Perceived Disempowerment as a Deterrent of Inpatient Complaining

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Abstract

Purpose : This paper attempted to understand the felt disempowerment that discourage consumers to voice their complaints in spite of their dissatisfaction with hospital services.

Design/Methodology/Approach : Data collected from 312 dissatisfied inpatients who were admitted and discharged from various 100+ bedded private and cooperative hospitals across Kerala revealed that a majority dissuaded from overt complaining behaviours despite dissatisfaction. Instead, they resorted to covert complaining behaviours like engaging in negative word of mouth with friends, relatives, or other inpatients ; switching behaviour ; exit ; or just keeping silent.

Findings : Factor analysis revealed that 'powerlessness' and 'subservient' attitude perceived by inpatients in hospitals deterred them from overt complaining behaviours like voicing, seeking third party redressal, or legal action. Bivariate analysis found out that while a significant difference could be established between dissatisfied inpatients holding different levels of occupation, admitted to hospitals belonging to various zones and with different levels of medical awareness, no true difference was observed between respondents possessing different socioeconomic and demographic status, nature of action resorted, admitted in different types of hospitals, and various durations of hospital stay with respect to their levels of perceived disempowerment.

Research Limitations/ Implications : The fact that patients are disempowered gives an upper hand to the provider, principally in a credence service like health care. As the respondents who participated in the survey opted to either switch provider or engage in negative word-of-mouth with friends and relatives than overtly complaining, their actions can be viewed as unfavorable from the health care providers' perspective.

Practical Implications : Only if the hospitals know that they have caused some sort of discomfort or dissatisfaction to their customers will they get an opportunity to rectify their mistakes.

Originality/Value : This study brought to light very important information that hospitals in Kerala need to be cautious about.

Keywords : **dissatisfaction, inpatient, disempowerment, powerlessness, subservience**

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Consumer deliberation and communication to producers are positive signals to the industry as it can lead to better and mutually beneficial relationship between the two. Given the fact that consumer complaints are not positively valued by its receivers in the chain of distribution, the possible structural aspects of such negative valuations that diminish the incentives to complain need special attention. Customer complaint, per se, is a boon to any industry as it helps them realize their mistakes. Complaints have the capability to provide an early

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warning to the organizations that help them thwart service failures and thus nip problems in the bud. On the contrary, industries need not be complacent when there are no complaints. Absence of complaints does not mean that things are fine and customers are happy. Instead of complaining, they indulge in other behaviours like silently taking the business somewhere (switching), exiting, telling everyone in their circle or other prospective customers about the poor service received, thus damaging the reputation (engaging in negative word of mouth), or just keeping silent. Practically, industries should be keeping a watch on these groups who do not overtly complain, but involve in covert behaviours. In the normal course, this group is overlooked by the industry, which unfortunately, is the majority.

Perceived service quality as a dimension to measure the service performance was studied by Kaur and Singh (2017) in the DTH (direct to home) TV industry. It was found that reliability was the most significant dimension to have an impact on consumer satisfaction among all other SERVQUAL dimensions. Patient satisfaction and its relationship with service quality of hospitals have been widely studied. Krishnamoorthy, Karthikeyan, and Prakash (2016), in their attempt to measure the influence of various hospital service quality aspects on patient satisfaction, found that admission procedure, reliability, infrastructure, clinical care, and trust had utmost impact on male patients ; whereas, the last two items impacted the female patients more.

Studies have documented the factors that persuade or dissuade complaining behaviour. Khadir and Swamynathan (2014) studied the deterrents of complaining and found patient credulousness as one of the very prominent reasons of their non-complaining behaviour. Khadir, Swamynathan, and Ali (2016) investigated the antecedents of inpatient complaining behaviour and identified four factors using factor analysis, namely, hospitality & cordiality, patient care & concern, amenities, and technical competence.

Service recovery was found to be a term associated with at least one service deviation and subsequent customer complaint. Khadir (2012) analyzed 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 analyze the presence of a power asymmetry in which buyer is a powerless party and 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.

Perceived disempowerment as a deterrent to react against the flaws in the marketplace has been studied by many researchers. Hamilton (2009) defined it as a social deprivation leading to feelings of consumer disempowerment and exclusion. The health care of vulnerable population was studied by McAuliff, Viola, Keys, Back, Williams, and Steltenpohl (2014) in which the low-income and low-power respondents expressed a 'felt disempowerment' with regard to their health care. Patel and Dowse (2015) in their work on patients' medicine information-seeking behavior attributed the disempowerment and passivity to their limited literacy. Consumer disempowerment in the banking sector was reported to be more visible than it was in other areas ("Central bank fine almost meaningless in era of consumer disempowerment," 2014).

According to the Merriam-Webster's Learner's dictionary, the word 'disempower' means to cause a person or a group of people to be less likely than others to succeed or to prevent them from having power, authority, or influence.

