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From fear to fraternity: doctors’ construction of accounts of complaints

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Abstract: This article considers one form of consumer activism which has been largely overlooked by academics: complaining. The results of a two-year study of hospital consultants’ responses to complaints about medical care are presented. It is argued that complaints have a significant and lasting effect on doctors and that they can lead to a legitimation crisis for them. Complaints cause an initial deconstruction of identity which is followed by a reconstruction anchored in the rhetoric of scientific rationality. Rather than being seen as legitimate expressions of grievance, complaints are commonly portrayed by consultants as symptoms of illness or manifestations of the problem personalities of the complainant.

Keywords: complaint, doctor, account, professions, identity, rationality

Introduction

As a professional group, doctors exercise considerable power in society. Whilst some academics have seen patients as unnecessary victims of power imbalances and domination by the medical profession (Ehrenreich and Ehrenreich, 1978), others have argued that this approach tends to indicate a concept of power as primarily abusive, which neglects to understand the structural necessities of power in medical practice (Maseide, 1991) and places undue emphasis on consumer passivity (see, for example, Abel-Smith, 1976; Cartwright, 1967). This article considers the subject of health service users’ complaints about medical care. The making of a complaint is an example of consumer activism which has largely been overlooked by medical sociologists and those interested in the interface between law and medicine (but see Nettleton and Harding, 1995; and Allsop, 1994). Despite this, complaints about medical care provide scholars with an excellent opportunity to explore a challenge to the life-world of the doctor.

An increasing amount of work is being undertaken on complaints about health services. Much of this has been orientated towards policy change or the setting of good practice standards (for a general review of the literature see Mulcahy et al., 1996). A number of studies have explored access to complaints procedures, organizational efficiency in the processing of
complaints, their use for quality assurance purposes and the development of criteria to judge what constitutes an ‘appropriate’ response to a complaint. Particular emphasis has been placed on the problems faced by those who want to complain and the extent to which they continue to remain dissatisfied after their complaint has been dealt with through formal procedures (Department of Health, 1994). In line with this, recent reforms to procedures for handling complaints about hospital staff and general practitioners reflect a policy shift towards more consumer-friendly systems and informal resolution of complaints (National Health Service Executive, 1996).

More academic studies have focused on how grievances emerge into complaints and how accounts of complaints and formal responses to them are constructed. These have moved away from an understanding of complaints and responses as competing realities to be adjudicated upon, towards an approach which accepts lay and professional accounts of events as equally valid discourses to be analysed and explained. An important part of this approach is, however, the understanding of how the deconstruction of competing claims can form an integral part of the construction of an alternative explanation.

The limited research on the perspective of doctors who are the subject of complaints has concentrated on four main themes that emerge from analysis of their written responses. First, the way doctors use vocabularies of scientific realism. Attention has been paid to the ways in which doctors place stress on the uncertainty of medical work and on how disease affects people differently. Secondly, researchers have commented on how doctors reattribute blame by emphasizing such things as the failure of lay medical work undertaken by relatives. In her study of complaints about general practitioners, for example, Allsop (1994) found that in almost 80 per cent of responses either the disease process or other people were blamed. Thirdly, the status of the complaint is undermined by casting doubt on the complainant’s account of what happened or by labelling them a bad patient. Fourthly, doctors are inclined to make appeals to professional standards and customary practice to give weight to their accounts (Allsop and Mulcahy, 1995; Allsop, 1994; Lloyd-Bostock and Mulcahy, 1994; Tedeschi and Reiss, 1981).

It has been suggested that when faced with a complaint about competence doctors do not know how to behave because they have no training in complaint-handling techniques (Bolt, 1989; Richman 1987). But the absence of a complaint-handling ‘role’ does not mean that there are not other identities that doctors can draw on to give structure to their responses. It has been suggested, for instance, that 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; Bosk, 1982; Dingwall, 1977). Moreover, Goffman has argued that for every activity there is a plurality of ‘frames’ which exist to organize experiences and that management of choice between them, as well as their rupture, inevitably occurs in the course of interaction (Richman, 1987).
In the research described in this paper I have attempted to broaden the scope of enquiry from an analysis of doctors' formal written defences to an exploration of what doctors do in reaction to complaints and how they reflect on their experience of them. In particular, I have been interested to discover how they came to depict and rationalize complaints and the impact that criticism had on their well-being and behaviour. I argue that responses to complaints are not isolated events but journeys of response with anchors in ever-changing notions of individual, professional and scientific identities. Complaints, as challenges to authority, are seen as causing a type of legitimation crisis (Habermas, 1976) which question the meaning through which the doctor interprets the world. This crisis and deconstruction of identity is followed by a reconstruction through recourse to the rhetoric of science.

