distribution of complaints within the main domains of Clinical, Management, and Relationships, along with the sub-categories for each domain.

DOI: 10.33897/fujd.v6i1.460

**Table 1: Distribution of Complaint Domains and Sub-Categories**

| Domains | Categories | Sub-Categories | | | |
|---|---|---|---|---|---|
| **Clinical** | 36 (17.1%) | **Quality** | 23 (10.9%) | Examinations | 0 |
| | | | | Patient Journey | 19 (9%) |
| | | | | Quality of Care | 3 (1.4%) |
| | | | | Treatment | 1 (0.5%) |
| | | **Safety** | 13 (6.2%) | Error in Diagnosis | 1 (0.5%) |
| | | | | Medication Error | 2 (0.9%) |
| | | | | Safety Incidents | 2 (0.9%) |
| | | | | Skills and Conduct | 1(0.5%) |
| **Management** | 91 (43.1%) | **Institutional Issues** | 63 (29.9%) | Bureaucracy | 0 |
| | | | | Environment | 1 (0.9%) |
| | | | | Finance and Billing | 2 (0.9%) |
| | | | | Service Issues | 52 (24.6%) |
| | | | | Staffing and Resources | 8 (3.8%) |
| | | **Timing and Access** | 28 (13.3%) | Access and Admission | 12 (5.7%) |
| | | | | Delays | 14 (6.6%) |
| | | | | Discharge | 1 (0.5%) |
| | | | | Referrals | 1 (0.5%) |
| **Relationships** | 84 (39.8%) | **Communication** | 9 (4.3%) | Communication Breakdown | 6 (2.8%) |
| | | | | Incorrect Information | 2 (0.9%) |
| | | | | Patient-Staff Dialogue | 1 (0.5%) |
| | | **Humaneness** | 73 (34.6%) | Respect, Dignity and Caring | 8 (3.8%) |
| | | | | Staff Attitudes | 65 (30.8%) |
| | | **Patient Rights** | 2 (0.9%) | Abuse | 1 (0.5%) |
| | | | | Confidentiality | 0 |
| | | | | Consent | 0 |
| | | | | Discrimination | 1 (0.5%) |

**Examinations:** Inadequate Examination by Clinical Staff

**Patient Journey:** Problems in the coordination of treatment in different services by clinical staff

**Quality of Care:** Standard Clinical/Nursing Care

**Treatment:** Poor, or unsuccessful treatment

**Error in Diagnosis:** Erroneous, missed, or slow medical diagnosis

**Medication Error:** Errors in prescribing or administering medication

**Safety Incidents:** Events or complications that threatened the safety of patients.

**Skills and Conduct:** Deficiencies in the technical and non-technical skills of staff that compromise safety.

**Bureaucracy:** Problems with administrative policies and procedure.

**Environment:** Poor accommodation, hygiene, or food.

**Finance and Billing:** Healthcare associated costs or billing.

**Service Issues:** Problems with hospital services for supporting patients.

**Staffing and Resources:** Inadequate staffing and resource levels.

**Access and admission:** Lack of access to services or staff.

DOI: 10.33897/fujd.v6i1.460

| |
|---|
| **Delays:** Delays in admission or access to patient. |
| **Discharge:** Early, late, or unplanned discharge from the hospital. |
| **Referrals:** Problems in being referred to a healthcare service. |
| **Communication breakdown:** Inadequate, delayed, or absent communication with patients. |
| **Incorrect Information:** Communication of wrong, inadequate, or conflicting information to patients. |
| **Patient-staff dialogue:** Not listening to patient, lack of shared decision-making, and conflict. |
| **Respect, Dignity and Caring:** Rude, disrespectful, or insensitive behavior to patients. |
| **Staff attitudes:** Poor attitude towards patients or their families. |
| **Abuse:** Physical, sexual, or emotional abuse of patients. |
| **Consent:** Coercing or failing to obtain patient consent. |
| **Discrimination:** Discrimination against patients. |