Not knowing where and whom to complain, rude and accusatory behavior of service providers, previous negative experiences, and anticipation of irresponsive behavior of the provider were found to be related to low complaining propensity by Durukani, Gokdeniz, and Bozaci (2012). They noted perceived dissatisfaction, expectations from complaint process, attributions toward problem, customer loyalty, and nature of the industry and product as the situational factors that affected customer propensity to complain to the firm. According to Whiteley (1995), some customers wished to exit rather than complain if they thought that service recovery to written complaints was not redressed on time.

According to the United Kingdom Customer Satisfaction Index (UKCSI) data, the reasons cited by non-complainers were 'did not think complaining would make any difference,' 'did not have time,' 'did not know who to complain to,' 'the complaint process is too much hassle,' 'do not like complaining,' and 'did not know how to complain.'

Toister (2013) observed that some of the reasons are difficulty in complaining, lack of confidence, fear of outcome post complaining, say, negative effect on an otherwise good relationship, fear of vengeance and rude treatment, and a general 'nothing to gain' feeling. Estepon (2013) observed the reasons as lack of confidence in finding a solution, no interest in complaining hassles, fear of voicing, and previous experience of poor service recovery.

Khadir and Swamynathan (2016), while studying the deterrents of complaining among the non-complaining inpatients, found that the most frequently quoted reason for non-complaining was the inpatients' apprehension of not receiving any positive outcome after complaining. Some of the non-complainers had decided not to come back to the hospital and wished to visit another hospital for future requirements rather than complaining. At the same time, as 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.

Complaining, according to the non-complainers, in the retail banking sector surveyed on technology-based service encounters by Snellman and Vihtkari (2003) was an ineffective and time-consuming task. Some even blamed the hopeless situation of service failure in which complaining would never have helped. Some could understand why the incidents had occurred and would not complain unless anything serious happened. The other reasons quoted were lack of awareness about where and how to complain, embarrassment to complain, finding of an alternative solution during the encounter, self-blame and technology failure, and not the provider's fault. Andreasen (1988) suggested the reasons that deterred dissatisfied consumers from complaining as cost/benefit analysis (small benefits vs. large costs), discouragement by others and intervening factors (e.g. leaving town, family crisis etc.) that caused a delay or the prevention of action. Some of the negative attitudes that prevented people from complaining are complaint-related personality variables like propensity to complain, low expectations, fear of confrontation, and intimidation.

The present study was conducted to explore the extent of disempowerment, given the fact that the pilot study revealed a majority of dissatisfied inpatients who were non-complainers than complainers.

Objectives of the Study

(1) To explore the perceived disempowerment of inpatients and find the various disempowerment factors.

(2) To analyze the relation of inpatient disempowerment with their socioeconomic and demographic variables.

(3) To study the relation that patient disempowerment has with patient action post dissatisfaction.

(4) To find whether there is any association between disempowerment and zone of the hospital in which the respondents were admitted belonged to, say North, Central, and South Kerala.

(5) To find whether there is any association between disempowerment and patient's medical awareness.

(6) To examine the relation between inpatient disempowerment and nature of hospital in which they are admitted, say, private and cooperative.

Hypotheses

↳ **H_1:** There is a significant difference between respondents possessing various levels of medical awareness with respect to their perceived disempowerment.

↳ **H_2:** There is a significant difference between respondents admitted in hospitals belonging to Northern, Central, and Southern Kerala with respect to their levels of perceived disempowerment.

↳ **H_3 :** There is a significant difference between male and female respondents with respect to their levels of perceived disempowerment.

↳ **H_4:** There is a significant difference between respondents of various age groups with respect to their levels of perceived disempowerment.

↳ **H_5:** There is a significant difference between respondents holding different levels of educational qualifications with respect to the levels of perceived disempowerment.

↳ **H_6:** There is a significant difference among the diverse occupation holders with respect to the levels of perceived disempowerment.

↳ **H_7:** There is a significant difference between respondents belonging to different financial statuses with respect to their levels of perceived disempowerment.

↳ **H_8:** There is a significant difference between respondents belonging to different religious backgrounds with respect to their levels of perceived disempowerment.

↳ **H_9:** There is a significant difference between respondents belonging to different marital status with respect to their levels of perceived disempowerment.

↳ **H_{10} :** There is a significant difference between respondents belonging to urban, semi urban, and rural areas with respect to their levels of perceived disempowerment.

↳ **H_{11} :** There is a significant difference between complainers and non-complainers with respect to their levels of perceived disempowerment.

↳ **H_{12} :** There is a significant difference between respondents admitted in private and cooperative hospitals with respect to their levels of perceived disempowerment.

↳ **H_{13} :** There is a significant difference between respondents with various lengths of hospital stay (LOS) with respect to their levels of perceived disempowerment.