About the study

The research described in this paper was carried out from 1992–4 and aimed to explore the reactions to complaints of all practising hospital consultants in the former Oxford Regional Health Authority, using a combination of qualitative and quantitative methods. A detailed questionnaire was sent to 848 consultants and replies were received from a sample of 443 (52 per cent), who were representative of regional proportions in terms of specialty, age and gender. In addition, in-depth interviews were conducted with thirty-five consultants from a range of specialties.

Both the questionnaires and the interviews specifically called for doctors to construct retrospective accounts of complaints. It was to be expected that they would present their views in ways which sought to explain untoward behaviour and to bridge the gap between actions and expectations. In doing so, doctors revealed a range of assumptions about the nature of medical care. Scott and Lyman (1968) distinguish such accounts from explanations, where untoward activity is not an issue, by the use of socially approved vocabularies to neutralize an act or its consequences. Viewed in this way accounts have the potential to become manifestations of the negotiation of identity and a way for doctors to legitimate their occupation (Moore, 1974).

The study focused on expressions of dissatisfaction about consultants or the clinical care they had provided which had been made in writing to them or to a manager. Technically, all complaints included in this definition - together with 'serious' verbal complaints - should have been handled under formal procedures prescribed by the Hospital Complaints (Procedure) Act 1985 and guidance issued in accordance with it. However, the incidence of complaint handling in the shadow of the formal procedures was also explored in the course of data collection.

Since the time of the study there has been a reform of formal complaint-handling systems so that there is now greater consistency in procedures across the primary and secondary health sectors and greater emphasis on informal handling of complaints by front-line staff. Because the research being described here concentrated on how consultants understand and give
meaning to complaints, the data are still relevant despite the reforms. Moreover, data from the study suggest a number of ways in which the reforms have sidestepped the issue of how organizational and professional rivalries between staff, which will undoubtedly continue to affect complaints handling, are to be addressed.

The incidence and subject-matter of complaints

The majority of consultants in the sample had experience of complaints. Of the 443 who returned the questionnaire, 246 (56 per cent) had received at least one formal complaint in their career (the complaints sample) – the average length of career being twenty-three years. Further details of complaints were only invited where a complaint had been received in the preceding twelve months but this additional data did suggest that the number of complaints being received by consultants is increasing and this is reflected in official statistics (Department of Health, 1993-4).

Consultants in the complaint sample (246) specified 767 allegations made against them and these fall into eight main categories. Table 1 shows the incidence of allegations as well as the number of consultants with experience of them. It is clear from these data that communication and attitude issues, rather than more technical aspects of clinical care or decision-making, form the most prominent cluster of allegations with more than half the consultants in the sample having experience of them. This suggests that it is a breakdown in the doctor–patient dialogue which most often acts as the catalyst to the voicing of a complaint and this view is supported by other studies of health service complaints (Allsop, 1994; Lloyd-Bostock and Mulcahy, 1994; Kadzombe and Coals, 1992; J. Scott, 1985; D. Scott, 1992).