## Complaint Categories and Domains

### Clinical Complaints

There were 36 (17.1%) clinical-related complaints reported and included sub-categories related to quality, patient journey, treatment, and safety issues. Complaints regarding quality were 23 cases (10.9%), highlighted dissatisfaction with care standards. Coordination issues in patient journeys accounted for 19 complaints (9%). Safety incidents, including diagnostic and medication errors, were reported in 13 cases (6.2%), with sub-issues addressing diagnostic errors (1, 0.5%), medication errors (2, 0.9%), safety incidents (2, 0.9%), and skills and conduct (1, 0.5%).

### Management-Related Complaints

In the Management domain, which accounts for 91 complaints (43.1%), the majority fall under Institutional Issues (63 complaints, 29.9%). Within this category, Service Issues are notably frequent with 52 complaints (24.6%), followed by Staffing and Resources with 8 complaints (3.8%), Finance and Billing with 2 complaints (0.9%), and Environment with 1 complaint (0.9%). The Timing and Access category, comprising 28 complaints (13.3%), includes Delays with 14 complaints (6.6%), Access and Admission with 12 complaints (5.7%), and Discharge and Referrals, each with 1 complaint (0.5%).

### Relationship-Based Complaints

In the Relationships domain, which includes 84 complaints (39.8%), Communication issues account for 9 complaints (4.3%), with Communication Breakdown being the most common (6 complaints, 2.8%), followed by Incorrect Information (2 complaints, 0.9%) and Patient-Staff Dialogue (1 complaint, 0.5%). The Humaneness category comprises 73 complaints (34.6%), including Respect, Dignity, and Caring (8 complaints, 3.8%) and Staff Attitudes (65 complaints, 30.8%). Lastly, Patient Rights includes 2 complaints (0.9%), with Abuse and Discrimination each accounting for 1 complaint (0.5%), while Confidentiality and Consent received no complaints.

### Complaint Status and Action Taken

The resolution status data was available for 137 complaints, as no recorded information on complaint resolution and actions taken was available for complaints registered in 2018. Of the 137 complaints tracked for resolution status, 101 (73.7%) were resolved, 33 (24.0%) were partially resolved, and 3 (2.1%) remained unresolved. Actions taken in response included providing information to patients in 67 cases (48.9%), implementing education, training, or counseling programs in 46 cases (33.5%), and developing or revising guidelines in 7 cases (5.10%). Reviewing guidelines and protocols was conducted for 11 complaints (8.0%), while defining roles and responsibilities was implemented in response to 6 complaints (4.3%). Table 2 provides details on the resolution status of complaints, as well as actions taken to address each complaint, including patient information provision, training programs, and guideline development.

**Table 2: Complaint distribution and Resolution Status and Actions Taken**

| **Type of Complaint (N = 211)** | |
|---|---|
| General | 56 (26.5%) |
| Personal | 155 (73.5) |
| **Year of Complaint (N = 211)** | |
| 2018 | 73 (34.6%) |
| 2019 | 71 (33.6%) |
| 2022 | 19 (9%) |

DOI: 10.33897/fujd.v6i1.460

| | |
|---|---|
| 2023 | 33 (15.6%) |
| 2024 | 15 (7.1%) |
| **Complaint Status (N = 137)** | |
| Resolved | 101 (73.7%) |
| Partially Resolved | 33 (24.0%) |
| Unresolved | 3 (2.1%) |
| **Type of Action Taken (N = 137)** | |
| Develop or Implement Guideline | 7 (5.10%) |
| Education, Training or Counseling | 46 (33.5%) |
| Review Guidelines/Protocols | 11 (8.0%) |
| Define Role and Responsibility | 6 (4.3%) |
| Provide Information to patient | 67 (48.9%) |

