From fear to fraternity

A socio-legal analysis of doctors' responses to being called to account by patients

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Abstract

From fear to fraternity: A socio-legal analysis of doctors' responses to being called to account by patients

This thesis considers how senior hospital doctors respond to challenges to their autonomy contained in complaints. It focuses on how doctors talk about, explain, circumvent and resist these threats. The aims were twofold. First, to contribute to the development of socio-legal theories of disputes. In particular, the study aimed to enhance understanding of reactions to voiced grievances which tend to be under-theorised. A second aim was to examine how a powerful elite, such as the medical profession, responds to attempts by the legislature to regulate their responses to complaints. The thesis raises issues of how and whether regulation of medical work can be achieved and the success of law as a medium through which to facilitate regulation. It considers the ways in which the impact of law is mediated by competing normative frameworks, such as those developed by the medical profession.

Exploration of these themes has been informed by an qualitative and quantitative empirical studies of how hospital consultants respond to complaints. A theoretical framework was developed using a grounded theory which was used to code three main datasets; interviews with 35 consultants, interviews with 25 managers and postal questionnaires from 443 consultants. The theoretical perspective adopted drew on and contributed to attribution theory, socio-legal theories of regulation, theories about doctor-patient interactions and work on the sociology of the profession.

It is concluded that complaints have a significant impact on the emotional well-being of consultants and are likely to lead to changes in the way in which they provide medical care in the future. Complaints cause consultants to question their abilities and, in their attempts to come to terms with the criticisms made of them, they rely heavily on medical networks for support, to the virtual exclusion of other networks. The medical fraternity has a large part to play in the re-negotiation and construction of doctors' damaged identities in line with the needs of the group.

As well as representing a challenge to the individual, complaints are viewed as a symbolic challenge to the medical group. There are two main reasons for this. Firstly, the very act of making a complaint implies that the complainant has the competence and knowledge to challenge expert medical work. Secondly, the making of a complaint provides the trigger for managerial interferences in the doctor-patient relationship. An understanding of these broader threats to the profession go some way to explaining why elite medical groups have worked so hard to resist regulation of their work.

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1 Introduction

> 'I argue that the ultimate practical and moral reality of human society lies in what concrete people do and how they interpret their problems in one setting of everyday life.' (Friedson, 1980, p xi)

Introduction

In recent years, a number of public enquiries have been launched which have considered whether instances of mismanaged medical care should have come to light much earlier than they did. The Shipman inquiry raises questions of whether quality initiatives in the NHS can ever be successful when so much medical work is carried out in the community, often by sole practitioners. The Kent and Canterbury Hospital cervical smear scandal has prompted concern over the failure of quality management systems in a large-scale hierarchical organisation. The inquiry into the deaths of babies with serious heart conditions at Bristol Royal Infirmary has initiated debate about the constraints on 'whistle-blowing'. In all these cases, colleagues or patients of those to whom blame is being attributed had voiced their dissatisfaction with aspects of the care being provided. In some cases, they were discouraged from pursuing their allegations. In others, there was insufficient evidence to pursue a case of poor performance. All these cases suggested that the way in which medical care is practised and organised needs to be reviewed. In this thesis, it is argued that appropriate responses to mismanaged care cannot be understood without an appreciation of doctors' attitudes to being criticised and making mistakes.

This thesis considers how doctors respond to challenges to their autonomy made by patients and their carers when they complain about the treatment they have received. It focuses on how doctors talk about, explain, circumvent and resist these threats. It is concluded that complaints have a significant impact on the emotional well-being of consultants and are likely to lead to changes in the way in which they provide medical care in the future. Complaints cause consultants to question their abilities and, in their attempts to come to terms with the criticisms made of them, they rely heavily on medical networks for support, to the virtual exclusion of other networks. The medical fraternity has a large part to play in the re-negotiation and construction of doctors' damaged identities. In time, doctors come to understand complaints as a manifestation of the illness experienced.

As well as representing a challenge to the individual, complaints are viewed as a symbolic challenge to the medical group. There are two main reasons for this. Firstly, the very act of making a complaint implies that the complainant has the competence and knowledge to challenge expert medical work. Secondly, the making of a complaint provides the trigger for managerial interferences in the doctor-patient relationship. An understanding of these broader threats to the profession goes some way to explaining why elite medical groups have sought to persuade policy makers against the setting-up of a formal regulatory framework for complaint handling. It also explains why consultants handling complaints at service level react so strongly to complaints and seek to circumvent and avoid formal regulations governing their responses.

On the basis of the analysis presented in forthcoming chapters, it is argued that there is a systemic distortion of meaning in interactions between doctors and patients. Conceptions of what constitutes appropriate care are formulated in significantly different ways by each of the parties to a complaint. Rather than representing a shared reality, accounts of illness, treatment and mistakes provided by doctors and patients represent two quite distinct forms of reasoning and narrative. While complainants concentrate on persuading their audience of the moral value of their complaint and the impact of the circumstances complained of on their lives, doctors in this study preferred to view such 'protest' as evidence of uninformed lay views of illness or as a manifestation of the illness itself.

These arguments are underpinned by an empirical study of how NHS hospital consultants react to being held accountable for clinical decisions by patients, their relatives and friends. The data presented are highly relevant to academic and policy debates about the purpose and success of regulation in the public sector. Complaint handling in hospitals has been the subject of formal regulation since 1985. Since that time, all doctors have been legally obliged to provide an answer to allegations made about the care they provide and to co-ordinate their responses to complainants with managers. Unlike many other forms of regulation which are proactive, this regulation of dispute handling occurs on an *ad hoc* basis. It is prompted by those using the service rather than salaried regulators. In this sense complaints about doctors are a form of reactive regulation; they operate as a type of safety valve. They can be used to bring to light bad practices which have not been revealed or dealt with by more proactive regulatory systems such as clinical audit, risk management and external reviews such as those undertaken by the Audit Commission or Public Accounts Committee. But, in common with other regulatory models, the overseeing of complaint handling by the state has been hotly contested. The medical profession has resisted state interference and the shift towards handing jurisdiction over complaint handling to NHS managers. The data presented in this thesis reveal the ways in which such resistance has manifested itself in national debate and service-level practice.

The making of complaints provides examples of consumer activism and challenges to professional power which have received little interest from academics. But despite the lack of attention given to the study of this type of grievance, the issues raised by complaints have currency across a range of contemporary debates relating to the nature of professional power, the dynamics of the doctor-patient relationship, and the impact of law on behaviour. This introductory chapter considers the contribution which can be made to such discussions by the present study.

The aims of this study

It is a basic tenet of the approach adopted in this thesis that the effective formation of policy and law is facilitated by an understanding of how human beings react to policy, rules and regulation and that issues of social control are central to issues of social policy. Set within this context, this thesis has two main goals. Firstly, it aims to contribute to the development of theories about the dynamics of disputes. Socio-legal scholars have devoted a considerable amount of attention to the emergence and transformation of grievances into disputes[1] and to identifying case characteristics[2]. Disputes continue to dominate discussions of law and other normative frameworks because of what they reveal about social interaction. Although they seem to be out-of-the-ordinary events, they nevertheless mobilise support systems, highlight social cleavages and are argued in terms of general morality (Colson, 1995). Trubek (1980-81) has argued that analysing disputes offers the possibility of greater insights into social relations and conflict and that this in turn allows us to use them to understand the wider social world in which they are embedded. Similarly, Caplan (1995) asserts that the study of disputes leads straight to key issues for social scientists and lawyers - norms and ideology, power, rhetoric and oratory, personhood and agency, morality, meaning and interpretation. It allows us not only to see social relations in action but also to understand the cultural systems in which they occur. But despite the relevance of such studies, research on reactions to voiced grievances is under-developed and under-theorised. The data collected for this these aimed to contribute to understandings of such reactions in a medical context.

Secondly, the thesis examines how groups respond to external controls. It considers how close-knit professional communities like the medical profession react to, and attempt to mitigate, the consequences of challenges to their autonomy and power. It is argued that complaints are more than just a challenge to the individual complained about. They pose a symbolic threat to all doctors since they help to prompt debate and set boundaries around what is considered to be appropriate behaviour and the degree of accountability that doctors owe to patients. The development of the hospital complaints procedure provides one example of how the medical profession has maintained power over its own work. It highlights the ways in which the elite of the profession have sought to shield their members from regulation of their handling of complaints. To date, much of this activity has only been visible to the laity at national level. Previous commentaries have placed emphasis on the various ways in which the medical elite have helped to frame national policy on complaints in a way which has reflected their interests and protected their jurisdiction. Such an approach provides an important context for the present study, but in this thesis the emphasis is on how such resistance also manifests itself at service level. Complaints made at service level are more representative of challenges to medical autonomy than those pursued to appeal and constitute the mass end of the disputes market. Focusing on these disputes allows consideration to be given to the various ways in which the non-elite develop collective coping strategies and mobilise support networks and organise social interactions within the medical group on a day-to-day basis. In short, it aims to cast a spotlight on what Kagan calls a 'handful of trees in the murky, ever-growing and incredibly diverse rainforest of regulatory programmes' (Kagan, 1984, p1).

The case for focusing on complaints

The subject of complaints remains relatively unexplored. In their literature review published in 1996, Mulcahy and colleagues concluded that while complaints systems are pervasive they remain under-investigated (Mulcahy *et al*, 1996a). Academics and practising lawyers have paid little serious attention to such systems of redress and even less attention to the issue of the place of complaints within the regulatory state. Complaints have been left alongside the study of other internal reviews in the public sector as something of a poor relation in mainstream administrative law (Mulcahy *et al* 1996a; Birkinshaw, 1985; McAuslan, 1985; Davis, 1969).

The characterisation of complaint systems as 'low-level' methods of handling grievances has meant that administrative lawyers interested in studying them are seen as 'descending' for the purpose of their perusal (Harlow and Rawlings, 1998). Administrative law textbooks tend not to include chapters on complaints and where notice has been taken of them there has been a tendency to view them in the context of their relationship to other things, most notably legal claims (see, for example, Harpwood, 1994; Carrier and Kendall, 1990). As Partington (1997) has summarised:

> '... most parts of the administrative justice system have an extremely low profile in the minds and priorities of those who have in the past shaped policy relating to dispute resolution.' (p5-6)

This attitude reflects the judiciary's tendency to construe narrowly the gateways to administrative and public law (Craig, 1994)[3] despite the fact that public sector complaints procedures handle many more thousand citizen grievances each year than the courts and that many of them involve serious policy issues. Emphasis has instead been placed by legal academics on: the appellate courts, their models of reasoning and adjudication (Hawkins, 1992); the structure of such rule-making bodies; on the rules themselves, rather than on the people who interpret and implement these rules; the growth of judicial review; and comparisons between courts and tribunals. This approach is often considered justified because of the so called 'radiating' effects of court decisions (Galanter, 1983, p119; Mulcahy, 1999). According to this view, judicial pronouncements have a direct influence on the way that service users and administrators handle similar cases in the future. The courts are seen as having a declaratory role or as bestowing a regulatory endowment which casts a shadow over all disputes or acts as an incentive to debate (Fiss 1984; Galanter, 1983; Mnookin and Kornhauser, 1979; Fuller, 1978).

However, there is also an argument that those cases which proceed to formal adjudication are unrepresentative of the range of disputes which arise in the citizen's interface with state authority (Ison, 1997). According to this view, the way in which complaints systems operate constitutes an important aspect of how justice is achieved and how conflict is managed in contemporary society. Moreover, whilst judicial review is important, it may be irrelevant to most citizens who want to challenge the decisions of public servants (Sainsbury, 1994). Empirical studies of decision making have demonstrated that the majority of official decisions in the legal system of the modern state are not made by the judiciary but by frontline workers, like doctors, whose decisions are rarely visible. Kagan (1984) has argued that:

> 'The great mass of official decisions in the legal system of the modern state are not made by judges after considering the arguments of legal counsel, but by the eligibility workers processing files in welfare and unemployment insurance offices, or by low paid regulatory inspectors, tax auditors, licensing officials and assorted other bureaucrats. In theory, of course, their decisions are subject to review by the courts; but in practice appeal is often unfeasible.' (p816)

The emphasis placed on more formal attempts at grievance resolution at the top of the civil justice hierarchy has not gone unnoticed. A handful of writers have made attempts to put complaints on the research agenda and the work of the 'Sheffield School' is particularly worthy of note (see, for instance, Seneviratne, 1994; Lewis and Birkinshaw, 1993; Seneviratne and Cracknell, 1988; Lewis *et al*, 1987; Birkinshaw, 1985 and 1985a). Writing in 1985, Birkinshaw suggested:

> 'Considering the wide range of discussion on tribunals, inquiries, non-departmental bodies, ombudsmen and courts, all of which act as umpires and/or regulators of affairs between citizens and the state there is surprisingly little discussion on one related theme. This concerns the informal processes or methods which Government Departments themselves adopt to respond to complaints or grievances by individuals or groups who are affected or will be affected, adversely as they believe, by departmental decision making ... The omission is more notable, perhaps, given that public lawyers have suggested for some years that the less formal or publicised processes of administrative decision-making, which include complaint resolution, have escaped close scrutiny.' (p15)

Over a decade ago, Rawlings criticised this lack of interest in the lower end of the civil justice system in his influential review of the literature on grievance procedures and administrative justice commissioned by the Economic and Social Research Council (ESRC). He suggested that the existing socio-legal literature be expanded to enhance our understanding of less formal internally-managed mechanisms for the handling of disputes between the citizenry and public sector organisations. In his words:

> 'The focus has been on the visible tip of the iceberg, especially as regards central government. Certain tribunals and inquiries have been heavily researched, others less so ... Within the various institutions researchers have often opted for soft targets, leaving complex and/or controversial issues such as efficiency, administrative impact and appointments unstudied.' (Rawlings, 1987, p5)[4]

This study represents a modest attempt to redress this imbalance.

What is the procedure for handling complaints about hospital doctors?

Since the inception of the NHS, the emphasis in hospital complaints procedures has been on service-level handling of medical complaints by doctors. The vast majority of complaints go no further than an initial investigation and reply to the complainant. It is unusual for complainants to appeal beyond this first stage and rare for the case to be pursued as a medical negligence claim. At the time the empirical study reported in this thesis was undertaken, the hospital complaints procedure was on the cusp of change. Since the passing of the Hospital Complaints (Procedure) Act 1985 it has been mandatory for hospitals to comply with centrally issued guidance on complaint handling from the Department of Health (DoH). A new complaints system came into being in 1996 in the wake of a major review and made significant changes to the appeal stage of the complaint procedure, but made scarcely any difference to the first stages (NHSE, 1994). If anything, it gave greater credence to self-regulation of complaints by doctors by stressing that complaints should be resolved as quickly as possible by the practitioners concerned.

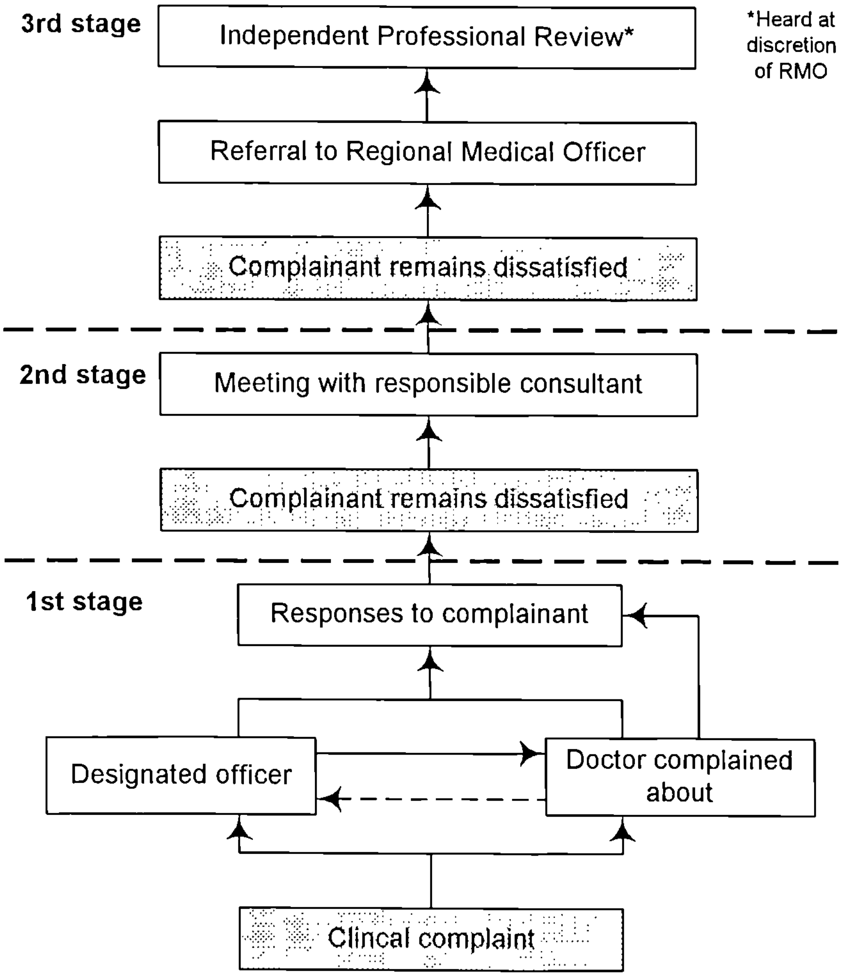
The formal procedure in place at the time of the study (HC37/88) attempted to bind doctors and managers to a set protocol in their handling of complaints. It prescribed how policy makers thought those responding to complaints should behave. Significantly, the guidance was in two parts. The main section appeared to lay down a procedure for handling all complaints and the principles which should govern the management of complaints. However, the document also contained and appendix which gave guidance on the handling of clinical complaints. The appendix was drafted separately by the Joint Consultative Committee of the British Medical Association and Royal Colleges. The two parts of the guidance were not been well integrated and, at times, appeared to contradict each other. As a result, the procedure reflected something of a fudged compromise between state and medical interests.

The guidance in Health Circular 37 of 1988 required that each hospital appoint a designated complaints officer and that this should normally be the unit general manager (chief executive[5]). This officer was charged with responsibility for receiving formal complaints and empowered to have access to all relevant records needed to investigate the allegations contained in them. Informal handling of complaints at service level was also sanctioned by the procedure, but the process through which informal complaints became formal remained somewhat opaque. Complainants could either choose to define their grievance as a formal complaint or staff could treat a complaint as formal because it was judged to be 'serious'. No further guidance was given as to the types of case which should fall into this classification.

The guidance prescribed that there should be three stages in the handling of clinical complaints (see Figure 1.1). At the first stage, the guidance anticipated that complaints would arrive through one of two routes. Firstly, they could be made directly to the person held responsible for the alleged poor care. Secondly, they could be made directly to the designated complaints officer. In order to facilitate receipt of complaints by the designated officer, hospitals and health authorities were required to publicise the procedure and the officer's name in leaflets, posters and patient booklets. Significantly, a distinction was made between the designated officer's role in handling clinical and non-clinical complaints. The officer was required to co-ordinate, *investigate*, record and monitor at quarterly intervals complaints about non-clinical matters and consider their implications for service provision[6]. As regards clinical complaints, they were only expected to co-ordinate, record and monitor complaints but not to investigate them. However, it was the duty of the designated officer to ensure that complaints were promptly dealt with. Despite this provision the guidance was not clear about whether all clinical complaints should be notified to the designated officer.

The appended guidance dealing with clinical complaints required that, where complainants remained dissatisfied with the first-stage handling of their complaint, then the consultant responsible for the patient's care should have a meeting with the complainant in order to talk through the issues at stake with a view to resolving them. If the complainant continued to be dissatisfied with the response, the complaint could be referred to the Regional Medical Officer who had the *discretion* to allow for an Independent Professional Review to be held. This final stage of the complaints procedure involved two independent consultants from other regional health authorities talking to all the parties involved in the dispute and coming to a conclusion about the medical efficacy of the care provided by the doctor being criticised. According t the appended guidance, the complainant did not have a right to get a copy of the report prepared by the medical assessors on the panel. Instead, the outcome of the panel was relayed to the Chief Executive of the hospital where the consultant was based and it was the chief executive's responsibility to pass on news of the outcome of the review. What is clear from this explanation of the guidance is that the primary responsibility for monitoring and handling medical complaints lay with doctors with minimal input from outside the profession.

Figure 1.1: Hospital complaints procedure for clinical complaints imposed by HC(88)37



The new complaints procedure introduced in 1996 has two stages - although no significant changes have been made to the initial handling of complaints, the stage which is the subject of this thesis. Complaints should initially be handled through the process of 'local resolution'. The rationale behind local resolution is said to be that it enables complaints to be dealt with promptly and at the point of service delivery, whilst also encouraging accountability by requiring providers to investigate, explain and reflect on their activity. Where a complainant remains dissatisfied, they may ask for their complaint to be referred to an Independent Review Panel (IRP). Service providers are required to appoint a designated officer to administer the procedure and ensure that complaints are dealt with. In addition, health authorities are required to provide conciliators to facilitate the resolution of primary care complaints where either the complainant or staff request conciliation (NHSE, 1996 and 1996a).

Requests for a panel are made to a convener who is usually a non-executive director of the health authority or trust and has responsibility for deciding whether a case should be referred. In reaching their decision, conveners are not permitted to investigate the complaint nor should they attempt to resolve it. Their options are: to refer the complaint back for further action at local resolution, if they think that more could be done at that stage to satisfy the complainant; refuse a panel if they think that all practicable action has been taken and a panel would not add to the process; or convene a panel if nothing short of independent review will achieve resolution.

When considering a request, conveners are required to seek advice from an independent lay chairperson. Where the complaint involves clinical judgement, a convener should also seek advice from clinicians. However, it is for the convener to decide whether a panel should be set up. It is anticipated in the guidance that IRPs should normally be made up of three people: the lay chair, the convener and a third panel member from a regional list. Where the complaint related to clinical judgement, panels should also be advised by at least two clinical assessors. The function of the panel is to investigate the complainant's grievance, as outlined in the convener's terms of reference, and to write a report setting out its conclusions. If appropriate, the panel's report should make suggestions for remedying any failings. The convener's decision about whether to refer a case and the conduct of a panel may also be the subject of an investigation by the Health Service Commissioner.

The structure of this thesis

How have doctors come to dominate the management of clinical complaints? To what extent has the state shown an interest in challenging clinical autonomy and self-regulation? How have the tensions between the state, the medical profession and patients been handled at national level? How do doctors at service level respond to complaints? How do they respond to the expectation that they tackle complaints in partnership with administrators and managers?

This thesis aims to answer these questions. It has 10 chapters. Following on from this introduction, the second chapter reviews a number of competing regulatory models of complaint handling and argues that it is a professional self-regulatory model which has dominated the regulation debate in the NHS. The chapter explains the attraction of this model to doctors by reference to sociological theories about professional groups. It concludes with a review of contemporary challenges to this dominant model and the role that complaints have played in questioning it. Chapter Three charts the development of the hospital complaints procedure and the ways in which it has become increasingly regulated by the state. The chapter highlights how the elite of the medical profession have reacted to national policies on complaints. The analysis provides a case study of the ways in which professional groups strive to insulate themselves from external control, maintain expert status and retain social power. It is argued that the elite of the profession have influenced policy debate about complaints in order to maintain their standing.

Chapter Four discusses formal guidance on complaints issued by the DoH and the roles it anticipates for service-level complaints actors. Using a range of studies conducted across the social sciences, it considers how those involved in the handling of complaints are likely to respond to criticisms levelled at them. Attention is drawn to the ways in which doctors respond to such events emotionally, the use they make of networks of colleagues and relatives to support them and the ways in which they come to understand and give meaning to complaints. Finally, the chapter considers the tensions between the roles of doctors and managers in complaint handling and the ways in which the autonomy of managers can be undermined by professionals.

The fifth chapter describes the methodology and methods adopted in the empirical study, and charts how the decision was made to concentrate on senior medics' handling of complaints. The approach adopted was to gather both quantitative and qualitative data through a postal survey and interviews but, because the research was being conducted in uncharted territory, the interviews were exploratory and relatively unstructured. Doctors were encouraged to set the agenda of issues which were important to them. This resulted in a rich qualitative dataset.

The next four chapters present the findings of the study. Chapter Six provides baseline data on the characteristics of complaints and suggests a variety of ways in which they have the potential to constitute a challenge to medical work. Chapter Seven contains an analysis of how doctors reacted to and understood complaints on a personal and emotional level. An appreciation of such responses to complaints allows us to understand why complaints procedures do not operate in the ways anticipated by bureaucrats and policy makers and to explore whether the formal goals of constructive and conciliatory approaches to complaints are realistic or achievable. Doctors feel threatened by complaints and they are likely to have a severe emotional impact on those who receive them. It is argued that the threat posed has to be understood in the context of other challenges to professional autonomy. Complaints appear to trigger stronger reactions than one might anticipate when looking at the allegations made. It is argued that the symbolic importance of complaints goes way beyond the particular criticisms made.

Chapter Eight explores how doctors make use of their social and professional networks in their attempts to come to terms with the criticism made of their professional work. The data presented make clear that the vast majority of doctors feel that medical networks are perfectly adequate to deal with their needs. Managers are rarely approached for support and when they are it is only for limited purposes. The chapter goes on to consider how doctors reflect on complaints. The data discussed demonstrate that doctors are most comfortable understanding complaints within the context of the illness being experienced. They provide bio-medical explanations of what causes complaints and the language of consumerism and rights is noticeably missing from such accounts. Reliance on a bio-medical model serves to undermine the validity of the complaint and the motivations of complainants. At the same time it externalises the causes of blame. Doctors rely strongly on notions of collective medical identity in these accounts and achieve a reconstruction of their damaged sense of worth by deconstructing complainants' accounts in this way. Complainants were often described in highly subjective and abusive terms and empathetic comments were rare.

Chapter Nine discusses how the making of a complaint exposes doctors to a double-jeopardy. Not only are they challenged by patients but a complaint can also provide a trigger for managers with interventionist inclinations to oversee the response made. Data are presented which suggest that managers are more likely than not to adopt a conciliatory approach towards doctors in the course of handling complaints and that this often amounted to almost complete autonomy being granted to them. However, a proportion of managers were much more interventionist in style and went to some lengths to establish their authority in complaint handling, although these were in the minority. But perhaps most significantly the data show that whatever the style of managers they are only able to intervene in complaint handling when they know that a complaint has been made. Data from the postal survey of consultants conducted for this study revealed that a large proportion of complaints received by doctors are never referred to managerial or administrative staff as the governing procedure requires.

The final chapter reflects on the data and discussion presented. It is argued that the topic of complaints provides an excellent case study in the ways in which social systems such as law and medicine interface and the ways in which the professional project of doctors is achieved on a day-to-day basis. It is concluded that, for doctors, law is seen as an oppressive force in the doctor-patient relationship. Like the accounts of illness and treatment provided by complainants, it presents a different discourse based on very different suppositions from those which underpin medical education and practice. All of these different discourses make claims to morality and all make reference to a communitarian rhetoric. But what is revealed are the limitations of law and the rhetoric of rights when placed within an alien culture.

Notes

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1. See for instance Felstiner, Abel and Sarat, 1980-81; Gollop and Marquardt, 1980-81; Kritzer, 1980-81, Miller and Sarat, 1980-81. Even where responses to voiced grievances are being discussed the focus is often on the claimant's perception and appraisal of the response. In the field of health care, almost no research has been undertaken on doctors' and managers' responses to complaints and what does exist tends to be prescriptive about the tone and form of response (see, for example, Pietroni and De Uray-Ura, 1994; Kadzombe and Coals, 1992; Scott, 1992;

Scott, 1985) or anecdotal (see, for example, Lavery, 1988).

2. Empirical studies have, for instance, focused on a variety of disputes from micro studies of Appalachian feuding in the nineteenth century (Blee and Billings, 1996) to environmental and land disputes (Burkardt, Lamb and Taylor, 1998; Gengenbach, 1998); inter-union work disputes in US ports (Herold, 1998) and other employment disputes (Herold, 1998); international territorial disputes (Radcliffe, 1998; Tir and Diehl, 1998; Tyler, Lind, Ohbuchi, Gugawara, Huo, 1998; Werner, 1998; Leeds, 1997); family and custody disputes (Emnett, 1998; Hill, 1998; Schetky, 1998; Simpson, 1998; Wilhelmus, 1998) and community disputes (Goldberg, 1997; Pavlich, 1996).

3. It may also be explained by the fact that many studies of complaints procedures have been empirical and that some public lawyers have afforded such studies lower academic status. McAuslan (1985), for instance, refers to the distinction between high and low constitutional theory, placing empiricists in the latter category.

4. In response to the Rawlings review, the ESRC funded six projects under a Citizen Grievance Initiative, which examined complaints procedures in hospitals, local authorities, social housing, Customs and Excise, prisons and the Department of Health and Social Security.

5. At the time the guidance was drafted the principal officer in each hospital was called a unit general manager.

6. The guidance states, for instance, that a case involving the exercise of clinical judgement which cannot be resolved by the designated officer through discussion with the clinician involved should be referred to the officer's senior manager. It is also noted that if complaints might involve litigation, the designated officer should get legal advice. The most prevalent form of litigation against hospitals is for medical negligence.

2 The relationships between the state, the medical profession and complaints

> 'The fundamental challenge to medicine is not from law but from governmentality that favours law as its operative strategy. But we should be reluctant to round up the usual suspects too quickly. The real rise in individual claims against all professions might suggest that the shift in governmentality has followed rather than led a shift to a less deferential and more interest orientated culture in which the individualist moral claw of law is an obvious resource.' (Dingwall, 1994, p61)

Introduction

The challenge to medicine posed by complaints cannot be fully understood without reference to the role played by medical professionals in our society. Doctors wield considerable power based on unique access to, and control of, a body of knowledge which is highly valued by both society and state. Their claim to such expertise is based on the notion that medicine is a scientific enterprise. This endows their accounts of disease with a generalisability and rationality which is commonly compared with the subjective and anecdotal accounts of patients. The acceptance of the profession's importance by the state has brought it considerable social, economic and political strength. In turn, it has facilitated the creation of a distance and inequality of status, knowledge and power between doctors and the people they treat.

Patients come into contact with doctors at a time when they are physically or mentally weak and emotionally distressed. They cannot lay claim to expert scientific knowledge and are forced to trust the professional. In this way, professional norms begin to structure and dominate the relationship which easily becomes paternalistic (Parsons, 1968; Dingwall, 1983).

In recent years, patient groups and medical sociologists have claimed that patients and their relatives can also develop expert understandings of illness. It is argued that theirs is a holistic and experiential expertise. The dominance of scientific discourse has made it hard for such accounts to be given the same level of legitimacy as those provided by doctors. But, when patients make complaints about the performance of doctors, they lay claim to an alternative view. They challenge the validity of the notion of an hierarchical compact between expert and client.

The privileged position of any group in society can usually only be secured by a process of continuous negotiations amongst politicians and other elite groups. When the power wielded by a group becomes visible it is increasingly common for there to be calls to regulate it in some way and render the group accountable to wider society. But, what constitutes a satisfactory regulation policy shifts over time and varies according to the perspective of the various stakeholders involved. It is influenced by such abstract ideas as efficacy, value, cost and social justice. How is a balance between the interests of the state, the profession and those experiencing medical care achieved? What is the role of the state in maintaining an equilibrium?

These questions are particularly important in the context of complaints. It is argued in this chapter that recent claims by patient groups that clinical complaint handling should be more intensively regulated reflect a crisis of confidence amongst consumers which has caused the elite of the profession to mobilise resistance to the call for change. The tensions created do much to reveal how experts and the laity conceptualise the doctor-patient relationship and the limits of trust. Calls for increases in consumer participation in complaint systems can be seen as threatening the delicate balance between state regulation and self-regulation and between clinical autonomy and managerial or consumer interference in medical work.

How has the medical profession come to wield so much power in our society? Are doctors sufficiently accountable to patients or the state? What is the role of the state in regulating the doctor-patient relationship? This chapter considers how the boundaries of what can be challenged and how it can be challenged have been drawn by the state, interest groups and the profession. It looks at how expectations of how accountable doctors should be to those outside their profession have emerged and become reinforced by the state. The chapter is in four sections. The first considers the different models of regulation which exist within the modern western state and the visions of accountability that they encompass. The second section concentrates on the extent to which regulation of medical work has been achieved and the regulatory theories on which policies have been based. Use is made of the literature on the notion of the professional project to illuminate why the medical profession has played such an influential part in the debate about regulation in the NHS. The third section considers the threat to the profession posed by complaints and the importance of understanding this challenge in the context of other debates about the relationship of law and medicine. Particular emphasis is put on understanding complaints as part of the debate on the so-called 'litigation crisis'. The final section explores the issue of whether the medical profession suffers from over-regulation or under-regulation and presents arguments which question the contention that use of law poses a significant threat to clinical autonomy in practice.

Regulation and its many guises

What is regulation?

Since most of our activity in society, particularly in the exchange of goods and services, takes place within a framework of rules, regulations can be seen as the foundation of social life (Moran and Wood, 1993). However, the term regulation is used in a variety of contexts and does not have one accepted meaning. This is not because it is impossible to come up with persuasive definitions, but rather that the concept changes over time with the prevailing values governing standards in society. As a result, the term remains hotly contested and is dependent on the political, social and economic perspective from which it is viewed. At its most simple, regulation involves control of market entry and exit, competitive practices, market organisation, standards and remuneration. But it can also involve a consideration and prescribing of standards of good practice, accountability, efficiency and ethical codes.

Ogus (1994) has argued that there are two main focuses for regulatory activity: the social and economic spheres. Regulation of the medical profession appears to straddle these two spheres. Social regulation deals with such issues as health, safety and environmental protection, where the need for regulation arises from information inequalities between individuals and organisations. It takes a number of forms from low regulation - such as obligations to disclose information - to high regulation - such as a requirement that an activity be licensed through a complex procedure. Economic regulation covers a narrower range of activities and applies primarily to industries with monopolistic tendencies which do not have the discipline of the market imposed on them. The principal function of regulation in this field is to provide a substitute for competition. Three techniques are recognisable. First the firm can be publicly owned, as is the case with the NHS. The expectation here is that direction by politicians, through democratic institutions with mechanisms to ensure accountability, will facilitate the pursuit of collective goals. Second, the firm may be privately owned, but subject to external constraints such as price and quality regulation. Finally, organisations such as the General Medical Council (GMC) wanting to obtain a monopoly right can be made to compete for it as doctors were made to compete with pharmacists, unqualified abortionists and midwives (Williams, 1999). As part of winning the contract, they will be forced to stipulate certain conditions of supply which will then become binding on them.

Theories about regulation are closely linked with those concerning law. Firstly, because it is legal rules which create formal regulatory frameworks. Secondly, because both are concerned with notions of accountability. Writing from a public law perspective, Longley (1993) suggests:

> 'By definition public power is exercised on behalf of all citizens. Each and every one of us has a right to be concerned with its application, which includes moral, political and practical matters. The challenge for society and the organization of its institutions is to try to provide a means of drawing together those three inherent elements in such a way as to safeguard the citizen, both as an individual and as a member of society, from arbitrary decision-making.' (p xi)

It is occasionally suggested that the term regulation should be used to indicate any form of control over behaviour whatever the origin and this view has been supported by socio-legal scholars (see Ogus, 1994; Allsop and Mulcahy, 1996). In this vein, Bosk (1979) has made a distinction between four analytically separate elements of social control which operate in the medical sphere. These are the formal regulatory challenges which are external to the professional group, formal challenges and rules internal to the group, informal external rules or pressures and informal internal challenges and rules. These are shown in Figure 2.1 together with examples of each type of control, adapted from Allsop and Mulcahy (1996).

Figure 2.1: Examples of the four elements of social control

	External	Internal
Formal	Court system Health Service Commissioner	General Medical Council Stage One – complaints procedure
Informal	Pressure from politicians and professional leaders	Gossip networks

The formal complaints system being discussed in this thesis has the potential to fall within either the formal external or formal internal categories. Many clinical complaints are handled only by doctors themselves. The remarks of a dissatisfied patient may not be referred to a formal system by the doctor who receives them. As a result, they will be processed as part of an informal internal system for managing grievances. Equally, a complainant may choose to complain through their MP or appeal to the Health Service Commissioner, in which case external pressure might be brought to bear.

Types of regulation

In addition to the different types of social control which might be used as a setting for regulatory structures, there are different ideological underpinnings to regulatory models which determine the degree to which external formal intervention is considered appropriate. In all industrial societies there is a tension between two extreme models of economic organisation: those which rely on the market to discipline the activity of an industry or service (the minimalist state) and those which rely on the state to protect collective interests (the interventionist state). The differences between the models can be explained by the difference in emphasis placed on individual autonomy and the necessity to protect and pursue collective needs and goals through formal regulatory policies. Although both models refer to collective goals, they make fundamentally different assumptions about the balance to be struck between the individual and the collective and how collective needs can be served. While the minimalist state achieves the collective goal by supporting the pursuit of individual goals through markets, the interventionist state is more likely to limit the excesses of individual freedom in the interests of the community (Allsop and Mulcahy, 1996).

According to the minimalist ideal, people should be left virtually free to pursue their own welfare goals. In this setting, regulation has a small role to play. In contrast, in the interventionist ideal, the state tries to direct or encourage behaviour which it assumes would not otherwise occur. It does this through a variety of legal 'rational' rules. The aim of regulation in this case is to correct perceived deficiencies in the market system in meeting collective or public interest goals. At times, it is used to attempt to adjust inequalities of bargaining power between consumer and state, or consumer and professional.

The role of law is different in each of these ideal types. The minimalist model uses the law to regulate private agreements between parties which are enforceable by the parties themselves. In this case, the law has a facilitative function but it is private and decentralised in the sense that it is left to individuals, and not the state, to enforce rights. In contrast, the model of legal regulation in interventionist states has three characteristics. First, it is directive, control comes from above. Second, it is public in the sense that it is the state which enforces obligations. Finally, since the state plays such an important role, regulation tends to be centralised (Damaska, 1988).

The design of grievance systems is also heavily influenced by such conflicting approaches (Allsop, 1998). Damaska (1988) has argued that the minimalist or 'reactivist' state views disputes as matters to be resolved between disputants. The state provides grievance resolution mechanisms but these are only to be used where settlement cannot be negotiated between the parties. When use is made of such mechanisms the state provides an adjudicator who remains neutral and decides between the competing claims of the disputants. The emphasis is on procedural rather than substantive justice. By way of contrast, the interventionist or 'activist' state is more concerned with the ways in which law can be used as an instrument of policy making and the purpose of the adjudicator is to implement state policy. In the most extreme form of this model, the claims of both disputants might be rejected in favour of an imposition of a 'comprehensive theory of the good life' (p412) as propounded by politicians.

These models are both extremes or ideal types. Few, if any, advanced societies exist without any form of regulation of key services. Debate tends to focus instead on the type of regulation which achieves the 'best' results. To a large extent, how this is defined will depend upon the values and ideologies of policy makers. But, even when operating, a regulatory regime is beset by the need to consider, and make trade-offs between, various interests. For Hawkins and Thomas (1984) these struggles explain why there is so much moral ambivalence surrounding regulatory activity.

The tensions revealed by such debates are immediately apparent within the medico-legal context where there has been intense discussion about who should handle and oversee complaints about doctors. In framing the debate, Sheila Maclean (1989) has argued that, at a philosophical level, the regulatory balance to be struck is between that of the needs of society and the needs of the individuals directly involved. Medicine is seen as a valued social good and the law and society might be expected to protect this social good from unnecessary or inappropriate challenge. On the other hand, the rights of the individual are also valued and their vindication can represent a social good as well. Within this context there is considerable debate about how far the protection of doctors' decision-making autonomy should go. On the one hand, there are those who hold that the medical profession should be left to regulate itself and that it alone can decide what is acceptable conduct. According to this view, the law is too blunt to tackle the problems faced, and caused, by doctors. The contrary view is that, by allowing the medical profession alone to decide on matters which may impinge on shared values, an opportunity for public debate is muffled and this allows the pendulum to swing too far in favour of therapeutic immunity (Mason and McCall-Smith, 1994; Kennedy, 1983).

The changing forms of regulation

In practice, all western political systems are characterised by some form of regulation of medical services. Such services have often been regulated by those responsible for the provision of care and this has been the case in the UK long after the inception of the NHS. But, increasingly, the regulatory powers of professionals are being shared with the state. Governments have attempted to become more penetrating and oriented towards the control of performance (Freddi, 1989).

It is unlikely that even the greatest proponent of the market model would suggest that health care should be left entirely to market forces or professionals. A number of reasons have been identified for this. As highly sophisticated mechanised and technological medical techniques emerge, the gap between scientific and lay understandings of health and illness have broadened and created new inequalities which legislatures have been keen to tackle. Such technological advances have expanded the ability of medicine to intervene in treating disease and larger numbers of citizens have gained access to new types of medical care. Although the capacity to improve and sustain life has progressed, provision has become extremely costly. Technological developments have taken place in a time of fiscal crisis for welfare states, which has reinforced governmental motivation to monitor medical services. Concerns about spending have been prompted by the perception that resources allocated to health care are not always deployed in an optimal fashion.

Until the late 1970s, there was a steady growth of formal regulation by the state in the NHS. During this time there were attempts to move away from a professional self-regulatory model of control towards a more bureaucratic model. This alternative to self-regulation is based on the notion that regulatory frameworks should be set by reference to external and generalisable standards. The authority for the enforcement of bureaucratic standards stems from law and parliament rather than the profession and its rational approach to moderating behaviour owes much to the theories of Max Weber. In its ideal type, formal bureaucratic systems have hierarchical structures with a chain of command in which all workers except the person at the top have supervisors and are subject to explicit regulations. Thus, the locus of power is at the apex of the system. The bureaucratic official, motivated by efficiency, demonstrates a disciplined conformity to rules and consistency across cases. They avoid trouble by minimal use of discretion and compliance with legal rules (Trubek, 1980-81).

Strong (1984) has identified law and its bureaucratic frameworks as providing the most serious challenge to medical autonomy and cites Ian Kennedy's 1981 Reith Lecture as a major indication that lawyers were interested in laying claim to jurisdiction over large areas of health care law. As Dingwall (1994) has suggested in his discussion of the challenges posed by increased regulation, complaints and claims:

> 'It is undeniable that British doctors in the 1990s feel threatened by law. They analyse it as a constraint on clinical autonomy, something that prevents the profession from doing a variety of things that it would otherwise do.' (p47)

He concludes that there has been an attempt at substitution of legalisation for medicalisation as the paramount mode of governmentality in the so-called contract state.

Commentators have expressed some scepticism about the ability of law directly to influence activity through bureaucratic structures. In part, this reflects a concern that the regulatory state is increasingly unable to cope with complex social issues. Gunningham (1999) has argued that there is a limit to which it is possible to add more and more specific prescriptions without this resulting in counterproductive regulatory overload. Traditional command and control forms of regulation are also seen as unresponsive to the needs of organisations, unable to generate sufficient knowledge to function efficiently and perceived as inflexible, costly and cumbersome (Baldwin, 1990). By the early 1980s, there was a perception that industry and the public sector had been subjected to unnecessarily complex and costly controls, many of which were difficult to reconcile with public interest goals (Harrison and Pollit, 1994). As a result, contemporary state governance in western nations has come to rely increasingly on regulatory strategies which encourage self-regulation. This has not necessarily led to a reduction in regulatory structures but it has heralded a shift in the location and ownership of regulatory policies.

Under the leadership of Margaret Thatcher, the Conservative government purported to pursue a policy of 'de-regulation' based on the political philosophy of public choice theory

(Harrison *et al*, 1990). Such changes have gone under a variety of names, such as the post-modernisation of the economy, the rise of post-Fordist economic arrangements and managerialism (Turner, 1996). In the UK, its programme of legislative reform in the public sector became known as 'the new public management', a programme which involved the introduction of less interventionist forms of regulation[1]. In the NHS, the discipline of the market has been introduced through the mechanisms of a purchaser-provider split and contracting for services within budgetary limitations. Increased emphasis has also been placed on the local management of quality issues. The search for efficiency in the health care sector, and concern about how it is to be achieved, has not been restricted to Britain. As Ham reports:

> '[P]olicy makers in a number of countries are reviewing the future of health services. Those countries which have traditionally relied on a market in health care are making greater use of regulation and planning. Equally, those countries which have traditionally relied on regulation and planning are moving towards a more competitive approach. In no country is there complete satisfaction with existing methods of financing and delivery, and everywhere there is a search for new policy instruments.' (Ham, 1995, p x)

In today's NHS many different regulatory systems can, and do, operate in parallel with each other. The NHS is funded from taxation and centrally managed and the extent of bureaucratic regulation from the top is considerable (Allsop, 1998) but, in reality, the regulatory system of the modern NHS is a hybrid of a legalistic-bureaucratic and self-regulatory model. Whilst the state remains primarily concerned with standards and efficiency, the profession has aimed to maintain control over everyday aspects of practice and to protect its clinical autonomy (Elston, 1991). Moreover, the profession continues to have considerable political influence over how standards and efficiency are judged. As Moran and Wood have argued:

> 'Doctors have many different roles, and operate in very different environments. From the point of view of regulation the doctor is far more than a physician: he or she is both an economic actor with skills to sell and commonly a member of a pressure group with interests to defend.' (1993, p13-14)

In the section which follows, consideration is given to the issue of why and how the medical profession has come to exert so much influence over the regulatory policies of the NHS.

The dominance of the professional model of self-regulation

Kelleher *et al* (1994) identify the challenge of management and bureaucracy as one of the major threats posed to doctors in the last two decades (see, for example, DoH, 1989; DHSS, 1983a). Davies (1983) has argued that bureaucracies and the professions are antithetical both at the level of structural principles for organising work and at the level of motivation and compliance. Professionals see themselves as equals with internal differentiation based on specialisation and the level of prestigious skills (Johnson, 1972). The notion of a bureaucratic hierarchy in which those supervising cannot perform the tasks being supervised is alien to them. Rather, professionals expect to be supported by bureaucrats who are seen as performing the 'housekeeping' tasks (Hunter, 1994). As a result, attempts to place professionals within bureaucratic organisations can promote conflict and strain. Scott (1966) predicts that professionals are likely to continue to resist bureaucratic rules, standards, supervision and the demand for unconditional loyalty. Debates about the management of complaints provide particularly fertile ground on which to do this.

Despite the fact that external regulation of medical work appears to have increased significantly during the last century, the medical profession has continued to be extremely successful in claiming significant jurisdiction over its work and, more specifically, over the handling of complaints. The argument that doctors should be judged by other doctors in a system of self-regulation with maximum clinical autonomy remains influential. Moreover, it is not just in the United Kingdom that such arguments prevail. All economically advanced societies have special forms of regulation for professional groups whether influenced by a minimalist or interventionist model. The effect is to transfer the responsibility for overseeing medical work from the state to the professional group (Allsop and Mulcahy, 1996).

Historically, certain professional groups have been able to self-regulate in areas of work where extensive training is necessary to acquire a high degree of specialist knowledge and expertise. Typically, the application of this knowledge requires not only technical skill, but also the exercise of expert judgement within a personal service. In such self-regulatory models, expert workers control the production of a service including complaint handling. It has been argued that self-regulation is the only appropriate form of control when criticisms are lodged about the standard of care because only the experts themselves have the ability and information to judge the competence of a colleague. The professions also argue that the public is best served by groups which are independent of state control. It is claimed that outside interference in this process would undermine the profession's public orientation and subject it to external regulation that would be harmful to both the profession and the public interest.

Such claims have been attractive to successive governments because they allow for the devolution of responsibility for, and the costs of, regulation to the medical profession, whilst providing a persuasive rationale for doing so (Stacey, 1992). Moreover, the granting of such powers to the profession has not been unpopular. Kelleher *et al* (1994) argue that the appeal of a strong medical profession has been fuelled by rising concern about public health, the decline of organised religion, the development of pharmacological products (access to which members of the profession act as gatekeepers), the growth of research laboratories and the increase in notions of the scientific foundations of medical practice. Moreover, it has been argued that the development of professional power in earlier centuries was an attractive alternative to a society in which the attainment of economic and social standing was largely dependent on class. In his impressive treatise on the rise of professional society, Perkin argues that the ideal of a society in which hierarchy was determined by expertise, rather than class, was seductive because it suggested their power was attainable by the disadvantaged. He argued:

> 'The ideal ... implied a principle of social justice which extended to the whole population the right to security of income, educational opportunity, decent housing in a clean environment and, some professionals would say, the right and obligation to work.' (Perkin, 1996, p9)

By making, maintaining and monitoring standards of practice internally, the professional group could be said to maintain its 'contract' with the state to protect the public interest. Parsons (1968) has argued that the profession's compact with the state brings with it an obligation not to abuse this asymmetry of expertise. According to this view, self-regulation only works while the profession is trusted. This argument is extremely important in the context of complaints since a rise in the rate of grievances suggests that trust has been undermined or breached.

Why has the professional model of regulation which treats the handling of medical complaints as part of the role of the professional been so influential in the NHS? Sociologists have long been interested in studying the professions and what it is about professional groups that allows them to wield authority and power. Two particularly influential ways of looking at professionals have emerged. In this century, there has been a shift between them from an emphasis on a functionalist approach towards symbolic interactionalism (MacDonald, 1995). Functionalists focused on the ethical and altruistic aspects of the professions and viewed them in a positive light as independent ethical centres of resistance to crude forces in society. The emphasis here was on their stabilising and social control function (Parsons, 1968; Durkheim, 1933). In his important work on the subject, Durkheim (1933) argued that the professions construct a system of rules which represents a moral order separate from the state. The medical profession is governed by codes of ethics which place the interests of individual patients at the fore. Respect for the needs of the patient provides a counterweight to the workings of the marketplace and the interests of capital. According to this view, self-regulation is necessary and sufficient to ensure quality and altruism.

By way of contrast, interactionalists viewed such professional traits as idealised and mythical. They viewed functionalist propositions as *ad hoc* rationalisations to support a political project. Interactionalists rejected the functionalists' emphasis on identifying the characteristics of professions and instead posed questions about how professional knowledge came to be classified as rare, how groups try to turn themselves into a profession (Hughes, 1963; 1958) and how they have maintained their monopolies over standards and remained in control of entry and exit to their profession (MacDonald, 1995; Baer, 1986; Atkinson, 1983). Instead of emphasising altruism they preferred to focus on how professions wielded power and gained the support of political, social and economic elites in order to secure for themselves the authority to control their own work (Johnson, 1972). Rather than taking characteristics such as expert knowledge as given, critics of functionalism characterised professional knowledge as a social construct (see, for instance, Turner, 1996; Abbott, 1988).

Within this context, Freidson (1983; 1973; 1970; 1970a) and Larson (1977) have been influential in developing the notion of the 'professional project', an approach favoured in this thesis. This is a process by which expert groups attempt to maintain or enhance their scarcity and have their power rewarded (Parkin, 1971). According to this theory, aspiring professionals construct their commodity and then control the production of it. Since control over exit is achieved through the mechanism of complaints and disciplinary systems, the issue of how complaints are handled should be a key issue for sociologists of the professions. Stacey (1992) has argued that, in modern societies, the elite of the professions gain authority from the state to self-regulate and formally exert their power over the group through the legalisation of restrictive licensing[2] (Stacey, 1992).

Abel (1985) conceives of the granting of a monopoly over supply as crucial to the professional project. But the project is conceived of as involving more than just the attainment of monopoly, it also entails the maintenance of upward social mobility. According to interactionalists, four factors are crucial in the attainment of these goals. Firstly, the distinctive autonomy of the profession depends on the state granting power and licensing the profession to operate independently of it. Its privileged position is secured by a process of continuous negotiations with politicians and other elites with the aim of maintaining its power base and jurisdiction (Perkin, 1996; Abbott, 1988). This brings with it social authority (Starr, 1984; Hughes, 1958).

Secondly, the cognitive and normative features of professions must be capable of changing. This factor is crucial to the continued existence of the profession. Whilst maintenance of the *status quo* is a goal insofar as its relationship with the state is concerned, a profession's claim to authority and legitimacy needs to be flexible so that it can respond to changes in the wider society. This idea has been developed by Luhmann (1985) in his work on systems theory. He has argued that systems, such as the medical profession, remain normatively closed but cognitively open. Put simply, this suggests that the maintenance of the status quo is preferred but that external risks to the profession's legitimacy may be contained by the group making token changes in their practices to satisfy policy makers and the public that they are responsive to needs (see also Jamous and Peloille, 1977).

Thirdly, once a profession has gained autonomy, its members need to be able to establish a position of social prestige which becomes independent of their original sponsoring elite. Finally, once established, they must be in a position to define social reality by claiming validity for their pronouncements, in particular their claims to altruism and ethicality. In this way, they are also afforded cultural authority (Starr, 1984; Hughes, 1958). Such authority is important because, as MacDonald (1995) suggests, trust will be accorded to those whose outward appearance and manner fit in with the socially accepted standards of repute and respectability. It is in this way that the credibility of the pact between the state and profession can be maintained.

Drawing on Larson's theory of the professional project, Abel (1985) has suggested that market control and class should be taken as the core of analysis. Arguing in Marxist vein, he has suggested that all occupations under capitalism are compelled to seek control over their market as the only alternative is to be controlled by it. The prospect of the latter is unattractive because it is fraught with uncertainty and may lead to economic extinction. According to this thesis, the regulation of supply is fundamental to being able to influence the market. In Abel's words:

> 'Market control is inextricably related to occupational status, not only symbolizing status but also enhancing its instrumentality, both by restricting numbers ... and by controlling the characteristics of entrants. Professions pursue market control and status enhancement through collective action. Having erected barriers to entry, professional associations seek to protect their members from competition, both external and internal. In order to avert external surveillance, they engage in self-regulation.' (p40)

He has focused on attempts at social closure, endogenous and exogenous influences on supply and demand and the growing role of the state in subsidising consumption. Unlike Larson, he places more emphasis on the economics of social closure and material benefits than on attempts at collective mobility. He argues that the emergence of professional factions - such as those which exist between hospital doctors, general practitioners and public health doctors - serves to highlight the interplay between market control and collective mobility. Abel places the acquisition of personal wealth at the centre of his thesis for a number of reasons. He argues that personal impoverishment undermines professional status and that the acquisition of wealth confers its own status. For Abel, the market economies of the West drive actors to neutralise competition and to control demand and supply.

In response to such materialist and necessitarian theories, others have sought to reclaim the notion of ideology from the writings of functionalists. Gordon (1984) has argued that the professions' claim to autonomy and their emphasis on ideology provide a counterweight to materialism. He cites a number of examples of professionals' attempts to check illegal or unethical behaviour (see also Burrage, 1990). Abel (1995) has responded to such criticisms by questioning the extent to which such assertions are based in empirical reality. He also stresses the inevitability of social closure:

> '[The professional project] does not require deliberation or conspiracy – although lawyers and other professionals, in desperation or at unguarded moments, often expose their self-interested motives ... Even a genuine dedication to ensuring quality inevitably promotes social closure.'

