

‘It’s sometimes hard to tell what patients are playing at’: How healthcare professionals make sense of why patients and families complain about care

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Abstract

This article draws from sociological and socio-legal studies of dispute between patients and doctors to examine how healthcare professionals made sense of patients' complaints about healthcare. We analyse 41 discursive interviews with professional healthcare staff working in eight different English National Health Service settings to explore how they made sense of events of complaint and of patients' (including families') motives for complaining. We find that for our interviewees, events of patients' complaining about care were perceived as a breach in fundamental relationships involving patients' trust or patients' recognition of their work efforts. We find that interviewees rationalised patients' motives for complaining in ways that marginalised the content of their concerns. Complaints were most often discussed as coming from patients who were inexpert, distressed or advantage-seeking; accordingly, care professionals hearing their concerns about care positioned themselves as informed decision-makers, empathic listeners or service gate-keepers. We find differences in our interviewees' rationalisation of patients' complaining about care to be related to local service contingences rather than to fixed professional differences. We note that it was rare for interviewees to describe complaints raised by patients as grounds for improving the quality of care. Our findings indicate that recent health policy directives promoting a view of complaints as learning opportunities from critical patient/consumers must account for sociological factors that inform both how the agency of patients is envisaged and how professionalism exercised contemporary healthcare work.

Keywords

experiencing illness and narratives, organisation of health services, patient–physician relationship, profession and professionalisation, theory

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Introduction

Since the 1990s, the relationship between complaints about healthcare made by patients and the quality of care received has been a focus of interest for health service managers, policy makers and researchers. There has been increasing international recognition that 'patient complaint' constitutes a unique and relatively low cost indicator of the quality of care given (Gallagher and Mazor, 2015; Schlesinger et al., 2015). English National Health Service (NHS) provider organisations and clinicians are encouraged to welcome 'complaints as a free gift' and to improve their reporting systems in order to 'listen and learn' from these events (Care Quality Commission (CQC), 2014; Healthwatch, 2013). The parallel rise in New Public Management directives in the United States and the United Kingdom – with its emphasis on service efficiency, market competition, and public accountability and devolution – promotes the value of 'consumer sovereignty' as a political and administrative technique (Aberbach and Christensen, 2005).

However, critical sociological research on the phenomena of patient dispute in medical care suggests that 'listening and learning' from complainants requires more than improvements in operational systems (Annandale, 1989; Mulcahy, 2003). Studies also note that the defensiveness of individual clinicians often silences the critical voice of patients (Hrisos and Thomson, 2013). Framing the issue more broadly than individual behaviours, Mulcahy's (2003) analyses of NHS doctor and patient dispute notes the endurance or and even hardening of defensive professional claims and identities. She identifies how collegial circles of medical experts continue to assert the authoritative expertise and moral entitlement of the doctor to define appropriate care. Mulcahy's findings indicate the intransigence of established styles of 'older professionalism' that recent sociologies of healthcare professionals (Elston, 2009; Freidson, 1994) describe as in decline. Our article builds on these sociological studies both to examine how care professionals working in different care services make sense of complaints made by patients and families (hereafter 'patients') and to explore what these complaints, and the rationales underpinning them, indicate about health professionals' exercise of authority and expertise in different relationships of care. Indeed, Annandale (1989) highlights the tendency for complaints made by patients within healthcare organisations to be framed as interpersonal matters, such as 'clinician-patient communication', rather than addressed as issues relating to organisational or national health policy agendas. Annandale's and Mulcahy's analyses offer more nuanced readings of patients' complaining about care as events that illuminate wider socio-political shifts in patient and healthcare professional identities. Their research invites closer investigation of how patients' complaining about care is interpreted and acted in different care settings and in relation to various healthcare professional identities.

Our study, guided by Mesman's (2008) notion of repertoire, explores the situational as well as the normative dimensions of healthcare professionals' responses to patients' complaining about care. The idea of 'repertoire' focuses analytical attention on the practical styles of reasoning as ordering strategies: the loose general principles by which people both decide what matters in particular situations and legitimate their views and actions according to 'what matters'. As Mesman (2008) notes, the evocation of a repertoire is a moral as much as reasoning activity.

Our study examines in-depth interviews with 41 healthcare professionals (doctors, nurses and allied health professionals) at different levels of seniority and working in eight NHS services in England in order to understand how they sought to make sense of the effects of patients complaining about care and the motives of those who complained.

Theoretical foundations

Sociological studies situate the rise of consumer-orientated regulation of medical work in the context of a wider, late modern destabilisation of independent/liberal professional authority and expertise (Freidson, 1994; Mulcahy, 2003). The crystallisation of NHS patients' legal entitlements, including the right to the hearing of complaints about medical and healthcare, was driven by wider recognition of the values of individual self-assertion and entitlement and of the legitimacy of experiential knowledge (Mold, 2012; cf. Habermas, 1981). As Mold (2012) notes, the accommodation of public commentary in health service reforms includes multiple, and sometimes inconsistent, framings as the interests of 'patients', 'citizens', 'consumers' or 'users' are articulated. These framings entail different assumptions about the interests of the public, ranging from concerns with 'care', 'equity', 'choice' or 'satisfaction'.