## DISCUSSION

The analysis of patient complaints offers a valuable perspective on the quality and safety of healthcare services. This reveal underlying systemic issues often ignored in traditional quality assessments. In this study, patient complaints were categorized into Clinical, Management, and Relationship domains using the Reader et al. taxonomy. This enabled a structured approach to understanding patient dissatisfaction in a secondary care hospital in Pakistan. The insights from this study align with global research, underscoring the universal relevance of patient complaints in identifying healthcare delivery gaps and shaping quality improvement initiatives.[2]

The most prominent category of complaints in this study was the Management domain, comprising 43.1% of all reported issues. This dominance shows findings in other healthcare systems, where issues related to institutional policies, resource allocation, and delays in service are recurrent themes in patient dissatisfaction.[10] Management complaints here largely stemmed from delays in access to services, discharge procedures, and referrals, indicating that administrative inefficiencies and resource limitations are main problems. Similar studies have noted that such delays are often linked to systemic factors beyond immediate clinical control, such as understaffing, inadequate training, and bureaucratic hurdles, all of which reduce operational efficiency and exacerbate patient frustration.[2,9] The prevalence of these complaints suggests an urgent need for streamlined administrative processes within Pakistani healthcare settings. Implementing lean management strategies, such as the A3 problem-solving method, as seen in other international settings, could prove beneficial in alleviating some of these systemic delays by promoting efficiency and eliminating non-value-added processes.[11] Addressing these management issues could improve patient-centered approach and enhance patient satisfaction and trust.[12] The predominance of Management-related complaints in our study reflects deeper structural and administrative constraints that persist in Pakistan's health-care system. Recent analyses indicate that public and private hospitals alike operate under significant resource limitations; including shortages of qualified medical and support staff, inadequate infrastructure, and insufficient funding, which undermine capacity to deliver timely and efficient care.[13,14] Under such conditions, even routine processes such as admissions, referrals, and discharge often become protracted or chaotic, creating frustration and triggering complaints. The high volume of delays, referral issues, and service-access problems observed in our dataset likely mirrors these systemic pressures rather than isolated institutional failings. Consequently, addressing these complaints meaningfully requires health-system reforms at multiple levels: improved staffing and resource allocation, better hospital management practices, and targeted administrative strengthening.

The Relationship domain accounted for 39.8% of the complaints, focusing on issues of communication and humaneness, such as respect, dignity, and empathy in patient-staff interactions. Research shows that interpersonal dynamics are vital for patient satisfaction, when these lack, patients are likely to perceive overall care as deficient, regardless of clinical outcomes.[15]In this study, respect and communication breakdowns were recurrent themes, highlighting a gap in empathic engagement between healthcare providers and patients. These findings are in accordance with studies conducted in Australia and Turkey, where patient complaints frequently cited inadequate communication and unprofessional behavior as grievances.[2,16] Communication issues in healthcare are not about information delivery only. They reflect a fundamental aspect of care where patients expect to be valued, respected, and heard.[17] A failure in these areas can lead to misunderstandings, eroding trust, and satisfaction. Patients who feel disrespected or dismissed may develop a negative perception of the entire healthcare experience, which can lead to recurring complaints.[18] Local evidence supports the significance of these concerns in Pakistan, a nurse-patient communication study in tertiary hospitals in Peshawar identified heavy workloads, inadequate

DOI: 10.33897/fujd.v6i1.460

communication skills, and staffing pressures as common barriers to effective interpersonal interactions.[19] Similarly, a survey of outpatients in Karachi revealed substantial dissatisfaction tied to staff attitudes and communication lapses, rather than purely clinical shortcomings.[20] Even in settings reporting overall high satisfaction, patients noted variability in domains related to communication, interpersonal manner, and time spent with clinicians, underscoring how communication remains a pivotal factor in perceived quality of care.[21] Therefore, a recommendation for healthcare institutions is to incorporate mandatory communication training for staff, focusing on empathy, active listening, and patient engagement strategies. Such initiatives have been shown to significantly improve patient satisfaction by addressing the relational aspect of care, which is an essential but often overlooked component of quality healthcare delivery.[22]