Methodology

This study is exploratory in nature and aims at finding the perceived disempowerment of inpatients. The population of the study are 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 (May-December 2014) and were dissatisfied with any of the services of that hospital. The sampling technique used is probability sampling. The data collection tool used is structured and self-administered questionnaire administered in the sampled nine districts of Kerala.

The scale to measure perceived disempowerment is a seven-item 5-point Likert scale anchored at the end points with *'strongly agree/ strongly disagree'* with *'neither agree nor disagree'* anchoring the middle position. The scale was developed after performing phenomenological research (Lester, 1999) and by incorporating expert opinion due to the lack of relevant measurement scales in the areas of consumer disempowerment.

Questions regarding location of the hospital, nature of the hospital (whether private or cooperative), number of days of stay as inpatient, whether the patient had undergone any surgery during the stay, and their self-assessment of medical awareness were asked. In addition, data pertaining to eight socioeconomic and demographic variables were also collected. The private and cooperative hospitals with at least 100 beds were considered in the final sample. For this study, the entire state of Kerala was divided into three zones, that is, North, Central, and South Kerala. Out of the 14 districts in Kerala, nine districts were considered, three each from three zones.

The sample size is 405 respondents, with almost equal distribution from the three zones. Out of the 405 questionnaires distributed, only 353 were found to be useful as the rest 52 were returned because those respondents were either not dissatisfied with any of the hospital services or were not available (death, not able to locate, or outstation inpatients) or non-response after a maximum of three reminder calls. The final sample size was 309 with a response rate of 88 %. The data were analyzed with bivariate and multivariate analyses using IBM SPSS 22.0. The statistical tests performed were factor analysis, one-way analysis of variance, and chi - square tests.

Analysis and Results

As the pilot study revealed that being dissatisfied does not necessarily culminate in formal complaints and that the major deterrent of complaining was the felt disempowerment of patients, it was pertinent to study the extent of disempowerment of inpatients. The seven-item scale that was developed to analyze the perceived disempowerment of inpatients showed good reliability. The Table 1 gives the reliability statistics of this scale.

(1) Results of Factor Analysis of the Perceived Disempowerment Scale : As literature on previous studies which have identified and established factors are lacking, an exploratory factor analysis was performed on the data using principal component analysis. Extraction was done on the basis of Cattell's scree plot as well as occurrence of Eigen value above 1. In other words, items whose Eigen values were greater than 1.0 were retained and others (whose Eigen value was less than 1.0) were excluded from the model. Varimax rotation was performed on the extracted factor structure. The Table 2 shows the results of rotated component matrix. The idea is to reduce the number of factors on which the variables under investigation have high loadings.

Table 1. Reliability Statistics of the Perceived Disempowerment Scale

Cronbach's Alpha	Number of Items
.829	7

Table 2. Rotated Component Matrix[a]

Item	Factor 1	Factor 2
Patients are powerless to complain against hospitals.		**.680**
Patients cannot control any cause of dissatisfaction by themselves.		**.616**
As the hospitals know better about medical care, patients should avoid possible confrontation with them.	**.728**	
There is a popular feeling that patients should not fight against hospitals.	**.722**	
Hospitals are busy with many patients, and that individual dissatisfaction cannot be given much importance.	**.785**	
Those who complain are generally quarrelsome.	**.767**	
People who have little else to do are the ones who complain the most.		

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.
[a.] Rotation converged in three iterations.

Table 3. Frequency Based on Disempowerment Classification of Respondents

Levels of Perceived Disempowerment (Summated Scores)	Frequency	%
Not at all Disempowered (7-15)	77	25.0
Moderately Disempowered (16-25)	93	30.2
Highly disempowered (26-35)	138	44.8
Total	308	100.0
Missing	1	
Total	**309**	

From the Table 2, it is evident that four items are loaded on Factor 1 and two items on Factor 2. The rotated component matrix yields a two-factor solution where most of the variables are found to be correlated with separate factors. As the four items that load on Factor 1 reflect a docile and submissive attitude of inpatients, the factor is labelled as Subservience. The second factor has items that echo the defenseless plight of the inpatient, and hence, is labelled as Powerlessness.

The possible range of summated scores for this scale is 7-35. The level of disempowerment increases as the score approaches from the minimum to the maximum value. The summated score on the seven items comprising the scale was calculated for each respondent. The respondents were divided into three classes based on their summated scores. Those who had a total score ranging between 7 and 15 were categorized as 'not at all disempowered,' those between 16 and 25 were categorized as 'moderately disempowered,' and those between 26 and 35 as 'highly disempowered'. The frequency table showing the distribution of respondents in each category is shown in the Table 3.

It is evident from the Table 3 that a little less than one-half of the respondents belonged to the 'highly disempowered' category (44.8%), a little more than one-fourth were 'moderately disempowered' (30.2%), and exactly one-fourth of them belonged to the 'not at all disempowered' (25.0%) group.