Freidson (1994) examines how the medical profession was restructured in response to administrative and popular challenges to prevailing forms of professional power and moral authority. He identifies a restructuring of the medical profession within the workplace and the wider political economy. This 'new professionalism' includes the exercise of various forms of social expertise and authority pertaining to technological development, bureaucratic rationalisation and risk associated with late modernity. However, as Elston (2009; following Giddens, 1990: 83) points out, such claims to expertise and oversight over abstract systems are ever more relevant, conditional and uncertain in present times. The position of front-line healthcare professionals who occupy 'key access points' to complex systems is precarious. Their authority often relies on individuals' situated and variable 'facework' of patient reassurance and collaboration. Commitment to self-audit and individual appraisal have become significant components of each professional's work agendas according to the values of 'partnership with patients', 'good communication skills' and 'lay involvement in regulation' (Davies, 2003 in Elston, 2009: 31). These behaviours seek to assure patients and the public of the trustworthiness of systems and practices that are assumed to be open to popular criticism.

Milewa (2009) suggests that it is against these contemporary politicisations and uncertainties about the work of systems and about those professionals who 'stand for' systems, that actual events of complaining about healthcare by patients takes shape.

To date, however, there is limited study examining if and how healthcare professionals experience and articulate any ambivalent positionality – as patient partners and systems representatives – in everyday work situations. Allen et al.'s (2015) study examines how midwives continually arbitrate between family preference and unit policy regulating family access to a hospital unit. These writers identify the underlying dissonance of these healthcare professional between 'the ideals of woman-centred care and the need to attend to the needs of the institution' (Allen et al., 2015: 26–27).

We build on these critical approaches to consider healthcare professionals' efforts to make sense of patients' complaining about care as indicative of underlying negotiations over the moral nature of 'patient care' and 'organisational care' work.

Study context and methods

Between 2009 and 2012 we conducted a national mixed methods study to investigate the influence of staff motivation, affect and well-being on patients' experiences of care in NHS acute and community health services across England (Maben et al., 2011). Following a nested case-study design, we conducted research in two acute and two community NHS trusts that had been purposively selected as 'high' and 'low' performing organisations for staff well-being at work and patient experience of care, based on routine national annual survey data. Two services were purposively selected in each trust following this same logic ('high' and low' performance in relation to patient experience and staff well-being at work). Service selection also took account of variations in disease trajectories and patient 'dwell time' in service. Each author led on the collection and analysis of the mixed methods data (staff and patient surveys; observation of practice and interviews with staff and patients) in two to four of the service case-study sites. In this article, only methods, analysis and findings for interviews with staff are reported.

The staff interviews were designed to explore, across the range of services, staffs' views and experiences of patient care work, their own well-being at work and their reflections on the relationship between these experiences and the experiences of patients. A semi-structured interview schedule was used to explore respondents' experiences without introducing issues that they might feel drawn to repeat.

Following our schedule, the interviews were designed to be discursive in style with authors interested in exploring with staff 'the assembly process as much as ... what was assembled' (Holstein and Gubrium, 2011: 143). This design was to allow exploration of how staff reasoned about the 'why, how and to what effect' of events of workplace events and conditions on the experience of staff and patients. Thus, staff could frame their narratives differently in responses to questions such as 'What makes a good/bad day for you?' and 'Tell me about a recent event that made you feel good/bad about your job?' For all emerging topics, interviewers prompted staff to flesh out the details of events and reflect on their experience by asking 'Can you tell me some more about that?' and 'What are your thoughts on that now?'

The study received ethical approval through the NHS Research Ethics Committee process (ref: 09/H0709/51) and all research participants gave informed written consent.

Data collection and analysis

The qualitative research in the eight services was conducted by the authors between January and June 2010 and included 86 narrative-style interviews with front-line healthcare professionals. The eight service case studies were emergency admissions (eau.), midwifery (mat.), older peoples' acute medicine (opm.), in-patient haematology (haem.), adult community nursing (cns1.), community matron service (cms.), intermediate care service (ics) and an adult community and palliative care nursing services (cns2.). For

each of the eight services, staff interviewees were selected for maximum variation in profession, discipline, seniority and time in service (see Table 1).

The audio-recorded interviews with staff in each service lasted approximately 60 minutes and were conducted either face-to-face with individuals in a private area of their workplace or by telephone. All recordings were transcribed verbatim and anonymised. Each transcript was coded for descriptors that included profession, seniority, specialism, work experience and responsibilities and service setting. The NVivo8 software program was used to organise the anonymised interview transcripts and to manage and audit qualitative data analysis. Transcripts were analysed iteratively by each research site using a grounded theory approach whereby emergent themes were discussed between the authors to develop a coding frame that was adapted as new themes emerged from the data (Charmaz 2006; Silverman 2009). Preliminary findings were also discussed in regular project meetings involving the wider study team. Two emergent themes were 'patients and families complaining about care' and 'staff attitudes to patients'.

The issue of patients' and families' complaining about care issue emerged as an *unsolicited* theme in the course of the research, as the authors began to notice that significant percentage (just over 47%) of staff across eight national case-study sites (n=41 of 86 transcripts) and greater percentage (almost 60%) of staff across seven of these eight national study sites (n=41 of 76 transcripts) identified 'patient and family complaints' as events that had significant effect on both 'attitudes to patients' and 'staff affect'. The exceptional study site was the midwifery service (mat) where no staff discussed complaints raised by patients as affecting them or their relationships to patients. This service was therefore excluded from our present analysis; however, we return briefly to this exception in our discussion.