The Clinical domain represented a smaller portion of the complaints at 17.1%, yet these complaints reflect critical areas concerning patient safety and care quality. Common issues included diagnostic errors, medication mistakes, and treatment coordination problems, all of which are consistent with the safety and quality concerns identified in other studies.[2,7] Clinical complaints are very important, as they directly impact patient health and outcomes, marking these areas as high-priority targets for intervention.[23] The existence of such complaints highlights the importance of continuous medical training and the implementation of latest clinical protocols.[24] In resource limited settings like Pakistan, where patient-to-staff ratios are high, addressing clinical complaints requires a systemic response to staffing and equipment shortages.

The complaint resolution data shows a notable performance in addressing patient grievances effectively. Of the 137 complaints tracked, nearly three fourth were fully resolved, while the rest remained partially resolved or unresolved. However, it is suggested to have a more structured, transparent, and responsive complaint-handling process. Other studies highlight that transparent complaint resolution is vital for maintaining public trust in healthcare institutions; unresolved complaints can lead to recurring complaints and shatters the patient confidence in the healthcare system.[25] Improving the resolution process can involve developing standardized guidelines for handling complaints, ensuring timely follow-up, and communicating resolution outcomes clearly to patients.[26]

The application of the Reader et al. taxonomy in categorizing patient complaints allows for a detailed analysis that can be compared across healthcare settings internationally. By employing this structure, healthcare institutions can identify high-impact areas for improvement, such as safety protocols, communication training, and efficient administrative processes, which are critical for enhancing patient satisfaction and care quality in a sustainable manner. The findings from this study highlight several key areas for policy and practice enhancements. Firstly, the prominence of Management-related complaints calls for a comprehensive review of hospital processes, especially related to admissions, discharge, and resource allocation. Applying lean management principles could streamline these processes and optimize resource utilization. Secondly, the focus on Relationship complaints emphasizes the need for healthcare providers to prioritize interpersonal skills and empathy. Integrating communication training into regular staff development programs could decrease these issues. Finally, addressing Clinical complaints requires targeted interventions to enhance safety protocols and improve clinical accuracy. Developing guidelines and safety checks for diagnostic and treatment procedures can minimize errors and enhance patient outcomes.

In addition to these practical implications, this study also points toward several areas for future research. Further work is needed to explore patient complaints across multiple healthcare facilities and provinces in Pakistan to improve generalizability. Comparative studies examining complaint patterns between public and private hospitals, or between inpatient and outpatient settings, may help clarify differences in dissatisfaction drivers. Qualitative research investigating patient perspectives in greater depth could also provide richer insights into the underlying causes of complaints, particularly in relation to communication and humaneness. Lastly, future studies could evaluate the impact of interventions, such as communication training or administrative reforms on subsequent complaint trends to assess their effectiveness over time.

Several limitations of this study must be acknowledged. Missing data for the years 2020 and 2021 restricts longitudinal trend analysis and may influence the interpretation of changes in complaint patterns over time. The study relied solely on complaints submitted through formal channels at a single hospital, which may

DOI: 10.33897/fujd.v6i1.460

not fully capture the extent of patient dissatisfaction; cultural barriers, literacy issues, or fear of repercussions may prevent some individuals from filing complaints. Additionally, while the Reader et al. taxonomy provides a structured framework for categorizing complaints, certain subcategories may not fully align with the operational realities of resource-limited Pakistani healthcare settings, potentially affecting classification precision. Incomplete documentation of complaint-resolution data, particularly for earlier years, also limits the ability to assess the hospital's responsiveness and evaluate the effectiveness of corrective actions over time. Furthermore, complaint rates were calculated using total patient encounters as the denominator, without distinguishing between inpatient and outpatient visits. Because these two groups differ significantly in acuity, service use, and opportunities for complaint generation, this approach may affect comparability of complaint rates and should be interpreted with caution.

