Why do systems for responding to concerns and complaints so often fail patients, families and healthcare staff? A qualitative study

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A B S T R A C T

Healthcare organisations' responses to concerns and complaints often fall short of the expectations of patients and staff who raise them, and substandard responses to concerns and complaints have been implicated in organisational failures. Informed by Habermas's systems theory, we offer new insights into the features of organisations' responses to concerns and complaints that give rise to these problems. We draw on a large qualitative dataset, comprising 88 predominantly narrative interviews with people raising and responding to concerns and complaints in six English NHS organisations. In common with past studies, many participants described frustrations with systems and processes that seemed ill-equipped to deal with concerns of the kinds they raised. Departing from existing analyses, we identify the influence of functional rationality, as conceptualised by Habermas, and embodied in procedures, pathways and scripts for response, in producing this dissatisfaction. Functionally rational processes were well equipped to deal with simple, readily categorised concerns and complaints. They were less well placed to respond adequately to concerns and complaints that were complex, cross-cutting, or irreducible to predetermined criteria for redress and resolution. Drawing on empirical examples and on Habermas's theory of communicative action, we offer suggestions for alternative and supplementary approaches to responding to concerns and complaints that might better address both the expectations of complainants and the improvement of services.

1. Introduction

Systems for processing and responding to concerns and complaints raised by patients, relatives and members of staff are critical for healthcare organisations worldwide. They provide a means of identifying and addressing problems, and are also source of organisational learning that can support improvement in quality and safety of care (Gillespie and Reader, 2018; Martin et al., 2015). Yet mechanisms for raising complaints and concerns often disappoint those who use them, or fail to produce a resolution that meets their expectations (Clarke, 2014; Martin et al., 2018; Mazor et al., 2013; Reinarz and Wynter, 2014). This breeds more general scepticism about the value of the process, such that staff (Attree, 2007; Francis, 2015) and patients (Wessel et al., 2012) may see raising concerns or complaints as a futile or even risky pursuit.

Recent reviews and inquiries into failings in the quality and safety of care in the United Kingdom (UK) highlight the costs of failing to respond to complaints and concerns appropriately. A recent government-commissioned review of harmful side-effects of medicines and medical devices, for example, described an "unresponsive and defensive" healthcare system that failed to listen to patients' concerns, allowing harms to continue over many years (Independent Medicines and Medical Devices Safety Review, 2020, p. ii). The public inquiry into poor standards of care sustained over many years at one UK hospital documented multiple instances of complaints and concerns raised by patients and staff alike, ignored by a system that preferred defensiveness and secrecy to responsiveness and transparency (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). These reports hint at the reasons why healthcare systems find it difficult to respond to concerns, and why those who raise them are often dissatisfied with the outcome. Asymmetric power relationships mean that the views of those in weaker positions may be discounted. For patients, failures in quality of healthcare may have lasting consequences for health, wellbeing and identity that cannot

easily be resolved or redressed (Hall et al., 2001), while for staff, a decision to speak up may have major implications for self-identity, relationships and career (Jones and Kelly, 2014).

In this paper, we argue that this location of complaints and concerns—at the interface between highly personalised motivations and consequences, and systems and processes oriented towards organisational objectives—is crucial to understanding what goes wrong in complaints and concerns processes and how to improve them. Using Jürgen Habermas's systems theory to analyse a large dataset of qualitative interviews, we identify structural features that militate against processes and outcomes that satisfy complainants, and offer new insights into what might be done to secure improvement.

In the next section, we offer an overview of Habermas's theory and its application in healthcare, and argue for its application to organisations' responses to complaints and concerns. Systems theory has been used in exploring areas of healthcare delivery where bureaucratic exigencies of healthcare organisations and the wider concerns of patients come into conflict (e.g. Barry et al., 2001; Greenhalgh et al., 2006). We propose that it also has strong relevance for understanding concerns and complaints in healthcare, where there is often a pronounced gap between organisational priorities and the intentions of complainants. We then introduce our methods and dataset, which includes a large number of narrative accounts of patients and staff of their experiences of raising concerns and complaints about quality, safety and interpersonal behaviour in healthcare. We present our data, and discuss our findings—including their implications for how we understand flaws in concerns and complaints processes, and how we address them.

2. Habermas, healthcare, concerns and complaints

Set out over two volumes, Habermas's (1984, 1987) *Theory of Communicative Action* brings together various strands of his thinking in relation to the history of modernity, the fate of the Enlightenment project, and the potential of human rationality to secure freedom and progress. Aspects of Habermas's theory, especially his distinctions between System and Lifeworld and between strategic and communicative action, have been used in the study of healthcare delivery, most notably in examinations of clinician-patient interactions and how certain forms of rationality come to dominate them (e.g. Barry et al., 2001; Greenhalgh et al., 2006; Mishler, 1984). The full analytic potential of these concepts, however, is best realised by understanding their location in Habermas's wider model of modernisation under capitalism.