(2) Results of Hypotheses Testing : One-way analysis of variance (ANOVA) was performed to test hypotheses H_1 and H_2. Post Hoc tests can be applied in that specific situation to determine which specific pair/pairs are differentially expressed. Homogenous subset table resulting from one way ANOVA helps to identify whether a significant difference occurs due to the formation of sub groups or not. A pictorial representation of the overall mean difference or variation between the groups is represented with the help of mean-plots. ANOVA test has been employed with the objective to study the difference among respondents possessing various levels of medical awareness as well as those admitted in hospitals belonging to various zones of Kerala with respect to their perceived disempowerment. The results are shown in the Table 4 (a).

The differences are statistically significant with [$F(3, 307) = 5.347$, $p = 0.001$] for medical awareness and [$F(2, 308) = 6.315$, $p = 0.002$] for zone of hospital and hence H_1 and H_2 are accepted. As the p - value is less than the significance level, we state that there is evidence to retain the hypothesis and hence there is a significant difference between respondents possessing various levels of medical awareness with respect to their perceived disempowerment. We also state that there is evidence to retain the hypothesis and hence there is a significant difference between respondents admitted in hospitals belonging to North, Central, and South Kerala with respect to their perceived disempowerment. Tukey HSD post hoc tests were performed for listing pair-wise comparisons as shown in the Table 4 (b).

Multiple comparisons using Tukey HSD tests, in order to assess further differences amongst groups, reveal that the respondents who were *'somewhat aware'* have a mean disempowerment level that is significantly higher than that for the other two groups and is different from those who were '*not at all aware'* ($p = 0.010$) and '*highly aware'* ($p = 0.019$) about the diagnostic and therapeutic procedures. Hence, these two groups did not differ from each other when compared pair-wise.

Table 4 (a). Disempowerment vs. Medical Awareness and Zone of Hospital (ANOVA)

Patient's Medical Awareness		*Sum of Squares*	*Df*	*Mean Square*	*F*	*Sig.*
Perceived	Between Groups	20.860	3	6.953	5.347	.001
Disempowerment	Within Groups	399.246	307	1.300		
of Inpatients	**Total**	**420.106**	**310**			
Zone to which the Hospital Belongs						
Perceived	Between Groups	16.548	2	8.274	6.315	.002
Disempowerment	Within Groups	403.558	308	1.310		
of Inpatients	**Total**	**420.106**	**310**			

Table 4 (b). Multiple Comparisons (Tukey HSD Post Hoc Tests)

Disempowerment Vs. Patient's Medical Awareness					
Dependent Variable	***(I)* Patient Medical Awareness**	***(J)* Patient Medical Awareness**	**Mean Difference *(I-J)***	**Std. Error**	**Sig.**
H_1:Perceived	*Not at all aware*	*Somewhat aware*	-.5547(*)	.17701	.010
Disempowerment		*Highly aware*	.0754	.25718	.991
of Inpatients	*Somewhat aware*	*Not at all aware*	.5547(*)	.17701	.010
		Highly aware	.6301(*)	.21557	.019
	Highly aware	*Not at all aware*	-.0754	.25718	.991
		Somewhat aware	-.6301(*)	.21557	.019
Disempowerment Vs. Zone to Which Hospital Belongs					
Dependent Variable	***(I)* Zone to which hospital belongs**	***(J)* Zone to which Hospital Belongs**	**Mean Difference *(I- J)***	**Std. Error**	**Sig.**
H_2: Perceived	North	Central	-.1196	.15448	.719
Disempowerment		South	.4353(*)	.17133	.031
of Inpatients	Central	North	.1196	.15448	.719
		South	.5549(*)	.15919	.002
	South	North	-.4353(*)	.17133	.031
		Central	-.5549(*)	.15919	.002

Note : * groups with significantly higher mean disempowerment level.

Table 5 (a). Post Hoc Tests - Tukey Homogeneous Subsets - Differentiation in Each Awareness Level

Disempowerment &	***N***	**Subset for alpha = .05**
Patient's Medical Awareness		1
Highly Aware	32	2.0759
Not at all Aware	51	2.1513
Somewhat Aware	223	2.7060

Note : Means for groups in homogeneous subsets are displayed.

Multiple comparisons using Tukey HSD tests reveal that the respondents who were admitted in hospitals belonging to South Kerala have a mean disempowerment level that is significantly higher than that for the other two groups who were different from those in North (p= 0.031) and Central (p = 0.002) Kerala. Hence, these two groups did not differ from each other when compared pair-wise.