## CONCLUSION

This study demonstrates the value of patient complaints in identifying priority areas for improvement within a secondary-care hospital in Pakistan. Three action-oriented implications emerge from the findings. First, the high proportion of management-related complaints highlights the need to streamline administrative processes, particularly admissions, discharge pathways, and service access. Second, the frequency of relationship-based complaints underscores the importance of strengthening communication and interpersonal skills through targeted staff training in empathy, respect, and patient engagement. Third, clinical complaints, though fewer, point to the need for reinforcing safety protocols and enhancing clinical accuracy through updated guidelines and continuous professional development. Together, these measures can support a more responsive, patient-centred, and safer healthcare environment.

## DISCLAIMER

None to declare.

## CONFLICT OF INTEREST

There is no conflict of interest among the authors.

## ETHICAL STATEMENT

Ethical approval was taken from the institutional review board of AlKhidmat Razi Hospital (Approval ID # ERB/01/24).

## FUNDING DISCLOSURE

The author(s) received no financial support for the research, authorship, and/or publication of this article.

## AUTHORS CONTRIBUTION

Conception and design of the study: U. Zafar
Acquisition of data: F. Ansar, M.B Ahmad, M. N. Butt, M. Suleman
Analysis and interpretation of data: F. Ansar, A. Iqbal
Drafting of the manuscript: F. Ansar, A. Iqbal, M. N. Butt
Critical review of the manuscript: U. Zafar, F. Ansar, M. B. Ahmad, M. Suleman
Approval of the final version of the manuscript to be published: U. Zafar, F. Ansar, M. B. Ahmad, M. Suleman, A. Iqbal, M. N. Butt

## REFERENCES:

1. Weingart SN, Pagovich O, Sands DZ, Li JM, Aronson MD, Davis RB, et al. Patient-reported service quality on a medicine unit. Int J Qual Health Care. 2006;18(2):95-101. doi:10.1093/intqhc/mzi087.

2. Harrison R, Walton M, Healy J, Smith-Merry J, Hobbs C. Patient complaints about hospital services: applying a complaint taxonomy to analyse and respond to complaints. Int J Qual Health Care. 2016;28(2):240-5. doi:10.1093/intqhc/mzw003.

3. Bouwman R, Bomhoff M, Robben P, Friele R. Patients' perspectives on the role of their complaints in the regulatory process. Health Expect. 2016;19(2):483-96. doi:10.1111/hex.12373.

4. Mirzoev T, Kane S. Key strategies to improve systems for managing patient complaints within health facilities: what can we learn from the existing literature? Glob Health Action. 2018;11(1):1458938. doi:10.1080/16549716.2018.1458938.

5. Khan SJ, Asif M, Aslam S, Khan WJ, Hamza SA. Pakistan's healthcare system: a review of major challenges and the first comprehensive universal health coverage initiative. Cureus. 2023;15(9): e44641. doi:10.7759/cureus.44641.

6. Muhammad Q, Eiman H, Fazal F, Ibrahim M, Gondal MF. Healthcare in Pakistan: navigating challenges and building a brighter future. Cureus. 2023;15(6): e40218. doi:10.7759/cureus.40218.

7. Reader TW, Gillespie A, Roberts J. Patient complaints in healthcare systems: a systematic review and coding taxonomy. BMJ Qual Saf. 2014;23(8):678-89. doi:10.1136/bmjqs-2013-002437.

8. Yaman Z, Kavuncu B. Investigation of online complaints notified to private hospitals through content analysis. Sivas Cumhuriyet Univ J Econ Adm Sci. 2020;21(2):282-97. doi:10.37880/cumuiibf.743201.

9. Montini T, Noble AA, Stelfox HT. Content analysis of patient complaints. Int J Qual Health Care. 2008;20(6):412-20. doi:10.1093/intqhc/mzn041.