Habermas's central concern in his systems theory is the development of human society since the Enlightenment. His view of modernity and modernisation is in many ways a positive one. Habermas aligns himself with Kant and other optimists of the Enlightenment in seeing the dawn of rational critique and the decline of religious and supernatural understandings of the world as representing a release from immaturity and superstition. Whereas Weber (1946) and first-generation Frankfurt theorists such as Marcuse (1978) document the distortion of rationality through bureaucracy, capitalist accumulation and instrumentalist relationships between humans, Habermas (1987) makes a crucial distinction between *functional* rationality and *communicative* rationality. Both forms of rationality have their proper place in securing freedom and progress. However, the relationship between them is not always as it should be, with functional rationality tending to encroach into domains of human activity where it does not belong.

Communicative rationality is the capacity of humans to engage in deliberation, constructive disagreement, and argument towards consensus. This is rationality in the original Enlightenment sense of the term: humanity's capacity to reason and, by communicating that reasoning, reach better understanding. Habermas (1987, p. 138) associates this form of rationality with the Lifeworld: that is, the field of human activity that produces human identities and relationships, including culture (the "stock of knowledge" that informs our understanding of the world), society (the norms and rules of "legitimate orders" that govern our interactions), and personality (our individual identities and communicative competencies). Through communicative action, humans are able to reach agreement on how we relate to one another, and thereby reproduce or transform the Lifeworld through collective human agency (at various levels, from individual-level interaction through to national and international institutions of democracy). The success or otherwise of communicative action can be judged by the extent to which decisions and actions are based upon a negotiated consensus between the parties concerned (Habermas, 1987).

Functional rationality, on the other hand, belongs in the domain of the System—that is, the world of material reproduction, including the economy and the state. It allows coordination between humans in pursuit of already-agreed objectives and criteria of success, without the need for conscious will on the part of those involved. Within systems governed by functional rationality, individual agents tend towards *instrumental* rationality, adopting a strategic orientation towards one another in which they are concerned only with their own success in achieving those objectives, not with cooperating with others to define what the objectives should be (Cook, 2005). This, then, is rationality as understood by many critical thinkers of the twentieth century, such as Weber (1946) in his parallel appreciation of the capacities of bureaucracy and critique of how it imprisons its participants in an 'iron cage'.

A crucial, but sometimes-overlooked, point is that in Habermas's understanding of human progress, both the communicative rationality of the Lifeworld and the functional rationality of the System are vital. The uncoupling of the System from the Lifeworld is a critical component of social progress, since it begins to free people from the mental and physical burden of meeting basic needs through material production and reproduction, which in pre-modern societies dominated human activity. Functional rationality—in the form, for example, of bureaucratic structures, Fordist mass production or contemporary modes of automation—removes material reproduction from the realm of conscious decision-making, allowing people to devote more time to symbolic reproduction of the Lifeworld (Cook, 2005). System and Lifeworld are thus interdependent.

However, Habermas also notes that in practice, the logics of the System often intrude into the Lifeworld. Famously summarised by Habermas (1987, p. 196) in his idea of the "colonisation" of the Lifeworld by the System, norms, rules and objectives that should be a matter of negotiation may be subject to "reification" (Habermas, 1987, p. 375)—they are removed from our communicatively rational mechanisms of developing agreement, such as argument and democracy, and thus from collective human control (Jütten, 2011). In this way, functional rationality may overreach the System to displace the role of communicative rationality. Lifeworld colonisation has been documented at various levels. For Habermas (1987, pp. 322–323) himself, it is to be found in the increasing invasion of family life by functional rationality in the form of welfare bureaucracies. Examples are also found in healthcare, particularly in analyses of how bureaucratic or medical concerns may come to dominate consultations, resulting in struggles for the concerns of the Lifeworld to be heard (Barry et al., 2001; Greenhalgh et al., 2006; Mishler, 1984).

Habermas's theorisation, we suggest, also offers a promising resource in the analysis of safety concerns and complaints processes in healthcare. Like the clinical encounter, concerns and complaints lie "at the seam between the system and lifeworld" (Habermas, 1981; quoted in Edwards, 2004, p. 115). They are located where Lifeworld and System concerns intersect, and so communicative rationality is most vulnerable to colonisation. In the analysis that follows, we seek to apply Habermas's systems theory to a large set of narrative interviews, many with individuals who raised concerns and complaints. We show how functional rationality comes to dominate these processes. We identify the consequences for individuals and organisations in terms of what is addressed and what is not, and the implications for how processes might be improved.

3. Methods

This paper draws on a wider study of culture around openness in English healthcare organisations, funded by the Department of Health and Social Care's Policy Research Programme. The principal focus was the impact of various policy initiatives launched following major shortcomings identified in the quality and safety of care provided by several National Health Service (NHS) organisations. Designed to encourage openness and candour in identifying and responding to problems of quality and safety, these initiatives included obligations on organisations to apologise to patients and families in cases of avoidable harm, new roles designed to help staff speak up about concerns, and new approaches to learning from serious incidents, among others.

The substudy drawn on here involved qualitative interviews with staff, patients and family members in six NHS organisations, sampled for diversity of organisation type, population served, and approach to implementation of the initiatives. Participating organisations were selected on this basis in the course of earlier stages of the study, and included three acute hospital trusts, two community and mental healthcare trusts, and one ambulance trust. Approval was granted by a National Research Ethics Service Research Ethics Committee, and local permissions were obtained from each organisation prior to the commencement of data collection, which took place from autumn 2018 to summer 2019.