The professional project in action

What is the empirical 'reality'? Commentators have paid considerable attention to the ways in which the professional project of medics has been achieved in practice. Harrison *et al* (1990) claim that one of the key accounts of health policy amongst academics has been a 'shared vision' of the power of the medical profession. They argue that, in the very least, this power has allowed doctors to frustrate those who wish to alter their training, conditions of service or patterns of practice. How did this come about? The rise of the medical profession was initially dependent on the acceptance of medical science as a legitimate activity. It is for this reason that it has been argued that medical sociology needs to incorporate a sociology of knowledge since what it is to be sick and in need of medical attention will depend upon the available cultural categories by which behaviour can be described and understood (Turner, 1996). In other words, much of the claim to professional expertise in medicine rests on 'knowledge' of diseases where the knowledge is socially produced rather than objective. Before a profession could emerge as a recognisable group, medical categories had to emerge as separate and distinctive forms of discourse about the body. Foucault (1973) has argued that there is a direct link between the growth of medical discourse and the exercise of power by the medical group. He claimed that this power or 'clinical gaze' enabled medical men to assume considerable social power in defining reality and hence identifying deviance.

The increasing reliance placed on medical categorisations of behaviour was facilitated by the secularisation of culture whereby religious symbols and beliefs lost their public dominance. It was also encouraged by an increased trust in science and the rationalisation of society. It has been claimed that the growing importance of the doctor as a professional man, the development of medical institutions around the hospital, the clinic and examination (Foucault, 1973), the emergence of medical classifications of deviance and the organisation of medical surveillance of society through the development of public health strategies allowed the doctor to replace the priest as the custodian of social values in the mind of the public (Turner, 1996).

It is frequently argued that the first formal recognition by the state of the prominence of doctors involved the securing of market control and took place in the mid-nineteenth century long before the foundation of the NHS. Stacey (1992) has argued that the establishment of the GMC was a crucial part of the profession's collective upward mobility and that this was achieved at the expense of other organisations. At the end of the nineteenth century, 22 licensing bodies accredited doctors and it was not until the Medical Registration Act of 1858 led to the establishment of the GMC that licensing was undertaken by one centralised body. This development was not easily achieved. A number of groups, such as those representing physicians, surgeons, apothecaries and medical associations, struggled to occupy a position of superior status to others (MacDonald, 1995). Some of these groups objected strongly to the setting up of the monopolistic GMC as offending the dominant ideology of *laissez faire*. To many, its establishment was perceived as a threat to a completely unregulated market and it took a number of parliamentary debates and bills before politicians were convinced that the move towards a monopoly was in the public interest. Parry and Parry (1976) have suggested that the ability of powerful groups within the profession to negotiate this power was largely due to the fact that medics had become an organised pressure group prior to the entry of the state into the formerly private field of health care. While the state did become more involved in the practice of medicine, through its operation of policies relating to the Poor Law and public health, there was no central state agency dealing with health from 1854-1919 other than the GMC. It was largely during this time that doctors came to dominate the emerging hospital sector.

Discussions about the setting up of the NHS after the second world war reflected the fact that the profession had become an established power with a continued interest in negotiating the conditions of its bargain with the state. Hardey (1998) has opined that while the NHS was founded on the principles of comprehensiveness, universality and collectivism medical elites also forced the Labour Government of the time to accede to the principle of clinical autonomy. As Harrison *et al* (1990) have argued:

> 'The NHS was founded on a complicated bargain between several parties most notably the government, which brought to bear both money and powers of legislation, and doctors, with resources of monopoly, expertise and popular esteem.' (p1)

Bevan later described how, in his dealings with the medical profession, he had 'stuffed their mouths with gold' (Stacey, 1988, p45). The medical model negotiated by Bevan has stood firm. Klein (1973) has argued that there has been a general political consensus about the desirability of the deal and that no subsequent government has challenged the basic agreement struck between Bevan and the medical profession during the NHS's founding period. In their review of the dynamics of health policy, Harrison *et al* (1990) conclude that debate about health policy continues to be carried out in the shadow of a complex web of mutual dependencies between government and the profession which support a 'shifting assembly of pacts and bargains, both formally negotiated and tacitly understood' (p2).

What are the implications of the deal struck between the medical profession, and more particularly hospital consultants, and the state? Ham (1992) has argued that the bargain has resulted in the medical profession being involved in the management of the NHS at four key points. Firstly, they make a contribution to policy-making within the NHS Executive and Department of Health and through their consultative machinery. Secondly, their views are heard through members of regional offices of the NHS Executive. Thirdly, health authorities have access to medical advice from doctors working in hospitals, on medical advisory committees and local medical committees. Finally, NHS trusts usually include a medical director on their board and rely extensively on advice from their medical staff (Ham, 1992).

The medical profession has also been placed in an influential position because doctors are direct providers of services. This has allowed them to define need and wield considerable power over local budgets. As an example of the type of power wielded in this setting, Oliver (1999) has argued that prior to the launch of the NHS Research and Development programme in Britain in 1991 doctors were responsible for the development of new research programmes and were not compelled to take account of user views.

All of these factors have had an impact on accountability. Although hospital doctors are salaried employees of the NHS, their actions have not been directly controlled by managers and health authorities. This has resulted in a mixed regulatory model in which the state provides a framework but relinquishes control over the details to the medical profession. The position was summarised in 1978 by the Normansfield Report:

> 'At the inception of the NHS, the Government made clear that its intention was to provide a framework within which the health profession could provide

> treatment and care for patients according to their own independent professional judgement of the patient's needs. Their independence has continued to be a central feature of the organisation and management of health services. Thus, hospital consultants have clinical autonomy and are fully responsible for the treatment they prescribe for their patients. They are required to act within broad limits of acceptable medical practice and within policy for the use of resources, but they are not held accountable to NHS authorities for their clinical judgements.' (DHSS, 1978, p424-5)

In her discussion of this crucial period, Allsop (1995) describes how there continued to be a division of interests between hospital doctors, general practitioners, politicians, public health specialists in local authorities and the voluntary sector. She claims that this was resolved by compromise on all fronts but that hospital consultants did particularly well out of the resulting deal (see also Gill, 1971). Hospital doctors were given the right to continue with their private practice alongside their new NHS work, able to maintain a high degree of control over conditions of appointment and granted control over a new merit award system set up to reward high achievers. Significantly, teaching hospitals staffed by the elite of the profession were given special status (Ham, 1992) and medics were also able to negotiate considerable control over expenditure and the development of policies in hospitals. In short, there was a trade-off of interests. The public ownership of hospitals suited the Labour government of the day and the steady flow of regular income suited hospital doctors.

Despite Bevan's acceptance and endorsement of such medical autonomy and power these compromises carried the 'seeds of future problems' (Allsop, 1995, p33). Bevan's acceptance of the contention that health care was about professionally determined and predominantly medical services was to be far from uncontroversial, but such assertions have to be placed in context. The NHS was a radical idea which might not have been achievable without the pact which Bevan negotiated with the profession. Alternative scenarios proved less attractive and the threat of non-co-operation from the medical profession was very real. Less than five months before the NHS was due to be launched, general practitioners were still threatening not to join the ranks of NHS doctors. The final bargain struck reflects political pragmatism as much as ideology, a representation of what was possible, rather than what might have been desirable (Ham, 1992).

As the NHS developed, the profession continued to protect the privileges it had negotiated for its members and resisted attempts to reign in their power (Perkin, 1996). Numerous examples of this tendency exist which serve to reflect the extent of the profession's influence. Professional groups within the NHS have generally fared better than others in terms of pay increases (Harrison *et al*, 1990). Managerialism has been resisted. The Cogwheel working party (Ministry of Health, 1967) attempted to promote a managerial consciousness in the medical profession, but this was eventually achieved only through a revised strategy of persuasion rather than imposition. More recently, attempts to encourage doctors into management have proved unsuccessful and suggest that a tribal culture still exists, despite widespread support for co-operation between managers contained in the Griffiths report (DHSS, 1983a). Finally, the co-operation of the profession in launching new initiatives has proved fundamental. Allsop (1995) has also charted how the medical profession's resistance to change resulted in negotiations about the 1974 reorganisation of the service taking 10 years to complete and eventually represented a compromise of interests in favour of the profession. Finally, Stacey (1992) draws attention to how the Merrison Committee, set up to inquire into the operation of the GMC in 1975, was specifically instructed by the government, under pressure from elite members of the profession, not to examine whether professional regulation worked. She argues that, as a consequence, nothing in the resulting report provides a check on the GMC's tendency to pay more attention to the interests of the profession than to the needs of patients.

Some visible attempts at change have also been made by the medical profession. Many of these constraints are also reflected in the reforms which have come from within the profession during the 1980s. The GMC has expanded the range of its activities in relation to both promoting good practice and identifying poor practice. In the case of the former, what the competent doctor should do has been spelt out with increasing detail. In the case of the latter, the health procedures introduced by the GMC put in place a mechanism for dealing with doctors who are identified as 'at risk'. Once identified, they can be offered treatment and support. But the GMC has made these changes under pressure from Parliament, the government and patients' groups, all of whom questioned its claim to be protecting the interests of the public in relation to poorly performing doctors. The new systems, like the old, remain closed to public scrutiny and will depend for their effectiveness on the willingness of doctors to report on colleagues[3] (Allsop and Mulcahy, 1996).

It is significant that attempts at increased internal control of the profession have come from within. Allsop and Mulcahy (1996) have argued that such moves could be seen to represent greater efforts to retain control, through internal agreement, by forestalling the need for external intervention in their work. Paradoxically, while these measures may reduce the individual clinician's autonomy, they also signal a movement towards greater rather than lesser conformity to the ideal type of a self-regulating professional group, since the mechanisms have been introduced from within the profession rather than imposed from outside it. At the same time it has been widely contended that there has been an increase in the number and typed of challenges to the profession.

Challenges to the profession

The growth of political, social, cultural and economic power by the medical profession has not gone unchecked. Indeed, it has been argued that the balance of power is in a constant state of flux, negotiation and re-negotiation (Dingwall, 1983). As well as enjoying the achievement of a successful professional project, the medical profession has also suffered certain crises of credibility of which the rising number of complaints is one aspect (Kelleher *et al*, 1994). Commentators have charted a number of ways in which confidence in the ability of the profession to moderate the behaviour of poorly performing doctors can be measured. These can be grouped into four categories: crises and scandals; a shift in the balance of responsibilities between the profession and state; competition from other professionals; and, perhaps most notably, the rise in consumer activism. It is argued in this section that it is of use to see the challenge posed by complaints as part of these other contemporary challenges.

The fact that most controls of the medical group remain hidden from public view has, at times, led to suspicion on the part of patient groups as to whether effective monitoring is taking place. Such concerns have been fuelled by a number of large-scale enquiries which have revealed the inadequacy of internal monitoring of medical work. These enquires have attracted media coverage, pressure group activity and political concern. They have played an important part in the formulation of health policy by providing an impetus for change based on a temporary diminishing of trust in the profession (Ham, 1992). Most recently, inquiries into systemic mismanagement of risk and poor practice - such as the current enquiry into events at the Bristol Royal Infirmary and the recent report of the Select Committee of the House of Commons into adverse events and claims (House of Commons, 1999) - continue to provide windows of opportunity in which the government can press for more radical mechanisms for accountability than might normally be possible in their negotiations with the profession (Rosenthal *et al*, 1999). The recent conviction in 1999 of Dr Harold Shipman for the murder of a number of female patients has also raised concerns about the adequacy of checks on medical autonomy. It is clear that public outrage remains an important bargaining tool in the negotiation process.

Poor publicity has not just focused on issues arising from official enquiries. Perkin (1996) cites a spate of malpractice suits in which doctors would not give evidence against medical colleagues, a number of widely publicised drug-abuse cases involving GPs and at least one notorious case of a forensic pathologist convicted of rigging legal evidence as contributing to a clouding of the profession's image in the public eye. More recently, research on the incidence of medical mishap has demonstrated that medical error and mistakes are common (Brennan *et al*, 1991) and this has provided an incentive for the introduction of more stringent risk management and clinical audit protocols (Mulcahy and Rosenthal, 1999).

Recent years have witnessed increased emphasis on managerial control of medical work and political will to steer the NHS in the direction of bureaucratic or legal models of regulation has been apparent. This has been most notable in initiatives involving management of budgets. Prior to the Griffiths Report in 1983 (DHSS, 1983a) the NHS was run by consensus teams with doctors and nurses sharing responsibilities with administrators. Attempts to get doctors to help manage the service were made but were largely unsuccessful (see, for instance, Ministry of Health, 1967). Reforms introduced in the wake of the Griffiths report turned administrators into general managers who had overall responsibility for budgetary control of health care. One consequence of this has been that managers have gradually been able to exert more control over the activities of doctors by means of such mechanisms as information systems, clinical budgeting and risk and quality management programmes.

It has proved difficult to introduce change which accommodates the needs of both sides of what is an organisation with both a bureaucratic component and a professional one (Harrison *et al*, 1990). Despite the difficulties inherent in trying to regulate a mixed model of provision, Harrison *et al* (1990) have argued there has been a very distinct movement from a scenario of medical 'professional monopolists' to one where a strong challenge is being mounted from managerial corporate rationlisers. They surmise: 'This shift from a situation characterized by two competing elites represents an erosion of one of the twin pillars of medical influences.'

Somewhat paradoxically, given the Conservative government's commitment to de-regulation, recent reforms in the health sector have led to more controls on the medical profession (Allsop and Mulcahy, 1996; Turner, 1996). This approach was particularly obvious in relation to the increasing numbers of 'spontaneous attacks' which Thatcher and her political colleagues made on the three ancient and self-regulatory professions of law, medicine and the clergy because the extensive power wielded by these groups was perceived to encourage inertia (Perkin, 1996, p476). In their drive for increased efficiency, Conservative governments have tended to perceive professionals in the NHS as obstacles rather than allies (Harrison and Pollitt, 1994).

A series of structural, institutional, and process changes such as privatisation and contracting out took place in the 1980s and have caused a radical transformation of public administration, (Austen, 1997). New notions of accountability and public service have come about as a result of the Next Steps Programme (Le Sueur and Sunkin, 1994; Cabinet Office, 1988), the creation of internal markets, the Citizen's Charter and the publication of information about NHS Trusts. These have all aimed to increase efficiency and to provide greater accountability to consumers at the level of service delivery through complaints and other mechanisms (see, for example, Cabinet Office Complaints Task Force, 1995, 1995a, 1995b, 1995c, 1994, 1994a, 1994b, 1994c, 1994d, 1993, 1993a; and Harper Mills and von Bolschwing, 1995; Citizen's Charter Unit, 1991).

The introduction of the National Health Service and Community Care Act 1990 allowed the Thatcher government to challenge the power of medical professionals by strengthening the NHS management structure (Allsop and Mulcahy, 1996). The Act gave managers unprecedented powers allowing them to take part in the appointment of hospital consultants, negotiate their job plans, and participate in decisions about which doctors should received distinction awards. A past president of the Royal College of Physicians suggests:

> '[T]he competitive marketing philosophy of the "new" NHS has introduced the need to improve outcome figures for medical intervention and, hence, to eliminate incompetence and inefficiency; the strengthening of managerial systems has given administrators the teeth to take action against a doctor whose performance appears not to match that of his colleagues.' (Hoffenberg, 1995, p xi)

The 1990 reforms of the service have provided a significant new set of incentives for doctors and managers to co-operate in the workplace and have encouraged a new wave of managerialism. These could be viewed as another instance of antagonistic and external threats to the collective integrity of the profession (Katz, 1977). Paradoxically, by giving hospitals greater autonomy and financial freedom, managers and doctors are now compelled to join in the common corporate pursuit of the winning of contracts for their services.

Within trusts two important new forms of management have developed. On the one hand, there are a number of organisation-wide systems such as quality management, risk management, complaint management and bed management, and, on the other, there are new structures within medicine to manage areas of clinical activity, such as management through clinical directorates and clinical protocols (Berwick, *et al* 1992a, 1992b).

However, evidence about the willingness of doctors to participate in hospital-wide risk management and audit structures suggests that, despite these moves, a culture of resistance to managerial authority continues to exist (Allsop and Mulcahy, 1996; Berwick *et al*, 1992 and 1992). Research suggests that, in practice, managers have made only limited in-roads into professional autonomy and that while managers may be questioning medical priorities more, their actions are being resisted (Flynn, 1991). Despite the potential for such developments to alter the balance of power between managers and medics, Harper Mills and Bolschwing (1995) suggest that doctors have resisted the collection of data about their own clinical conduct. Reporting on their experience in US hospitals, they comment that doctors became protective when their own information was being screened for quality analysis.

Other professional groups have also provided challenges. Kelleher *et al* (1994) argue that the nursing elite have been embarking on a process of occupational development which has forced a redefinition of the relationship between medicine and nursing (see also Dingwall *et al*, 1988). Such developments have led to claims that medicine is being de-professionalised as part of a more general trend of rationalisation and codification of expert knowledge (Haug, 1988; Haug and Lavin, 1983; Haug, 1973). Others have claimed that professionalism is being proletarianised in line with the requirements of advanced capitalism (McKinlay and Stoekl, 1988). According to this view people no longer believe in doctors' special status. Little research has focused on how doctors view challenges by consumers but, in a small scale empirical study of Australian doctors and patients, Lupton (1997) found that the discourse of consumerism was commonly employed by doctors to describe the changes they had noticed in patients' attitudes and that this has served to make them more accountable. Most of the doctors she interviewed agreed that their status had diminished in recent years.

Challenges to medical power from the laity have also had some impact. Consumer groups have emerged as a political force demanding improved conditions and rights for the population. Patient choice and information for patients as consumers have become more important. At the same time, the intimacy of the doctor-patient relationship, the potential for exploitation and the serious consequences of medical mistakes have all been given as justifications for regulation from a consumer perspective. A better-educated population also has higher expectations of care. The emergence of a consumer movement, especially the women's movement, and better education amongst the laity has provided an impetus for alterations in the ideal form of the doctor-patient relationship. The formation of Community Health Councils in 1974, funded by the state, did much to help strengthen the consumer voice in policy making. These challenges have expressed themselves in a number of ways, through complaints and litigation, non-compliance with treatment plans and more obviously through political action. Because their co-operation is usually vital to the implementation of policy, consumer groups often rely on exerting pressure through parliament and the mass media. Williams and Popay (1994) cite the women of the Bristol Survey Support Group's challenge to the findings and interpretation of the data they themselves had provided, and the residents' fight for an independent inquiry into polluting of the Lowermoor Treatment Works near Camelford as examples of such political action which attracted media attention.

Consumer activists have consistently argued for an alternative model of regulation which favours their interests. In this 'grass roots' model the emphasis is on empowering users of services by allowing them to maintain control over the issues being considered (see, for example, National Consumer Council, 1994). This emphasis often manifests itself as a challenge to the notion of medical expertise and as a call for greater joint decision making between doctor and patient or, more radically, for the de-professionalisation of services. More fundamentally, consumerist critics of self-regulation have argued that distinctions between doctors and patients made on the basis of medical knowledge are often inappropriate as not all medical issues are so complex that they cannot be understood by patients (see, for instance, Oliver, 1996; Oakley, 1980). It has also been suggested by consumer groups that the public interest cannot be served by self-regulation where the predisposition is logically for members of the group to protect other members of the same group. Medical regulatory systems have been perceived to be slow, unresponsive and overly protective of the profession's interests. In addition, many writers have recognised that the empirical reality of professional self-regulation may be far from the ideal (National Consumer Council, 1999).

Other writers have cited the growth of self-help groups in society as evidence of this challenge to expertise by the laity (Kelleher *et al*, 1994; Horobin, 1983) although Kelleher and colleagues suggest that their prevalence and rate of growth is difficult to detect. Many of these groups have been set up as a result of discontent with management of chronic morbidity but consumers have also been encouraged to take greater responsibility for their health by the policy makers (see Department of Health, 1992). Lupton (1997) has also drawn attention to the challenge posed by the number of patients turning to complementary or alternative medicine and Saks (1994) has charted the growth of complementary medicine as a direct attack on the bio-medical model of care. Kelleher and colleagues (1994) suggest that the interest in alternatives may be explained in a number of ways: as part of the disillusionment many people feel with the dehumanising effects of 'scientific' medicine; the manifest lack of interest that doctors display in treating them as people; or the failure of modern medicine to match up to expectations.

The development of a consumer movement has been symbiotic with the growth in media coverage of doctors and a tendency for the media to be more critical of doctors than in the past (Kelleher *et al*, 1994). In particular the media have given more extensive coverage to the failings of medicine and the mistakes made by doctors. In the words of Lupton (1997):

> 'As in the United States and Britain, media representations of the medical profession in Australia have veered from portraying doctors as the saint-like saviour of lives or restorer of good health (particularly if they are surgeons), to criticising doctors for medical negligence, avarice and sexual harassment.' (p483)

Strong (1983) has argued that the media's role in the transformation of views about the medical profession *rarely gets the attention, or credit it deserves* (Strong, 1983). Not only has press coverage of health matters increased but so too have the use of lay as opposed to medical perspectives (Kelleher *et al*, 1994). Ham (1992) cites the example of television coverage of 'Cinderella' services - such as the reporting of the abuses at Rampton Special Hospital in the 1970s - as an example of this. He argues that, at times, journalists and television producers have taken on the mantel of pressure groups for under-privileged sections of the community. All these factors are seen to contribute to an erosion of the traditional power of doctors, an increase in their economic vulnerability and alienation in the medical workforce (Lupton, 1997). This development has in turn, empowered readers, listeners and viewers to challenge medical decision making.

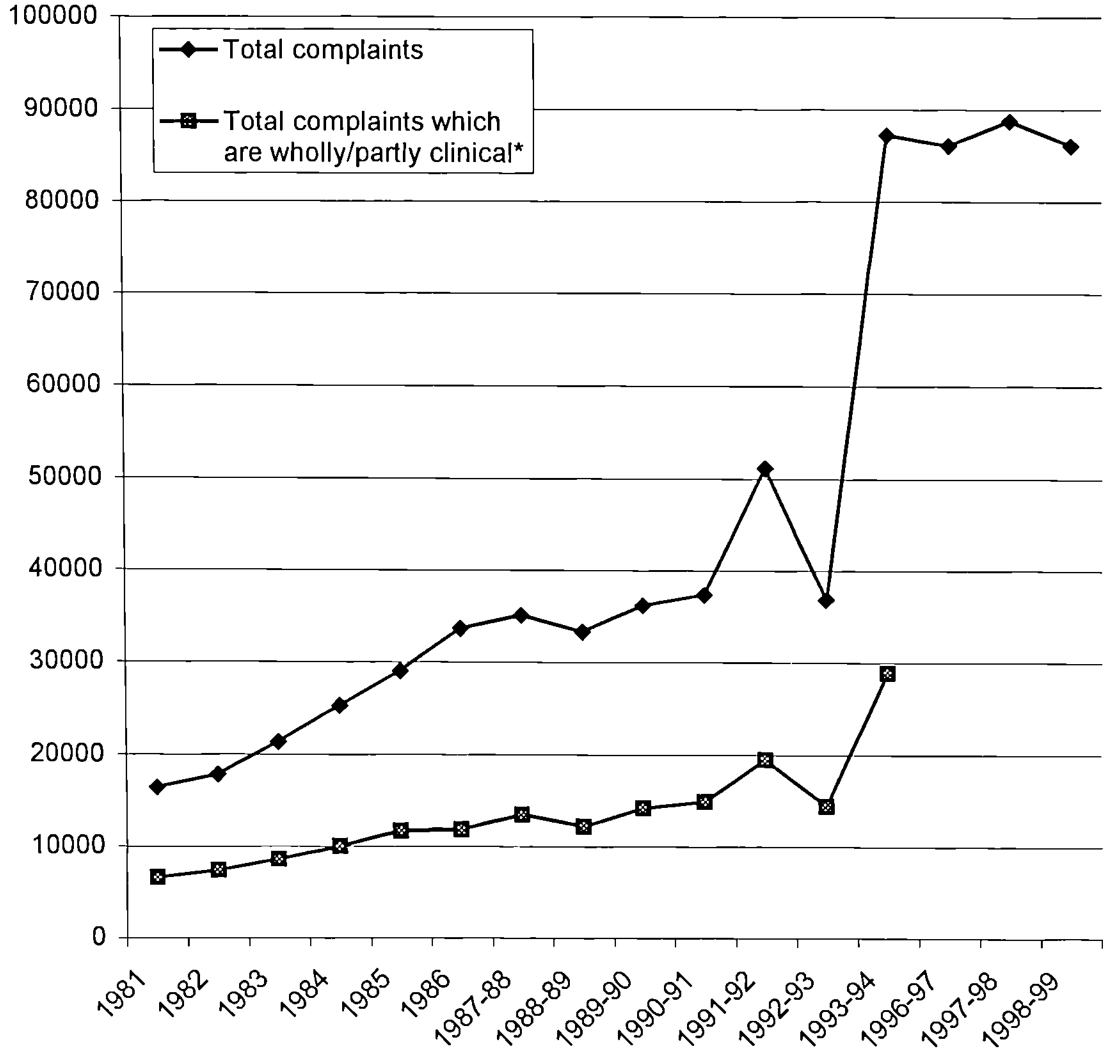
The challenge posed by complaints and legal claims

Finally, this chapter turns to the challenge to doctors posed by complaints. Key aspects of the threat of complaints are reviewed: the increasing incidence of complaints; their potential to become legal claims; and the challenge they pose to the construction of knowledge.

One of the most obvious signs that complaints can be seen as an increasing threat is the general rise in their incidence. The number of formal complaints in the hospital sector has risen from 16,363 in 1981 to 86,013 in 1998-99. Figure 2.2 shows the steady increase until 1994 after which there has been an eight per cent drop off. Over the same period the proportion of complaints relating specifically to clinical care have remained constant and these are also shown in Figure 2.2.

The rise in complaints has not been viewed negatively by all providers. In the UK, consumers of health care are being encouraged to become more active in voicing their views and concerns and health care providers are increasingly expected to canvass user views and respond appropriately (see, for instance, Cabinet Office Complaints Task Force, 1993). These policy initiatives have been underpinned by legislative reforms which have encouraged the generation of information for consumers about quality and risk in order to facilitate the better regulation of medical work and improvements in service. The approach has led policy makers to encourage a proactive approach to complaints, welcoming the voicing of dissatisfaction as a useful management tool.

Figure 2.2: Total number of hospital complaints 1981-1994



Source: DoH, Statistics Division: *Hospital Complaint Statistics 1981-1994* and DoH website
*From 1995 the DoH did not make a distinction between clinical or non-clinical complaints.

Recent research actually suggests that the rate of complaints remains modest when compared to the number of grievances. Miller and Sarat (1980 81) suggest that despite the rise in the incidence of public disputes, Western societies are relatively uncontentious and even passive. They argue that disputes may be relatively uncommon when compared against a baseline of perceived injurious experiences. Similarly, Felstiner *et al* (1980-81) argue that a study of the emergence and transformation of disputes may lead to a judgement that there is too little conflict surfacing in society and that too few wrongs are perceived, pursued, and remedied. According to this view, conflict and disputes are seen as the norm in society, but formal resolution through state-sanctioned systems for redress as atypical. These assertions are supported in a medico-legal setting by the findings of an influential study of the incidence of adverse events in medicine and their relationship with complaints and claims. It is known from an extensive study of medical records in New York State conducted by a research team at Harvard University that there were far more adverse events than were ever reported through complaints or claims (Leape *et al* 1991; Hiatt *et al.* 1989).

If doctor-patient disputes do not pose a significant economic or professional threat to doctors, why is it that they cause such defensive responses? Research into complaints in a health care setting suggests that the answer lies in the fact that complaints are seen by doctors as constituting a criticism of, and challenge to, medical expertise. Complaints invariably contain a number of allegations of either technical or normative failure (Allsop, 1994; Lloyd-Bostock and Mulcahy, 1994) and statements of implicit or explicit allegations are always present (Lloyd-Bostock and Mulcahy, 1994). One of the reasons for this appears to be that the accounts of treatment given by patients are alien to doctors.

The differences in the ways in which patients and doctors come to understand and account for the same medical experiences have been well documented in recent years by medical sociologists. Patients' narratives have been found to be quite different in form and content from the more scientifically orientated accounts by doctors (see, for example, Arksey, 1994; Kelleher, 1988; Cornwall, 1984; Blaxter, 1983; MacIntyre and Oldman, 1977). Toombs (1992) argues that the patient and doctor are motivated to attend to different aspects of a 'shared' experience and that each gives it meaning in a qualitatively distinct manner.

The doctor is trained to perceive illness essentially as a collection of physical signs and symptoms which define a particular disease state. They 'thematize' the illness as being a particular case of multiple sclerosis or diabetes (see Linnea Schneid, 1994). In contrast, the patient focuses on the effect of the illness on everyday life rather that on the disease process (for a general review of the literature on medical decision making, see Hughes *et al*, 1988). Toombs (1992) argues that the motivation for these different emphases is intimately related to the individual's world. She surmises:

> 'In the practice of a profession certain "habits of mind" develop that provide a horizon of meaning by means of which reality is interpreted. Such "habits of mind" are in many ways peculiar to the profession that utilizes them. They represent a distinct approach to the world and compose the culture of a profession.' (p11)

Mishler (1984) has confirmed the validity of this analysis. He noted that there are two frameworks of meaning characterising the discourse between doctor and patient. These are the voice of medicine which reflects the technical-scientific assumptions of medicine and the voice of the lifeworld which represents the natural attitude of everyday life. In his analysis of medical interviews, he noted that doctors tend to control the form and content of interviews by defining what is considered relevant. The voice of the lifeworld tends to be seen as not medically relevant and is typically suppressed.

Patients' common-sense stories of illness and complaints often contain explicit and implicit challenges to the bio-medical accounts of doctors. Such lay narratives of illness represent a challenge to the objectivity of expert knowledge, contest the impartiality of that knowledge and raise questions about whether the truth claims of scientific knowledge permit a proper understanding of health problems in the 'new modernity' (Williams and Popay, 1994, p120). Williams and Popay call this an epistemological challenge to expert knowledge. However, patients' accounts continue to be viewed within clinical medicine as a product of irrationality or subjectivity (Nettleton and Harding, 1994).

Complaints also appear to pose a threat because of their potential to escalate into litigation. In reviewing the literature on complaints it is difficult to separate out the threat they pose from that of legal claims as the two subjects are commonly treated as synonymous. As Dingwall (1994) has argued ' ... professional anxieties tend to be closely bound up with concerns about the possible interaction of the complaints systems with ... tort litigation' (p48). He cites the numerous medical conferences and working parties which have viewed the problem of complaints and claims and the parallel panic reflected in grass roots correspondence to medical journals as evidence of this. Fears have been expressed in terms of the dangers of hospital wards having to be closed down because of the draining of NHS funds by plaintiffs and lawyers, concerns about low levels of recruitment to the profession and high-risk specialties in particular, and fears that the high rate of claims could lead to defensive medicine being practised.

The escalation of complaints into legal claims has long been of concern to policy makers. As long ago as 1973, the Davies Committee[4] commented on the dangers of complaints being responded to in a defensive manner because of the perceived danger of them being pursued as claims. Moreover, it is often suggested that the rise in the rate of medical litigation is a reflection on the adequacy of NHS complaints procedures (NHSE, 1994). Thus, making a legal claim is seen as a natural progression for those wishing to pursue their complaint and the complaints procedure is often seen as a filter system which weeds out the less serious incidents and identifies those grievances which should properly be dealt with in the courts (Carrier and Kendall, 1990). Clearly, there might be the potential for grievances registered as formal complaints to evolve or escalate into claims but, what statistical evidence do we have about the likelihood of this happening? How realistic is the fear that complaints will progress to legal suits?

Only two previous empirical studies have looked at the relationship between legal claims and complaints. The first of these, undertaken in an American setting by Jost *et al* (1993), examined the possible overlap between complaints to the Ohio State Licensure Board and the tort system. An analysis was undertaken of 200 records of complaints made to the Medical Board, a body that used complaints to determine whether a doctor should have their professional registration suspended. Two indications of a claim were looked for: suggestions that the complaint was capable of being lodged as a medical negligence action; and indications on the file that the complainant had independently filed a malpractice suit. The study found that, in spite of the fact that 16 complainants mentioned contacting an attorney prior to filing the complaint and that 11 threatened a lawsuit, analysis of the files suggested that only two (1%) complainants actually filed a lawsuit before, or after, making their complaint.

In their study of hospital complaints in a UK setting, Mulcahy and Lloyd-Bostock (1994) explored the issue of the proportion of complaints which had the potential to become claims. First, they looked at whether the allegations made might constitute a cause in action. They focused on: whether the complaint related to clinical care; whether an allegation of physical harm had been made; the severity of physical harm alleged; and any attributions of fault and requests for compensation. Secondly, they looked for any indications that the complainant might want to pursue the complaint further such as: the use of solicitors and other agents; and the stage that the complaint reached in the complaints machinery. Their study suggested that, even when cases which fell into all these categories were added together, only four per cent of complaints had the potential to 'progress' to legal claims.

In a series of publications Dingwall and colleagues have argued that the threats of dangerous after-effects of doctor-patient disputes have largely been manufactured and that the production of a crisis serves to benefit the profession by creating public sympathy for doctors (see, for instance, Dingwall, 1994; Ham *et al*, 1988). Despite the sharp increase in the frequency of these disputes, it is argued that such atrocity stories have exaggerated the dangers of complaints and litigation. While the medical defence organisations were brought to the edge of bankruptcy in the 1980s, Dingwall (1994) argues that this was more explicable in terms of the undercapitalisation and lack of insurance expertise in these organisations than a national crisis[5]. He concludes that litigation and complaints are a problem for the profession in a way that they are not a problem for the NHS.

Conclusion

This chapter has attempted to place the challenge of complaints within a political and social context. It has explored the connections between the state, the medical profession and patients and suggested that expectations about their relationships are in a constant state of flux and negotiation. The expectations of all these stakeholders have changed considerably over time and changes in the balance of power and responsibility have been particularly noticeable since the inception of a welfare state. Whilst the hiving off of responsibility for regulating medical work was once an attractive option for politicians, an acceptance of welfarism and more interventionist policies as the more appropriate form of governance in the latter half of the twentieth century challenged the validity of the compact between state and profession. Medical power and medical discourses have also been challenged by the growth of consumerism, of which complaining is one aspect. Consumerism has manifested itself in many other ways in the media, political campaigning and increasing use of the courts. It has been argued in this chapter that complaints have to be viewed as part of this general threat to medical autonomy. This approach goes some way towards explaining the defensive attitude to complaints charted by empirical researchers.

Doctors' authority in society and within the medical consultation depends on an acceptance of their monopoly of power and the legitimacy of medical discourse. The traditional medical model involves the imparting rather than the sharing of information. When patients call doctors to account by questioning their judgement they step out of 'the sick role' anticipated of them. They lay claim to an expertise which contrasts with, and threatens, the scientific basis of knowledge claimed by the doctor.

Notes

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1. But, in some areas, such as financial services and the environment, regulation continued to grow and the privatisation of leading public utilities led to the introduction of elaborate new regulatory frameworks (Allsop and Mulcahy, 1996; Freedland, 1994).
2. Thus, the modem profession spans the categories of economic and social regulation suggested by Ogus (1994), referred to earlier in this chapter.
3. The Calman report (DoH, 1995) recommended that as a condition of employment there should be an obligation on doctors to report colleagues.
4. Davies Committee on Hospital Complaints Procedures (1973).
5. Also, the increased rate of claims started to level off around 1987 and has since slowed down considerably. Moreover, only 20-28 per cent of claimants receive any compensation and those that do divert just 0.2 per cent of the NHS budget each year.

3 Hospital complaints: The policy context 1966-1996

'Power is not only exercised upon the participants within the decision making arenas but also operates to exclude participants and issues altogether; that is power not only involves who gets what, when and how, but also who gets left out and how.' (Handler, 1991, p334)

Introduction

This chapter charts the development of the hospital complaints procedure and the attempts which have been made by policy makers to fashion it on the bureaucratic or legal models of regulation described in the last chapter. The chapter aims to expose the various ways in which the elite of the profession have attempted to insulate doctors from managerial intervention into complaints handling and maintained the professional model of regulation. Tracing the development of a distinct complaints procedure for hospitals provides a case study of how the professional project discussed in the previous chapter came to be achieved. While the hospital complaints procedure has been increasingly overseen by bureaucrats, significant powers continue to be reserved for doctors at service level to self-manage complaints about their work.

In the pages that follow the evolution of complaint handling in the NHS is described in five sections. The first chronicles the introduction of early versions of the current hospital complaints procedure in the 1960s. The second section reviews how this came to be revised as part of a major government investigation into NHS complaints procedures under the chairmanship of Sir Michael Davies. The third section goes on to examine how a separate clinical complaints procedure emerged and the fourth part considers the criticisms made of the procedures. In the final section, the current procedure and its relationship to previous systems is discussed.

Early versions of the current procedure

It can be assumed that complaints about the quality of care have been a feature of medical work since the time when medical assistance was first given. But, until the mid-nineteenth century, there appears to have been no public debate about the need for an integrated approach to complaint handling. Framing responses to complaint was a matter for the individual and their conscience. This approach undoubtedly reflects the fact that, until that period, the state had no part in the regulation of medical work and played a much less interventionist role in society than the modern state. This situation changed when the General Medical Council (GMC) was set up by the Medical Act of 1858. Handling complaints about poor practice was identified as a function of the GMC and constituted a key part of the bargain struck with the state at its inception (Stacey, 1992). At the time it followed naturally from the granting of monopoly power to the GMC over who should be allowed to enter the profession, that they should also be able to determine who should be expelled. There was no expectation (as there has been since the birth of the welfare state) that professional groups would be subject to the levels of control that we have come to accept as given today. Instead, the contemporary choice was between a self regulated market for medical care and an unregulated one (Allsop, 1998). Policy makers of the day chose the former by granting power to the GMC to control entry and exit to the profession without interference from the state. Harrison *et al* (1990) have viewed the agreement reached between the state and profession as an example of liberal corporatism; a process through which the state eases its own problems in managing society by offering favours and status to a few selected interest groups in return for their agreement to behave in 'moderate' ways. They have argued:

> 'The big deals [are] worked out between the state and "the peak associations" (the favoured, elite, organised groups) and then "sold" to the rank and file and general public.' (p23)

But the 'big deal' reached by the government and medical elite in 1858 merely reflected power relations. In practice, the relationship continues to be negotiated and the medical profession has shown itself adept at securing deals which favour the interests of its members. In particular, medical elites continue to be in close and constant contact with ministers and government officials as Barbara Castle's and Richard Crossman's diaries testify (Castle, 1980; Crossman, 1977). This is not a position enjoyed by patients' groups.

But the monopoly licensing power of the GMC was not achieved without cost in the form of some check on autonomy. In return for being given competitive advantage in the market, the GMC was required to stabilise the profession's internal institutional arrangements (Belant, 1975). This required them to put in place some arrangements for the exclusion of incompetent doctors and resulted in the introduction of a mechanism for the expulsion of doctors found guilty of serious professional misconduct. The standard was a minimal one. Critics have suggested that the high threshold of incompetence put in place has meant that in reality the vast majority of doctors complained about to the GMC have had the case against them dismissed (Smith, 1994). But, at the time the GMC was being established, it was conceded that as long as they undertook to discipline poorly performing doctors and fulfilled this obligation then the state would respect their claim to clinical autonomy and allow self-regulation. For over a century after the GMC was established, formal complaints were limited to these atypical cases involving serious professional misconduct.

Complaint handling systems operating outside the one overseen by the GMC have been much slower to follow. Even when the NHS was created in 1948 the state declined to take responsibility for overseeing or managing complaint handling by doctors. This was despite the fact that hospital consultants became paid employees of the state. When the NHS came into being doctors inherited dual responsibilities, to their employers and to the GMC. The Health Service Commissioner's post was created by the legislature relatively recently in 1973[1] and it is only in the latter half of the twentieth century that the common law has properly recognised the right of patients to sue doctors for medical negligence (Mason and McCall-Smith, 1994).

Even when procedures did become compulsory for NHS hospitals, they operated in addition to the one managed by the GMC rather than instead of it. Stacey (1992) has argued that the NHS hospital complaints system has emerged as a different type of regulatory procedure from that of the GMC and that it tends to display more characteristics of a bureaucratic or legal model of regulation than the self-regulatory model adopted by the GMC. She has explained that policy makers initially thought to enforce the same model of accountability for doctors which applied to bureaucrats within the NHS. This had a certain logic as both administrators and doctors were employees of the NHS. But it was successfully argued by the profession that the nature of hospital medicine was such that purpose-designed arrangements would be needed which would run in parallel with bureaucratic models. The tension between the bureaucratic and self-regulatory model reflected an aversion on the part of doctors to being line-managed by bureaucrats or other doctors and concern lest the special nature of medical work went unrecognised[2].

For the first two decades of the National Health Service, Regional Hospital Boards, Boards of Governors and Hospital Management Committees dealt with complaints about hospital services without any detailed advice from the government other than that relating to serious disciplinary matters (Davies Committee, 1973). Until 1966, complaints procedures in the hospital sector were largely unstructured and varied between hospitals and districts. Centralised guidance from the Department of Health and Social Security (DHSS) was circulated that year but tended to concentrate on atypical complaint-handling scenarios involving the setting-up of occasional independent *ad hoc* committees to investigate the most serious complaints, such as physical abuse of patients by staff in hospitals for those with learning disabilities.

It was not until 20 years after the creation of the NHS that an attempt was made at standardisation of local complaint handling practices within hospitals with the circulation of a Health Memorandum (HM(66)15). This brief, 850-word document privileged medical discourse above others. It recommended the adoption of skeletal procedures in which much discretion to set up a complaint procedure was left to those providing the care being criticised. It had two important functions. First, it laid down two principles according to which complaints should be managed. It recommended that all complaints should be dealt with 'as promptly as the circumstances required' (p1). It also required that complaints should be investigated and complainants made aware that their complaints had been fully and fairly considered.

Secondly, it recommended a crude appeals procedure. It advised that oral complaints which could not be dealt with to the complainant's satisfaction should be reported to a senior member of staff in the same department, who should make a brief note of the complaint and take 'appropriate' (p2) action. In cases where the complainant wanted to take the matter beyond this level it was recommended that a written complaint be directed to the hospital management committee or a senior member of staff. Action taken in response to the complaint was to be agreed, after consultation, with the Head of Department concerned. Any complaints not dealt with satisfactorily in this way could then be reported to the Hospital Management Committee or to 'an appropriate committee' (p2) for a decision as to further action. Where this was considered necessary the case could be referred to the Regional Hospital Board which was empowered to establish an enquiry chaired by an independent lawyer.

Three particular features of the 1966 guidance are worthy of note. Each of them reflects a preference for local and informal self-regulation by the profession. Firstly, it allowed for handling of complaints about doctors to be conducted almost exclusively by doctors. Secondly, there was little opportunity for grievances to be considered by others outside the organisation involved in the complaint. This situation was exacerbated by ambiguity about how and to what extent members of hospital authorities should be involved with, or informed about, investigations of complaints. Finally, the memorandum was not binding on hospitals or clinicians. Instead, it was anticipated that local providers would complement its broad statements of principle with detailed rules at service level.

By the mid-1970s a series of government inquiries into poor quality hospitals provided an extraordinary environment in which more radical inroads into clinical autonomy could be contemplated. Commentators on the development of social policy have suggested that it is important to distinguish between ordinary and extraordinary opportunities for change (Ham, 1992). Legitimation crises in the public sphere are capable of creating a climate for change which can be manipulated by those involved - stakeholders who usually occupy a relatively weak bargaining position. They may also signal a breakdown in the normal negotiating positions of the parties and make relationships more adversarial. Such situations are more likely to push negotiators into 'brinkmanship' in which they make significant threats to withdraw from long-term co-operation (Murray *et al*, 1989). In Solesbury's (1976) terms, they succeeded in commanding attention, claiming legitimacy and invoking action. When the Ely (DHSS, 1969), Fairleigh (DHSS, 1971), Whittingham (DHSS, 1972) and Normansfield (DHSS, 1978) inquiries reported, they highlighted the need for a thorough review of hospital complaints procedures. More strategically, they hinted at serious failure in the regulatory compact between the profession and the state made at the time the GMC was established.

The enquiries made serious allegations of neglect of vulnerable patient groups, such as elderly people and those with learning disadvantages. The deficiencies highlighted related to nursing and medical standards, facilities and custodial attitudes towards care (Ham, 1992). The enquiries were partly set up as a consequence of the failure of internal NHS complaints procedures being used to highlight quality issues and pointed to the need for more effective monitoring of hospital services (DHSS, 1973; Crossman, 1972). Public outrage ensued on the publication of the reports (Ham, 1992) and focused on the suppression of complaints and the victimisation of staff who complained on behalf of patients. Hospital management committees were also shown to have failed to provide safeguards or remedies for such abuses. Ham (1992) argues that the Ely Hospital enquiry in particular encouraged the issues raised to become generalised into a wider concern with social justice and humanitarian values.

As a result of the publicity, and of pressure group activity and ministerial concern, the DHSS set about reviewing problems surrounding the failure of complaints procedures to identify poor practice and how these might be resolved. Soon after the publication of the reports, the Hospital Advisory Service was set up to improve and oversee the management of long-stay hospitals and the possibility of introducing a Health Service Commissioner (HSC) was widely debated. Moreover, within a few years of the abuses coming to light, the DHSS also set up a committee under the chairmanship of Sir Michael Davies to look more generally at the problems with hospital complaints procedures (see Box 3.1 for terms of reference). Stacey (1999) has argued that doctors gave their support to this initiative because they feared that, unless complaints were adequately handled, there would be an escalation of medical negligence claims.

The Davies Committee on Hospital Complaints

The Davies Committee was the first official government investigation of the NHS hospital complaints procedure. Its report remains the most comprehensive and in-depth review of its kind ever to have been undertaken[3]. Much of the discussion contained in it remains relevant to contemporary debates about complaint procedures and reflects tensions in the provision of services which are still prevalent today.

Box 3.1: The terms of reference of the Davies Committee

'To provide the hospital service with practical guidance in the form of a code of principles and practice for recording and investigating matters affecting patients which go wrong in hospitals; for receiving complaints or suggestions by patients, staff or others about such matters; and for communicating the results of investigations; and to make recommendations.'

Davies Committee, 1973

It is significant that the chair of the committee was a high-court judge, as the investigatory style he adopted was formal, legalistic and evidence-based. This provides a stark contrast with the review of NHS complaints procedures, conducted exactly 20 years later, under the chairmanship of a University Vice Chancellor, Alan Wilson, which was asked to report in four months and which was influenced much less by the formal evidence submitted to it (Stacey and Moss, 1996).

The 16 places on the Davies Committee were occupied by senior administrators (4), academics (3), senior medics (3), representatives of consumer organisations (2), journalists (2), an NHS trade unionist and a senior nurse. The Committee undertook its own empirical research; commissioned research by the Institute for Operational Research[4]; met formally on 30 occasions; held several other informal sessions; and invited written evidence. Evidence was received from all the Regional Hospital Boards, 64 per cent of Boards of Governors (21), 91 per cent of Hospital Management Committees and Boards of Governors (302) and 49 per cent of other organisations and individuals approached for evidence. In addition, as a result of a widespread publicity campaign, 859 letters were received from members of the public. The tone of the report was formal and legalistic. The duties of NHS employees and government departments were discussed in the context of formal responsibilities and channels of authority.

Criticisms of the 1966 procedure

The Committee had four major criticisms of the 1966 procedure in existence at the time of its report. Each suggested a failure on the part of practitioners to take complaints seriously. Firstly, defensive attitudes to complaints were common and appeared to be having a detrimental effect on staff morale. It was also argued that this encouraged indifference to complaint-handling and tended to repress grievances. Secondly, inadequate information was available to staff and complainants about the procedures and how they might be accessed. Thirdly, there was no effective system of external checks in operation on how complaints were being managed. Finally, the committee wanted complaining to be seen as a legitimate activity and felt that inadequate attention was being paid to encouraging complaints, most of which were thought to be but a small challenge to medicine or its administration.

Research commissioned by the Committee supported the view that hospital staff had operated the procedures in a way which insulated them from criticism. Submissions from interested parties threw much light on how the hospital complaints procedure governed by the circular HM(66)15 operated in practice. The Committee found that there was an unwillingness to activate the 'appeals' procedure to the Regional Hospital Board or authority member level[5]. The only other option open to dissatisfied complainants was to turn to the courts. More complaints appeared to filter through to members of the hospital authority than to regional boards, especially where they involved clinicians, but evidence submitted to the Committee suggested that in the majority of cases members of health authorities decided that no further action was necessary. In addition, the challenge of supplementing the rather vague procedure outlined in the governing memorandum by the introduction of a more detailed local one had not been taken up by local providers of NHS services.

Significantly, the report also revealed that, under the 1966 procedure, consultants maintained considerable control over the investigation of both clinical and non-clinical complaints. In a survey of all 330 hospital boards operating in England and Wales, it was found that three main categories of postholder were responsible for the investigation of complaints which could not be dealt with adequately at service level. These were; group secretaries; hospital secretaries (administrators); and professionals/heads of departments[6]. While professionals had little formal *responsibility* for complaint handling (a maximum of eight per cent of those who responded to the survey were responsible for complaints about standards in patient care), an entirely different picture emerges from survey data on who actually *conducted* investigations and suggests that doctors wielded considerable power over the investigations (see Table 3.1).

Table 3.1: To show who conducted complaint investigations at the time of the Davies Committee research (by person responsible and subject of complaint)

	Category of complaint				
Person	Medical treatment (n = 291)	Treatment facilities (n = 284)	Standard of care (n = 291)	Criminal offences (n = 284)	Hotel facilities (n = 291)
Group secretary	23%	13%	15%	29%	9%
Hospital secretary	5%	14%	13%	13%	21%
Professional/head of department*	70%	73%	82%	14%	73%
Members of authority	10%	1%	1%	1%	1%
Police/security officer	0%	0%	0%	49%	0%
Totals[†]	**108%**	**101%**	**111%**	**106%**	**104%**

* The roles of professional and department head are conflated so that a consultant and head of catering may both be represented under this heading. This accounts for the high number involved in complaints about hotel facilities. [†] Percentages add up to more than 100 as more than one person might be involved in carrying out an investigation.

This table shows that where complaints involved medical treatment, treatment facilities or standards of care, doctors were usually involved in investigation procedures.

But, although doctors tended to be the people conducting investigations, the Committee identified concerns they were likely to adopt a reactive approach to clinical complaints. Consultants were seen by colleagues and patient groups as particularly unwilling to review or evaluate the clinical judgement of another hospital consultant and jeopardise a fellow doctor's reputation, especially where litigation might be involved. Many were not prepared to become involved in investigations at all and, in any case, fear of litigation often inhibited full investigation.

Recommendations made by the Committee

The Davies Committee report was published in 1973. There are five particular features of its recommendations which are worthy of attention. Firstly, where the 1966 guidance was vague and opaque, the 82 recommendations made by the Davies Committee were complex and intricate. It argued that existing guidance on complaints was too narrow and not sufficiently useful as an aid to practice, concentrating as it did on broad principles and the responsibilities of those at higher managerial levels. It identified a number of principles which should steer the design of complaint procedures but also drafted more specific guidance on how such procedures should operate. The report argued that complaints must be properly investigated; a fair review or evaluation of the matter made; and remedial action taken where necessary or a reasoned explanation given as to why this was not appropriate.

Box 3.2: Stages in the Davies Committee recommended complaints procedure

- Service-level resolution of oral complaints, led by managers;
- Consideration by the chief officer of the area health authority or person responsible for the staff or service provided (the consultant, in medical complaints);
- Where the complainant was not satisfied, a referral to a standing independent investigating panel, akin to a tribunal, was possible;
- Dissatisfied complainants could also refer any complaint handled at Area Health Authority level to the Regional Health Authority for further review by an investigating panel.

Secondly, the Committee was strongly of the view that external involvement in complaint handling was essential. It recommended a convoluted procedure, with tangential procedures being established where a clear course of action could not be decided upon. At its simplest, it allowed for a four-stage procedure which would involve increasing amounts of external involvement as complaints progressed through it (see Box 3.2).

The Committee anticipated that doctors would be particularly critical of these proposals but concluded that fair and visible procedures were essential:

> 'This improvement is in the interests of complainants, who have a right to expect that their complaints will be fully and impartially considered; in the interests of professional staff, whose action may have been misrepresented or misunderstood; and in the interests of good management by health authorities, who are responsible for administering administrative defects or failures of service that may not otherwise be brought to light.' (p65)

Thirdly, unlike any previous guidance, it stressed not only the responsibilities of health providers but the *rights* of patients. Complaining was characterised as a legitimate activity and public bodies were presented as having particular responsibilities to those they treated. It was argued:

> ' ... a public body is under a higher duty to disclose matters which have gone wrong ... It should proceed on the basis that it is more important to investigate complaints and put matters right that have gone wrong than simply to protect itself.' (p78)

Moreover, the Committee made clear that, as far as accountability was concerned, doctors did not enjoy a special status. It was argued that the duties which public servants owed to service users applied equally to administrators and professionals:

> 'We believe that people who complain about medical treatment should never be given the reply that the complaint (or part of it) cannot be investigated "because it involves the exercise of clinical judgement". They are entitled to a full answer from the consultant concerned and the hospital authority in our view has a clear duty to make sure they get it.' (p44)

Fourthly, unlike official commentaries which preceded or postdated its investigation, the Davies Committee recognised the potential conflict between clinicians and manager-bureaucrats when managing complaints. It anticipated that consultants and managers might well disagree about how complaints should be handled. The Committee recommended the setting-up of a separate grievance procedure to deal with disputes of this kind. If cases could not be resolved in this way, it was suggested that they should be referred to the chair of the medical advisory committee and then on to external medical advisors. Thus, while it recognised the tension between the responsibilities of bureaucrats and medics, it conceded that the final arbiter of such disputes should be a medic.

Such an approach is typical of the report. While the language of consumerism, procedural fairness and managerial responsibility for complaint handling is rife within it, its most significant recommendations did much to further the cause of those committed to clinical autonomy. The report set other important precedents which have subsequently served to insulate the profession from external regulation of complaints. This was most obviously achieved by a distinction being made between the handling of clinical and non-clinical complaints. Despite evidence that doctors were reluctant to criticise each other and that the profession was not fulfilling its side of its pact with the state, the Davies Committee differentiated between complaints about the exercise of clinical judgement and other complaints. Its membership was persuaded of the apparent necessity of this approach by evidence about the distinctiveness and complexity of clinical complaints. In doing so, medical discourse was once again privileged and medical knowledge treated as synonymous with complex knowledge. It was assumed that expertise was necessary if the work of a medic was to be evaluated[7]. Upon what information was such an assumption based?