A secondary phase of manual coding of staff interview data was undertaken by M.A. to further develop the themes presented in this article: the connection between patients complaining and care relationships and understanding why patients complain. After agreement on these themes with J.M. and G.R., M.A. refined these themes into sub-themes. We identified the theme of negative staff attitudes towards patients' complaining and further subthemes of complaining as mistrust; complaining as disregard of staff and services; complaining as misjudgement; complaining as distress; complaining as advantage-seeking and the outlier theme of complaining to improve things. More abstracted theoretical categories were developed by all authors by tracing variations, reoccurrence and the range of perspectives on themes and subthemes within and across transcripts. These categories were identified as 'healthcare professionals' expectations of care relationships' and 'healthcare professionals' notions of patients' care entitlements', which run through the subthemes above.

Findings

The incidence and effects of complaining by patients

With few exceptions, healthcare professionals viewed events of patients' complaining as damaging to themselves and to their wider relationships with their patients. A significant finding is that all experiences of patients complaining were highly emotive for front-line

Table 1. Outline of Service and Number of Interviews Discussing Patients Who Complained.

	'LOW' PERFORMING SERVICE (STAFF WELLBEING AND PATIENT EXPERIENCE)		'HIGH' PERFORMING SERVICE (STAFF WELLBEING AND PATIENT EXPERIENCE)	
	Total Interviews (n)	Interviews discussing patients who complained (n)	Total Interviews (n)	Interviews discussing patients who complained (n)
Trust A (High performing)	Older People's Acute Medicine (opm)		Haematology (haem)	
	16 (senior and junior doctors and nurses)	9 (senior and junior doctors and nurses)	10 (senior and junior doctors and nurses)	5 (senior and junior doctors and nurses)
Trust B (Low performing)	Emergency Admissions (eau)		Midwifery (mat)	
	9 (senior and junior doctors and nurses)	7 (senior and junior doctors and nurses)	10 (senior and junior midwives)	0
Trust C (High performing)	Adult Community Nursing (cns1)		Community Matron Service (cms)	
	12 (senior and junior nurses)	7 (senior and junior nurses)	8 (senior nurses)	3 (senior nurses)
Trust D (Low performing)	Intermediate Care Service (ics)		Adult community Nursing (cns2)	
	12 (senior and junior allied health professionals and nurses)	8 (senior and junior allied health professionals and nurses)	9 (senior and junior nurses)	2 (senior and junior nurses)
	All interviews = 86 Interviews Discussing Patients Who Complained = 41			

healthcare staff, often irrespective of their profession and seniority. Interviewees described feelings of 'gutting', 'devastation', 'awful shame', 'disbelief', 'shock' or 'incomprehension' that a complaint should be raised about themselves or colleague and, as often, about the service where they worked. This view was not directly related to the progression of a complaint through clinical or general management structures or to the issues comprising the subject of a complaint.

According to our interviewees, it was rare for complaints about care raised by patients to involve more than immediate teams or to be progressed beyond the clinical division. There were only two cases where complaints about care were progressed beyond the clinical division described. Events of patients complaining ranged from letter writing to

senior ward or unit staff to a short direct or indirect conversations with colleagues or front-line care staff in another service. As shown in Table 2, interviewees described a wide variety of complaints made by patients – including complaints about direct care and service delivery issues – that affected their work and their wider attitudes towards patients. Complaints described included delayed discharges from hospital, overly busy wards, poor access to single rooms, limited availability of pain relief, inadequate personal care for frail patients, poor communication with relatives, and complaints about rude or careless staff. Indeed, many of the issues that generated complaints made by patients had already been identified in our wider study and were already widely recognised as patient care or service delivery issues.

As Table 2 also illustrates, staff-reported issues raised by patients who complained often resonated with staff's experiences of work in the service settings.

We found that staff who worked in service settings where overall work experiences and patient care experiences were poorer were more likely to describe complaints made by patients as having a negative effect on their work and on their wider attitudes towards patients. While some senior staff from all professional backgrounds noted that they had learned, over the years, to 'stand back' and 'not feel the effects' of a complaint, an issue common to 33 of the 41 transcripts was the lasting effects of at least one complaint made by a patient at some point in a healthcare professionals' career.

Some interviewees indicated why events of patients complaining, even when about wider failings in services, might be upsetting for healthcare professionals. For example, a nurse manager in the emergency admissions unit remarked,

Complaints should give you an indication of how things are going ... like what we should be addressing and can't see for ourselves ... but it's when patients pick up on it and take it up themselves ... it's like we shouldn't have let it get to that point. (eau:int.2)

As this nurse manager implies, the felt disruptions of a complaint raised by a patient was often less about the *grounds* of complaint and more about the *event* of complaint.

Expressed dissatisfactions with care provision by patients indicated that something was amiss in their relationships with healthcare professionals. Similarly, a community matron, reflecting on the effects of a patient's relative raising a complaint about one of her colleagues, commented:

Well, it wasn't the best [care] ... so we can all learn from that one ... but it's the way he did it [complained] ... why would he do it like that [go to the Head of Department] and not come to us? That's the thing that really threw us all ... and now we all think that it's about how they felt about us really ... that's the really difficult thing. (cms:int.:6)

These reflections suggest that beyond the particular issues at stake in a patients' complaint about care, a significant concern for many care professionals is what is indicated by patients' complaining: a rupture in the expected and professionally valued qualities of the patient–clinician relationship.

We examine this issue in the following section, focusing on how staff interpreted patients' complaining as indications of mistrust or poor appreciation of their efforts to care.

Table 2. Service settings as experienced by staff and staff-reported issues of patients who complained.