<table>
<thead>
<tr>
<th>Category of allegation</th>
<th>No. of allegations</th>
<th>No. of consultants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication and attitude, e.g.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>incomplete explanation of care</td>
<td>209 (26%)</td>
<td>128 (52%)</td>
</tr>
<tr>
<td>Treatment problems (other than surgery), e.g.</td>
<td>141 (17%)</td>
<td>79 (32%)</td>
</tr>
<tr>
<td>improper choice of treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tests and diagnosis, e.g. failure to diagnose</td>
<td>129 (16%)</td>
<td>91 (37%)</td>
</tr>
<tr>
<td>Problems with surgery, e.g. improper performance</td>
<td>92 (11%)</td>
<td>53 (22%)</td>
</tr>
<tr>
<td>General care of patient, e.g. failure to monitor</td>
<td>77 (10%)</td>
<td>52 (22%)</td>
</tr>
<tr>
<td>Waiting times, e.g. urgency of treatment</td>
<td>72 (9%)</td>
<td>41 (17%)</td>
</tr>
<tr>
<td>Medication, e.g. wrong dosage</td>
<td>38 (5%)</td>
<td>29 (12%)</td>
</tr>
<tr>
<td>Other</td>
<td>9 (1%)</td>
<td>9 (4%)</td>
</tr>
<tr>
<td>Missing</td>
<td>47 (6%)</td>
<td>n.a.</td>
</tr>
<tr>
<td>Total</td>
<td>814 (101%)</td>
<td>n.a.</td>
</tr>
</tbody>
</table>
From fear to fraternity

The evolution of explanations of complaint

The study found that the receipt of complaints has a significant and lasting impact on doctors. Respondents often reacted to a complaint by explaining their own sense of grievance and the wider impact on their approach to other patients. This supports the assertion that grievances and disputes are not discrete events which can be managed through a grievance resolution process but have long and complex lives (Abel, 1982). The data also show that, although the emotional impact varies, a threat to identity can occur whether or not the allegation of error is considered to be justified and the sanctions which might follow it. In other words, it is not the threat of sanctions which may occur but rather the challenge to expertise which triggers a crisis. In the words of one clinical director:

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. They feel injured, because the complainant does not understand what they have done. When the complaint is justified they feel irritation. Finally, they get round to asking the most important question of all — is the complaint actually about the standards of clinical care?

A grounded approach to understanding consultants’ explanations of complaints was adopted and revealed three dominant themes: the threat to their emotional well-being; the threat to their group or professional identity; and the reconstruction of a challenged identity by reference to a scientific explanation of cause.

The threat to emotional well-being

Practically all of the consultants in the sample talked about the huge impact on them at an emotional level and how this struck at their identity. As one doctor said:

Complaints are very hurtful. One gets emotionally involved because they strike at one’s perception as a person and a doctor. That perception may be idealistic but it’s important to me.

Respondents mentioned forty-four different emotional responses, the ten most frequent of which were irritation, experienced by 52 per cent of the sample; worry (42 per cent); concern (38 per cent); surprise (38 per cent); annoyance (37 per cent); anger (33 per cent); distress (32 per cent); disappointment (31 per cent); anxiety (28 per cent); and vulnerability (28 per cent). Emotional responses varied according to the facts of the case, whether the complaint was considered justified, and over time. An initial feeling of fear or isolation was a common response. As one consultant explained:

I was scared. I had sleepless nights. I was devastated. Colleagues told me not to worry but my reputation was being questioned.

And, in another case:

Practising medicine is all about exercising judgement. We are given high
salaries to give opinions. That is why we are so opinionated. But we are vulnerable prima donnas. Each doctor is a sadist. They play God with patients and like God they have to stand alone by their decisions.

Another theme which emerged was a feeling of loss of control or powerlessness, of being under siege. What Scott and Lyman (1968) have called ‘sad tales’ (p. 52). In the words of one respondent:

The greatest sense is of futility – why bother to try when resources are inadequate and patients are complaining?

And:

The hospital complaints system does not reject complaints, it absorbs them. We are never defended. Our actions are explained, but they are not defended.

The study did not attempt to analyse data according to whether the complaint could be substantiated. The hospital complaints procedure does not allow for the formal adjudication of the majority of complaints and the exercise was irrelevant to the project’s concerns which were to explore the meanings attached to complaints. However, consultants were asked to categorize complaints according to whether they were considered justified, partly justified or wholly unjustified, as we anticipated that this might have an impact on the type of emotional response experienced. Overall, respondents considered that 85 (12 per cent) of the complaints made about them were justified; 244 (35 per cent) were partly justified; and 363 (53 per cent) were not at all justified (but see also Kaye and MacManus, 1990, on this point).

The impact of complaints on consultants was much greater and long-lasting where they felt that they were wholly or partly unjustified. One consultant explained:

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

Consultants in this ‘unjustified’ category were five times as likely to feel disappointment or anxiety; four times as likely to feel vulnerability, irritation, annoyance or anger; and three times as likely to be worried, concerned, distressed or surprised.