Thirty per cent of hospital authorities who responded to the Committee's survey identified clinical complaints as the most difficult to handle and resolve, followed by only 14 per cent of hospital authorities who believed that complaints about the attitude of staff were the most problematic. Clinical complaints were also perceived as different because the task of establishing the validity of a complaint was more complex. In the words of one hospital authority cited in the report:

> 'Obviously [complaints] with medical overtones tend to be more difficult than those allied to nursing and lay administration. With the clinical freedom enjoyed by medical staff the method of treatment and approach differs between doctors and, what may be acceptable to one patient or to one doctor is looked upon with disfavour by another patient or another doctor.' (p18)

The commentary emphasises two key factors which have been used to distinguish professional from lay work - the emphasis on specialised knowledge and the emphasis on the art of practising medicine. Read carefully, the quotation admits of the possibility that no medical work can be criticised. By accepting the distinction between clinical and non-clinical complaints, the Committee acceded to the claim of the profession to make judgements about and regulate challenges to doctors which occurred in a hospital setting. Accordingly, it recommended that complaints about medical care should, in the first instance, be dealt with by the doctor responsible for the medical care being criticised. Where they could not be resolved informally in this way, it was suggested that they should be referred to another medical consultant. The consultant was expected to agree a response with a chief officer of the hospital authority. Only after that could dissatisfied complainants refer the complaint to an independent investigating panel. These rationales for separating clinical and non-clinical complaints have proved influential and have remained virtually unquestioned since.

Responses to the report

The Davies Committee made an important contribution to the debate about the handling of complaints. It recognised many of the problems which deterred patients and their carers from voicing grievances and the serious consequences of inadequate procedures when provision of care went seriously wrong. The Committee expressed its commitment to the right to complain and get an adequate response. It also supported the managerial co-ordination of complaints and non-medical involvement in appeal mechanisms in the form of a legally qualified chair. In supporting such initiatives it hoped to introduce a bureaucratic structure underpinned by notions of due process to a predominantly medical model. It even suggested that these factors would challenge medical determinations of responsibility by subjecting them to opinions and suggestions which came from outside the professional culture group. Perhaps most importantly the Committee was able to suggest a design for the complaints procedure which paid heed to some of the principles of procedural justice. In these ways it placed primary emphasis on the mechanics of accountability to the public rather than just to the professional group.

But the rhetoric of accountability was not applied with such vigour to complaints about clinical care as it was to other complaints. The same barrier was inserted between the medical and administrative sphere as has characterised the organisation of the NHS since its inception.

This achievement is all the more remarkable because it occurred at a time of extraordinary negotiation between the state and the profession, in which there were important prizes to be fought for and won in the contemporary discussion of how the NHS should be organised. As Margaret Stacey, a member of the Davies Committee, later reflected:

> ' ... the doctors worked hard to have the machinery the way they wanted it: for example, a veto was put on recommendations that a notice about the complaints procedure should be widely displayed in wards, out-patients departments and so on. We were told that would damage the doctor-patient relationship which was painted as sacred. A patrician attitude was much in evidence.' (1999, p2)

Support for the Committee's recommendations was not universal. In a private interview, Stacey (1999) has explained how a minority of Committee members, including herself and a senior medic, considered submitting a minority report to the DHSS because of their concern about the level of compromise agreed with the profession. The group was dissuaded from doing so by the Sir Michael Davies. The disgruntled members were swayed by the impending announcements about the introduction of a Health Service Ombudsman and this encouraged them to adopt a more conciliatory approach. But they were to become even more disenchanted about the 'thundering silence' which followed the report and Michael Davies' 'unwillingness to stir it' (Stacey, 1999). The report of the Committee was not even referred to in any of the official guidance, Executive Letters or circulars which came after it. Margaret Stacey later reflected that the compromise reached was unattractive to all stakeholders:

> 'At this stage, I became sorry I had agreed a compromise at a last minute breakfast meeting. A radical minority report might have attracted more attention to the complaints debate and the Davies report. After about 10 years, a complaints system emerged, but what a mouse it was. I learned later from an authoritative source that the Royal College of Physicians had held

> progress up and had relegated a member of the College who had been on the Davies Committee to a backwater for signing the report.' (1999, p3)

Developments following the Davies Committee Report

As Stacey suggested, the recommendations of the Davies Committee were not immediately translated into new guidance. The handling of clinical complaints does not appear to have been the subject of further review until it was considered by the DHSS in light of an independent review of the subject by the then recently created House of Commons Select Committee on the Parliamentary Commissioner for Administration and the HSC in 1977. In its first (Select Committee, 1977) and subsequent reports, the Select Committee emphasised the need for appeal structures rather than front-line handling of complaints by doctors. It recommended that the independent appraisal of complaints should be the task of a lay HSC, and that the HSC should be given the scope to review the operation of the handling of clinical complaints and any complaints which health authorities could not resolve.

As a result of the pressures exerted by the Select Committee and repeated fears about increasing litigation, the Joint Consultants' Committee (JCC) which draws members from the British Medical Association and Royal Colleges produced its own set of recommendations on how clinical complaints should be handled. These reflected a more overt attempt at maintaining control over clinical complaint handling than had previously been the case and rested on the assumption that the distinction between clinical and non-clinical complaints should be maintained. They suggested that whilst complaints about organisational or administrative aspects of medical care and treatment should be investigated by health authorities, complaints concerning clinical judgement should be handled by clinicians. Even the principle that there should be an independent review of clinical complaints was not accepted. Instead, it was argued that, where complainants were not satisfied with the handling of clinical complaints at service level, these could be referred to a panel of two senior clinicians for further review.

The stated aim of such a review panel was to provide a less formal redress procedure than that provided by the courts. It was argued that complainants who sought an investigation and an explanation of their case, rather than punitive measures or compensation, should have somewhere to take their concerns in order to have them addressed (Watson, 1992). The recommendations were described by the Association of Community Health Councils in England and Wales (ACHCEW, 1990) as a deliberate attempt to forestall other attempts at closer regulation of doctors' work and, in particular, to resist the otherwise likely extension of the Ombudsman's role to include clinical complaint handling. Others have described them as a 'fudge' (Stacey, 1992).

The emergence of a separate clinical complaints procedure

About the same time, the DHSS issued a substantial draft code of practice for complaint handling and circulated it for comment in June 1976 (DHSS, 1976). Significantly, the protocol accepted the distinction between clinical and non-clinical complaints, but it did this by concentrating on non-clinical complaints and avoiding the issue of how clinical complaints should be managed. The draft code reflected many of the concerns of the Davies Committee. In particular it suggested that complaints procedures should be publicised; that complainants should be assisted in making complaints; that complaints should be recorded; and that they should be referred to a more senior level if necessary. But while the principle of managerial control of complaint handling appears to be accepted for the handling of non-clinical complaints, this was not the case where complaints involving clinical judgement were concerned. Appendix Four of the document reproduced the guidelines drafted by the JCC for the separate handling of clinical complaints and, thus, the foundations of a formal, but dual, system were laid.

The draft code was followed in 1978 with a further consultation document (HN(78)39) which took account of the comments of health authorities and other interested parties. It claimed to reflect the 'widespread' (p1) view that the arrangements proposed were too detailed and complex and that a simple procedure was needed. This recommendation was in direct contrast to that made by the Davies Committee which had felt that much tigher regulation of complaint handling was necessary. As was the case with the draft code, this consultation document did not deal with the handling of clinical complaints as this issue was still being considered in light of the Select Committee's first report. However, it was followed in 1981 by a Health Circular (HC(81)5) on the subject. Despite the lack of full or public consultation on the clinical complaints procedure, the circular incorporated the trial procedure suggested by the draft code of practice in 1976 and made clear that this had been formally agreed between the DHSS and the JCC. Thus, while non-clinical complaints were considered worthy of full consultation with interested stakeholders, arrangements for the handling of clinical complaints were negotiated between the profession and DHSS in a more private and less visible forum.

The medical profession worked hard to persuade policy makers that the new trial procedure was a success. In 1983 the DHSS circulated a brief report on the operation of the third stage of the new procedure. This involved an Independent Professional Review (IPR) by two medical colleagues of the kind originally suggested by the BMA and Royal Colleges (see Figure

1.1). The report drew on data supplied by doctors and NHS managers (DHSS, 1983a) and concluded that on the basis of this, the new trial 'appeals' procedure had been a success. Significantly, the views of complainants and patient groups were not sought. The report suggested that encouraging compliance with the procedure was not a problem within a self-regulatory setting. It was reported that the independent assessors appointed to review the work of colleagues had received the full co-operation of the doctors involved and had gained access to health records of patients in all cases. In government circles the new procedures were praised as satisfying the compact between the state and profession. Shortly after the report was published, the then Minister for Health, Kenneth Clarke argued:

> 'The procedure is still at an early stage, and we will continue to watch progress to see whether we have effectively provided patients and relatives with the response to complaints to which they are entitled. But it is already clear that the medical profession has responded constructively. "Second opinions" have given frank and expert assessments, and their colleagues whose actions they have scrutinised have offered full co-operation.' (Department of Health, 1983a, p2)

Despite such assertions, the DHSS report also revealed that the operation of the procedure was dominated by medical opinion including that of the doctor complained about. It demonstrated that, on receipt of a referral, the Regional Medical Officers charged with the discretion of calling for an IPR asked for and studied all relevant case notes and correspondence. But, while they discussed the matter with medical staff involved, they rarely chose to visit the complainant as part of their review.

Formalisation of the clinical/non-clinical divide

Further changes to the procedure were prompted, quite fortuitously by the chance intervention of a back bench MP in 1985 who argued for reform from an entirely different perspective. His interest in improving communication and accountability for health service users led to his private member's bill getting the backing of government and becoming law. In a private interview with the author, Sir Michael McNair Wilson described how the impetus for reform came about when he was hospitalised for a kidney complaint and became concerned about the lack of information available to patients. His response was to draft a patient's charter which placed emphasis on the service user's needs rather than those of professionals. When he secured a place in the private members' ballot, he decided to try and transform his charter into legislation. The Secretary of State for Health informed him that this initiative would not get government backing unless he choose just one clause of the charter to transform into legislation. He selected the clause relating to hospital complaints and his bill became law in 1985 as the Hospital Complaint (Procedure) Act. This continues to be the only statute governing the operation of the hospital complaints procedure (McNair-Wilson, 1989).

This legislation required for the first time that all hospitals put in place a procedure for complaint handling. In promoting the bill, which received all-party backing, Sir Michael emphasised the needs of patients over those of doctors. In Parliamentary debate he posed the questions:

> 'Whose chance? Whose life? Whose body? Who is the sufferer? What is the compensation? What is the complaints procedure? There appears to be no such procedure. The patient is just the fall guy who is in the hands of doctors who think they know better than the patient.'

The Act attempted to remedy some of the weaknesses of earlier codes of practice issued by the Department of Health, none of which had statutory backing, and was well received across the political spectrum. Lord Winstanley described Lord Colwyn's introduction of the Bill in the House of Lords as being in a mood of 'benevolent neutrality'[8]. Ministers are reported to have welcomed the opportunity the bill provided for the re-examination of existing complaints procedures and for ensuring that the procedure commanded the confidence of the public, health authorities and health professionals alike. But despite such laudable aims, the legislation was described elsewhere as 'modest' (Brazier, 1987, p126). With only two sections, the second of which constitutes the short title, it is only notable because it forced health authorities to set up a formal complaints procedure in compliance with centrally agreed guidelines. But the guidelines themselves had still to be negotiated with the profession.

It took three years for guidance to be issued under the Act (HC(88)37). When it did appear, it served to rubberstamp the arrangements made between the DHSS and JCC in 1976. The trial complaints procedure was formally adopted and allowed a clinical complaints procedure to exist in parallel to a non-clinical one. The dual system was justified by the Minister for Health and Social Security who suggested that the ideal of self-regulation alone was appropriate to place boundaries on clinical autonomy. He described the procedure as an 'important innovation, because doctors have now accepted responsibility for scrutinising and assessing the clinical actions of colleagues' (DHSS, 1983b, p10). The regulations remained in force until April 1996 and were operative at the time that the data presented in subsequent chapters were collected.

In the early nineties there was some discussion in policy circles about the need to update the complaints procedure in the light of reforms to the NHS and the Patient's Charter initiative. Supporters of the status quo remained sensitive to the need to persuade other stakeholders of the value of a bifurcated system. In 1992, when the IPR had been in operation for 10 years, the JCC seized the opportunity to conduct its own review of the procedure which drew on reports to the JCC from independent clinical assessors used to review complaints about academic colleagues. The JCC concluded that the procedure had an important role in monitoring and improving patient satisfaction and that, in the majority of cases, it was of value to the complainant and doctor involved. It did report some concerns about the operation of the procedure but these related more to the threat of independent regulation by the HSC than they did to any worries about the fairness of the procedure for complainants. Once again, the threat of external regulation was alluded to. The JCC was extremely concerned that the HSC had been reviewing cases which had gone to an IPR and worried that consultants would be less likely to act as assessors if they thought their actions would be subject to review[9]. It was also argued that the HSC's intervention had served to change the interpretation of the guidance which the JCC had negotiated with the DoH. At the time the HSC was specifically precluded from investigating complaints relating to actions taken solely in consequence of clinical judgement but he considered it within his jurisdiction to review RMO decisions on whether an IPR should be held. This meant that the Commissioner could force an IPR to be held if necessary. Such intervention clearly posed a threat, as it sought to blur the distinctions traditionally drawn between the clinical and non-clinical procedures. Moreover, the HSC had made public his view that his office was capable of overseeing clinical and non-clinical complaint handling.

Criticisms of the 1988 procedure

Between 1988 and 1996, when further reforms to complaints procedures were made, concerns that the hospital complaints procedure tended to protect the interests of doctors over those of patients were widespread amongst patient and complainant advocates, the Health Services Commissioner, the Select Committee and academics. Four major concerns were expressed in these circles about the clinical complaints procedure: that it was too complex; insufficient publicity was given to it; there was a lack of confidence in the procedures and outcomes; and responses to patients were poor and defensive. In the words of one critic speaking on behalf of Community Health Councils:

> 'The processes for airing grievances, investigating complaints and providing explanations when things go wrong are considered by those who use them to be long winded, cumbersome, bureaucratic and strongly weighted in favour of the medical profession.' (ACHCEW, 1990, p15)[10]

There was strong evidence that a substantial number of complainants did not know how to make a complaint. In one study, it was reported that in four districts surveyed only five per cent of members of the public questioned knew how to make a formal complaint (Prescott-Clarke *et al.*, 1989). In line with such criticisms, the Association of Community Health Councils argued that, in its experience, few health authorities were fully meeting their obligations under current guidelines to publicise their complaints procedures (ACHCEW, 1990). Instead of producing special leaflets providing information on how to complain, many relied on sections inserted into patient information booklets. They argued that not only did this make the information less accessible, it meant that those using outpatient, accident and emergency and long-term residential care did not receive the information. In a similar vein, the Audit Commission found that 45 per cent of the wards visited by its representatives did not have any posted or written information about the complaints system (Audit Commission, 1993).

Part of the problem was that guidelines operating at the time required, amongst other things that information about how to complain should not be displayed in hospital wards lest it encourage patients to make 'unfounded' or 'frivolous' complaints. Dame Elizabeth Ackroyd, Chair of the Patients Association, argued that, no doubt, some complaints did deserve such epithets but that such prejudgement should not be made about all complainants (Ackroyd, 1986). Research in other fields has since suggested that the decision to make a complaint is rarely taken lightly by the complainant (Mulcahy and Tritter, 1998; Maguire and Corbett, 1991).

It was also suggested that, despite some evidence of good practice, NHS procedures were often ineffective in meeting complainants' objectives. Several commentators highlighted the lack of satisfaction with the procedure among complainants (Lloyd-Bostock and Mulcahy, 1994; Scottish Management Executive, in NHSE, 1994; Donaldson and Cavanagh, 1992). The Patients Association claimed that the clinical complaints procedure was drawn up in an attitude of defensiveness and was used as a device for filtering out and discouraging potential claims (Ackroyd, 1986). The claimants' group Action for Victims of Medical Accidents suggested that the procedure was better designed to do this than to provide explanations to complainants as to what might have gone wrong. They argued that there was an undue emphasis on the fear of litigation and in their experience most complainants did not want to sue. Instead, they wanted information, an apology or an assurance that the same thing would not happen again (Simanowitz, 1999).

There was also research evidence that suggested that complainants' needs were not being served. It was argued that replies to complainants continued to appear defensive despite the hope of the Davies Committee that this approach was to be discouraged. In their review of 71 letters of response to complainants, Donaldson and Cavanagh (1992) commented:

> 'Our experience is that complaints are not welcomed by health service managers or doctors. At best they tend to be greeted neutrally, but we have found that they are regarded by some doctors as an affront to their professional standing, and on occasions there has been talk of action being initiated by the doctor concerned on the grounds of defamation.' (p24)

Similarly, in the words of Kaye and MacManus (1990):

> 'We can easily sympathise with ... defensive responses, but all too frequently this initial reflex dominates the subsequent handling of the complaint and fails to either treat the complainant as an individual customer or identify and respond to the substance of the complaint. This sequence regularly produces an exchange of written denials or evasions resulting in mutual frustration. Thus the form is observed - the complaint is "dealt with" - but the essence is denied.' (p1254)

In their analysis of 399 hospital complaint files, Lloyd-Bostock and Mulcahy found that letters of response to complainants commonly corrected (17%) or cast doubt (15%) upon the details of the complainant's account; included comments to the effect that if the event did occur it was not complaint-worthy (18%), or in some other way undermined the complainant's account or competence. Although 64 per cent of replies contained a form of apology or expression of regret many of them were characterised as pseudo-apologies - they contained the word 'apology', 'sorry' or 'regret' but did not acknowledge that anything complaint-worthy had happened or indicate a willingness to improve matters (Lloyd-Bostock and Mulcahy, 1994). Interviews with 78 complainants in the same study confirmed that replies frequently appeared defensive and that the elements of a full apology related strongly to their satisfaction with the response. Thirty-six per cent rated the hospital as 'not-at-all' accepting responsibility; and 57 per cent rated the hospital as trying to defend itself. A further 41 per cent felt they had been given an inadequate explanation.

Critics were also concerned about the lack of information about how independent reviews worked. Most evidence suggested that the independent review could be a daunting experience for the complainant. A number were deterred from using the procedure because it could involve meeting the very clinician being complained about. Complainants also voiced fears of being victimised or labelled as troublesome by clinical staff (Lloyd-Bostock and Mulcahy, 1994). Moreover, the operation of the procedure lacked consistency. Complainants had no *right* to a review. Rather, the Regional Director of Public Health had a discretion to decide whether an IPR was appropriate and it was suggested that some Directors were unwilling to exercise their discretion in favour of the complainant (ACHCEW, 1990). Statistics on the use of the IPR certainly illustrate great diversity of practice between regions. Regions such as Anglia and Oxford had conducted less than a fifth of the number of reviews carried out in other regions over the period 1985-1991. The result was not only that a review would not always be granted, but that a complainant might succeed in securing a review in one region where a similar case might not be sent for review in another.

Delays in resolving complaints were also apparent. The independent review came at a very late stage in the complaints process and a complaint could take as long as three years to get there. By the time the case was heard, the complainant would have had to go over the history of the case at least three or four times in a formal setting. The delays to resolution caused by the review were clearly a problem. Donaldson and Cavanagh (1992) found in a review of 71 Stage III complaints that the median time to deal with the complaints was 381 days. Similarly, in a review of 171 cases considered for a Stage III review, Geffen (1990) found that the time taken to handle them was between six months to over two years.

The decision to call the review 'independent' was also considered a peculiar one. It was suggested that:

> ' ... features of the peer review process call into question whether the process is intended to be an objective investigation of the complaint and whether it will be perceived as such by the complainant. Moreover, they perhaps further highlight the ambiguity about whether the procedure is perceived as addressing the patient problem or addressing the needs of a problem patient.' (Donaldson and Cavanagh, 1992, p24-25)

The ability of the assessors to deliver an independent assessment was also called into question. Donaldson and Cavanagh (1992) found that the proportion of complaints upheld at IPR stage varied significantly by category of allegation. Most of the variation was due to a higher proportion of complaints about communication being upheld than those involving the application of clinical skill. They suggested that this might be due to the fact that communication and behaviour complaints are seen as more acceptable and less threatening aspects of professional practice on which peers can rebuke a colleague.

Finally, the procedure was shrouded in mystery and largely invisible. Discussions between the consultants after the review were confidential. They were required to send a copy of their report to the Regional Medical Officer who would then instruct district personnel to reply to the complainant. The complainant has no right to see the report and no chance to question the judgement of the reviewers. In some cases, complainants were merely been told that their case was not proven. There were no immediate sanctions which could be taken against staff found responsible for an adverse event or occurrence, although recommendations can be made to the authority.

The new quality agenda

These various criticisms of the 1988 complaints circular led to pressures on policy makers to revise the system in order to make it more 'consumer friendly'. The issue of how the necessity for change came to be identified is partially explained by a shift in the two main political parties' policy agenda towards a quality agenda. The rhetoric of consumerism was used to legitimate policy initiatives which stressed the importance of quality mechanisms in the public sector. Significantly, complaints were seen as an important facet of quality data which could be used to facilitate public sector managers' increasingly quality- and value-for-money-orientated goals (Allsop and Mulcahy, 1999).

The 1991 Citizen's Charter introduced a programme for the reform of public services which had a significant impact on thinking about how complaints procedures should be designed. Each government department was required to produce a charter which listed entitlements, set performance targets and outlined mechanisms for the redress of grievances. The original charter promised a further examination of complaints procedures and a review of public sector complaint systems was subsequently undertaken by the Cabinet Office Complaints Task Force.

Three main themes run throughout the Charter programme documentation on complaints. First, there was a concern to improve management within public services to make them more responsive to patient's needs. Second, there was a view that in monopoly services, where the opportunity for exit and using alternative services was limited, consumers should be encouraged to voice their concerns. Third, there was a belief that private sector business offered an appropriate model for learning from complaints. The effective company aimed to satisfy the customer and complaints data were reviewed at board level (see for example, Cabinet Office, 1992, 1988; Cabinet Office Complaints Task Force, 1995, 1995a).

In response to the criticisms of the existing procedure and the change in the policy making climate, the DoH set up its own enquiry into NHS complaints procedures under the chairmanship of Professor Alan Wilson which reported in 1994 (NHSE, 1994). The Committee acknowledged that the procedure in existence at the time tended to favour the needs of staff over those of complainants. In particular, it drew attention to the lack of knowledge about how to complain, the ways in which people were deterred from complaining, the lack of satisfactory responses and the ways in which handling of complaints often appeared to increase the complainant's sense of grievance. It was contended:

> 'Complainaints can face an uphill struggle when using NHS complaints procedures: firstly in making their views known; and secondly, in receiving the sort of response they would wish for.' (NHSE, 1994 p20)

Their views were not universally supported as was made clear by their recognition that the JCC, despite considerable evidence to the contrary, continued to maintain that the clinical complaints procedure satisfied the needs of complainants.

The Committee which was made up of a mix of businesspeople, academics, and consumer groups had the unenviable task of steering a course between the needs of complainants, staff, managers and policy makers. Unlike the Davies Committee which had reported 20 years earlier, the Committee did not take extensive evidence, conduct research or deliberate at length. Committee meetings were all held over seven months. As a result the Wilson report's analysis of the problems encountered by users of the existing system lacks the depth of its predecessor. Significantly, a number of different models of complaints handling were suggested to the Committee including those based on tribunals, self-regulatory models of the kind operated by the GMC, consumerist models, managerial bureaucratic models which placed emphasis on organisational needs, as well as various combinations of all the above. An analysis of submissions to the Committee by Moss and Stacey (1994) demonstrated that it veered towards a managerial model despite the bulk of submissions favouring something more consumerist. In their view, this reflected a reformist rather than a radical approach to change.

The *Committee took the unprecedented step of developing a checklist of* general principles which ought to govern reform of the procedure. These were: responsiveness; quality enhancement; cost-effectiveness; accessibility; impartiality; simplicity; speed; confidentiality and accountability. The majority of these standards reflect the requirements of natural justice but the managerialist political culture of the time is also reflected in the emphasis on quality enhancement. In contrast to the Davies report, Wilson made proposals for the broad features of the new complaints procedures but suggested that the implementation and operation should be left to individual organisations in order to allow them to tailor processes to suit local conditions.

One of the most important recommendations of the Committee was that clinical and non-clinical complaints should be dealt with under the same procedure. The reasoning for this reversal of previous policy seems to have been based on pragmatic rather than principled grounds as the quotation below suggests. It was contended that:

> 'We also think there is no need for a separate system for complaints about clinical judgement, whether of doctors or of other clinical staff ... it is unhelpful to draw what is sometimes an artificial distinction between causes of particular concern , sometimes within a particular complaint. Complaints may, for example, be about facilities , behaviour or clinical practice , and often combinations of some, or all of these. It can be confusing if these are handled under separate procedures.' (NHSE, 1994, p40)

Neither did the recommendation necessarily signal a shift towards greater managerial interference in complaint handling. A major tenet of the Committee report was that in the majority of cases resolution and satisfaction could be achieved most effectively by the provision of rapid personal and informal responses to complaints by those responsible for the service being complaint about. Thus, while the Committee recommended the abolition of a separate clinical complaints procedure and introduction of a panel made up of lay people advised by clinicians, it recommended hardly any changes to the first stage of the complaints procedure within hospitals which was the subject of the data presented in this thesis. If anything, additional emphasis was placed on the provision of quick responses by frontline staff.

Handling complaints – the current system

Following on from the publications of the Wilson Committee report, a new NHS complaints procedure was introduced. It came into force from April 1996 and remains so at the time of writing. The Guidance, already outlined in Chapter One, reflects the current fashion for 'rolling back' the State and increasing the discretion of local organs of the state in the provision of services. Guidance from the NHS Executive is not prescriptive about how health organisations should conduct the process of local resolution. Instead, emphasis was placed on the principles which should guide good practice, such as openness, flexibility, fairness and understanding what complainants want. As was the case with the recommendations of the Wilson Committee, what is significant about the changes is that they place considerable emphasis on the handling of complaints by practitioners at local level. Despite the increased formality of 'appeals' procedures consultants are now actively encouraged to manage their own complaints.

How well is the new procedure working? The first independent evaluation of the new procedure undertaken by the Public Law Project (PLP)(Wallace and Mulcahy, 1999) shows that whilst local resolution can work well, complainants and their representatives were concerned about the lack of impartiality and visibility. Some were sceptical about whether they would receive an open and fair explanation from those directly involved in their care and many feared that they might suffer some form of retribution[11]. Data from the national surveys conducted suggested that there were inherent weaknesses in the local resolution process. The informality and flexibility of local resolution was thought to allow too much scope for grievances to be handled in inappropriate ways. There was also a failure to take sufficient account of the imbalance of power in the health professional-patient relationship. Those involved in local resolution often failed to recognise how difficult it can be to complain and complainants reported feeling that they were one voice against a large organisation. Participants in the research also reported that, while local resolution expected the parties to a dispute to be open honest and trusting, in truth service-level disputes were often emotionally charged.

The PLP research has also shown that there are weaknesses in how local resolution is being conducted. Conveners in the survey sent back nearly half (47%) the cases referred to them for further local resolution. In many cases this was because inappropriate responses had been made to complainants by those involved in the complaint or because inadequate investigations had been conducted. The same research revealed that the ways in which Independent Review Panels (IRP) are established and conducted did not give complainants confidence in their independence or effectiveness in holding the NHS to account. There was a lack of transparency in the ways in which the panels were conducted. For example, the parties to the complaint typically were seen separately and consequently there was no opportunity for them to question each other about their accounts and explanations. Panel hearings were rarely held on neutral premises and they were sometimes administered by the same staff who were involved in local resolution.

The same research has suggested that complainants are doubtful about whether their complaint would help to raise the quality of services, although one of the main reasons for complaining may be to prevent the same thing happening to someone else. Whilst many health organisations endeavour to use complaints for quality management, this is often hampered by fragmentary co-ordination of data from these and other sources of information, for example audit and adverse clinical incidents.

The PLP research also highlighted concerns about the convening role and the ability of conveners to establish an impartial stance. Almost half (46%) of the 169 conveners in their survey felt that their independence was compromised by existing links to the health care provider and a number were also concerned that they did not have a sufficient caseload to have gained enough experience of the role. The research also drew attention to conveners' and IRP chairs' concerns that they were stepping beyond their formal remit and trying to resolve complaints. Such activity can appear confusing to complainants who may have been led to expect a greater element of impartiality at this stage of the procedure.

Despite the recommendations of the Wilson Committee that complaints should be recorded and used for quality and risk management, little guidance has been given and a national classification system for complaints has not been developed. The data required by the DoH do not break down the largest single category, clinical complaints, into further sub-sets. GPs are not required to give information on complaints made to them Furthermore, in their study of 12 trusts, Kyffin and colleagues (1997) argue that oral complaints are often not recorded at all and that complainants' letters which contain a number of allegations are, in practice, reduced to a single category. This therefore under-records the sources of dissatisfaction.

Commentators have expressed concerns that the new procedures have encouraged the privatisation of justice by legitimating service-level handling of complaints without adequate checks on whether complaints are being handled well (Mulcahy and Allsop, 1997). Although attempts at visibility have been made by policy makers, these have concentrated on the second stage of the procedure designed to deal with the small minority of complaints which can be taken further in the procedure at the discretion of conveners. For doctors the new arrangements for complaints handling appear to have considerable benefits. They now have the opportunity for early notification of dissatisfaction and time to resolve or divert an issue before it escalates. New emphasis has been placed on the privacy of dispute resolution, especially where local resolution and conciliation are used. But concern has been expressed that the new procedures do little to enhance the power of patients and their relatives who are still in the weaker position of being at the receiving end of a largely monopolistic service. The procedures reveal an on-going tension between the needs of complainants, doctors, managers and the general public. In the words of Mulcahy (1999):

> 'While the new guidance employs the rhetoric of consumerism and managerialism, it may actually have reinforced self-regulation by encouraging complaint handling to go underground at practice level. Complaints may be being handled in an exemplary fashion … but how do we know whether this is the case?'(p81)

Conclusion

This chapter has suggested that the fortunes of the hospital complaints procedure have closely mirrored on-going debate about doctors' claims to clinical autonomy. Concessions to the idea of the closer involvement of the state in the regulation of the profession have been made and have served to reiterate the point that the authority of the medical profession to self-regulation and clinical autonomy derives from the state. The profession has conceded that there should be a hospital complaints procedure, formulated by the executive body of the NHS, which operates in parallel to the GMC's own procedure. They have agreed that the hospital procedure should have an 'appeals' process which is removed from service level.

But in many other ways the claim to clinical autonomy and self-regulation has been successful. The profession managed to limit for many years the operation of the 'appeals' procedure to include only medics in the review process and to fashion it as a medical consultation rather than a legal procedure. Moreover, the discretion to instigate change as a result of a finding of fault was left in the hands of the senior medical officer at regional level. The procedure which operated until 1996 was very different from the tribunal-like structure recommended by Sir Michael Davies. Moreover, throughout the development of the procedure there has been minimal monitoring of complaints at service level and somewhat ambiguous provisions about the reporting of complaints.

These were remarkable achievements in the pursuit of the professional project and reflect an ability on the part of senior medics in the NHS to circumvent the demands of consumerism and the movement towards acceptance of legally orientated ideals of administrative justice in the public sector. So far, this thesis has concentrated on the ways in which medical elites have been able to negotiate deals at national level which serve their interests. In the chapter which follows, the formal requirements of the clinical complaints procedure are discussed alongside studies of reactions to regulation which suggest that the struggle against external regulation by the profession has been as keenly fought at local level as it has been in national debate with policy makers.

Notes

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[1]. National Health Service Reorganisation Act 1973.

[2]. There are procedures in place to allow for the suspension of doctors working for NHS hospitals based on the contract of employment. However, these are extremely convoluted and are rarely used.

3. The final report of the committee is 163 pages long.

4. This involved a survey of 455 former in-patients and 558 former out-patients and case studies at five individual hospitals.

5. Several years later the Minister of State for Health and Social Security was to assert that at the time the only real alternative to internal resolution of complaints was to go to the courts (DHSS, 1983a).

6. Unfortunately, the Davies report does not distinguish between professional and head of department when presenting the data.

7. Research undertaken by the Committee suggested that clinical complaints were distinct from other types of grievance because they tended to be written and so more easily designated as formal. It remains unclear why formality alone constituted a justification for distinguishing complaint-handling practice but evidence to the Committee suggested that oral complaints were more likely to be made about hospital facilities and routine matters of procedure whereas written complaints tended to be about professional staff.

8. The Bill received all-party backing but three objections to it were reported in Parliamentary debate. The first two of these reflect a concern about the impact of complaints. The BMA argued that existing procedures were adequate to deal with complaints. The second objection came from COHSE who supported the Bill but wanted reassurance that any new procedures would give their members adequate time to prepare a defence to any allegation. The third objection came from Baroness Marsham of Ion who argued that the Bill should include a provision that complainants would not suffer any disadvantage as a result of making a complaint. Her suggested amendment was withdrawn when Lord Caithness argued that this was an impossible area on which to legislate and an undertaking

given that a suitable provision would be included instead in guidance to health authorities on the operation of the Act.

9. Attention has also been drawn to the fact that allegations of bad practice in the handling of complaints by health authorities comprised about a sixth of the workload of the Health Service Commissioner in 1989-90 (Donaldson and Cavanagh, 1992).

10. This view has been repeated by many. See, for example, Action for Victims of Medical Accidents, *Lawyers Service Newsletter,* March 1988.

11 The Health Service Commissioner has deplored the fact that some GPs have asked patients, and sometimes their families as well, to leave their practice following a complaint. It has been recommended that changes be made to the GP contract so that GPs must give reasons for removing a patient.

4 Responding to complaints: The 'is' and the 'ought'

> 'In virtually all fields of regulation there are large numbers of rules that are regularly ignored or disobeyed. In spite of statutes, regulations and codes, rivers continue to be polluted, discrimination still takes place and many workplaces remain unsafe. Why do rules fail to work? How might rules be designed so as to work more efficiently? What is it that impedes the making of effective rules?' (Baldwin, 1990, p321)

Introduction

Previous chapters have focused on understanding how the elite of the medical profession has responded to the increasing incidence of complaints and the burgeoning regulation of procedures designed to deal with them. They have concentrated on how policies have been negotiated at a national level. This chapter explores how the regulatory framework for complaint handling described in the previous chapter operated at a micro level. It is argued that an appreciation of rules governing the handling of complaints is but one starting point from which to understand doctors' reactions to being regulated. In the last chapter, it was contended that the development of regulatory frameworks for complaint handling can only be understood by reference to the historical and political cultures from which it emerged. In this chapter, it is suggested that the implementation of the guidelines is also much better understood when placed within an organisational and social context. Viewed in this way, it is the law in action rather than the possibilities allowed by doctrinal law, which is revealed.

The focus here is on the use of rules rather than the rules themselves. One suggestion to emerge from the chapter is that it is important to admit of the possibility of formal rules about complaint handling having no impact at all on doctors. Whilst previous chapters have discussed examples of symbolic resistance to regulation at policy-making level, this chapter discusses how circumvention of rules can allow for total resistance at service level. Thus, it is argued here that the interpretation of the rules and what they hope to achieve is as important as the rules themselves.

The chapter is in two parts. The first section explores how those involved in the handling of complaints behave. The section draws heavily on academic studies of rules and their impact and suggests that avoidance of rules is as important a topic as compliance with them. It places emphasis on understanding the organisational context within which complaints actors operate and the incentives that work settings provide to either obey or avoid rules. The second and final section considers what is known about how doctors respond to allegations of mismanaged care. Since the academic literature on hospital complaints is sparse, an attempt is made to anticipate how doctors might respond to criticisms levelled at them by patients and carers by drawing on empirical studies of doctors' reactions to medical mishaps and litigation. Attention is drawn to the ways in which doctors respond to such events emotionally, the use they make of networks of colleagues and relatives to support them and the ways in which they come to understand complaints.

The importance of legal rules - what *ought* to be done ?

In Chapter Three it was suggested that law poses one of the most significant new threats to medical autonomy. Formal external rules remain a central focus of lawyers interested in the operation of any grievance procedure. Most debates on legal accountability have focused on the content and structure of legislative rules and legal accountability to courts and this reflects the focus of traditional constitutional theory (Harlow, 1999). In many legal and non-legal contexts it is assumed that it is unusual for the progression of particular cases to diverge significantly from the route the applicable rules prescribe. Where there is not an exact compliance, the assumption is that something has gone wrong (Twining and Miers, 1987). It is often taken for granted that administrators and others not only take their lead from formal rules but that they respond to the directions given to them by those in authority.

Such approaches to studying the implementation of administrative rules, have been influenced by ideal types of bureaucratic behaviour such as those suggested by Dicey (1905) and Weber (1947). They rely heavily on a command theory of law which presupposes an orderly view of human behaviour (Kadish and Kadish, 1973). As Kahn (1999) has reflected in an American context:

> 'The tort professor tells us about tort reform. The professor of constitutional law spends most of her time explaining how the Supreme Court should have ruled, or should rule. Even jurisprudence falls into this pattern of critique and reform. When it is not pursuing the analytic question of the conditions of legal validity, contemporary jurisprudence is telling us how judges should rule or how regulatory regimes *should* work. There is remarkably little study of the culture of the rule of law itself as a distinct way of understanding and perceiving meaning in the events of our political and social life.' (p.1, my emphasis)

According to this rationalist view of the relationship between law and society, legal rules are expected to have an impact on decision making by institutionalising and facilitating the enforcement of certain standards and ideals (Fiss, 1984; Fuller, 1978). Guidance for case management is seen as deriving directly from precedent and doctrine (Manning, 1992)[1]. Viewed in this way, it could be argued that formal legal rules should play a central role in the way in which the hospital complaints procedure operates in practice.

Predicting how complaints actors actually behave

How do doctors and managers actually respond to such formal legal framework? What factors play a role in attempts to comply with or avoid the formal legal procedure imposed by the Hospital Complaints Act (1985)? Since so little is known about the handling of complaints at service level, this section considers how the answers to such questions can be framed using the findings of other studies of reactions to rules and regulation. It starts by reviewing the approach adopted by socio-legal scholars to such questions and then maps out strategies of rule avoidance. It then considers the importance of the organisational context and the possible incentives to avoid regulation.

Socio-legal approaches to the study of rules

The assumption that formal rules will govern behaviour has been seriously questioned by a number of socio-legal scholars. Ross (1970) suggests that it is an approach favoured more by observers of courtroom law than those interested in the law in action. He argues that the approach assumes that legal authority is monopolistic and denies or marginalises the legitimacy of other normative systems of rules which do not have legal authority. In this way the study of law becomes internalised, a self-sustaining, closed communication system in which 'decisions' are seen as clear and dominant messages to society (see also Luhmann, 1985).

Commentators have identified a number of criticisms of approaches to legal scholarship which assume the authority of rules. Firstly, it is argued that organisational actors' decisions are not purposive choices made by informed, disinterested and calculating people working within a clear set of individual, organisational or legislative goals (Harlow and Rawlings, 1998; Wildavsky, 1979). Secondly, policy rules, used by those working towards the base of an organisation, do not have a clear, unambiguous and singular purpose (Barrett and Fudge, 1981; Kadish and Kadish, 1973). Thirdly, decision-making is not best understood by working backwards from the decision rather than understanding the context within which it has been made. Finally, a legally-prescribed approach to a problem is not inherently correct (Hawkins, 1992).

It is becoming more commonplace for lawyers to reject the view that the law is an autonomous set of rules rather than a reflection of a particular view of society (Richardson, 1986). In recent years, there has been a move away from the rule-centric legal models described above towards more sociologically-orientated ones which portray formal rules as just one of a number of systems providing a framework for dispute settlement (Feldman, 1994). Approached in this way, the law could be viewed as nothing more than symbolic; a way of legitimising certain viewpoints and prompting certain types of normative discourses. According to this school of thought, reactions to formal rules are always constrained by compelling non-legal values and social forces (see, for instance, Baumgartner, 1992). Put simply, socio-legal scholars have viewed legal rules and systems as just one normative framework within which to understand law (Cownie and Bradney, 1996; De Sousa Santaos, 1980). Such shifts of emphasis owe much to the American Realists movement and an 'action-centred' rather than a 'policy-centred' approach to understanding organisational behaviour (Barrett and Fudge, 1981). Taken to their extreme, such arguments suggest that regulations relating to the handling of complaints may have no impact on the behaviour they seek to regulate.

Commentators are increasingly placing emphasis on both formal *and* informal regulation of behaviour within organisations (Allsop and Mulcahy, 1996; Rosenthal, 1995; Harvard, 1981): an aspect of the accountability debate which Harlow (1999) argues is ripe to be placed at the top of the academic agenda. It is recognised that formal rules and powers can be ineffective, cumbersome, slow and excessively adversarial. The traditional view that agencies exist merely to implement legislative intent has also been rejected. Eisenberg (1976) has claimed that a major contribution of the sociology of law has been to emphasise the general continuities between legal and social systems rather than to see them as dichotomous. Emphasis has instead been placed on regulatory negotiation (Stewart, 1975). This practice is increasingly seen as a vital instrument in private ordering.

Rule-avoidance strategies

While doctrinal lawyers have often assumed the link between standard setting and compliance, socio-legal researchers have tended to concentrate more attention on the study of avoidance techniques (Hawkins, 1992). In contrast to rational legal models, socio-legal scholars have stressed the natural processes by which decisions to act or comply with official guidance are made. They have placed emphasis on how decisions are arrived at, unencumbered by assumptions about what the resultant behaviour ought to be. The importance of understanding the context and meaning which individual actors attribute to choice are stressed in this approach.

Within these contexts, Moore (1978) has proposed that it is equally important to identify those social processes which might cause doctors and administrators to abuse, abandon, bend, reinforce, reinterpret, sidestep or replace rules as it is to place emphasis on compliance.

Similarly, Galanter (1983) suggests that people react to rules in a number of ways, not all of which are dependent either on them accepting the legitimacy of the rule, or on choice. He argues that the radiating effects of formal rules can be seen in terms of 'special effects' and 'general effects'. Special effects relate to the changes on the specific actors affected by the rule. An individual may *refrain* from certain types of behaviour for fear of being exposed to legal regulation or they may *reform* by accepting the validity of the judgement against them. Formal rules may also have general effects. They impact on the way others, outside the dispute, behave in the future.

Galanter (1983) has argued that communication of information about decisions may cause others to re-assess the risks and advantages of engaging in similar activity. General deterrence of this kind does not necessarily involve a change in the moral evaluation of such action, it merely makes the person concerned more aware of the risks, costs and benefits of acting in a certain way. Thus, they can treat formal rules as a factor to be taken into account rather than as a normative framework to which they are committed. Where communication of rules does change the moral evaluation of a person, this has been called *encultration*. Alternatively, the decisions may maintain or intensify existing valuations of conduct. Rules might also *facilitate* compliance; be used as a 'cookbook' by which we can learn how to bring about desired results. In this way it can be argued that actions are not necessarily seen as the product of intention, conscious choice or planning. Rather decision-making is much more accurately seen as a collective process, in the sense that individuals are influenced by others and that decisions have knock-on effects (Hawkins, 1992).

The organisational context

As Galanter's (1983) work suggests, understanding the organisational context within which doctors and administrators work is also seen as important. According to his model, decisions can be made which do not necessarily reflect the formal aims of the organisation or government as much as the interests of the individual in maintaining their own position. In a similar vein, Hawkins (1992) has argued:

> 'People both anticipate and adapt. They follow rules, but they also create rules, norms, patterns of behaving. They make decisions in ways which are situatedly rational, that is, rational in a particular context. On this view, there are not necessarily any broad, clear, taken-for-granted organisational or other goals whose attainment is sought through choice.' (p26)

Appreciation of organisational context involves looking at an institution's public-relations needs, budgetary constraints, conflicting networks of official rules, workload, staff morale, promotional prospects, colleagues' preferences, power relations, rewards and incentives, political controversy surrounding activity, time spans allowed for implementation, leadership styles, organisational socialisation and cultures, the limits on autonomy and control, access to resources, interdependency with other groups, and the individuals, groups and interests upon which policy impinges. Each of these factors imposes constraints and offers opportunities. Ross (1970) refers to the actors subjected to constraints as 'adjusters', people who, in addition to their personal views of equity and justice bring to regulatory tasks the pressures of their job.

Others have argued that responses to being called to account have, in particular, to be seen as 'situated'. They are reflexive of the status and power of the people who give them their position within an organisation and the power that organisation wields (Scott and Lyman, 1968). Within organisations, accounts are likely to become standardised and stabilised. Manning (1992) argues that large-scale organisations such as hospitals and the NHS are based on routines and contain stabilising mechanisms to absorb the shock of challenges such as complaints which have the potential to cause 'big-bangs' (p251) (see also, Luhmann, 1985).

The act of calling doctors to account implicitly makes the boundaries of what constitutes legitimate behaviour for doctors and patients contentious. Some writers have attempted to understand boundaries on behaviour according to the notion of a social role sustained by particular organisational settings. According to this school of thought, a person's role is sustained by the role-activities of others. Kadish and Kadish (1973) give the example that it is no use having power unless other people accept your command. To act within role means making choices in the context of an evaluation of what is proper to that role.

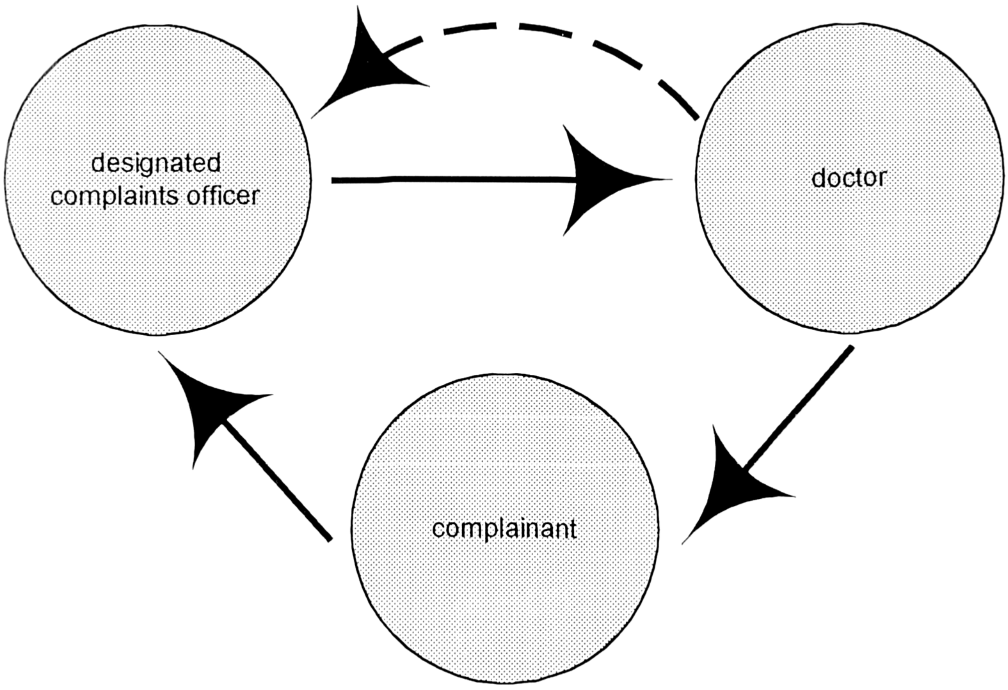
Justifications for acting within role rely on three main factors: recognition of the explicit limitations on what it is appropriate to consider; identification of the prescribed ends of the role; and knowing the role by reference to historical and systemic considerations. Significantly, individual aspirations and ethics are seen as existing outside the role, but may cause a departure from it. They are 'excluded reasons' which cannot normally be taken into account when making decisions (Kadish and Kadish, 1973).

Within a medical context, it has been argued that a role such as the Parsonian notion of the 'sick role' may be adopted unconsciously because of the dominance of a particular discourse in the setting being studied (Turner, 1996). Others have also applied role theory to the medical arena. Strong and Davis (1977) have discussed how role format can set the ceremonial order of the clinic and guide professional medical behaviour. In their empirical study of patient-doctor interactions, they identified how patients accepted doctors' adoption of the medical role because they lacked the expertise to challenge it. Challenging role format also had its costs and these in turn reflected the balance of power between the parties. Patients felt that if they engaged in a dispute with the doctor they would effect their chances of recovery.

Are managers disposed to regulate doctors?

Both the 1988 and 1996 guidance anticipate that managers will be made aware of the number of complaints made regardless of their subject matter and whether they are formal or informal[2].

Figure 4.1: Roles anticipated by the guidance



Three main roles emerge from analysis of both sets of guidance about stage one of the complaints procedure and these are illustrated in Figure 4.1. First, there are the subjects of complaints who either receive the complaint personally or have it referred to them for investigation by a designated officer. Secondly, the subjects may act as gatekeepers in control of progression from informal handling of complaints into the formal system. Thirdly, there are the designated managers who co-ordinate complaints. Once they have knowledge of a clinical complaint they have certain obligations to oversee the management of its investigation and response. Their formal powers appear weak, although the 1988 guidance allows that they can take any concerns about complaints and complaint handling to a higher authority with significant power - the district health authority board.

An important part of understanding the organisational context in the present study is a consideration of how doctors might respond to the threat of managerial interference in complaint handling. As public servants technically guided by legislation laying down clear responsibilities, managers are placed in the difficult position of being expected to consider the interests of service users, colleagues and staff, as well as taking into account the efficient use of hospital resources. Moreover, whilst discussion so far has focused on the official aims of the procedure, it is clear that the machinery may be called upon to achieve a number of other goals which may be prioritised in different ways by doctors and managers. It can, for instance, form part of a public relations exercise, act as a filter or buffer for more serious allegations, and provide an alternative to litigation and thus a way of protecting public assets. Managerial responsibility for risk and quality management also anticipates that these actors have a duty to be organisational trouble-shooters. For some managers, complaints may be seen positively. They may be viewed as providing opportunity to improve public relations and prevent unfavourable word-of-mouth communications with the service-user community (Kadzombe and Coals, 1992; Gilly *et al*, 1991). Finally, the jurisdictional tensions between managers and clinicians may well mean that complaints provide an excellent opportunity to regulate medical behaviour under the guise of the rhetoric of patient empowerment.

What is the nature of the managers' role? Can they be seen as third parties to disputes who conciliate, mediate, arbitrate and adjudicate, or as minimalist actors who merely facilitate responses? To what extent are attempts at adoption of a non-partisan stance hampered by the fact that they are actors within the organisation being complained about? These issues are important because they provide insights into the issue of who wields power in the processing of complaints. If managers perform a minimalist role and defer to clinicians, this suggests that, whatever the expectation of the guidance, a self-regulatory model of complaint-handling has emerged. If managers are playing a more proactive, interventionist role, then the model being adopted is much more akin to a legal/bureaucratic model.

How do doctors react to such managerial interference in their complaint handling? Do managers make use of other less formal methods for controlling doctors in this context? Significantly, empirical research suggests that proactive complainant-orientated approaches to managing complaints are likely to leave medics feeling that their interests are not being sufficiently protected (Kaye and MacManus, 1990). Baldwin's (1990) important empirical work in this field suggests that a variety of strategies are used in the enforcement of rules by those with the formal power to enforce them. His research on the Health and Safety Inspectorate suggests that informal persuasion is more often used to overcome resistance to compliance than formal sanctions. Such negotiation might include reference to the regulatee's self interest and general standards of morality. In many situations, formal rules and sanctions are not referred to directly at all (see, Macaulay, 1963), although this may be a case of bargaining in the shadow of rules with the *threat* of enforcement underpinning all negotiation (Mnookin and Kornhauser, 1979). Baldwin suggests that the willingness to refer to formal rules may be dependent on the size of the hazard identified, the reaction of the responsible party, their past record and a consideration of whether the relationship between regulator and regulatee is likely to be long-term. One of the most important characteristics of the managers in the present study is that they handle complaints about people with whom they are likely to have a long-term relationship, a factor which is likely to encourage the adoption of an internal and conciliatory stance (Macauly, 1963).

In his discussion of the willingness to enforce sanctions, Baldwin (1990) suggests that the formal imposition of rules may also depend on the knowledge and approach of the person regulated. He distinguishes between: the well-intentioned well-informed; the well-intentioned ill-informed; the ill-intentioned ill-informed; and the problematic regulatee who is itinerant or ephemeral. Figure 4.2 presents these ideas in diagrammatic form and provides additional details of the characteristics which each of the scenarios anticipated might involve.

It can be seen from Figure 4.2 that the intentions of the regulated have much more impact on enforcement strategy than their level of knowledge about the regulatory framework. It would seem that failure of good will, or moral failure, rather than ignorance are much more likely to prompt a proactive approach to the enforcement of formal legal rules. Baldwin argues that when those who are reasonably well-disposed to comply with rules do not follow them, it is usually because they are unwilling to find out about them or cannot process the information. It is clear from his work that those formally enforcing rules are just as often involved in advice giving, awareness raising and education through use of the rules as they are with sanctioning[3].

Figure 4.2: The dynamics of rule enforcement – after Baldwin (1990)

	Well-informed	***Ill-informed***
Well-intentioned	Well disposed to comply but not wholly efficient. Rules remain unsaid and uncontested. Characterised as professional talking to professional. Regulation by negotiation. Rules are used to inform and educate.	Regulators disinclined towards legalism. Agree hazard-reducing actions and timetables for implementation. Regulation by negotiation, advice, education and information giving.
Ill-intentioned	Threats used openly. Little time wasted on negotiation or persuasion.	Voluntary compliance unlikely. Bad attitude and record. Legal powers used to reinforce negotiating stance. Legalistic terms used.

In a similar vein, Bartrip and Fenn (1980) have argued that the ability of the factory inspectors they researched to enforce sanctions depended on the extent to which their decisions were subject to review, the scope of their power, the resources available and the cost of compliance. They have suggested that regulators are less inclined to sanction regulatees where the breach or hazard is a minor one. Similarly, Hutter (1988) has highlighted the ways in which environmental inspectors in her empirical study sought to enforce procedures only when the problems that came to light involved what they considered to be serious misconduct. Another reason for their reluctance to act in accordance with procedures was their moral evaluation of behaviour and their assessment of whether sanctions available were appropriate or effective.

In practice, research suggests that managers pose a minimal threat to doctors in complaints handling and prefer not to adopt the role of regulator. In their study of formal hospital complaints, Mulcahy and Lloyd-Bostock (1994) found little to suggest that managers were adopting an in-depth investigatory or proactive role in complaint handling. In their detailed content analysis of 399 files kept by complaints staff, they found that a total of 422 letters of response were sent to complainants incorporating an account of what had happened. The task of responding to complaints was generally performed by a senior manager with 324 (77%) of responses to complainants coming from a chief executive or assistant chief executive. A further 39 (9%) came from directors of services or the head of administrative services and eight (2%) from either the chair of the health authority, district general manager or district medical officer. Despite the fact that 34 per cent of the complaints in the sample could be classified as involving a clinical element, only 20 (5%) of the officially processed responses to complainants came directly from clinicians. Moreover, managers actively suggested in only four per cent of investigation cycles that clinicians respond directly to the complaint. These data suggested that, in practice, the clinical and non-clinical complaints procedures are both overseen by management.