	'LOW' PERFORMING SERVICE (STAFF WELLBEING AND PATIENT EXPERIENCE)	'HIGH' PERFORMING SERVICE (STAFF WELLBEING AND PATIENT EXPERIENCE)
Trust A (High performing)	<p>Older People's Acute Medicine (opm) Short-term, intensive, emotionally and physically demanding medical and nursing care; high nursing and staff turnover; inconsistent and limited medical staffing.</p>	<p>Haematology (haem) Long-term (intermittent, life-long), emotionally and technically demanding medical, nursing and therapeutic care. High staffing levels with intense and complex interpersonal care of patients.</p>
	<p>Emergency Admissions (eau) High intensity nursing and medical care; hort 'dwell' time; small group of frequent attenders. A 'stress hotspot' noted by directors of services</p>	<p>Midwifery (mat) Midwifery-led services with strong ethos of women-centred care supported by informal and long-standing staff support networks and local learning sets</p>
Trust B (Low performing)		<p>Written or spoken complaints about care were managed by the clinical director for the directorate or local service managers. These were occasional but expected to be very upsetting for staff. Complaints most frequently described by staff were 'poor team co-ordination'; 'poor clinical decisions'; 'disorganised clinics'</p> <p>Staff noted difficulties of meeting raised family expectations but none discussed complaints as a factors affecting them or their relationships with patients.</p>

Table 2. (Continued)

	'LOW' PERFORMING SERVICE (STAFF WELLBEING AND PATIENT EXPERIENCE)	'HIGH' PERFORMING SERVICE (STAFF WELLBEING AND PATIENT EXPERIENCE)
Trust C (High performing)	<p>Adult Community Nursing (cns1)</p> <p>High volume of home to home visits to temporary and long-standing patients to meet service targets; enduring staff shortages and reliance on bank staff. Staff 'disillusionment' and 'apathy' noted by directors of services.</p>	<p>Community Matron Service (cms)</p> <p>Intensive care, highly skilled and low-volume nurseservice. Patients have highly complex health and social care needs, remain in the service on a long-term basis and develop close relationships with single professionals</p> <p>A few matrons had been subjects of family complaints to service managers and private solicitors. These professionals and their immediate colleagues noted these events as highly traumatic to them. Complaints more frequently described by staff were by families noting 'care not explained'; 'no communication with family'</p>
	<p>Intermediate Care Service (ics)</p> <p>High-volume and geographically spread joint-funded (health/social care) service to meet patients' personal and rehabilitation care needs for up to six-weeks after hospital discharge.</p>	<p>Adult community Nursing (cns2)</p> <p>In contrast to cns1, a lower volume of home to home visits with longstanding patients supported at home for community, palliative and terminal care delivered by three established, and collaborative nursing teams.</p>
Trust D (Low performing)	<p>Two recent external investigations of poor care supervision in one care home.</p> <p>Staff considered management of complaints of patients and families had contributed towards work stress, staff sickness and high turnover and vacancies for qualified staff.</p> <p>Complaints most frequently described by staff were 'poor planning'; 'poor supervision of [residential] care'; 'inadequate advice before discharge.'</p>	<p>Complaints were rare in this service. Occasional verbal or written complaints to a nursing team manager were to do with 'misunderstandings' or 'family pressures'.</p>

Complaining as mistrust

We've had some humdinger of complaints [about care in residential homes] ... but those families didn't come to us so it makes you wonder what's wrong that they didn't come to us ... that's the bigger sort of question for us now. (ics:int 4)

The comments of this intermediate care nurse highlight one way in which complaints made by patients were rationalised by staff: as revealing a 'bigger sort of question' about patient mistrust in their authority or expertise. This interpretation of why complaints happened was more frequent in community health services, but also arose for other interviewees; doctors, nurses and therapists who worked in the haematology/oncology hospital wards. These clinical areas were distinctive because practices and conditions of patient care work often relied on ongoing care relationships being sustained between individual patients and a particular staff team overtime. In these services, the ideals of professional care work relied on interactions with individual patients that progressively build confidence in professional expertise. In such circumstances, a complaint raised by a patient indicated a profound loss of trust. Thus, a haematologist and senior ward sister both reflected on one family's complaining about treatment decisions for their son as about mistrust. The ward sister described the case as 'one boy's family just lost it with us' (haem:int6); while the haematologist reflected:

so now there are going to be problems ... like that point of losing faith ... like now we are on different sides. (haem:int5)

Also, in their discussions about such events, nurses, doctors and therapists spoke of their naivety or incompetence in anticipating their patients' declining confidence in them. Similarly, a community nurse recalled, from many years previously, the event of a complaint raised by a patient who she often visited. The patient complained about her advising him on the adjustment of a clinical procedure so that it would be more convenient for him:

I thought I'd handled the situation very well but later found out the patient obviously wasn't happy. He didn't say he wasn't happy but he basically went to the hospital and told them. I misread the situation, because I really didn't realise that he was so upset that he would do something about it and I felt that the patient hadn't been totally honest with me. I did feel hurt. I felt betrayed really ... I didn't see it coming. (cns2:int3)

Staff with different disciplinary backgrounds, and various years of experience, spoke of the gradually acquired informal skills for anticipating situations where trust begins to dissolve and complaining is likely to happen. Thus, an occupational therapist commented:

sometimes it's hard to tell what patients are playing at but you can often see it [a complaint] coming ... you spot the rumblings ... like the looks or something ... when you say or suggest something ... so now I'm like 'I can feel one coming on today' I'm always on tenterhooks now and that's about gaining experience about patients really. (ics:int7)

This ‘gaining experience of patients’ was described more candidly by another member of the intermediate care team as

just sort of finding out that families can really stab you in the back and not even know they’re doing it. (ics:int9)

Complaining as disregard of staff and services

In hospital settings where care provision relied less on ongoing interpersonal relationships with patients, events of complaint were more often rationalised by care professionals as signs of ingratitude or disregard for the individual efforts or services involved in providing care.