To test whether a significant difference is because of the sub groups, homogeneous subset table of ANOVA - Tukey HSD has been analyzed in Table 5. The Table 5 (a) lists homogenous sets or groups that do not differ using

Figure 1. Mean Plot - Disempowerment vs. Zone of Hospital

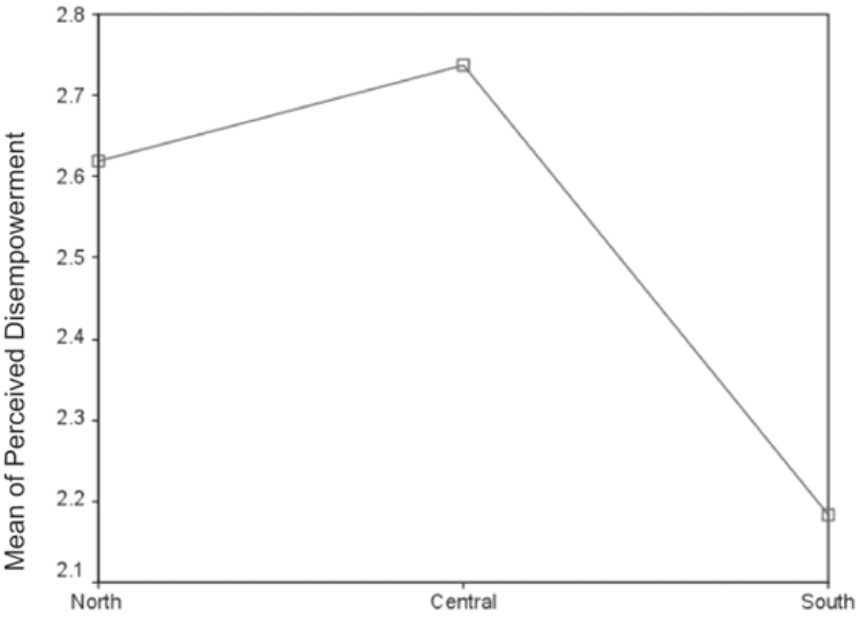

Table 5 (b). Post Hoc Tests -Tukey Homogenous Subsets - Differentiation in Each Zone of Hospital

Zone of Kerala to which	*N*	Subset for alpha = .05	
Hospital belongs to		1	2
South	85	2.1832	
North	94		2.6185
Central	132		2.7381

Note : Means for groups in homogeneous subsets are displayed.

alpha = 0.05. It can be observed from the homogenous subsets table that the respondents belonging to the three groups, namely, *highly aware*, *not at all aware*, and *somewhat aware* did not differ from each other.

The Table 5 (b) lists groups that did not differ using alpha = 0.05. It can be observed from the homogenous subsets table that the respondents admitted to hospitals belonging to South Kerala differ significantly from respondents admitted to hospitals in North and Central Kerala with respect to disempowerment and hence, are listed separately in the table. The Figure 1 shows the mean plot of zone to which the hospital belongs on the *x*-axis and mean of disempowerment on the *y*-axis.

The Figure 1 explains the difference that the respondents admitted in the hospitals belonging to North and Central Kerala exhibit with respect to perceived disempowerment when compared to those admitted in hospitals in South Kerala.

The hypothesis H_3 was tested using chi - square test. The Table 6 illustrates the results of chi - square test to examine the difference between male and female respondents with respect to various levels of perceived disempowerment. The difference between these variables is not significant; $[X^2(4, n = 304) = 3.547, p = 0.471]$ and hence, H_3 is rejected. As the *p* - value is higher than the significance level, we have evidence to reject the hypothesis and therefore state that there is no true difference between male and female respondents with respect to the various levels of perceived disempowerment.

Table 6. Disempowerment Level vs. Gender (Chi-Square)

Test	*Value*	*df*	*Asymp. Sig. (2-sided)*
Pearson Chi-Square	3.547	4	.471
Likelihood Ratio	3.630	4	.458
Linear-by-Linear Association	.907	1	.341

Table 7. Age vs. Levels of Perceived Disempowerment (One-Way ANOVA)

Levels of Perceived Disempowerment	*Sum of Squares*	*Df*	*Mean Square*	*F*	*Sig.*
Between Groups	72.099	4	18.025	.366	**.833**
Within Groups	14241.275	289	49.278		
Total	14313.374	293			

Table 8. Education vs. Levels of Perceived Disempowerment (ANOVA)

Levels of Perceived Disempowerment	*Sum of Squares*	*Df*	*Mean Square*	*F*	*Sig.*
Between Groups	528.895	6	88.149	1.859	**.088**
Within Groups	13988.522	295	47.419		
Total	14517.417	301			

Table 9. Occupation vs. Levels of Perceived Disempowerment (ANOVA)

Levels of perceived disempowerment	*Sum of Squares*	*Df*	*Mean Square*	*F*	*Sig.*
Between Groups	569.668	5	113.934	2.426	.036
Within Groups	13855.282	295	46.967		
Total	14424.950	300			

Table 10. Financial Status vs. Levels of Perceived Disempowerment (ANOVA)

Levels of perceived disempowerment	*Sum of Squares*	*Df*	*Mean Square*	*F*	*Sig.*
Between Groups	264.351	3	88.117	1.848	.139
Within Groups	14258.798	299	47.688		
Total	14523.149	302			

To test hypothesis H_4, one-way analysis of variance (ANOVA) was performed to compare the effect of age on perceived disempowerment as depicted in the Table 7. It can be inferred from the Table 7 that there is no statistically significant difference between groups as determined by one-way ANOVA [$F(4, 289) = 6.137$, $p = 0.833$] and hence, H_4 is rejected. As the p- value is higher than 0.05, we reject the hypothesis and therefore state that there is no evidence of difference between respondents of various age groups with respect to perceived disempowerment.