Within each organisation, we sought to recruit participants via two routes. First, we approached a small number of senior-level staff with remits around openness in general, identified by local collaborators, from publicly available sources, and through snowball sampling. These participants gave overviews of their organisations' approaches to implementing policies around openness, and related local initiatives. Second, we recruited staff, patients and family members who had been affected by openness initiatives, for example by raising concerns or complaints, in the course of disclosures of harm, or through participation in organisational investigations into problems of quality and safety. A key consideration here, given the sensitivity of the topics covered, was to ensure confidentiality, and avoid any possibility of disclosure to the organisation or to colleagues. Organisations were asked to distribute information about the study to potential participants with an interest in the issues, for example individuals who had been involved in the disclosure of a serious incident, who had raised concerns or complaints, or who had approached Patient Advice and Liaison Services (parts of NHS organisations offering advice, support and information on care to patients and families), and who had given permission to be contacted again. Potential participants were asked to provide contact details via a secure form hosted on a university website, and were assured that only study staff (not associated with the participating organisation) would have access to these details. Those who left their details were contacted by the lead researcher, given further information, allowed to ask questions, and invited to interview. Informed consent was given orally only, to provide further assurance of confidentiality.

For participants recruited through the first route (senior individuals with responsibilities for openness), topic guides focused on their approach to policy implementation around openness, and their perceptions of its strengths and weaknesses. We took a narrative approach (Ziebland, 2013) to interviews with the second group of participants (those affected by openness initiatives). We took as a starting point the

event (e.g. incident of harm; disclosure; decision to speak up; investigation) that had led to their experience of organisational processes and systems for identifying and acting on problems in quality of care. The interviewer (Author2) then invited participants to tell the story of 'what had happened to them'. As participants recounted their experiences, she probed with questions to elicit more information about the background, the process and the consequences.

Across both recruitment routes, we undertook 88 interviews in total (70 staff; 18 patients and family members), averaging 50 minutes in length (Table 1). In analysing the data we drew on the constant-comparative approach (Charmaz, 2006). Assisted by NVivo software, [Author1] led analysis of the data, first coding for high-level themes developed *a priori* and themes identified inductively from close reading of the data. A striking feature of the dataset that became apparent during this initial coding round was the convergences between the accounts of many staff, patients and relatives who had raised concerns and complaints. Despite their rather different positions within or outside healthcare organisations and their differing roles in healthcare service delivery, the trajectories of their narratives (and particularly patterns of disappointment and disillusionment in the response received to the concerns they raised) bore striking similarities. A second round of coding and analysis therefore focused specifically on accounts in the narrative interviews of concerns and complaints processes, covering the experiences of all three groups of raising concerns and complaints through official channels (as opposed to discussions 'in the moment' about their concerns). Further iterations of codes and themes followed, along with sense-checking across the authorship team and comparison with themes from the existing literature, leading to the findings presented below.

In keeping with our narrative interview approach, when presenting data excerpts from interviews with participants in the second group, we provide brief accounts of the nature of the concern or complaint raised. To ensure anonymity, we make minor changes to the detail of some accounts.

4. Findings

Many participants shared a sense of frustration and disappointment in the processes encountered when raising concerns or complaints about quality, safety, staff behaviour and other issues. We illustrate some of these negative experiences, before highlighting how certain features of the operation of complaints and concerns processes—regardless of intention—systematically tended towards privileging some forms of concern and marginalising others, guided, we suggest, by the functional rationality of the System. We demonstrate the consequences for the fate of concerns raised, for individuals, and for organisations, before identifying some ways the downsides of functional rationality might be mitigated.

4.1. Bureaucratic processes and their discontents

Common to many participants' accounts was a sense that the systems they encountered were poorly designed and poorly realised. Participants described obscure procedures for raising concerns and complaints, long delays in responding to concerns, and attempts to resolve cases that they found unsatisfactory. They described systems that seemed poorly

Table 1
Breakdown of participants.

Organisation	O1	O2	O3	O4	O5	O6	Total
Type of trust	Acute	Community and mental health	Community and mental health	Ambulance	Acute	Acute	
Staff	11	8	12	9	22	8	70
Patients and relatives	7	2	2	0	7	0	18
Total	**18**	**10**	**14**	**9**	**29**	**8**	**88**

thought through and poorly resourced, which moved along achingly slowly, and where the onus lay on them as complainants to keep things moving.

> "The system, that's right. It's bogged down and convoluted and extremely complicated, and it needn't be." (O1/patient – complained about communication of clinical results)
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> "It just didn't feel like anything was going anywhere. Like I was just banging my head against a brick wall and I was just being pacified and told, 'Oh, it's OK, we'll deal with it', but things never changed." (O5/staff – raised concerns about bullying)
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> "I have had to plug away each and every time in order to get anything done, basically. Whenever I see anybody, they agree it's not right. 'Leave it with me', and then I never hear again from them until I, you know, wait a few months and then e-mail again and say, 'Has anything happened? Do I need to—is there anybody else I need to speak to?'. So no, they've never come back to me. It's been me pushing all the way along. And so much so that it gets a little bit embarrassing really." (O5/relative – made complaints about various aspects of relative's treatment during inpatient stay)

For some participants, their general impression of an ill-coordinated system was amplified by a sense that those within it were more concerned with addressing the needs of the bureaucracy itself than with either resolving their concerns or seeking to improve the quality of healthcare provision.