Further analysis of the files by Lloyd-Bostock and Mulcahy (1994) attempted to explore this claim. This revealed that despite the expectation that complaints handling was the province of the chief executive it was, in reality, delegated to low-level secretarial or administrative staff - although chief executives or other senior staff commonly ‘signed letters off’. Did administrative staff play an active role in complaint handling? The research team originally anticipated that letters to doctors from the officer initiating an investigation cycle would involve a commentary on the complaint made. However, in most cases, ‘investigations’ consisted of copying the complainant’s letter to doctors under cover of a short note asking for a response. Thus, the investigatory stance taken was perfunctory rather than proactive. They found no instances in which either a doctor or complainant was asked for additional details of their account despite the vague nature of many allegations made. In 139 (35%) cases, letters of response to complainants incorporated exact passages of text from clinicians’ letters of response to the complaint, compiled as part of the investigation cycle. The number of words ‘transplanted’ in this way ranged from 10 to 840 and in a number of cases included extremely detailed and technical material taken from medical notes. Few attempts were made in these cases at 'translation' of technical or 'defensive' material. It would seem then, that in over a third of the files examined, officers were little more than a vehicle through which the counter-arguments of the clinician involved could be expressed (Lloyd-Bostock and Mulcahy, 1994).

Other research has actually suggested that neither those handling complaints on behalf of an organisation or those being criticised are disposed to 'hear' complaints about themselves or others and that they strive systematically to protect other members of staff in the organisation from criticism. A number of buffers to criticism are adopted. Attempts may be made to undermine the validity of criticism by condemning it as excessive behaviour, or by attributing the cause to a problem outside their control, such as lack of resources. It is clear that there can be a considerable difference between the intellectual acceptance of a client as a person with rights and a willingness to help that person assert those rights (National Consumer Council and Institute for Social Work, 1988; see also Lindsay, 1991; Seneviratne and Cracknell, 1988).

In his unusual study of the California Department of Insurance, Serber (1980) describes how complaints staff 'deselected' cases, that is, turned certain complainants away without justification. He describes how the department being studied characteristically failed to answer or 'misplaced' up to 50 per cent of initial correspondence from the complainant. Deselection of cases was particularly likely when the department was overworked, when the case was a complex one and when the complainant had low status, was inarticulate[4] or upset. In addition to these deselection criteria, the frontline member of staff discouraged complaints by just being unhelpful:

> 'A number of techniques are used by the ... staff to avoid processing complaints. They discourage walk-in complainants by requiring them to fill out long and unnecessary forms and by simply being rude. Complainants are frequently asked to leave and return some other time or to return with documents that are hard to obtain. The staff member is often discouraging about the prospects of resolving a claim and speaks in abstractly, legalistic, or highly technical jargon that is incomprehensible to the complainant.' (Serber, 1980, p330)

In a health care setting, a MORI survey (1995)conducted for the Cabinet Office found that many NHS users perceived staff to be hostile to complaints and reluctant to report poor practice to other professionals. Similarly, Andreasen's (1985) study of 547 complainants in an American health-care setting suggests that service providers are inclined to discourage the voicing of complaints by withholding information about the quality of service which should be expected and exit options. A study by Gilly and colleagues (1991) also found that customer contact personnel were particularly averse to passing important information up the organisational hierarchy. This was especially the case where they implied that policies were inadequate and might be taken as a criticism of complaint handlers' social organisational superiors. Carmel's (1988) research on hospital patients' responses to dissatisfaction has suggested that certain complainants are more susceptible to such discouragement. She places particular emphasis on the impact of social and situational power. Complainants less deterred by the organisation were found to be those who had acquired social power through education or situational power through having stayed in hospital for a longer period.

More senior officers with a specific dispute-handling brief may find it more difficult to deflect complaints at source. Kolb (1987) describes the tensions experienced by corporate ombudsman, employed by an organisation to resolve disputes between employees and employers. Role ambivalence was managed by favouring one set of normative expectations over the other, that is, adopting a partisan stance. This manifested itself in one of two ways. Firstly, 'helping' ombudsmen attempted to resolve the dispute in a way which satisfied the complainant. They defined their role as assisting individuals who were aggrieved and arranging to alter a troublesome situation for them. Helping ombudsmen tended to see their goals as being client satisfaction, usage rates, cost savings and organisational change. Here, the focus was on the ethics of care, recognition of needs and individualisation of solutions.

By contrast, the main function of 'fact-finding' ombudsmen was perceived to be containment of the problem for the sake of the organisation. These ombudsmen tended to take a more procedural view of their role and to focus on the degree to which organisational policies and procedures were followed. They prioritised 'due process' criteria and placed emphasis on notions of fairness, convenience, consistency and timeliness. They were also much less apt to go out of their way for the individual grievant. In contrast to helping ombudsmen, most of their cases seem to involve helping the complainant accept disappointment by offering rational explanations for the situations they had complained about.

In practice, the distinction between these roles was not as simple it might seem. All the ombudsmen in the study felt the strong draw of organisational demands and the organisation's interest in quiet management of the dispute.

> 'Disputes, while they may be about significant organisational change, always threaten to disrupt efficient work flow and productivity. Hence there is a shared interest in avoiding such events.' (Kolb, 1987, p688)

What do we know about how doctors react to criticism?

The study of emotional reactions to being the subject of a complaint has much to tell us about why the regulated respond in the way they do to the imposition of rules. It also facilitates a sensitivity to the needs of the regulated and provides important indications of the sort of regulatory framework most likely to encourage their co-operation. Emotional reactions to criticism, the use of support networks and the ways in which doctors make sense of, and understand, such criticism are key issues in this debate.

Emotional reactions

Despite this, few researchers have looked at the impact of criticism in terms of the feelings it arouses in individuals. Moore (1995) asserts that discussions of emotion in disputes tend to present emotional displays as strategic tools. Commentators have rarely allowed for the possibility of uncontrolled emotional explosions. She concludes: 'Of course, strategic action is often involved. But when the stakes are high for the participants, strong feelings may also play their part, not just cool strategies.' (p17) In support of such an argument, Felstiner *et al* (1980-81) have asserted:

> 'We believe that the study of dispute processing has been too removed from the actual difficulties and choices that accompany the recognition that one's life is trouble and that relief from trouble is uncertain, contingent and costly.' (p653)

Caplan (1995) points to the limited work which has been undertaken in this field as evidence that recognition of the high emotion involved in disputes renders it unlikely that resolution will be achieved; a view not palatable to those who believe that the natural and proper end to dispute resolution should be peace and settlement or to designers of grievance procedures[5]. Research has suggested that disputes are often not resolved to the satisfaction of both parties and that this will have an impact on the possibility of emotional closure. A number of studies of complaints systems have, for instance, found that complainants are often left with a residue of dissatisfaction long after the complaint is considered closed by the organisation handling it (Lloyd-Bostock and Mulcahy, 1994; McCarthy *et al*, 1992). Formal processes may 'resolve' the disputes by persuading the disputants to accept an outcome, but that does not necessarily mean there is emotional closure (Caplan, 1995; Kerruish, 1991). Abel (1982) has contended that grievances and disputes are never completely relegated to the past because they remain unsettled or affect future thresholds of tolerance.

The making of a complaint clearly has the potential to prompt strong reactions amongst doctors because it challenges the core assumption that healthcare professionals heal or alleviate pain. It is clear that basic tenets of the relationships between patients and doctors and managers and doctors are called into question and this can lead to a breach of trust, suspicion and anger (Mulcahy and Rosenthal, 1999). If complaints are pursued beyond the first stage of the complaints procedure, they are likely to be drawn to the attention of senior medical colleagues and may well affect a doctor's career prospects. Information supplied by complainants can also be used to mount disciplinary proceedings or a medical negligence action.

Although little work on doctors' reactions to complaints has been undertaken in a medical context, research on reactions to other criticisms of medical work suggests ways in which responses are framed and understood. One area which is receiving an increasing amount of interest from researchers is the incidence and impact of medical mishap (see for instance, Rosenthal *et al*, 1999). Mishaps can be broadly defined as advertent or inadvertent sub-standard performance. There are a number of parallels between reactions to mishaps and complaints. Not all medical complaints will have been prompted by a medical mishap - as complainants may make factually incorrect allegations about performance. But some will, and claims of failure will be made in both scenarios. Recent large-scale studies of error in medicine suggest that the incidence of mishap in the provision of medical care is high but that practitioners are ill-prepared to deal with it (McL.Wilson *et al*, 1999; Walsh *et al*, 1991; Brennan *et al*, 1991; Leape *et al*, 1991).

Many of the studies undertaken in this field argue that intense reactions to these events have to be understood within the context of the 'perfectibility model' to which doctors are taught to aspire in the course of their education (Nathanson, 1999). Doctors are trained to function at high levels of proficiency. They are socialised in medical schools to strive for error-free practice. As Leape (1999) explains:

> 'There is a powerful emphasis on perfection, both in diagnosis and treatment. In everyday hospital practice, the message is equally clear: mistakes are unacceptable. Physicians are expected to function without error, an expectation that physicians translate into the need to be infallible. One result is that physicians ... come to view error as a failure of character - you weren't careful enough, you didn't try hard enough.' (p22)

It would seem then that strong emotional reactions to complaints do not just reflect concerns about the personal risks to promotion prospects or standing, but also induce self-criticism and introspection.

Other commentators have suggested that doctors are often emotionally devastated by causing serious medical mishaps and suffer a mixture of fear, guilt, anger, embarrassment and humiliation (Smith, 1999; Wu *et al*, 1991). Particular emphasis has been put on anger. In the context of medical negligence, Lavery (1988) has argued:

> 'The response is anger ... By bringing legal action, the patient also assaults the physician's credibility, insinuating faulty judgement or treatment. Self-esteem and status as a successful practitioner in the community or member of the academic environment are suddenly jeopardized. A malpractice suit challenges professional reliability and authority.' (p139)

In their important review of the literature on doctors' responses to medical negligence, Ennis and Vincent (1994) have also suggested that feelings of anger and betrayal are not unusual in doctors reporting on the personal effects of litigation. They place particular emphasis on the feelings of isolation caused by claims and the ways in which litigation and the threat of litigation subtly change doctors' relationships with all patients and not just those who actually initiate claims against them. Other research has demonstrated that doctors are likely to experience a host of symptoms characteristic of stress-induced illness in response to legal claims (Charles, 1984). Lavery (1988) has drawn an analogy between these reactions and grief reactions flowing from the death of a close family member.

It is clear that many doctors take litigation as a personal affront and argue that this can cause a loss of confidence in their own ability or their enjoyment of their professional work (Charles and Kennedy, 1988; Charles, 1984). Doctors have reported insomnia, appetite change, irritability, headaches and many other symptoms of stress as responses to having made mistakes (Ennis and Grudzinskas, 1993). Despite the intensity of reactions, doctors have demonstrated a reluctance to get help from psychiatrists or counsellors, most commonly because it could be viewed as a sign of weakness (Nathanson, 1999; Ennis and Grudzinskas, 1993).

When individuals are criticised, it is usually a common reaction to look to others for support. Disputants often utilise networks of kin, affinity and close patronage (Caplan, 1995). Commentators have identified how support networks can provide emotional backup and act as 'sounding boards'. Third parties can also take on the roles of go-betweens or champions for the person criticised (Black and Baumgartner, 1983). It has been argued that third parties of this kind often become embroiled in the dispute and play an active role in it. According to this view, there is a danger in viewing disputes as involving only individuals when important collective interests may be involved which encourage the mobilisation of support networks (Mulcahy and Tritter, 1998; Felstiner *et al*, 1980-81).

In their review of the anthropological literature, Mather and Yngvesson (1980-81) stress the importance of third parties in providing support and narrowing or expanding the issues involved. They have argued that such transformation of a dispute can involve antagonists and third parties in one or more of three processes. Firstly, that of 'rephrasing', that is, a reformulation of the issues in dispute into a public discourse. After rephrasing the new account of the dispute will continue to reflect the perspectives of the antagonists, but it is suggested that this will also reflect the interests of any third parties involved in the rephrasing. Secondly, expansion involves a challenging of existing established categories for defining the ambit of the dispute. In this way accepted frameworks are 'stretched'. Thirdly, there is 'narrowing', a process through which established categories for classifying events and relationships are imposed in a way which makes it amenable to conventional categories. Narrowing is particularly common amongst officials in formalised grievance procedures where there are routine-driven ways of handling claims. Established categories in this sense are those which are linked to the interests of the third party managing the dispute.

Patterns of help-seeking are a form of protection in which individuals may talk to others who share the same framework of meaning and knowledge-base. But, in a medical context, two influential writers have emphasised the barriers to doctors approaching others for help. Leape (1999) claims that doctors are typically isolated by their emotional responses to medical mishap because there are rarely support networks which can serve to facilitate 'emotional healing for the fallible physician' (p23). Similarly, in their empirical study of house doctors' responses to complaints, Wu *et al* (1991) found that only 50 per cent of house officers discussed their most significant mistakes with attending physicians.

However, the suggestion that doctors do not readily seek help when held to account has not been substantiated in a UK setting where complaints, rather than mishaps, are being considered. In her study of primary care complaints, Allsop (1994) found that doctors did mobilise support networks. Doctors were usually accompanied at the tribunal hearings, which provided the focus of her study, by a medical colleague, although 20 per cent (21 cases) argued their case with no supporter. Where doctors did bring a 'friend', it was most commonly either the Local Medical Committee secretary or another doctor. In a similar vein, Mulcahy *et al*'s (1997) small scale study of 56 GPs' reactions to complaints, also found that doctors handling less formal complaints relied heavily on the use of medical support networks, both inside and outside of their practice, and rarely went outside these for advice and emotional support.

How do doctors make sense of complaints?

There are a host of theoretical frameworks which might be used to analyse how doctors make sense of complaints. Sociological studies suggest that doctors' defences to complaints could be interpreted as part of the social process of impression management (Goffman, 1967, 1961), as accounts which provide justifications and excuses (Scott and Lyman, 1968) or in the context of the politics of identity (Giddens, 1991). Social psychologists have also applied attribution theory to explain how disputants come to terms with criticism (Lloyd-Bostock and Mulcahy, 1994). At its simplest, the theory suggests that people prefer to find meaning and order in the world and usually develop explanations of why events happen and why people behave as they do. Tedeschi and Reiss (1981) have suggested that there are a number of common responses when people seek to attribute cause for untoward events which are related to awarding responsibility and blame to themselves, others or to fate. Coates and Penrod (1980-81) and Lloyd-Bostock (1992) have applied this framework to disputes.

According to Weiner *et al*'s (1972) three-dimensional model for plotting the perceived causes of an outcome, there are a number of ways of classifying responsibility for any given phenomena. Perceived causes of outcome can vary in terms of being: external (something about the environment) or internal (something about the individual); stable (not capable of changing in the future) or unstable (capable of change); intentional (foreseen, wilful) or unintentional (not consciously desired). The use of data on perceptions of cause from empirical studies of complaints and medical mishaps demonstrates quite visibly that, in a medical context, the preference is for explanations of cause which place emphasis on external factors. This is demonstrated by using the data collected and reported by Allsop (1994), Ennis and Vincent (1994) and Lloyd-Bostock and Mulcahy (1994) to fill in the fields suggested by

Weiner *et al* (1972) (see Figure 4.2).

It is clear from this that doctors who have participated in these projects have rarely internalised blame for mishaps or grievances. Where they accept some responsibility, they tend view fault as unintentional. Problems with framing responses to criticisms in these ways have been identified by Tennen and Affleck (1990) who suggest, in their wide-ranging review of the social psychological literature on this topic, that blaming others for threatening events is dysfunctional and suggests impaired psychological well-being. Similarly, Ennis and Grudzinskas (1993) have suggested that unwarranted generalisations about patients as a whole are an example of perceptual distortions which may result.

Figure 4.3: To show examples of attribution in a medical setting using Weiner *et al*'s (1972) three dimensional model *

INTENTIONAL

	Internal	External
Stable		Greedy lawyers Lack of funding in service Distortion by media Unreal expectations of medicine Complainants are selfish
Unstable		The complainant had not carried out lay medical work properly

UNINTENTIONAL

	Internal	External
Stable	Ignorance of regulations and responsibilities	The uncertainty of the disease process The uncertainty of medical work Outside of their contractual obligations
Unstable	Pressures of work	Traffic jams or the weather caused delays

* Using data from Allsop (1994), Ennis and Vincent (1994) and Lloyd-Bostock and Mulcahy (1994) to illustrate the model.

In Allsop's study (1994) of 110 formal complaints to Family Practitioner Committees, she determined that, in almost 80 per cent of responses, either the disease process or other people were blamed for what had happened. Doctors commonly acknowledged a failure had occurred but attributed the cause to an external event (41%), blamed the disease process or patient (21%) or claimed that uncertainty in medical practice had made outcomes difficult to predict (18%). In her interpretation of the data, Allsop stresses the ways in which the defences offered served to defend the doctor's professional identity. This was done by making references to considered clinical judgement, the opinions of other doctors, their normal practice or their qualifications. She concludes that doctors display certainty about their clinical judgement whilst using the uncertainty of the disease process as a defence. Like complainants, they defended their position by shifting blame and, in doing so, often stepped outside the parameters of professional detachment to attack the identity of complainants.

Other research on doctors' responses to complaints has placed emphasis on the ways in which medical socialisation and education *encourage such strategies by constantly reiterating* the divide between expert and lay perceptions. Four main themes emerge. First, that in accounting for mistakes or complaints, doctors place stress on the biomedical model which emphasises the certainty of medical work to an external audience and the uncertainty of science within the medical fraternity. Secondly, doctors re-attribute blame by emphasising such things as the failure of lay medical work undertaken by relatives. Thirdly, doctors undermine the status of the complainant by casting doubt on their account of what has happened or by labelling them a bad patient. Finally, appeals are made to professional standards and customary practice to give authoritative weight to doctors' defences (Allsop and Mulcahy 1995; Lloyd-Bostock and Mulcahy, 1994; Tedeschi and Reiss, 1981).

Sociological studies, based on empirical work in the US and undertaken in the 1950s and 1960s showed how doctors are socialised into these norms of biomedical culture. The process served to create distance between doctors and others (Stelling and Bucher, 1973; Becker *et al*, 1961; Bucher and Strauss, 1960-61; Fox, 1957). In particular, commentators have stressed the importance of experts being able to present authoritative judgements to patients whilst maintaining an appreciation of the uncertainties of medical science within the medical group. Studies have demonstrated that doctors learned collective ways of coping with uncertainty and the inevitable failures which are part of medical practice. Fox (1957) used the term 'vocabularies of realism' to describe how doctors came to terms with uncertainty. The devices used included emphasis on uncertainties about the course of the disease process in individuals, the limits of clinical knowledge and the practitioner's grasp of this knowledge (Atkinson, 1995, 1984, 1981)[6]. When doctors are called to account there are opportunities for them to reiterate the authoritative judgement made or reveal the uncertainties of diagnosis and treatment to the patients involved. The question of which is considered preferable is explored in the chapter which follow on from the next.

Conclusion

This chapter has discussed the potential chasm between the formal guidance on hospital complaints and management of complaints. The focus has been on the use of rules and the meaning attributed to them rather than the rules themselves. The chapter has attempted to place the study of rules within an organisational and social context and suggests that situated power, workload, personality, long-term interests and relationships may have as much impact on the way complaints systems operate as the formal legal framework developed at policy level. Taking such factors into account facilitates what Kahn (1999) describes as the 'larger culture of law' (p.128). It has been argued that the very idea of the legitimacy of formal rules rests on a model of political power that is rarely realised. The idea of a model in which decisions are made and radiate downwards from the top of a hierarchy is untenable. What the empirical data discussed reveal. is that there exist a plethora of other decision makers and influences on the choices made by those involved in a complaint - such as colleagues, professional groups, and patients - which serve to facilitate and restrict behaviour. Many of these are pervasive and are not subject to hierarchical control of the kind which lawyers are accustomed to dealing with.

The research reviewed suggests that there is much to be learned from empirical studies of how rules operate. Rule circumvention and avoidance may be seen as choices which are just as rational for organisational actors as compliance is. Such reactions to rules are likely to be perceived as deviant by rule makers but competing evaluations are also possible which place the activity within an alternative moral framework. The effect of rule breaking may be mitigated by the fact that the breach was *unintentional* or *condoned by colleagues.* Alternatively, whilst the letter of the law might be preserved the spirit of it might be abused. What the studies reviewed reveal is that formal rules compete with other normative frameworks for attention.

The chapter also suggests that allegations of mismanaged care can have a significant impact on the confidence and wellbeing of doctors. Trained for perfection and the promotion of certainty, allegations of bad treatment render doctors vulnerable. Research suggests that their coping strategies are not well developed and that they may be reluctant to seek the help of colleagues for fear of appearing inadequate.

Despite the intensity of their reactions to allegations about the quality of care they provide, research on the operation of the hospital complaints system suggests that administrators responsible for co-ordinating the management of complaints do not take a proactive role in conducting investigations and drafting responses. It would seem that the dominance of professional interests - which was apparent in earlier discussions of how the hospital complaints procedure was negotiated - is also reflected at service level. Doctors may be left feeling unsupported but the accounts they provide in responses to complaints appear to go unchallenged and there is little evidence of conflict between clinicians and managers. The distinction between formal power and situated power is clear and suggests that the rhetoric of the guidance should not be confused with the reality.

Notes

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1. According to some writers with whom such views are popular, discretion is seen as something to be avoided. Amongst many administrative lawyers, strict conformity to rules is prescribed in an attempt to protect users of state services against the official injection of personal will into the exercise of government power. Within this context, the allowance of discretionary decisions has been seen as a defect in the design of a system, hence the efforts of many to devise ways in which to check discretionary power (Davis, 1969; but see also Dworkin, 1997; Hawkins, 1992; Richardson *et al*, 1985). Unfortunately pressures of space mean that the rule-discretion debate can not be fully rehearsed in this thesis.

2 In the 1988 guidance, this interpretation is supported by the inclusion in the guidance of the duty imposed on the designated officer to record, co-ordinate and monitor all complaints and to report all formal complaints to the health authority. Clearly, this would not be possible unless all complaints were reported to them. A more purposive interpretation suggests that this is only the case in complaints where attempts at informal resolution have been exhausted and the complainant remains dissatisfied, the complaint is serious, or the complainant did not want to address their concerns directly to the consultant involved. Moreover, because there is no guidance in the circular as to what constitutes a serious complaint doctors are left with considerable discretion as to whether they alert colleagues and superiors to the receipt of a complaint about the care they have provided.

3. However, the success of negotiations of this kind may be undermined by the regulatee's lack of knowledge of the appropriate rules being enforced.

4. Articulateness is defined operationally as better than average control of standard English, a college vocabulary, familiarity with the relevant jargon and enough information to discuss the case intelligently.

5. Colson (1995) has criticised much anthropological work on disputes because of the expectation that third-party intervention should lead to harmony. She suggests that law is not about justice, but that people appeal to the law to remedy their ills, not to facilitate harmony.

6. Bosk (1979) found that technical errors were often tolerated in juniors and Mizrahi (1984) found that coping strategies for distancing and denial were developed by medical interns in relation to such events.

5 Methodology and methods

> 'And here Alice began to get rather sleepy, and went on saying to herself, in a dreamy sort of way, "Do cats eat bats? Do cats eat bats?" and sometimes "Do bats eat cats?" for you see, as she couldn't answer either question, it didn't much matter which way she put it.' (Carrol, 1994, p4)

Introduction

The primary aim of the research on which this thesis is based was to assess the impact of clinical complaints on hospital consultants, and to explore the ways in which they understood complaints and constructed responses to them. This objective informed the methodology adopted and in this chapter the link between the research questions posed in previous chapters and the methods of data collection and analysis are described. The approach adopted combined both quantitative and qualitative methods and was conducted in two main stages. As a preliminary stage, a questionnaire was sent out to all hospital consultants in the Oxford Regional Health Authority. Data collected in this initial exercise were then further explored in in-depth semi-structured interviews with hospital consultants and senior managers. The chapter seeks to highlight the dilemmas and problems experienced when designing research instruments and conducting and analysing the data collected through questionnaires and interviews.

The chapter is in four parts. Firstly, the origins of the project are discussed in order to place it in context. Secondly, ethical considerations relevant to the research are reviewed. The third section describes the processes of data collection and analysis. This section provides the central focus of the chapter and outlines the multi-method approach adopted and the influence of grounded theory on the design and analysis of the data. The chapter closes with a section which draws together dominant themes. The difficulties encountered during the research are discussed where relevant throughout the chapter.

The origins of the project

In 1993, I was approached by Dr Harvey Marcovitch, Chair of the Regional Health Authority Medical Advisory Committee of Oxford Regional Health Authority[1]. Members of the committee, a multi-disciplinary group of doctors who represent all the main medical specialties practised in the region, were concerned that complaints were having a damaging effect on consultants and that consultants were losing control of the management of clinical complaints. In addition, the Health Authority was concerned about the drain on resources caused by complaints that escalated to litigation or to the appeal procedure. Dr Marcovitch had received £56,000 from the Regional Health Authority in order to commission a research project on the topic and I was asked to undertake the work because of my experience in the field. For the four years prior to starting the project, I had been working on an Economic and Social Research Council study of hospital complaints with Dr Sally Lloyd-Bostock at the Centre for Socio-Legal Studies in Oxford (for further details of this work see Lloyd-Bostock and Mulcahy, 1994)[2].

I was interested in extending my understanding of the dynamics of disputes between doctors and patients. As has already been argued in previous chapters this area was ripe for development as studies of disputing behaviour in this context are rare. Moreover, those working in the socio-legal tradition have placed much more emphasis on the complainant's perspective than on that of the respondent. In line with this approach, my earlier study with Sally Lloyd-Bostock had looked at the ways in which complainants constructed their letters of complaint and explained their motivation for complaining. The new study provided an excellent opportunity to use some of the same conceptual paradigms to analyse doctors' responses to complaints and to explore how they come to understand why the complaints are made. The emphasis placed on consultants rather than junior doctors was an interesting one as previous studies in the field have tended to concentrate on junior doctors and how they cope with mistakes (Bosk, 1982). As a result, the current study provided the opportunity to explore uncharted territory.

An advisory committee was set up to help frame the research and met on four occasions. It was chaired by Dr Harvey Marcovitch and attended by a number of other NHS representatives[3]. The existence of this advisory group and the source of the funding had the potential to compromise the independence of the research project and placed me in the position of a partial 'insider' at the Regional Health Authority. The difficulties of being an insider in research have been widely discussed amongst social scientists. This is especially the case in anthropology where there is a long tradition of participant observation which involves researchers living alongside their research subjects. However, there are obvious advantages for researchers who gain privileged access of this kind.

First, the advisory committee was able to make suggestions about how to encourage doctors in the region to participate in the study. One example of this kind of assistance was that Dr Marcovitch co-signed the covering letter (see Appendix 1) which went out with the questionnaire to consultants. Many respondents may have felt much more inclined to participate in the research, knowing it had the backing of a senior and well respected consultant. Another example was that I was able to use the services of the Regional Health Authority information and marketing officer to publicise the research in hospitals and through region-wide newsletters. This publicity also led to three interviews on local radio about the research. Secondly, members of the committee served as a source of ideas, read and commented on the various drafts of the postal questionnaire and commented on the research findings.

But there were also disadvantages to being so closely linked to the Health Authority. Consultants may have felt pressurised into participating because it had the backing of leading doctors in the region. Sapsford and Abbott (1992) have argued that even where there is not an authority or dependency relationship between the researcher and the researched, participants may still feel bound to co-operate however fairly the request is put. The intervention of the advisory group in the design, conduct and analysis of the research could also have compromised my autonomy and independence. A final difficulty was that by working so closely with senior medics, I could have internalised their assumptions and approach to the subject of complaints without being conscious of it.

It would be impossible for the researcher not to be influenced by such factors but I tried to minimise the impact of these effects by constant reflection during the research process. A computerised research diary was kept in which I wrote my impressions after conversations, advisory group meetings and interviews. By reflecting on the ways in which my ideas changed over time and by talking this over with an academic colleague involved in inputting the data onto a computerised database, I tried to maintain a distance between the interpretations offered by funders, advisors and myself. I was aided in this exercise by the fact that virtually all of my previous research had been conducted from a complainant's perspective and the impressions I had gained in earlier projects often provided useful counter-arguments to those put forward by the advisory group. This helped me to achieve some balance between competing interests and perspectives. Moreover, I was fortunate that the advisory group did not adopt a very proactive approach to managing the research. The relationship became one in which I reported to them rather than one in which we were in constant debate about design and conduct. As a result, I was never placed in a position where I felt seriously compromised by the suggestions they were making about the research.

Ethics

I was advised early on in the commissioning process by the Regional Director of Public Health that the research would not require ethical approval from the Regional Health Authority Ethics Committee. The rationale for this was that the project would not involve research on patients, analysis *of their files or the use of* NHS *equipment*[4]. *However, the fact* that formal ethical approval did not have to be sought did not mean that thought was not given to potentially unethical activity or that ethical issues were not raised. Ethical considerations inform and underlie virtually all the decisions made about research.

A number of writers have expressed concerns that much empirical research is exploitative and oppressive. They argue that it consists of a researcher with power controlling and manipulating research subjects (Sapsford and Abbott, 1992; Mies, 1993). The power wielded by the researcher can be seen in terms of their ability to determine what needs researching, the issues to be raised, the timing of the questions and their power to interpret data. In this sense, researchers have considerable autonomy and those being researched very little. Careful consideration needs to be given to the ways in which anyone whose interests are touched upon by the research might be harmed by it or by the dissemination of its conclusions. In my attempts to tackle ethical issues in the research, I was greatly guided by the ethical codes of the British Sociological Society and the Socio-Legal Studies Association. All research participants were assured that I considered myself bound by the provisions of the ethical code of the latter[5] and a copy of this was made available at the office of the Regional Health Authority for participants to refer to if they so wished.

It was also recognised that the issue of complaints is a sensitive one for consultants to talk about. A first principle of all ethical codes is that the subjects of the research should not be harmed by it, but this project did have the potential to cause harm. A doctor's career prospects can be adversely affected by the knowledge amongst senior colleagues that a complaint has been made against them. A number of steps were taken to insulate doctors from such effects which may have occurred to them as a result of the research. Anonymity was promised throughout the project and no data were reported without the agreement of research subjects. All doctors in the region regardless of whether they had been the subject of a complaint were sent a questionnaire by staff at the Regional Health Authority, using address labels generated there (see Appendix 2). Direct access to the labels was not requested by me so I had no idea of the particular individuals who were involved.

Consultants were not required to fill in the questionnaire but instead were asked to 'opt in' to the study by completing it. In an effort to ensure that their decisions to take part in the research were informed, the aims of the project, methods to be employed and possible uses of the data were all outlined in the letter which accompanied each questionnaire. Consultants who wanted to discuss the research further were invited to ring the research team, and a handful of doctors did do this. In the interests of preserving their anonymity respondents were not asked to provide details of their name, the hospital at which they worked or the district in which they were based. Return envelopes with district postal stamps were discarded on receipt. Questionnaires were not given unique identifiers until they were ready for analysis.

At the end of the questionnaire, doctors could opt in to the second stage of the project; the interview phase. Where they gave their name and address for such purposes these were separated from the rest of the questionnaire as soon as they arrived in the post and the details copied into an interview log book which was kept locked in a separate cabinet from the completed questionnaires. The original sheets with names and addresses on were then shredded. In this way the identity of questionnaire respondents could not be linked to the questionnaire they had filled in. Throughout this thesis and the final report to the health authority the use of data which allow identification of particular consultants has been avoided. For example, minority specialities which employ a handful of consultants who tend to be known to each other have been included in broader categories.

But research subjects can be harmed by research in other ways. The very process of giving information to researchers may cause distress and psychological problems. This was not an impact I anticipated in advance of the research but I was aware of such effects during the course of interviews. One very successful orthopaedic consultant interviewed explained how he had sought independent counselling as a result of his difficulties in coming to terms with a complaint he had received. Another senior consultant brought to the interview all the documentation relating to a complaint he had received 20 years previously. He explained that his verbal account of the complaint was still so detailed because of the amount of thought he had given, and continued to give, to it.

The semi-structured grounded approach to interviews adopted in the study facilitated a sensitive treatment of such respondents. Although the questions I posed steered the interview, the flow of interviewees' responses was not interrupted and there was no time limit imposed on the interview. I listened to their accounts for as long as they wanted to discuss matters and, as a result, the most lengthy interview lasted almost two-and-a-half hours. Attention was also paid to the need to 'cool down' the interview as it came to a conclusion. Interviewees were routinely asked questions at this stage that were less sensitive and allowed subjects to regain their composure. Examples included asking them how long they had worked at the hospital and how they would like to see the research disseminated.

Where interviews were recorded (see below) the permission of respondents to do this was requested in advance of the interviews and again at the beginning of them. It was made clear that only the interviewer and a transcriber would listen to the tape and that it would be destroyed as soon as transcription had taken place. All of the interviewees asked agreed to have the interview taped, but I did not consider this appropriate in two interviews where the consultant was treating a patient. In one instance, a consultant asked me to conduct the interview while they oversaw the administration of a CATscan. In another, a consultant anaesthetist fully gowned for theatre talked to me in between anaesthetising patients in an adjoining room. In both cases, I felt extremely uncomfortable about conducting the interview and kept the interview to a bare minimum of about 15 minutes.

Data collection and analysis

A multi-method approach

The decision was made to collect data from three main sources (see Table 5.1): a postal questionnaire to all consultants in the region, face-to-face in-depth semi-structured interviews with doctors and face-to-face in-depth semi-structured interviews with managers. A mixture of qualitative and quantitative, highly structured and unstructured methods were employed in an attempt to provide both an overview of activity across the whole regional health authority in which the study was based, and a more in-depth understanding of particular issues. The relatively generous grant of £56,000 received from the health authority made possible a study which placed emphasis on depth and breadth. The quantitative part of the study was used as a preliminary base for the development of research questions. It allowed the conceptual frameworks developed by other writers, and reviewed in previous chapters, to be examined in the context of patient-doctor disputes but it also provided an opportunity to identify new topics which could be further explored in the in-depth interviews.

Table 5.1: To show the main forms of data collected

Type of data	Sample size	Response rate
Postal questionnaire	All practising consultants in Oxford RHA (848)	52 %
Face-to-face interviews with doctors	35 interviews with a spread of consultants drawn from 170 postal questionnaire respondent volunteers.	100% of those selected
Face-to-face interviews with managers	25 interviews with UGM or CE of all acute units and trusts in the region.	100% of those selected

In addition to these three main sources of data, in-depth interviews were carried out with Margaret Stacey, a medical sociologist who had been a member of the Davies Committee on Hospital Complaints and Michael McNair Wilson, the MP responsible for the introduction of the Hospital Complaints Act. Both these interviews helped place these historical episodes in context and allowed explanations to be put forward for a set of events which has not been fully described in public sources.

Guba and Lincoln (1994) argue that the success of choice of method can often depend on the skills and expertise of the researcher. I approached the study as an experienced researcher who had previously used several methods in my work such as telephone interviewing, group interviews, postal questionnaires and in-depth interviews with individuals. This allowed me to reflect on my experiences of different methods. As a result, I was able to select the methods which best suited my particular research style and were able to address the research questions posed.

My preference was for in-depth studies and a qualitative approach but I had also found that these could be usefully informed by quantitative data. There were several reasons for this. I was conscious from other studies I had conducted and reviewed that the concerns and attitudes of doctors may well be affected by their medical specialty and their status within the medical hierarchy. For these reasons it seemed important to introduce a survey element to the research in order to capture this variability in sufficient numbers to be able to identify clear themes. This decision was reinforced by the fact that the funding body had expressed its concern about the impact of complaints on *all* hospital consultants. Another consideration was that a mixture of methods was most likely to be seen as credible by those being researched. Quantitative approaches tend to be given much more credence by those with a natural science background. It was hoped that this would encourage consultants' participation in both the quantitative and qualitative phases of the project.

The decision to adopt a multi-method approach to the collection of data has been identified as controversial by some methodologists. It has been argued that qualitative and quantitative research techniques result in the collection of different sorts of data, based on different premises, and that the tendency to use such datasets to reinforce each other can be dangerous. The final decision to use a mixed method approach was based on a number of factors. First, it was felt that the multi-method approach was capable of serving a number of goals. Qualitative research is sometimes regarded as being better able to produce information about interactional processes and about participants' perspectives, whereas quantitative research is presumed to be better at documenting frequencies and causal patterns (Hammersley, 1996). Feminist researchers have tended to espouse qualitative methods arguing that quantitative methods are imbued with male assumptions that researchers should decide what is to be researched, set the parameters of the research and need not listen to the alternative views of those being researched. As a result, they argue that the approach is unresponsive to the complexity of the social world (Mayall *et al*, 1999; Oakley, 1999).

The tendency in this study was towards the collection of qualitative data. Whilst the questionnaire relied on some pre-coding of responses, considerable opportunity was given to consultants to write in 'free style' about their experiences. At the same time, the postal survey data facilitated some generalisation and revealed causal relationships between variables. The interviews provided a more in-depth understanding of particular cases and showed how these relationships operated in a natural setting. This was an essential part of the grounded approach to the data analysis, described more fully below. In-depth semi-structured interviews provided an opportunity for participants to talk at length about issues which one would expect to have been highly charged emotionally. The multi-method approach also allowed for changes in direction during the course of the research project as I had the opportunity to reflect on the initial findings (see Blaxter *et al*, 1996). The in-depth qualitative stage followed on from collection of the questionnaire data so that the interviews were able to explore issues raised in the questionnaires.

A number of writers have asserted that two types of methods can be used effectively in the same piece of research and that quantitative data can be used to validate qualitative analysis through the process of triangulation (Kelleher *et al.*, 1994; Strauss and Corbin, 1990; Denzin, 1970). Hammersley (1996) also reports that this type of methodological eclecticism has a long history and allows for the diversity of theoretical approaches which are found in psychology and the social sciences to be reflected in methodology. But, such an approach is not without its difficulties. Hammersley (1996) claims that such eclecticism can encourage the researcher to ignore unresolved differences between a quantitative and qualitative approach. For instance, quantitative research tends to assume the existence of reproducible causal patterns whilst qualitative researchers often stress the contingent, unique and diverse character of human perceptions and actions and the role of these in interpretation. Moreover, it is argued that qualitative data generally suggest a more holistic view of phenomena. Hammersley claims that links between the two sets of data are often emphasised in order to argue for generalisation of the results of the interview data and that theoretical inference and empirical generalisation are often conflated in the process. By contrast, Kelleher and colleagues (1994) contend that:

> '... it can be argued that all social research rests upon some commonly accepted reference points by which researchers can transmit and translate their particular observations more widely to others. In order to achieve the highest standards of reliability researchers would expect to share data in ways that correspond to real-world concepts of everyday events, that is both quantity and quality.' (p121)

The approach adopted in this study was not to equate a multi-method approach with the need for triangulation. It was not assumed that one set of data could be used to validate another but rather that different methods and people were to be used to explore a theme from different angles. It was anticipated that at times the dominant themes emerging from the two data-sets might be in conflict, but the intention was to use such occurrences as a way of identifying possible points of dissonance or a variety of interpretations assembled from those with different perspectives (Fielding and Fielding, 1986). In this way, the multi-method approach should facilitate a sharper focus on reference points (Kellaher *et al.*, 1994).

The postal questionnaire

As has already been explained, the study used questionnaires to give some breadth to the data. The questionnaire encouraged respondents to help set the agenda for the next stage of the research by prompting them to provide personalised, long-hand accounts of their experiences of complaints. In the second phase of the project, issues identified in the questionnaires were further pursued in interviews.

The use of questionnaires in the collection of data has been criticised. Concerns focus on the ways in which their use imposes rationality on experiences which in reality may be ambiguous and chaotic. There is a danger that the imposition of researchers' interpretative frameworks through the use of pre-coded questions can often give a form and order to accounts that is deceptive (Plummer, 1983; Rock, 1979). Feminist methodologists in particular have been concerned that this allows dominant conceptual frameworks to be imposed on the participant's social world which do not exist (Sapsford and Abbott, 1992). In this study, an attempt was made to meet some of these criticisms by adopting a semi-structured framework on the questionnaire and by taking into account the need for participants in the research to help frame the issues rather than being seen as mere respondents. Consultants were encouraged to help set a context for their responses and to identify complexities not always captured by pre-coded responses. This was achieved by combining a structured and unstructured approach to the questionnaire.

A number of 'closed' pre-coded responses were used in the postal questionnaire in order to minimise the amount of time that consultants would have to spend completing it. Doctors on the advisory panel reported that they were constantly being asked to complete questionnaires and did not always have time to co-operate in research. Another advantage to this approach was that pre-codes, tested in other empirical studies in which I was involved, were utilised in order to produce comparable data (see, for instance, the use of allegation codes and ethnicity codes developed by Mulcahy and Tritter, 1998; Lloyd-Bostock and Mulcahy, 1994). Use was also made of Ennis and Vincent's (1994) work on emotional reactions to mistakes and medical negligence claims, Weiner *et al.*'s (1972) attribution model and Lloyd-Bostock and Mulcahy's (1994) and Allsop's (1994) work on how complainants and doctors construct accounts and defences (see Chapter Four).

In order to temper the rigidity of this approach each question allowed ample space for additional comments on the issue to be made by respondents and there was extra room at the end of the questionnaire for consultants to add general comments. This meant the questionnaire took longer to complete and, therefore, to analyse but this approach had a number of benefits. Most importantly, respondents' beliefs were not constrained totally by pre-determined categories. They were encouraged to believe that full account was being taken of their unique perspective and that their replies were not being reduced to mere numerical values. The approach proved to be very successful. A large number of comments were made in the space provided and consultants often sent in additional materials and wrote detailed covering letters. These addenda were a rich source of qualitative data. The comments were subjected to detailed content analysis, using techniques traditionally associated with qualitative research and are used in this report to explore the theories suggested by some of the quantitative data.

Several versions of the postal questionnaire were prepared and the advice of the project advisory group was sought on the version which was piloted. In addition, colleagues of the author were asked to review the questionnaire and comment on the clarity of the questions. The final version of the questionnaire aimed to collect data on seven main topics each of which related to issues identified as important in previous chapters of this thesis. Each of these are considered in turn below.

1. Characteristics of the sample

The first cluster of questions on the questionnaire concentrated on identifying key characteristics of respondents which might have an impact on their response to complaints, such as age, gender, ethnic identity, colour and country of origin, qualification date and medical specialty[6]. These are standard categories adopted by social scientists to organise data. They allowed preliminary analysis to be undertaken which organised the sample according to crude groups in order to determine whether these aspects of identity had an impact on the likelihood of doctors receiving complaints and on the ways in which they formulated responses to them.

Ethnicity and ethnic identity were considered to be particularly important to the study. The issue of the link between receipt of complaints and ethnicity has seldom been explored although the General Medical Council has reported that it gets more complaints, and upholds more complaints, about doctors who qualified overseas (Smith, 1994). But there were problems in pursuing these themes. Race, ethnic origin and ethnicity can be regarded as socially constructed concepts and there are many unresolved debates surrounding the notions. Andrews and Jewson (1993) argue that many of the categories traditionally used by researchers are vague and heterogeneous and are insensitive to complex variations of history, values, languages and experiences. Similarly, they make the point that national boundaries are the products of political processes and struggles which may or may not be connected with ethnic differences.

In this study it was hypothesised that ethnicity might have three impacts on complaint making and management. First, consultants from different ethnic groups might demonstrate different ways of coping with criticism which were rooted in cultural expectations. Second, complaints about doctors and the handling of them might be prompted by racial prejudice. Third, there might be conflicts between patients and doctors as to what is appropriate behaviour, based on cultural assumptions. For these reasons three different questions on ethnicity appeared on the questionnaire. The question of country of birth was designed to give some data on possible ethnic origin and whether or not English was likely to be the doctor's mother tongue. The next question sought to establish the description of ethnic identity preferred by the respondent. It was hoped this would to indicate the type of cultural assumptions which might guide their decision making and assessments. Finally, it was hoped that information on their colour would give an indication of whether complaints received by a consultant had been racially motivated.

An extensive list of potential ethnic identities with which consultants might identify had been successfully piloted in another study of complaints commissioned by the Department of Health (DoH) and directed by Mulcahy and Tritter (1998). The list incorporated all the categories included in the 1991 Census and a number of those used by the DoH statistics division. However, it was felt that a number of these classifications were too broad and conflated notions of ethnicity and race. To avoid this, new groups were identified which did not neatly accord with geographical regions, such as the category Jewish.

The advice of the officer responsible for ethnic monitoring at the Regional Health Authority was also sought in relation to these categories. She warned that her experience of collecting data on ethnicity from doctors was that they did not appear to give much weight to the importance of the exercise. For this reason, questions about ethnicity, colour and country of origin appeared at the end of the questionnaire so the consultants were encouraged to complete as much of it as possible before being 'distracted' by questions about ethnicity. Also, a preamble to the questions was drafted to explain their purpose of these questions. The advice of the ethnic minority officer was borne out in part. Although consultants' responses was good in terms of the their willingness to provide the data, facetious remarks, about colour in particular, were not uncommon.

It was anticipated that specialty would also be a key factor in analysing complaints activity. Doctors are organised into teams in hospitals on the basis of their chosen specialty. Each specialty has different characteristics in terms of the physical environment in which work is conducted; the level of technological support; the hours of work; the level of expertise and training required and the risk and severity of harm which might be caused to patients. Specialties were listed on the questionnaire using 35 detailed codes developed from information made available by the Regional Health Authority[7]. These allowed consultants to indicate more than one specialty in which they practised and to indicate their sub-specialty if they wished to. Additionally, the codes could be collapsed into mutually exclusive categories used by the DoH and so compared with national statistics on 'first' specialties (see Appendix 3).

2. Knowledge of the complaints procedure

A second cluster of questions concentrated on knowledge of the complaints procedure. Knowledge of regulatory procedures has been shown to be a key step in understanding the effectiveness of regulation (Prescott-Clarke *et al.*, 1989). It is also a way of assessing whether deviant behaviour is conscious or intentional (Baldwin, 1990). Consultants who did not know of the existence of a formal complaints procedure had to be distinguished from those who knew about it and had deliberately chosen to flout it. In line with these enquiries, consultants were asked whether a formal procedure for handling complaints existed within their trust and, if so, who had designed it. The section also explored whether they knew anything about the Health Service Commissioner's role[8].

3. Focusing the sample

The third group of questions identified the sample of consultants who were to provide the core data for the study. Consultants in this group were asked to provide a retrospective account of complaints activity. A set of filter questions allowed for the identification of a group who had received a formal clinical complaint in the course of their career and in the last 12 months[9]. Respondents who had never received a complaint were still asked to provide details of personal characteristics (see characteristics of sample above) but were not required to fill in the remaining questions. This allowed a comparison to be made of the features of the complaint and non-complaints sample and generalisations to be made about the propensity for certain types of doctors to receive complaints.

The phrasing of questions about receipt of formal clinical complaints proved difficult. Identifying an operational definition of a complaint can be complex. It has been argued that many of the 'labels' attached to inter-personal conflict do not capture the full subtlety and complexity of conflicts and ways in which they constantly transform (Trubek, 1980-81).The 1988 guidance does not define clinical complaints and elsewhere there is not one generally accepted definition. While some complaints managers have interpreted a clinical complaint as any complaint involving a clinician, others have restricted it to those which relate to the standard of clinical care received (Mulcahy and Lloyd-Bostock, 1994). Thus, a complaint about a rude doctor could appear in the former category, but not the latter. Further difficulties were anticipated surrounding the use of the word 'formal'. Since not all staff are aware of the existence of what the DoH refers to in governing circulars as the 'formal procedure', there was concern that data from different consultants would be inconsistent. Previous research demonstrated that some complaints managers and consultants only described written complaints as formal, whilst others, in accordance with the 1988 regulation, included verbal and written expressions of grievances. Problems of faulty recall were also likely if consultants were to be asked to report on all verbal complaints about clinical care ever made. Finally, the decision to classify a verbal complaint as formal, in practice, is a discretionary decision which is likely to be exercised differently by different people.

Box 5.1: Definition of a clinical complaint

For the purposes of this project, a formal clinical complaint is defined as an expression of dissatisfaction about a clinician or clinical treatment which has been made in writing to a consultant or to a manager about a consultant,

p2, *Project Questionnaire*

For these reasons, and for simplicity, a definition of a formal clinical complaint was provided for consultants in the project which did not tally exactly with the definition of a formal clinical complaint contained in the DoH guidance (HC(88)37). This was printed in large bold type on the questionnaire and appears in Box 5.1. The definition was both broad, in the sense that it included any complaint about consultants, and narrow, in the sense that it excluded verbal expressions of dissatisfaction which the guidance suggested might be formal.

Despite attempts to make clear exactly what was meant by a formal clinical complaint, it was obvious from some questionnaire responses in the pilot study that a small group of consultants had given details of medical negligence claims which had been made against them. This gives credence to the arguments made in Chapter Three that complaints and claims are often treated by doctors as synonymous. Since medical negligence claims do not always begin as clinical complaints, it was necessary to distinguish between these two categories. In the main study, three additional questions were included in the questionnaire about medical negligence claims in order to encourage clinicians to distinguish between complaints and claims[10]. Where a consultant was clearly referring to a medical negligence claim which involved a solicitor or claims manager and had not been processed in the formal complaints procedure, then the data were excluded for the purposes of analysis.

It was possible that consultants could have received more than one complaint in the course of their career. However, it was not considered practical to design a questionnaire which asked for details to be given of each individual complaint. Rather than allowing for detailed histories of each complaint, the questionnaire asked for generic information about doctors' experience of complaints. Thus, in cases where two or more complaints had been received it was not always possible to tell which complaint was being referred to in subsequent answers. However, within the set of doctors who had received a formal complaint, there was a sub-set who had experienced only one complaint in the course of their careers. As a result, all their responses in the questionnaire could be related to that specific incident. This group (co-incidentally exactly one third of the consultants who had received a formal complaint) provided a useful sub-sample which could be used to clarify certain trends discernible in the main data-set. In the analysis which follows, the 246 consultants who had received a complaint are referred to as 'the complaint sample' and the sub-sample of 82 who had received only one complaint is referred to as 'the pure third'.

4. Mapping complaint channels

The fourth group of questions attempted to trace the channels used by complainants when making complaints and by consultants when responding to them. Mapping complaint handling channels was another way of identifying whether consultants had acted in accordance with the statutory guidelines for complaint handling. It allowed me to test whether complaints sometimes remained hidden from managers charged with responsibility for co-ordinating responses. Questions included in this category sought to identify how consultants became aware of complaints, the proportion of complaints which were written or oral and whether the permission of doctors had been sought by managers before sending out responses they had drafted[11]. Also included was a question on the allegations made in the complaint as it was anticipated that this might have an impact on the type of channels used[12].

5.Consultants' emotional reaction to complaints

The fifth group of questions sought to gather data on the emotional impact of complaints. This theme has been explored in relation to claims (Ennis and Vincent, 1994) but not complaints. Consultants were asked to describe the range of their emotional responses to complaints and any changes in behaviour and attitude prompted by them[13]. They were also asked to provide an evaluation of whether or not the complaint was justified. The results of the pilot study suggested that emotional reactions to a complaint differed according to whether the complaint was considered justified, partly justified or completely unjustified. As a result of this finding, pre-codes were provided for respondents to indicate which of these three categories the complaint they were discussing fell into and they were also asked to provide further details in their own words if they wanted to.

6. The use of networks

Discussion of the use of networks features prominently in the literature on disputes and identity (see for instance Black and Baumgartner, 1983; Mather and Yngvesson, 1981). This set of questions aimed to trace the use of personal and professional networks and what motivated doctors to access them. The questions on emotional impact described in the last section sought to explore the potential threat to self. This cluster of questions set about determining the importance of networks in providing such things as emotional support, information and advice in the construction and re-construction of disputing identities. Respondents were asked whether they had discussed complaints they had received with a medical colleague and, if so, whether they were senior to them and if they were inside or outside the trust where they worked. This allowed for a more sophisticated analysis of networks since they could be divided into both horizontal and vertical, and internal and external[14]. Use of non-medical networks was also explored as was the consultant's reason for approaching others.

It was anticipated that a number of different needs might motivate respondents to access others including support, comfort, advice, information, confirmation of views and in order to pass on information. A number of pre-codes, constructed on the basis of data collected at the pilot stage, were presented to respondents in a grid which allowed them to match their motivation and need with the type of people approached. I was concerned that the grid might be too complex a mechanism to yield reliable data but, in fact, the vast majority of respondents understood the instructions and code keys and made ample use of the opportunities it provided to map their contacts[15]. In addition, consultants were encouraged to describe in their own words the extent to which the people contacted had an impact on the way they responded to the criticisms contained in the complaints they had received and whether they would have liked someone else to talk to about them[16].

7. Perceptions of complainants

The final group of questions concentrated on generating data on consultants' views of complainants and complaint processes. These questions sought to explore whether doctors positioned themselves in opposition to complainants and managers and the extent to which they were able to empathise with them. Respondents were asked to give their assessment of five aspects of complaints: whether certain complaints or complainants were more difficult to deal with than others; whether certain types of people were more likely to complain; what motivated complainants; whether they liked or disliked certain aspects of complaint handling in their trust; and whether they had developed any complaint handling techniques which they thought could be usefully employed more widely[17].

Sample size and representativeness

The quality of the inferences which could be drawn from the responses to the postal questionnaire are related to both sample size and sampling method. At the time of the research, Oxford Regional Health Authority was one of 16 Regional Health Authorities in Scotland, England and Wales. A finite sample of consultants was identified (848) by the RHA in March 1994. The inclusion of all 848 doctors in the sample maximised the level of precision which might be achieved by analysis of the data collected (Sapsford and Jupp, 1996).

The questionnaire was piloted in the autumn of 1993. Fifty names and addresses were selected by regional office staff from the list of 848 practising consultants supplied by the Regional office. Those selected for the pilot stage came from a range of specialties and hospitals. Thirty-two questionnaires (64%) were returned by these consultants and minor amendments were made to the questionnaire in the light of their responses. The amendments mainly involved clarification of issues which had been clouded by the wording of questions and a shortening of the questionnaire.