The threat to group or professional identity

The second major theme to emerge from the data was consultants’ reliance on group or professional identity. An important facet of professional identity is the sense of being part of a group of people with common interests. Group ideology is seen as performing a legitimating function by protecting the established order as well as being a shield from internal conflict or outside challenges, such as complaints. Sociologists have traditionally viewed medical professionals as being different from the laity by reason of their power to exclude by means of specifying terms of entry to the medical
register, and their power to regulate their own activity, for example disciplining of members. More recently emphasis has been placed on the importance of ownership of a unique knowledge base (for a general review of the literature see Fox, 1993).

The concept of a group may be overly simplistic since doctors practise within specialties, sub-specialties, thought collectives, segments and disciplines, all of which may have different ideologies and missions and be in conflict. The assumption of homogeneity of views and joint sense of identity may be misplaced but differences within the profession have not been widely discussed. Some scholars, such as Bucher and Strauss (1960–1), have preferred to describe professions as loose amalgamations of segments, only delicately held together, pursuing different objectives in different manners. Other empirical studies have suggested that there is little evidence to show that ideas are circulated and exchanged even between groups of medical specialists (Arksey, 1994) although thought-styles may none the less unite them (Fleck, 1936). The notion of group is also problematic when it comes to distinguishing group ideas and ideologies from those held by individuals within them (Linnea Scheid, 1994), and from those held by wider groups or environments.

Whatever the approach adopted, an essential part of defining group identity is being clear about who is outside the group, or the 'other'. Consultants' discussion of complaints identified two key outsiders – the complainant and managers who sought to co-ordinate and oversee replies to the complaint. Both complainants and managers were seen as incapable of possessing sufficient scientific knowledge or rationality to be able to construct a valid challenge to doctors' technical expertise.

Interviewees suggested that the whole notion of expert implies that valid challenges to specialist knowledge can only come from within the group. One consultant explained the approach thus:

Clinical complaints about clinicians must be dealt with by clinicians. What do managers know about treating patients?

And, in another case:

I think that the creation of separate tribes and cultures is a right that people have to remain apart. This lack of us all having to be co-operative doesn’t wash with me.

The data also show that such rhetoric was translated into activity designed to exclude and protect. Despite the fact that the Patient’s Charter called for all responses to complaints to come from senior management and an expectation in the governing guidance that ‘designated officers’ would at least be informed of the fact that a complaint had been made (Department of Health, 1991; Health Circular 37, 1988) many responses to complaints are made in the shadow of formal procedures – without the knowledge of managers.

To clarify this point it is necessary to understand that consultants came to hear about complaints through a variety of channels. The highest proportion
(40 per cent) were referred to doctors by managers to whom the complaint had been sent, but a further 25 per cent were addressed directly to the consultant responsible for the care being criticized. Most consultants who received complaints in this way had on at least one occasion responded to the complainant without involving a manager or notifying them that the complaint had even been made. Most commonly, this group had written back to the complainant, discussed the complaint with them the next time they saw them, or specifically arranged a meeting to discuss it.

Interviewees explained this behaviour in three different ways, not all of which reflect deliberate attempts to exclude managers from the handling of medical complaints. One group did not refer complaints to managers because they did not know of the existence of a formal complaints procedure or the obligation imposed on them by the Patient’s Charter. The second explained that if a complaint was addressed to them they felt it was only courteous to give a personal response. But the third group took the more radical stance suggested by the quotations above. They felt that it was not a manager’s place to respond to complaints about clinical activity.

Other types of distinctions were made between doctors and complainants which relied on recourse to the ‘other’. Complainants were typically described as irrational in contrast to the rational doctor. Moore (1974) describes a similar characterization of non-believing colleagues amongst progressive clergy. The most popular caricature of complainants was of the problem patient, the problem personality incapable of making valid criticism (see also Rosenthal et al., 1980; and Richman, 1987). This might be an example of condemning the condemners (Scott and Lyman, 1968). In this context the cause of the complaint was not seen as bad care but the personality of the complainant, and in this way blame was transferred back to them.

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.