> "They just seem to want to fob us all off and hope we'll go away. They don't seem to be taking the complaint serious enough and being proactive about doing something about it. They just seem to be wanting to avoid the issue completely, and thinking, 'Well, not many women complain'." (O1/patient – complained about treatment following painful invasive investigation)

Often, participants saw this as a consequence of a system in which bureaucratic demands outstripped the time available to address concerns and complaints properly and individually. Several characterised processes for responding to concerns raised by staff or complaints raised by patients or carers as a matter of 'box-ticking'. Some went further, echoing the language of critical government-commissioned inquiries, and suggesting that organisations tended towards deflection and defensiveness when faced with complaints or concerns.

> "I do think they're just so protective. Frightened of anybody suing, and that's their first priority, not 'Can we do this any better?' […] They're so defensive. And bat off these complaints back at the people, […] like when you have a car accident and they say, 'Never say it's your fault'." (O1/relative – complained about poor outcomes following surgical procedure)

To this extent, participants' accounts echoed the findings of recent studies of how organisations and their agents deal with complaints and concerns (e.g. Adams et al., 2018; Montgomery et al., 2020). Participants perceived that administrative expediency, the need to serve bureaucratic requirements, or fear of disciplinary or legal consequences trumped efforts to address the concerns they raised.

And indeed, these influences on the quality of concerns and complaints processes were acknowledged by some of those responsible for managing them. As one manager noted, some of the indicators by which processes were governed were focused explicitly on the task of managing cases through to closure, with little regard for the quality of those processes or satisfaction with their outcomes:

> "Part of my role is to, on a quarterly basis, look at complaints that have come through—not necessarily how they've been dealt with to conclusion, because some of them, to be perfectly honest, are cosmetic jobs—but to see that they've been responded to promptly,

all the information is clear to the person. So that's more of a technical process." (O1/staff – middle-management role)

Yet these participants also hinted at a mismatch between the expectations of those raising concerns and complaints, and the outcomes that processes were designed to achieve.

> "They will frame it […] in terms of whistleblowing. They're framing it in terms of whistleblowing, and I'm not framing it in that, because it's usually something that is personal to them, rather than an organisational patient safety issue." (O3/staff – responsible for processing concerns)

Staff responsible for managing the response to concerns and complaints sought to categorise them according to organisationally defined frames. The view of these participants as agents of the system on the nature of complaints and concerns raised, however, could differ from that of complainants. Moreover, as we discuss next, while some concerns and complaints were readily recognisable as issues that a healthcare organisation needed to solve, others were less easily categorised (cf. Martin et al., 2018).

4.2. Functional rationality and irreducible concerns

Routes for dealing with complaints and concerns within organisations were often complicated, perhaps of necessity. Interview participants who were involved in responding to concerns described an often-tangled web of pathways for speaking up, reporting issues, raising grievances, commenting on care and complaining. These included more and less formal channels that varied by organisation and for staff and non-staff; typically, they included incident-reporting systems, systems for reporting behavioural concerns, formal incident investigation processes, various complaints pathways oriented towards different groups, and cases handled by third parties such as Patient Advice and Liaison Services (PALs) and Freedom to Speak up Guardians. The route through which the issue was raised did not always map onto the pathway best suited to handle it, and concerns and complaints had to be sorted into one of these pathways. Each pathway had its own procedures, policies and personnel, as well as timelines and terms of reference, all oriented towards its own, functionally rational objective. Sometimes, the pathway worked well—particularly where there the concern was relatively simple, the process for handling it was well-suited to resolving it, and the rational objective was easy to serve.

> "The original e-mail just says, 'We'll send to you in due course', or something similar to that. Which I was starting to be anxious and thinking, 'Well it's six weeks next week, when is this going to be? Is it going to be weeks, is it going to be months?' And so that's when I got on to PALS, and they were absolutely brilliant, within two hours I had an appointment date." (O5/patient – complained about delays in rehabilitation)
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> "Issues that I have at the moment, it takes a long time to do investigations, that seems to be an issue. But I had a safety issue last week, and when I did escalate it, it was addressed the next day […] because it was a safety issue. So I was pleased about that." (O5/staff – responsible for processing concerns)

Relatively straightforward concerns about uncontroversial aspects of organisational function, then, were generally well served by the functional rationality of this bureaucracy.

Other pathways were more prone to misaligned expectations and objectives among those involved. For instance, one pathway for concerns frequently discussed by participants was the formal investigation of serious incidents that had occurred or had been narrowly averted (so-called 'near misses'). Incident investigations were predominantly concerned with establishing *why* the incident had happened (or nearly happened), including the contributing factors and root causes

underlying the problem, with a view to taking preventive action to reduce the likelihood of recurrence (see NHS England, 2015). Participants typically understood the rationale for incident investigations, and the reason why they took precedence over other processes for responding to their concerns. But they often found that investigations failed to do justice to their concerns.

> "I felt as though it minimised it really, and for us, obviously we didn't really have the chance to complain down the normal route because it was superseded by this investigation, and it feels—although we have had our input and communicated our feelings and our experience—a little bit like one-way traffic. I understand it is being done so they can ensure that the learning happens." (O2/relative – child detained for over 24 hours under the Mental Health Act)

Processes for addressing concerns such as incident investigations ruled some contributions within scope and others out-of-scope. Features such as terms of reference and strict timelines for conclusion and reporting ensured, by design, that the investigation process focused on the functionally rational aims of identifying underlying causes and reducing risk.