To test hypothesis H_5, a one-way analysis of variance (ANOVA) was performed to compare the effect of educational qualification on perceived disempowerment as depicted in the Table 8. There is statistically no significant difference between groups as determined by one-way ANOVA [$F(6, 295) = 1.859$, $p = 0.088$] and hence, H_5 is rejected. As the p - value is higher than 0.05, we reject the hypothesis and therefore state that there is no evidence of difference between respondents holding various educational qualifications with respect to perceived disempowerment.

In order to test hypothesis H_6 , a one-way analysis of variance (ANOVA) was performed to compare the effect of occupation on levels of perceived disempowerment as depicted in the Table 9. It can be inferred from the Table 9

Table 11(a). Levels of Perceived Disempowerment and Religion (Cross Tabulation)

Levels of Perceived Disempowerment	Religion of the Respondent				
	Hindu	Muslim	Christian	Preferred not to Respond	Total
Not at all disempowered	32	19	20	6	77
Moderately disempowered	41	21	27	2	91
Highly disempowered	49	34	45	10	138
Total	**122**	**74**	**92**	**18**	**306**

Table 11(b). Religion vs. Perceived Disempowerment Levels (Chi-Square)

Test	Value	*Df*	Asymp. Sig. (2-sided)
Pearson Chi-Square	5.138[a]	6	**.526**
Likelihood Ratio	5.743	6	.453
Linear-by-Linear Association	.931	1	.335
N of Valid Cases	306		

Note : a. 0 cells (.0 %) have expected count less than 5. The minimum expected count is 17.00.

Table 12. Marital Status vs. Levels of Perceived Disempowerment (ANOVA)

Perceived Disempowerment Levels	*Sum of Squares*	*Df*	*Mean Square*	*F*	*Sig.*
Between Groups	333.282	4	83.320	1.756	.138
Within Groups	14278.666	301	47.437		
Total	14611.948	305			

that there is a statistically significant difference between groups as determined by one-way ANOVA [$F(5, 295) = 2.426, p = 0.036$] and hence, hypothesis H_6 is accepted. As the p- value is less than 0.05, we retain the hypothesis and hence state that there is evidence of significant difference among the different occupation holders with respect to their levels of perceived disempowerment.

A one-way analysis of variance (ANOVA) was performed to compare the effect of financial status of respondents on their perceived disempowerment (hypothesis H_7) as depicted in the Table 10. It can be inferred from the Table 10 that there is no statistically significant difference between groups as determined by one-way ANOVA [$F(3, 299) = 1.848, p = 0.139$] and hence, hypothesis H_7 is rejected. As the p - value is greater than 0.05, we reject the hypothesis and hence state that there is no evidence of difference between respondents of various categories of financial status with respect to their perceived disempowerment.

The hypothesis H_8 is tested using chi square. The Table 11(a) gives the cross tabulation of religion and perceived disempowerment. Among the respondents who reported to represent the Hindu religion, a descending order is observed in disempowerment frequencies with 40.2%, 33.6%, and 26.2%, respectively being highly, moderately, and not at all disempowered ; whereas, a similar descending pattern is observed for respondents belonging to Muslim and Christian communities. However, it is different for respondents who did not disclose their religion, with 55.6% of the respondents reporting highest disempowerment. The Table 11(b) illustrates the chi square testing to examine the difference between respondents from various religious backgrounds with respect to perceived disempowerment. The test is not significant; [$X^2(6, n = 306) = 5.138, p = 0.526$] and hence, hypothesis H_8 is rejected. As the p - value is higher than the significance level, we have evidence to reject the hypothesis and hence state that there is no true difference between respondents from different religious backgrounds with respect to their levels of perceived disempowerment.