Thus, an emergency admissions practitioner commented,

We get a lot of people that clearly feel they want to write and complain, so it’s nice to get that other side. That is the thanks and gratitude. (eau:int3)

Staff in all services remarked on the felt tensions that they experienced between the increasing expectations of those receiving care and the declining resources for meeting these expectations. At the same time, hospital nurses and doctors, in particular, expected patients to recognise, and adjust their expectations to, the time and service constraints that staff had to deal with. Thus, one consultant in the acute medicine for the elderly unit commented,

we’ve had some very positive feedback ... so there are families who manage to see through the stress the staff are under, because it is never perfect [because] there’s not enough resource but they can see we do our best. (opm:int5)

This expectation that patients should accommodate service constraints rather than voice their concerns about service limitations was notable in service areas where the efforts of staff were more visible. For example, in the haematology chemotherapy day service, senior physicians noted the frequent delays in referrals and treatments but as one of them explained,

they all know that we are trying to get them through and they know that it’s hard for all of us really. (haem:int4)

This sense that patients’ should accept care and treatment delays because staff are ‘doing their best’ was echoed by community nursing staff. As one district nurse described,

So you’ll get somebody who needs pain relief and you won’t get a call [from the call centre] for an hour and then no full address and the family are saying ‘what took you so long?’ and we have done our best and they have to see that we have other families as well as them. So then we take a breath and speak to them and most of the time people do see it from our side and they back down and they’re very sorry and thankful. (cns2:int2)

This nurse indicated how events of patients' complaining about the limitations of a service rather than the practices of healthcare staff themselves became located and negotiated within immediate care relationships. However, we also found that healthcare professionals' assumptions about, and behaviours towards, patients who complained was influenced by their uncertainties and concerns about patients' motives for complaining.

Complaining as misjudgement

Interviewees from all services often noted their felt lack of influence over those aspects of care that can lead patients to complain. Senior doctors and nurses, in particular, noted their declining capacity to address patients' dissatisfactions as aspects of care management were felt to be 'actually beyond my control', 'coming from somewhere else' or 'out of our hands'. One interviewee, a senior doctor in older peoples' acute medicine, commented that the complaints raised by patients 'just scapegoat those people who are trying to give them the best' (opm:int5). Also, in some services, notably in emergency admissions and older people's medicine, interviewees often discussed patients' complaints in terms of the limited public understanding of the complexity or urgency of acute care. Thus, a staff nurse in emergency admissions noted,

It's always a problem with 'discharges', they can't go home when they want. We have to go up to Pharmacy, obviously the patients don't understand, they think they can just get their tablets, that's it and go but there's a lot of planning into a discharge.

It could be two hours getting it all together and the 'discharges' are like, 'I've got a taxi ordered at 4 o'clock'. Well it doesn't work that way. (eau:int 5)

In services where resources were particularly stretched and where reported complaints was felt to operate as a proxy of clinical and service performance for managers (emergency admissions; older people's medicine; intermediate community care), both nurses and senior doctors felt that the time demanded to attend to complaints about care diverted attention away from real clinical priorities. A senior nurse in emergency admissions noted,

Half the patients that we see, we make a massive difference to their health. We stop them arresting. And it's not being dramatic, we really do and half the patients are oblivious to what you've done and they're more bothered about, 'they haven't even offered me a bloody cup of tea for five hours ...' and you think, 'oh, my God, if only you knew'. (eau:int3)

The assumption that patients who complain often lack insight into their own care and treatment priorities was echoed in the comments of a senior consultant in the same service:

A lot of it is, 'Can you take this venflon out?' I get that every day. Or, 'My chair is not very comfortable'. I had that this morning. Or, 'when will I be moved to the ward? Or, when can I go home?' There's nothing that I can do about that but this is the stuff of written complaints you know. (eau:int1)

A view based on misunderstanding or ignorance about care practices or priorities was indicated more often by interviewees working in acute care for the elderly. Ward staff elaborated that patients and families complained because they ‘missed the whole picture’ and ‘only saw just in front of them’, thus failing to appreciate why particular care decisions were made. Staff also tended to dismiss the complaints voiced by families on the grounds that family members were only partial witnesses of what actually happened on the ward, because of limited visiting hours, patient privacy, and the possibility of patients recalling and reporting events inaccurately.