Other pathways for responding to concerns and complaints tended towards even more narrowly defined functionally rational objectives. Responses led by organisations' human resources functions, for example, tended to focus solely on employees' accountability and appropriate disciplinary responses, to the exclusion of other considerations not reducible to the pre-ordained objectives associated with functional rationality.

> "There was a concurrent HR process. I have no difficulty with there being an HR process; I have a difficulty with your trying to put it into blame. The purpose we're sitting here is to understand the facts, and those human factors, and how the Swiss cheese holes lined up, and what the circumstances were at the time, and […] how we as an organisation can take that back on board and learn. The moment you put HR in the room, you change what happened." (O1/staff – senior manager)

Participants thus found their complaints and concerns channelled into various response pathways. But often, the issues they raised were not easily allocated without significant contortion. Many of the concerns raised by staff, for example, did not relate to a single clinical incident, near miss or unpleasant interaction. Rather, they took the form of behaviour repeated over time, or specific episodes that typified broader patterns, or an intuitive sense of a hostile or unsupportive culture. Similarly, for patients, complaints tended to relate to overall experiences of a whole interaction with the healthcare system, rather than to discrete, identifiable incidents or acts. Yet they were sometimes allotted to pathways that were not equipped to handle such unwieldy concerns, instead rendering them manageable by imposing simpler terms of reference.

> "The gentleman concerned was from Pakistan, but I don't believe there was any sort of racial motivation, and I have always believed that. It was interesting, I think HR were pushing me into saying that. I remember expressing to them in the investigatory meeting, 'No, I don't believe this is racially motivated'. But it was still mentioned again, even though I didn't even say. Even though I denied it, it was mentioned in the minutes. […] At times it did feel like they were almost, like when you're having counselling, and people are trying to put words into your mouth." (O5/staff – raised concerns about bullying by a group of colleagues)
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> "On quite a few occasions I went to the senior management and told them I wasn't being treated nicely. Also, the other bank staff, she was also going to the management and saying she wasn't being treated nicely, with respect. […] So a few months down the road, it's

continuing. And we arranged it again with the management, the senior management there and eventually, they just sent out an e-mail to all members of staff asking them to all get along and be professional. And they weren't really willing, weren't interested because […] the problem with where I work is the culture's dreadful." (O2/staff – raised concerns about organisational culture)

In these examples, racial discrimination and professional etiquette offered frames for making sense of the concerns raised, and functionally rational scripts for responding to them. But in both instances, these frames and scripts failed to do justice to the concerns as the participants saw them: the long-running, malign influence of a clique of staff in the first case, and an intimidating organisational culture in the second.

Participants describing these experiences had little reason to believe that their concerns were handled this way because of any intent to suppress or deflect them. In each case, a resolution of sorts was reached, serving a functional purpose that addressed legitimate organisational objectives. But the system offered the complainants limited opportunity to articulate their concerns in their own terms, or to open the organisation to challenge on issues that it had not already defined for itself: it was governed by functional, rather than communicative, rationality. This extended also to the way in which patients or staff with concerns or complaints were invited to set them out in the first place.

> "They sent me a form, which was—this was quite interesting, because the form bore no resemblance. So my complaint did not fit the form. I imagine for most people at that point they give up, because it was one of those deliberately boxy things where you had binary choices and you know, it was very reductive, it stripped it right down. So I filled it in. […] I'm almost certain that they will look into my case on the basis of the really useless form and go, 'We can't see anything here'. At which point I will go again." (O1/patient – complained about poor quality of gynaecological care)

Such processes, participants perceived, stripped the issues they raised of meaning in the interests of packaging them in a form that could be processed. Disparate concerns and dispersed timeframes were reconstructed as bureaucratically manageable episodes. This was not a simple matter of ill-intent in the way organisations' systems for responding to concerns were designed or the way those administering them behaved, but of the inability of these systems to process, cope with, or even understand the kinds of concerns that some participants sought to raise.

4.3. Concerns distorted and concerns discarded

Much of the frustration and disappointment described by participants seemed, then, to stem from systems whose ability to respond was limited by their own functional rationality, expressed in categorisation processes, terms of reference, and pathways for response. While this functional rationality could cater for simpler issues, more complex ones were difficult to present in ways that complaints and concerns bureaucracies could recognise and process. Some staff members anticipated this problem, describing various strategies to portray their concerns as discrete issues amenable to functionally rational responses.

> "We felt like that was indicative of a crisis really, in terms of the staff managing the work, and as a team of psychologists, we'd had concerns for a number of weeks and months, probably, but we didn't have anything tangible to report. […] This [leaflet] was something that I could hold in my hand, that I could take to my manager and say, 'This is being circulated on the wards'. […] I think we all saw it as a symptom of something wider that was going on that was going on across the wards. […] So we agreed that we would take this to our manager, together. And we wrote a letter, and I think we included

this leaflet, attached to the letter." (O2/staff – raised concerns about excessive workload and delays in treating patients)

Such efforts had mixed success, however: specific, delimited concerns elicited specific, delimited responses. In this case, the participant reported that the offending leaflet (which, she and her colleagues felt, made inaccurate claims about the quality of service that patients could expect to receive) was withdrawn, but the wider concerns it represented around inadequate resourcing and staff overload were not.