Positive or empathetic comments about complainants were made in just six out of 141 commentaries on why people complained. Complainants were most often described in negative or dismissive terms as ‘moaners’, ‘nasty’, ‘abusers’ and ‘malcontents’. Interestingly, twenty-one consultants, only twelve of whom were specialists in psychiatric medicine, described complainants as exhibiting symptoms of psychiatric illness such as ‘personality disorders’, ‘paranoia’ and ‘neuroticism’.

Another way in which the doctors’ reliance on group identity became clear was through their use of support networks. The majority of consultants (92 per cent) talked to at least one other person about the complaint and only 9 per cent said that they would have liked someone else to talk to. Significantly, professional medical networks were used almost to the exclusion of all
others. Other doctors were most often approached for advice (19 per cent); support (17 per cent); information (10 per cent); and in order that feelings could be unburdened (10 per cent). Medical colleagues were even approached as often as family and friends.

Bucher and Strauss (1960–1) have identified brotherhood, or circles of ‘collegueship’, as one of the most important indicators of segmentation within a profession and the key to understanding the different types of cultural identity which exist. Within this context it is interesting to note that consultants were most likely to turn to senior medical colleagues within the same trust or unit for practical and emotional support of all kinds. This suggests that there is little concern about letting those with authority know about the complaint as long as they are doctors working in the same organization. Bucher and Strauss (1960–1) also suggest that segments within a profession may have more in common with neighbouring occupations than with other segments in their own. This was not reflected in the present study as far as managers were concerned. Senior non-medical management, or legal claims advisers, were rarely approached for any type of support or advice (8 per cent).

**The reconstruction of the challenged identity**

I suggested in my introduction that the threat to doctors and their various identities is followed by a reconstruction. The data suggest that the vehicle for this process is recourse to notions of scientific truth. A scientific account of complaints leads the doctor to argue that there are objective signs which explain the dissatisfaction experienced by the complainant whilst negating the threat posed to the doctor. In these situations the complainant’s feeling of being aggrieved is presented as a physical manifestation of disease in the same way as the cause of the complaint was attributed to psychological disorders in the examples given above. The presentation of scientific ‘facts’ of this kind make it difficult for the logic of their justification to be questioned, and indeed this is the purpose of the construction.

This approach allows the doctor to re-interpret criticism as a symptom of disease. 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 who does not know. In this way the doctor is getting at the ‘real’ problem (Dodier, 1994). The presentation of facts involves an analysis of the problem in terms which suggest that the doctor is the most appropriate person to resolve them and hence legitimates their professional role.

This argument reflects the traditional biomedical model of providing care. According to this the patient’s experience is only relevant in so far as it provides data about abnormality and 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 of their illness and bringing the voice of their life-world into medicine (Maseide, 1991). Significantly, if the cause of the dissatisfaction can be understood by reference to disease then the validity of the complaint as a challenge to the doctor's world is undermined.

The data in this study provide some very good examples of attempts to attribute a scientific or medical, rather than a fault-based, cause to complaints. This construction is especially interesting 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, in the accounts in this study both the diseased and the healthy became medicalized.

All the interviewed doctors were unanimous in their view that complaints were not representative of mistakes made and, at best, felt that they could only be used as a blunt measure against which to judge the standard of care. As one 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.

Research has indeed demonstrated that the relationship between dissatisfaction, complaint-making, poor care and adverse events is complex. Complaints are not necessarily indicative of bad care and not all grievances come about as a result of an adverse event. Adverse events occur which never become the basis for a complaint either because the patient or carer is unaware of them or because they have been explained by staff and not considered 'complaint-worthy'. It is known, for instance, from the Harvard study of medical accidents, that there were more adverse events occurring in the hospitals in the study than were ever reported through claims or complaints (Brennan et al., 1991). Conversely, claims were made where there had been no adverse event. Similarly, much dissatisfaction, whether related to an adverse event or not, will never mature into a complaint or legal claim. For a variety of reasons – such as gratitude, low expectations, fear of retribution and deference to health professionals – dissatisfaction remains unvoiced (Mulcahy and Tritter, 1994).