A one-way analysis of variance (ANOVA) was performed to compare the effect of marital status on perceived

Table 13. Nature of Place of Stay vs. Disempowerment Levels (ANOVA)

PDS levels	*Sum of Squares*	*Df*	*Mean Square*	*F*	*Sig.*
Between Groups	73.674	2	36.837	.767	**.465**
Within Groups	14548.091	303	48.014		
Total	14621.765	305			

Table 14(a). Respondent Action vs. Disempowerment Levels (Cross Tabulation)

Levels of Perceived Disempowerment	Respondent Action when Dissatisfied		Total
	Complained	Not Complained	
Not at all disempowered	19	58	77
Moderately disempowered	14	79	93
Highly disempowered	35	103	138
Total	**8**	**240**	**308**

Table 14(b). Respondent Action vs. Disempowerment Levels (Chi square)

Test	Value	*Df*	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.834[a]	2	.147
Likelihood Ratio	4.045	2	.132
Linear-by-Linear Association	.183	1	.669
N of Valid Cases	308		

Note : [a].0 cells (.0 %) have expected count less than 5. The minimum expected count is 17.00.

disempowerment (hypothesis H_9) as depicted in the Table 12. It can be inferred from the Table 12 that there is no statistically significant difference between groups as determined by one-way ANOVA [$F(4, 301) = 1.756$, $p = 0.138$] and hence, hypothesis H_9 is rejected. As the p - value is higher than 0.05, we reject the hypothesis and state that there is no evidence of difference between respondents belonging to various categories of marital status with respect to perceived disempowerment.

A one-way analysis of variance (ANOVA) was performed to compare the effect of nature of place of stay on perceived disempowerment (H_{10}) as depicted in the Table 13. It can be inferred from the Table 13 that there is no statistically significant difference between groups as determined by one-way ANOVA [$F(2, 303) = 0.767$, $p = 0.465$] and hence, H_{10} is rejected. As the p - value is higher than 0.05, we reject the hypothesis and state that there is no evidence of difference between respondents belonging to urban, semi urban, and rural areas with respect to their perceived disempowerment.

The chi - square test was performed to test hypothesis H_{11}. The cross tabulation and chi square results are depicted in the Table 14(a) and Table 14(b), respectively. Though disempowerment is argued as a deterrent of complaining, overt complainers are found to be highly disempowered at 51.5%. The highest score of moderate disempowerment is observed among non-complainers (32.9%).The test is not significant; [$X^2(2, n = 308) = 3.834$, $p = 0.147$] and hence, hypothesis H_{11} is rejected. As the p- value is higher than the significance level, we have evidence to reject the hypothesis and state that there is no true difference between complainers and non-complainers with respect to their levels of perceived disempowerment.

The Table 15(a) and Table 15(b), respectively illustrate the cross tabulation between nature of hospital and perceived disempowerment and chi square test results of H_{12}. Respondents who were admitted in cooperative hospitals had a higher incidence of disempowerment at 54.2% as compared to 41.9% respondents who were admitted in private hospitals. The difference between these variables is not significant; [$X^2(2, n = 308) = 4.565$,

Table 15(a). Nature of the Hospital vs. Disempowerment Level (Cross Tabulation)

Levels of Perceived Disempowerment of Inpatients	Nature of the Hospital in Which the Patient was Admitted		
	Private hospital	Cooperative hospital	Total
Not at all disempowered	59	18	77
Moderately disempowered	78	15	93
Highly disempowered	99	39	138
TOTAL	**236**	**72**	**308**

Table 15(b). Nature of the Hospital vs. Disempowerment Level (Chi-Square Test)

Test	Value	*Df*	Asymp. Sig. (2-sided)
Pearson Chi-Square	4.565	2	.102
Likelihood Ratio	4.045	2	.132
Linear-by-Linear Association	.183	1	.669
N of Valid Cases	308		

Table 16. Length of Hospital Stay vs. Disempowerment Levels (ANOVA)

PDS levels	Sum of Squares	*Df*	Mean Square	*F*	*Sig.*
Between Groups	11.529	27	.427	.701	**.866**
Within Groups	172.413	283	.609		
Total	183.942	310			

$p = 0.102$] and hence, hypothesis H_{12} is rejected. As the p - value is higher than the significance level, we have evidence to reject the hypothesis and state that there is no true difference between respondents admitted in private and cooperative hospitals with respect to their levels of perceived disempowerment.

A one-way analysis of variance (ANOVA) was performed to compare the effect of length of hospital stay on perceived disempowerment (H_{13}) as depicted in the Table16. There is no statistically significant difference between groups as determined by one-way ANOVA [$F(27, 283) = 0.701, p = 0.866$] and hence hypothesis H_{13} is rejected. As the p - value is higher than 0.05, we reject the hypothesis and state that there is no evidence of difference between respondents with various durations of hospital stay with respect to perceived disempowerment.

The consolidated results are shown in the Table 17. The results of factor analysis reveal pertinent information regarding the customers in the healthcare sector. The powerlessness and subservience could be due to the nature of the industry in general, and credence property in particular. The perceived disempowerment of inpatients was measured using a 7-point Likert scale. The summated scores of this scale reveal that as high as 44.8% of the respondents were highly disempowered which explains the highest number of covert complainers in the study. This value was much higher than the moderately disempowered category, which was only 30.2%. These values could be attributed to the physical condition of the respondents which might have triggered their disempowerment to much higher levels.