"It didn't feel very satisfactory. I didn't come away feeling, 'Oh, I'm really glad we did that, because it really feels like something's changed'." (O2/staff – raised concerns about excessive workload and delays in treating patients)

Patients had no such insider knowledge, and so moulding their complaints into the shapes expected by bureaucracies was all the more challenging. Moreover, the scope of the issues that troubled them often extended through time and space. Misdiagnosis, ill-coordination between teams, and other forms of poor-quality care were often highly consequential for patients and relatives, but fitted complaints and concerns systems poorly.

"They didn't really monitor her heels. She got a grade two [pressure ulcer], she was discharged, and now she's bedbound, because she can't step out on to her heel. And it's a massive knock-on effect. She's now bedbound and extremely poorly. Huge quality of life, and she's got 24-hour carers. [Daughter]'s moved in with her. And that, and that's it, so we've got, on an RCA [root cause analysis], lessons learned about we should have got a different mattress earlier and we should have been monitoring it and filling the forms." (O5/relative – made complaints about various aspects of relative's treatment during inpatient stay)

"I said to them, 'You are seeing me just as a patient, you're not seeing me as [Participant] the wife, [Participant] the grandmother, [Participant] the daughter. I've got a mother who's got Alzheimer's. I care for my grandson. […] And they look at you, and you sit there thinking, 'Haven't you been taught anything in your medical career, that we're not just bodies?'" (O5/patient – complained about quality of care during treatment for a life-threatening condition)

From participants' perspectives, these Lifeworld impacts demanded attention and resolution. The negative impacts were profound, but the bureaucracies they encountered were not set up to acknowledge them, let alone to address them. More than this, though, these impacts offered wider learning that could be *organisationally* valuable, and might help to improve care for others. Yet functionally rational bureaucracies, bounded by a focus on discrete problems and governed by narrow timeframes and terms of reference, were liable to discard these untidy forms of evidence.

"We are looking at a snapshot of 60 days following the incident, and this draft report will be finalised and presented to the trust, lessons will be learned. But what happens, for argument's sake in 12 months' time, if [my son] finds himself with post traumatic stress, or flashbacks? He is already struggling at school because they have erected one of these very high fences for safeguarding over the summer holidays, and already it is a problem. So, in terms of capturing the wider picture, how accurate are the lessons to be learned at this stage? […] If the idea is to learn, how much is lost in the learning when people are pushed at times when they actually can't mentally or physically do any more other than survive what has happened?" (O2/relative – child detained for over 24 hours under the Mental Health Act)

4.4. Decolonising complaints and concerns processes?

Interviews with participants involved in administering organisations' responses to concerns and complaints suggested that they were well aware of the shortcomings of the systems they worked in, but often could do little to moderate their effects. Instead, the functional rationality of the System took over and gave rise to instrumental rationality on the part of its actors: consciously or unconsciously, preoccupation with meeting the preordained needs of the bureaucracy eclipsed interest in dialogue with people raising concerns and complaints, especially when those concerns and complaints were not set out according to the System's logic.

"If you've got somebody who is NHS, or is of high intelligence and has done some research, the letter is usually a lot better. Then the response is, you know, 'Oh dear, this person knows what they're talking about, I'd better do something'. Whereas if you get a genuine letter that's a bit rambly—[…] I've read some complaint letters, and you think, 'I'm losing it on this one now, the spelling's not good, and that shouldn't feature'. […] But that's human nature, regrettably." (O1/staff – middle-management role)

Nevertheless, some participants (including both those making and responding to concerns) were able to offer indications of how better processes could serve to acknowledge and address irreducible concerns and complaints, and seek to resolve them in ways that were more satisfactory for the individual and offered important learning for organisations.

One organisation had made significant revisions to its processes following a major failing in patient safety, including the introduction of a dedicated role to liaise with families in the event of incident investigations and complaints. The role was centred on fostering productive dialogue between those affected, including both explanation of the process to patients and carers, and ensuring that they could feed into the process on their own terms.

"What I would be doing when I ring up to introduce myself is to let them know that we'll be investigating the incident, the reasons why we investigate it, how we found it et cetera. One of the main things I'll discuss even at that first interview is actually what do they want from the investigation. Have they got any concerns; what are they; how can we help them to answer any questions that they've got?" (O4/staff – responsible for processing concerns)

Participants reported that this approach could result in both a sense for patients and families that their concerns were being taken seriously—not ruled out of order by a system's functional rationality—and a dialogue that could aid understanding of the full range of problems and consequences that merited investigation.

In some units in other organisations, staff similarly described efforts to move beyond the narrow terms of reference of incident investigations to encourage a more dialogical, less reductive understanding of the range of issues that could lead to harm.