Consultants in the study argued that the specialty involved in the care, rather than fault, was the most likely indicator of a propensity to complain. Data on the incidence of complaints show that certain specialists were much more likely to have received complaints in the twelve months prior to the study than others and that this phenomenon is in need of explanation. The average number of complaints per consultant in specialties such as obstetrics and gynaecology (3.4), surgery (2.7) and general medicine (2.6) was much higher than psychiatry (1.3), radiology (0.9) and pathology (0.6). Such variations exist even when account is taken of the different levels of activity.

Interviewees drew attention to the fact that each specialty has its own characteristics, working practices, environment, equipment and connections with other services, and deals with distinctive clinical problems and needs which
explain a greater propensity to complain about certain types of care. The
likelihood of a particular illness or treatment prompting complaints was linked
to five particular factors: whether the diagnosis or treatment involved the
imparting of bad news; the length and intensity of the treatment episode; the
level of uncertainty involved in care; the serious consequences of mistakes; and
the emotional investment involved in particular types of treatment.
Respondents explained how a number of specialties could be described as
bad news specialties. In their use of this term they were describing
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 from the emotional aftermath of this situation. One
consultant, specializing in general medicine, remarked:

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
onto someone else. It's a case of shooting the messenger.

Other specialties also have bad-news elements. As one obstetrician remarked
about obstetrics and gynaecology:

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.

Conversely, they argued that good news specialties 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.

The length of the relationship – or ‘at-risk’ period – with the patient was also
highlighted as important. Paradoxically, doctors argued 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 a generally satisfactory service. A
good example of this was said to be nephrology where a relationship with a
patient could last twenty years. 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 specialties were thought to attract complaints because of the risks
and uncertainties involved and the difficulties of conveying these notions to
patients. The problem of uncertainty in medicine has been stressed by
medical sociologists. Fox (1959) claims that three types of uncertainty
disturb physicians: their own incomplete knowledge; the limitations in
medical knowledge; and an inability to distinguish between their own
ignorance and that of the science they practise. The problem of handling uncertainty in the disease process and how it affects individuals has been seen as a central aspect of learning to be a doctor. As Allsop argues: ‘the body is not a map which can be clearly read . . . medicine is an exploratory process’ (Allsop, 1994: 167).

Consultants placed particular emphasis on the unpredictability of the disease or treatment process. One consultant summed up the problem, thus:

The problem of what is ‘bad’ is difficult. Patients don’t know. Doctors do not always know. Even standardized treatments can be difficult to deal with.

Notions of risk discussed also included perceived risks. As 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.

In contrast, risks in other specialties 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. In cardiology you can liken treatment to wiring a house or putting in new plumbing.

Consultants also argued that in certain specialties 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.

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.

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 criticize 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.

Conclusion

It is clear from the data presented that complaints represent a severe challenge to medical order. They are known to be able to cause a deep and
lasting effect on the emotional well-being of those criticized and to affect future relationships with patients. In this sense they appear to lead initially to a disruption or legitimation crisis. Consultants talked about their sense of fear and hurt, concern about their reputation, distress at the lack of understanding of their actions and motives, and their vulnerability.

The crisis prompted by the challenge to authority most often leads to a recourse to the ideology and support of the other members of medical fraternities. Almost all consultants in the study had felt it necessary to talk to someone about their concerns and they relied, almost exclusively, on medical colleagues to support their needs. Those complained about strengthened group identity by recourse to notions of the ‘other’ which exist outside of the group— in this context complainants and managers. Managerial input to responses to complaints was often made impossible and complainants’ claims to rationality were questioned.

But the lasting impression is of a discourse employed by medics which was structured to privilege their position and leave the complainant as a passive patient. Doctors used a variety of the linguistic devices employed by actors subject to criticism to construct particular versions of reality. The accounts of complaints offered by doctors suggest that lay perceptions of unsatisfactory care are given little credence as valid criticism. In an era of consumerism, charters and pluralistic approaches to explanations of illness and standards of care, the discourse of patients’ rights and the validity of the stories they tell is lacking from explanation about what prompts a challenge to medical care. The rhetoric of scientific knowledge about illness was used to identify the signs and observable clues of complaints as an offshoot of disease. By seeing complaining as a predictable reaction to disease it becomes a universal phenomenon rather than something that is a personal problem. In claiming the expertise to identify these clues, the consultants in this study undermined the patient’s right to authenticity and the readers of the signs, having been challenged, emerged afresh as a credible occupational group.

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