The notion that ‘some people complain about just about anything’ was another way in which interviewees rationalised patients’ complaining. This sense of randomness of the complaint furthered the view of patients as unreliable commentators on the quality of care given. Thus, a senior nurse and complaints manager in emergency admissions remarked,

It always amazes me how you can have two patients in a bed beside each other at the exact same time, one will have a good experience, and one will have a bad experience. I don’t know whether it’s down to individual patient expectation and whether we have let them all down in some ways so it’s difficult to rationalise sometimes. (eau:int2)

Interviewees in all services also reflected on how they negotiated the increasing expectations of patients and employers for them to respond to complaint even if this ran counter to their clinical priorities. The notion of a ‘front stage’ service delivery and ‘back stage’ clinical priority was indicated by senior professional staff. Thus, one senior physician and clinical manager commented,

It’s as soon as the food’s gone cold or someone’s waiting then there’s a complaint ... I think if you walk in a ward that’s clean, you can forget about the medical care, but, you know, if it’s clean and tidy, the relatives will be happy, you know, they get their food on time, you know, that’s fine. (opm:int2)

While clinical managers noted patient sensitivity to ‘front stage’ care and sought to improve this with training interventions, some staff expressed their frustrations at patients whose expectations of important aspects of care were misinformed. One relatively junior nurse working in the older people’s medical ward spoke about the risk of ‘front stage’ service overtaking more fundamental care priorities:

It’s generally good [here] but maybe that’s because the patient isn’t aware of what it could be. So although the patient is very happy, they’ve been lying in bed having drinks and food, but they’re not aware that actually their experience could be much, much better if their drug is on time, which they might not know about. (opm:int2)

Complaining as distress

Another way that interviewees rationalised complaints made by patients was as a symptom of distress caused by illness. Understood in these terms, the professional care task was to deal with emotional upset with empathy and interpersonal skills. Interviewees

from the most time pressured services, notably emergency admissions and older people's medicine, often felt that they 'took the blame', or 'the brunt' or 'got the backlash' for patient anxieties expressed as complaint. By contrast, interviewees from services where relational care was recognised as important, understood the issue of complaint arising from patient distress differently. Thus, a senior nurse in haematology commented,

They are mindless complaints because at the end of it there are patients that come in and they're so stressed that they want ... that's just how they find themselves. (haem:int3)

In all services, interviewees who were more experienced described the particular skills required to respond to patients who had complained about one issue because they were actually distressed about wider events. For two consultants in older people's medicine, this meant attending personally to those family members who appeared more likely to raise a complaint. A ward sister in emergency admissions described her approach to reducing written complaints as 'just listening to unhappy patients' (eau: 3). Other staff in hospital and community services described their work as 'fielding' and 'diffusing', 'just apologising and finding it [the apology] easy to say' and 'letting [complainants] get it out of their system'.

This 'listening' work, as described by several interviewees, often involved simply accepting the version of events given by complainants. Thus, a haematology registrar recalled a meeting with relatives who had complained about care given to their deceased father:

They had questions about what happened on the day [that he died] and you can understand that the family might be upset and they need to grieve and get all of this out of the way, but particularly when you think that you've done a really good job, [it] is quite disheartening. Like you have to remind yourself that these people are grieving, and even though I want to stand up and say, 'We didn't do this, we did this, and we did this, I can't say that'. (haem:int1)

Staff in services with high patient 'through put' discussed the value of accommodating complainants' emotional needs in more cynical terms: to 'cover yourself' or 'anticipate and avert', and 'to smile and deal with it'. Here also, different staff spoke of the need to appear contrite so as to protect themselves or their junior colleagues from intimidation by both complainants and by some senior managers.

Complaining as advantage-seeking

In the more resource-squeezed services, interviewees described complaints as a means by which patients sought advantage over others in the timing or quality of their care. Particularly in emergency admissions, interviewees shared the view that patients sought to secure best services by threatening to 'write a complaint'. Here also interviewees spoke of their personal vulnerability to aggravated and complaining patients with several senior staff recalling a dread of ward rounds where they all felt 'ganged up on' by dissatisfied patients. Several interviewees discussed the same examples of senior consultants being intimidated by families and unable to respond to this because 'you'd be frowned upon about being assertive and dealing with it in case they actually do raise a complaint' [eau:int3]. This sense of shared vulnerability to threats to formalise complaints by patients in some service settings was accompanied by comments that such

services ‘harden you up’. Thus, one ward sister noted the need for those working in this service to listen to patients but ‘not take it too seriously’ and ‘not to get too involved’ (eau: int2). However, emergency admissions staff, nurses and doctors, also noted that the threat of a patient or family to ‘write a complaint’, coupled with management directives to reduce ‘complaints’, affected clinical judgement, often to the detriment of other patients. For example, a senior nurse commented,

It’s unfair that the people that are truly sick and very ill sometimes have to wait an unacceptable length of time and when you look at the whole bulk of people that are here you could weed quite a few out who don’t need investigation, that don’t need this, that don’t need that, but expect it. And doctors, and us now as nurse practitioners, over-investigate people because you dare not. Because there is always the feeling that they’ll complain. It’s almost like a threat. They dictate exactly what they want even if it’s not necessarily right. (eau:int3)

In this service also, staff described the time-consuming work of negotiation over available resources in order to prevent patients from formalising a complaint that took ‘time away from other patients’. Medical consultants described situations where limited resources, like single side rooms reserved for the patient with infectious diseases, were found for those threatening to formalise a complaint to hospital managers. Similarly, in the two community health settings where two families had progressed their complaints to service managers, and outside regulatory agencies, staff felt particularly vulnerable when organising or giving care, and discussed the compromises in judgement they felt it necessary to make when families voiced complaints about receiving limited care for their relatives. Thus, the mental health practitioner in the intermediate care team commented,

The fear of complaints puts power in the hands of a few and it’s only the ones who know their way around the system, are genned up, who we end up listening to and that’s wrong. (ics:int3)

In this service interviewees often noted their important role as decision-makers in the rationing of hard-pressed public resources and the inequities that arose when service managers’ priorities were driven by the reduction of ‘patient complaints’.