"We're doing an awful lot more work to do more constructive investigations. I think it's still quite hard because we're driven nationally as well, but certainly from the point of view of my service line, I've just introduced a couple of new approaches. The majority of serious incidents that we have within my service line are in relation to pressure ulcers and falls. One of the things we've done is we've […] moved away from investigating whether we failed or didn't fail, to more of a 'OK, let's have a talk about this, a discussion around the patient, the patient's needs and what we could have done'." (O3/staff – senior manager)

The recently introduced role of the Freedom to Speak Up

Guardian—responsible for coordinating organisations' responses to employee concerns—could also help staff with concerns make sense of both the nature of the concern and the range of pathways that might offer resolution. Enacted the right way, an intermediary or brokering role of this kind could help to frame concerns a way more likely to secure an appropriate response, and ensure that concerns were treated holistically rather than being reduced to components that did not do them justice (cf. Martin et al., 2020).

> "It provides somebody who is fairly well defined as being independent of trust processes but nevertheless is sufficiently integrated to make those processes work when they should. Quite a bit does depend on the individual. I'm fortunate, perhaps, in being old and ugly, and I've been around a long time, and so I feel reasonably empowered to ensure that people in the trust take action. [...] That's why the Guardian post is important, because it allows me, where it's necessary, to say that this is not a problem that you can just dump somewhere else." (O6/staff – responsible for processing concerns)

More broadly, the response of individuals working in complaints and concerns bureaucracies could also make a difference. Instrumental rationality was not the only response available to actors working in the System. They could also moderate the tendencies of functional rationality, and find ways to open organisations to challenge on the more disparate fronts that complainants brought. For example, they could go beyond official pathways to demand intervention from those in positions of power, removing concerns from the domain of functional rationality and placing them in the arena of communicative action.

> "She didn't brush it off; she took it extremely seriously. [She]'s always been very open with us, and we know the wheels and cogs move very slowly in the NHS. [... She] has really listened, she's let you speak, she's taken it down, she's made sure that she's understood it as you're putting it. And there's no confusion. She has been amazing, and like I say, I think the place would be in the same position if she hadn't have come to help, because she's just not let it go." (O5/staff – raised concerns about bullying and intimidation)

5. Discussion

Our analysis shows how the operation of complaints and concerns bureaucracies is underpinned by a logic or, in Habermasian terms, rationality that is oriented towards certain preordained (and arguably desirable) objectives, but which is ill-equipped to handle the full range of issues, concerns and hoped-for outcomes brought by stakeholders. Our analysis raises some familiar themes from past research, including the organisational tendency to become preoccupied processing concerns rather than with their substance (e.g. Adams et al., 2018; Montgomery et al., 2020), and how classification and categorisation of concerns and complaints may result in the loss or distortion of their most important features (e.g. Martin et al., 2018; Waring, 2009). But an approach informed by Habermasian thinking, while confirming the relevance of these themes, also offers fresh insights. Many participants' concerns and complaints were to be found at the seam of the System and the Lifeworld: while they might concern technical problems that required a technical solution, they often also related to things that were not reducible to functional rationality. They required communicative action—both to understand, make sense of and appropriately resolve the impacts on the individual or group complaining, and to work out the implications for organisations themselves.

One important implication of our findings is that they challenge narratives that portray poor handling of concerns and complaints solely as a consequence of sinister or malign organisational actors seeking to impose silence. Although this does occur (and when it does, it is egregious—Goodwin, 2020), it does not fully explain the limitations of systems' abilities to address the expectations of those raising concerns and complaints. Instead, our analysis parallels Habermasian accounts of Lifeworld colonisation in micro-level healthcare encounters, where the 'voice' of the Lifeworld is silenced through operation of a functional rationality that prioritises the efficient resolution of discrete, manageable ailments over the development of shared understanding between patients and clinicians (Barry et al., 2001; Greenhalgh et al., 2006; Mishler, 1984). Such colonisation may take place without deliberate intent on the part of clinicians as agents of the System, since they can "act with an orientation towards success, not understanding, but yet sincerely and in good faith" (Scambler and Britten, 2001, p. 54). Similarly, organisational systems for processing concerns and complaints may parse, repackage and process them in ways that achieve formal objectives but leave those who have sought to give voice feeling unheard and dissatisfied—all without necessarily involving ill-intent on the part of those who design and operate systems.

This insight is also consistent with research showing, for example, how the collection of patient experience data by clinicians can become estranged from understanding patient experience itself, preoccupied instead with processing data for its own sake (Montgomery et al. (2020, p. 1429) and unhelpfully "tied up with audit and admonishment" (cf. Adams et al., 2018; Sheard et al., 2019). Liu et al. (2019, p. 896) describe how management of patient complaints can become a matter of "putting out fires," by "defusing emotional situations [...] in order to prevent escalation to a risk management episode". Similarly, we have previously found that formal mechanisms used to process staff concerns about quality and safety render them amenable to organisational action—resolution of a problem or exoneration of an individual—but provide a poor means of understanding, and gaining insight from, the richness of concerns that staff raise (Martin et al., 2018). In all of these cases, as in this study, system objectives direct activity much more than the will to understand the concerns and complaints from the perspective of the individuals raising them.