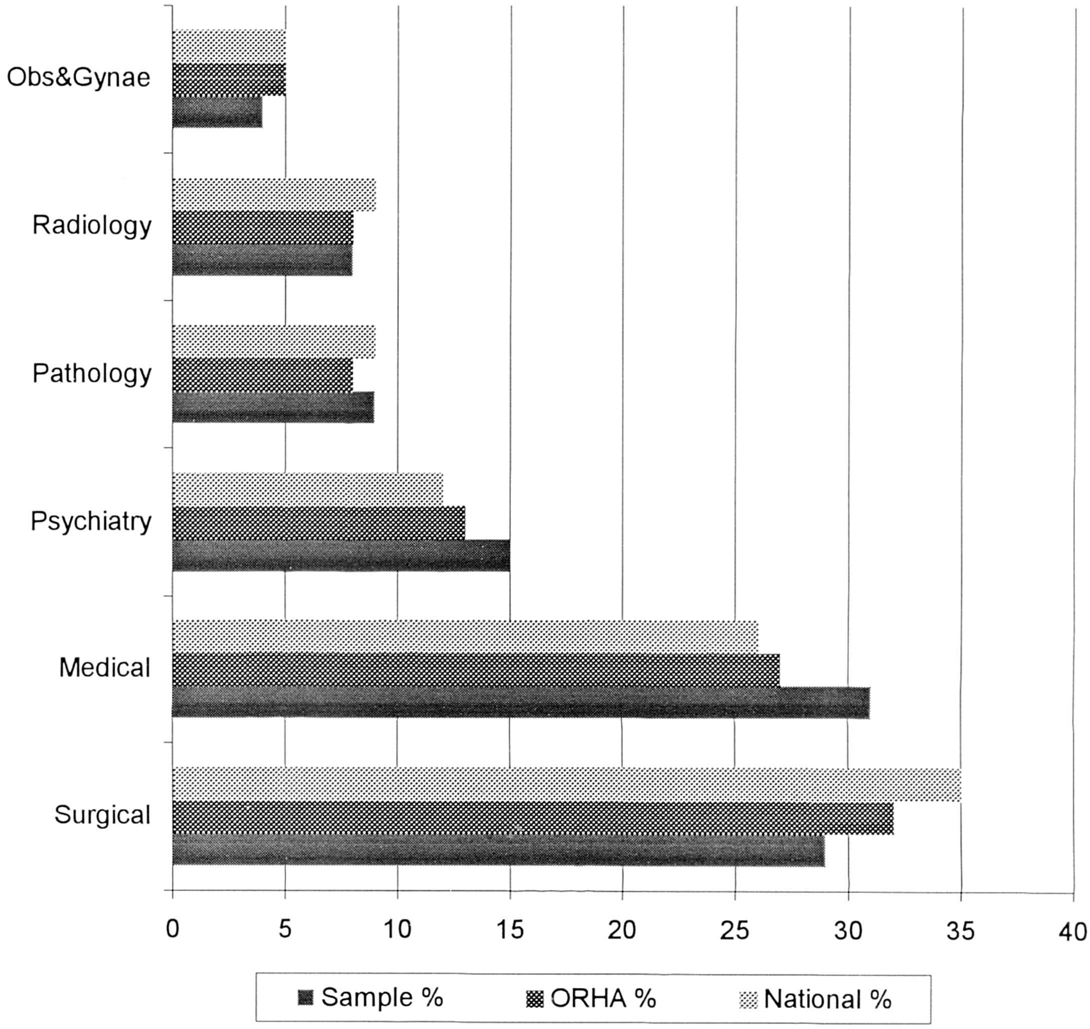
The importance of making questionnaires as attractive and easy to complete as possible has been stressed by a number of methodologists since it can have a significant effect on the response rate (Sapsford and Jupp, 1996). Several factors guided the preparation of the final questionnaire. It was made to look as attractive as possible so that text was not cramped. Boxes were aligned so that the respondent could move their writing hand down the page in a straight line and clear instructions were given and printed in a different type style. In the main study, questionnaires and an accompanying explanatory letter were sent to all remaining consultants in clinical practice.

Of the 848 consultants who received a copy of the questionnaire in the pilot and main study, 443 (52%) responded. This meant that a sizeable proportion of the sample was lost through failure to respond as well as by non-response to certain questions in the questionnaire. Sapsford and Jupp (1996) report that non-response rates of 50 per cent or more are frequently reported and response rates of over 80 per cent rarely achieved in postal surveys even where second copies of the questionnaire are sent out. This is especially true of academic research (Wilson, 1994). They also argue that data lost as a result of clerical error is seldom reported but may be as high as eight per cent.

Reminder letters were not sent out in this study but, in an attempt to ensure that the project was brought to the attention of all consultants in the region, a press release was sent to all hospitals. As a result of this, articles and news items about the project appeared in a number of hospital magazines and in the *British Medical Journal*. In addition, a poster was distributed in June 1994 alerting all consultants to the project and giving them a telephone number from which they could request a copy of the questionnaire if they had not already received one. Ten consultants availed themselves of this opportunity although not all of them returned the second questionnaire they were sent.

The sample of 52 per cent of consultants was broadly representative in terms of medical specialty, gender and age when compared with both regional and national statistics on NHS consultants. Figure 5.1 shows how the main specialties of consultants in the sample (see Appendix 4 for all specialties) compared with all consultants in Oxford Region and also with national figures.

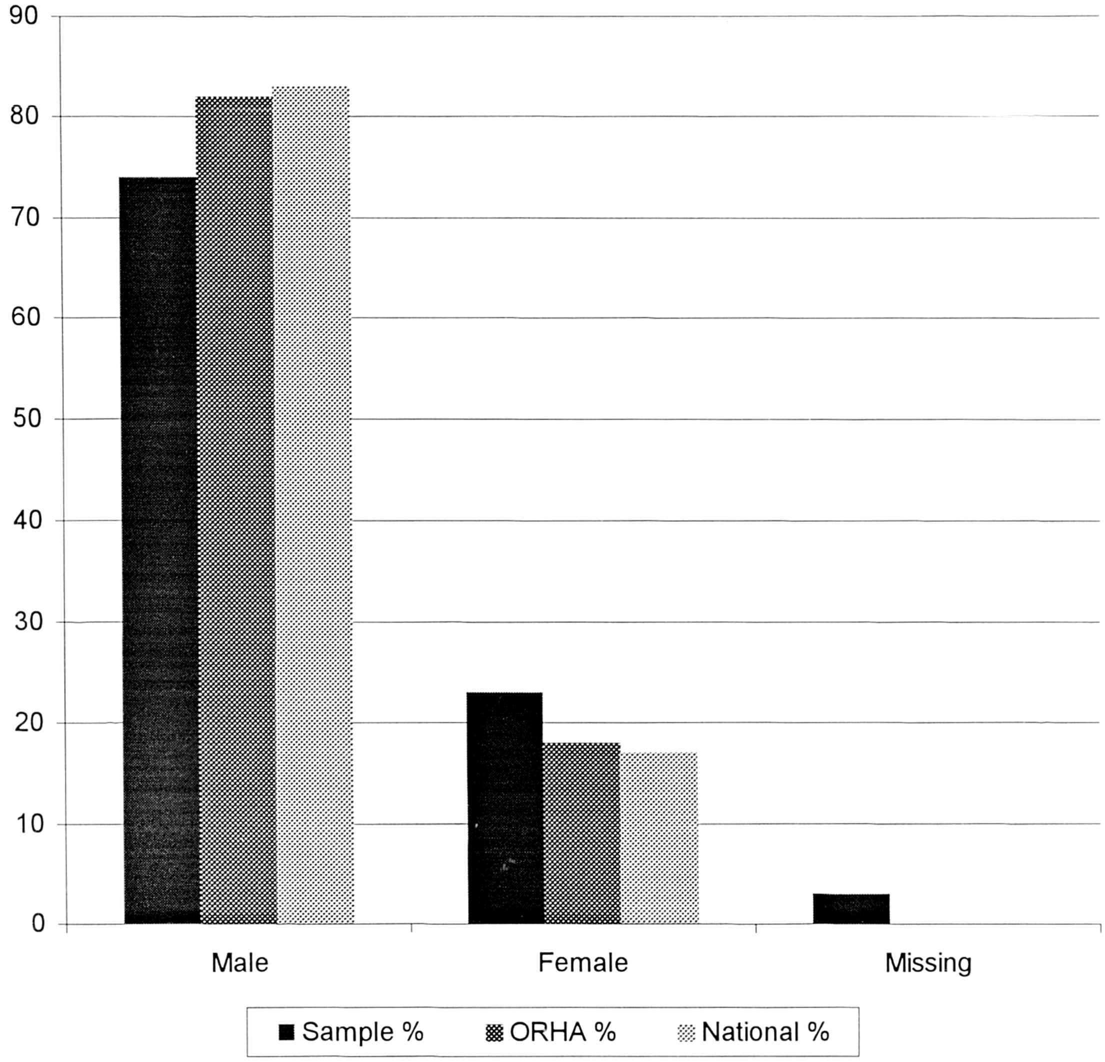
Figure 5.1: Representativeness of sample by specialty (n = 420)*



*23 = missing or other [18]

The data in Figure 5.1 demonstrate that Oxford Region has a similar make-up of specialties as England as a whole and that the sample of respondents in this study was also broadly representative of these proportions.

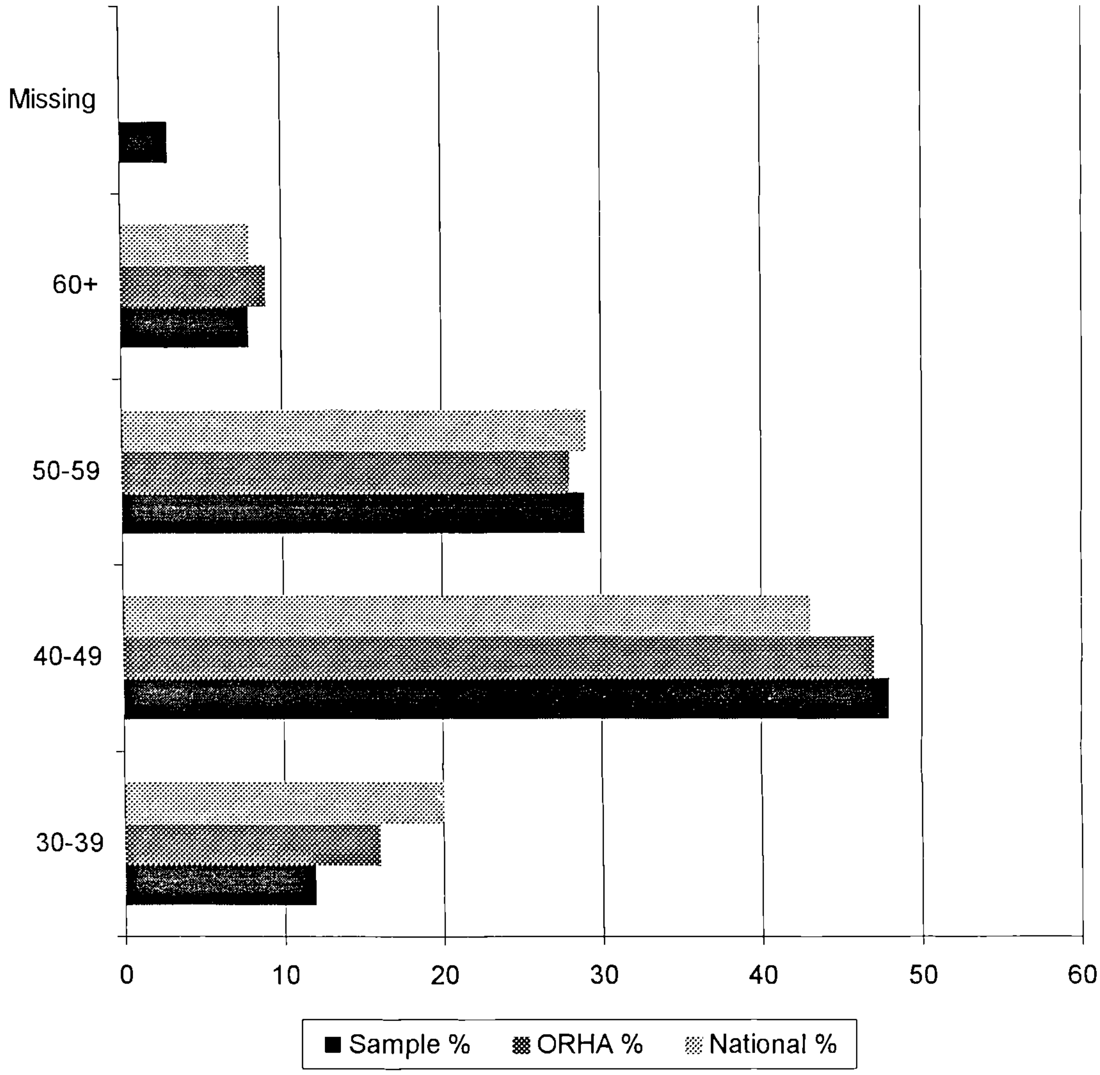
Figure 5.2: Gender of consultants in sample



It can be seen from Figure 5.2 that the number of males in the sample of respondents was marginally disproportionate being 7.4 per cent fewer than that reported by the Regional Health Authority.

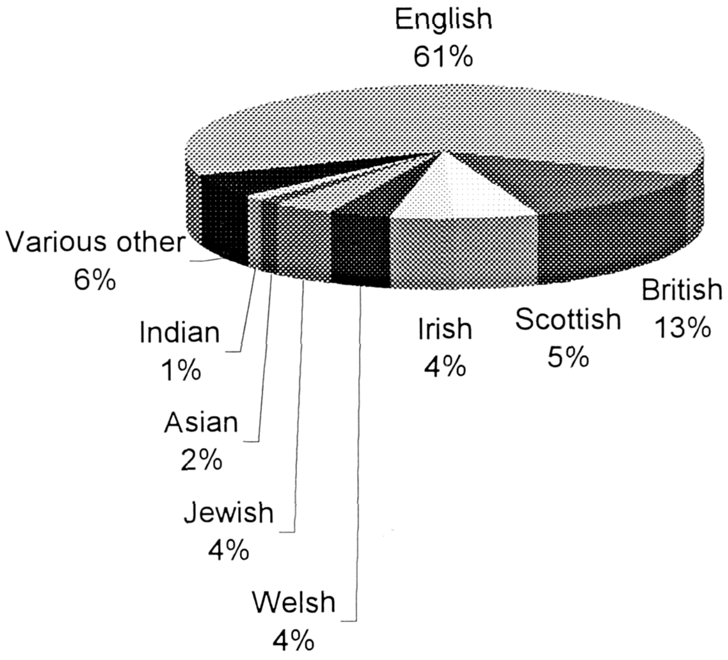
Data were also collected on the age consultants qualified as a doctor. Figure 5.3 shows that most consultants in the study were in the 40-49 category. Again, this reflects the age breakdown in the region and nationally. Further analysis of the data showed that 92 per cent of consultants qualified before the age of 30 and that they all qualified before the age of 34.

Figure 5.3: Age of respondents



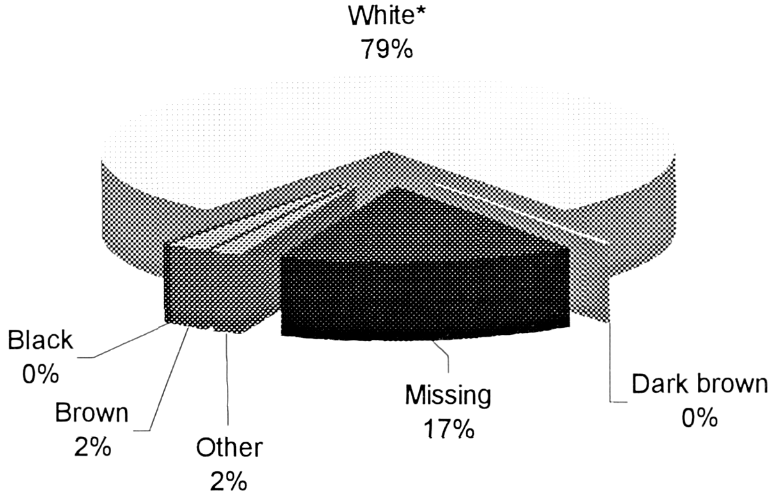
The importance of the issue of ethnicity in the study has already been discussed, as have the problems of using pre-existing research instruments which tended to conflate notions of race with ethnicity. For these reasons, three questions relating to ethnicity and race were posed in the postal questionnaire, relating to their sense of ethnic identity, their colour and their place of birth. Figure 5.4 shows how consultants described their ethnic identity. These data on ethnicity demonstrate that English and British are the dominant ethnic identities with which respondents related.

Figure 5.4: Ethnic identities of sample



Respondents were also asked to describe their colour. Once again one dominant category, that of white, emerged.

Figure 5.5: How consultants described their colour

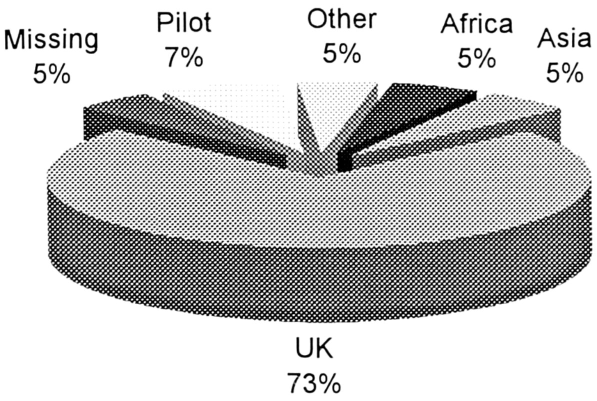


*Some consultants offered more than one definition e.g. W.A.S.P./white, or white/Caucasian.

It is not possible to provide comparable data either regionally or nationally for Figures 5.4 and 5.5 as the DoH does not collect extensive data on this topic. The categories of data which were made available by the Department were not considered rigorous enough for this study as they conflated notions of colour, ethnic origin and identity. However, it is clear from the data available that the percentage of doctors described as 'white' in this study tallies closely with the 70 per cent of consultants nationally who use this category.

Finally, a question relating to place of birth was also included to give broad indications of ethnic origin.

Figure 5.6: Birthplace of consulants in sample



This reveals that the majority of respondents were born in the UK although over 10 per cent of consultants were from Africa or Asia. The dominance of English ethnicity, white colour and UK origin in the sample meant that it was extremely difficult to pursue the impact of these factors on complaint handling. This was a cause of considerable disappointment as it is clearly an important issue on which no previous research has focused.

Management and analysis of postal questionnaire

A database for the questionnaire data was designed using Statistical Package for the Social Sciences for Windows (SPSS) and set up prior to the mail-out. Returned questionnaires were given unique identifiers so that apparent inconsistencies in the data generated could always be located and checked. Completed questionnaires were kept in a locked filing cabinet in a secure office. When the transcribing of respondents' commentaries and cleaning of pre-coded data were complete the questionnaires were shredded as a way of guaranteeing confidentiality.

Quantitative data from questionnaires is not present in a form which can simply be reported by the researcher. Like qualitative data, it is constructed by the investigator. Although the production of numerical totals gives a stronger impression of objectivity and accuracy, interpretation and manipulation takes place before data are analysed. Novel relationships have to be appreciated, as do new possibilities for developing methodologies and ideas. In this study, the data were analysed in five stages. The first stage of analysis involved checking for programming and respondent error. During the data-inputting stage, respondent errors - such as multi-code response to a single code answer - and missing variables were initially given separate codes so as to reduce the number of anomalies which might appear during frequency dumps. In a number of cases, missing information could be filled in if the answer to the question could be gleaned from elsewhere in the questionnaire.

As soon as inputting was complete, a period of data 'cleaning' was undertaken. Initially, this involved conversion of raw data into spreadsheet mode and the generation of print-outs. These were scanned in order to identify frequencies which appeared out of line with other responses. Where anomalies came to light, hard copies of individual questionnaires within the dubious category were retrieved, reviewed for their accuracy and, where necessary, amendments were made to the database.

However, amendments of this type were not always possible, especially since consultants did not always provide consistent data. Figures given by consultants in later sections of their questionnaires did not always tally with the 'base' number of complaints given at the beginning. As a result, when the data were analysed, there were sometimes discrepancies between numbers which should have been the same. This is particularly apparent when comparing numbers of complaints received with channels of complaint; numbers of allegations; whether complaints were justified; and the response channels used. Inconsistencies of this type were not possible to resolve and are identified in the forthcoming chapter when the data are presented. Once this process was completed the data were declared 'clean', although in reality small anomalies constantly emerged and had to be checked. This meant that the postal questionnaires were not finally shredded until the research report was complete.

The second stage of analysis after the cleaning phase involved the categorisation and coding of qualitative data supplied by respondents on the questionnaire. Separate 'write-in' files were created to record all the additional qualitative data supplied by respondents in the spaces after each pre-coded list of responses. This involved a considerable investment of time but the advantages of this approach were that the record was permanent and allowed sorting and re-sorting of the data.

Respondents made extensive use of the spaces in which additional details could be supplied to add categories to the pre-coded ones or in order further to expand upon their response. These open-ended commentaries provided a rich source of additional data but needed structuring. 'Write-in' responses appeared in separate WordPerfect files alongside the code number allocated to the returned questionnaire. A separate file was created for each set of 'write-in' responses, although some responses were moved to other files when it became apparent that the commentary related to a previous or subsequent question.

These responses served two purposes. First, respondents were able to give examples of experiences covered by the pre-coded responses. These are used in subsequent chapters to illustrate and illuminate the pre-coded categories. Secondly, consultants were able to supply additional responses where they felt that the pre-coded categories did not cover their experience. This gave them the opportunity to challenge the order imposed on their accounts by structured pre-coded responses. The files were perused several times with a view to the creation of new category codes. The new codes allocated to emergent categories were used to label new generic categories which would then appear alongside those contained in lists of pre-codes.

The third stage of analysis involved a 'straight dump' of frequencies for each question. These provided a valuable source of descriptive data. Frequency scores, percentages, means and standard deviations are used throughout forthcoming chapters in order to present key findings. Before data analysis began, certain guidelines were established for deciding what constituted rigorous and reliable analysis. In cases where proportions were being compared, a difference of more than five per cent was required before figures were considered worthy of further investigation or comment. This applied both to the complaint sample and the pure third. Care was also taken to achieve consistency in interpreting the data by using pre-set guidelines on frequencies deemed high enough for comment. For example, specialties containing fewer than 50 consultants, though of interest in building up a detailed pattern of consultant activity in one area, were not used to support generalised comments about the specialty.

Frequency distributions revealed much that was of interest but did not produce information on the relationships between variables(Blaxter *et al*, 1996). The fourth stage of data analysis was to explore the correlation between pairs of variables through the production of a series of cross-tabulations. These generated a number of inferences. This method of analysis made wide use of proportions, percentages, dispersion of ranges and plotting of tendencies. It was a fairly exploratory process with cross-tabulations between all key variables initially prepared. These data were used to produce a series of commentaries which are discussed throughout subsequent chapters.

The development of a grounded theory

A key aim of the research was to attempt to understand how consultants attributed meaning to complaints and the act of complaining. In exploring these issues the research aimed to develop a theory which was grounded in the data (Strauss and Corbin, 1990; Glasser and Strauss, 1967). Grounded theory is the term coined by Glasser and Strauss (1965) to describe an iterative process involving the *generation* of theory through continual sampling and analysis of qualitative data gathered from real settings. Research which adopts this approach develops a theoretical formulation of the reality under investigation rather than consisting of a set of numbers or a group of loosely related themes (Strauss and Corbin, 1990). The theory emerged as a reaction to the perceived neglect of issues relating to qualitative methodology by academics. Glasser and Strauss (1965) were also concerned about the developing tendency for the process of collecting and analysing data to be sterilised by overly rigid methodological prescriptions.

This approach was chosen over others because of its potential for generating theory and its sensitivity to the interactive and interpretative nature of qualitative data and the narratives produced in conversation. Pidgeon *et al* (1996) claim that grounded theory is particularly well suited to the study of meanings and the social context in which they occur. Essentially, the approach leads to a model of analysis which is flexible, carried out in everyday contexts and has as its goal the construction of participants' symbolic worlds and social realities. Given the exploratory nature of the research and the lack of previous research in this area, the theory had many attractions and seemed to address the aims of this study.

As a result, the design of the study and the size and characteristics of the sample were influenced by grounded theory. The theory encourages the researcher to adopt a purposive sampling strategy as emerging theories are developed. Participants are selected on the basis of what they can reveal about emergent ideas or concepts identified during on-going data collection. A key characteristic of developing theory is the on-going nature of project design and data analysis. For this reason, data analysis was not viewed as a discrete activity which took place after all the data had been collected, but was continuous and informed changes made in the process of data collection.

In line with this approach project design was on-going and flexible. It was decided to include all consultants in the region in the sample for the postal questionnaire but resource constraints meant that a maximum of 50 interviews could be conducted. One hundred and seventy consultants offered themselves as interviewees on returned questionnaires and the initial approach adopted was to select a sample of these by reference to specialty, gender and workplace so that there was a representative spread across the region. As early interviews were completed, they were transcribed and studied. Attempts were made to identify categories, their properties, frequency and the context in which they occurred. In a number of cases, these revealed the emergence of issues at the instigation of the interviewees which had not been anticipated. As these seemed important to the subjects of research, it was decided to actively encourage their discussion in subsequent interviews. Examples of issues which fell into this category were the failure of complaints managers to adjudicate between the competing claims of doctors and patients, the failure of complainants to identify genuine problems with the standard of care and discussion of the ethical obligations which doctors felt they owed to patients in complaint handling. Thus, the design of the study did not evolve as a discrete stage of the project which pre-dated data collection. Design and analysis are much more accurately seen as symbiotic, with each constantly informing the other.

Interviews

Box 5.2: Core issues discussed at interviews with consultants

- the consultant's personal accounts and experience of complaints
- the impact of the complaint and their coping mechanisms
- their view of the cause of the complaint
- the handling of complaints and the relationship between medics and managers in the handling of complaints
- the extent to which complaints are discussed amongst the medical profession and whether news of complaints is transmitted through 'gossip' networks
- how representative they felt complaints are of adverse events or badly-managed care
- the features of medical specialisation which make it more or less likely that consultants will get complaints

Once the questionnaire data had been collected and a preliminary analysis undertaken, arrangements were set in place to begin the second stage of data collection. The aim had been for the design of this second phase to be influenced by responses to the postal survey. The latter influenced the interview phase in three particular ways. First, it suggested a greater intensity of emotion was experienced by consultants than had been anticipated. Secondly, the data suggested that the strength of emotional reaction was closely tied to consultants' assessments of whether the allegations were justified, with much stronger emotions likely when consultants felt they had a strong defence. Thirdly, images of complainants were invariably negative and abusive, suggesting that complaints caused a serious breakdown in the normal doctor-patient relationship; a shift from a paternalistic to antagonistic attitude by doctors. Finally, consultants made clear that they often felt threatened or insulted by managerial interference in complaint handling. In-depth interviews provided an excellent opportunity to explore these issues and the duration of such impacts further. Interviews with managers also allowed for these themes to be examined from another organisational perspective.

Interviews allowed for much more flexibility than the self-administered questionnaire used in the first part of the study. The approach to interviewing adopted was naturalistic in style. It is crucial to this method that the researcher does not direct the research participant by guiding or probing but allows the subject to talk as freely and spontaneously as possible. The approach was also influenced by the work that medical sociologists have undertaken on the production of narratives. These have been viewed as a prism through which to understand the subject's experiences of patients and their understanding of the world of illness (Fitzpatrick, 1984). Underpinning both of these styles was that theories generated would be grounded in such accounts.

Box 5.3: Core issues discussed at interviews with managers

- how complaints - in particular clinical complaints - were handled in the unit
- the manager's personal experience of complaint handling
- the role played by consultants in the handling of clinical complaints
- the incidence of conflict and co-operation between medics and managers in management of the response to complainants
- the numbers of complaints received and the percentage which were pursued to litigation or an Independent Professional Review examples of good and bad practice in the handling of complaints
- the impact of complaints on staff and the organisation

No interview can be totally unstructured but attempts were made to encourage an informal atmosphere and to model the interaction on a conversation. Viewed in this way, the interview is seen as a social event and as such had its own set of interactional rules (Holland and Ramazanoglu, 1994) such as 'turn-taking' (Wilson, 1994). A semi-structured *aide memoire* was developed over time which listed key issues to be discussed. These issues were memorised so that constant reference did not have to be made to a list in the interview. The issues covered are listed in Boxes 5.2 and 5.3. In many interviews respondents spontaneously addressed these issues without being prompted or asked.

An initial pilot study of five in-depth interviews with hospital consultants and five with managers was carried out to test the research instrument and some questions were modified before the rest of the interviews were undertaken. However, the process of modification and refinement carried on well into the data collection stage. This re-aligning of issues and sample is a common feature of studies which aim to ground theory in accounts.

Problems with this approach

The adoption of a naturalistic approach meant that many extraneous variables, which might change the information being collected, are uncontrolled. An example of this is that the interviews took place in the respondent's workplace. This had advantages as it meant that they were more likely to be seen as everyday and 'situational' events (Wilson, 1994). But, it also meant that interviewees could be interrupted. An additional constraint on the naturalistic approach was that the interviews were being undertaken with high status professionals. Sisson's (1970) work on the different responses given to the interviewer depending on whether they adopted a middle-class or working-class dress code, demeanour and accent, has demonstrated that status clearly does have an impact on the data collected. But, whilst several commentators have dealt with the issue of the power wielded by the researcher (see for instance Wilson 1994; Simkin, 1992), much less has been written about interviewing high status professional which I could use to help me reflect on the interview dynamics in this study. High-status interviewees, for instance, may be less concerned about the 'social desirability' of their responses in order to present themselves in a positive way since they are less likely to rely on others with lower social status to endow approval.

The issue of the high status of the interviewees required me to be particularly sensitive to the need to establish my credentials as a fellow professional in addition to establishing my credibility as a competent and interested researcher. Managers and consultants were much more likely to ask questions about official approval for the research and the uses that would be made of it than I had experienced in interviews in other related studies with patients (see, for example, Lloyd-Bostock and Mulcahy, 1994). Moreover, several of the hospital consultants asked me where I had received my own academic degrees and two made disparaging remarks about the fact that I was based at a new university at the time of the study.

Use of open-ended questions allowed respondents the maximum opportunity to elaborate on their problems and concerns. The issues were not raised in an invariant order and the phrasing of questions was altered according to the issues already touched upon by the respondent. Supplementary questions were put according to the replies received so that they did not appear to interfere with the flow of the conversation. Doctors and managers were informed that I had some issues that I wanted to discuss with them but that the main purpose of the interview was for them to identify the issues raised by patient complaints which they considered important. Interviewees were encouraged to raise alternative or tangential issues and stress was placed on hearing their interpretations of events. In this sense, the interviews were exploratory or 'free' (Wilson, 1994) although I was clearly aware that they were not as free as an everyday conversation since the discussion was being recorded and would be analysed for a final report to the Health Authority. But, in this way, it was hoped that research participants would have an input into the setting of the research agenda. This was particularly important in developing grounded theory but also because no previous interview-based studies had been undertaken in the subject area.

Responses were recorded in full for later analysis. The decision was made to try to record all the interviews but this could have caused problems. Whilst taping the interview meant that I could concentrate on asking questions and listening, engage in eye-to-eye contact and non-verbal communication, tape-recording could also have made respondents anxious and less likely to reveal confidential information (Blaxter *et al* 1996). Since doctors were being asked to describe episodes which had invariably caused distress to them, it was anticipated that this might affect the quality of the data. In order to test out the likelihood of this happening the first five interviews were conducted without a tape recorder, although contemporaneous notes were taken, and the next five were recorded. On reflection, the presence of a tape recorder appeared to have no impact on doctors' willingness to describe their experiences. On the whole, they appeared extremely open and anxious to talk at length. In each subsequent interview the doctor's permission was asked to record what was being said. A small tape dictating machine was used as this was not obtrusive[19]. The interviews lasted between 40 minutes and two hours and were transcribed by a secretary funded by the project grant.

About the sample

One hundred and seventy-eight (40%) consultants who responded to the postal questionnaire agreed to be interviewed. This provided a large pool of possible interviewees. An initial interview sample of 10 was selected on the basis of specialty (see Appendix 5), district (see Appendix 6), hospital and gender in order that the interviewees reflected a cross-section of practitioners across the region. Twenty-five additional interviews were conducted with a cross-section of specialists. I felt that by the end of 35 interviews 'saturation' point had been reached in terms of the generation and exploration of new ideas and explanatory categories. As a result, no further interviews were conducted.

In order further to explore the impact of complaints on doctors and impressions of the complaint handling process, I conducted 25 interviews across the region with managers identified as being responsible for the handling of complaints. Use was made of naturalistic interview techniques of the kind already discussed above. This generated a third dataset which allowed me to explore the presence of 'disconfirmatory evidence', that is, an account of complaints which conflicted with that of medics (Kelleher *et al.,* 1990). A letter was sent to all chief executives or unit general managers at the beginning of the project and interviews conducted with 25 managers identified by chief executives as being responsible for complaint handling. A wide range of managers were interviewed including chief executives, directors of quality assurance and directors of administrative services. These were drawn from units across the region.

Using grounded theory in the coding of qualitative data

A key component of developing grounded theory is creativity. The researcher is encouraged to break through assumptions and create new order out of the old (Strauss and Corbin, 1990). Despite the weight given to the flexibility of the process, two key exercises are essential to the approach: constant comparison and theoretical sampling. Constant comparison involves continual sifting and comparing of cases, categories and theoretical propositions, throughout the lifetime of the project. This exercise aims to sensitise the researcher to both similarities and differences. Emergent categories and theories developed during the data collection phase are then used to guide subsequent collection. The use of negative case analysis, whereby the researcher explores cases which do not appear to fit the emergent categories, serves to challenge initial assumptions. One implication of the adoption of this approach, which has already been alluded to is that the distinction between the data collection and analysis phases breaks down.

Grounded theorists do not approach data analysis with strong views about which theory will best 'fit' the data collected. Glasser and Strauss (1967) advocated the development of an open-ended indexing system whereby the researcher works through the data generating codes which refer to low-level concepts as well as abstract categories and themes. The researcher is encouraged to be as flexible and open as possible, the only requirement being that there should be a direct link between the data and the explanatory concepts generated. Several examples of categories that did not fit more abstract themes emerged in the research. It became clear after 10 interviews with doctors that the coping strategies of those working in specialties which received a large number of medical negligence claims were much more developed than those in other specialities and claims were seen as much less of a strain. In addition, women in high-status specialties did not make use of *medical networks* during the aftermath of a complaint. This caused me to reflect on these interviews and focus on the issues raised. In all subsequent interviews, consultants were asked about the different coping strategies brought into play in different specialties and more interviews than were originally anticipated were conducted with women and those from claims-averse specialties.

Ideas, even if they did not appear directly relevant to the research, were noted down in a research diary. Interview transcripts were all typed within two weeks of interviews occurring. They were read closely while data collection continued. Interviews became increasingly focused as themes emerged and ideas matured. Predictably, the process was time-consuming but continued until a saturation point of new ideas occurred (Pidgeon and Henwood, 1996).

The development of a grounded theory is not without its problems. Pidgeon *et al* (1996) argue that it ignores the tensions which arise from a simultaneous commitment to objectively reflecting the participants' accounts and perspectives and to recognition of the multiple perspectives and subjectivities inherent in symbolic interactionism and the researcher's interpretative work. Strauss and Corbin (1990) suggest that the balance between creativity and science can be encouraged by periodic distancing from the data, the maintenance of an attitude of scepticism, and by alternating between collecting and analysing data in order that the challenging of early assumptions is encouraged. But, critics have reacted to Glasser and Strauss' (1967) assumption that data is there to be 'discovered' and that researchers can directly access their participants' lived experiences. Another concern is what grounds grounded theory? As Feldman (1995) argues, 'The difficulty in interpreting qualitative data is not in learning how to create interpretations but in learning how to get away from pre-established interpretations.' (p64). Recent methodologists have attempted to resolve this problem by recognising that what appears to be the discovery or emergence of theory is in reality the result of a constant interplay between data and the researcher's experience and theoretical leanings (Pidgeon *et al*, 1996; Charmaz, 1990).

The review of literature presented in earlier chapters, as well as experience of the field being researched, undoubtedly encouraged the creation of certain types of categories which might emerge from the data. Particular attention was paid to the work undertaken on accounting and defence strategies by authors such as Allsop (1994), Lloyd-Bostock and Mulcahy (1994), Tedeschi and Reiss (1981), Scott and Lyman (1968) and Bucher and Strauss (1960-61). But the test of these approaches in developing a grounded theory came in trying to balance this with an open-minded approach, and combine rigour with exploration. As a first stage, patterns were looked for in the data as well as exceptions which might challenge such ordering. This constituted the 'open coding' stage during which the text is broken down into information units (or 'data bits') such as events, ideas, explanations, process description and examples of identity-building work. There was a constant reconsideration of such embryonic categories and sub-categories and comparison of what was classified in each. In line with the advice offered by Strauss and Corbin (1990), questions of 'who', 'when', 'what', 'how', 'how much' and 'why' were posed in order to avoid standard ways of thinking about categories and to avoid the mere reflection of categories suggested by research subjects. The 'flip-flop' technique was also used during which opposite categories were also imagined. These techniques helped better to define the key characteristics of the categories.

Attention was also given in later analysis to the advice of 'dimensional analysts' who pose much broader questions at the initial stages of data collection. Rather than attempting to address the question of what is the basic social process that underlies the phenomena being considered, they suggest that a more open-ended inquiry - such as 'What is involved here? - will encourage the expansion of conceptual possibilities.

Labels were created for emergent categories and recorded in a project diary and in the margins of transcripts. These were reviewed on a number of occasions and a number of interviews replayed on tape. Unmarked copies of transcripts were produced and marked up with labels (using letters, numbers and colour coding). A number of examples of dominant labels are given in the storyline developed in Box 5.4. The labels reflected descriptive categories, abstract accounts; and theoretical reference points.

Table 5.2: To show one example of linked categories*

Causal condition	Phenomenon	Context	Intervening conditions	Action/ inaction	Consequences
Criticism	Anger	Justified? Received direct?	Lack of funding Other doctor involved	Less time spent with patients Referral to colleagues	Low morale Less efficient treatment

*After Strauss and Corbin (1990)

Attention was also paid to the context in which each category was embedded and the consequences of what was discussed. In this way, the categories become linked in what Strauss and Corbin (1990) have called a paradigm model. Table 5.2 gives one example of how this paradigm was used in the case of one emergent category.

Box 5.4: The storyline

In talking about complaints made about them, consultants focused on the various ways in which they had been *wrongly* held responsible for what had occurred. They were especially concerned that poor communication between doctors and patients, rather than poor care, often prompted grievances. In many instances, they considered complaints unjustified because there had not been a *technical failure*. At the same time, *external* constraints on their ability to perform well were identified, such as lack of resources.

Complaints cause *emotional pain* to them which could be long lasting. Consultants often discussed the complaint with others bur rarely went outside medical networks to do this as they felt that only a fellow medic would understand their particular concerns. Managers were seen as unsupportive and as being unduly driven by concerns about complainant satisfaction rather than establishing the rights and wrongs of the case.

Consultants explained how complaints caused them to question their abilities, knowledge and standing. In coming to terms with the complaints, their accounts reflected a need to assert, maintain and protect their professional identity and sense of self. This involved them highlighting their skills as an expert who knew things that complainants could not. Complaints were not seen as instances of legitimate expressions of concern which needed to be taken seriously, but rather as manifestations of the illness being experienced. In re-establishing their professional identity, they emphasised the distinctions between their rational selves and sick complainants. Their narratives presented them as competent, knowledgeable and reasonable.

When this process was complete the task of identifying main storylines was undertaken. The construction of a storyline is encouraged by grounded theorists as a way of identifying a dominant account of experience which emerges from data. The technique reflects the commitment of grounded theories to naturalistic and discovery-based methodology. A storyline is produced which reflects common ways of explaining phenomena. It facilitates the identification of data which fit and data which do not fit with the theoretical paradigm being constructed. The storyline developed for this study appears in Box 5.4. It can be seen from this that, in this research, two main themes emerged: the threat to identity posed by complaints and the medicalisation of the complaining act.

Validation

Once the main themes of the storyline were identified these were validated during a drawn-out process by which all the data was revisited in order to test whether these themes really did dominate the interview data. Labels and storylines were discussed in meetings of the project advisory committee and three conference presentations given to medics during the course of the research. These were used as a 'credibility check' on preliminary analysis of dominant themes. This process of fine-tuning of the themes was time-consuming and generated a significant number of sub-categories which constantly moved in and out of major categories Once the labelling process was completed, data assigned to the same categories were compared (Strauss and Corbin, 1990). Analysis proceeded from data collection to outcomes in a slow and loosely linear way.

A final report to the regional health authority was prepared around the themes suggested by the data. The writing up of the data involved an attempt to integrate emerging categories by presenting groups of related concepts (Pidgeon and Henwood, 1996). The transcripts were trawled for striking examples of categories used and quotations lifted in order better to illustrate both typical and untypical responses. The latter were often used in order to demonstrate other possible understandings of the data than those which emerged in dominant categories. A certain amount of counting of instances within categories was implicit in the text which was written using terms such as 'strong', 'dominant', 'the majority' to denote the strength of a category.

Conclusion

This chapter has outlined the various methodological concerns underlying data collection and analysis. It has described the origins of the project and the ethical dilemmas posed by it. The rationale for adoption of a multi method approach has been explained, as well as the choice of the various methods. It is clear from this that the data were framed by a grounded approach to collection and analysis. This methodological approach was deemed most appropriate in a study which had an exploratory dimension. It was felt that the production and analysis of naturalistic narrative was the most appropriate way to unravel the issues to which doctors give priority in their discussion of complaints.

The purpose of the chapter has been to provide a link between the aims of the study and the empirical investigation undertaken. It has sought to assure readers that data collection and analysis has been reflexive and rigorous. The four chapters which follow these describe the data collected and present an analysis of it.

Notes

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1 Since the time the research was conducted, the Oxford Region has been merged with the former Anglia Region.

2.The research funding covered the cost of salaries, travel costs, and the printing of the questionnaire. The author undertook the work on behalf of the health authority and was assisted for nine months in the mailing out of questionnaires, inputting of data and generation of statistics by a research fellow, Marie Selwood. This researcher worked under the guidance of the author at all times. The project was conducted over a two-year period from February 1993 to March 1954. During this period, the author was employed as a senior research fellow at the Social Science Research Centre at South Bank University.

3. They were the assistant to the Regional Director of Public Health, a retired GP, the Region's Litigation Co-ordinator, a senior hospital consultant and a retired Unit General Manager.

4. Nonetheless it did involve NHS premises, as consultants were interviewed in their workplace and this is

sometimes cited as a reason why projects should be given ethical approval.

5. This code is largely based on that devised by the British Sociological Association. During the process of re-interpreting the data in this report, reference has also been made to the guidelines produced by the University of North London's ethics committee.

6. See questions 1,2,3,4,33,34,35.

7. A list of the pre-codes is contained in the questionnaire which appears at Appendix 2.

8. See questions 28, 28a and 29.

9. See questions 5, 6, 7, 7a, and 7b.

10. See questions 32, 32a, 32b.

11. See questions 8, 21, 21a, 22, 22a, 23, and 23a.

12. See question 9.

13. See questions 11,12, 13,14,15.

14. See question 16.

15. See questions 17 and 18.

16. See questions 19 and 20.

17. See questions 24, 24a, 25, 26, 27, 30, and 31.

18. A direct comparison cannot be made between the percentages in the sample and national and regional figures. First, in addition to the mail-out to all the consultants identified by Region (848 including the pilot study), a poster campaign was undertaken to attract, amongst others, recently appointed consultants who may not have appeared on the master list. Second, some consultants named two specialties and others named three or even four. National and regional percentages – which are compiled using first specialty only – are presented in this figure (where available) as a general guide to the representativeness of the sample and in order to include all the information available to me when analysing this material. It is hoped that this table (in conjunction with Appendix 6c) will give some indication of the complexity of this area, but also assist in building up a detailed picture of the spread of specialisation within Oxford Region – as defined by the consultants themselves.

19. In addition to taping the interview, brief contemporaneous notes were taken in case the tape recorder failed and impressions of the interview were made in the form of field notes immediately after the interview had been completed.

6

The nature of the threat posed by complaints

> 'Grown-ups love figures. When you tell them that you have made a new friend, they never ask you any questions about essential matters. They never say to you, "What does his voice sound like? What games does he love best? Does he collect butterflies?" Instead they demand, "How old is he? How many brothers has he? How much does he weigh? How much money does his father make?" Only from these figures do they think they have learned anything about him.' (Saint-Exupery from Oakley, 1999, p154)

Introduction

Previous chapters have reviewed the theoretical issues which framed this empirical study. The next four chapters describe the data collected and explore the ways in which these data contribute to our understanding of complaints. This chapter provides some baseline data about the number of complaints received by consultants in the sample and the extent to which they become the subject of appeals or litigation. It goes on to consider the characteristics of complaints and the allegations they contain. It is shown that one way in which doctors come to understand complaints is to embed them within a description of the working conditions of specialities in which they occur. What begins to emerge is a technical and bio-medical critique of the cause of this 'malaise'. Particular attention is paid to allegations of poor communication and it is argued that these are better understood as a reflection of the difficulties inherent in doctor-patient discourse than as a collection of discrete episodes.

It becomes apparent in the course of the chapter that the challenges of complaints go beyond the particular allegations made to a threat to the symbolic and ceremonial order of doctor-patient consultations. The data suggest a number of ways in which complaints are seen to pose a threat to clinical autonomy at service level. Images of an impending crisis were not uncommon. In part, this is blamed on a policy environment which encouraged criticism of doctors. The data also reveal much about how law and procedural formality is viewed by consultants who were anxious to avoid the escalation of complaints. The notion of crisis was also encouraged by the fact that, as was predicted in earlier chapters, complaints and legal claims were often viewed as synonymous and the threat of litigation clearly cast a shadow over complaint handling.

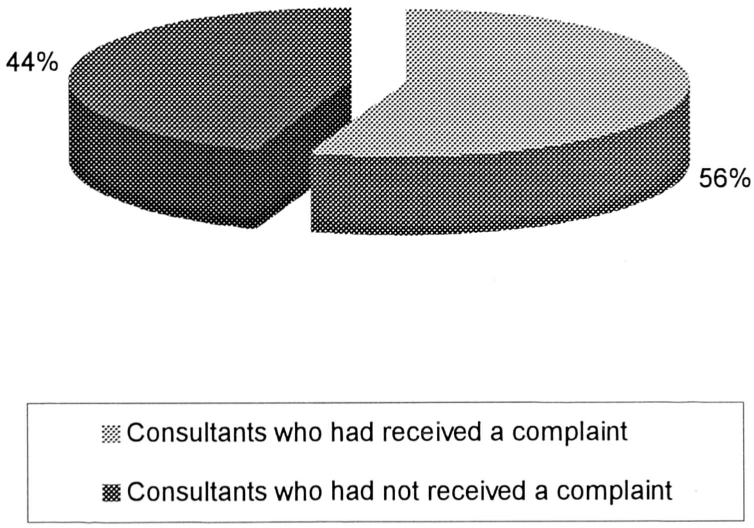
Increases in the rates of complaints and experience of complaints amongst the sample

The data collected for this study clearly demonstrate that over the last three decades the number of formal complaints about doctors has been increasing nationally and that complaints in the Oxford region increased at a rate above the national average. For instance, while nationally complaints barely doubled in the nine years up to 1991, complaints in the Oxford Region increased by two and a half times in the same nine-year period. Another feature of the regional statistics is that the proportion of all complaints which were clinical was consistently lower in Oxford than across England and Wales. Clinical complaints in the region averaged out at 37 per cent of all complaints received whilst the national average was 41 per cent for the same period. Oxford was also amongst the four regions that received the fewest clinical complaints in the country in the period 1987-91.

The majority of consultants in the postal survey conducted for this project had experience of a formal clinical complaints. Of the 443 consultants in the sample, 246 (56%) had received at least one formal complaint in the course of their professional career[1] (see Figure 6.1). For those consultants who had been the subject of a formal clinical complaint, the number received ranged from 1 to 31, but most consultants had experience of either one (33%) or two (21%)[2].

Because of the potential for problems of faulty recall over long periods, consultants in the postal survey were also asked how many complaints they had received in the last 12 months. The Medical Protection Society has suggested that 2.5 per cent of its membership have a claim or complaint against them in any one year although this figure only relates to those complaints considered serious enough to warrant seeking legal advice (Ennis and Vincent, 1994). In this study a much greater proportion (52%) of consultants from the complaints sample reported having received a complaint within the previous year with a total of 204 complaints were received by 127 doctors in the sample during this period. Thus, the data provided by recipients of complaints suggest that the number of written complaints processed both through the formal system and by consultants far outstrips the proportion of complaints known to defence societies.

Figure 6.1: Recipients of complaints



The majority of consultants expressed concerns about the increase in complaints and the threat they posed to clinical autonomy. They were particularly concerned that the Citizens' Charter initiative had encouraged patients to complain. The following quotation from a consultant neurologist was typical:

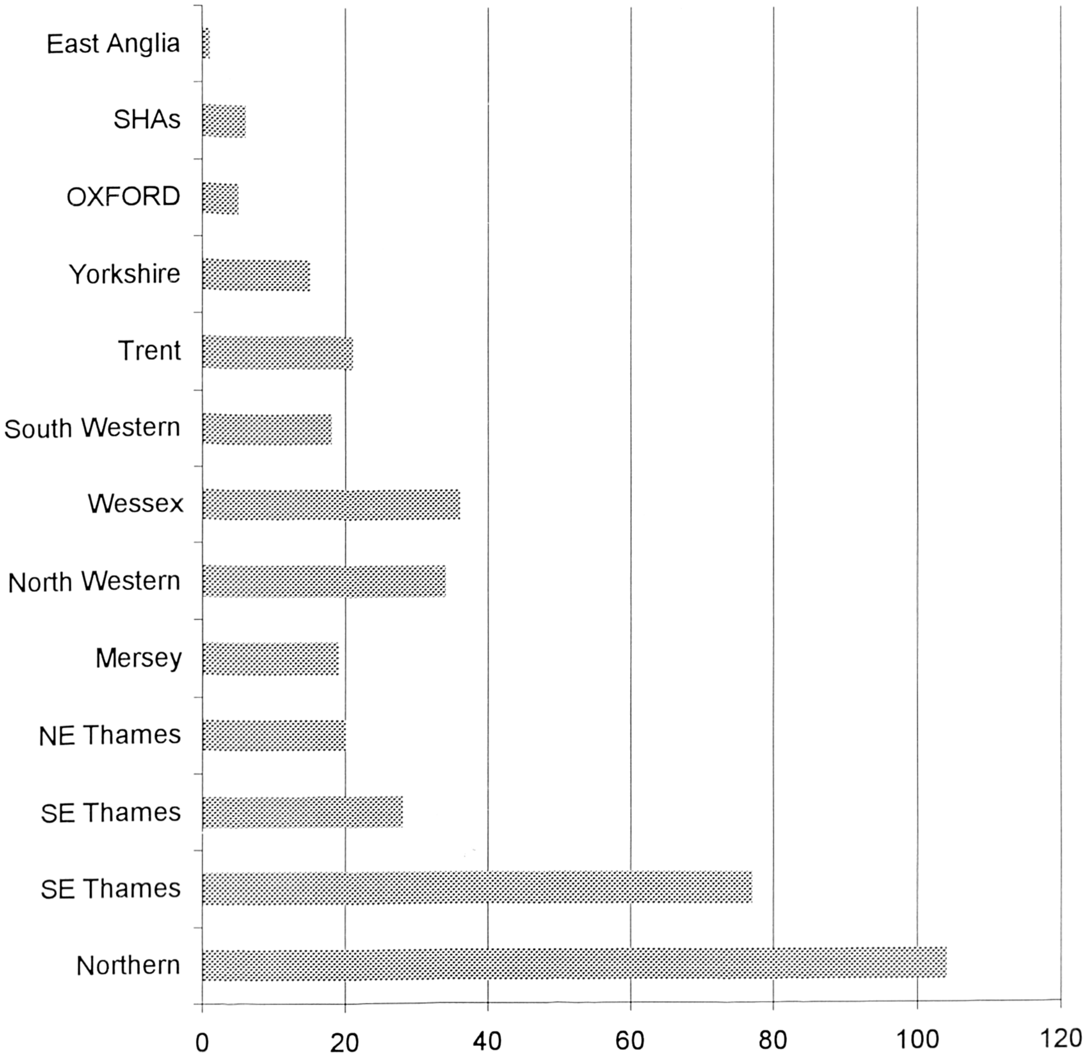
> 'We are just under more and more pressure from patients and what really gets to me is that patients are being told to complain. It's all got out of proportion. The number of complaints has rocketed as has the amount of time we spend on them ... everybody is using up their time on them.' (D24)

The image of an impending crisis was not uncommon. Another consultant said:

> 'It's a bit of a joke really. We get less money, patients get tetchy, increasingly they complain. I don't understand why they direct it at us. It's getting out of hand.' (D22)

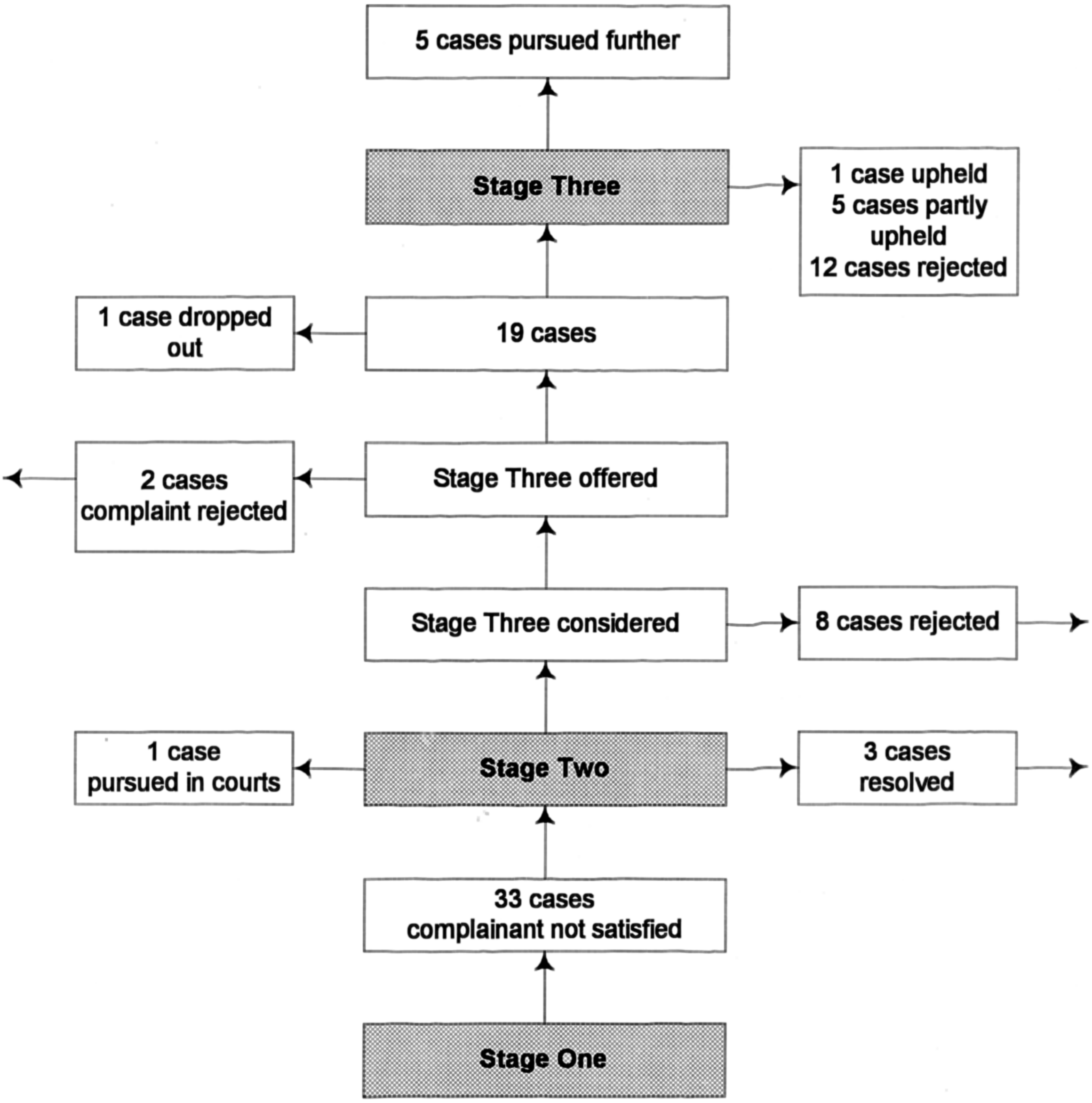
Despite fears of increasing numbers of complaints few complaints are pursued beyond stage one of the procedure into a more public and visible arena. The number of complaints that reached Stages II and III of the complaints procedure represented a tiny percentage of formal clinical complaints in the region. In 1991, for example, 0.4 per cent of clinical complaints proceeded to an independent review (Stage III of the procedure). Moreover, in the period from 1987-91, the region consistently had fewer clinical complaints going to Stage III of the clinical complaints procedure than any other Regional Health Authority in England apart from East Anglia. Figure 6.2 shows the distribution of referrals to Stage III across the country.