10. Gifford R, van de Baan F, Westra D, Ruwaard D, Fleuren B. Through the looking glass: confronting health care management's biggest challenges in the wake of a crisis. Health Care Manage Rev. 2023;48(2):185-96. doi:10.1097/HMR.0000000000000365.

11. Harolds JA. Quality and safety in healthcare, part XC: the A3 approach and lean in healthcare. Clin Nucl Med. 2023;48(7): e358-60. doi:10.1097/RLU.0000000000003851.

12. Tur-Sinai A, Barnea R, Tal O. Analyzing patient trust through the lens of hospital managers: the other side of the coin. PLoS One. 2021;16(4): e0250626. doi: 10.1371/journal.pone.0250626.

13. Baig A, Rahat T. Addressing the challenges faced by Pakistan's healthcare system. Pak J Med Res. 2024;63(3):115-116.

14. Ahmad U, Khan FU, Kanwal H. Efficiency and productivity of public hospitals in Pakistan. Ann Hum Soc Sci. 2024;5(2):541-54. doi:10.35484/ahss.2024(5-II)50.

15. Saultz JW, Albedaiwi W. Interpersonal continuity of care and patient satisfaction: a critical review. Ann Fam Med. 2004;2(5):445-51. doi:10.1370/afm.91.

16. Esen Koç H. Analysis of patient complaints in a public hospital. Genel Sağlık Bilimleri Derg. 2024;6(2):279-94. doi:10.51123/jgehes.2024.129.

17. Simon M, Danner S, Saavedra S, Flowers F, Jackson A, Ross J, et al. The complex interplay of communication and trust in healthcare delivery. Harv Public Health Rev (Camb). 2021; 39:10.54111/0001/mm5. doi:10.54111/0001/mm5.

18. Grissinger M. Disrespectful behavior in health care: its impact, why it arises and persists, and how to address it—part 2. P T. 2017;42(2):74-7.

19. Iqbal M, Shah SA, Naz A, Naz S, Gul Z, Ali A, et al. Identify the communication barrier among nurse–patient in tertiary care hospitals in Peshawar. J Media Horiz. 2025;6(5):51-75.

20. Khan NA, Aslam SK, Rehman AU, Qureshi MS, Inam S, Samo KA, Shallwani A. Satisfaction level and its predictors among outpatients at a public sector hospital in Karachi. J Dow Univ Health Sci. 2014;8(3):104-110.

21. Khurshid F, Khurshid A, Haq AU, Awan KH, Qureshi S, Tariq S. The evaluation of patient satisfaction and perceived quality of care in OPD settings in Mirpur AJK: a cross-sectional study. Found Univ Med J. 2024;6(Suppl):28-36. doi: 10.33897/fumj.v6iSuppl.165.

22. Kwame A, Petrucka PM. A literature-based study of patient-centered care and communication in nurse-patient interactions: barriers, facilitators, and the way forward. BMC Nurs. 2021;20(1):158. doi:10.1186/s12912-021-00684-2.

23. Sameera V, Bindra A, Rath GP. Human errors and their prevention in healthcare. J Anaesthesiol Clin Pharmacol. 2021;37(3):328-35. doi:10.4103/joacp.JOACP_364_19.

DOI: 10.33897/fujd.v6i1.460

24. Ciapponi A, Fernandez Nievas SE, Seijo M, Rodríguez MB, Vietto V, García-Perdomo HA, et al. Reducing medication errors for adults in hospital settings. Cochrane Database Syst Rev. 2021;11(11):CD009985. doi:10.1002/14651858.CD009985.pub2.

25. van Dael J, Reader TW, Gillespie A, Neves AL, Darzi A, Mayer EK. Learning from complaints in healthcare: a realist review of academic literature, policy evidence and front-line insights. BMJ Qual Saf. 2020;29(8):684-95. doi:10.1136/bmjqs-2019-009704.

26. Fukami T. Enhancing healthcare accountability for administrators: fostering transparency for patient safety and quality enhancement. Cureus. 2024;16(8):e66007. doi:10.7759/cureus.66007.