One-way analysis of variance was performed to find any difference between respondents possessing different levels of medical awareness and those admitted in hospitals belonging to the three zones of Kerala, namely, North, Central, and South Kerala. The test was significant and there is evidence to state that a significant difference existed between respondents possessing various levels of medical awareness as well as those admitted in hospitals belonging to different zones of Kerala with respect to their perceived disempowerment. Multiple comparisons reveal that the respondents who were *'somewhat aware'* were different from those who were *'not at all aware'* and

Table 17. Consolidated Results of Hypotheses Testing Based on Perceived Disempowerment

Sl. No. of Hypotheses	Independent variable	Test Performed	Sig. (*p* - value)	Decision
H_1	Respondents' medical awareness	ANOVA	.001	**Retain the hypothesis**
H_2	Zone to which hospital belongs	ANOVA	.002	**Retain the hypothesis**
H_3	Gender	Chi square	.471	Reject the hypothesis
H_4	Patient age	ANOVA	.833	Reject the hypothesis
H_5	Patient education	ANOVA	.088	Reject the hypothesis
H_6	Patient occupation	ANOVA	.036	**Retain the hypothesis**
H_7	Patient financial status	ANOVA	.139	Reject the hypothesis
H_8	Patient religion	Chi square	.526	Reject the hypothesis
H_9	Patient marital status	ANOVA	.138	Reject the hypothesis
H_{10}	Place of stay	ANOVA	.465	Reject the hypothesis
H_{11}	Respondent action	Chi square	.147	Reject the hypothesis
H_{12}	Nature of hospital	Chi square	.102	Reject the hypothesis
H_{13}	Length of hospital stay	ANOVA	.866	Reject the hypothesis

Note : Dependent variable: Levels of Perceived Disempowerment

'highly aware' about the diagnostic and therapeutic procedures, and respondents who were admitted in hospitals belonging to South Kerala were different from those in North and Central Kerala with respect to disempowerment. The results are in conformance with the findings of earlier studies of Patel and Dowse (2015), who concluded poor awareness of information sources and lack of health-related knowledge as reasons for patient disempowerment. Another study by Edwards, Davies, and Edwards (2009) on shared decision making in healthcare consultations found that a non-empowered patient is one who does not deliberately seek information, but completely depends on the healthcare professional. The results of the current study have brought to light the fact that patients with perception of high to low medical awareness differ significantly in their levels of disempowerment.

Suggestions

The results regarding the difference between respondents holding different levels of medical awareness with respect to disempowerment would be pertinent information for the hospitals, especially those in the private sector. People who rated themselves as possessing 'medium knowledge' about diagnostic and therapeutic procedures exhibited levels of disempowerment different from those with extreme awareness ratings. Hence, covert complaining propensities were exhibited by those who felt that they possessed sound medical awareness which the hospitals need to be vigilant about. A zone-wise differentiation was seen among respondents who were admitted in hospitals belonging to South Kerala when compared to those from hospitals in North and Central Kerala with respect to disempowerment. Hence, hospitals in the Southern part of Kerala can devise strategies that would ensure pleasant and satisfying stay for inpatients.

Managerial Implications

Inpatient disempowerment could be due to personality variables, situational, or socioeconomic variables. The fact that patients are disempowered gives an upper hand to the provider, principally in a credence service like health care. As the respondents who participated in the survey opted to either switch provider or engage in negative word-of-mouth with friends and relatives than overtly complaining, their actions can be viewed as unfavorable from the

health care providers' perspective. Only if they know that they have caused some sort of discomfort or dissatisfaction to their customers will they get an opportunity to rectify their mistakes. However, this study has brought to light a very important information that hospitals in Kerala need to be cautious about. People engaging in negative publicity are sure to bring harm to the reputation of the organization, especially in an era when social media is impacting the lives of even the common man. The reason behind such acts might be purely altruistic on one hand, or purely detrimental on the other.

Conclusion

Inpatients possess a subservient and powerless attitude which deters them from complaining overtly even after being dissatisfied with hospital services. It can be concluded that a significant difference was found only between respondents holding different levels of occupation, admitted to hospitals belonging to various zones, and with different levels of medical awareness. However, no significant difference could be established in the case of other patient-related variables, namely, socioeconomic and demographic status, nature of action resorted to after being dissatisfied, nature of hospital admitted, and length of hospital stay with regard to levels of perceived disempowerment of inpatients.

Limitations of the Study and Scope for Further Research

The data were collected in the year 2014. Hesitation from some respondents to reveal their bad experiences due to fear of being exposed was a hindrance to collect data in some instances. There were also cases where respondents could not remember the dissatisfaction situation in a vivid manner to reveal their experiences. Perceived disempowerment of customers may be studied across various products and service sectors. Future research may be conducted to explore the extent of disempowerment across industries. The reasons behind customers' subservience and powerlessness may be explored in various scenarios.

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