Our findings go some way to explaining why, as Clarke (2014, p. 259) has put it, organisations seem so incapable in dealing with apparently "modest complaints." The concerns of many patients and some staff in our study straddled the "blurred and problematic boundary" (Clarke, 2014, p. 263) between areas of activity that are strictly codified and areas that are subject to norms, contextual judgements and negotiations. Complaints and concerns bureaucracies seem well equipped to deal with issues in the first area, where both establishing the facts of the matter and determining what should be done can be achieved through functionally rational processes, and where past incidents offer meaningful precedents for current action. Less readily addressed were more inchoate and complex matters: what to do about a malign organisational culture, for example, or how to account for the longer-term impact of suboptimal care on a patient's life, or even how best to achieve continuity of care across different teams. Historically produced frames of reference and preordained criteria for processing and acting on such issues offer a poor basis for an organisational response. Yet these issues are not just important for the individual complainant: resolving them effectively is also vital to organisational improvement.

A key question, therefore, is what a better way of responding to these kinds of complaints and concerns might look like. Here, too, Habermasian theory is helpful. Reflecting the importance, often underplayed in secondary accounts, that Habermas ascribes to functional rationality, we should be cautious in suggesting that our findings imply that existing processes are simply dysfunctional, and accordingly should be jettisoned wholesale. Many of these processes, while potentially capable of being improved further, retain an important role in addressing some kinds of issues—including matters for which communicative rationality offers a poor basis for action, given legal and regulatory requirements that organisations must abide by (Murphy, 2019). The task, therefore, is not to displace functional rationality with communicative rationality—a counter-colonisation of the System by the Lifeworld—but rather to ensure that each resides in its proper place, which might include a role

for communicative rationality in some parts of the System (Brown, 2008; Edwards, 2012; Habermas, 1996).

Habermasian writers offer some sketches of how this might be achieved. Detchessahar and Journé (2018) and Baur and Abma (2011), for example, present outlines of participatory deliberation in organisations, drawing on Habermasian discourse ethics to indicate how the concerns of different groups might be discussed with a view to consensus, decision and organisational improvement. They posit Habermas's (2008) concept of the ideal speech situation as an aspirational model for such forums, with its emphasis on inclusion of all relevant views, sincerity and validity in contributions, and the bracketing of coercive forces that might impede communicatively rational approaches to resolving disagreement.

Some of the approaches to handling concerns and complaints described by our participants indicated that the foundations for forums of this kind may already exist in places in the healthcare system. Changes introduced in some organisations to their incident-investigation approaches, for example, or to the ways they interacted with patients or family members who had been affected by serious incidents or had made complaints, sought to ensure that wider considerations were deliberated, rather than being discarded by functionally rational processes that had no means of addressing them. A common feature of these approaches was the role of individuals responsible for handling concerns and complaints in making initial judgements about whether they were amenable to resolution through existing functionally rational processes, or whether they required further discussion with the complainant, for example to articulate or specify the nature of the problems more fully. They thus involved the creation of forums governed by communicative rationality, alongside existing functionally rational processes. To realise the potential for achieving communicative action of this kind of forum, it may also be necessary to ensure that those with concerns and complaints are supported in raising them. The interventions of intermediaries, brokers and other actors working in and around organisational bureaucracies could provide the opportunity to discuss concerns raised by staff in the round, and to decide whether issues were amenable to resolution through a functionally rational pathway, or whether they necessitated a more deliberative response. As outsiders to healthcare organisations, patients could face even greater difficulties in articulating their concerns and pursuing their resolution, and there may be an important role for similar intermediary roles and organisations—for example, in the UK context, Patient Advice and Liaison Services—in helping patients make sense of concerns and advocating for an appropriate organisational response. The goal is not to attempt to disband processes that, in many cases, appeared very effective in doing what they were designed to do. Rather, it is to ensure that alternative arenas exist for the expression of concerns and complaints that cannot be resolved through the application of functional rationality, and to help staff and patients with concerns of this kind to access these arenas and frame their concerns in ways most likely to elicit an appropriate, deliberative response.

Our study has limitations. Our narrative interview approach was appropriate given the difficulties of identifying and observing instances of openness in real time, and offered some important insights, but necessarily limits the range of insights that can be gained. Additionally, our approach to recruiting organisations and individuals is susceptible to some biases in the kinds of systems and experiences covered by our data. We cannot be certain of the degree to which our data are representative either of staff, patient and family experiences, or of the experiences of groups with different demographic characteristics. Given evidence that that certain characteristics, notably sex and ethnicity, may be associated with different attitudes towards and experiences of giving voice to concerns (Francis, 2015), further research attending explicitly to their influence on complaints, concerns and the response received would be valuable.

6. Conclusion

Government inquiries and empirical studies have repeatedly highlighted the frustration caused by healthcare organisations' responses to patients, families and staff when concerns and complaints are raised, and the risks these responses pose to quality and safety. Our study shows how these problems can in part be understood to arise from processes designed to achieve certain reasonable but narrowly defined objectives, following the functional rationality characteristic of the System, as described by Habermas. This has important implications for how best to improve such organisational responses, in particular by providing supplementary means of addressing those complaints or concerns that are not reducible to functional rationality, and instead demand communicative action.

Credit author statement

Graham Martin: Conceptualization; Methodology; Formal analysis; Investigation; Writing – Original Draft; Writing – Review and Editing; Supervision; Funding acquisition. Sarah Chew: Methodology; Formal analysis; Investigation; Data Curation; Writing – Review & Editing; Project administration. Mary Dixon-Woods: Conceptualization; Methodology; Writing – Review and Editing; Funding acquisition.

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