Figure 6.2: The number of Stage III cases by RHA 1987-1991



The statistics shown in Figure 6.2 suggest that the operation of Stage III of the procedure is very different in Oxford from the majority of other regions. It can be seen that this is especially the case when the region is compared with the Northern or South West Thames Regions. Figure 6.2 reveals that during the same period (1987-91), just five clinical complaints were referred to a Stage III review in Oxford. This compares with the 72 clinical complaints referred in the Northern Region and a nationwide average of 7.4 referrals.

Figure 6.3: The progress of cases pursued beyond Stage I of the procedure



In order further to explore the reasons for so few clinical complaints progressing to appeal in Oxford, a review of regional case summaries for cases going beyond Stage I of the procedure was undertaken. Thirty-three summaries dealt with cases from 1983 to 1993 and their progress through the system. Figure 6.3 shows how the cases progressed. The reasons given on case files for rejection of applications for a Stage III review were not always helpful in illuminating how the Regional Medical Officer's discretion to hold a review panel had been exercised. Three cases were rejected because they were 'not substantial'; a further three because sufficient attention had already been paid to the case; and two because opportunities for clinical explanations had already been offered through the district health authority involved. Of the 19 cases in which Independent Professional Reviews took place, only one complaint was completely upheld. Of the other 17 where the result was known, five were partly upheld and 12 were rejected (see Figure 6.3).

It became apparent during the course of the research that considerable efforts were put into avoiding Stage III reviews by doctors. During interviews with managers, it was suggested that referrals to Stage III had been actively discouraged by a former regional medical officer[3]. More recently, the launch of a pilot scheme for dealing with Stage II complaints by the regional medical officer meant that alternative methods of resolving the disputes were being experimented with. This new scheme came about as a result of a number of concerns on the part of the regional medical officer. In an interview, he put forward three reasons for the change. Firstly, he felt that the emotional and financial cost of pursuing a complaint to this stage were extraordinarily high and that satisfaction was rarely achieved by the parties to the dispute. Secondly, Stage III reviews were seen as daunting for all concerned and were much more like a tribunal hearing than the clinical consultation anticipated by the guidance. Finally, he was worried that the region had no discretion to pay out *ex gratia* payments under the formal system when this might well be the most appropriate remedy.

Although the present study did not focus on the appeals procedure, many of these concerns were reflected in interviews with consultants who had experience of a Stage III review (9). Some who had acted as assessors were concerned that the exercise took them out of role and that there was a tension between the notion of clinical and 'judicial' review:

> 'I have acted as an independent assessor on three IPRs. I felt a little like a judge. I was being one really, it was very tricky. The procedure may be an appropriate one when people feel that they haven't been heard, but I felt very awkward pronouncing judgement on a colleague while pretending to be conducting a consultation.' (D34)

There was also a recognition that by the time the complaint had reached Stage III of the procedure there had already been much delay and that this had caused positions to become entrenched. As one senior consultant explained:

> 'I helped manage a third stage review and was commended by the regional medical officer for my part in it, but I didn't feel that I deserved the praise. The complaint had taken two years to get that far. Two years! I felt that all along the way I had been encouraged to tell half-truths in order to protect the hospital.' (D16)

These concerns reflect a number of motives for avoiding the use of the appeals procedure some of which relate to its inability to satisfy complainants but more commonly a feeling that clinicians were being compromised by the procedure and placed in a position in which their natural affinities which incline them to protect colleagues and be honest, were placed under strain.

The pilot scheme, introduced by the regional medical office to avoid use of Stage III of the procedure, involved the appointment of a retired consultant psychiatrist to mediate between the parties to a dispute where a request for a Stage III review had been made. The 'mediator' visited the complainants in their homes in order to clarify their concerns and identify their needs. This was followed by a meeting between the complainant and the doctor being criticised or the commissioning of an independent report into the allegations being made. At the time of the study, 10 complaints had been handled in this way and the regional medical officer considered the scheme to be a great success. In interview, the mediator argued that the response of doctors had been much more open than in more formal settings and they had been willing to co-operate in this informal procedure.

The shadow of legal claims

It has already been argued (see Chapter Five) that consultants tended to confuse complaints and legal claims and that complaints were often discussed in the context of them having the potential to evolve into claims. Concern about legal claims has been shown to have a detrimental effect on complaints handling and the suggestion has been made that it leads to defensive attitudes (see Chapter Four). Many of the doctors surveyed and interviewed talked about the relationship of complaints to legal claims and the danger of complaints escalating in this way.

A large portion of doctors in the study had direct experience of a medical negligence claim being brought against them. Of the 246 consultants who had received complaints in our sample, exactly a third (33%) had also been the subject of medical negligence actions. Some had been the subject of more than one negligence action in their career, the average number being 1.5 cases. Of these claims, nearly half (46%) had originated as a clinical complaint. These data confirm the findings of an independent study of medical negligence claims in the region which reported shortly after this research began (Merrett Health Risk Management, 1992). The study looked at all recently closed medical negligence claims in the region and found that a large proportion of claims began their life as complaints. It was asserted in that review that many cases reviewed only became claims of negligence because of the inadequacy of health authority staff in the initial handling of the complaint.

Despite these data the number of complaints received by the NHS far outweighs the number of medical negligence claims made. While almost a third of doctors in the survey had experience of a legal claim, a much smaller proportion of complaints received by them had become claims. Put in this context, the spectre of legal claims seems less threatening. Of all the 929 complaints made about consultants during the 12 months prior to the study, only 57 (6%) became claims. In interviews, a number of consultants confirmed the view that complaints and claims were largely separate activities. As one consultant explained:

> 'Some people just want to complain to let off steam. Others might have their cases mishandled and go on to litigation. Some see a claim as a way of getting money. But the majority just want to complain and will go away if the complaint is well-handled.' (D4)

But, whatever the reality, the fear of what might happen if a complaint is taken further is very real. As one consultant made clear:

> 'The situation is getting worse since the Medical Records Act because we don't always know what is going on. A patient can request their records and just go to a solicitor and formulate a statement of claim there and then. It's actually causing an increasing amount of distress amongst clinicians.' (D22)

A number of doctors identified how their responses to complaints which were potentially litigious were affected by such concerns:

> 'Of course, we worry. We worry all the time. And it is there every time you formulate your response to complainants. Whilst wanting to deal sensitively with a sensitive topic, you have to make sure you are not admitting anything or encouraging them to pursue.' (D27)

And in another case a respondent hinted at how other medics may be called upon to support a doctor who is criticised:

> 'We are perhaps a bit cold in the way we respond because we are concerned about litigation. I think there is also a defensive mechanism in the clinical team because they tend to collaborate on what is said.' (D19)

Whilst the assertion that most complaints do not become legal claims is supported in principle, it still does not ease the fear of litigation. As one doctor made clear:

> 'There is a bearded man who works for a "victims" group who goes to a lot of conferences telling us we should all be a lot more open because all people want is an explanation. I believed him. I dealt with one complaint openly and frankly. The patient even said they were satisfied. It wasn't my fault. A few months later, they sued.' (D9)

These data suggest that it is not just the incidence of complaints which threatens doctors but their capacity to render criticism more visible. The potential for complaints to evolve into legal claims overshadows complaint handling and fuels the construction of complaints as a problem. They support Dingwall's (1994) claim that doctors view law as a constraint on clinical autonomy, something that prevents the profession from doing a variety of things it would otherwise do and rejects a vision of regulation as a 'creative force, constitutive of social and economic orders in which medical practice occurs' (p47).

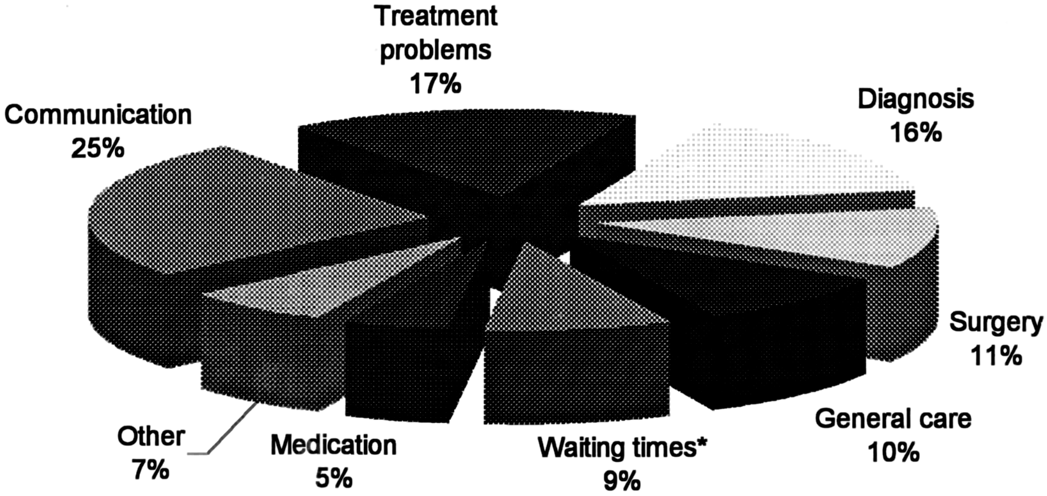
Types of allegations made in complaints

This study suggests that the threat posed by complaints may also be linked to the type of allegations contained in them. Discussion of the nature of the threat posed by particular allegations has been difficult in the past. The Department of Health (DoH) has never collected comprehensive data on allegations. Statistics on complaints which have traditionally been available have made a simple distinction between those which are wholly clinical, those which are partly clinical and those which have no clinical element. Returns to the DoH[4] show that in the period 1992-1993, 39 per cent of complaints received by NHS trusts and directly managed units in Oxford Region were either wholly or partly clinical[5]. As was made clear in Chapter Two, the classification of complaints as clinical or non-clinical is potentially important in determining the extent to which the medical profession maintains control over the complaints procedure.

This project concentrated on clinical complaints. Consultants in this study were asked to give an indication of the type of allegations made in the clinical complaints they had received. Since there may have been more than one allegation per complaint, or more than one complaint per consultant, it was not anticipated that the number of allegations made would equal the number of complaints or the number of consultants. In fact, respondents did not give details of all allegations and there were more complaints (929) than allegations specified (767). Where data on complaints and allegations were present, complaints contained an average of 1.9 allegations.

Allegation code categories were pre-coded using a coding framework developed in the Harvard Medical Practice Study (Brennan *et al*, 1991) and further developed in a study of complaints by Mulcahy and Lloyd-Bostock (1994). A number of examples of what might fall into each of these were given on the questionnaire. Consultants could make their own decisions about which of the eight categories provided best described the allegations against them. They were also given the opportunity to specify complaints that were not covered by these definitions and these were analysed and coded separately - resulting in some of the original categories being expanded. Figure 6.4 shows the incidence of the different categories of allegation.

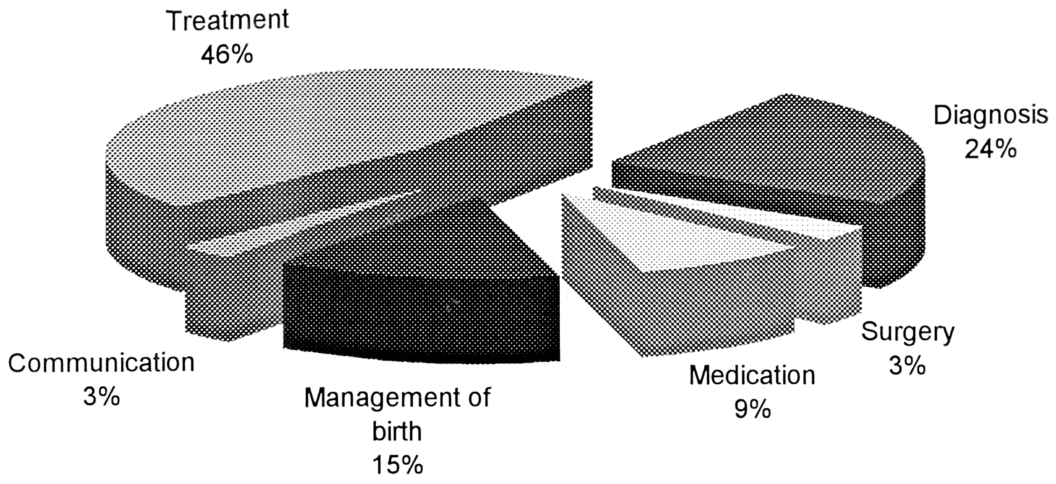
Figure 6.4: To show the incidence of types of allegations
(n = 814)



*Although forming less than 10 per cent of the total of all complaints covered by the larger survey, waiting time allegations prompted a number of comments from consultants - all of which suggested that they received so many complaints about this problem that the doctors had given up counting[6].

A rather different balance of allegations is apparent amongst those cases considered at Stage II of the procedure which involved a greater proportion relating to inappropriate treatment choices and a smaller proportion to communication and attitude problems. However, the numbers are much smaller. Figure 6.5 shows the main allegations made in the 33 complaints considered at Stages II and III of the procedure. Allegations ranged from unnecessary surgery through failures of diagnosis and inappropriate medication to bad treatment decisions. It can be seen from the table that bad treatment decisions and problems surrounding diagnosis figure particularly prominently.

Figure 6.5: To show allegations made in complaints that went to Stage II or III of the clinical complaints procedure in Oxford RHA (n = 814)



The only other detailed available data on allegations made in hospital complaints is that collected in a study of 399 hospital complaints files by Lloyd-Bostock and Mulcahy (1994) and the study used compatible allegation codes to those in the present project. A number of differences are apparent in the two datasets. Whilst the data collected from complainants yielded more allegations relating to communication and attitude (37%); general care of patient (12%); and waiting time (22%); there were fewer allegations which related to treatment problems (15%); tests and diagnosis (9%); and problems with surgery (2%). The differences may well reflect a tendency on the part of clinicians to concentrate on the technical aspects of complaints[7] while patients are more likely to emphasise experiential aspects of care. In the context of research about general practitioners, Allsop has also concluded:

> 'Generalising from this case study of 110 cases, an obvious point is that the parties to such disputes make their complaints from differing perspectives. They interpret what has occurred from the point of view of their own experiences, interests, knowledge and their ideas about their obligations and responsibilities for handling illness.' (Allsop, 1994)

In line with this argument there was a recognition amongst some respondents in the present study that their perception of allegations would differ from the complainant's account. As one consultant suggested: 'The nature of the complaint usually differs from the complainee's perspective, which in turn changes with time and experience.'

Box 6.1: Examples of communication allegations

- A patient's complaint that a consultant had been insensitive by recommending a general anaesthetic rather than an epidural for her caesarean section
- An elderly woman's complaint that a consultant had described her as 'older' in front of a nurse
- Concern that a consultant was rude in telling a patient that he had inappropriately attended A&E

The most common allegations

It is clear from Figure 6.4 that according to consultants there are three major groupings of criticism which account for 60 per cent of all allegations. These are communication and attitude, treatment problems and tests and diagnosis. Box 6.1 provides some examples of the sort of allegations which fell into the largest of these categories.

Issues surrounding communication and attitude, rather than aspects of clinical care or decision-making, form the most prominent cluster of allegations (26%). Why is communication a problem? It has been widely argued that doctors are under pressure to improve their relationships with patients and that effective training in communication skills exists but is only erratically implemented in medical schools (Ennis, 1999). Heavey (1988) has argued that what is required above all is recognition of its central importance in medical education at all levels. The fact that this is the largest group of allegations also suggests that it is a breakdown in doctor-patient dialogue which acts as a catalyst to the voicing of a complaint. One consultant suggested that when he heard that someone had been sued, he suspected it was because they had been rude and abrupt rather than because, or only because, they had made a mistake.

General clinical treatment problems form the basis of the second major category of allegations, and 32 per cent of the complaints sample had experience of these. This was the broadest category of allegation and encompassed all treatment problems other than surgery, medication, tests, diagnosis and the general care of the patient. Consultants provided many examples of allegations included in this category, such as a scar caused by a heat poultice following an extra-vascular infection; and seven failed attempts at a lumbar puncture. The third major grouping of allegations was tests and diagnosis. Complaints about these issues were experienced by 37 per cent of consultants in the sample. Examples of such allegations provided by consultants included a 'deluded' patient's belief that part of his brain had been removed by the KGB and that his consultant had failed to verify this by refusing to arrange a brain scan; a failure to arrange a second opinion; and inaccurate interpretation of test results.

Data from survey results and interviews suggests that allegations of incompetent technical care really distressed doctors. As one consultant argued:

> 'I dealt with one case where a patient was seriously ill. No one would touch the case, the care had been really messed up by a plastic surgeon. An SHO and I really pulled that patient out of the embers. We worked jolly hard and long after our normal hours. We were so pleased, we even presented the patient to meetings of clinicians. I couldn't believe it when we received a complaint about the care. The relatives complained that we had done an incompetent job and jeopardised the patient's chances of recovery. I was so much more upset than if I had been at fault. The whole team was upset, really demoralised.' (D18)

Such distress seems likely when a technical bio-model of good treatment is dominant within the profession. Significantly, other commentators have drawn attention to the fact that doctors assess their own competence according to the technical standards of bio-medicine rather than the more qualitative aspects of care, such as 'bedside manner' (Hughes, 1963). It has been argued that medical education tends to place emphasis on a dominant role model of the infallible and technically competent technician, what Leape (1999) has called the 'perfectability model'

The specialty factor

It is apparent from survey data that certain specialties are more likely to get complaints than others. By analysing data relating to how many complaints and allegations each specialty had received and the number of consultants in that specialty who had responded to the questionnaire, it was possible to arrive at a mean number of complaints and allegations for each specialty. These data are presented in the Table 6.1.

Table 6.1: To show the mean number of complaints and allegations received by consultants in different specialties during their careers

Specialty[8]	Mean number of complaints in career	Mean number of allegations in career
Obstetrics and gynaecology	4.5	4.5
Orthopaedics	8.1	4.5
General medicine	3.4	3.6
General surgery	5.1	2.5
Paediatrics	1.9	1.9
Mental illness	2.7	1.8
Geriatrics	2.1	1.7
Dermatology	2.4	1.7
Psychiatry	1.5	1.4
Anaesthetics	1.1	1.0
Haematology	0.8	0.8
Radiology	0.8	0.8
Histopathology	0.3	0.4
All consultants	**2.1**	**1.9**

These data need to be contextualised. In particular, it is important to balance them against data on the amount of activity within each of the specialties. Clearly, the risk of complaints is more accurately seen in the context of the number of complaints per patient episode. A finding that consultants in obstetrics and gynaecology receive more complaints than any other specialty, for instance, will be of little use if attention is not also drawn to the fact that obstetrics and gynaecology departments also see a high number of patients each year.

The task of comparing patient contacts with the number of complaints is not an easy one. Activity in hospitals is recorded in a number of different ways and for a variety of different purposes. When a patient first enters hospital they will be given a READ code which provides a narrative description of their condition from which a certain level of activity might be predicted. Thereafter they are categorised by an ICD code, a detailed diagnosis code which reflects the type of procedures undertaken. The only datasets which record the specific activity of consultants appears to be Finished Consultants Episodes (FCEs), Referral Attendances to consultants and Consultant Initiated Attendances. Since the data on complaints presented in this report is concerned only with consultants, I have used these three sets of figures as a broad indicator of the number of patients consultants in each specialty can be expected to come into contact with each year.

However, there are difficulties in using these figures as a yardstick against which to judge activity. Only one episode of any kind is recorded per patient treatment, so that in procedures where more than one consultant is concerned with the care, only one of them will have the FCE recorded. Thus, consultants who facilitate the making of decisions about diagnosis and treatment, such as laboratory-based specialties and haematology, are hardly represented at all. Moreover, one very large specialty, anaesthetics, appears extremely under-represented.

Some of these difficulties can be overcome. By using generic categories of specialties, it is more probable that teams of consultant activity will be reflected across discrete specialities. For instance, by using the category 'surgical', the work of anaesthetists is captured in the figures. Also, particular emphasis can be placed on comparing levels of activities with complaints in those specialties where these data are more reliable indicators of patient contacts. These methods, though crude, do at least provide us with a way of contextualising the data on complaints presented above.

Whilst equal weight cannot be given to all the findings outlined, it is clear from the data on consultant activity by specialty (see Table 6.2) that certain features of the four specialties with the lowest number of patient contacts per complaint are shared. Psychiatry, mental illness and geriatrics are all low-status specialties where relatives and carers are closely involved in treatment and care. Moreover, interviewees suggested that complaints in these areas may involve feelings of guilt on the part of the carers. Perhaps most notably, consultants specialising in these fields have little power to cure, but rather are involved in the process of relieving conditions.

Table 6.2: To show consultant activity and specialty by complaints in the sample[9]

Specialty	No. complaints	% Complaints (n = 204)	Activity	% Activity (n = 2108059)	No. patient contacts per complaint
General medicine	34	16.7	207501	9.8	6103
Orthopaedics	25	12.2	23140	11.0	926
Paediatrics	17	8.3	106217	5.0	6248
Psychiatry	19	9.3	19509	0.9	1027
Obs & gynae	15	7.3	281089	13.3	18739
Mental illness	13	6.4	61025	2.9	4694
General surgery	11	5.4	206231	9.8	18748
Dermatology	8	3.9	79528	3.8	9941
Geriatrics	6	2.9	29530	1.4	4922
Haematology	2	1.0	56928	2.8	48464

Conversely, specialists in obstetrics and gynaecology, general surgery and haematology have the highest number of patient contacts per complaint. Data presented later suggest that one reason why general surgeons and haematologists did not receive large numbers of complaints is that, despite a high patient throughput, verbal interactions with patient in these specialties is increasingly limited.. The fact that obstetricians, gynaecologists and general surgeons were within this group is fascinating, given that they are amongst the consultants most likely to have a legal claim made against them. A possible explanation is that the consequences of error are so great that dissatisfied patients are much more likely to pursue their grievance in law. This explanation has also been put forward in relation to anaesthetics.

Consultants interviewed suggested that other features of specialty and the type of care being received also had a more general impact on the propensity to complain. They made clear the importance of various factors in understanding disputing dynamics, such as the type of care being received; the level of contact between the doctor and patient; the visibility of the doctor; and the public's comprehension and knowledge of particular medical procedures. According to these arguments, clinical specialty is a key variable in analysis. Each specialty has its own care characteristics, working practices, environment, equipment, connections with other services and deals with distinctive clinical problems and needs which impact on the possibility of disputes arising.

It is also apparent that certain specialties are more likely than others to attract particular types of allegation and these data aid further analysis of this phenomenon. Figure 6.6 shows the distribution of complaints according to the three main categories of allegation outlined above.

Figure 6.6: The correlation between the most popular allegations and specialty

Communication and attitude	Treatment problems	Tests and diagnosis
HIGH	**HIGH**	**HIGH**
Dermatology (50%)[10]	Anaesthetics (34%)	Radiology (50%)
Orthopaedics (44%)	General medicine (30%)	Histopathology (40%)
General surgery (40%)	Psychiatry (30%)	Paediatrics (31%)
Radiology (36%)	Geriatrics (26%)	Haematology (25%)
Haematology (33%)	Mental illness (23%)	General medicine (22%)
Obs & gynae (28%)	Paediatrics (23%)	Psychiatry (18%)
Sample as a whole 26%	**Sample as a whole 18%**	**Sample as a whole 16%**
Paediatrics (25%)	Dermatology (15%)	Mental illness (14%)
Anaesthetics (25%)	Obs & gynae (15%)	Anaesthetics (13%)
Geriatrics (21%)	Haematology (8%)	Dermatology (8%)
Histopathology (20%)	Orthopaedics (4%)	Obs & gynae (7%)
Psychiatry (16%)	General surgery (3%)	Orthopaedics (7%)
Mental illness (14%)		Geriatrics (5%)
General medicine (14%)		General surgery (3%)
LOW	**LOW**	**LOW**

It might be predicted that some specialties were more likely to receive complaints relating to treatment problems than were others. In part this is because of the way in which the allegations were grouped. Surgical errors formed the basis of a distinct (treatment) category so it is to be expected that they do not feature prominently in complaints about treatment. Other data reflect the type of work undertaken by particular disciplines. Specialties such as histopathology and radiology which are involved in diagnosis rather than treatment did not receive a high level of allegations about treatment. Similarly, specialties such as radiology and histopathology which involve a strong diagnostic element, featured prominently in this cluster of allegations. Comparisons between specialty ranking in the three categories also suggests some interesting trends. Specialities such as general surgery and orthopaedics did not feature prominently in allegations about treatment problems, tests or diagnosis, but they do feature prominently in complaints about communication and attitude.

A handful of consultants argued that colleagues practising in what they labelled 'people specialties', such as psychotherapy, where communicating is an integral part of the treatment being provided, were much less likely to get a complaint because the patient's concerns would be fully explored as part of the process. This suggestion appears to be borne out by the data presented in Figure 6.6 as communication complaints do not feature prominently in mental illness and psychiatry although this might also be explained by the fact that patients in such specialities are less empowered than others. However an endocrinologist also suggested:

> 'My specialty prompts very few complaints. It involves long-term care plans. It is both fascinating and necessary to get patients involved from the start in drawing up a care plan and setting objectives. As a result, patients have a high level of understanding, despite the fact that many of the concepts involved are hard to explain. I believe that we do not get complaints because we are in a position to share information.' (D5)

The particular problem of communication

Communication allegations stood out in the study as being deserving of particular attention. Firstly, as has been suggested above, they figure prominently in complaints about consultants and appear to act as a catalyst for the voicing of a grievance. Secondly, a large number of consultants had experience of them. It was found that although 26 per cent of allegations related to communication and attitude, more than half the consultants in the sample (52%) had experience of such allegations. Thus, it seems that there were not clusters of consultants receiving all the complaints with a communication element, but that it is seen as a general problem by service-users.

How did consultants talk about communication allegations? A number of consultants in the study externalised blame for the problem by arguing that clinicians are perfectly able to communicate effectively if they should so wish but that circumstances and work conditions prevent them. One surgeon commented:

> 'Communicating well is an expensive luxury. I have never yet had a complaint from one of my private patients because in private practice I have the time to handle all aspects of a case. You can see a complaint coming, so you make a mental note and go the full distance in sorting their dissatisfaction out.' (D33)

It was also argued that consultants are well able to communicate effectively in their NHS practice should the occasion arise:

> 'When you know that something has gone wrong, that's when you pull out all the stops and over-compensate by listening to the patient and making them feel that you really care. When you have a potential lawsuit, good communication may be the only way to protect yourself.' (D16)

In another case a surgeon suggested:

> 'You can best guess a lot of complaints in the National Health Service. You see them on the brew. You spot a loss of empathy. If you notice it brewing you can try and shoot it in the foot by offering a second opinion.' (D8

Other interviewees focused on what complaints revealed, or failed to reveal, about technical expertise. For this group, technical failure was the only justification for holding doctors to account. They were frustrated because, in their view, the use of good communication skills could actually hide the provision of poor care. For them, this reflected the injustice of judging doctors by this standard rather than more technical aspects of clinical competence. This viewpoint assumes reliance on a bio-medical model of competence rather than a holistic one but was popular amongst consultants. As one consultant explained: 'The problem is that someone with a lovely caring manner who is able to fight off complaints may well be the one leaving the forceps in.' (D12)

Others viewed the problem from a different perspective and took the high incidence of communication complaints as a deeper and more serious malaise. Almost half the interviewees expressed concerns about what communication issues said about the current state of the doctor patient relationship and the various ways in which it had moved from the professional ideal. Again these explanations serve the purpose of externalising responsibility for grievances. One consultant argued:

> 'People look at systems which are their specialty but medicine is an art. We have lost our basic skill; our ability to communicate. We have no choice - GPs are rushed, consultants are rushed. Patients are treated as a body, a disease. It's all about technique these days. It may be because it is a free system - a conveyor belt. It makes us scientific but we lose our humanity.' (D9)

A more sociologically-orientated explanation of these data might suggest that the high incidence of complaints relating to communication does not necessarily result from inattentiveness or insensitivity but from a more fundamental disagreement about the nature of illness. Williams and Popay (1994) argue that the differences between the ways in which medicine and everyday thinking represent matters of health and illness have been well documented in recent years. They suggest that this body of work has clearly demonstrated that lay beliefs about illness are often quite distinctive in form and content from those given by doctors. It has been argued that rather than representing a shared reality between doctor and patient, illness represents two distinct realities.

In a similar vein, Toombs, (1992) has argued that there is a systematic distortion of meaning in the doctor-patient relationship resulting largely from the fact that illness is experienced in significantly different ways by each party. This makes it particularly difficult for the parties to construct a world of shared meaning. In her words:

> 'The physician is trained to perceive illness essentially as a collection of physical signs and symptoms which define a particular disease state. He or she thematizes the illness as being a particular case of "multiple sclerosis", "diabetes", "peptic ulcer", and so forth. The patient, however, focuses on a different "reality". One does not "see" one's own illness primarily as a disease process. Rather one experiences it essentially in terms of its effects upon everyday life .'(p11)

Williams and Popay (1994) suggest that this lay challenge to medical knowledge is not an issue related to the aesthetics of discourse but is more accurately seen as a political challenge to the status of scientific knowledge and the power of those whom we are encouraged to trust with such knowledge.

Conclusion

This chapter has provided baseline data which will be referred to throughout the rest of this report. The data presented has demonstrated that complaints about clinical care are on the increase and that the majority of consultants have direct experience of having a complaint made against them. The data also confirm the importance of specialty as an organising concept. Complaints were not evenly distributed across specialties and when interpreted in conjunction with data on the number of patient episodes clearer patterns emerge. This suggests that complaints are best seen as situated within particular types of care and that the features of different specialties have an important role to play in the incidence and types of complaints received. In some cases, this is due to minimal patient contact, in others because the exploration of grievances is an integral part of treatment. In later chapters it is argued that, somewhat ironically, it is consultants who receive the most complaints who are better able to deal with them because they become the norm and therefore they are discussed more openly.

The number of complaints received by doctors was clearly a cause for concern amongst the sample. Such concerns were heightened by the fact that the spectre of complaints was often conflated with the spectre of claims and the additional risks to reputation and livelihood that the latter posed. Although a significant proportion of legal claims begin their life as clinical complaints, the data presented in this chapter have shown that the proportion of complaints that escalated to become claims or were pursued to the 'appeals' stage of the clinical complaints procedure remained very low. This suggests that concern about complaints expressed by doctors in the sample reflected unease at something other than the mere incidence or progression of complaints. The reality would appear to be that few doctors are publicly exposed by disputes with patient in court of law or subjected to scorn amongst colleagues because a complaint has been made about them. Instead, complaints appear to pose a serious challenge to medical work because of the risk that they might evolve into something else or because of the symbolic challenge they pose to the order of the medical world. Complaints implicitly challenge how issues have been constructed by doctors, they represent an alternative discourse which is alien.

These themes were particularly apparent when attention was paid to allegations about communication and attitude. Interactions between doctors and patients represent an interface between the worlds of expert and laity in which the order of the medical work is imposed on those who come to doctors for treatment. A complaint by a patient reflects a rejection of this view of the way in which knowledge is acquired. Seen in this way, communication is less accurately viewed as a temporary failure and more realistically seen as a questioning of the process. Complaints about communication are easily dismissed by doctors as a product of large scale provision of medical care. Yet it might also be argued that communication difficulties between patients and doctors reveal more fundamental problems which relate to the competing narratives they employ and medics continued reliance on a bio-medical models of care.

Notes

1. The average number of years since qualification as a doctor for consultants in our sample was 23. The average number of complaints received by all consultants who responded to the questionnaire was 2.1.
2. A total of 929 formal complaints were received by consultants in our sample, an average of 3.8 each.
3. This same officer was criticised by a Parliamentary Select Committee over her involvement in Stage III complaints.
4. However, doubt has been cast on the validity of statistics kept by the DoH as variations have been found in what is classified as clinical amongst units in the same region. A study by Mulcahy and Lloyd-Bostock (1994) suggests that when classified consistently the number of complaints which are wholly or partly clinical is nearer 34.0 per cent.
5. Source: *Written Complaints by or on Behalf of Patients*, 1992-3, DoH.
6. One consultant suggested that they should not even be classified as complaints since they were not caused by doctors: '... these are too numerous to even consider listing. They are a manifestation of an unsatisfactory system. I do not regard them as formal complaints against myself.' Similarly, another remarked: 'Waiting times generate telephone calls or letters requesting earlier treatment. I have not called these complaints, they are commonplace and do not reach the level of a "complaint".'
7. It is necessary to exercise some caution when comparing the data in this study with that collected from complaint files. As has been shown above, many of the complaints reported to us by clinicians have not been processed through the formal complaints system with the result that a hospital file on them would not be opened.
8. Responses were received from more than 10 consultants in all the specialties shown here.
9. Source: DoH. Figures are an amalgamation of Finished Consultant Episode, Outpatient Referrals and Consultant

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Initiated Attendances for Oxford Region, 1993-94.

10. I was concerned that data on some specialties would not yield reliable figures since the number of consultants representing them in the sample was low and their experience might be atypical. To allow for this, all those specialties which featured responses from at least 10 consultants were extracted - this being regarded as the smallest meaningful figure of use in comparing percentages. This method yielded 13 specialties about which it is possible to make more general comments. Of these, dermatology, general medicine, general surgery, mental illness, obstetrics and gynaecology and orthopaedics received more than the mean number of complaints (2.1), geriatrics received the average and anaesthetics, haematology, histopathology, paediatrics, psychiatry and radiology received fewer than average.

7 The impact of complaints on doctors

> 'When doctors receive complaints they go through a series of emotions. First of all they are frightened, because it is the beginning of a process they don't understand. Then they feel injured, because they feel they are only doing their best or the complainant does not understand what they have done. Where the complaint is unjustified they feel irritation. Finally, they get round to asking the most important question: Is this complaint actually about the standard of clinical care?' (D13)

Introduction

This chapter explores the impact of complaints on doctors. The academic literature to date has tended to assume strong reactions to being blamed but no empirical studies have been undertaken which have focused on the issue. This chapter considers how doctors describe their emotional reactions to complaints and the way in which complaints prompt them to alter their attitudes to patients and medical care. An understanding of such reactions is important if the challenge of complaints is to be placed in context. The data presented go some way to explaining why some doctors are so passionate about wanting to retain jurisdiction over complaint handling. The data also reveal what Friedson (1980, p.x) has called the 'underbelly' of social policy. Previous studies of complaining behaviour have stressed the huge emotional costs experienced by complainants when they voice a grievance (see for example Allsop, 1994; Lloyd-Bostock and Mulcahy, 1994). It is argued in this chapter that in many cases there is also a huge emotional cost to doctors receiving complaints. For many, the challenge of complaints prompted an identity crisis. Subsequent chapters outline the ways in which doctors' sense of identity as a competent expert came to be reconstructed.

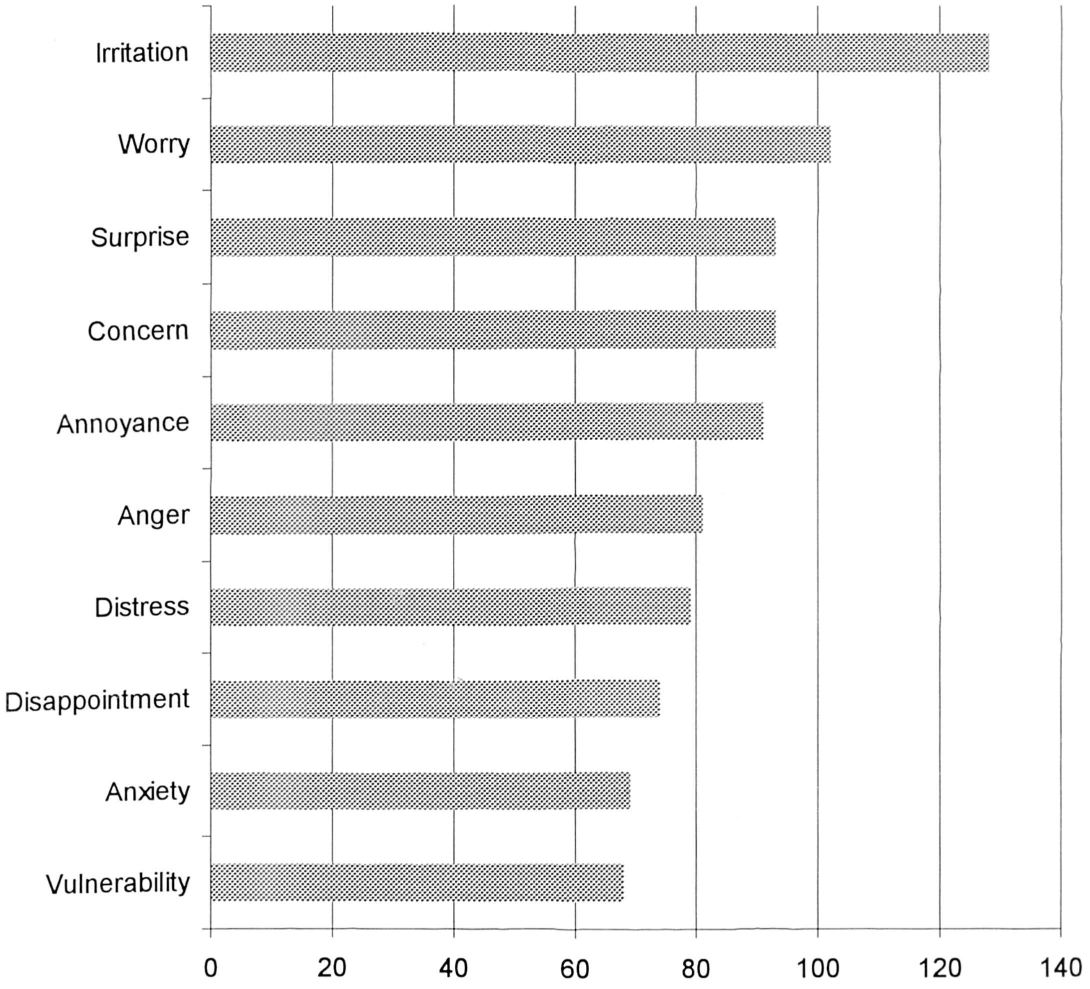
This chapter is in six parts. The first section describes doctors' general emotional response to complaints and the various ways in which complaints are seen as an intrusion in their lives and career. The second section adds to this by discussing emotional responses to particular allegations. It reiterates the importance of communication in understanding the dynamics of complaints. Section three considers the impact of doctors' evaluation of whether complaints are justified on their emotional reaction. Section four considers the effect that complaints have on doctors' medical practice and their general attitudes to care. This leads on to concluding arguments in which the major themes of the chapter are revisited and discussed.

Emotional responses to complaints

In order to explore the emotional impact of complaints, consultants in the postal survey were asked to describe the feelings they experienced when they received a complaint. The questionnaire presented a list of emotions and asked respondents to indicate which they had experienced when they had received a complaint. The list was constructed with reference to an important study of doctors reactions to medical negligence claims conducted by Vincent *et al* (1994). It also drew on work conducted by Lloyd-Bostock and Mulcahy (1994) on how complainants described their feelings about making a complaint. The list was piloted (see Chapter Five) and consultants were also invited to add categories to the list if they found an appropriate emotion was not included. Twenty-six per cent of consultants availed themselves of this opportunity.

The data provided by respondents suggest that complaints have a significant and often long-term impact on doctors. Consultants mentioned 44 different emotions and, on average, each claimed to have experienced five different sorts of strong emotional reaction. Figure 7.1 shows the 10 most frequently cited.

Figure 7.1: The 10 most frequent emotions experienced by consultants on receiving complaints



Fifty-five (22%) of consultants made additional comments about the emotional impact of complaints. The dominant theme in their comments was a sense of powerlessness. In some cases this was because it did not seem to be possible to resolve the complaints made about them: 'Where we were in the wrong, we accept it, feel bad and do something about it. However a lot of these complaints are "unsatisfiable" by any criteria' (D16). In other instances, frustration was caused by the fact that consultants did not have control over all aspects of patient care: '... because I was expected to sort it out when the problem was about another part of the service over which I had no control' (D32). In a similar vein, a number of comments were made about external causes of complaints most notably a lack of resources. One consultant opined: 'Irritation usually arises from the fact that if adequate facilities were provided, many complaints about waiting time would not arise' (D3). And again: 'The greatest sense is of futility - why bother to try when resources are inadequate and patients are complaining?' (D16)

Consultants stressed in both interviews and their postal questionnaires that emotions are not static. A number of consultants made the point that their responses tended to differ, depending on the facts of the case and whether they considered the complaint justified. Emotions also varied over time: 'At the time I considered myself in the right - it was much later that I reversed my opinion' (D27) And again: 'Perhaps one gets used to it, but I ran the gamut of emotions on the first occasion' (D9) As the clinical director quoted at the beginning of this chapter made clear that there was a pattern in the way in which doctors came to terms with complaints. His assertion that fear and injury slowly lead into a reflective phase in which they re-assess their culpability was well supported by the data collected in the study. As another doctor explained:

> 'When it first happens everything flashes before your eyes. Being disciplined, ridiculed by colleagues, denied promotion and generally thought of as not up to scratch, a bit shoddy. Then you start talking to colleagues and you realise that even if they haven't had a formal complaint patients have made their dissatisfaction felt. I came to see that everyone experiences complaints in one form or another and that most of the time they are ill-founded so why worry?' (D19)

It is clear from Figure 7.1 that a number of consultants see complaints as an unwelcome intrusion on their clinical practice. More than half the correspondents were irritated by complaints and a significant proportion were annoyed or angry. One consultant described the circumstances which had prompted such reactions:

> 'I recently received a letter from Douglas Hurd about a constituent who had to wait three months for a hysterectomy and was complaining about it. Of course she had to wait three months! We were trying to see if any drug treatment would help before we cut her. Douglas Hurd was not aware of that. He spent time on it when he should have been debating Bosnia. I spent time on it when I should have been healing.' (D14)

Another consultant experienced a similar reaction and was typical of this group :

> 'The thing is, all she [the complainant] had to do was write a letter. I have to spend my Saturday morning ploughing through files in response to it. We are obliged to respond, however vexatious. (D1)'

In these accounts doctors felt they were victims of unreasonable and improper demands. Complaint handling was not seen as an integral part of what they did but the cause of extra work which gets in the way of more important tasks. Consultants in this group were far from recognising a *prima facie* right of complainants to hold them to account. Rather they characterised complaining as a morally reprehensible activity which had an adverse effect on their ability to care for other, more worthy patients.

The number of consultants experiencing worry, concern, distress, anxiety and vulnerability makes it clear that complaints also had a more serious impact on respondents' sense well-being. Many doctors described how they faced a paradox. They had been consulted as experts, but that expertise was then questioned. They described the difficulties they experienced in coming to terms with their expert advice not being accepted. Some doctors reflected on the need to make a fair and balanced judgement of risks. But they were also aware that there were pressures on them from the patients to provide a definite diagnosis in the face of inevitable clinical uncertainty. A number described the ways in which professional judgement facilitated their isolation. One doctor commented: 'Practising medicine is about exercising judgement, that is why we're so opinionated. But we are vulnerable prima donnas, [we] play solo with patients and have to stand alone by decisions.' (D14)

It is interesting that a significant number of consultants experienced either disappointment or surprise at receiving a complaint. The following account is typical of this group:

> 'I dealt with one case where a patient was seriously ill. No one would touch the case. The care had been really messed up by a plastic surgeon. An SHO [junior doctor] and I really pulled that patient out of the embers. We worked jolly hard after our normal hours. I couldn't believe it when we received a complaint about the care. They said we had jeopardised their chances of recovery. I was so hurt. The whole team was really upset, really demoralised.' (D30)

This account, like others of its kind, makes a link between technical clinical competence and the fairness of the complaint made. The doctor presents themselves as a champion of patients who have been able to reverse the effects of poorly managed care. She stresses the extent of the efforts made and how the clinical team went beyond what was expected of them. In this account, the doctor sees themselves as the hero rather than being worthy of criticism. The case illustrates the arguments put forward in the previous chapter about the different ways in which doctors and patients experience treatment. As another doctor suggested: 'There are numerous understandable reasons for faulty perception, but sometimes it is extremely difficult to know where patients' ideas spring from.' (D21) Again doctors in this group commonly referred to technical expertise as being the appropriate standard against which to judge the validity and moral standing of a complaint.

Despite their feelings of vulnerability, many doctors' emotional reactions to complaints were rarely passive. The most extreme example of this was the group of doctors who made strong counter allegations against complaints, and described *their* desire for redress. A number drew attention to the fact that whilst complainants could expect redress if their complaint was justified, the same opportunity was not afforded consultants when complaints were considered unjustified. In the words of one consultant:

> 'The problem is that there is no real mechanism for redress. We say we know that some complaints aren't justfied, but we can never really make our views known. There should be a mechanism to deal with frivolous complaints. Doctors want their say as well. If someone is wrong, then that has to be said publicly as well. I thought of going to a solicitor to sue the complainant for defamation. But that would have caused weeks of misery. I wanted to get my own back.'(D18)

And another explained: 'It's not that I want to fine them or anything, but the relationship is so one-sided. They have done the damage as soon as they make the complaint. All we can do is sue for defamation.' (D20) And again: 'The hospital complaints system does not reject complaints. It absorbs them. We are never defended. Our actions are explained, but they are not defended' (D35).

These quotations highlight a tension which exists when designing any internal complaint system. Should the complaints system be seen as part of a service to patients and relatives which addresses their concerns in a way which satisfies them, or should it be a wrong-righting activity which judges the respective merits of opposing versions of events? Interview data suggest that, while doctors could accept that satisfying the complainant may be an expedient way to deal with the complaints and reduce the risk of escalation, denial of adjudication is considered unjust and appeared to rankle long after the complaint has been dealt with.

Many of the emotional responses to complaints outlined above draw attention to the way in which complaints destabilise the expected order in the doctor-patient relationship. The doctor tends to assume that their superior technical knowledge and moral authority is accepted by the health care user (Strong and Davis, 1977). A complaint transgresses both these norms and, perhaps for this reason, is taken in a personal way as an attack on the self. In interview, one consultant argued that complaints are a serious challenge to identity: 'I had sleepless nights - I was devastated. Colleagues told me not to worry, but it was my reputation being questioned.' (D30) Such feelings were not uncommon. In the words of another: 'Complaints are very hurtful. One gets emotionally involved because they strike at one's perception [of oneself] as a doctor. That perception may be idealistic, but it's important.' (D7)

Emotional responses to particular allegations

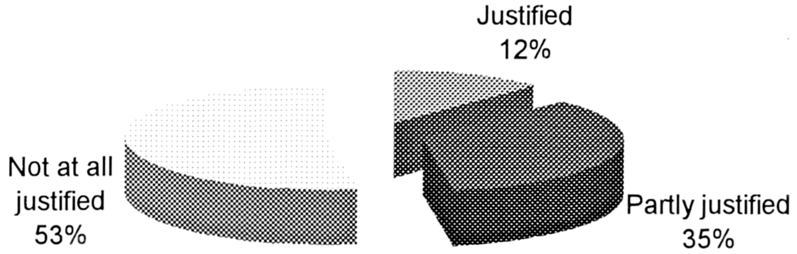
As has already been shown in chapter 6 complaints invariably contain a number of allegations of either technical or normative failure (Allsop, 1994; Lloyd-Bostock and Mulcahy, 1994) and statements of implicit or explicit allegations are always present (Lloyd-Bostock and Mulcahy, 1994). But it has been suggested that different types of complaints prompt different sorts of emotional response. In their evaluation of the handling of Stage III complaints against doctors, Donaldson and Cavanagh (1992) have argued that certain types of allegations - most notably those about communication and behaviour - are more palatable and less disturbing, than those which appear to question the technical aspects of clinical care.

The hypothesis that the type and intensity of emotion varied with the type of allegation made is also borne out by data in this study. The 10 most commonly-felt emotions (see Figure 7.1) were analysed in relation to the allegations made. When the allegations were about tests and diagnosis, consultants were much more likely to feel worried and vulnerable. In cases relating to general care of the patient, there were slightly higher levels of concern and annoyance amongst consultants. Problems with treatment also caused a much higher level of annoyance. Interestingly, the allegation that caused the largest number of emotional reactions was criticism of medication (an average of six emotions felt by each consultant concerned) followed by treatment problems (five emotions per respondent). Allegations about surgical interventions were least likely to provoke emotional responses (three emotions in each doctor).

Was the complaint justified?

The present study did not attempt to analyse data according to whether the complaint was substantiated. The hospital complaints procedure does not allow for the formal adjudication of complaints. Moreover, gathering of evidence to substantiate claims would have been expensive and the exercise was irrelevant to the project's concerns which were to explore reactions to complaints. Instead, consultants were asked to categorise complaints according to one of three classifications relating to *their own view* of whether the complaint was valid. The data suggest a reluctance to accept the validity of the complaint. Respondents evaluated 692 complaints in this way and, of these, just 85 (12%) were considered to be justified; 244 (35%) partly justified; and 363 (53%) not at all justified (see Figure 7.2).

Figure 7.2: Was the complaint considered justified?



When these classifications were looked at in the context of emotional responses, it became clear that there are intense emotional reactions to complaints, regardless of whether the complaint is considered justified or unjustified, but that the emotions are of different types. Those consultants who felt that one or more of the complaints was unjustified were much more likely to give details of their emotional response. Only consultants who felt the complaints were totally unjustified felt anger and indignation, suggesting that feelings ran particularly high where there is a sense of fault having been wrongly attributed. Moreover, a larger proportion of consultants in this group experienced irritation and anger than the general sample. The same group were much less likely to feel distress, worry, vulnerability and anxiety.

Explanations offered in interviews suggested that assessments of the validity of allegations impacted on doctors' ability to identify an appropriate reaction. As one consultant made clear:

> The complaints that have the greatest impact are often those which are unjustified. If a complaint is justified, then there is a clear route for you to take. You apologise and improve your practice. Where it is unjustified, you are left to mull it over, and over, and over ... (D25)

Consultants were also concerned that, where a complaint was seen as unjustified, colleagues tended to assume that they needed less support than if it were considered justified. In fact, many doctors argued that the emotional impact and sense of unfairness are greater, the quality of support may need to be increased. Typical comments included:

> I discussed the complaint with the Assistant Chief Executive. He is a senior nurse of the old school and understands clinical aspects of care. He said I was fortunate, it was my first complaint. It was nice of him to say it, but I really wanted someone to confirm that it was totally unjustified. They said it in their reply to the patient, but not to me.'(D5)

And again:

> 'The ideal person to talk to would have been a colleague, but I didn't want to be placated or hear that they thought the complainant was unbalanced, because we get a lot of unbalanced patients who don't complain.'(D16)

Together with doctors' call for redress outlined above, these commentaries suggest that there are emotional penalties for consultants to pay when a complaints system focuses too strongly on satisfying the complainant at the expense of an authoritative statement of the rights and wrongs of the complainant's and the doctor's case.

The impact of complaints on clinical practice

As well as prompting strong emotional reactions, complaints can also alter the future provision of medical care. They can effect a doctor's attitude towards patients and encourage them to adopt strategies for the avoidance of such criticisms and challenges in the future. Within medico-legal circles there has been much debate about the so-called dangers of defensive medicine in relation to medical negligence claims. In their review of the literature relating to the impact of medical accidents and litigation on doctors, Ennis and Vincent (1994) argue that: 'The most often cited effect of litigation on clinical practice is the adoption of "defensive medicine".'(p99) Some judicial pronouncements on the issue suggest that there is something of a crisis in the medical world precipitated by legal intervention into medical decisions. Possibly, the best known of these is contained in the judgement of Lord Denning in the classic case of *Whitehouse and Jordan* [1980][1]:

> 'Experienced practitioners are known to have refused to treat patient for fear of being accused of negligence. Young men are even deterred from entering the profession because of the risks involved.' (p658)

In a similar vein, Bolt (1989) has suggested that defensive medicine can lead to the doctor patient relationship shifting from one based on trust to an adversarial one which is totally foreign to everything for which the profession purports to stand. Annandale (1989) has also argued that defensive medicine can lead to strategies which can serve to mask errors in clinical medicine. For these reasons it was considered important to explore whether complaints encouraged defensive medicine in the present study.

Ennis and Vincent (1994) define defensive medicine as occurring when specific procedures, tests or treatments are either employed or withheld explicitly to the purpose of diverting a possible law suit. They review how changes in practice in response to legal claims have been characterised as either 'positive' or 'negative'. Positive reactions occur when doctors undertake additional precautionary procedures which might be unnecessary for the proper care of the patient in order to insulate themselves from the possibility of criticism that they had not done everything they could to cure the patient. Negative defensive medicine occurs where treatment which might be justified is withheld because of fears that the risks inherent in treatment might lead to additional harm being caused to the patient. Defined in this way, defensive medicine provides an example of the general effects of rules discussed by Galanter (1983) in his typology of reactions to rules (see Chapter Four). General deterrence of this kind does not necessarily involve a change in the moral evaluation of such action; it merely makes the person more aware of the risks, costs and benefits of acting in a certain way. Thus, doctors can treat the formal rules of medical negligence as a factor to be taken into account when providing treatment rather than as a normative framework to which they are morally committed. It may be the case, for instance, that much defensive medicine is practised because of the 'perceived' risks of complaints and litigation rather than the 'actual' risks.