Complaining to improve things

A far less common way that interviewees rationalised the complainants’ motives was to acknowledge that ‘they have a point’. Particularly in hospital settings, front-line staff generally felt that they could do no more than offer a cursory apologies to complainants. Few interviewees in community or acute services felt willing or able to agree with complainants or explore with them care and service deficiencies. Thus, while some staff in particularly hard-pressed services noted the need to ‘increase public awareness of the pressures on staff and patients here’ (ics:int4), other clinical managers considered such dialogue inappropriate. A unit manager in emergency admissions noted,

you get staff blatantly telling waiting patients that we’re very short-staffed but at the end of the day patients don’t want to hear this, as it’s not their fault that we’re short staffed and it’s not professional and staff need to get on with it, the patients don’t need to hear it. (eau:int4)

By contrast, a senior clinical manager in older people's medicine indicated a different reason for avoiding any candid discussion of service shortcomings with complainants:

When I worked here years ago we only had one complaint and it was different then.

We were all horrified, absolutely horrified, people were in tears about it but now you hear nurses just saying 'Well, if you don't like it, here's a complaint leaflet' and it goes up the chain. [Years ago] we were mortified and we had to do something about it [ourselves]. (opm:int 4)

These contested claims over the responsibilities of care professionals for acting on complaints made by patients indicate their ongoing dissonance over the values of patient care and the interest of their service or employing organisation. Indeed, several interviewees from some services (notably intermediate care and emergency admissions) discussed the events surrounding a patient's complaint about care as these were felt to reveal the loyalty of managers to them. In these services, staff felt betrayed by their organisation as well as distrusted by many patients. Thus, an intermediate care nurse recalled that

the thing was how it [a grievance raised by a family] all panned out with them [she signals to offices of service managers] because that really taught us a thing or two with where loyalties lie. (ics:int4)

Notably, nurses and doctors in one service setting, haematology, gave greater credence to the constructive potential of complaints made by patients. Here, interviewees described how repeated complaints about ward catering and cleaning had inspired them to petition for change by involving complainants in this work. A senior nurse explained the rationale for such involvement:

Particularly for haematology patients they do have very specific needs and, yeah, because they understand their illness probably better than we do, they're very observant, checking that everything's been done, they have the experience. (haem:int5)

These reflections indicate how more fundamental assumptions about patients' capacities and expertise condition the ways in which care professionals rationalise the events and motivations of complaint. In this exceptional service, where 'expertise by experience' was recognised in both decision-making and care practices, patients' grievances could, in particular circumstances, be taken seriously and patients could be envisaged as valuable collaborators for improving hospital services.

Discussion

Repertoires of care and complaint

Our findings have identified and explored the underlying repertoires of care evoked by professionals as they seek to understand events of patients complaining. We found that such events are almost always considered damaging – to healthcare professionals themselves and, potentially, to care and service arrangements for other patients. This view of

complaining as disruptive is particularly marked in services where the care of patients and experiences of work were already felt to be compromised (our poor performing services).

We found that healthcare professionals tended to understand events of patients' complaining as indicative of wider breaches in the clinician–patient relationship – notably, in the sense of patients' trust in and appreciation of professional care work. This was a recurring concern for staff who felt that their work or relationships with patients were affected by patients complaining, and this concern was often irrespective of the issues raised in complaints by patients.

Additionally, healthcare professionals also sought to understand the 'real' motive for a patient complaining and to develop and legitimate an appropriate response according to 'what matters' (Mesman, 2008: 198). We found an array of moral positions elaborated by healthcare professionals in relation to patients' motives. We identified some relationship between the local structural features and tacit ethos of patient care of healthcare delivery and the legitimisation of appropriate response to patients who complained. Furthermore we noted that, from the point of view of the majority of our staff interviewees, the complaining of patients bore limited relationship to care or service realities or improvement priorities.

Service settings and patients' motives

Our findings highlight the significance of service settings and occupational differences, rather than professional distinctions, for understanding how complaints raised by patients were rationalised by staff. Considering how staff in the eight different services (see Table 2) tended to make sense of the complaints made by patients, a series of general trends are notable. Staff were more likely to interpret complaints as a sign of breached relationships of trust in clinical areas such as haematology and community health services where ongoing care relationships, rather than 'on off' care encounters, were more common (cf. Potter and McKinlay, 2005). In these service settings where there was often greater 'dwell time' and where the relational care of patients was recognised, the art of fostering interpersonal relationships of trust, and of anticipating discontent, was emphasised by staff, irrespective of professional background. In services where the ideal of relational care carried greater purchase for staff, as in haematology and palliative care services, complaints were more often interpreted as signs of distress or misunderstanding. By contrast, in services such as emergency admissions where transient care encounters predominated, staff more often assumed that complaints happened when patients failed to notice or appreciate their efforts to care. In services with more limited resources, staff tended to assume that patients complained to manipulate improved access. In domiciliary care settings, in contrast to wards or clinics, the work demands of staff, and the relative needs of others, were often invisible to patients and so were often expected to be overlooked.

As previously noted, it was rare for a complaint raised by patients to be attended to 'in and of' itself: as legitimate knowledge or experience of care. Instances when patients' complaints were taken at face value were reported only by staff, doctors, nurses and therapists, working in a haematology ward that fostered a distinctive and unorthodox

vision of patients. His setting was exceptional for promoting a vision of patients that stressed the values of patient autonomy, self-care and expertise by experience. Here, complaints made by patients about services were harnessed as authoritative observations that required, or permitted, care professionals to work with managers to address their concerns in order to improve things.