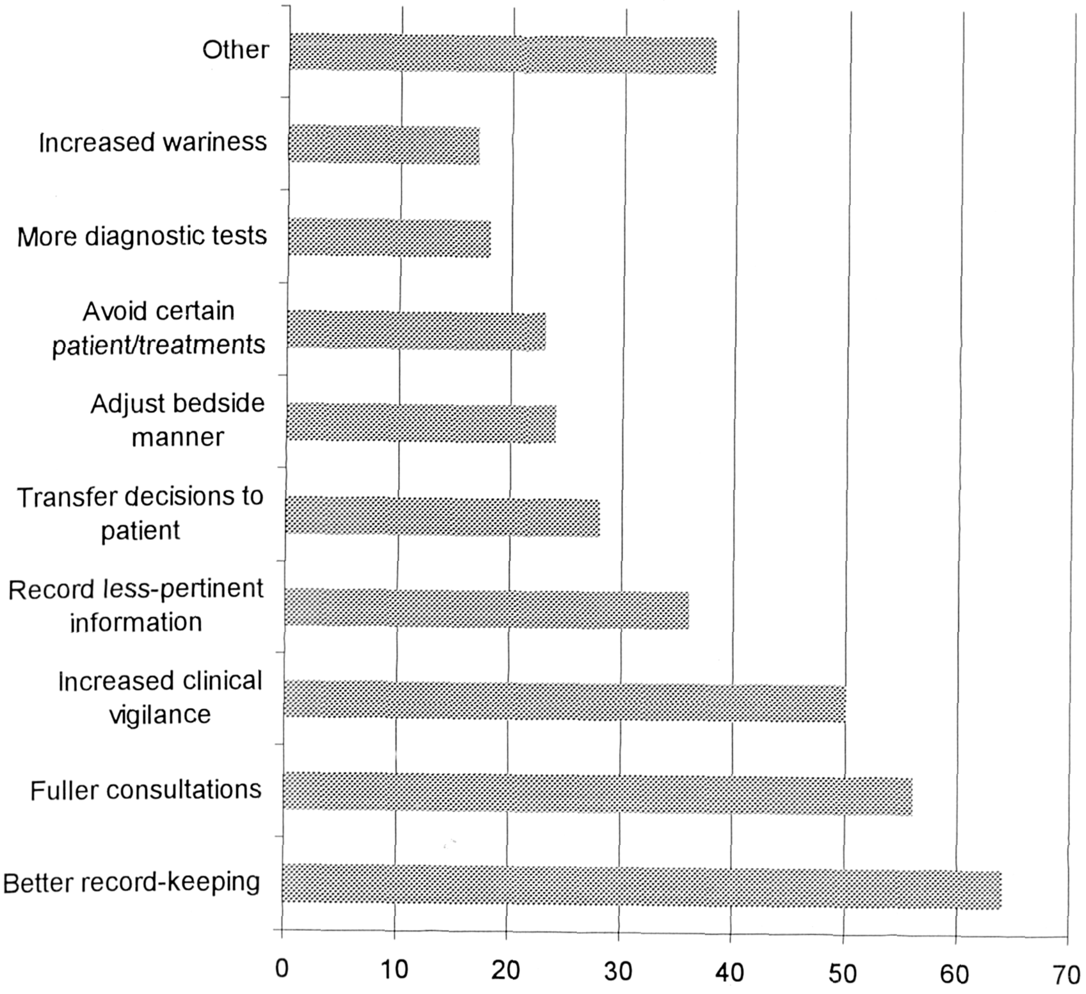
In his survey of general practice doctors, Summerton (1995) found that they made significant changes to their practice to avert the possibility of a patient complaining. Of the defensive medical practices adopted, the most common strategies (for more than half of the doctors surveyed) were: an increase in diagnostic testing; an increased referral rate and follow-up;

more detailed patient explanations; and more detailed note-taking. Summerton recognised that some of the changes in medical practice, such as more detailed note-taking and increased explanations to patients, might have beneficial effects for those being treated (positive defensive medicine). But he predicted that the adoption of more negative defensive medical practice will ultimately have adverse consequences for the patient.

Consultants in this study were asked whether the way they practised medicine was influenced by the complaints they had received. They were provided with a list of pre-coded responses which drew on the review of literature on defensive medicine conducted by Ennis and Vincent (1994). As with other pre-coded lists, they were given the opportunity to add other responses if they did not appear. The data they provided demonstrate that complaints have a considerable impact on clinical practice. One hundred and fifty-seven (64%) consultants specified 371 ways in which their medical practice had changed. Figure 7.3 shows the 10 most frequent categories of response.

As with Summerton's (1995) research better record/note keeping and fuller consultations with patients feature quite prominently amongst the reactions described by the sample group. Increased use of diagnostic testing also feature in the two data sets[2]. Whilst some of the categories shown in Figure 7.3, such as avoidance of certain patients and increased wariness, may be suggestive of a more negative approach to treatment, the data support the proposition that long-term reactions to complaints may be inappropriately characterised as 'defensive'. It is significant that many of the categories in Figure 7.3, for example 'fuller consultations with patients' and 'increased clinical vigilance', reflect the provision of improved care.

Figure 7.3: The most common ways in which complaints had an impact on the practice of medicine



Cross-tabulation of these data with other data already described suggests that there is an even spread of emotional reactions and age groups across the various changes in clinical practice made. However, there is a strong correlation between the intensity of emotional response and propensity to change practice. Doctors with stronger emotional reactions to complaints were more likely to alter their clinical practice. Interestingly, those who made no change in practice recorded fewer emotional responses to the complaint than those who did; averages of four and five respectively.

Female doctors were much more likely to change at least one aspect of their clinical practice in response to a complaint than were male doctors. Of the 193 male consultants who had had a complaint, 117 (61%) made changes in comparison with 38 (72%) of the 53 females. Where reliable statistics were available, it was shown that men were more likely to engage in fuller consultations with patients and improve their standards of record-keeping. Although a larger percentage of the female practitioners claimed that complaints had had an impact on their medical practice, they were much less likely to implement multiple changes, an average of just one each compared to an average of three alterations each for the male consultants.

A number of respondents (64) volunteered further commentaries on the ways in which complaints had changed their attitude towards service-users. They used the additional space provided in the questionnaire to make clear that their experience of complaints and complainants had caused them to have a more negative general attitude towards patients even if this has not resulted in changes in their technical care. Typical comments were that the complaint had hardened attitudes; caused disillusionment and cynicism; and increased levels of anxiety. In the words of one consultant: 'I have increased my distrust of certain managers. When you smile the world smiles with you, when you cry you cry alone.'(D5) Another remarked: 'I'm rather more cynical, I suppose. I don't expect patients to be grateful for my efforts, although it's nice when they are.' (D22)

Another common thread that emerged from analysis of comments on the questionnaire was that the complaints received had had an impact on the handling of criticism generally. In some cases the reaction was positive: 'I try to anticipate and pre-empt any complaints by dealing with people face-to-face before they make a formal complaint.' (D27) Some consultants drew attention to the perceived necessity to pay greater attention to the needs of patients' relatives. In one case: 'I compromise. What is medically best for a patient may not meet relatives' requirements - and they have to live with the consequences.' (D14) But, in other cases, the response was more negative. In a particularly extreme case, a consultant claimed that they refused to deal verbally with any complainant unless a stenographer was present, or the meeting was recorded on audio-tape. Others spoke more generally of an awareness that their statements or actions might be misinterpreted or that full discussions do not always take place. One said: 'I expect I am slightly more alert to the possibility of unexpressed feelings on behalf of the patient.' (D8)

Conclusion

The data presented in this chapter have revealed that complaints are seen by doctors to pose a significant threat to their sense of well-being and career prospects. Complaints have a severe and often long-lasting impact on doctors' emotional health and cause them to experience a wide range of emotions. Some complaints were mere irritants but more intensive reactions were apparent when the complaint was considered unjustified. Complaints appear to threaten a doctor's sense of worth. Doctors feel disempowered by complaints because the process is driven by patients. This creates a distortion in the traditional order of doctor patient encounters.

One explanation for the intensity of emotional reactions was that they serve to challenge the doctors identity as an expert. Giddens (1991) has suggested that we are a bundle of identities which are brought into play through social action. The clinical identity may be dominant in the conception of self among doctors. Many things serve to reinforce a collective sense of identity amongst doctors including: the long training, the intense socialisation process, the role of patronage in career development, the framework of self-regulation, the web of promotional organisations and activities, the collegiate setting of much work practice and the norm of clinical autonomy. These create the conditions for work shelter, but also the incentives for identity maintenance and for professional politics in a wide range of institutional areas (Rosenthal, 1999; Allsop and Mulcahy, 1998). In his seminal account of how general practioners manage complaints and bad practice, Freidson (1980) argues that physicians have a shared conception of themselves as ethical, conscientious, competent and stable which is severely challenged by complaints. He found that it was inherent in this set of beliefs about their identity that patients should trust them.

Viewed in this way, criticisms of doctors' work are criticisms of doctors. They can prompt a group, as well as, an individual 'legitimation crisis' because they call into question the doctor's technical and moral authority over biomedical knowledge (see Habermas, 1976). A complaint may represent a double challenge: to have got something wrong technically and not to have used their knowledge in the interest of the patient and, thus, to have broken a basic trust. Moreover, this challenge has come from a lay person who is not considered to be in a position to judge medical work. As Schutz comments:

> ' ...the expert ... knows very well that only a fellow expert will understand all the technicalities and implications of a problem in his field, and he will never accept a lay man or a dilettante as the competent judge of his performance.' (1964, p123)

Complaints impact on doctors' sense of identity but they also lead to counter-allegations, and denials. Doctors' were strongly inclined to consider complaints as unjustified because the allegations made demonstrated a lack of understanding of medical treatment or failed to take sufficient account of the doctors commitment to patients or moral authority. Putting forward defences when criticised could be viewed as a natural reaction to being criticised but data presented in the chapter also suggest that doctors and patients have very different expectations of medical treatment. This has a radical impact on their evaluation of whether something is complaint-worthy.

Doctors contested allegations of incompetence on the basis that medicine is a complex art and that what constitutes the most appropriate course of treatment in any case may be unclear or hotly disputed. Allsop (1994) suggest this is a theme that runs throughout the sociological literature on medical socialisation. It would seem that the problem of handling such uncertainty in the disease process is a central aspect of learning to be a doctor. Viewed in this way, medical practice is exploratory and the difference between good clinical judgement and bad is often hard to distinguish within the academy. According to this construction the nature of medical work is misunderstood by the laity.

This view of medical work is not without its problems. It might be argued that doctors have been instrumental in promoting a different view of medical activity to their patients which places emphasis on scientific tendencies towards the presentation of certainty. In the course of becoming a doctor and expert, medical students may also be encouraged to rely on experience and personal judgement to make authoritative statements to patients which suggest a certainty of knowledge. As Smith, the current editor of the *British Medical Journal*, has argued: The problem is that medicine has had a culture in which medical students have been humiliated for not knowing and so have learnt to hide their ignorance (Smith, 1995, p402). This positivist model of medicine allows less readily for acknowledgement of error and failure. It encourages the idea that medical knowledge is coherent and consistent.

Others have argued that the presentation of medicine as a science has broader implications when it comes to contested care and error. It has been suggested that the perceived need to be infallible creates a strong pressure to intellectual dishonesty, to cover up mistakes rather than to admit them (McIntyre and Popper, 1989). Nathanson (1999) has argued that a general ethos has traditionally prevailed which discourages doctors from reporting errors or co-operating with investigations of allegations of mistakes by themselves or others. Empirical research has suggested that errors are rarely admitted or discussed because of the fear of censure or that colleagues will regard the subject of the allegations as incompetent. In his study of trainee doctors' ways of rationalising their mistakes, Mizrahi (1984) found that denial, distancing and discounting were common strategies. In a similar vein, Rosenthal's (1995) work on doctors' reactions to bad practice suggests that a considerable degree of tolerance of deviant activity exists within the medical profession, but that knowledge that colleagues are regularly under-performing can prompt informal regulation of their behaviour by social distancing, extra scrutiny of medical work undertaken, the re-direction of work, and 'quiet chats'. The next chapter goes on to explore such themes and considers the extent to which reference to collective ideals has an impact on reactions to complaints.

Notes

1 Whitehouse v Jordan [1980] 1 All ER 650 at 658. CA.

2. It was not anticipated that increased referrals would feature in the present study as it did in Summerton's research. This is because his research was conducted with general practitioners. Hospital consultants tend to be recipients of referrals rather than gatekeepers of the referral process.

8 Reconstructing medical identities

> 'My experiences show that patient anxieties are at the crux of complaints. All the complaints I have received relate, in some way, to the illness episode. Patients who have complained about me often feel that their care has gone adrift. What is irksome is that there is rarely anything wrong with the clinical care they have been receiving.' (D7)

Introduction

Previous chapters have demonstrated that doctors are concerned about the rising incidence of complaints and that receiving a complaint can prompt a severe emotional reaction. This chapter considers how doctors come to terms with complaints in the longer term. It charts how after an initial period of turmoil they come to rationalise the complaining act and externalise blame for the events and circumstances complained about. It is argued that while the emotional reactions to complaints described in the last chapter reflect a personal and individualised reaction to being challenged, the process of coming to terms with challenges from patients ultimately relies on recourse to the medical fraternity. Doctors gave meaning to the act of complaining by positioning it within a particular illness episode. This allowed them to understand complaints by reference to a bio-medical model of care.

Commonly, the reconstruction of a positive sense of identity relied on a deconstruction and undermining of both the complainant and complaint. In seeking to re-build *their* damaged sense of identity, doctors strive to emphasise the differences between their perception of the cause of events and those put forward by the complainant. The data demonstrate that while doctors present themselves as rational scientists they see complainants as putting forward irrational or illogical accounts whilst they defended their own work in medical terms, and paid little heed to the contrasting discourses and concerns expressed by complainants.

This chapter is in two main parts. In the first section, there is a discussion of how doctors used networks of support in their attempts to find ways of coping with complaints. After an initial period of reacting to complaints alone, the response of most doctors was to seek the help of medical colleagues from inside or outside the hospital in which they practice. Most of them felt that use of these networks was a perfectly adequate way for them to come to terms with the emotional trauma of complaints. These findings support the suggestion to be made in Chapter Nine that, in the wake of a complaint, a significant number of consultants do not want or need managers and other non-medical support networks to be involved. It would seem then, that doctors are comfortable managing complaints with the support of colleagues who are able to share and understand their perspective. In the second part of the chapter, there is a discussion of how doctors rationalise or try to understand the causes of complaints. Again, it is argued that doctors rely heavily on medical networks in their attempts to come to terms with the causes of complaints and that their recourse to a scientific explanation of complaints allows them to re-establish their identity as competent experts.

Use of support networks

It has already been argued that when individuals are criticised, it is a common reaction to look to others for support. Disputants often utilise networks of kin, affinity and close patronage (Mulcahy and Tritter, 1998; Caplan, 1995; Felstiner *et al.*, 1980-81). In their review of the anthropological literature, Mather and Yngvesson (1980-81) stress the importance of third parties in providing support and in narrowing or expanding the issues in dispute. Other commentators have identified a number of different roles performed by third parties and support networks. These include the provision of emotional backup, acting as 'sounding boards', go-betweens and champions (Black and Baumgartner, 1983).

This help-seeking is a form of protection in which individuals can talk to others who share the same frameworks of meaning and knowledge base. Despite this, it has been argued above that previous research suggests that a number of barriers exist for doctors in approaching others for help and that doctors are typically isolated by their emotional responses to mishaps (see, Leape, 1999; Wu *et al*, 1991) However, these previous studies involved mistakes which had been made and recognised. With complaints the validity of the allegations made may have yet to be determined. It was demonstrated in the last chapter that liability is commonly hotly contested. Moreover, complaints are much more public events than recognitions of mistakes by those responsible. Does the contested and public nature of complaints affect the propensity to seek support?

The dominance of medical networks

In contrast to studies of medical mishaps, this study found that extensive use was made of support networks when a complaint was received. A number of consultants who were interviewed confirmed the vital place occupied by these networks in the process of coming to terms with a complaint. As one explained:

> 'I didn't sleep. I felt guilty. There was a lot of truth in her accusation. I had assaulted her in a way. I needed to talk it over with a medic who would be

> sympathetic. The next day I rang an ex-colleague. In retrospect, I realise it was a form of counselling.' (D34)

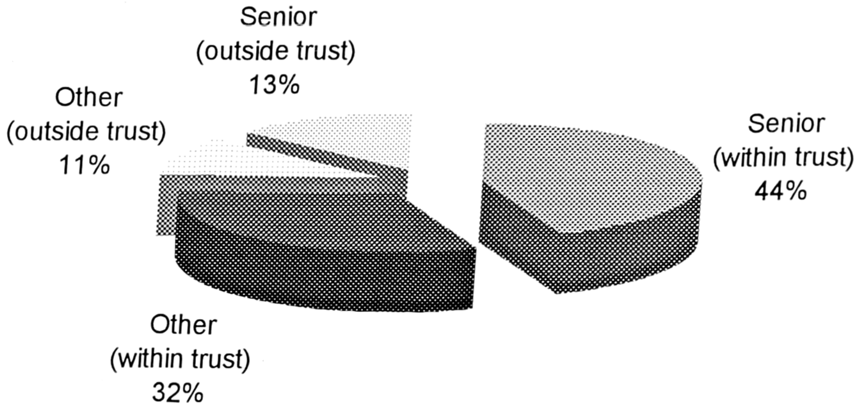
And again:

> 'I went home. I shouted at my wife. She shouted back. I felt better and then we talked it through and I let her know what was really upsetting me. But, I needed to let go of the burden and it is only someone who loves me dearly that would allow me to behave in that way.'(D10)

The postal survey of consultants revealed that the vast majority of respondents (88%) had made some sort of approach to another person after receiving a complaint. The main purposes for approaching others were given as being: for advice (19%); to inform (17%); for support (17%); to gain information (10%); and to unburden their feelings (10%). As the above quotations suggest, two types of network were identified: medical and non-medical.

One hundred and ninety-four consultants (79%) who had received a complaint discussed it with a medical colleague and 166 (68%) discussed it with a non-medical colleague or someone else. Consultants also made 100 approaches to medical defence societies in the course of getting advice and support. Figures 8.1 and 8.2 provide additional details of who was approached. These figures divide the data into colleagues involved in medical care of the patient and colleagues *not* involved in the care.

Figure 8.1: Medical colleagues involved in patient care (n = 187)



These data show that consultants were most likely to turn to a colleague within the same trust for help. Within this group the most commonly approached colleagues were senior ones (44%). It is clear that senior colleagues from both inside and outside of the trust in which the doctor worked featured prominently. Senior colleagues were approached in 56 per cent of cases.

Figure 8.2 shows that a majority of the sample also sought out support from medical colleagues not involved in patient care. Once again, senior medical colleagues are approached more often than other colleagues. This was the case whether or not they were involved in patient care. Doctors in the study turned to senior medical colleagues within the same trust or unit for practical and emotional help of all kinds. At least a third of all consultants had made an approach to them for advice (37%) or support (36^{0} o). The data demonstrate that despite the fears expressed in previous chapters about complaints affecting promotion prospects, the majority of doctors felt comfortable confiding in doctors more highly placed in the medical hierarchy than they were. The hypothesis that there is a risk in discussing complaints with colleagues (discussed in previous chapters) is undermined by these data. On the contrary, colleagues within the same trust were approached in 76 per cent of cases where they were involved with the care and 70 per cent of cases where they were not.

But interview with consultants suggested that doctors' willingness to talk about complaints was often related to the content of the complaint and perceived level of stigma attached to criticism. Thus, there were particular risks attached to discussion of some types of complaint. One doctor suggested: 'Complaints about sexual impropriety might be difficult to shake off, but complaints about wrong diagnosis or medical care are everyday events.' Others suggested that complaints about the unit or lack of funding might be talked about openly, but that those which were more personal were much less likely to surface.

However, many consultants described how there were other ways of using support networks and airing concerns where more 'risky' allegations had been made. One explained:

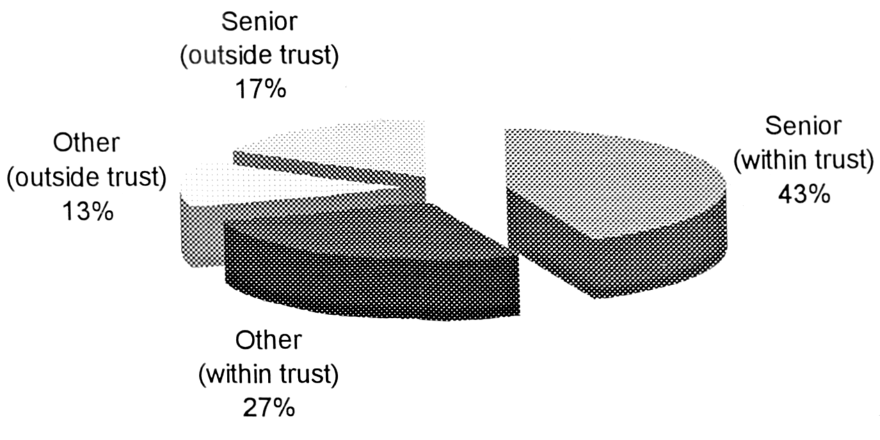
> 'Doctors do want to share the information and, in fact, they do it all the time. You are having lunch and you just start talking generally about a problem in the department or the *potential* for something to happen. Often you do not want guidance. You just need to get it off your chest.' (D7)

Another supported this argument:

> 'You get support in a semi-joking way. You can be light-hearted with medical colleagues in a way which wouldn't be understood by outsiders. We share the same sense of humour and it may sound sick, but it's a way of managing stress.' (D13)

A number of researchers have identified how such informal training for challenges to authority or coping with mistakes occurs through such things as the telling of 'horror stories' or jokes amongst clinicians (Rosenthal, 1995; Richman,1987; Dingwall, 1977). Bosk's (1982) seminal ethnographic study of how doctors coped with error also placed emphasis on the importance of the lunch-time chat in relieving stress.

Figure 8.2: Medical colleagues not involved in patient care (n = 148)



Consultants were also keen to stress the sense of responsibility they felt to colleagues who were upset by complaints. A number argued that they would like to think they were there to hear the troubles of colleagues. However, a number expressed concern that they were not always as accessible as they should be. One interviewee summed up this common concern, thus:

> 'A colleague committed suicide last year and our first question was, 'Did a patient push him to this? Was there a complaint festering that he did not tell us about? Was he keeping something to himself that he could have shared?' Basically, we felt guilty that we were not there.' (D33)

Thus, whilst there was an intellectual acceptance of the need for support, there was also a reticence to be proactive about offering it. This raises the issue of the quality of support given by colleagues. The dominant image to emerge was that complaints are an extremely sensitive issue which made both the doctor complained about and the supporter feel uncomfortable. One explained:

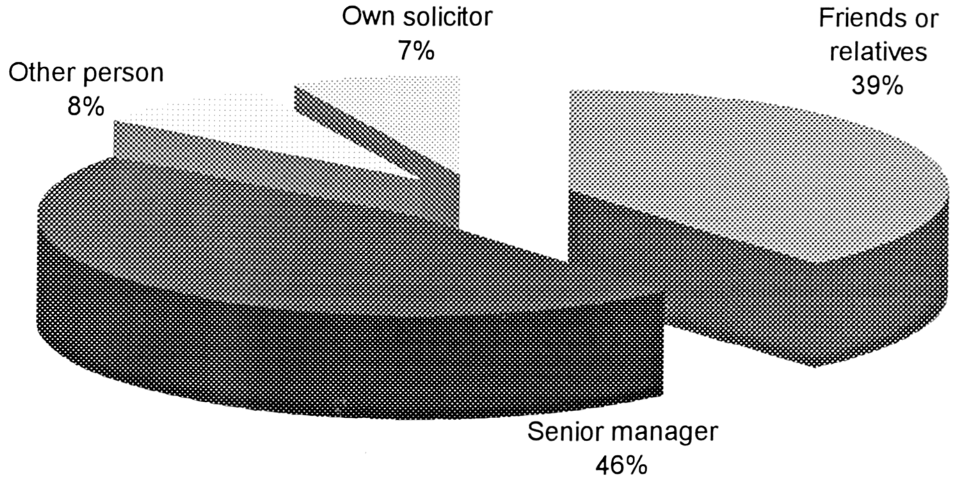
> 'When someone gets a complaint we all feel uncomfortable. We may want to talk about it, but not appear nosy. Many of the staff I spoke to when I was clinical director said how appalled they were at the sense of isolation.' (D19)

A high percentage of clinical directors interviewed described feeling embarrassed at having to deal with a complaint about a colleague, whilst other consultants suggested that they did not feel that colleagues wanted to hear of the minutiae of criticism about them.

The use of non-medical networks

The dominance of medical networks for support and advice is further illustrated when one turns to look at consultants' use of other non-medical networks. One hundred and sixty-six consultants made 242 different approaches to members of non-medical networks. But the data reveal that although 20 per cent of consultants surveyed made at least one appeal to their family and friends, this is a relatively insignificant channel when compared with the 79 per cent who discussed the complaint made against them with a medical colleague. Figure 8.3 shows other non-medical networks used.

Figure 8.3: Non-medical networks



Consultants focused on getting support from non-medical networks for much more specific reasons than they did with medical colleagues who might be approached for multiple forms of help. What is interesting from Figure 8.3 is that the majority (54%) of consultants approached people other than managers or administrators for help. This issue will be discussed again in the next chapter but it was clear from responses in the write-in section of the postal questionnaire that consultants were concerned about managerial interference in complaint handling. In the words of one consultant:

> 'I have asked for help from security staff because of the behaviour of drunk and aggressive complaining patients and their relatives in interviews set up by management to offer "explanations". I don't think the manager quite believed me beforehand when I expressed this anxiety, but the security staff were very helpful and certainly appreciated why I had asked for their help.' (D2)

And again:

> 'I think, along with most consultants, we feel that where the complaint definitely was not justified, we waste a considerable amount of time and appear to have little support from either District or Region in the letters they write, which appear to be always sympathetic to the patient and never the consultant, even where the complaint is inappropriate.' (D21)

The legal claims department was approached by 50 consultants in the sample for advice (21%), but even this figure was overshadowed by the number of approaches to senior medical colleagues for that reason. It is also clear that legal advice was rarely sought from independent solicitors. The reasons for going to friends and relatives were, predictably, rather different from the reasons why consultants went to managers and defence organisations. For example, one consultant suggested: 'Talking about [it] to friends/relatives/colleagues was all essentially part of reducing the distress that caused a significant interference with work performance.'

Once a network had been activated by the complainant, consultants tended to stay within its confines. When a complaint had been referred to a doctor by a manager, they were much more likely than the norm to discuss the complaint with non-medical colleagues

(70%). Conversely, when news of a complaint was received through a medical colleague, consultants were less likely to use non-medical channels of support (11%). These data suggest that while doctors were willing to approach others for advice, they prefered to refer the matter only to a small network of people.

There were no significant differences between the proportions of male and female consultants who chose non-medical support networks. But, women (87%) were more likely to discuss the complaint with a medical colleague than men (77%). In particular, women were more likely to talk to a peer, within the same hospital, who was involved in the care of the patient concerned. But, when men discussed the complaints with a medical colleague, they tended to do so with a greater number (3) than women did (2).

Further analysis revealed that two trends emerged from data on the use of medical networks and age groups. Firstly, the older the consultant, the less likely they were to discuss the complaint with a medical colleague - 92 per cent of those in their thirties compared with only 42 per cent of those in their sixties. Secondly, the older the consultant the more likely it was that medical networks outside their hospitals would be accessed. The data may reflect one of two things. First, that senior medics have fewer peers to approach within the hospital in which they practice because of their seniority, but that their networks are wider because of the greater number of years they have had to establish them. Secondly, it may be that consultants grow more confident with age, are less threatened, or desensitised to complaints. As far as non-medical networks are concerned, use of friends and relatives drops consistently with age - starting at 65 per cent for those in their thirties and dropping to only seven per cent for the sixties age group. The use of defence unions was fairly stable (between 55 and 60%) until consultants reached their sixties, when it increased to more than 85 per cent. This may reflect the fact that the older the consultant, the greater their level of vicarious responsibility is likely to be.

The isolated minority

A smaller proportion of doctors were more reticent about approaching support networks and suggested a number of disadvantages to pursuing this route. Only 19 consultants (8%) did not talk to anyone and only 22 (9%) said that they would have liked someone else to talk to about the complaint. But, this important sub-sample of consultants often felt they were barred from seeking support by the way in which medical work is practiced and organised. One extremely successful orthopaedic surgeon in the early forties age group explained:

> 'In a high profile specialty like mine, people are very competitive and it's difficult to talk about mistakes because we all pretend that we don't make any. I felt very lonely. Eventually, it got so bad that I went to get help from occupational health and they arranged for me to have counselling.' (D16)

Another suggested that her gender made it difficult for her to seek help:

> 'Basically, I am one of the only females in the region who specialises in [name of specialty]. I have a lot of young women who see me as their role model and a lot of men who are just waiting for me to make a mistake. No, I would not go and talk to a colleague. That's actually the last thing I would do!' (D23)

One suggestion from a member of this data set was that there should be someone independent who was available to talk to consultants, someone who is not part of the medical hierarchy. A number of consultants were concerned that details of complaints about them might leak out and damage their career prospects. One suggested:

> 'I am unhappy when complaints about me come out into the open. As a result, I much prefer it when they come directly to me. I feel confident that my clinical director is fairly discreet, but I do worry that others would talk. I don't like my dirty linen to be washed in public.' (D31)

For some this was because of fear of reprisal:

> 'Most people who get complaints don't tell their colleagues. I was so innocent when I got mine that I told everyone. But that could rebound on you. You might just tell the wrong person.' (D8)

Medics as rational experts

Talking to colleagues and intimate networks of friends and family acted as a rehearsal ground for the account of their behaviour which doctors gave to complainants and produced for this research. Doctors in the study stressed how their help-seeking activity acted as a form of catharsis and allowed them to come to terms with the criticism made. But before this process could be completed they described the necessity of attributing meaning to complaints. Why had the complaint been made? Had the complaint revealed inadequecies in the care provided? Was the lay explanation of the treatment episode put forward by the complainant a more accurate account? The data collected for this study suggest that these questions were addressed with reference to a bio-medical model of care which allowed doctors to understand complaints as part of the illness episode.

In the accounts they provided in interview, doctors were keen to stress how their expertise as medics singled them out within the hospital environment and distinguished them from managers and patients. Complaints were seen as a manifestation of the disease being experienced. Significantly this meant that they could claim that there were features of complaining behaviour that only doctors could understand. This can be interpreted as professional identity work which serves to externalise blame and maintain the dominant image of the competent and expert knowledge worker. In this way the doctor's narrative was presented as being superior to that provided by complainants.

Doctors explanations of why complaints had been made focused on critiques of both the complainant and the complaint. Complainants were typically seen as irrational in contrast to the rational medic. The most popular caricature of complainants was of the problem patient - the difficult personality incapable of making valid criticism (see also Richman, 1987; Rosenthal *et al*, 1980). In this context the cause of the complaint was not seen as poor care but was attributed to the personality of the complainant. Thus, blame and responsibility were transferred back to the person responsible for making the allegations. One consultant offered the following comments:

> 'You could do a psychological profile of patients coming into hospital and select those who were likely to complain before giving them any clinical care. Critical incident analysis is a much better way to identify adverse events. Too many mistakes are *not* complained about. Complaints are nebulous events involving *perceived* deficiencies of care.'(D5)

Positive or empathetic comments about complainants were made in just six out of 141 commentaries in postal questionnaires on why people complained. Complainants were most often described in negative or dismissive terms as 'moaners', 'nasty', 'abusers' and 'malcontents'. Interestingly, 21 consultants out of the 141 (only 12 of whom were specialists in psychiatric medicine) described complainants as exhibiting symptoms of psychiatric illness such as 'personality disorders', 'paranoia', and 'neuroticism'. These descriptions of patients run counter to the idealised model of the doctor as a professional who maintains affective neutrality towards the patient as outlined in the bureaucratic role format developed by Parsons (1951) and demonstrated by Strong (1979). However, it could be argued that these accounts are the other side of the tales told by patients about disrupted relationships (Dingwall, 1977; Stimson and Webb, 1975). In both cases, the function of typifications and atrocity stories serve an important purpose. They serve to justify actions and to regain control of the interaction in terms which best suit the speaker.

Doctors also discredited complaints as irrational unscientific accounts. They were characterised as 'irrational' and inaccurate indicators of quality. Many doctors stressed that they were confident that they had more reliable ways of spotting incompetent colleagues. One suggested:

> 'I have my own opinions about who is good or bad. These are not based on complaints, but intuition, experience of whether they are know-it-alls, and whether their patients get a lot of post-operative infection.' (D26)

As another made clear:

> 'Doctors vary in ability but, they are all basically intelligent. Yet some get more complaints than others. That doesn't mean anything and no-one should feel they can make a comment on it.' (D9)

The reconstruction of scientific identity

Commonly, complaints were viewed as a manifestation of the illness experienced. References to the need to understand a complaint in the context of medical care received occurred in a majority of interviews (65%). This way of conceptualising complaints allowed doctors to re-interpret criticism as a symptom of illness. In turn this meant that the cause of the complaint could be externalised. Within social psychology, attribution theory has been used to explain the need to relocate blame. At its simplest, the theory suggests that people prefer to find meaning and order in the world and usually develop explanations of why events happen and why people behave as they do. Tedeschi and Reiss (1981) have suggested that there are a number of common responses when people seek to attribute cause for untoward events which are related to awarding responsibility and blame to themselves, others or fate. (See also Lloyd-Bostock, 1992; Coates and Penrod, 1981.) Significantly, attributing the cause of complaints to disease allows blame to be re-attributed in a way which is morally neutral since neither the doctor or patient are usually responsible for the onset of illness or disease. In this model the doctor no longer deals with an individual, consciously attacking them, but a dual personality who is sincerely complaining whilst unconsciously coming to terms with disease and its treatment. The complainant is transformed into a passive and objectified being in a state of ignorance.

This way of rationalising complaints places emphasis on the status of the doctor as an expert because it is the doctor who is able to recognise and explain the dual personality. In this way, the doctor is getting at the 'real' problem (Dodier, 1994). In contrast to the patient, the doctor remains the expert healer who can diagnose complex symptoms. The doctor reclaims the ground as an observer and transforms the complainant into the subject (Hardey, 1998). This is an especially interesting interpretation given that previous studies have shown that around 60 per cent of complaints to hospitals are made by someone other than a patient undergoing medical care (Lloyd-Bostock and Mulcahy, 1994). Thus, it was not only patients who had their accounts medicalised in this way.

These assertions draw on the traditional biomedical model of providing care. According to this, the patient's experience is only relevant insofar as it provides data about abnormalities recognised by the expert doctor. The patient does not take part in the doctor-patient interaction as an autonomous individual capable of criticism. This can be compared to the co-operative model which stresses the value of hearing the patient's view and bringing the voice of their lifeworld into the voice of medicine (Maseide, 1991). In the bio-medical model causes and rules are only open to 'discovery' classification and understanding by scientific methods (Hardey, 1998, p.9).

Sociological studies, based on empirical work in the US and undertaken in the 1950s and 1960s, showed how doctors are socialised into the norms of biomedical culture which create the distance between themselves and others (Stelling and Bucher, 1973; Bucher and Strauss, 1960-61; Becker *et al*, 1961; Fox, 1957). Many of these authors have stressed the importance of experts being able to present authoritative judgements to patients whilst maintaining an appreciation of the uncertainties of medical science (see, for instance, Atkinson, 1995, 1984, 1981; Mizrahi ,1984; Bosk, 1979; Fox, 1957). Significantly, if the cause of the dissatisfaction can be understood by reference to illness, then the validity of the complaint as a challenge to the medic's world is clearly undermined. The data in this study provide further examples of attempts to attribute a scientific or medical cause to complaints.

In their quest to establish scientific explanations of complaints, doctors in this study argued that certain types of treatment were more likely than others to prompt complaints. This analysis was justified by reference to their experts' view of what distinguished medical treatments from each other. The data presented in Table 6.2 in Chapter Six does indeed demonstrate that certain treatments such as those carried out in obstetrics, gynaecology, surgery and general medicine were more likely to receive complaints. Doctors linked the propensity for a particular illness or treatment to prompt complaints to five main factors: whether the diagnosis or treatment was likely to involve the imparting of bad news; the length and intensity of the treatment episode; the level of uncertainty involved in care; the seriousness of mistakes; and the emotional investment involved in particular types of treatment. In all of their accounts these explanations provided a justification for not attributing blame to doctors for complaints and in the remainder of this section each of these factors is considered in turn.

Respondents explained how a number of treatments could be described as 'bad news' medicine. In their use of this term they drew on different specialists' capacity and ability to improve or cure. They argued that specialties involving terminal care and diagnosis, such as oncology and general medicine where bad news was regularly imparted, were in particular danger of suffering an emotional aftermath. One consultant, specialising in general medicine, argued that the problem revolved around the need for complainants to displace their anxieties:

> 'We are definitely a bad news specialty. Young patients often die unexpectedly and there is a lot of guilt at the death. When it comes to it, people often do not know how to deal with it and their obvious reaction is to channel the emotions on to someone else. It's a case of shooting the messenger.' (D17)

Other treatments also have bad news elements. One obstetrician suggested that treatment by obstetricians and gynaecologists often involved patients having to come to terms with a reconstruction of their sense of who they were:

> 'Sure, we deal with a life fulfilling event but we also have the opposite. There is the problem of miscarriage which has to be handled sensitively because people see themselves as having lost a child. Other conditions can ruin your sex life or strike at your identity as a woman.' (D25)

Conversely, doctors in the study argued that good news treatments had fewer complaints. One orthodontic consultant explained:

> There are few down sides to orthodontic treatment. It does not involve excessive discomfort and I only feel able to take on patients who really want it done. We only take someone on for treatment if we feel their looks can be improved significantly. In other words the specialty is designed so that it makes them happy. (D34)

The length of the relationship - or 'at-risk' period - with the patient was also highlighted as important. Paradoxically, doctors argued that, the longer the at-risk period, the less likely it was that a complaint would be received because, with frequent contact, the patient was much better able to place episodes of *unsatisfactory* care within the context of *satisfactory* care. A good example of this was said to be nephrology where a relationship with a patient could last 20 years. This allowed for a relationship of trust to develop. Conversely, accident and emergency specialists were expected to get a lot of complaints because of the abrupt and emotionally-charged nature of their interactions with patients.

Other treatments were thought to attract complaints because of the risks and uncertainties involved in the care and the difficulties of patients had in understanding this. Allsop has argued that: 'the body is not a map which can be clearly read' and that medicine is an exploratory process' (Allsop, 1994). Sociological studies of the doctor patient relationship suggest that doctors learn collective ways of coping with uncertainty and the inevitable failures which are part of medical practice. Fox (1957) used the term 'vocabularies of realism' to describe how doctors came to terms with uncertainty. The devices used included emphasis on uncertainties about the course of the disease process in individuals, the limits of clinical knowledge and the practitioner's grasp of this knowledge. (see also Atkinson, 1995, 1984, 1981). However, it has also been argued that doctors proceed on the basis of certainty, relying on their experience and personal judgement (Atkinson, 1984).

Clearly, this has the potential to create a mismatch of expectations between staff and patients. One consultant summed the problem up, thus: 'The problem of what is "bad" is difficult. Patients don't know. Doctors do not always know. Even standardised treatments can be difficult to deal with.' Consultants also discussed the problem of patients not understanding the risks involved in procedures. One consultant virologist explained:

> 'People's perception of lab work is that everything is black and white with yes or no results. There is actually a fair amount of interpretation to be done, but the complaints we get tend to relate to perceptions rather than truths.' (D4)

In contrast, risks in other treatments were seen as easy to explain and less likely to lead to problems. One consultant made the point: 'Issues in cardiology are easy to explain ... you can liken treatment to wiring a house or putting in new plumbing.'(D16)

Consultants also argued that, in certain situations, the consequences of error were more serious than others and that this increased the propensity to complain about certain types of treatment. Anaesthetics, obstetrics and orthopaedics were all cited as specialties where the effect of mistakes can be life threatening. As one anaesthetist remarked:

> 'Mistakes in anaesthesia are all or nothing. If you make a mistake it tends to be a really serious one. In medicine as a whole, doctors are pleased with a 60 per cent response rate, but in anaesthetics that one mistake means that your severity average shoots right up.'(D19)

Finally, doctors talked about the impact of high emotional investment by patients and others in the care received. In a psychiatric setting, it was suggested:

> 'There are lots of problems in dealing with relatives. They have lots of trouble coming to terms with your diagnosis and there is a lot of guilt

> around. They deal with this by being aggressive to me. Some relatives even have psychiatric problems themselves.'(D22)

In a similar vein, a paediatrician explained:

> 'There are very intense emotions wrapped up in the care of children. A number of relatives become attached and so there are more people to criticise us. People often feel guilty about sick children. If you feel bad, the best way to deal with this is to put blame on somebody else.'(D6)

Conclusion

This chapter has explored the professional and social networks used by consultants when they received a complaint and the impact these had on the ways in which they came to terms with complaints. It has been argued that the medical fraternity has an impact on the accounts of complaints given in two ways. First, medical networks are used to support doctors in receipt of complaints to the virtual exclusion of other avenues of support. Secondly, when doctors reflect on complaints they explain them by reference to bio-medical models of care which allow them to detract blame away from the medical care received.

Consultants relied most heavily on medical networks to meet many of their needs and most commonly, they turned to senior medical colleagues within the same trust or unit for practical and emotional support. Support networks appear to facilitate and influence the development of an account of the complaints which minimises the internalisation of guilt or responsibility. The lasting impression is of a discourse employed by medics which was structured to privilege them and leave the complainant as a passive patient. The explanations offered by doctors suggest that lay perceptions of unsatisfactory care are given little credence. In an era of consumerism, charters and pluralistic approaches to explanations of illness and standards of care, the discourse of the patient's right to complain and the validity of the stories they tell is lacking from explanation about what prompts a challenge to medical care.

The data presented suggest that the incidence of complaints can be explained in terms of factors associated with disease and the healing process. Complaints were often viewed as part of the emotional aftermath of diagnosis, a stage in patients coming to terms with their change in status, or prompted by their ignorance of the inevitable risks involved in medical treatment. In this way doctors reverted from being the subjects of criticism to healers with expert diagnostic powers. The model relies on doctors laying claims to a group identity. Medical practice was given an objective reality beyond the actions of individual doctors. In contrast to the unsympathetic images of complainants discussed when consultants were asked to explain their personal reactions to particular complaints about them the tone of accounts about cause is much more empathetic. This suggests that reference to group ideals provides a more palatable route in attempts to come to terms with criticism. As Cassell (1991) has argued physicians come to believe that to know the disease and its treatment is to know the illness and treatment of the ill person.

In drawing on the collective identity of the medical group doctors draw on identities which are familiar and provide some insulation from external challenges to medical work. Both Cohen (1994) and Weeks (1995), in their discussion of group identity, comment on the problem of maintaining common practices and the symbolic re-enactments which reaffirm group identity and difference. Complaints provide an opportunity for group interaction and the demonstration of solidarity as well as providing a sense of belonging through access to networks of support for the individual doctor. The data presented in this chapter suggests that responses to complaints are not isolated events but journeys of response which have an anchor in ever-changing notions of individual, professional and scientific identities.

The vehicle for the process of reconstructing damaged identities is the affirmation of scientific truth. Scientific approaches to the understanding of complaints lead doctors to look for objective signs which explain the dissatisfaction experienced by the complainant whilst negating the threat posed to the medic. The rhetoric of scientific knowledge about illness was used to identify the signs and observable clues of complaints as an illness manifestation - an offshoot of disease. In claiming the expertise to identify these clues, the consultants surveyed and interviewed undermined the patient's right to authenticity and the reader of the signs, having been challenged, emerged afresh as the expert.

9 Jurisdictional tensions in complaint handling

Introduction

Previous chapters have explored the ways in which complaints impact on, and mobilise doctors at an individual and collective level. It has been argued that complaints can have a significant and long lasting impact on doctors' sense of emotional well being and can alter the ways in which they practice medicine. It has also become clear in the course of the study that complaints represent a threat to group identity. Most obviously they challenge the claim to expertise which is at the heart of doctors' notions of professionalism. Discussion of these issues has focused on the threat posed to doctors by patients and their relatives. But complaints facilitate another type of challenge. The formal complaints procedure also acknowledges a role for managers in complaint handling and this has the potential to encourage another jurisdictional battle requiring collective identity work, this time between managers and doctors.

Doctors argue that medical training and knowledge marks them out from others such as patients and managers. This is the basis of the argument which has historically allowed them to claim insulation from external regulation. In this chapter it is argued that complaints provide a valuable case study in how the professional project is maintained in light of the threat of managerialism. The chapter explores the ways in which doctors attempt to forestall such threats by avoiding the regulatory framework imposed on them by the statutory complaints procedure. The chasm between the expectations of the formal complaints procedure and actual practice from the perspectives of both doctors and managers is examined. How doctors and managers interpret rules about complaints procedures is considered as well as how some doctors seek to circumvent or avoid managerial involvement. It is argued that in this way doctors protect either themselves or the professional group of which they are a part.

As was predicted in Chapter Four, the willingness of doctors to comply with official guidance is dependent on a number of situational factors. These include their knowledge of procedures, whether compliance is in their personal or professional interest and whether or not they think the controls on their activity facilitated by the complaints procedure are legitimate uses of power. The latter is particular important and highlights issues which are of crucial importance to socio-legal scholars in determining whether, and how, formal rules impact on activity. Attention is also paid to the different ways in which doctors and managers view complaints and the extent to which there is a jurisdictional battle between them about how the procedure operates.

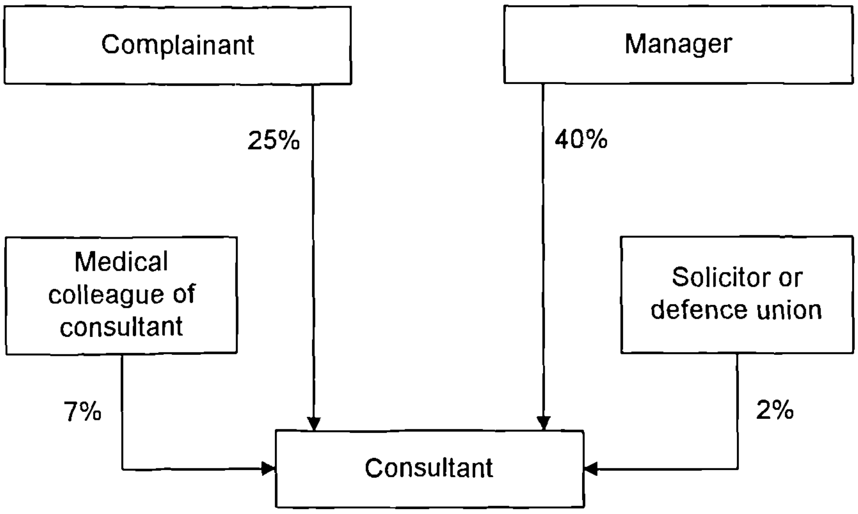
The chapter is in three sections. The first section presents information on doctors' knowledge of the complaints procedure and how doctors become aware of complaints about the care they have provided. The second section presents data on the channels through which doctors respond to complaints and the ways in which the guidance is interpreted. It is clear that the choice of channel for the receipt of complaints affects how doctors respond to them and their perceptions of 'ownership' of the complaint. The final substantive section describes the various complaint handling roles of managers. What emerges from the analysis are three main models of responses to complaints by doctors and managers: one based on conflict, one based on conciliation and one based on partnership.

Complaint channels

The formal procedure governing hospital complaint handling anticipates that there will be open channels of communication between consultants and managers about complaints. In addition, the *Patient's Charter*[1] requires that all responses to formal complaints should come from senior managers. Despite this, data from the postal survey reveal that much activity in response to complaints occurs in the shadow of the procedure. The guidance suggests that an administrator or manager should be informed about the receipt of a complaint so that they can provide accurate statistical returns to the Department of Health on the number of complaints received. This practice also put managers in an ideal position to co-ordinate responses to complaints, especially those which have a clinical and administrative element. There is a clear goal underlying this structure which acts against the potential for professional self regulation. When complaints were received or channelled through to a complaints administrator or chief executive, it is much more likely that they are logged and managed according to official guidance.

Data from the postal survey revealed that complaints reach consultants through a number of routes. Interestingly, the largest proportion of complaints (40%) were brought to the attention of consultants by a manager or administrator but as Figure 9.1 shows a significant proportion are addressed to consultants directly.

Figure 9.1: How do consultants become aware of complaints?



Note: In a further 26% of cases, consultants did not give information about how they received complaints

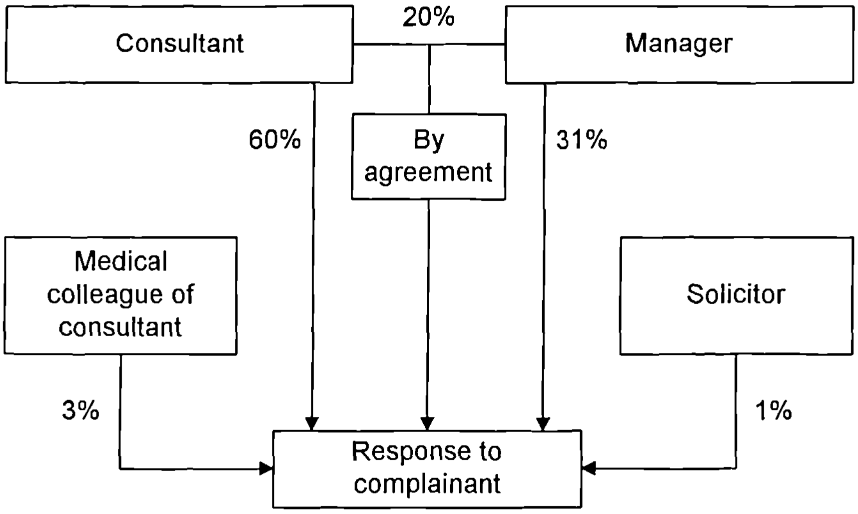
A further seven per cent of complaints were referred to consultants by medical colleagues and two per cent to consultants by a solicitor or defence union. This placed a third of the consultants complained about in a position to withhold information about criticisms of their behaviour from managers should they choose to do so.

In order to explore what consultants did in response to complaints received, doctors taking part in the postal survey were asked how they had responded to complaints once they had knowledge of them. Regardless of the channel through which the complaint was received (see Figure 9.1), the majority of consultants (60%) attempted to resolve complaints themselves without involving managers. Figure 9.2 shows the frequency with which each of the possible channels was used.

Who prepares and makes responses to complainants?

Consultants who responded directly to complainants used a variety of methods for doing so. One hundred and seventeen (48%) who had received a complaint had written to the complainant themselves, on at least one occasion. A further 64 had discussed the complaint with the complainant next time they saw them; 83 had specifically arranged a meeting with the complainant in order to discuss the grievance; and 19 had telephoned the complainant for the same purpose. The fact that so many doctors responded to complainants directly without involving managers suggests that they kept a firm control of the complaint-handling procedure. Managers co-ordinated and wrote replies, with the agreement of consultants, in only 20 per cent of cases and were involved in responding to complainants in just over half the cases.

Figure 9.2: What channels do consultants use when responding to complaints?



Note: Figures total more than 100 per cent because consultant may have used more than one channel

Using the grounded theory outlined in Chapter Five, a detailed content analysis of questionnaire and interview data was undertaken in order to explore how doctors and managers talked about their complaint handling role. This revealed that two main approaches to complain handling were adopted by managers and consultants who had received complaints. These did much to reveal the ideological tensions implicit in a complaints procedure which gives both professionals and managers an active role in complaint handling. The first was based on confrontation, with both doctors and managers taking a principled stance against the involvement of the other in managing disputes. This was an approach in which doctors and managers attempted to exclude each other from complaint handling. The second was more conciliatory, with doctors and managers describing the various ways in which they attempted to act in partnership with each other. In the sections which follow each of these models is visited in turn.

The confrontational approach

A significant group of both consultants and managers argued that the other should be less involved in complaint handling. Twenty of the 35 consultants interviewed gave three justifications for why they should respond to complainants directly without involving managers. Firstly, a number made it clear that they did not know about the existence of a hospital complaints procedure governing their activity. They said they were ignorant of the requirement to involve managers. Secondly, some consultants considered it appropriate to respond directly, as a matter of courtesy. They felt that if a complainant had taken the trouble to write to them, then the least they could do was respond personally. Consultants in this group tended to see the allegations as a matter between themselves and the complainant but what was most striking was their appeal to a standard of politeness and to ethical responsibilities. Many saw these as professional normative frameworks which should take precedence over bureaucratic rules. They also stressed the privacy of the doctor-patient relationship. Discussion of the formal procedure was absent from these accounts even though it was obvious from their questionnaire responses that the group were aware of the regulations[2].

But the strongest theme to emerge from the interviews was consultants' outright rejection of the necessity for managerial input in complaint handling. Amongst this group, managers who sought to co-ordinate and oversee replies to the complaint were identified as outsiders who did not possess sufficient medical knowledge to be able to construct a response to a complaint about medical care. This group of 18 of the 35 consultants interviewed felt a direct response was appropriate because the complaint was about a purely clinical issue. They were assertive in their claim that managers ought not to be involved in complaints about the standard of care. One consultant was typical of this group and made his position clear. He said:

> 'Clinical complaints must be dealt with by clinicians. What do managers know about treating patients? Apart from anything else they are dealt with much more quickly and directly that way. When I was clinical director, I would phone people up or go and see them and the complaint would just fizzle.' (D12)

And in the words of one former consultant who had been appointed as a chief executive:

> 'There is a problem when none of the people involved in complaints have a direct clinical knowledge or background and can't respond to patients in as sensitive a way as somebody who is used to dealing with patients ... Often *we* can short circuit or answer questions just from basic knowledge.' (M4)

Consultants justified this reaction by reference to the degree of control they felt they lost when they referred complaints to managers. One consultant explained his concern over this matter:

> 'Of course it helps to have an impartial person who will collect comments from clinicians, collate them and send them to the divisional director to draft a reply. But the clinicians involved should be given the final say before they go off. The way things work here, if there is a disagreement then the manager has the last word. That is just plain wrong.' (D5)

These concerns were echoed in a number of interviews and to some extent their fear of loss of control was substantiated by other data in the study. Data from questionnaires revealed that, where the response to the complainant was drafted by an administrator or manager, just under a third of consultants (62) were not even given an opportunity to approve the response, whilst 112 (59%) were. In a number of cases they were not kept informed of the outcome of the complaint and were still uncertain about whether the complaint had become a legal claim.

Managerial claims to jurisdiction

These data suggest that managers were also sensitive to jurisdictional tensions between themselves and doctors. A group of just over a third (9) of the managers interviewed were as jealous of their jurisdiction over complaints and as sensitive to possible infringement of their territory as were the doctors discussed above. At one extreme a manager was prepared to express her concerns in extremely adversarial language:

> 'Medics never, never accept that anything has ever gone wrong. I don't think the profession should be allowed to investigate their own mistakes. We're all

> employed by one organisation and we should have one method of investigating all complaints ... (M12)

Some managers were prepared to go to great lengths to preserve their authority in complaints handling. In one hospital, a manager felt compelled to get advice from the British Medical Association and Medical Defence Union to prove the scope of his powers under the formal procedure to a group of clinicians who had challenged him. In another hospital, a service director explained:

> 'One complainant asked to speak to a surgeon in my presence. I wrote to the surgeon asking if this could occur and hadn't heard anything back, so I went to see him and he said he had made an appointment to see the complainant on his own. That's the sort of thing that does happen, they do try and claw it back.' (M17)

These managers were sensitive to the fact that a major implication of complaints not being processed through the correct channels was that an official record of them could not be kept or the issues raised further investigated. One manager told the story of a retired consultant who left a whole drawer of unanswered complaints in his filing cabinet on his departure, many of them going back years. Another manager reflected on similar cases:

> 'I don't know how we get over the issue of doctors not telling us about complaints, but I worry about it. The only way would be to open all of their mail. We do try to advertise as fully as possible so that complaints are more likely to come through to us. Our biggest concern is to find out about consultants who are receiving a lot of complaints that they are not telling us about.' (M9)

Whilst maintaining what one manager called 'a healthy suspicion of doctors', this group of managers was more likely to be supportive of complainant's right to voice their grievance and to be empathetic about their concerns. In some cases, they also saw themselves as a champion of consumers. A handful referred to their responsibility as watchdogs of the patient's interests in the NHS:

> 'Most complainants just don't want it to happen to someone else. Most of them aren't in it for the money. This hospital is very much a town hospital. People locally raise a lot of money for us so they want to make sure that the hospital is the best. If things don't work properly they want to let us know. I find that encouraging.' (M4)

And again:

> 'My style is very simple because the complainant is often right. I think we should treat every complainant with respect and sensitivity. They are angry and unhappy about our service and my job is to tell the people who pay for the service the facts.' (M3)

It is significant that managers in this group were also more likely to be new-style chief executives than long-standing unit general managers and that the majority of those interviewed commented that their relationship with clinicians was changing since the introduction of the 1990 health service reforms. As one manager argued:

> 'On the whole, the consultants are very good but you have to understand that what has been happening in the NHS is a tremendous culture change for them. I was a laboratory manager until two years ago and a lot of other new managers have come up through nursing or finance. It is very difficult for them to accept that people they would have seen as administrators or

> subordinates a few years ago are now directing the organisation they work for.' (M18)

And again:

> 'There is change but it is happening slowly. A while ago they were more likely to say, "You are an administrator," and I was left saying, "I am a manager who makes his own decisions." This happens less often now.' (M12)

Managers justified their intervention in complaint handling on a number of grounds. The majority stressed that complaint handling was a role which had been formally assigned to them and for which they were accountable. This group was much more prepared to adopt a confrontational approach to doctors who would not co-operate because they saw such activity as a threat to their jurisdiction. One chief executive argued that the level of regulatory power they had should be commensurate with the amount of responsibility adopted:

> 'The legal obligation for the handling of complaints falls on me. If they are not handled well, then I am accountable. If a complainant takes the matter to the Health Service Ombudsman, then it is me who gets the flak. If a purchaser is critical of our handling of complaints, then they come to me. If a complaint goes to litigation, then the damages come from the budget I have to manage. I am the person with ultimate responsibility for the hospital. Basically, the buck stops here and not with clinicians.' (M21)

All managers interviewed were keen to stress their pivotal role in the organisation and the various ways in which complaints served the interest of the organisation regardless of the threat they posed to an individual doctor. The majority talked about complaint handling within the context of their quality remit. This group was worried that if they were not involved in handling complaints then complaints would become invisible to the organisation.

Some managers had a complaints group specifically responsible for discussing the lessons which could be learned from complaints and almost all the managers interviewed ensured that their board received a quarterly memorandum which outlined the number of complaints received, the time-scale taken to deal with them and some details of the issues raised. One unit was in the process of setting up a review body which would have the responsibility to comment on the tone and content of responses.

It was argued that quality management strategies were important for a number of reasons. Managers had contractual responsibilities to let their purchasers know the number of complaints received and how they dealt with them. The 1992 Patient's Charter required each unit to assess its standards and make sure it complies with them. Moreover it was argued that complaints were a way of getting free feedback about how an organisation's services were viewed by users which can be used to identify under-performing staff and make improvements. As one general manager, formerly a consultant, suggested:

> 'I am responsible for the clinical risk management policies, discipline and medical personnel matters. That necessitates an active involvement in complaint handling. I think it is important to know about quality and performance and a manager is the only person who is really in a position to co-ordinate information received by the organisation.' (M8)

One of the values of using complaints for quality management purposes was thought to be that it was a way of channelling negative reactions into a more positive direction. But the practical limitations of achieving this when medical issues were at stake was also recognised:

> 'When people complain, we should be grateful. They haven't gone to the press, they have taken the trouble to write to us and let us know. But getting

> that philosophy across is difficult, especially when investigations are inadequately resourced and tend to be something which is tacked on to someone's job. So far, doctors have been so busy reacting that the proactive approach hasn't got a look in.' (M27)

Managers also justified their increased involvement in complaint handling by reference to the need for impartiality. A dominant theme which emerged from discussions with these managers was that they felt that doctors faced insurmountable difficulties in being objective and measured about the allegations made about them. But one manager described how manager-led complaint handling could also involve adopting more than one role:

> 'You have to remind them that they are not alone. They are not the first doctor who has ever done something so terrible to be complained about. You need to support them. You should show them that you are a real person who can be in touch with them. The second thing you have to do is to take the complaint away from them so that it can be handled fairly by a manager.' (M4)

And again:

> 'No one should be allowed to investigate complaints made against them because they don't have a broad enough perspective when judging their own activity. Doctors tend to hide behind the facts as stated. So, if the opening sentence says the food is awful, then they will take that as read rather than digging deeper down for the real problem. It takes a manager who is wise to come in and take an independent view on what is really being said.' (M1)

Such commitment to impartiality varied according to the type of case. Some argued that where fault was found, managers should be prepared to act on their judgement to the detriment of staff within their organisation by disciplining them. For most of the mangers in this group, making a judgement on the merits of a case was considered to be an essential feature of managerial intervention. In the words of one manager:

> We do make judgements on whether we think we've been wrong or not. If we think we have been wrong, we say so. We invite people up and offer them some form of redress or apology. It's not just a matter of facilitating a traffic of documents. (M34)

And again:

> 'I do take statements from people and then interview them if necessary and then, on the basis of the evidence, make a judgement. If someone has done something wrong, then I ask them to apologise.' (M5)

The importance of attempting to make a determination of the truth of allegations or adjudicating between doctor and complainant was frequently referred to. It was felt that staff were often not content unless they had an opportunity to exonerate themselves fully from blame by putting their case. Moreover, it was argued that if complaints were to be of use for quality assurance purposes, the validity of particular allegations had to be established. In this sense, the needs of administrative justice reflected the needs of the quality remit.

Being distanced from the care relationship or circumstances of the complaint was one way in which managers saw themselves as being able to create a form of independence from the parties to the disputes. As one manager explained:

> 'It's easy to be apologetic about something that has gone wrong when you are not personally involved in it. It's also easier to see the problems with a service when you are not working your guts out every week trying to produce it.

> Inevitably our staff have an ownership of issues which makes them defensive about complaints. We are here to redress the balance of their inevitably defensive behaviour.' (M28)

Amongst these managers more frequent reference was made to the necessity of providing redress, such as apologies and admission of culpability where appropriate. They were also more likely to make clear their sensitivity towards process and, in particular, the importance of being able to provide a credible explanation of the cases being put by both sides.

A smaller number of managers also recognised the importance of facilitating an independent external review of certain complaints. This group demonstrated their willingness to bring in external agencies to effect the resolution of complaints. Two managers in the study had introduced a scheme whereby clinical complaints about specialities with few representatives in that hospital were referred to an independent clinical specialist for review. The results of the review were made available to both the complainant and the clinician complained about. Another manager had used his powers, on several occasions, to order an independent enquiry into cases which had been taken up by the media and which he felt were so serious that no one within the hospital would be seen as being impartial enough to handle them fairly.

But, such interventions tended to occur only in very serious cases. All senior managers were in agreement that the level of impartiality expected in independent enquiries was a luxury which could not always be justified. Two reasons for this were put forward. Firstly, a dispute involving competing arguments and requiring a determination between them may not yet have evolved. Managers described a number of complaints that seemed to be prompted by misunderstandings which might easily be put right without a member of staff having to adopt an oppositional role. Secondly, the nature of the complaint may not justify the expenditure of resources on an independent review. One manager explained:

> 'To look at every complaint as an independent ombudsman with a whole department and a lot of bureaucracy and antagonistic interrogating for 100-odd complaints a year is an overkill and would take a lot of money out of patient care.' (M23)

Partnerships

A second group of managers and doctors were less sensitive to jurisdictional tensions and preferred to characterise their relationship as being more akin to a partnership. Such arrangements between consultants and managers were much less common than the conflictual situations described above and, as the survey data presented in Figure 9.2 suggest, occurred in only a fifth of cases. Additional information supplied by consultants in the spaces provided in the postal questionnaire and in interview suggested a number of ways in which the partnership approach manifested itself. The most common scenario described was for consultants to talk complaints through with managers in an attempt to deal with the issues raised in them. One consultant explained how the partnership arrangement could work. He said:

> 'The managers in the trusts round here are very good and are accessible. They have got to know the consultants in their hospitals very well - there aren't that many of us. They work to the same purpose as the rest of us and give us good advice.' (DQ301)

One of the situations in which consultants were keen to operate in partnership with managers was when the complaint had the potential to become a legal claim. In some instances, doctors were actually advised by their defence union to draw the complaint to the attention of managers and discuss it with them. Interviews with managers revealed that complaints about clinical care which managers believed had the potential to form the basis of a medical negligence claim, were commonly referred to as those warranting the most attention by doctors and managers alike. Complaints classified as serious in this way were more likely to be seen as calling for a more impartial and interventionist stance in attempts to redress the grievance.

It was also accepted that managers could also be of use to doctors in other way by providing an alternative route for discussions. A number of consultants explained how they had offered to meet with the complainant, but their offer was not taken up or the complainant had been hostile to further discussion. In the words of one consultant: 'I went to the ward to see the patient. I thought it would be the best way to resolve the complaint. But all he did was shout abuse at me and ask for the manager!'

However, further analysis of data which had originally been placed in the partnership category revealed that for many the relationship was one in which a hierarchy existed. In this revised account of the approaches adopted, it was clear that partnership arrangements were highly contingent. As one doctor explained:

> 'Formal complaints are generally dealt with through management. Where a complaint involves clinical judgement then the clinician involved will be asked to respond and I would expect the manager to top and tail his response in line with the clinician's comments. This is only reasonable. As long as the facts are correct and what they are doing is documenting our opinions, then I think that's fair enough. But if it's about a clinical decision then there is no doubt in my mind that the clinician must respond directly.' (DQ401)

In this scenario the partners are not equal. Rather the manager was seen as servicing the consultant's need to make a response to a complaint. It is clear that the partnership arrangement was dependent on the manager acting in a way which is acceptable to the doctor. According to this approach, doctors should retain a power of veto over responses to complaints.

A large proportion of managers interviewed seemed prepared to take on this role and justify it. The adoption of this minimalist stance was particularly a feature of interviews with those managers who had either a medical or nursing background. These managers were happy to sanction self-regulation of clinical complaints in this way. Eighteen of the 24 managers interviewed made some form of statement in the course of the interview in support of this vision of the doctor-manager relationship. One chief executive explained the rationale behind such a position, as well as the potential risks. Thus:

> 'There are undoubtedly defensive mechanisms at play when staff send their account of events to me - people are naturally defensive and will collaborate on what is said. You will never get beyond that. But, we have to work in good faith with each other on the basis of the information that staff make available to us and it is their view that we promote. Occasionally, you realise after that the complainant was right and you have been misled. That's a price you have to pay for organisational harmony.' (M7)

Other managers justified a partnership of this kind with doctors for practical reasons. This group were most likely to talk about the long terms costs of pursuing an adversarial strategy with consultants. In the words of one:

> 'This medical-profession-versus-the-managers lark doesn't wash with me. I think that the creation of separate tribes and cultures is a right that people should have, but really it's just an excuse by doctors and managers for not taking joint responsibility for the delivery of care. I see some managers who posture a little. They tend to see it as a victory that they have lessened the clinical input into complaint handling. They are out of their depth. But the professional managers see their role as helping things happen in partnership. There is a well of sadism in all of us. We just have to make sure it doesn't leak!' (M22)

It was felt by many managers that the effective provision of services was not possible unless there was a partnership approach. This view of complaint handling provided doctors and managers with an incentive to give some weight to the others' claims, even if they regarded the opinions expressed were invalid or wrong. Some respondents argued that the adoption of an overly interventionist stance in complaint handling by managers merely resulted in one power elite (doctors) being replaced by another (managers). As one senior service manager explained: 'You see some managers struggling to topple doctors off their pedestal and all they do is just get up there and keep the space warm for themselves.'

This type of manager had more of a preference for the *status quo* than was evident among the 'interventionists' described in the last section. They were less likely to express concern about consultants handling their own complaints and were averse to the adoption of an approach which facilitated the handling of all complaints through the same system. They were also much more likely to adopt a liberal interpretation of the governing guidance. As one manager argued:

> 'Obviously, some of the individual doctors still get complaints of a totally clinical nature which won't appear in our database or in our logging system

> but those that we know about come to those of us in a position to co-ordinate them. At the moment there is no requirement for them to report them ... Often clinicians are invited to respond themselves. We use our judgement on it. Generally, they get back to us to let us know what happened. That way we both get to deal with the complaints we feel most comfortable with.' (M15)

Some managers respected the clinical opinion of medical colleagues so much that they claimed to merely transport sections of clinicians' responses to allegations into the final letter of complaint:

> 'Medics generally write a response to us and we paraphrase it back to the complainant. Sometimes we just transcribe it or say, "Here's a letter from your consultant which we hope answers your problems." On other occasions, the doctor writes the response and then just lets us know about it.' (M6)

Those adopting a minimalist approach were also more disparaging of complainants' motives than their interventionist counterparts. Their characterisations of complainants were similar to many of those outlined in the last chapter. One manager, an ex-nurse who estimated that eight out of every ten complainants was 'deranged' said:

> 'There are those who complain because they do not like the colour of the walls and lots of other petty concerns. Sometimes they are out of their tree and the CHC person is deeply embarrassed by this lunatic talking rubbish. You have to be polite, but you also have to avoid meetings with those ones.' (M13)

Along similar lines, another opined:

> 'It's fascinating to see that the level of complaint is inversely proportional to the seriousness of the patient's illness. People who are actually well, women having babies and things, complain constantly because they have got nothing else to do. They don't feel ill, they are just in there to complain, basically.' (M4)

Another argued:

> 'There has to be an element of defensiveness because it is NHS money. We are dealing with money earmarked for patient care, so until you know a complaint is not frivolous you have to be defensive.' (M22)

A number in this group described the tactics they employed in an attempt to discourage complaints, included the imposition of time delays on the making of complaints, failure to return calls and referral of complaints to other members of staff. These approaches were often justified by reference to two main arguments. Firstly, that any criticism of a member of staff was also, by implication, a criticism levelled at the services for which the individual manager was responsible. Secondly, that complaints can have a detrimental effect on good, as well as bad, staff that needs to be tackled.

Minimalist managers were also the least likely to see the value of adjudication and were critical of the use of legalistic terminology to describe what, for them, remained a medical issue. One chief executive explained:

> 'We shouldn't take complaints out of the hands of clinical teams and put in an unbiased third party to judge. They're not matters that need judging. They

> are all generally things for discussion within the specialty to come up with a consistent attitude to what they tell patients.' (M13)

Conclusion

It is clear that from the data presented in this chapter that managers and consultants react to jurisdictional tensions in the handling of complaints in different ways. Whilst some adopted an interventionist approach which challenged the autonomy of their 'opponent' in establishing their jurisdiction, others preferred to see themselves as supporting colleagues in a partnership. For many doctors the claim of 'outsiders' handling complaints was as real as being challenged by complainants. In both cases a significant proportion of doctors were concerned that threats to their autonomy were being posed by non-experts.

There was evidence that despite the fact that the majority of managers were content to play a subsidiary role to that of doctors attitudes were changing. Conflicts of interest clearly existed between managers and consultants. Managers' priorities may well be to use complaints as a public relations or damage limitation exercise. In contrast, the consultants' concerns focus more on professional reputation, the ability to voice defences and the provision of redress to the wronged party. These conflicts may cause the doctor to question both the legitimacy of managerial complaint handling and the degree of trust to be afforded managers when handling complaints. The jurisdictional tensions inherent in the formal procedure and day-to-day interpretation of it are most apparent from the data presented in this chapter on the channels used to respond to complainants. It was clear from this that a significant number of complaints never came to the attention of managers. The data reveal the chasm which exists between formal law and the law in action. As has been argued earlier in this thesis, whatever the intention of policy makers the effectiveness of any formal rules is reliant on the extent to which those operating formal systems embrace the ideologies they reflect.

Important interests are at stake in the debate over who should manage complaints. It is relevant that, shortly after the close of the study, the most confrontational of managers interviewed left the NHS after medical colleagues passed a vote of no confidence in him. These tensions reflected wider changes in the NHS, most notably the increasing moves to place formal power in the hands of managers and the emergence of hospital-wide programmes, such as risk and quality management schemes. These initiatives assume that doctors should account for their behaviour and require them to do so. But the differences of opinion between managers and between managers and doctors reflected ideological and political arguments about self-regulation which have been rehearsed throughout the history of the NHS. In the next and final chapter of this thesis these issues will receive further consideration.

Notes

1. Department of Health (1991)

2.Official guidance on the hospital complaints procedure (HC(37)88) anticipates that systems for the handling of complaints will be well publicised and made clear to patients and staff. Data from the postal survey of 848 consultants conducted for this thesis revealed that three-quarters of consultants who had been the subject of a formal clinical complaint were aware of the complaints procedure. One hundred and eighty-nine (77%) respondents said that they were aware of a formal procedure for the handling of complaints in their trust or unit. However, there were seven respondents who said that no such procedure existed and 16 did not know one way or the other.
Although the majority of consultants knew about the procedure, few had knowledge of its origin or an understanding of its detail. Almost a quarter of consultants in the complaints sample said that they had no knowledge of who had been responsible for drafting the procedure. The data suggest that the process of negotiating the separation of the clinical complaints procedure remained almost as invisible to rank and file members of the profession as it did to those outside policy-making circles. The majority (60%) of consultants thought that the procedure had been designed by health service managers at local (45%), district (9%) or regional (5%) level. Significantly, only two per cent mentioned any medical involvement in the drafting of the procedure. There was also a lack of knowledge of the role of the Health Service Commissioner. One hundred and twenty-five (51%) consultants said that they did not know what his role entailed. By contrast, all the managers interviewed had a detailed knowledge of the procedure. Interviews revealed a common process for dealing with complaints which involved written enquiries being made to members of staff who were either mentioned in the complaint, or who worked in, or supervised, the department being criticised. The person contacted tended to be a head of department or a clinical consultant approached in his or her managerial capacity. Any one complaint might involve several issues and thus generate several enquiries.

10 Conclusion

> 'Then the emperor walked along in the procession under the gorgeous canopy, and everybody in the streets and at the windows exclaimed, "How beautiful the emperor's new clothes are! What a beautiful train! And they fit to perfection!" Nobody would let it appear that he could see nothing for then he would not be fit for his post, or else he was a fool.' Andersen (1994, p219)

Introduction

The aim of this study has been to examine the ways in which doctors react and attribute meaning to complaints about clinical care. It has sought to explore one aspect of the interface between the state, the individual and powerful professional groups in society and has much to say about the impact of formal law in regulating such relationships. Most importantly, it has provided an opportunity to examine how a form of regulation negotiated by policy makers and elite groups at national level operates, and is constantly re-negotiated at service level. When looking at the connections between these two levels the study has sought to emphasise the general continuities between the legal system of formal rules and the social system of which it forms a part.

The study of complaints tends to have been seen as irrelevant to the study of key themes in public and administrative law. Complaints have not been viewed as involving matters of principle or sufficiently serious grievances. Instead emphasis has been placed on the dominant role of the courts, tribunals and ombudspeople and their role in regulating societal behaviour is assumed. In truth, the basis for judicial intervention in public administration is so narrow and adjudication by the courts and many tribunals so rarely sought that such contentions are ripe for challenge. This thesis has attempted to redress such imbalance and to make the case for the study of complaints to occupy a more central role in the study of administrative law. It has sought to draw attention to the various ways in which the parameters of legitimate public activity are constantly being negotiated away from the gaze of the legal system.

Despite the ambivalence of administrative lawyers to the study of complaints systems, these systems of grievance resolution are important for a number of reasons. They provide a system of justice and they enable those who provide services funded by the public purse to be held accountable for their activity. The need for effective complaint procedures is particularly critical in the public sector. These services are often in a monopoly position and the option of exiting a service is rarely available for users. Considerable inequalities of bargaining power between service-provider and service–user are the norm and these are further exacerbated when a service based on particular expertise is being provided, as is the case in the NHS. Many public services are provided for those who are amongst the most vulnerable, frail and disadvantaged members of our society. These are often the very people who cannot afford to access more complex and expensive systems for redress, such as the courts. For many, complaints systems are the first and only part of the civil justice system they will use.

In the final chapter of this thesis I will reflect upon the main themes to emerge from the study and some of their wider implications. The chapter is structured around the two main issues raised in Chapter One. Firstly, what does the study reported in this thesis reveal about how individual doctors react to being complained about? Secondly, what has the study revealed about the ways in which the medical profession respond to the challenges posed by complaints and regulation? The chapter concludes with a discussion of the policy implications of the research.

How has the study contributed to an understanding of reactions to complaints?

In the introduction to this thesis it was argued that reactions to voiced grievances have been under-researched and under-theorised. This is surprising given that the study of disputes raises important issues for social scientists and lawyers, such as norms and ideology, power rhetoric and oratory, morality, meaning and interpretation. Previous chapters have also suggested how complaining prompts the construction and re-construction of professional and disputing identities. It is in this way that this thesis has sought to bring the sociological imagination of macro-level abstract theories to bear on the mundane drama of everyday life.

The academic literature on disputes suggests that there are strong emotional reactions to being blamed. But, while previous studies have placed emphasis on the huge emotional costs to complainants in making complaints, no work has been undertaken within the context of the NHS which focuses specifically on doctors' reactions. The data in this thesis make clear that complaints prompt a severe, and often long-lasting, emotional reaction. Doctors argued that they were often the victims of unreasonable and improper demands and feelings of powerlessness and vulnerability were not uncommon. The emotional responses of doctors to complaints are not those generally associated with members of powerful elites. The strength of their response suggests that complaints can cause a temporary loss of confidence and a legitimation crisis. Why is this so?

The impact of complaints can only be understood if they are placed in the context of an understanding of the nature of the doctor-patient relationship in advanced Western societies. Doctors wield considerable power based on unique access to, and control of, a body of knowledge which is highly valued by society and State. This is particularly true of hospital consultants who have been successful at negotiating access to a range of workplace privileges since the NHS first came into being.

Commonly, their reconstruction of a valuable sense of identity relied on a deconstruction and undermining of both the complaint and the complainant. Doctors strove to emphasise their different explanations of the cause of events complained about. Patients were allocated the roles of difficult, irrational or unknowing subjects in comparison with the rational and knowing doctor. In this professional identity, doctors sought to externalise blame and maintain the image of the competent expert-knowledge worker. In this way, they were able to make assertions about the superiority of their form of narrative.

Doctors' claim to expertise is based on the notion that medicine is a scientific and rational exercise. This has allowed them to argue that they can approach patients, the objects of their experience, with the purity of an unprejudiced gaze. It has been suggested that the emergence of scientific rationality has allowed modern medicine to promote a different vision of illness from that which went before. Foucault (1976) has argued that, for medical experience to become possible as a form of knowledge, it has been necessary for hospitals to become organised, for a special status to be developed for the patient, for the State to enter into partnership with the medical profession and for a certain relationship between help and knowledge to be developed. In short, that the patients have to be enveloped in a collective homogenous space. The impact of this, is that the disease and diagnosis is substituted for the person being treated. The ways in which medical work is organised provides conditions for work shelter in which the collective identity of doctors as ethical, conscientious, competent and stable is maintained.

Complaints call into question the doctor's technical and moral authority and require that this identity be re-negotiated. Patients' common-sense accounts of illness and treatment contain explicit and implicit challenges to the bio-medical accounts of doctors and suggest patients also possess an understanding of health and illness. They represent a threat to the objectivity of expert knowledge and question the impartiality of that knowledge. These signs of dissent become even more explicit in complaints. It was noticeable from the data presented that doctors rarely accepted the validity of the complaint. This analysis of the alternative accounts of the medical encounter offered by patients provide important hints as to why complaints are met with such acute resistance from the medical profession. In this way complaints can be seen as sites of resistance to the imbalance of power in the doctor patient relationship and as claims to alternative ways of knowing.

Complaints draw attention to the ways in which the patient and doctor are motivated to attend to different aspects of 'shared' experiences which result in different qualitative meanings being attached to their encounters. Whilst the doctor is trained to perceive illness as a collection of physical signs and symptoms which define a particular disease state, the patient focuses on the impact of the illness on their everyday life. The notion of different discourses being employed to describe the same encounter is particularly well borne out by the data on allegation relating to communication and attitude. These allegations were by far the most common of those made and over half the consultants in the study had experience of them. I have argued that the high incidence of complaints relating to communication does not necessarily result from conscious insensitivity or inattentiveness on the part of doctors. Rather, it is suggested that these allegations reflect a systemic distortion of meaning in the doctor-patient relationship which results from the fact that doctors and patients experience illness and disease in significantly different ways.

The process of patients calling doctors to account has a transformative effect on the doctor-patient relationship. Complaints represent a challenge to the usual ceremonial order of the doctor patient encounter. Moreover, the patient expects, and is increasingly supported in their claim to be able to demand a reasoned response. It is anticipated by the state, the legal profession and patient groups that doctors should have to justify their behaviour. In so doing, they may well be called upon to articulate what is involved in their expert work and answer questions different from those usually posed. Complaints also provide an opportunity for managers to ask questions about and oversee the work of medics. Viewed in this way, complaints can be seen as political challenges to the status of scientific knowledge and the power of those whom are entrusted with it.

How has this study contributed to our understanding of how medical groups respond to external challenges?

The second goal of this thesis was to consider how close-knit professional communitie like the medical profession react to, and attempt to mitigate, the consequences of challenges to their power. As a group doctors face constant challenges. Attitudes towards regulation of the profession and their handling of complaints have changed radically over the last two hundred years. It is crucial to understand the political setting and social context in which debates on regulation have arisen if the forms of collective resistance are to be fully understood. The significance of complaints goes way beyond their impact on individuals. Each complaint reflects the dissatisfaction of an individual as well as a growing trend for traditional conceptualisations of the relationship between the State, profession and consumer to be challenged. But policy debates about the development and design of the hospital complaints procedure demonstrate how debates about complaints at national level have also focused on the need of the profession to gain and retain power over its own work.

In their attempts to come to terms with challenges to their expertise, doctors in this study drew on collective understandings of the nature of medical work which allowed them to reassert the importance of scientific rationality and expertise. Doctors relied heavily on medical networks for support. In time, with the support of medical colleagues, they came to understand complaints in the context of illness and, at times, as a manifestation of disease. In turn, this allowed them to explain complaints by reference to a bio-medical model which positioned the doctor as the giver of the diagnosis and observer of signs.

It has already been argued that individual doctors make extensive use of collective notions of identity when coming to terms with the challenge posed to them by a complaint. The extensive use of support networks by consultants in the sample and assertions amongst respondents about the adequacy of existing networks are suggestive of the ways in which the medical fraternity plays a part in the day-to-day responses to complaints made by individual doctors. The dominance of the medical collective is reinforced by the fact that so few consultants in the study sought help from people outside it.

Data presented in this thesis have revealed that the threat of outside interference also existed in relation to managerial handling of complaints. For some, the initial threat posed by a patient complaint was exacerbated by the opportunity it gave managers to question and attempt to oversee medical work. Viewed in this context, complaints are more than just a challenge to the individual complained about. They also pose a symbolic threat to all doctors since they help to promote debate and set boundaries around what is considered appropriate behaviour. In this context, they prompt discussion about the degree of accountability that doctors owe to patients and managers. They open up debate about the construction of competency to those who are outside the medical group.

Both doctors and managers were sensitive to the jurisdictional tensions posed by the formal complaints system. It was also apparent that managers and consultants reacted to these 'turf wars' in very different ways. In this setting, doctors were concerned that managers did not have sufficient interest in the protection of medical reputations and that their interest in handling complaints was to adopt an overly conciliatory stance with complainants. Managers were concerned that the tendency of some doctors to react defensively to complaints could cause an escalation of issues and that under-reporting of complaints meant that the quality issues raised by complaints could never be fully considered. Some were adversarial and would go to considerable lengths to assert their formal or moral authority over complaint handling, while others sought to act in partnership.

Complaints also provided an opportunity for doctors to flout bureaucratic rules and often such avoidance was justified by reference to opposing normative frameworks, in particular, the higher ethical standards imposed by the profession. As expert workers with high social standing and significant levels of control over their own work, doctors are well placed to resist the degradation and compulsion which they see managers as routinely attempting to inflict on them. The data which have been presented on the number of complaints which remain hidden from managers emphasise the built-in constraints on the capacity of organisations, and governments, to impose their categorisations on unwilling participants. Such resistance is an important expression of selfhood and collective power. In this way, it can be seen that complaints provide opportunities for mundane and everyday resistances to being called to account by outsiders which are supported by collective ideals.

What next?

What are the implications of the research being reported here? In the introduction to this thesis, I argued that policy initiatives, such as increasing attempts to regulate complaint handling, can only be realistic if we improve our understanding of how people providing services respond to the broad range of threats posed to the integrity of the professional group. The issues of how social power is wielded by professionals at service level and challenged in complaints are central to identifying how social policy is most likely to be effective.

This thesis has drawn attention to the many ways in which doctors have resisted regulation of their work. Their resistance has taken many forms and operated at many levels. Some of these have been more visible than others. They have challenged formal bureaucratic controls on their autonomy in national debate, they have promoted the development of self-regulatory models of complaint which emphasise the supremacy of medical knowledge over other understandings of health and illness. Other forms of resistance to being regulated have been less obvious and have not been researched. This thesis has shown how resistance is also an everyday activity of those treating patients and that it goes on in local hospitals as well as on the national stage. The data reveal much about the difficulties of integrating bureaucratic and professional models in the provision of public services.

Discussion of how professional groups can be integrated within bureaucratic structures is not new. In the NHS, doctors are an active and important force in determining the ways in which services are provided and professional workers held to account. As Hunter (2000) has suggested:

> 'Ministers think they have doctors on the run as they turn up the heat under the General Medical Council and the Royal Colleges in the aftermath of several celebrated cases of malpractice or worse … If the government truly wishes to redesign the NHS, then it needs to adopt a radically different prescription and model of change management that appreciates the distinctive features and seeks to work with doctors not against them.' (p18)

But the situation is not as simple as taking the needs of doctors into account. It is undoubtedly the case that the NHS remains highly fragmented in its culture, and that several sets of values compete for supremacy. It is, at best, a coalition of vested interests an it may only be through a process of negotiated order that reforms of the kind discussed in this thesis will succeed. It also remains the case that there continue to be many different models of regulation and each rests on a different ideological foundation.

But, the policy environment is changing rapidly and there are many indications that debate on complaints will become one of the forums where tensions between policy makers, the profession, managers and patients will be played out. There are several signs that the public is less sympathetic to the needs of hospital doctors than was once the case. Debates about the most appropriate form of regulation and concerns about the effectiveness of self-regulation are becoming increasingly common. At the time of writing, the most recent inquiries into the murder of patients by Harold Shipman, the handling of poor practice at the Bristol Royal Infirmary and concerns about the irregularities in smear testing at Kent and Canterbury hospital have brought concerns about the safety of patients to the fore (House of Commons, 1999; *British Medical Journal*, 1998; *Daily Telegraph*, 1998). In parallel with these developments, the Department of Health has launched a raft of initiatives aimed at encouraging a more systemic approach to the identification of quality issues, including most notably the setting up of the Commission for Health Improvement and the National Institute for Clinical Excellence. These developments have led to the proliferation of clinical protocols which seek to regularise the practice of clinical work (see, for instance, Bristol Inquiry, 2000; National Institute for Clinical Excellence, 2000). These have provided a policy environment in which more radical re-negotiation of the compact between the state and profession could take place.

Since coming to power in 1997, the Labour government has laid stress on achieving higher standards in health care; better and more equal outcomes from health care interventions; greater partnership with patients; greater accountability and the undermining of elites. Complaints also remain on the agenda. In 1999, the Cabinet Office published new guidance on how to deal with public sector complaints and the new complaints system introduced in 1996 is again being evaluated. New policy objectives will be achieved within the context of a stricter regulatory regime designed for early identification of poor practice by professionals or managers. It has been widely accepted in policy circles that complaints have an important part to play in such systemic approaches to quality.

There is a commitment to 'modernising' the NHS and proposals to improve quality are set out in *A First Class* Service (DoH, 1998; DoH, 1997). In future, the monitoring of both the content and handling of complaints is likely to play a part in reviews carried out as part of clinical audit and clinical governance within health authorities, trusts and primary care groups as well as the reviews undertaken by the Commission for Health Improvement. In addition, professional bodies have introduced changes which increase the amount and extent of regulation. The General Medical Council (GMC) has brought in measures to improve the standards of doctors who have been identified as performing poorly. There is also a new scheme for regular revalidation of practising doctors (GMC, 1998). But there are also signs of tensions between elite medical groups with an interest in regulation as the BMA's vote of no-confidence in the GMC following the publication of the Ritchie report on Rodney Ledwerd suggests (DoH, 2000; Moore, 2000). Significantly, it has been claimed by commentators that tensions between the BMA and GMC have been growing for several years since the latter has made a more concerted effort to control the quality of practising doctors by a process of revalidation (Moore, 2000).

What is clear from all of these developments is that the provision of health care is becoming increasingly politicised. The greater the demand for personal equality and the greater the move towards a web of regulatory frameworks, the louder the calls for changes to the organisation of medicine. This study of complaints has provided a prism through which to view such pressures. The challenges to medical work posed by complaints are both an antecedent to, and a reflection of, changes in societal attitudes towards doctors. It can only be hoped that in the future they will become a more effective tool for improving the responsiveness of the medical elite and opening up debate about the validity of the different voices to be heard in the medical encounter.

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Appendices

Appendix 1: The covering letter to consultants

Dear Consultant

Oxford Clinical Complaints Project – The Clinician's Perspective
Questionnaire for Doctors

Oxford Regional Health Authority is interested in finding out more about the impact on doctors and other staff of clinical complaints and has funded a two year research study to look into the matter.

Underlying aims are to give voice to the opinion of clinicians and to discover the impact complaints have on them. The research director will be working closely with a medical board chaired by Dr Harvey Marcovitch, chairman of the Regional Medical Advisory Council.

Possible outcomes might include a model of how best to handle complaints and provision of teaching material for under- and post-graduates.

The Chairman of your regional specialty group has been kept informed throughout and all have offered support.

As a first stage, the research director would like to get some idea of the following:
1. How many complaints are received regarding clinical care or involving clinical staff;
2. What proportion are dealt with directly by clinicians as opposed to being handled through other channels;
3. What impact they have on practice;
4. What support clinicians seek in resolving complaints;
5. How responses are formulated;
6. How often complaints escalate to further review or litigation.

The RHA and the project team would be extremely grateful if doctors could support this research by giving up the time to complete the enclosed questionnaire.

Participation is, of course, entirely voluntary but success of the project depends entirely on your goodwill in agreeing to take part.

All information will be treated in strict confidence; you need not identify yourself unless you wish to contribute further.

If you do not have the time to complete the questionnaire but are willing to be interviewed at your convenience; please fill in section one of the last page and return it to the address below.

Because of the number of questionnaires being sent out we have been unable to personalise each of the letters. Please accept our apologies for this in advance.

Yours sincerely

Linda Mulcahy, Research Director Harvey Marcovitch FRCP, Clinical Director

Appendix 2:

Oxford Regional Health Authority

Clinical Complaints Project

Consultants Questionnaire

About Yourself

1. In what year did you qualify as a doctor?

Please insert number as appropriate: 19 ____

2. What is your medical specialty?

Please tick as many as are appropriate:

A&E [ ]
Anaesthetics [ ]
Cardiology [ ]
Cardio-thoracic surgery [ ]
Chemical pathology [ ]
Clinical genetics [ ]
Community medicine [ ]
Dermatology [ ]
General medicine [ ]
General surgery [ ]
Genito-urinary medicine [ ]
Geriatrics [ ]
Haematology [ ]
Histopathology [ ]
Medical microbiology [ ]
Mental handicap [ ]
Mental illness [ ]
Neurology [ ]
Neuropathology [ ]
Obs&gynae [ ]
Opthalmology [ ]
Oral surgery [ ]
Orthodontics [ ]
Orthopaedics [ ]
Otolaryngology [ ]
Paediatrics [ ]
Palliative medicine [ ]
Plastic surgery [ ]
Psychiatry [ ]
Psychotherapy [ ]
Radiology [ ]
Radiotherapy [ ]
Rheumatology [ ]
Urology [ ]
Other [ ] *Please specify below*

3. What was the year of your birth?

Please insert number as appropriate: 19 ____

4. What sex are you?

Please circle as appropriate: male
female

Your Experience of Complaints

Formal Clinical Complaints:
A Definition

For the purposes of this project,

a formal clinical complaint is defined as:

'An expression of dissatisfaction about a clinician or clinical treatment which has been made in writing to a consultant or a manager about a consultant.'

5. Have you personally, in your career, ever been the subject of a formal clinical complaint?

Please circle only one: Yes
No *Go to q.33*

6. Approximately, how often has this happened in your career?

Please insert number as appropriate: __________

7. Have you been the subject of a formal clinical complaint in the last twelve months?

Please circle only one: Yes *Go to q.7a*
No *Go to q.7b*

7a. **If yes,** of how many formal clinical complaints have you been the subject in the last twelve months?

Please insert number as appropriate: __________

7b. **If no,** in what year did you receive the last formal clinical complaint?

Please insert year as appropriate: 19 ____

Details of complaints

Please answer all the remaining questions in relation to all the formal clinical complaints you have mentioned above.

8. How did you become aware of the formal clinical complaint(s) of which you were the subject?

Please insert number(s) as appropriate:

Complaint channel	**No. of instances**
Written complaint – addressed to you directly	
Written complaint – made known to you by medical colleague	
Written complaint – made known to you by administrator manager	
Other *please specify:*	

If you would like to give further details, please do so below:

____

____

____

____

9. Please give some idea of the type of allegations made in the complaints you have mentioned above:

Since there may be more than one allegation per complaint, the number of allegations made does not necessarily have to equal the number of complaints detailed above.

Type of allegation	**No. of instances**
Waiting time for treatment e.g: cancellations; waiting lists.	
Communication and attitude e.g: problems with explanation of treatment and risks; incomplete, inaccurate, hurried explanation; failure to answer or respond to questions; breach or lack of confidentiality; rudeness; discrimination on grounds of race, sex, religion or age.	
Problems with tests and diagnosis e.g: refusal or failure to offer tests; improper performance of test; loss of test results; conflicting test results; failure to diagnose condition; wrong diagnosis; delay in diagnosis.	
Problems with surgery e.g: failure to perform necessary surgery; improper performance or management; delay; foreign body retained after surgery; improper choice of anaesthetic.	
Medication e.g: failure to medicate; wrong medication or dose administered.	
Treatment problems (other than surgery) e.g: failure to treat when necessary; improper choice of treatment; improper performance or management; unnecessary treatment; delay; premature end of treatment.	
Care of patient prior to, during and after treatment e.g: failure to monitor patient; failure to respond to patient's requests; failure to report on patient; undignified treatment; premature discharge.	
Lack of hygienic methods e.g: unhygienic personal habits; unhygienic procedures.	
Other	

If you would like to give further details, please do so below:

10. In your view was/were the complaint(s) justified?

Complaint justified?	**No. of instances**
Yes, completely	
Partly justified	
Not at all	

If you would like to give further details, please do so below:

Your reactions to the complaints

11. Do any of the following emotions describe the way you felt when you received news of the complaint(s)?

Please tick as many as are appropriate.

Anger ☐
Irritation ☐
Exposure ☐
Vulnerability ☐
Devastation ☐
Worry ☐
Distress ☐
Surprise ☐
Indignation ☐
Humiliation ☐
Sadness ☐
Disappointment ☐

Annoyance ☐
Upset ☐
Isolation ☐
Panic ☐
Embarrassment ☐
Concern ☐
Anxiety ☐
Disgust ☐
Hurt ☐
Betrayal ☐
Frustration ☐

None of the above ☐

If you would like to give further details, please do so below:

12. Did you experience <u>other emotions</u>?

Please circle only one: Yes
No *Go to q.13*

If yes, please give details below:

13. Was there anything in particular which bothered you <u>about the complaints</u>?
Please circle only one: Yes
No *Go to q.14*

If yes, please give details below:

14. Has/have the complaint(s) had an impact on the way in which you practice medicine?

Please circle only one: Yes
No *Go to q.15*

If yes, tick any of the following which describe these changes:

Increased clinical vigilance [ ]
Tendency to seek more advice [ ]
Better record-keeping [ ]
Recording information which is less pertinent [ ]
Ordering of more diagnostic tests [ ]
Avoidance of certain types of patients [ ]
Fuller consultations with patients and/or relatives [ ]
Adjustment of bedside manner [ ]
Reducing size of clinics [ ]
Giving more responsibility for decision-making to patients [ ]
None of the above [ ]

15. Are there any other ways in which you behaviour or attitude has changed?

Please circle only one: Yes
No *Go to q.16*

If yes, please give details below:

16. Did you discuss the complaint(s) with a medical colleague?

Please circle only one: Yes *Go to q.16a*
No *Go to q.17*

16a. **If yes,** with how many medical colleagues did you discuss it?

Please insert number as appropriate: __________

We are interested in the particular medical colleagues with whom you discussed the complaint. Please give details in the table below, circling Yes or No as appropriate.

Medical colleague with whom the complaint was discussed	**Involved in the patient's care?**	
A <u>senior</u> medical colleague **within** your Trust/Unit	Yes	No
A <u>senior</u> medical colleague **outside** your Trust/Unit	Yes	No
Another medical colleague **within** your Trust/Unit	Yes	No
Another medical colleague **outside** your Trust/Unit	Yes	No

If you would like to give further details, please do so below:

____

____

____

____

17. Did you discuss it with a non-medical colleague or other person?

Yes	*Continue*
No	*Go to q.18 (unless **no**, to* <u>*both*</u> *q.16 and q.17, then go to q.20)*

Please circle Yes or No as appropriate:

Non-medical colleague or other person with whom the complaint was discussed	Please circle Yes or No	
	Yes	No
Senior manager within Trust/Unit		
Legal claims department or solicitors used by Trust/Unit or Health Authority	Yes	No
Own solicitor	Yes	No
Medical Protection Society/Medical Defence Union	Yes	No
Friends or relatives	Yes	No
Other – *please specify*	Yes	No

If you would like to give further details, please do so below:

18. What was your purpose in discussing the complaint with [those listed at q.16 and/or q.17]?

Please circle as many as are appropriate using the following key:

A = Senior medical colleague
B = Other medical colleague
C = Senior manager
D = Legal claims dept. or solicitor of Trust/Unit/Health Authority
E = Own solicitor
F = Medical Protection Society/Medical Defence Union
G = Friends and relatives
H = Other

Purpose in discussing the complaint	Please circle appropriate Letter(s)							
Support	A	B	C	D	E	F	G	H
Comfort	A	B	C	D	E	F	G	H
Getting it 'off you chest'	A	B	C	D	E	F	G	H
Advice	A	B	C	D	E	F	G	H
To gain information	A	B	C	D	E	F	G	H
To inform	A	B	C	D	E	F	G	H
Confirmation of your views	A	B	C	D	E	F	G	H
Feedback	A	B	C	D	E	F	G	H
Other purpose – *please specify*	A	B	C	D	E	F	G	H

If you would like to give further details, please do so below:

19. Did anything they said have an impact on the way you responded to the complaint on an emotional or practical level?

Please circle only one: Yes
No *Go to q.20*

***If yes**, please give details below:*

____

____

____

____

20. Would you have liked to have someone [else] to talk to about the complaint?

Please circle only one: Yes
No *Go to q.21*

***If yes**, please give details below:*

____

____

____

____

Your response to the complaints

21. For any of the complaints mentioned above did you ever respond directly to the complainant?

Please circle only one: Yes *Go to q.21a*
No *Go to q.22*

If yes, please give details below:

21a. **If yes,** how did you respond?

Please insert numbers as appropriate:

Your response	**No. of instances**
Wrote directly to complainant	
Discussed the complaint with the complainant next time you saw them e.g. patient's next outpatient appointment	
Telephoned complainant to discuss complaint	
Called/attended a meeting with the complainant and others in order to discuss the complaint	
Other – *please specify*	

If you would like to give further details, please do so below:

22. For any of the complaints mentioned above did anyone else respond directly to the complainant on your behalf?

Please circle only one: Yes *Go to q.22a*
No *Go to q.24*

22a. **If yes,** why didn't you respond personally?

Please insert numbers as appropriate:

Reasons for not responding personally	No. of instances
All complaints are dealt with through management	
Handled by management without your knowledge	
Handled by management by agreement with yourself	
Handled by senior medical colleague	
It involved a legal issue	
Not asked to/consulted about response	
Advised not to – *please specify by whom:*	
Other – *please specify:*	

If you would like to give further details, please do so below:

____

____

____

____

23. Where any response(s) was/were drafted by someone else, were you given an opportunity to approve the response(s)?
Please circle only one: Yes *Go to q.23a*
No *Go to q.24*

23a. **If yes,** how many times did this occur? ____________

General

24. Do you find particular types of complaint(s) or complainant(s) are more difficult to deal with then others?

Please circle only one: Yes
No *Go to q.24a*

If yes, please give details below:

24a. Do you think that certain types of people are more likely to complain than others?

Please circle only one: Yes
No *Go to q.25*

If yes, please give details below:

---

25. Are there any aspects of the way complaints are currently handled in you hospital/district/ region that you particularly dislike or disagree with?

Please circle only one Yes
No *Go to q.26*

If yes, please give details below:

---

26. Are there any aspects of the way complaints are currently handled in you hospital/district/ region that you particularly like or agree with?

Please circle only one: Yes
No *Go to q.27*

If yes, please give details below:

27. Have you personally developed any techniques for handling complaints which you think could be usefully employed more widely and/or do you have any suggestions as to how complaint handling might be improved?

Please circle only one: Yes
No *Go to q.28*

If yes, please give details below:

28. Does a formal procedure for the handling of complaints exist within your Trust/Unit?

Please circle only one: Yes *Go to q.28a*
No *Go to q.29*

28a. **If yes,** who designed the formal procedure?

Please tick as many as are appropriate:
Parliament [ ]
Department of Health [ ]
Regional Health Authority [ ]
District Health Authority [ ]
Trust/Unit managers [ ]
BMA [ ]
Citizen's Charter Unit [ ]
Health Service Commissioner (Ombudsman) [ ]
Don't' know [ ]
Other – *Please specify* [ ]

29. Do you know what the Health Service Commissioner does?
Please circle only one: Yes
No

30. In your opinion what are most complainants looking for when they make a complaint?

Please tick as many as are appropriate:

An apology [ ]
An explanation [ ]
Treatment/remedial treatment [ ]
Redoubled efforts [ ]
A decision reversed [ ]
Doctors to be reprimanded or disciplined [ ]
Something to be done more quickly [ ]
Compensation [ ]
Wavier or reduction of a fee [ ]
Assurance that the event will not recur [ ]
An investigation [ ]
None of the above [ ]

If you would like to give more details, please do so below:

31. Is there anything else which you think complainants commonly seek?

Please circle only one: Yes
No *Go to q.32*

If yes, please give details below:

Litigation

32. Have you ever, in your career, been the subject of a medical negligence action?

Please circle only one: Yes *Go to q.32a*
No *Go to q.33*

32a. **If yes,** on how many occasions? ________

And

32b. Did any of these begin as the formal clinical complaints you have mentioned above?

Please circle only one: Yes
No *Go to q.33*

If yes, how many? ________

Ethnicity

> *We are particularly interested in finding out whether ethnic culture has an impact on: the likelihood of receiving; reaction to; and handling of complaints. We would be most grateful if you could provide answers to the following:*

33. In which country were you born?

34. Which of the following categories best describes you ethnic identity?

Please tick as many as are appropriate:

English ☐
Scottish ☐
Welsh ☐
Irish ☐
British ☐

Indian ☐
Bangledeshi ☐
Pakistani ☐
Asian ☐

Greek ☐
Greek Cypriot ☐
Turkish ☐
Turkish Cypriot ☐
Kurdish ☐

Chinese ☐
Vietnamese ☐

Arab ☐

African ☐
Caribbean ☐
Afro-Caribbean

Jewish ☐

Polish ☐

Other – ☐ *Please specify:*

If there is some other way you prefer to describe your ethnic identity, please do so below:

35. How would you describe your colour?

Please give details below:

Thank you for you assistance, it is much appreciated.

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Appendix 3: Classification of specialties by main and sub-specialties used by the Department of Health

Medical	Cardiology Clinical genetics Dermatology Endocrinology Gastroenterology General medicine Genito-urinary medicine Geriatrics Infectious diseases Neurology Neurophysiology Oncology Orthodontics Paediatrics Pain management Palliative medicine Rehabilitation Thoracic medicine Rheumatology
Obstetrics & gynaecology	Obstetrics and gynaecology
Pathology	Chemical pathology Cytopathology Haematology Histopathology Medical microbiology Neuropathology
Psychiatry	Mental handicap Mental illness Psychiatry Psychotherapy
Radiology	Radiology Radiotherapy
Surgical	Accident & emergency Anaesthetics Cardio-thoracic surgery General surgery Intensive care/therapy Ophthalmology Trauma & orthopaedics Otolaryngology/ENT Oral surgery Plastic surgery Transplantation &/or vascular surgery Urology
Other	Community medicine Family planning Public health Spinal injuries

Appendix 4: To show specialties of consultants in sample as compared with ORHA and nationally

Specialty	Frequency	Sample %	ORHA %	National %[1]
A&E	8	1.8	1.7	1.5
Anaesthetics	58	13.1	11.3	13.4
Cardiology	6	1.3	1.0	1.2
Cardio-thoracic surgery	0	0.0	0.7	0.8
Chemical pathology	3	0.7	1.0	1.0
Clinical genetics[2]	3	0.7	0.9	0.1
Clinical immunology*	2	0.4	other	0.02
Community medicine	3	0.7	0.9	0.1
Cytopathology[3]*	4	0.9	other	other
Dermatology	15	3.4	1.8	1.5
Endocrinology[4]*	3	0.7	2.1	other
Family planning*	1	0.2	0.2	other
Gastroenterology[5]	5	1.2	other	0.3
General medicine	32	7.2	6.6	7.6
General surgery	14	3.2	5.5	5.9
Genito-urinary medicine[6]	7	1.6	1.1	1.0
Geriatrics	11	2.5	2.5	3.4
Haematology[7]	14	3.2	2.7	2.2
Histopathology	13	2.9	3.0	3.4
Infectious diseases[8]	4	0.9	0.4	0.3
Intensive care/therapy*	7	1.6	other	other
Medical microbiology[9]	9	2.0	1.6	1.8
Mental illness[10]	20	4.5	6.3	7.2
Nephrology*	1	0.2	0.2	0.5
Neurology[11]	8	1.8	2.1	1.2
Neurophysiology*	2	0.4	0.6	0.3
Neuropathology	1	0.2	0.7	0.2
Obs&gynae[12]	18	4.1	4.6	5.1
Occupational health*	1	0.2	0.2	0.3
Oncology*	6	1.3	other	0.3
Ophthalmology	11	2.5	2.9	2.9
Oral surgery	5	1.1	1.2	1.4
Orthodontics	5	1.1	0.8	0.9
Otolaryngology/ENT*	5	1.1	2.2	2.3
Paediatrics[13]	36	8.1	5.3	5.1
Pain management*	7	1.6	other	other
Palliative medicine	5	1.1	0.7	0.2
Plastic surgery[14]	3	0.7	0.9	0.7
Psychiatry[15]	54	12.2	4.8	3.3
Psychotherapy	7	1.6	1.0	1.5
Public health*	1	0.2	other	other
Radiology[16]	29	6.5	6.7	7.2
Radiotherapy	7	1.6	1.2	1.3
Rehabilitation	3	0.7	0.6	0.2
Thoracic medicine*	6	1.3	0.6	0.7
Rheumatology	9	2.0	1.6	1.4
Spinal injuries*	1	0.2	other	other
Transplant &/or vascular surgery*	3	0.7	other	other
Trauma* & orthopaedics	21	4.7	5.0	4.7
Urology	4	0.9	0.6	1.5
Other	n/a	n/a	3.5	4.0
Missing	16	3.6	n/a	n/a

*Respondents were given the option of 'other' when answering this question. These are all new categories introduced following a detailed analysis of their responses to this part of q.2.

Notes on Appendix 4

[1] Excluding Northern Ireland.
[2] Includes genetics (1).
[3] Includes cytology (1).
[4] Includes diabetology (1) and diabetology and lipidology (1).
[5] Includes hepato-biliary surgery (1).
[6] Includes vulval clinic (1).
[7] Includes one case that specified paediatric, clinical and laboratory haematology.
[8] Includes tropical medicine (1).
[9] Includes virology (1).
[10] Includes epilepsy clinic (1).
[11] Includes neurological disability (1).
[12] Includes conception and reproductive medicine (1) and obstetric medicine (1).
[13] Includes neonatology (1).
[14] Includes burns (1).
[15] Includes child and adolescent psychiatry (9), forensic psychiatry (1) and old age psychiatry (1).
[16] Includes radiology of breast disease (1).

Appendix 5: Selection of interview sample by specialty

Priority and specialty	ORHA total	ORHA %	Target figure	Actual figure
1 Anaesthetics	101	11.9	6	8
2 Radiology	60	7.1	3	3
3 General medicine	59	7.0	3	4
4 Mental illness	56	6.6	3	2
5 General surgery	49	5.8	2	2
6 Paediatrics	47	5.5	3	3
7 Psychiatry	45	5.3	3	4
8 Orthopaedics	45	5.3	2	2
9 Obs&gynae	41	4.8	2	2
10 Histopathology	27	3.2	2	0
11 Ophthalmology	26	3.1	1	2
12 Haematology	24	2.8	1	1
13 Geriatrics	22	2.6	1	1
14 Otolaryngology	20	2.4	1	0
15 Community medicine	19	2.2	1	1
16 Dermatology	16	1.9	1	1
17 Medical microbiology	14	1.6	1	1
18 Rheumatology	14	1.6	1	1
19 Oral surgery	11	1.6	1	1
20 Radiotherapy	11	1.3	1	1
21 Genito-urinary medicine	10	1.2	1	1
22 Cardiology	9	1.1	1	1
23 Chemical pathology	9	1.1	1	1
24 Urology	9	1.1	1	1
25 Other*	104	12.3	7	8
Total	**848**	**100.0**	**50**	**52**

*One of each of orthodontics, rehabilitation, intensive care, nephrology, endocrinology, A&E, gastroenterology and psychotherapy, chosen to balance district representativeness.

Appendix 6: Selection of interview sample by district

District	ORHA total	ORHA %	Target figure	Actual figure
Aylesbury Vale	69	8.1	4	4
East Berkshire	86	10.1	5	6
Kettering	59	7.3	4	4
Milton Keynes	54	6.7	3	3
Northants	73	9.0	4	4
Oxfordshire	351	41.7	20	20
West Berkshire	105	12.4	6	7
Wycombe	70	8.2	4	4