Professionalism and patient criticism

At a more critical theoretical level, our findings offer insight into how contemporary healthcare professionals positioned themselves – affectively, socially and politically – in relation to the critical voices of their patients. In particular we suggest that professionals' ongoing reflections on 'underlying' patients' motives and so 'what matters' in term of their response resonates with wider socio-political realignments of professional power and authority in late modern healthcare systems.

Following Elston (2009) we note that, at least for front-line healthcare professionals, the restructuring of prevailing expertise and moral authority in response to consumer-orientated regulation of their work is more complex than Freidson (1994) suggests. Indeed, professionals' interpretations of patients' complaints, as signs of breaches in patients' trust or appreciation of them, evokes claims of liberal professional authority exercised by competent, ethical, conscientious and ever-reliable experts. Similarly, considerations of patients' motives for complaining were generally discussed in terms of mistake, irrationality or illegitimacy. Our interviewees indicate that recent ideological commitments to 'patient partnership' (Davies, 2003 in Elston, 2009) must often be trumped by the exercise of other knowledge claims, such as professional expertise and authority in technological, emotional or bureaucratic aspects of patient care. Thus, when a complaint about care was interpreted in terms of complainants' ignorance of service complexities or clinical priorities, staff claimed moral authority over aspects of care that was more important than, and extended beyond, 'front stage' customer service delivery. Similarly, when complaints were rationalised as expressions of emotional distress over illness, care professionals positioned themselves as those who were able to placate and mediate patients' upset and anguish, as an important part of their role as care-givers, but without having to acknowledge the grounds of their concerns (Mulcahy, 2003). Also, when complaints were rationalised as a means of seeking advantage in access to time or services, care professionals positioned themselves as the arbiters of resources for the benefit of the general patient community (Allen et al., 2015).

At the same time, however, front-line healthcare professionals were inevitably situated in the often contradictory popular and managerial expectations of contemporary professional work as a 'system of service'. These include, as Davies (2003 in Elston, 2009: 31) describes, 'face work' to sustain public trust in or avert popular criticism of, ever more friable systems well as the bureaucratic rationalisation of care in these systems. Concerns with, and repertoires for, patient motive for complaining indicate how healthcare professionals seek to interpret the expectations of professional healthcare at a time when 'patients' comprise complex political, legislative and administrative categories of contemporary healthcare recipients. Milewa (2009) and Mold (2012) trace the various framings of patients as citizens, experts, users or customers in NHS policy. Our

interviewees variously elaborated these perspectives on patients' motives for complaining (as service consumers; vulnerable patients; advantage-takers or as responsible citizens) and thus exercised claim over appropriate moral position and expertise (as hard-pressed care providers; comforters; service gate-keepers or patient advocates).

Strengths and limitations of this study

A particular strength of this study is the in-depth investigation of healthcare professionals' narratives of their experiences of, and attitudes towards, patients' complaining about care. A range of healthcare professionals, of differing levels of seniority, were included in the study and the interpretation of findings drew from our wider study findings to understand how professionals' experiences and attitudes were differently configured in eight local service areas. This approach provided a strong contextualisation of interview findings and new insights into the dynamics between patient-mediated quality improvement work.

Since this study purposively sampled healthcare professionals who felt that the complaining of patients affected their experiences of work or general relationships with patients, the resulting sample is not representative of, and does not indicate a prevalence in, the wider population of NHS healthcare professionals. Also our study only reports findings from the NHS staff interviews subgroup, perspectives of patients and families, researchers' observations and other data sources are not considered here. A methodological limitation of the study is that it is developed from a secondary phase of analysis of a study with broader aims and objectives. Specific questions about patients complaining were not included in the interview schedule; this topic emerged spontaneously. Therefore, the detail and breadth of data on this topic is not consistent across all service areas or for all interviewees. Notably, we were unable to explain why complaints about care was not considered significant to the work experience of staff in our maternity services case study (see Table 2). This gap in our data is significant given that NHS maternity services generally tend to have high incidences of poor satisfaction with care (Allen et al., 2015).

Conclusion

Our analysis offers novel and empirically grounded insights into how care professionals rationalise patients' complaints about care. Drawing from interview data collected from different care settings, we have explored the particularities and contingencies of these rationalisations in terms of wider historical revisions in care professional, management and patient relationships, and in terms of local care structures, values and material constraints. We found that local workplace structures, values and experiences were more significant than fixed professional or disciplinary distinctions for understanding how our interviewees made sense of complaints made by patients in everyday care work.

These findings indicate some of the obstacles to using patient complaints for clinical team and organisational learning for improvements in the quality of care. We suggest that current consumer orientated/learning approaches that advise staff to 'take complaints seriously' or 'receive them as gifts' are unlikely, in themselves, to convince care professionals of the value of patient insight and experiential knowledge. The development of

‘complaint management’ models requires research-informed awareness of how such approaches inform, revise or retrench subjects’ positions within the particularities of local service relationships.

More generally, our study indicates the potential for more sustained analyses of what happens to the critical voices of patients as these offer important insights into the dilemmas of virtue and of practice that accompany the rise of ‘new professionalism’ in healthcare. As Elston (2009) notes, this professionalism relies on the conditional and meritocratic quality of trustworthiness that is demonstrated in both expert judgements and in partnership with patients. At the same time, healthcare professionals work assumes ‘patient facing’ responsibilities for increasingly complex divisions of labour in patient care and for ever tighter rationing of care resources. In this sense, patients’ complaints about care articulate an uncomfortable contradiction in what it means to be a healthcare professional.

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